Combined Statutory Advisory Committee (Public)

26 February 2021 09:30 AM - 12:00 PM

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WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

AGENDA

Combined Statutory Advisory Committee

Meeting date **Friday 26 February 2021**

Start time **9:30am**

Venue Board Room
Fourth Floor
Ward and Administration Building
Whanganui Hospital
100 Heads Road
Whanganui

Embargoed until Saturday 27 February 2021

Contact
Phone 06 348 3348
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Also available on website
www.wdhb.org.nz

Distribution

Board members *(Public & Public Excluded)*

Board members

- Ms A Main, Chair
- Mr C Anderson
- Mr G Adams
- Mr J Chandulal-Mackay
- Mr K Whelan
- Mrs P Baker-Hogan
- Mrs S Peke-Mason

External committee members *(Public & Public Excluded)*

- Mr Frank Bristol
- Ms Debra Smith
- Ms Christie Teki
- Ms Maraea Bellamy
- Ms Te Aroha McDonnell
- Ms Heather Gifford

Executive Management Team *(public section only)*

- Mr R Simpson, Chief Executive
- Ms L Adams, Director of Nursing/Chief Operating Officer
- Ms L Allsopp, Kaiuringi General Manager Patient Safety, Quality and Innovation
- Mrs A Kemp, Director Allied Health Scientific and Technical
- Mrs R Kui, Kaiuringi, General Manager, Māori Health and Equity
- Mr A McKinnon, Kaiuringi General Manager, Corporate
- Mr P Malan, Kaiuringi, General Manager, Strategy Commissioning and Population Health
- Ms N Mackintosh, Executive Officer, Board Secretary
- Ms D Holden, Executive Assistant, Strategy Commissioning and Population Health, Secretary

Agendas are available at www.wdhb.org.nz one week prior to the meeting

Interest Register

Name	Date	Interest
Annette Main *Chair CSAC*	21 August 2020	▪ Appointed to the Whanganui Community Foundation
Adams Graham	16 December 2016	▪ A member of the executive of Grey Power Wanganui Inc. ▪ A trustee of Akoranga Education Trust, which has associations with UCOL.
Anderson Charlie	16 December 2016 3 November 2017	An elected councillor on Whanganui District Council. A board member of Summerville Disability Support Services.
Baker-Hogan Philippa	10 March 2006 8 June 2007 24 April 2008 29 November 2013 7 November 2014 3 March 2017	An elected councillor on Whanganui District Council. A partner in Hogan Osteo Plus Partnership. Her husband is an osteopath who works with some of the hospital surgeons, on a non paid basis, on occasions hospital patients can attend the private practice, Hogan Osteo Plus, which she is a Partner at. Chair of the Future Champions Trust, supporting promising young athletes. A member of the Whanganui District Council District Licensing Committee. A trustee of Four Regions Trust.
Bellamy Maraea	 4 May 2018 1 February 2019	▪ Te Runanga O Ngai Te Ohuake (TRONTO) Iwi Delegate for Nga Iwi O Mokai Patea Services Trust. ▪ A trustee of Mokai Patea Waitangi Claims Trust ▪ Hauora a Iwi – iwi delegate for Nga O Mokai Patea Services Trust Director of Taihape Health Limited Trustee of Mokai patea Waitangi Claims Trust
Bristol Frank	8 June 2017	▪ A member of the WDHB Mental Health and Addiction (MH&A) Strategic Planning Group co-leading the adult workstream. ▪ Management role with the NGO Balance Aotearoa which holds Whanganui DHB contracts for Mental health & addiction peer support, advocacy and consumer consultancy service provision. ▪ The MH&A consumer advisor to the Whanganui DHB through Balance Aotearoa as holder of a consumer consultancy service provision contract. ▪ A member of Sponsors and Reference groups of National MH KPI project. ▪ A Member of Health Quality and Safety Commission's MH Quality Improvement Stakeholders Group. ▪ Various roles in Whanganui DHB MHA WD, Quality Improvement programmes and Strategic planning ▪ A member of Whanganui DHB CCDM Council ▪ A steering group partner via Balance Aotearoa with Ministry of Health on Disability Action Plan Action 9d).This is legal and improvement work associated with MH Act, Bill of Rights and UN Convention on Rights of disabled people. ▪ A member of the Balance Aotearoa DPO Collective doing work with the Disability Action Plan representing the mental health consumers. ▪ Life member of CCS Disability Action
Chandulal-Mackay Josh	10 December 2020 21 February 2020	An elected councillor on Whanganui District Council A member of Aged Concern Deputy Chair for Whanganui Youth Services Trust
Gifford Heather	20 November 2018	▪ Ngāti Hauiti representative on the Hauora a Iwi Board; ▪ A senior advisor and founding member of Whakauae Research for Māori Health and Development (currently engaged in research with WDHB); and ▪ A member of Te Tira Takimano partnership Board of Nga Pae o Te Maramatanga (Centre for Māori research excellence, Auckland University).

Name	Date	Interest
McDonnell Te Aroha	6 March 2020	Pouherenga – Chairperson – Te Orangqanui Trust : Delivery of contractual services with Whanganui DHB
Peke-Mason Soraya	21 February 2020	▪ Chair, Te Totarahoe o Paerangi – Ngāti Rangi (Ohakune-Raetihi) ▪ Director, Ruapehu Health Limited ▪ Trustee, Whanganui Community Foundation ▪ Iwi Rep, Rangitikei District Council Standing Committee ▪ Labour Candidate for Rangitikei District Council
Smith Debra		Nil
Teki Christie	12 March 2020	Employee, AccessAbility Whanganui
Whelan Ken	13 December 2019	Crown monitor for Waikato DHB Crown monitor for Counties DHB Board member RDNZ (NZ) Chair Eastern Bay of Plenty PHO Contractor General Electric Healthcare Australasia

Minutes
Public session

Meeting of the Combined Statutory Advisory Committee

held in the Board Room, Fourth Floor, Ward/Administration Building, Whanganui Hospital, 100 Heads Road, Whanganui
on Friday 13 November 2020, commencing at 9:30am

Combined Statutory Advisory Committee (CSAC) members in attendance
Ms Annette Main (Chair)
Mr Charlie Anderson
Ms Christie Teki
Ms Debra Smith
Mr Graham Adams
Ms Heather Gifford
Mr Josh Chandulal-Mackay
Ms Te Aroha McDonnell
Ms S Peke-Mason

In attendance for Whanganui District Health Board (WDHB)
Mr Russell Simpson, Chief Executive Officer, WDHB
Mr Paul Malan, General Manager, Strategy Commissioning & Population Health
Ms Louise Allsopp, General Manager, Patient Safety Quality & Innovation
Mr Steve Carey, Integrated Community Impact Strategist
Ms Deanne Holden, Secretariat

Member of the Public

1. Procedural

1.1 Karakia & Welcome

The Chair invited H Gifford to open the meeting with Karakia at 9:30am.

The Chair welcomed S Peke-Mason back to the table following her involvement in recent Government elections. Congratulations were provided for the support she received during the period.

All present were reminded by the Chair of the importance of continuing to use the COVID app as an important tool in our efforts to keep our District safe.

Apologies

It was resolved that apologies be accepted and sustained from the following:

Mr K Whelan, Mr F Bristol and M Bellamy

The Chair confirmed to S Peke-Mason that the requirement to step down from committee during the 2020 National Elections had been noted.

Moved: A Main **Seconded**: H Gifford

1.3 Conflict and register of interests update

1.3.1 Amendments to the register of interests

A copy of declarations from S Peke-Wilson as per the Whanganui Board Register of Interests be transferred to the Committee Interests Register.

1.3.2 Declaration of conflicts in relation to business at this meeting

Dr H Gifford declared a conflict in relation to item 3.4 "Using data to improve the health outcomes – the D3 Research"

1.4 Minutes of the previous committee meeting

The minutes of the public session of the meeting of the Combined Statutory Advisory Committee held on 21 August 2020 be accepted as a true and correct record:

Moved: A Main **Seconded**: Te Aroha McDonnell

1.5 Matters Arising

The following updates to the Matters Arising were noted:

05/15-01	"Oral Health update – u5" to be added as item on next agenda	Complete: Agenda item 3.4 13/11/2021
08/21-01	Health Protection Team to provide insight on the drinking water assessment component, what it captured and how it can inform discussion	Complete: Agenda item 3.1 13/11/2020
08/21-02	Faster Cancer Treatment results be provided to WDHB communications department	Complete

1.6 Committee Chair's Report

The Chair led a brief discussion regarding meeting format and agenda. The Chair advised a preference that presentations, in particular from community groups, be held at CSAC rather than full Board meetings. This provides an opportunity for robust discussion and debate prior to any submission of final papers to Board.

Meetings are scheduled, and agenda items, set in relation to external factors including reporting deadlines. If committee members have a request for an agenda item, these should be provided to either the Chair or Paul Malan directly.

2. Chief Executive update
R Simpson, Chief Executive Officer, Whanganui District Health Board

A verbal report was provided by R Simpson with key points summarised below:

Dr Ashley Bloomfield to be a guest speaker at the Porritt Lecture Series taking place on Thursday 19 September. Dr Bloomfield will speak at both the Porritt Lecture and again at a public event commencing 7:00pm at the War Memorial Hall. Risk assessments have been completed in relation to security, with Maori wardens supporting the evening event. COVID tracer app QR codes, sign in book and hand sanitiser will be available.

National Chief Executives and Chairs recently met Stephen McKernon, Lead Health & Disability Review Transition Team, alongside the Director General. Communication channels remain open with an expectation the review will progress at pace.

Hospital volumes remain high both at Whanganui at other DHB's throughout the country. This may be in part the result of external factors relating to COVID earlier this year.

Staff welfare remains paramount with a recognition that staff throughout the sector will benefit from a break over the holiday period. To this end, elective procedures will reduce over the Christmas period, however, acute and urgent services will remain available. Managers continue to support staff by encouraging them to stay at home if unwell and ensuring staff are aware of supports available to them such as EAP counselling.

The Change of Life Bill will come into effect on 7 November 2021. Discussions to identify and address issues arising for the DHB are ongoing with relevant parties including Hospice and the Health Network.

Dr Rob Beaglehole, former advisor to the Minister of Health, has accepted an invitation to work with the Whanganui DHB, Council, Safer Whanganui and other interested parties in relation to local alcohol policies and changes to the Sale and Supply of Alcohol Act.

3 Discussion Papers

3.1 Public Health Services overview and update

Paul Malan, GM Strategy Commissioning and Population Health

A paper titled "Public Health Services overview and update" was tabled by P Malan with a verbal summary of the key points provided and summarised below:

The paper provides insight into how the Public Health Service operates and how health protection is delivered in Whanganui. It was noted the paper also provides a response to action 08/21 in matters arising.

A need to initiate the ways in which, at a local level, we can make changes to ensure strategic goals of the He Hapori Ora strategy are met in the Public Health Services space.

It was noted, that within service specification, there is scope in terms of promotion, preventative interventions, and opportunities to re-orientate with a local perspective.

S Peke-Mason instigated a robust discussion on water testing. Horizons Regional Council test water across the catchment which includes Whanganui, Ruapehu and Rangitikei. Testing results are provided to the WDHB by water technicians in the Health Protection Team monitoring safe ranges. National water safety standards have recently been updated following issues in Havelock North. Information is available online for registered water supplies in relation to testing results with the team also involved with testing for bottled and tank water. Council and Public Health are integrated in the process. If water testing shows results outside the acceptable range the Medical Officer of Health can direct Council to action. Health Protection provides guidance alongside regulatory requirements.

It was noted that information on how individuals can test their own water supplies from Public Health would be useful including upkeep, cleaning of tanks for those using rainwater supply.

Confirmation was provided that the Health Protection team is resourced sufficiently to undertake their mahi.

In relation to the misuse of drug and alcohol, the Health Promotion Team work alongside colleagues from the Mental Health & Addictions Team to integrate service design and link to national programmes and/or drug agency learnings to ensure local response to local issues.

It was resolved that the committee:

a. **Receive** the paper titled Public Health services overview and update

b. **Note** the overall scope and linkages across Public Health Services

c. **Note** the current structure of the WDHB Public Health Service

d. **Note** Drinking Water details provided in the Appendix in response to action 08/21-01

Moved: A Main **Seconded:** S Peke-Mason

3.2 Annual Plan 2020-21 timeline
P Malan, GM Strategy Commissioning and Population Health

A paper titled "Annual Plan 2020-21 timeline" was tabled by P Malan with a verbal summary of the key points provided and summarised below:

Two important deliverables in the formation of the 2021/22 Annual Plan have already been completed. These are the endorsement of the He Hapori Ora Strategy by the Joint Boards, and the Annual Planning workshop held in October.

The Minister's Letter of Expectation, although not yet released, is not expected to have greatly altered priorities. However, it is likely the ongoing COVID pandemic and response, the health and disability system review and progression of responses to WAI2575 will influence planning priorities.

It was resolved that the committee:

a. Receive the paper titled Annual Plan timeline for 2021/22

b. Note the pre-cycle deliverables already completed

c. Note the key deliverables within the timeline

Moved: A Main **Seconded:** G Adams

3.3 Annual Planning Workshop Overview
P Malan, GM Strategy Commissioning and Population Health

A paper titled "Annual Plan Workshop Overview" was tabled by P Malan with a verbal summary of the key points provided and summarised below:

Traditionally a Board workshop is held in February. This year the workshop was bought forward to allow further engagement by Board and Committee in the planning process.

The programme involved three sessions. The first was led by the WDHB Chairs with the themes "The Health and Disability system review" and the second led by the Chair of Haoura ā Iwi on the theme "He Hapori Ora – Thriving Communities and equity".

The third and final session was in the form of roundtable discussion. Key points from above discussions were identified to support the development of strategic focus areas for the annual planning process in 2021/22.

Feedback was supportive of both timing and content of the workshop. It was noted that although the venue (racecourse conference centre) was suitable, it was at times difficult to hear speakers. A roving microphone may be useful at future events.

It was resolved that the committee:

a. **Receive** the paper titled "Overview of Annual Planning workshop held on 30 October 2020"

b. **Note** the high-level summary of the workshop sessions

c. **Note** further detail is available on request

Moved: A Main **Seconded:** C Anderson

3.4 Using data to improve the health outcomes – the D3 Research
Dr Heather Gifford, Senior Advisor Business and Research, Whakauae Research for Maori Health and Development

A paper titled "Using data to improve health outcomes – the D3 Research" was tabled by Dr H Gifford followed by a workshop style presentation. A summary of the key points are shown below:

Dr Gifford and L Cvitanovic of the Whakauae Research programme were introduced to those present. Dr Gifford declared a conflict of interest in relation to this paper.

It was noted the paper also provides a response to action 05/15-01 in matters arising.

The D3 research project has taken place over three years, funded by the Health Research Council of New Zealand. The study followed a Kaupapa Maori approach and explored how specific health data in relation to Maori is gathered and utilised at both DHB and Ministry levels.

Three case study sites were established, of which Whanganui was one. Each site had a researcher supporting the site and for Whanganui data relating to the oral health of children at age five and year eight was explored in detail.

All three study sites showed similar results with inequity remaining clear across the collation and use of data.

Small group discussion highlighted the following thoughts:
- Data alone does not shift equity
- A solid foundation of active participation is critical
- The HEAT tool may be under utilised
- From an equity perspective clinical expertise is not the same as understanding

It was agreed unconscious bias still exists across health and social systems. To effect change, all must accept responsibility to find opportunities for change. Discussions must continue and remain at the forefront for the next reporting round.

The Chair thanked Dr Gifford and L Cvitanovic for their mahi, time and insightful presentation.

It was resolved that the committee:

a. **Receive** the presentation titled "Using data to improve health outcomes – the D3 Research" (action 05/15-01)

b. **Note** the research brief attached as Appendix 1 to this item

Moved: A Main **Seconded:** J Chandulal-Mackay

3.5 Quarterly reporting

A paper titled "Quarterly Reporting" was tabled by P Malan with a verbal summary of the key points provided and summarised below:

Quarterly reporting to the MOH is a requirement of our Operational Policy Framework with the process linking closely with the targets and agreed activity in the Annual Plan.

CSAC is provided with quarterly reporting data for review and discussion. This is to provide surety to the Board on quality and appropriateness of reporting. Meeting dates are set to enable timely presentation to committee of reporting following submission to MOH.

Submission and confirmation of reporting to MOH follows a timeline with the initial report being provided to MOH on the 20th of the month following the end of the quarter. MOH then review, request clarifications which are subsequently provided and confirmed. The process to completion can take 6-8 weeks with data being collated from across the DHB and its partners.

Discussion followed regarding the benefits of committee receiving the full report some weeks after quarter end, versus committee receiving the unmoderated report which may change following feedback from MOH.

P Malan advised it was helpful to management to have the opportunity to receive commentary from committee. It was noted that although not finalised, initial unmoderated reporting is of a very high standard and may provide committee with an opportunity to identify learnings and/or concerns for the following quarter.

Decision was taken: that "committee receive unmoderated non financial reporting data with meetings for 2021 scheduled as close as possible to the end of each quarter. Final results, as agreed by MOH, will be provided to the full Board at the next available meeting following ratification".

It was resolved that the committee:

a. **Receive** the paper titled "Quarter Reporting" and the appendices attached

b. **Note** the issues associated with timing

c. **Agreed** that "committee receive unmoderated non financial reporting data with meetings for 2021 scheduled as close as possible to the end of each quarter. Final results, as agreed by MOH, will be provided to the full Board at the next available meeting following ratification".

Moved: A Main **Seconded:** H Gifford

4. Information papers

4.1 Planned Care update

A paper titled "Planned Care Update" was tabled by P Malan with the paper taken as read.

It was noted that COVID had impacted many areas of health including 'Elective services patient-flow indicators' (ESPIs). Whanganui DHB has historically been compliant with ESPI requirements, however it was noted that COVID had impacted recent results. Local tracking shows ESPI compliance will likely be achieved within the expected timeframe of 31 December 2020.

It was resolved that the committee:

a. **Receive** the paper titled "Planned Care update"

b. **Note** the three different plans that the DHB has been required to submit in respect of planned care initiatives

c. **Note** the improvement in Elective Services Patient-flow indicators (ESPIs)

d. **Note** the current increase in acute workload

Moved: A Main **Seconded:** G Adams

4.2 Family Funded Care

A paper titled "Funded Family Care" was tabled by P Malan with the paper taken as read.

There was some support for the consideration given to "Equity" as a subject heading with agreement to add "Equity Considerations" to the CSAC Paper Template.

It was resolved that the committee:

a. **Receive** the information paper titled "Funded Family Care"

b. **Note** Whanganui DHB has implemented the changes to Family Funded Family Care are effective from 1 July 2020

c. **Note** Ministry (DSS) change of direction from Funded Family Care to Individualised Funding

d. **Note** Impact for DHBs who use bulk funding for Home and Community Support Service providers

e. **Note** Opportunity for Whanganui DHB to consider "Individualised Funding" in the future

Moved: A Main **Seconded:** H Gifford

4.3 COVID-19 activity update

A paper titled "COVID19 update" was tabled by L Allsopp with the paper taken as read.

It was noted that the term "post COVID" is a misnomer as the pandemic continues internationally with complacency leading to potential significant challenges both for the country and region.

R Simpson confirmed that a contingency plan is in place whereby the hospital can be turned from "green" to "red" in 24 hours. This would include red "no go" areas being clearly marked with a 35 bed COVID area available.

All were encouraged to support and use the COVID tracer app, practice good hand hygiene and lead by example.

It was resolved that the committee:

a. **Receive** the paper titled 'COVID update'

b. **Note** Whanganui continues to have zero active cases

c. **Note** a contingency plan for the Holiday period has been submitted to MOH

Moved: A Main **Seconded:** S Peke-Mason

4.4 Q2 reporting workplan

A paper titled "Q2 reporting workplan" was tabled by P Malan with the paper taken as read.

It was confirmed data for Quarter 2 reporting will be provided to committee in line with the accountability measures framework. This framework captures performance against targets and activities set in the Annual Plan.

It was resolved that the committee:

a. **Receive** the paper titled "Quarter 2 reporting workplan"

b. **Note** the expected reporting schedule for Quarter 2

Moved: A Main **Seconded:** C Anderson

6. Date of next meeting

Friday 26 February 2021 from 9:30am in the Board Room, Whanganui District Health Board, 100 Heads Road, Whanganui

7. Reasons to exclude public

It was resolved that:

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

Agenda item	Reason	OIA reference
Combined Statutory Advisory Committee minutes of the meeting held on 21 August 2020 (Public – excluded session)	For the reasons set out in the committee's agenda of 15 May 2020	As per the committee's agenda of 15 May 2020

Persons permitted to remain during the public excluded session.

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

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

Moved: A Main **Seconded**: S Peke-Mason

The public session of the meeting ended at 11:50am

Adopted this day of 2020

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Chair

February 2020 **Public**

1.5 Matters arising from previous meetings

Meeting Date	Detail	Response	Status
~~10/18-01~~	~~Draft commissioning cycle framework be re-visited by committee for further discussion following inclusion of any response and comment from HAI Board~~	~~Confirmation paper presented to Hauora A Iwi who confirmed they are comfortable the framework aligns with the values under which we operate and had no suggested changes.~~	~~Complete~~
~~11/22-01~~	~~Faster Cancer Treatment: BSS11 to include ethnicity breakdown.~~	~~Item 4.2 for discussion on Agenda, 21 August 2020~~	~~Complete~~
~~03/13-01~~	~~Access to "Diligent Board Books" requested for all committee members~~	~~Roll out not implemented due to cost implications. WDHB Board members to receive papers via Diligent, nominated members via email (PDF).~~	~~Complete~~
~~05/15-01~~	~~"Oral Health update – u5" to be added as item on next agenda~~	~~Research referred to in minutes 15/5/20 due to be presented end August 2020. Item carried forward.~~	~~Complete~~
~~08/21-01~~	~~Health Protection Team to provide insight on the drinking water assessment component, what is captured and how it can inform discussion~~	~~Item on agenda for meeting dated 13/11/20~~	~~Complete~~
~~08/21-02~~	~~Faster Cancer Treatment Results to be provided to WDHB communications department for dissemination~~	~~Complete~~	~~Complete~~
11/13-01	Roving microphone to be used for further hui's held at Racecourse Conference Centre as speakers difficult to hear	Noted	n/a
11/13-02	"Equity Considerations" be added to CSAC Paper Template	Actions	Complete

February 2021 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Discussion Paper**
	Item No. 3.1
Author	Kilian O'Gorman, Business Support Strategy, Commissioning and Population Health
Endorsed by	Paul Malan, General Manager Strategy, Commissioning and Population Health
Subject	Quarter 2 Non-Financial Performance Framework

Recommendations

Management recommend that the Combined Statutory Advisory Committee:

Receive the paper titled Preliminary Quarter Two Ratings, Non-Financial performance framework measures

Note that while the Quarter 1 results are now final (section 1), Quarter 2 results are preliminary.

1. Purpose

This paper provides an update on Quarter 2 Non-Financial Performance Framework results and detailed Quarter 2 non-financial reports as provided to the Ministry of Health.

2. Index

1) Preliminary Ratings Quarter 2 Non-Financial performance framework measures

2) Detailed Quarter 2 non-financial reports to the MoH

1) Preliminary Ratings Quarter Two Non-Financial performance framework measures

February 2021 **Public**

Measure	Q-1	Q-2	Q-3	Q-4
Ratings confirmed?	✓	✗		
Key Achieved / Partial / Not achieved / Not req'd / Update due		15/02/21		
Child-wellbeing				
CW01: Children caries-free at five years of age				
CW02: Oral Health- Mean DMFT score at school Year 8				
CW03: Improving the number of children enrolled in and accessing the Community Oral Health Service.				
CW04: Utilisation of DHB-funded dental services by adolescents from School Year 9 up to and including age 17 years				
CW05: Immunisation coverage 8 month				
CW05: Immunisation coverage 5 year				
CW05: Immunisation coverage HPV				
CW05: Immunisation coverage influenza				
CW06: Improving breast- feeding rates				
CW07: Improving newborn enrolment in General Practice		No rating		
CW08: Increased Immunisation 2 years				
CW09 Better help for smokers to quit (Maternity)				
CW10: Raising healthy kids		No rating		
CW12: Youth mental health				
Mental wellbeing				
MH01: Improving the health status of people with severe mental illness through improved access				
MH02: Improving mental health services using wellness and transition (discharge) planning				
MH03: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds				
MH04: Mental Health and Addiction Service Development PRIMARY				
MH04: Mental Health and Addiction Service Development SUICIDE PREVENTION		No rating		
MH04: Mental Health and Addiction Service Development CRISIS RESPONSE				
MH04: Mental Health and Addiction Service Development OUTCOMES FOR CHILDREN				
MH04: Mental Health and Addiction Service Development EMPLOYMENT & PHYSICAL NEEDS				
MH05: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders				
MH06: Output delivery against plan				
MH07: Improving mental health services by improving inpatient post discharge follow-up rates				

Primary health care

February 2021 **Public**

PH01: Improving System Integration & SLMs				
PH02: Improving the quality of data collection in PHO and NHI registers				
PH03: Improving Maori enrolment in PHOs to meet the national average of 90%				
PH04 :Better help for smokers to quit (primary care)				
Improving wellbeing through prevention				
PV01: Improving breast screening coverage and equity for priority women.				
PV02: Improving cervical screening coverage and equity for priority women.				
Strong and equitable public health and disability system				
SS01: Faster cancer treatment (31 days)				
SS02: Delivery of Regional Service Plans		No rating		
SS03: Ensuring delivery of service coverage				
SS04: Implementing the Healthy Ageing Strategy				
SS05: Ambulatory sensitive hospitalisations (ASH adult)				
SS06: Better help for smokers to quit in public hospitals				
SS07: Planned Care Measures				
SS09: Improving the quality of identity data NHI				
SS09: Improving the quality of identity data NATIONAL COLLECTIONS				
SS09: Improving the quality of identity data PRIMHD				
SS10: Shorter stays in Emergency Departments				
SS11: Faster cancer treatment (62 days)				
SS12: Engagement and obligations as a Treaty partner				
SS13: FA1 Long Term Conditions				
SS13: FA2 Diabetes services				
SS13: FA3 Cardiovascular health	No rating			
SS13: FA4 Acute heart services				
SS13: FA5 Stroke services				
SS15: Improving waiting times for colonoscopies				
SS17: Delivery of Whānau Ora				

2) Detailed Quarter 2 non-financial reports as provided to MoH

February 2021 **Public**

Child wellbeing

CW05: Immunisation coverage 8 month

Indicator: Increased Immunisation 8 months
DHB: Whanganui
Reporting period: Quarter 2 2020-2021
Contact (role and name): Barbara Charuk Portfolio Manager
Target definition Percentage of eligible children fully immunised at eight months of age for total DHB population, Māori and Pacific; achievement requires that the target is met for the total population and the equity gap between Māori and non-Māori is no more than two percent. Note: Immunisation coverage of less than 90 percent for any one of the priority groups or an equity gap between Māori and non-Māori populations of five percent or more will be rated as Not Achieved regardless of any other results.

Summary of results: coverage at age 8 months						
Target: 95%	**Total**	**Māori**	**Pacific**	**Dep 9-10**	**Change: total**	**Change: Māori**
Q1 2019/20	**80.7%**	**73.3%**	**81.8%**	**85.8%**		
Q2 2019/20	**85.2%** **(203/173)**	**77.7%** **(94/73)**	**93.3%** **(15/14)**	**77.0%** **(74/57)**	**+4.5%**	**+4.4%**
Q3 2019/20						
Q4 2019/20						

February 2021 **Public**

Progress report

Not immunised on time

There were 10 children not immunised on time:

- Two have completed but after turning eight months
- One child requires follow up for both 3 and 5 months events and has moved GNA
- Four remain with Outreach needing their 5 months to complete
- Three have not had any immunisations and have not been able to be contacted

Decliners
This quarter saw 19 children have their immunisations declined, 15 of whom were Māori.

Māori continue to be over represented in the overdue/decliners of immunisation outreach service numbers. Working with Iwi/Maori health providers to find solutions. A representative from our Māori Health providers group will attend the steering group hui to replace previous member who left the organisation. Focus on increasing Māori immunisation forms part of a several prong approach: continued awareness within general practice by Immunisation coordination services, within WCTO providers, at pregnancy and parenting education sessions, when tamariki present at ED, paediatrics (ward, Gateway, child development) and at Whanganui Accident and Medical.

The later has formed part of our annual plan to increase imms rates. In addition, we are working to integrate comms across the DHB in preparation for Immunisation month and a longer lead in time.

Actions to address issues/barriers impacting on performance

Factors affecting coverage in the quarter and actions to address these factors:
Competing demands in a very busy sector of health continue to put pressure on these providers. The up-date to the immunisation schedule had to be socialised to general practices, supporting general practices to adapt to the new norm post COVID-19 lockdown and subsequent challenges of encouraging whanau that is was safe to bring in their tamariki for immunisations, we are also running an HPV catch up programme, and launching the Measles campaign as well, preparing for a COVID resurgence and for COVID vaccine roll out. These competing demands are all important and put pressure on a limited workforce in a small DHB.

New initiatives and successes

- The Maternal, child and youth service level alliance has been launched and the first meeting took place in December with excellent representation across sectors. This group will provide guidance and feedback into our 2021-2022 annual plan.
- The Director of Midwifery is leading a project group to improve integration between primary and secondary that includes the journey from conception to 6 weeks specifically so all tamariki have the best start in life. Increased childhood immunisation will be included as it will be by the imms steering group, as we are wanting to develop a longer term strategy across the whole continuum, from conception to age 4.

February 2021 **Public**

CW08: Increased Immunisation 2 years

Indicator: Increased Immunisation 2 years
DHB: Whanganui
Reporting period: Quarter 2 2020-2021
Contact (role and name): Barbara Charuk Portfolio Manager
Target definition Percentage of eligible children fully immunised at 2 year olds of age for total DHB population, Māori and Pacific; achievement requires that the target is met for the total population and the equity gap between Māori and non-Māori is no more than two percent. Note: Immunisation coverage of less than 90 percent for any one of the priority groups or an equity gap between Māori and non-Māori populations of five percent or more will be rated as Not Achieved regardless of any other results.

Summary of results: coverage at 2 years						
Target: 95%	**Total**	**Māori**	**Pacific**	**Dep 9-10**	**Change: total**	**Change: Māori**
Q1 2019/20	**90.1%**	**91.7%**	**100%**	**85.8%**		
Q2 2019/20	**88.4%** **(189/167)**	**84.1%** **(82/69)**	**100%** **(8/8)**	**87.8%** **(74/65)**	**-1.7%**	**-7.6%**
Q3 2019/20						
Q4 2019/20						

February 2021 **Public**

Progress report

Not immunised on time

There were five children not immunised on time:

- There were three children who remain with Outreach Immunisation Service who all need to complete their 15 months imms.
- Two have declined outreach service and have been returned to the care of their GP

Decliners

This quarter saw 17 decliners, 13 were Māori and 4 were European.

Māori continue to be over represented in the overdue/decliners of immunisation outreach service numbers. Working with Iwi/Maori health providers to find solutions. A representative from our Māori Health providers group will attend the steering group hui to replace previous member who left the organisation. Focus on increasing Māori immunisation forms part of a several prong approach: continued awareness within general practice by Immunisation coordination services, within WCTO providers, at pregnancy and parenting education sessions, when tamariki present at ED, paediatrics (ward, Gateway, child development) and at Whanganui Accident and Medical.

The latter has formed part of our annual plan to increase imms rates. In addition, we are working to integrate comms across the DHB in preparation for Immunisation month and a longer lead in time.

Actions to address issues/barriers impacting on performance

Factors affecting coverage in the quarter and actions to address these factors:
Competing demands in a very busy sector of health continue to put pressure on these providers. The up-date to the immunisation schedule had to be socialised to general practices, supporting general practices to adapt to the new norm post COVID-19 lockdown and subsequent challenges of encouraging whanau that is was safe to bring in their tamariki for immunisations, we are also running an HPV catch up programme, and launching the Measles campaign as well, preparing for a COVID resurgence and for COVID vaccine roll out. These competing demands are all important and put pressure on a limited workforce in a small DHB.

New initiatives and successes

- The Maternal, child and youth service level alliance has been launched and the first meeting took place in December with excellent representation across sectors. This group will provide guidance and feedback into our 2021-2022 annual plan.
- The Director of Midwifery is leading a project group to improve integration between primary and secondary that includes the journey from conception to 6 weeks specifically so all tamariki have the best start in life. Increased childhood immunisation will be included as it will be by the imms steering group, as we are wanting to develop a longer term strategy across the whole continuum, from conception to age 4.

February 2021 **Public**

CW05: Immunisation coverage 5 year

Indicator: Increased Immunisation 5 years
DHB: Whanganui
Reporting period: Quarter 2 2020-2021
Contact (role and name):
Target definition Percentage of eligible children fully immunised at 5 year of age for total DHB population, Māori and Pacific; achievement requires that the target is met for the total population and the equity gap between Māori and non-Māori is no more than two percent. Note: Immunisation coverage of less than 90 percent for any one of the priority groups or an equity gap between Māori and non-Māori populations of five percent or more will be rated as Not Achieved regardless of any other results.

Summary of results: coverage at 5 years						
Target: 95%	**Total**	**Māori**	**Pacific**	**Dep 9-10**	**Change: total**	**Change: Māori**
Q1 2019/20	**86.9%**	**83.3%**	**83.3%**	**69.7%**		
Q2 2019/20	**86.8%** **(228/198)**	**82.9%** **(105/87)**	**92.3%** **(13/12)**	**86%** **(93/80)**	**-0.1%**	**-0.4%**
Q3 2019/20						
Q4 2019/20						

February 2021 **Public**

Progress report

Not immunised on time

There were 14 children who failed to complete their immunisations before turning 5 years old:

- Seven completed their B4 School Check (five of these children did complete their 4 year old immunisation but after they turned 5 years)
- One had completed their 4 year in Australia but not yet given proof
- One had competed but data is not on NIR
- Five remain with Outreach team on follow up.
- Two have declined Outreach and been returned to the care of their GP.

Māori continue to be over represented in the overdue/decliners of immunisation outreach service numbers. Working with Iwi/Maori health providers to find solutions. A representative from our Māori Health providers group will attend the steering group hui to replace previous member who left the organisation. Focus on increasing Māori immunisation forms part of a several prong approach: continued awareness within general practice by Immunisation coordination services, within WCTO providers, at pregnancy and parenting education sessions, when tamariki present at ED, paediatrics (ward, Gateway, child development0 and at Whanganui Accident and Medical.

The latter has formed part of our annual plan to increase imms rates. In addition, we are working to integrate comms across the DHB in preparation for Immunisation month and a longer lead in time.

Actions to address issues/barriers impacting on performance

Factors affecting coverage in the quarter and actions to address these factors:
Competing demands in a very busy sector of health continue to put pressure on these providers. The up-date to the immunisation schedule had to be socialised to general practices, supporting general practices to adapt to the new norm post COVID-19 lockdown and subsequent challenges of encouraging whanau that is was safe to bring in their tamariki for immunisations, we are also running an HPV catch up programme, and launching the Measles campaign as well, preparing for a COVID resurgence and for COVID vaccine roll out. These competing demands are all important and put pressure on a limited workforce in a small DHB.

New initiatives and successes

- The Maternal, child and youth service level alliance has been launched and the first meeting took place in December with excellent representation across sectors. This group will provide guidance and feedback into our 2021-2022 annual plan.
- The Director of Midwifery is leading a project group to improve integration between primary and secondary that includes the journey from conception to 6 weeks specifically so all tamariki have the best start in life. Increased childhood immunisation will be included as it will be by the imms steering group, as we are wanting to develop a longer term strategy across the whole continuum, from conception to age 4.

February 2021 **Public**

CW07 Improving new born enrolment in General Practice

QUARTER 2 2020-21

Period: to December 2020

Measure 1
Number of newborns enrolled with a general practice by 6 weeks of age

% Enrolled by 6 weeks of age
72.7 %

17.7% above target of 55%.

Measure 2

% Enrolled by 3 months of age
86.7%

1.7% above target of 85%

CW09 Better help for smokers to quit (Maternity)

Data provided by the DHB employed midwives and forward to the Ministry on a quarterly basis

Whole of DHB

Number of events (a)	Number of Smokers	Brief advice given	Offered cessation support	Referred to cessation support	Smokers' gestation (weeks) (b)	% offered brief advice	% offered advice and support to quit	% accepted cessation support	Smoking prevalence (c)
7	2	2	2	0	12	100	100	0	29%

Maori

Number of events	Number of Smokers	Brief advice given	Offered cessation support	Referred to cessation support	Smokers' gestation (weeks)	% offered brief advice	% offered advice and support to quit	% accepted cessation support	Smoking prevalence
5	2	2	2	0	12	100	100	0	40%

(a) Number of events: number of pregnancies
(b) Smokers gestation: average for all events (pregnancies) included in the table
(c) Smoking prevalence is for the pregnancies that their data is included here

2019/20 *Better help for smokers to quit* quarterly reporting template - Maternity

DHB:	Whanganui
Reporting Quarter:	2
Name and contact details of person completing the report	Rosie McMenamin

Please answer ALL of the questions below		
What planning has occurred in your DHB to support the maternity health target, specifically for Māori and Pacific women? Please include information on how your DHB is supporting LMCs and/or DHB-employed midwives to increase the number of pregnant women being offered brief advice and support to quit smoking.	Discussions with the director of midwifery have led to the potential of funding being allocated towards this important kaupapa. Research and conversations are being undertaken into the best use of this resource. The rural midwives are having smokefree upskill and vape training in the next coming months.	*Target:* 90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.
What actions and/or projects is your DHB undertaking that reduces smoking in pregnancy, specifically for Māori and Pacific women?	We have trained the dieticians and diabetes nurses who run pregnancy clinics and have provided them with a pregnancy smokerlyzer to use at their clinics.	
Is there anything else you would like to tell the Ministry?	We are planning to complete a needs analysis which will identify gaps that need work and resource targeted at them.	

CW10 Raising Healthy Kids

Target: 95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions
Deliverables definition: Each DHB must provide narrative comments on activities being taken to improve performance and achieve the target agreed through their 2019/20 Annual Plan. The narrative is to include: • specific activities undertaken for Māori and Pacific[1] populations
Note: Please either complete this template or add your report (including the following points) to the website. All DHBs are expected to submit a report.

Name of DHB: Whanganui	**Quarter reported on: Quarter Two 2020-2021**	
Target performance to date and rate of progress based on data provided.		Action / deliverable timeframe
DHB Comments:	**Result for Quarter Two: 85**%. This corresponds with a national decrease in referral rates for this target. Within WDHB there was some data entry errors by administration staff (as detailed below) due to the B4Sc co-ordinator putting work tasks on hold due to competing interests over covid-19 pandemic.	

<table>
<tr><td colspan="2">Your activity to support the achievement of the target and initiatives to realise a reduction in childhood obesity, as reflected in your commitments in your Annual Plan, including:
• progress with getting referrals acknowledged from the B4 School Check (B4SC)
• progress with the development of referrals pathways from the B4SC for assessment and family based nutrition, activity and lifestyle interventions
• activity to ensure DHBs, PHOs and other primary care and community partners work together to ensure families experience seamless transition and support post referral from the B4SC
• activity to support primary care and community partners having the conversation with families.</td><td>Action / deliverable timeframe</td></tr>
<tr><td>DHB Comments:</td><td>Some inequity has been noted in terms of referral rates for Maori and Pasifika children over this quarter, however when reviewed by the coordinator, it was revealed that incorrect data entry in the B4School database by administration staff has contributed to this. Staff have been briefed about this and the coordinator is auditing each B4School check for any data entry errors (this process was put on hold during covid-19 due to coordinator workload). Whanganui's referral decline rate of 13% for ongoing lifestyle management remain below the national average of 33%. This shows that families are willing to accept ongoing support to manage their child's weight, however within WDHB specific programmes for preschoolers and their whanau, particularly Maori and Pasifika tamariki are lacking in both urban and rural areas. WDHB is consistently over-represented in the number of obese 4 year olds nationally, and having wrap-around support for whanau to make lifestyle changes in a culturally acceptable and relatable way would be invaluable.
• Initiated discussions with Sport Whanganui to look at programmes for childhood obesity
• The child health team is continuing to network and share information between agencies and communities such as Plunket, Pasifika church groups, Iwi organisations, NIR, and general practices to locate transient children that fall within our priority groups to help reduce inequalities within our WDHB population.</td><td>Quarter 3</td></tr>
<tr><td colspan="2">Barriers to achieving the target and mitigation strategies over the next quarter by DHB and the PHOs.</td><td>Action / deliverable timeframe</td></tr>
<tr><td>DHB Comments:</td><td>The WDHB via our provider, the WRHN continuously perform well and meet the targets as set out.</td><td></td></tr>
<tr><td colspan="2">Collective action and link to broader approach to reducing childhood obesity across government agencies, the private sector, communities, schools, families and whānau.</td><td>Action / deliverable timeframe</td></tr>
</table>

DHB Comments:	The WDHB and Sport Whanganui have had initial discussions about developing a broader approach to reducing childhood obesity. Together an action plan will be developed to include key stakeholders. The child health team is continuing to network and share information between agencies and communities such as Plunket, Pasifika church groups, Iwi organisations, NIR, and general practices to locate transient children that fall within our priority groups to help reduce inequalities within our WDHB population. Involving Health promotion to develop a plan that addresses childhood nutrition and exercise.	**Plan by Q3**
What the DHB is doing to build in evaluation, measure effectiveness, and monitor outcomes over time.		Action / deliverable timeframe
DHB Comments:	For discussion with WRHN	**Quarter 4**

CW12: Youth mental health initiatives

Template CW12 Quarter 2 2020-2021

Initiative 1: School Based Health Services (SBHS)

Success is measured through regular reporting on provision of SBHS in all decile one to four secondary schools, and decile 5 as rolled out from 2019/20; teen parent units and alternative education facilities, and implementation of Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with SBHS.

Initiative 5: Improve the responsiveness of primary care to youth

By delivering youth mental health initiatives, DHBs will support Government's priority to make New Zealand the best place in the world to be a child and young person, and our health system outcome that we have equity for Maori and other groups. This report focuses on two of the Youth Mental Health initiatives:

- School Based Health Services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities
- the work programmes and actions of the Youth Service Level Alliances Teams (SLATs) to improve the responsiveness of primary care to youth.

Please complete in all quarters: Success is measured by concrete and targeted actions implemented to address gaps in access, service provision, clinical and financial sustainability for primary and community services for the DHB's youth population. These actions will be developed, jointly agreed, implemented and monitored as per the work programme for youth Service Level Alliance Team (SLAT), or an equivalent group with a mandate to make recommendations to the Alliance Leadership Team.

Describe actions undertaken in this quarter to ensure the high performance of the youth SLAT (or equivalent) in your local alliancing arrangements.	The SLAT has been reviewed to now include maternal, child and youth health. The first service level alliance hui was held in December with a wide community representation. This group will contribute to the development and identification of local health priorities within this continuum. In addition, networks are being developed with the District council youth committee to determine how we can better reflect youth voices in health services.
	The family harm initiative (FLOW) led by the Police continues to provide leadership across sectors. The children's team governance group has merged into the FLOW strategic leadership group. A

	transition plan has been implemented and the WDHB will continue to be involved in future service development.
Describe actions the youth SLAT has undertaken in this quarter to improve the health of the DHB's youth population (for the 12-19 year age group at a minimum) by addressing identified gaps in responsiveness, access, service provision, clinical and financial sustainability for primary and community services for the young people, as per your SLAT(s) work programme.	Mash Trust are our new provider of youth respite services. Initial feedback from users has been very positive and there is an increase in utilisation despite having to travel to Palmerston North. The facility has the ability to provide respite for a lower age group, planned activities, youth worker trained staff and a higher level of clinical expertise on hand. The local YOSS was given additional funding to manage the increase in referrals for mild to moderate mental health issues. With this, they are able to better triage their referrals with one dedicated social worker in place, who also deals with urgent cases, can see higher level acuity youth and refer on as appropriate.

Name and describe progress on concrete and targeted actions in 2019/20 to address identified gaps in responsiveness, access, service provision, clinical and financial sustainability for primary and community services for the DHB's youth population, as per your SLATs work programme

Name actions, milestones, dates and measures

- *Describe progress on milestones. If off track, please provide mitigation strategies to get on track.*

Action	Measure	Milestone	Progress
Working with SLAT to develop up to date workplan	3 year plan developed	Quarter 4	On Track

Improved Mental wellbeing

MH02: Improving mental health services using wellness and transition (discharge) planning.

Mental wellbeing MH02: Improving mental health services using wellness and transition (discharge) planning

The Community Mental Health and Addiction Service (CMHAS) transition nurse continues to accept referrals from CMHAS key workers for service users who are transitioning from secondary to primary health services to be followed up their GP services.

There have been examples of transitions from primary to secondary services (GP to Transition nurse) so that early intervention has prevented acute inpatient admissions.

CMHAS works closely with Te Awhina, the inpatient ward who are referring service users for Key Worker allocation and follow up. Te Oranganui Mental Health Service (Iwi service) are working closely with CMHAS when reviewing tangata whaiora/service providers wellbeing plans to ensure consistent holistic follow up is maintained.

Te Awhina inpatient and Te Oranganui Mental Health Service representatives and NGO's representatives attend weekly multi-disciplinary meetings at CMHAS to support discharge planning follow up.

All clients will have at least one form of Wellness/Transition Plan on file

Audit of Wellness /Transition Plans in place - data to cover the 3 months to 30 September 20.

Wellness (Relapse) Plans - data information (for those current clients who have been in the service more than 12 months) was extracted from JCC036 Mental Health Ethnicity Report which shows start and close dates for all referrals.

All clients have Wellness (Relapse) plans in at least one of the following forms – Letters to GP, Risk Assessments, CP Notes

Transition (Discharge) Plans - data information (for those clients who have been discharged from the service in the 12 months) was extracted from WDHB MHS JCC036 Ethnicity Report which shows start and close dates for all referrals.

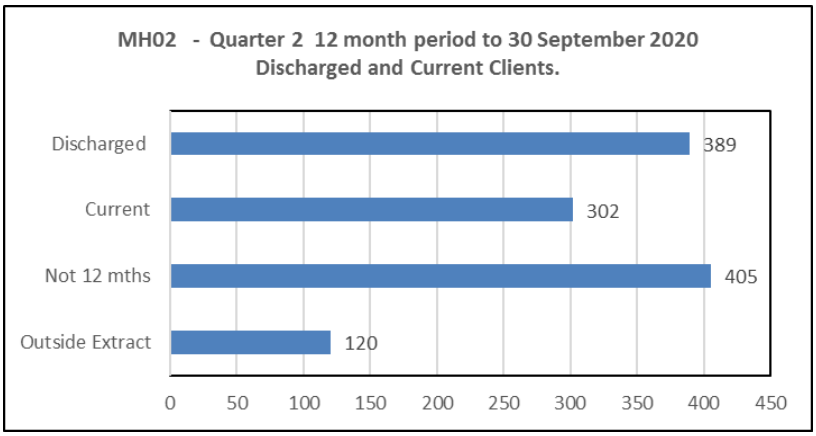
All clients have Transition (Discharge) plans in at least one of the following forms –Letters to GP, Risk Assessments, CP Notes

Inpatient data information extracted from WDHB MHS JCC032 Admission-Discharge

with LOS report . Plans found in Transition/Discharge CP Notes. Risk Assessments, Discharge Summaries.

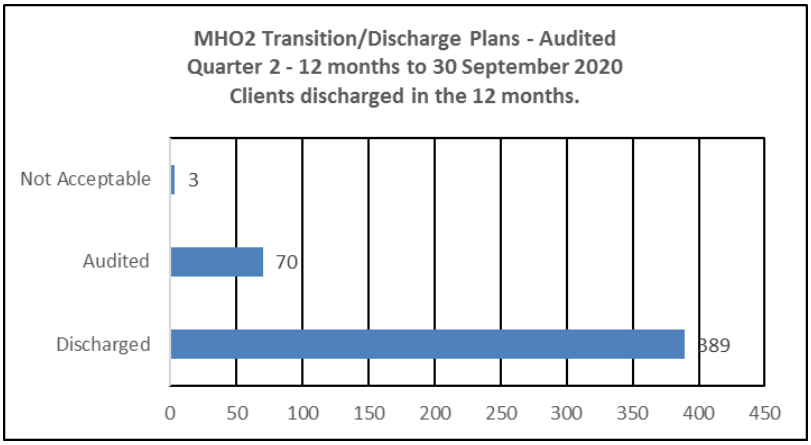
Note

- Still no one identified Transition Form with required information being utilised in CMH
- Inpatient now have identified transition / discharge form being completed by RMOs usually found in CP notes not a CP form.
- The Risk Assessment is the only common form used across all services and it would be expected that any client in the service for 3 months or more would have one in place. This form has been used for reporting wellness/ relapse and transition /discharge plans for many years while waiting for other more suitable forms to be developed and implemented.



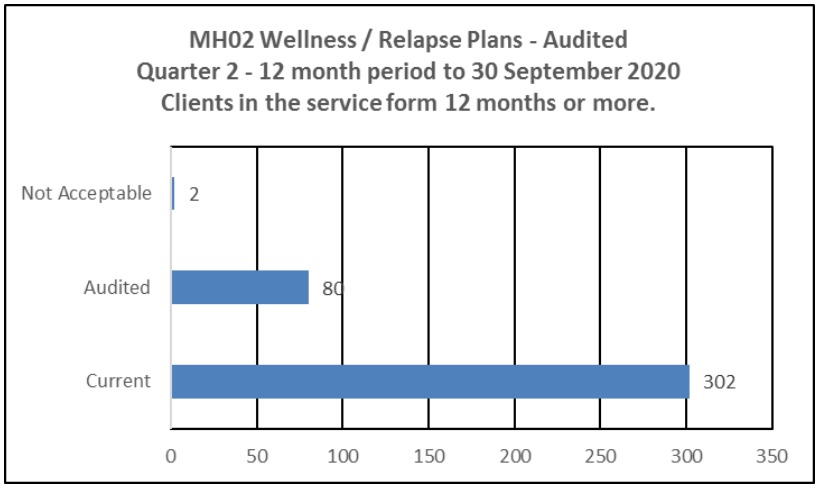
Reporting template

Percentage of MH&A clients discharged from MH&A community services with a transition (discharge) plan		
Numerator	Denominator	Percentage
Number of MH&A clients discharged from the community with a transition (discharge) plan (Data Source: DHB)	Number of MH&A clients discharged from the community MH&A services (DHB data source DHB)	Percentage of MH&A clients discharged from the community with a transition (discharge) plan
398	389	100%
Number of files audited with a transition (discharge) plan of acceptable standard (Data Source: DHB)	Number of files audited (Data Source: DHB)	Percentage with a transition plan of acceptable standard
67	70 – (25.4%)	96%



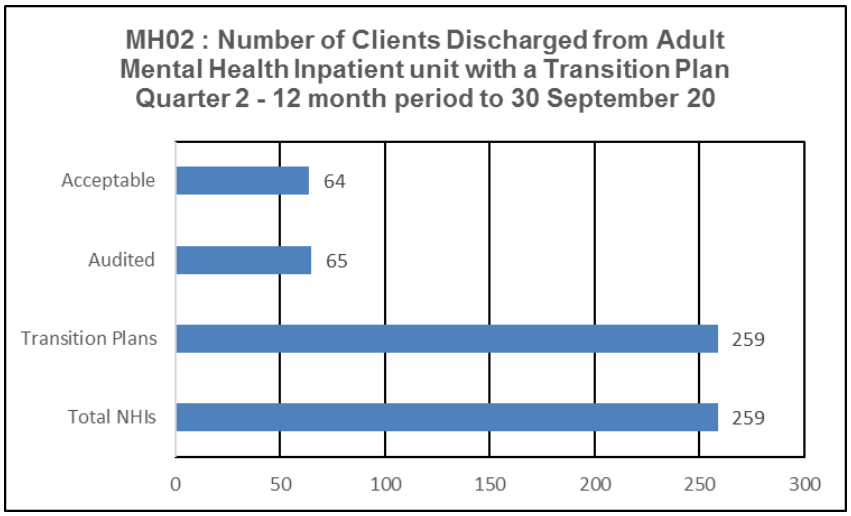
Reporting template

Percentage of MH&A clients open to services for greater than 12 months with a wellness plan		
Numerator	Denominator	Percentage
Number of MH&A clients open to services for greater than 12 months with a wellness plan (Data Source: DHB)	Number of MH&A clients open to services for greater than 12 months (DHB data source DHB)	Percentage of MH&A clients open to services for greater than 12 months with a wellness plan
302	302	100%
Number of files audited with a wellness plan of acceptable standard (Data Source: DHB)	Number of files audited (Data Source: DHB)	Percentage with a wellness plan of acceptable standard
78	80 – (27%)	97%



Reporting template

Percentage of MH&A clients discharged from MH&A adult inpatient services with a transition(discharge) plan		
Numerator	Denominator	Percentage
Number of clients discharged from MH&A inpatient services with a transition (discharge) plan (Data Source: DHB)	Number of clients discharged from MH&A inpatient services (DHB data source DHB)	Percentage of clients discharged from MH&A inpatient services with a transition (discharge) plan
259	259	100%
Number of files audited with a transition (discharge) plan of acceptable standard (Data Source: DHB)	Number of files audited (Data Source: DHB)	Percentage with a transition (discharge) plan of acceptable standard
64	65 – (25%)	98.50%


MH02 : Number of Clients Discharged from Adult Mental Health Inpatient unit with a Transition Plan Quarter 2 - 12 month period to 30 September 20
Acceptable
64
Audited
65
Transition Plans
259
Total NHIs
259
0
50
100
150
200
250
300

MH03 Wait times: Alcohol and other drug wait times by adult, older child/youth services

Mental Health Provider Arm

	<= 3 weeks		<8 weeks	
Age	**target (%)**	**Achieved (%)**	**Agreed target (%)**	**Achieved (%)**
0-19	80%	86%	95%	100%

Addictions (Provider Arm and NGO)

	<= 3 weeks		<8 weeks	
Age	**Target (%)**	**Achieved (%)**	**Target (%)**	**Achieved (%)**
0-19	80%	85%	95%	95%

MH04: Mental Health and Addiction Service Development PRIMARY

MH04 Focus Area 1

Quarterly Primary Mental Health and Addiction reporting template

You can record phone/audio visual contacts for treatment/support in the purple cells (not mandatory), marked as "PH/AV" below.

Note: NR = Not reported

DHB Whanganui Year 2020/21

1	**Client Information**	The number of people where the service is begun or delivered in the quarter				
	People seen by service	Q1	Q2	Q3	Q4	
	Clients aged 12-19					
1.1	Number of females seen	56	51			
1.2	Number of males seen	38	41			
1.3	Number of clients seen - unspecified gender	0	0			
1.4	Total number of youth seen	94	92	0	0	
1.5	People re-presenting to service					Number of people who re-present and are seen by PMHI service within 6 months of concluding a course of treatment (note that this period is recorded across reporting years)
1.6	Number of females seen (PH/AV)					
1.7	Number of males seen (PH/AV)					
1.8	Number of clients seen - unspecified gender (PH/AV)					
1.9	Total number of youth seen (PH/AV)	0	0	0	0	
1.10	People re-presenting to service (PH/AV)					
	Clients aged 20+					
1.11	Number of females seen	282	281			
1.12	Number of males seen	138	141			
1.13	Number of clients seen - unspecified gender	0	0			
1.14	Total number of adults seen	420	422	0	0	
1.15	People re-presenting to service					Number of people who re-present and are seen by PMHI service within 6 months of concluding a course of treatment (note that this period is recorded across reporting years)
1.16	Number of females seen (PH/AV)					
1.17	Number of males seen (PH/AV)					
1.18	Number of clients seen - unspecified gender (PH/AV)					
1.19	Total number of adults seen (PH/AV)	0	0	0	0	
1.20	People re-presenting to service (PH/AV)					
1.21	Number of referrals (12-19)	13	15			
1.22	Number of referrals (20+)	203	142			
	Ethnic group					
	Clients aged 12-19					
1.23	NZ European	44	44			

1.24	Maori	29	45
1.25	Pacific Island	0	1
1.26	Asian	2	0
1.27	Other	0	2
1.28	NZ European (PH/AV)		
1.29	Maori (PH/AV)		
1.30	Pacific Island (PH/AV)		
1.31	Asian (PH/AV)		
1.32	Other (PH/AV)		

Clients aged 20+

1.33	NZ European	282	249
1.34	Maori	134	140
1.35	Pacific Island	8	11
1.36	Asian	8	10
1.37	Other	6	10
1.38	NZ European (PH/AV)		
1.39	Maori (PH/AV)		
1.40	Pacific Island (PH/AV)		
1.41	Asian (PH/AV)		
1.42	Other (PH/AV)		

Kessler 10 Score

The average score at the start of care and at discharge for all clients discharged per quarter

		Q1 at start	Q1 At exit	Q2 at start	Q2 At exit	
1.43	K10 average score (12-19)			40		No result
1.44	K10 average score (20+)	31	36	41		No result

PHQ-9 Score

The average score at the start of care and at discharge for all clients discharged per quarter

		Q1 at start	Q1 At exit	Q2 at start	Q2 At exit
1.45	PHQ-9 average score (12-19)				
1.46	PHQ-9 average score (20+)				

Other outcome measure

The average score at the start of care and at discharge for all clients discharged per quarter

		Q1 at start	Q1 At exit	Q2 at start	Q2 At exit
1.47	Average score (12-19)				
1.48	Average score (20+)				
1.49	What is the outcome measure?				
1.50	Please explain this measure				

	Number of Referrals to	Q1	Q2	Q3	Q4
1.51	Psychologist/psychotherapist (youth 0-19)	0	1		
1.52	Specialist CAMHS or Adult Mental Health	6	7		

	Service (youth 12-19)		
1.53	Psychologist/psychotherapist (youth 0-19) (PH/AV)		
1.54	Specialist CAMHS or Adult Mental Health Service (youth 12-19) (PH/AV)		
1.55	Psychologist/psychotherapist (adults 20+)	22	10
1.56	Specialist CAMHS or Adult Mental Health Service (adults 20+)	47	42
1.57	Psychologist/psychotherapist (adults 20+) (PH/AV)		
1.58	Specialist CAMHS or Adult Mental Health Service (adults 20+) (PH/AV)		

2 Extended Consultations

The number of consults delivered to those clients during reporting quarter:

		Q1	Q2	Q3	Q4
2.1	Youth (aged 12-19) who received an extended consult	37	45		
2.2	Adults (aged 20+) who received an extended consult	288	270		
2.3	Total	325	314		
2.4	Youth (aged 12-19) who received an extended consult (PH/AV)				
2.5	Adults (aged 20+) who received an extended consult (PH/AV)				
2.6	Total (PH/AV)				
2.7	General Practitioner - number of consults	209	222		
2.8	Practice Nurse - number of consults	111	100		
2.9	Total	325	314		
2.10	General Practitioner - number of consults (PH/AV)				
2.11	Practice Nurse - number of consults (PH/AV)				
2.12	Total (PH/AV)				

3 Brief Intervention Counselling (BIC)

Definition: Includes assessments, reviews and problem solving support or counselling provided by primary mental health clinicians or counsellors. Usually 1-2 sessions and can be planned or unplanned.

The number of BIC commenced and delivered to those in reporting quarter

		Q1	Q2	Q3	Q4	
3.1	Number of BIC sessions for youth aged 12-19		18			All talking therapy data is now in the package of care section of this report
3.2	Youth (12-19) average wait time from referral to first seen		0			
3.3	Youth (12-19) DNA Rate (%)		0%			
3.4	Number of BIC sessions for youth aged 12-19 (PH/AV)					
3.5	Youth (12-19) average wait time from referral to first seen (PH/AV)					
3.6	Youth (12-19) DNA Rate (%) (PH/AV)					

3.7	Number of BIC sessions for Adults aged 20+	N/A	
3.8	Adult (20+) average wait time from referral to first seen	N/A	
3.9	Adult (20+) DNA Rate (%)	N/A	
3.10	Number of BIC sessions for Adults aged 20+ (PH/AV)		
3.11	Adult (20+) average wait time from referral to first seen (PH/AV)		
3.12	Adult (20+) DNA Rate (%) (PH/AV)		
3.13	Total Number of BIC sessions		
3.14	Total average wait time from referral to first seen		Date referral received by the provider (e.g. GP) to the time of the first appointment. (Time of the first appointment may be influenced by the client choice as well as availability).
3.15	Total number of clients that missed any session or DNA		
3.16	Total number of clients attending any session		
3.17	Total number enrolled (if different to total attending sessions)		
3.18	Total DNA Rate (%)		Client did not turn up to a scheduled/agreed appointment, and/or did not postpone or cancel the appointment within 24 hours
3.19	Total Number of BIC sessions (PH/AV)		
3.20	Total average wait time from referral to first seen (PH/AV)		
3.21	Total number of clients that missed any session or DNA (PH/AV)		
3.22	Total number of clients attending any session (PH/AV)		
3.23	Total number enrolled (if different to total attending sessions) (PH/AV)		
3.24	Total DNA Rate (%) (PH/AV)		

4 Alcohol Brief Intervention (ABI)

The number of BIC commenced and delivered in reporting quarter

		Q1	Q2	Q3	Q4
4.1	Number of ABI sessions for youth aged 12-19	12	13		
4.2	Number of ABI sessions for adults aged 20+	113	115		
4.3	Number of ABI sessions for youth aged 12-19 (PH/AV)				
4.4	Number of ABI sessions for adults aged 20+ (PH/AV)				

4.5 Please describe the specific services being offered for the ABI service (youth)

If alcohol and drug conversations are held as part of most brief intervention sessions and if part of the rangatahi history are checked on in packages of care sessions. Advice given includes education around AoD use, effects and supports available. Alcohol SBI in general practice

4.6 Please describe the specific services being offered for the ABI service (adults)

Alcohol SBI in general practice

5 Group Therapy

Definition: A psychotherapy/skill development or education programme designed for more than two individuals which lasts between one and three hours. Group therapy usually involves a series of sessions that are part of a programme with a particular focus.

Number of group therapy sessions begun and delivered during reporting quarter

		Q1	Q2	Q3	Q4	
5.1	Number of group therapy sessions for youth aged 12-19	22	12			No current group therapy is being provided
5.2	Youth (12-19) average number of group sessions per client	12	9			
5.3	Youth (12-19) average wait time from referral to first seen	NR	0			
5.4	Youth (12-19) DNA Rate (%)	NR	0%			
5.5	Number of group therapy sessions for youth aged 12-19 (PH/AV)					
5.6	Youth (12-19) average number of group sessions per client (PH/AV)					
5.7	Youth (12-19) average wait time from referral to first seen (PH/AV)					
5.8	Youth (12-19) DNA Rate (%) (PH/AV)					
5.9	Number of group therapy sessions for adults aged 20+	NR	N/A			
5.10	Adults (20+) average number of group sessions per client	NR	N/A			
5.11	Adults (20+) average wait time from referral to first seen	NR	N/A			
5.12	Adults (20+) DNA Rate (%)	NR	N/A			
5.13	Number of group therapy sessions for adults aged 20+ (PH/AV)					
5.14	Adults (20+) average number of group sessions per client (PH/AV)					
5.15	Adults (20+) average wait time from referral to first seen (PH/AV)					
5.16	Adults (20+) DNA Rate (%) (PH/AV)					
5.17	Total number of group therapy sessions	NR				
5.18	Total number of clients that missed any session or DNA	NR				
5.19	Total number of clients attending any session	NR				
5.20	Total number enrolled (if different to total attending sessions)	NR				
5.21	Total average number of group sessions per client	NR				
5.22	Total average wait time from referral to first seen	NR				Date referral received by the provider (e.g. GP) to the time of the first appointment. (Time of the first appointment may be influenced by the client choice as well as availability).
5.23	Total DNA Rate (%)	NR				Client did not turn up to a scheduled/agreed appointment, and/or did not postpone or cancel the appointment within 24 hours
5.24	Total number of group therapy sessions (PH/AV)					
5.25	Total number of clients that missed any session or DNA (PH/AV)					
5.26	Total number of clients attending any session (PH/AV)					
5.27	Total number enrolled (if different to total attending sessions) (PH/AV)					
5.28	Total average number of group sessions per					

client (PH/AV)

5.29 Total average wait time from referral to first seen (PH/AV)

5.30 Total DNA Rate (%) (PH/AV)

6 Packages of Care (POC)

Definition: Involves development of a care plan (i.e. an assessment is done to identify needs and a plan is developed, with the client/patient, that includes a timeframe for review and completion of the plan). Plan involves a series of interventions such as CBT, medication reviews, counselling and other psychosocial interventions (those that are not captured 2-6 above).

Number of POC begun and delivered in period

		Q1	Q2	Q3	Q4	
6.1	Number of POC for youth aged 12-19	30	34			
6.2	Youth (12-19) average number of sessions per POC	6	13			
6.3	Youth (12-19) average wait time from referral to first seen	27	30			
6.4	Youth (12-19) DNA Rate (%)	35%	20%			
6.5	Number of POC for youth aged 12-19 (PH/AV)					
6.6	Youth (12-19) average number of sessions per POC (PH/AV)					
6.7	Youth (12-19) average wait time from referral to first seen (PH/AV)					
6.8	Youth (12-19) DNA Rate (%) (PH/AV)					
6.9	Number of POC for adults aged 20+	239	220			
6.10	Adults (20+) average number of sessions per POC	3	4			
6.11	Adults (20+) average wait time from referral to first seen	25	24			
6.12	Adults (20+) DNA Rate (%)	12%	12%			
6.13	Number of POC for adults aged 20+ (PH/AV)					
6.14	Adults (20+) average number of sessions per POC (PH/AV)					
6.15	Adults (20+) average wait time from referral to first seen (PH/AV)					
6.16	Adults (20+) DNA Rate (%) (PH/AV)					
6.17	Total number of POC	269				
6.18	Total number of clients that missed any session or DNA					
6.19	Total number of clients attending any sessions	19				
6.20	Total number enrolled (if different to total attending sessions)					
6.21	Total average number of sessions per POC	3				
6.22	Total average wait time from referral to first seen					Date referral received by the provider (e.g. GP) to the time of the first appointment. (Time of the first appointment may be influenced by the client choice as well as availability).
6.23	Total DNA Rate (%)	11%	12%			Client did not turn up to a scheduled/agreed appointment, and/or did not postpone or cancel the appointment within 24 hours
6.24	Total number of POC (PH/AV)					
6.25	Total number of clients that missed any session or DNA (PH/AV)					
6.26	Total number of clients attending any sessions					

(PH/AV)

6.27 Total number enrolled (if different to total attending sessions) (PH/AV)

6.28 Total average number of sessions per POC (PH/AV)

6.29 Total average wait time from referral to first seen (PH/AV)

6.30 Total DNA Rate (%) (PH/AV)

7 Youth PMH Narrative Report

7.1 Overall Assessment of services delivered (including actions taken to enable early identification of mental health and/or addiction issues, better access to timely and appropriate treatment and follow up and equitable access for Maori, Pacific and low decile youth populations).

7.2 Any major achievements/successes

There was a death of a popular young man in a car accident just before Labour weekend. Pakohe (alternative education service) rang our kaimahi to ask what to do to support students . On Labour Day 2 of our kaimahi supported the Pakohe staff with 18 young people to express their grief and support each other. The kaimahi were known to the students so were comfortable to have them there.

The session the team did for the joint workshop was designed for rangatahi on their feelings around Covid-19 but no rangatahi came. However the teachers and other adults did the session and were thrilled because they got to express thier thoughts and feelings which some had not had the opportunity to do.

7.3 Major issues that have affected the achievement of contracted services.

The very supportive male Maori worker has gone to work in Rangatahi Innovations took 2 of the caseload and had 3 on the cohort before this while still with us. 4 out of the 5 finished that programme which gave them not only certificates like first aid, height and forklift work but a better sense of who they are. The new primary health clinician has proved to be right for the role with an assertive way of working in the community. She goes to them and does not wait for people to come to us.

7.4 Whether the service has been externally evaluated/reviewed/audited and the status of recommendations made.

No external audits have been completed in this quarter.

8 Adult PMH Narrative Report

8.1 Overall Assessment of services delivered.

Overall adult PMH services appear adequate. Ethnicity of 20+ year olds seen (34% Māori) indicates service supporting equitable access for enrolled 20+ year old population (22% Māori). IPMHA practices also improve timely access to early brief intervention through HIPs and HCs (these contacts are not reported here).

8.2 Any major achievements/successes

8.3 Major issues that have affected the achievement of contracted services.

Staff resignations at Family Works have lead to reduced capacity and, at times, increased wait times for this provider.

8.4 Whether the service has been externally evaluated/reviewed/audited and the status of recommendations made.

N/A

MH04: Mental Health and Addiction Service Development

SUICIDE PREVENTION

Focus Area 2 District Suicide Prevention and Postvention

All DHBs are expected to provide quarterly progress against their DHB Suicide Prevention Plan, along with any highlights or issues. Please also provide specific updates in the areas of: suicide / mental health literacy training or education, community-led development, and mental health and addiction service collaboration.

The following templates are offered as suggested formats for reporting on these focus areas:

1. Training / education evaluation template

An example of a training template which may be provided as part of the quarterly reporting to the Ministry of Health

WDHB response:

Training description	Initiated by DHB Y/N	Provider	Number of attendees	Intended audience	Outcome/impact
Suicide Screening and introduction of screening tools	yes	WDHB			All community nurse specialist have now been trained

Note that the training programme was disrupted by COVID related issues

Planning for 2021 is underway that includes rolling out training to community partners and their staff

2. Community initiatives evaluation template

WDHB Response:

Event description	Initiated by DHB Y/N	Supported by DHB Y/N	Number of attendees	Outcome /impact	Approach to safety
Postvention Support Group (3 meetings)	No	yes	5 attendees x 3 meetings	Peer support for whanau bereaved by suicide	Facilitated by experienced NGO who support whanau The NGO is working with Skylight to arrange facilitator training for their Waves Programme Intent is for training to be delivered twice yearly

3. Mental health & addiction service collaboration reporting template

Update on the design of the Whanganui District / Regional Suicide Prevention Strategy, reporting period (October - December)

AREA OF FOCUS: SUICIDE PREVENTION

INITIATIVE: Growing Collective Wellbeing: A whole of community - whole of systems approach to the prevention of suicide

STRATEGIC INTENT AND POTENTIAL IMPACT:
- To reduce suicide within the Whanganui, Rangitikei Ruapehu rohe
- To increase community wellbeing
- To amplify and accelerate systems change through stakeholders and community working together

CURRENT STATUS/UPDATE: The strategic approach, Growing Collective Wellbeing has been developed and signed off by the Sponsor (CEO, Whanganui District Health Board). The Growing Collective Wellbeing Insights Report has been produced, with ten key themes for future decision-makers and community leaders to consider. The final edits to the Regional Strategic Approach are in progress, then will be sent on to the designers for production, ready for socialisation and distribution by mid-February.

The Sponsor has agreed for Healthy Families WRR to be the backbone of the Regional Strategic Approach, which ensures we maintain the momentum gained during the development of the regional response to suicide prevention.

NEXT STEPS:
Healthy Families WRR will work with its Advisory Group and sponsor to coordinate the next phase of this approach, which is to convene all partners and collaborators and socialise them with Growing Collective Wellbeing - Regional Strategic Approach. In addition we aim to utilise this process of engagement for connecting the various parts of the strategic approach with each other, celebrate and acknowledge their courage and willingness to contribute, participate, and leverage their existing strategies / membership in the first phase activations.
Healthy Families WRR and relevant partners have contributed to the Strategic Approach with the following initiatives:

1. Child Health & Wellbeing - reduce the impacts of toxic stress for whānau and children (0 - 5 years)
2. Neighbourhood and Community Regeneration - creating greater social inclusion, connectivity and responsiveness to healthy well communities
3. Prevention of Alcohol-related Harm
4. Matauranga Māori prevention systems

In the first quarter of 2021 Healthy Families WRR will work with our Growing Collective Wellbeing Advisory Group and partners to:
- Finalise the operating model and complete year one planning
- Establish / implement backbone start-up systems and processes within Healthy Families WRR
- Engage and enrol leaders to support and activate the approach

Develop the early stage communications and community engagement to ensure communities have the opportunity to connect with the way forward
- Work with the Whanganui District Health Board to complete a funding map of existing contracts and investment in suicide prevention
- Facilitate an investment plan and investment decisions session with the Whanganui District Health Board to determine how they will direct the existing investment towards the new approach
- Produce and release the stories of Tāne Māori to influence the need to change the narrative from stoic hard men to vulnerability is strength and courage

KEY LEARNINGS – WHAT WORKED AND WHAT DIDN'T, AND WHY?

- High Trust was achieved through brokering and sustaining strong relationships with Iwi leaders, communities, services and national influencers whilst developing the strategic framework. This was important to ensure open and honest conversations could be had, and the story sharing was a safe and respectful space for whānau and professionals to participate in.

- The process of listening to whānau, communities and practitioners and consistently going back to close feedback loops, work through any concerns or issues, informing the community of the processes and methods we were using along the journey - created momentum and a sense of confidence in the approach.

- The approach has been endorsed by well respected experts, Iwi Leader, Gerrard Albert, National Hauora Coalition, Dr Rawiri Jensen, and Health Physiologist Barry Taylor from Taylor Made. Barry is quoted as saying "**What I like about this - it's about building a movement of people, not just key stakeholders sitting around a table with evidence and writing the plan. It truly has a bottom up approach. People at leadership levels have believed in the Healthy Families NZ approach, because it's not caught up in outputs and performance indicators, but has been facilitating dreaming and thinking with and for the people of the region. It's reframed to be wellbeing focussed - that's something that everyone can see themselves in. I hope that all DHBs take this approach and use this**."

- Through this approach partners are coming on board the kaupapa without hesitation or doubt wanting to be part of the movement of making innovative and positive change for the improved well being of their communities. ***"The Healthy Families WRR approach has been significantly different to a clinical approach that's previously been undertaken. This has been about the communities we live in and the causes of people taking their lives."*** said Frank Bristol Poutū Whakahaere - General Manager, Balance Aotearoa

- Healthy Families WRR convened a group of Tāne Māori to explore what preventative action should be designed to encourage increased wellbeing and reduce the impacts of mental distress, particularly for Māori males. The group morphed to a movement within weeks of convening because the Tāne experienced great benefits in sharing and telling their stories, reflecting on each other's experiences, and the safe space that enabled them to download the top-of-mind issues and thoughts they were having. The group grew every time we met. This has continued on with learnings taken from each other and implemented into their own personal spaces. One of the men stated, ***"I have never sat in a space like this before, but it felt safe to just sit and be vulnerable."*** He also said, ***"I believe this was possible through the two women (Healthy Families WRR) that were there and held space for us."*** He then went on to say, ***"I too have implemented into my home with my children some learnings that were shared about the 5 love languages. My relationship with my children instantly improved."***

- During the first COVID-19 lockdown Healthy Families WRR supported team members to sit on various response groups, one of which was the Taihape Civil Defence response - a collaboration of volunteers, services, iwi, and local government. Healthy Families WRR access to information and real time intelligence made possible because our System Innovator, Meretini, was a key member of the response team. The Taihape Neighbourhood Support Group played a lead role in the response, coordinating the various teams to ensure communities were kept informed and safe. The approach they took within their community was successful because of the strong informal networks that exist across the Taihape community. Healthy Families WRR has then been able to re-engage the Civil Defence reponse team to explore if their successful COVID-19 response could be replicated as a suicide prevention solution. In particular, can this well-coordinated mobilisation of services and communities improve the wellbeing and connectivity of their communities. Healthy Families WRR has convened community champions in partnership with the Taihape Neighbourhood Watch and facilitated an insight gathering process and design session to identify how their design challenge can work. Having developed a set of principles the group were able to choose what they thought would be appropriate and applicable for them to guide their way forward. During our reflections post-workshops, we identified the challenge some community champions face when working in complexity - the default behaviours often pushing back against positive changes and new ways of thinking and activating. We can help our champions to lean into the space more easily by encouraging progress, showing quick turn around of progressive wins, and demonstrating the shared value.

- Some health leaders and practitioners have struggled to align with the new approach and move away from the clinical model. The traditional mindsets of 'do-to' and 'intervention-only' have dominated their decision-making and contribution. Healthy Families WRR ensured therefore, that the strategic framework and approach was peer reviewed and guided throughout the journey, thus validating the whole-of-community-whole-of-systems approach and providing expertise throughout the development of the approach.

MH04: Mental Health and Addiction Service Development CRISIS RESPONSE

Mental wellbeing MH04: Mental Health and Addiction Service Development CRISIS RESPONSE

CMHAS crisis team called Mental Health Assessment Home Treatment (MHAHT) are undergoing a change process that has involved their unions to relinquish night duty and provide an on call duty service. Home Care Medical (HCM) are a telephone crisis triage service that went live on the 9th December 2020 - The 0800 number for Mental Health Assessment Home Treatment (MHAHT) team switches over from 1630 to 0700 hrs in the morning.

The change process involves working on projects that prioritises improving response times to the community and emergency services. A swing shift is part of the change process that affords flexibility in meeting the demands of keeping people in their homes via home treatment support and crisis respite care as well as responding to urgent referrals from emergency services.

Crisis respite beds have been underutilised despite the necessity in keeping them available strategies are underway to aim at over 80% occupancy rates. Currently occupancy is running between 25% and 45% utilisation.

MH04: Mental Health and Addiction Service Development OUTCOMES FOR CHILDREN

Mental Health and Wellbeing Focus Area 4 Supporting Parents Healthy Children (COPMIA) MOH Quarterly Report 01/10/2020-31/12/2021

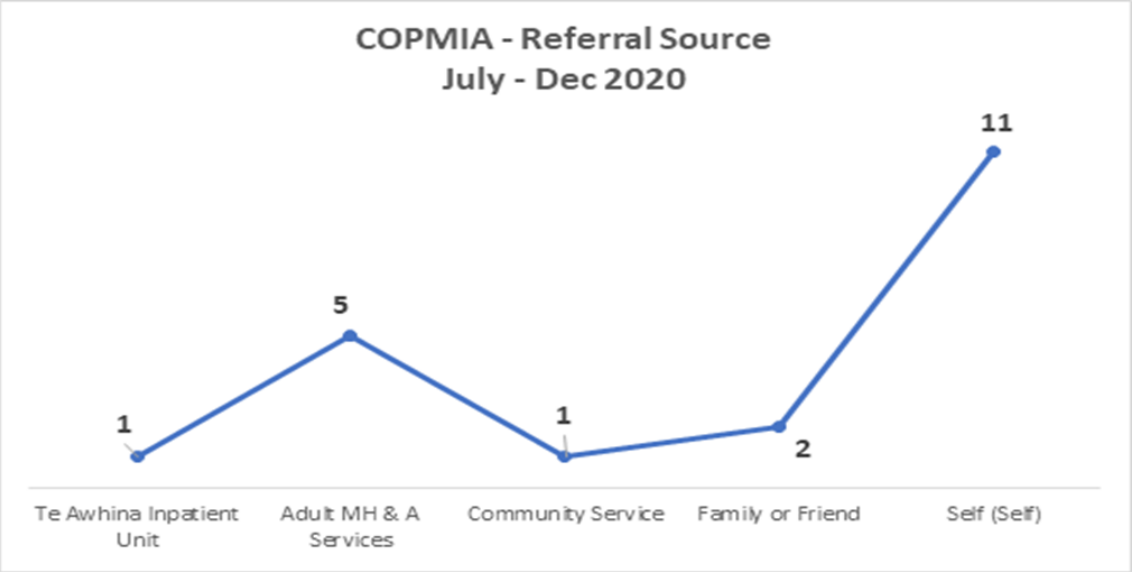
In this quarter the National Supporting Parents Healthy Children (SPHC COPMIA) Project team decided to encourage the training program 'Let's Talk About Children' (MOH SPHC Guidelines, 2015, p 51-52, 54). This is one of the programs that has been offered in the Whanganui DHB region since 2016 however is just being picked up nationally. Other regions are now interested in offering and implementing this program and so two telephone consultations (with Northland and Lakes District) have been completed, and a presentation to a Lakes District conference (via zoom).

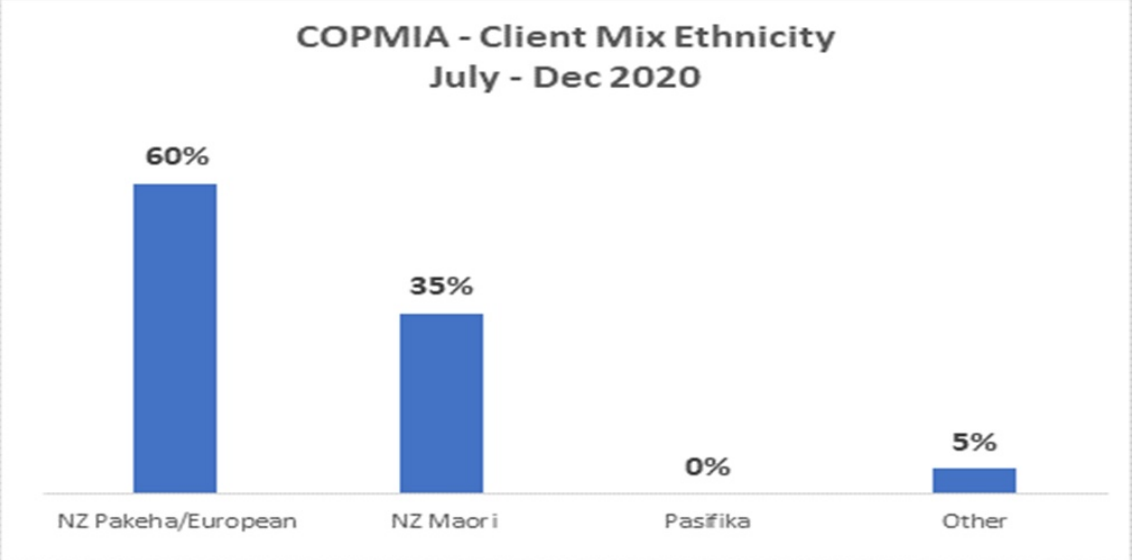
Following on from a meeting earlier in the year, 'He Puna Ora' Project Coordinator Lisa Turia-Bennett regarding the new pregnancy and parenting extensive outreach service (for hard to reach mothers' with addiction issues and children under 3 years old) there has been increased interest by Māori Oranga providers in SPHC COPMIA training and opportunities with provision of 'Keeping Families and Children in Mind' training in Whanganui (in September 2020), presentation in Taihape (October – SPHC COPMIA update), and facilitation of a full day 'Let's Talk' workshop training in Taihape in November 2020. There is also further interest in the SPHC COPMIA training 'Single Session Family Consultation' in the rural sector. Further SPHC COPMIA training has been booked to take place in January 2021 for all He Puna Ora staff orientation.

A biennial audit was completed on Mental Health services to assist WDHB in identifying areas of improvement with regard to Supporting Parent's Healthy Children (COPMIA), ensuring practice complies with the Ministry of Health guidelines for supporting parents with mental illness and or addiction and their children *(MOH, 2015).* The audit involved interviewing a percentage of staff members from all mental health teams, observations of service environments (see SPHC (COPMIA) Audit tool) and file audit to compare with the base line measure of the completion and the ongoing effectiveness of the Supporting Parents Healthy Children (COPMIA) questions in the Whanganui DHB AMH&AD risk assessment forms. These questions were added as part of the implementation of the Ministry of Health SPHC COPMIA Guidelines (2015) to identify any service users who were parents/caregivers who experience Mental Illness or Addiction and had children, particularly those children aged 0-18 years, potentially affected by their parent/caregiver's mental illness or addiction.

As part of a CAPA quality project, MICAMHAS received national recognition for improvement to environment (waiting room) in December 2020.

The WDHB funds an NGO to provide support to children and youth. There group work has been disrupted due to COVID however they have been providing 'one on one' support and the graphs below outlines referral source and ethnicity.


COPMIA - Referral Source
July - Dec 2020
1
5
1
2
11
Te Awhina Inpatient Unit
Adult MH & A Services
Community Service
Family or Friend
Self (Self)


COPMIA - Client Mix Ethnicity
July - Dec 2020
60%
35%
0%
5%
NZ Pakeha/European
NZ Maori
Pasifika
Other

MH04: Mental Health and Addiction Service Development EMPLOYMENT & PHYSICAL NEEDS

Mental wellbeing MH04: Mental Health and Addiction Service Development Focus Area EMPLOYMENT & PHYSICAL NEEDS

Physical Needs

Service users have a baseline recording that is monitored and recording to measure metabolic progress. The Clinical Portal electronic patient management system has a dedicated Anthropometric data spreadsheet for service providers to update and monitor.

The GP practice's who enlist the newly implemented Health Improvement Advisor's and Health Coach's also work with the CMHAS Mental Health Liaison service providers to better transition physical health distress related conditions early to prevent worsening physical conditions requiring secondary care input.

The three monthly mental health clinical MDT meetings are also booked in GP practices and managed by the transition nurse to encourage holistic oversight in preparation for transition from secondary to primary care.

Employment Needs

Six weekly Service Providers meeting is attended by Work Wise representative who liaises with Whanganui community employment agencies as required.

From October to December 2020 Work Wise reported the following:

- 21 people have been referred into service since 1 July 2020; with 10 being referred during Quarter 2.
- From these referrals we have seen 18 people enter the service; 8 during this quarter.
- 6 people moved into work during Quarter 2, with one person gaining two positions. Of these seven paid employment outcomes, three were for 40+ hours per week; one for 30 hours per week; one for 20 hours per week and two were for less than 20 hours per week.
- Exit figures have seen 7 people leave the service for this quarter – two settled in employment; four opted off and one did not engage with us despite contact attempts.
- 17 people are currently active within the service at the end of December 2020.

MH05: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders

Outcome priority: We have equity for Maori and other groups

- ***Improving mental wellbeing***

WDHB Qualitative Report Quarter 2 – October 2020 to December 2020:
A focus on reducing Maori under compulsory treatment orders continues and is being led by MHAS Medical Director
The measures the DHB is undertaking are:

- Understanding the profiles of Maori under the MHA
- Peer review in the SMO peer review meeting of decisions regarding continuation of the MHA.
- Consumer advocate (Balance peer support) participation in section 76 review
- Having the Haumoana navigator, Te Hau Ranga Ora (Maori cultural advisor) physically based in Te Awhina inpatient unit from mid-September.

In this quarter the number of Maori under any part of section 29 has unfortunately increased. Whilst the DHB internal data and QLIK data do not fully align with the data received back from MoH (PRIMHD) there is an unequivocal increase starting from September 2020, which then plateaus from October to December 2020.

The initiatives commenced earlier in 2020 continued, with input from the Balance peer support into section 76 reviews and Haumoana navigator being based in the inpatient unit from mid-September 2020. However the likely cause of the increase of rate of Maori under section 29 community treatment orders is a reduction in discontinuations due to a change to service delivery effected between August 2020 and October 2020. As this involved a change of responsible clinician for a significant number of tangata whai ora, there was almost certainly an impact, with less familiar clinicians yet to build up effective therapeutic alliances with tangata whaiora and whanau.

Coupled with this however there was an ongoing need for new section 29 orders –five people went from inpatient orders onto community orders via section 30 (2) and three were granted directly as section 29 orders, one after adjournment by the court.
Two court-ordered section 29 were made from Section 25 (1) (a) of the CP (MIP) Act.

Due unforeseen circumstances the Haumoana Navigator whilst based on the inpatient unit from September 2020 has been less available to the unit than was first anticipated.

SMO Peer review of situations of Maori under section 29 will resume in 2021, with a specific focus on those on indefinite orders. This has resulted in increased confidence for one responsible clinician with a high caseload and allowed adoption of a supported decision making process which has continued in this quarter.

In addition there will be reconsideration of the contract with the kaupapa Maori service as there has been very significant recruitment of registered nurse clinicians who may be able to act as keyworkers and second health professionals for Maori under section 29. This offers hope of greater understanding between tangata whaiora, whanau, key-workers and kaiawhina and the responsible clinician and the alliance may support engagement more effectively without the need for compulsion.

As previously noted, one of the DHBs challenges is a discrepancy between the MoH figures and the figure which we have locally compiled and that from the QLIK data base (which should be the same as MOH).
To address this a manual data-set merged between the WebPAS PRIMHD reporting and the records kept by our MHA administrator has been obtained.
An exercise of comparing these record by record is ongoing.

MH06 Output Delivery

Utilisation Data by DHB 2019/20 Quarter 4

District Health Board	Full Time Equivalents June Quarter			Overall Bed Days				Programme Expenditure $000	
	Service Level Agreement	Actual	Percentage	Service Level Agreement	Available	Actual	Occupancy Rate	Service Level Agreement	Actual
Auckland	469	437	93%	17,013	53,554	46,016	86%	2,142	2,167
Bay of Plenty	201	191	95%	17,013	16,153	15,039	93%	505	748
Canterbury	426	422	99%	64,605	64,605	53,806	83%	120	120
Capital and Coast	300	344	115%	45,322	45,324	44,380	98%	31	238
Counties Manukau	475	438	92%	34,668	34,668	26,841	77%	788	1,239
Hawke's Bay	120	115	96%	10,951	11,748	10,475	89%	976	1,252
Hutt	124	123	99%	2,197	2,197	1,469	67%	-	-
Lakes	79	71	90%	5,110	5,475	5,245	96%	286	405
MidCentral	153	154	101%	9,671	9,674	10,150	105%	41	41
Nelson Marlborough	135	134	99%	11,346	11,346	10,141	89%	1,097	1,055
Northland	180	187	104%	20,952	20,952	20,361	97%	95	77
South Canterbury	42	40	96%	2,404	2,404	2,809	117%	23	6
Southern	292	268	92%	34,524	34,524	24,639	71%	-	-
Tairawhiti	47	41	87%	3,449	3,449	2,629	76%	7	7
Taranaki	96	93	97%	8,550	8,596	7,707	90%	86	70
Waikato	325	320	99%	45,474	44,676	46,092	103%	293	183
Wairarapa	39	37	96%	-	-	-	0%	1,157	1,115
Waitemata	652	677	104%	75,209	69,988	68,356	98%	2,282	1,471
Whanganui	64	65	102%	9,667	9,668	10,115	105%	-	-
West Coast	53	44	82%	3,650	3,660	2,469	67%	1,307	1,307
Total	**4,271**	**4,203**	**98%**	**421,773**	**452,661**	**408,739**	**90%**	**11,237**	**11,503**

Price Volume Schedule 2020/21 Quarter 1

Source: DAP Production Plans 2020/21 (as at 17/9/20)

Please provide quarter 1 volumes in columns I, M and Q. Please provide an explanation for missing data or zero volumes in column S.
If you provide data in a different unit to that stated (eg: programme instead of FTE) please add an explanation (in column S).
If you change contracted figures please include an explanation in column S.
If inpatient bed occupany or FTE vacancies are high, please explain in column S.
Thank you

PU Code	Description	2020/21 Vol	2020/21 Prices	2020/21 Total $	Unit of Measure	Unit of Measure (revised)	Contract Delivery FTE's or Available bed days 2020/21			
							Qtr 1 Vo	Qtr 2 Vo	Qtr 3 Vo	Qtr 4 Vol
MHA01	Acute 24 Hour Clinical Intervention (inpatient)	2,190	824	1,804,714	Available bed day	Bed days	547	547		
MHA02	Intensive Care	2,190	976	2,136,429	Available bed day	Bed days	547	547		
MHA04C	Crisis Intervention Service - Nursing and/or allied health	9	122,837	1,044,114	FTE	FTE	8.10	9.0		
MHA06	Acute Package of Care	2	48,515	72,773	Occupied bed day	Bed days	2	2		
MHA09A	Community Clinical Mental Health Service - Senior med	4	308,494	1,079,729	FTE	FTE	3.10	3.0		
MHA09C	Community Clinical Mental Health Service - Nursing and	13	122,837	1,596,880	FTE	FTE	13.00	13.0		
MHA11C	Mobile Intensive Treatment Service - Nursing and/or alli	2	122,837	245,674	FTE	FTE	1.90	2.1		
MHA18C	Needs Assessment and Service Coordination - Nursing	1	122,837	73,702	FTE	FTE	1.00	1.0		
MHAD14C	Co-existing disorders (mental health & addiction) - Nurs	3	122,837	380,795	FTE	FTE	3.00	3.0		
MHD69	Alcohol & Other Drugs Service - Opioid Substitution Tre	45	2,712	122,054	Client	Client	48.00	47.0		
MHD70	Alcohol & Other Drugs Service – Opioid Substitution Tre	90	3,591	323,165	Client	Client	109.00	110.0		
MHD71C	Alcohol and other drug consultation liaison service – Nu	0.2	157,541	26,782	FTE	FTE	0.20	0.2		
MHD74A	Community based alcohol and other drug specialist se	1	308,494	308,494	FTE	FTE	1.20	1.0		
MHD74C	Community based alcohol and other drug specialist se	6	122,837	786,157	FTE	FTE	6.10	6.3		
MHDI48C	Child, adolescent and youth alcohol and drug communi	1	122,837	122,837	FTE	FTE	1.10	1.0		
MHE30C	Community service for eating disorders - Nursing and/o	1	152,885	183,462	FTE	FTE	1.00	1.0		
MHF81	Forensic Mental Health – Extended Secure Service	5,286	1,042	5,505,413	Available bed day	Bed days	1321	1321		
MHI44A	Infant, child, adolescent & youth community mental hea	2	308,494	616,988	FTE	FTE	1.80	2.0		
MHI44C	Infant, child, adolescent & youth community mental hea	12	122,837	1,474,043	FTE	FTE	12.20	11.4		
MHM90C	Specialist Community Team – Perinatal Mental Health -	2	143,215	214,823	FTE	FTE	1.00	1.0		
MHO101C	Mental Health Older People Dementia Behavioural Sup	1	122,836	61,418	FTE	FTE	1.00	1.0		
MHO99A	Mental Health of Older People – Specialist Community	1	308,494	154,247	FTE	FTE	1.00	1.0		
MHO99C	Mental Health of Older People - Specialist Community S	2	122,837	245,674	FTE	FTE	2.00	2.0		
MHW68D	Family whanau support education, information and adv	5	99,854	469,315	FTE	FTE	5.00	5.0		

MH07: Improving mental health services by improving inpatient post discharge follow-up rates

Data Reporting template

Inpatient 7-day follow-up post discharge measure

DHBs to supply data via the templates below – data to be sourced from the KPI programme

Reporting template

Percentage of MH&A Total clients discharged from MH&A adult inpatient services that are followed up within 7 days.		
171	237	72.2%
Number of in-scope referrals discharged within 7 days from MH&A inpatient services (Data Source: PRIMHD/KPI)	Total number of overnight acute inpatient discharges in the reference period. (Data Source: PRIMHD/KPI)	Percentage of clients follow up within 7days

Percentage of MH&A Maori clients discharged from MH&A adult inpatient services that are followed up within 7 days.		
68	93	73.1%
Number of in-scope referrals discharged within 7 days from MH&A inpatient services (Data Source: PRIMHD/KPI)	Total number of overnight acute inpatient discharges in the reference period. (Data Source: PRIMHD/KPI)	Percentage of clients follow up within 7days

Percentage of MH&A Pacific discharged from MH&A adult inpatient services that are followed up within 7 days.		
2	4	50%
Number of in-scope referrals discharged within 7 days from MH&A inpatient services (Data Source: PRIMHD/KPI)	Total number of overnight acute inpatient discharges in the reference period. (Data Source: PRIMHD/KPI)	Percentage of clients follow up within 7days

Narrative quarterly reporting

The data for this report was extracted from PRIMHD data by Te Pou on December 28 2020 to cover the 12 months ending September 30 2020. This data includes people followed up by the same DHB, different DHB and NGO. This data comes with the caveat that there may be data still missing or incomplete.

This data extracted by Te Pou using the revisited 7 day follow up definition gives a truer picture of our follow-up. The improvement in the percentage of Maori followed up within 7 days appears to prove that a significant number are followed up solely by NGO services after discharge including especially our Kaupapa Māori services in urban and rural locations. Work on this is well underway, greater accuracy of data gives us a clearer starting point to improve from in ensuring all data is entered correctly and timely. As part of the HQSC connecting care project, timely identification of people who have not been followed-up within the 7day timeframe is work in progress. Live monitoring (as opposed to retroactive review) of the days between discharge and follow up is in development so that our best effort will help us meet the target.

Primary Health

PH03: Improving Maori enrolment in PHOs to meet the national average of 90%

Result 17233 Maori enrolled in PHO from Population of 18700 = 92%

ACHIEVED

MINISTRY OF HEALTH
MANATŪ HAUORA

PHO Enrolment Demographics as at January 2021

Lead DHB	(All)
DHB of Domicile	Whanganui DHB
PHO ID	(All)
PHO Name	(All)
Funding Formula Type	(All)
Funding Age Band	(All)
Reporting Age Band	(All)
Age	(All)
Gender	(All)
Deprivation Quintile	(All)
HUHC Status	(All)
CSC Status	(All)
Maori/Pacific	(All)
Highly Deprived	(All)
High Needs	(All)

Row Labels	Sum of ENROLCOUNT
Asian	2,186
European	43,815
Maori	17,223
Non Stated	149
Other	387
Pacific	1,695
Grand Total	65,455

PH04 :Better help for smokers to quit (primary care)

	Better Help for Smokers to Quit Health Target – Primary Care *90% of enrolled patients who smoke and are seen by a health practitioner in primary care will be offered advice and help to quit*
Name of DHB	**Whanganui**
DHB contact person for this report	**Name: Candace Sixtus** **Job title: Portfolio Manager** **Email: Candace.sixtus@wdhb.org.nz** **DDI: 06 3473400 / 027 2069500**
Quarter reported on	**Q2**
Which PHOs does this report cover?	Whanganui Regional Health Network
Do you think you have met the overall target (as noted above) this quarter? If not, what issues are preventing the target from being met and sustained? What actions are being put in place to improve performance and how will these actions be monitored?	No, the percentage is sitting lower than expected. There are a number of potential reasons for this. Clinicians are expected to opportunistically address multiple different issues when patients are being seen. The demand for appointments outstrips the availability and pressure is on clinicians to manage this time succinctly to ensure that their enrolled population have their needs met. Additionally, post lockdown there have been an ongoing catchup of deferred health needs. What is being done? Follow up education of smoking screening/ABC and current quit service is scheduled for the clinical education programme. Initiating remote access for a centrally based kaiāwhina resource to specifically target those enrolled smokers (this resource has been used for some years successfully, but usually sits in a practice, and they now no longer have physical space available. Access to practice management systems has impacted on their ability to support the practice to deliver on the expected targets). We are also using social media to ensure that practice populations identify this person as part of their general practice team (making subsequent contact better for all).
Do you think you have met the target for Māori and Pacific (as noted above) this quarter? If not, what issues are preventing the target from being met and sustained? What actions are being put in place to improve performance and how will these actions be monitored?	Help for our enrolled Māori who are registered as smokers has been better from an equity perspective, with a greater percentage of Māori than non-Māori being provided with advice and referrals. We will continue to highlight the inequities in health outcomes and support increasing the volume of Maori who are being offered this advice & support to meet the MOH target.
Is there any further support you require from the Ministry to achieve the target? If so, what support is required?	
Is there anything else you would like to tell the Ministry?	

Improving wellbeing through prevention

PV01: Improving breast screening coverage and equity for priority women.

	Period to Eligible population	1/09/2020 Screens	Coverage
Maori	1808	1154	64%
Pacific	136	81	60%
Asian	226	137	61%
Other	7257	5247	72%
Total	9427	6619	70%

Whanganui District Health Board Breast Screening report

Quarter Two 20/21

The result for this quarter reflects the impact of COVID-19 on breast screening across all populations but particularly for Maori and Asian women. The return to screening for outreach clients was delayed until August 2020 as the screening unit focussed on clearing the backlog of women who had missed out due to COVID-19. The unit has worked hard with outreach to catch up on outreach women since August and have agreed to a new process where bookings can be made at the home visit.

The appointment of the Regional Equity Coordinator for Breast Screening Coast to Coast will support participation and reduction of inequities in coverage for priority women for our DHB region. An initial Hui has been held to establish effective working relationships and identify support required including review of the Memorandum of Understanding and address the barriers experience with data matching.

Discussions have started with Te Kotuku Hauora and Breast Screen Coast to Coast to undertake a smear clinic in February 2021 while the breast screening unit is visiting. A Pacific employee is working with the local church groups to engage Pacifica women.

The outreach Kaiawhina supports women to screening including home visits to engage wahine, book appointments and provide transportation if required.

Strong and equitable public Health and Disability system

SS01: Faster cancer treatment (31 days)

Delayed reporting- no MoH data available

SS02: Delivery of Regional Service Plans

This measure is managed and reported via TAS

SS03: Ensuring delivery of service coverage

DHBs are asked to provide reports on the following areas as part of quarter two reports:
Reporting requirements

1. Confirm that your DHB is collecting data on urogynaecological procedures involving surgical mesh as per the minimum data set
   RESPONSE: we confirm this is the case
2. For the period 1 July 2020 – 31December 2020 please identify:
   i) the number of surgeons that performed urogynaecological procedures involving surgical mesh
   RESPONSE: One (1)

ii) the number of urogynaecological procedures involving surgical mesh performed by each of the surgeons identified in (i) above
REPSONSE; Four (4).

SS04: Implementing the Healthy Ageing Strategy

SS04 Implementing the Healthy Ageing Strategy

Deliverable Part 1: DHBs are expected to provide a progress report on:

Actions and milestones to deliver on the commitment in the DHB's Annual Plan to implement the Healthy Ageing Strategy as set out below:

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1.a National Framework for Home and Community Support services The DHB is actively engaged in the national work on the preferred funding case-mix methodology and the implication of this approach for the local DHB. Is also working on the system design that will met the needs of the WDHBs population.
1.b Integrated Falls and Fracture Prevention and Rehabilitation Services[2] DHB Response Participants of the in-home strength and balance Otago exercise programme are encouraged to continue with the exercise programme even once home visits have ceased. This includes referring people directly onto community exercise groups and not discharging them from in home strength and balance programme until they are established into the community exercise group. They are also encouraged to participate in the Nymbl site ACC and partner DHBs have developed community service pathways** which can be used to enable identification of the subsequent appropriate community response required on discharge or to prevent an admission. The non-acute rehabilitation within the community is being factored into the system development for home and community support.

·Report the number of older people (65 and over, or younger if identified as a falls risk) that have received these services:

Component	DHB Response					Ministry of Health Guidance	Additional Health Sector Guidance
	Classification	**# of People (Quarter)**	**# of People (YTD)**	**Annual Target**	**Commentary / Narrative from DHB**		
Report the number of older people (65 and over, or younger if identified as a falls risk) that have received **in-home strength and balance retraining services:**	Number of people that received in-home strength and balance retraining (65-74, people under 65 if identified as a falls risk):	13	33		3 people under 65	The number of people should only apply to those that have received in-home strength and balance within your DHB.	This number will be the same number provided to ACC as per the **Partnering Agreement** your DHB has with ACC.
	Number of people that received in-home strength and balance retraining (75+):	30	72 Total = 105		2 people over 90		
There where another 26 people seen for falls prevention assessment and education this quarter who did not participate in the OEP for reasons such as: they were already participating in a community exercise group but wanted advice on such things as hand rail placement or it was unsafe for the patient to complete exercise programme for medical or neurological reasons. All 26 people seen did require some intervention i.e. Education, information or onwards referrals to other support services i.e. Continence Nurse, Dietitian.							

Component	DHB Response					Ministry of Health Guidance	Additional Health Sector Guidance
	Classification	**# of People (Quarter)**	**# of People (YTD)**	**Annual Target**	**Commentary / Narrative from DHB**		

Report the number of older people (65 and over, or younger if identified as a falls risk) that have received **community / group strength and balance retraining services:**	Number of people that received community / group strength and balance retraining (65+**,** people under 65 if identified as a falls risk):	490 (as determined by phone call to exercise groups mid-December 2020)	1011			The number of people should only apply to those that have received community group strength and balance within your DHB.	ACC is working with the Community Group Strength and Balance Lead Agency to obtain **<u>regional</u>** attendee levels (including regular attendance) and develop community capacity. A reporting process and template will be provided to Lead Agencies for guidance.
Only one community exercise programme has remained at a reduced level of one class from the previously having four. All other community groups are operating at similar numbers to post COVID19. (Determined by phone conversation of all community groups by Lead Agent).				Regular phone contact has been maintained and emails have been sent by the Lead Agent to the coordinators of community groups to keep them up to date with current events i.e. the availability of the Nymbl App and the outcome of ongoing support and promotion by ACC of the Live Stronger for Longer website.			

1.c Locally prioritised action(s)

- DHBs are to report progress during the quarter (in brief) to deliver on one (or more) DHB-identified action (not included above that may or may not be included in the DHB's Annual Plan) that the DHB has prioritised locally to highlight implementation of the Healthy Ageing Strategy and that it expects to have the greatest impact on outcomes for older people locally. Older people should be included in service co-design, development and review and other decision-making processes.

WDHB Response

Below is the Injury Prevention Pressure Injury Management Program Update

1.d Activity in the community and primary care settings

DHB Response

- Local representation attended the regions virtual hui on the LifeCurve and the opportunity it provides in the identification of frailty for older people and health services.
- The DHB is planning to promote the LifeCurve approach at the Masters Games this year that are being hosted by Whanganui in early February.
- Regional planning is also underway for a Frailty Forum.

And locally work is in progress understanding the capacity and capability of the primary, allied health and community nursing teams for the provision of an integrated connected primary and community-based service (inclusive of NGOs and home health agencies). Networking with other providers nationally to gain an understanding of alternative delivery models.

WRHN Board approval has been given to invest in a co-designed model on the WDHB campus that will include relocation of urgent care, a primary hub and general practice. Approval in principle also provided by WDHB Board.

A community funding options programme contract agreed December 2020. Initial stage (Jan-June 2021) will focus on IV therapy in the community that aligns with Think Hauora approach and community health pathways.

COPD Health Pathway continues to be in development phase and will be aligned with changes to national guidelines. The development of supporting services model to be developed in quarter 3-4

Trained 3 trainers on serious illness conversations (SIC)
Strategic plan to be developed in new year for how ACP and SIC is consistently delivered across the health sector

Deliverable Part 2:

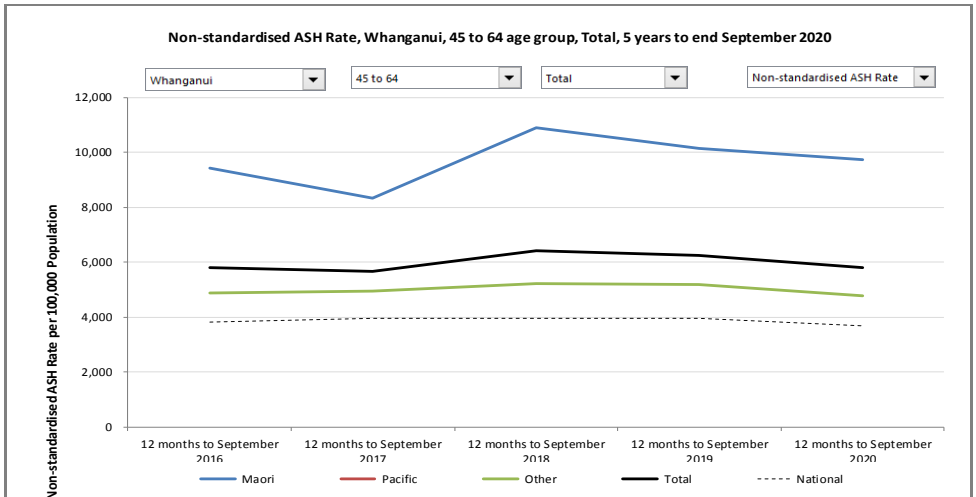
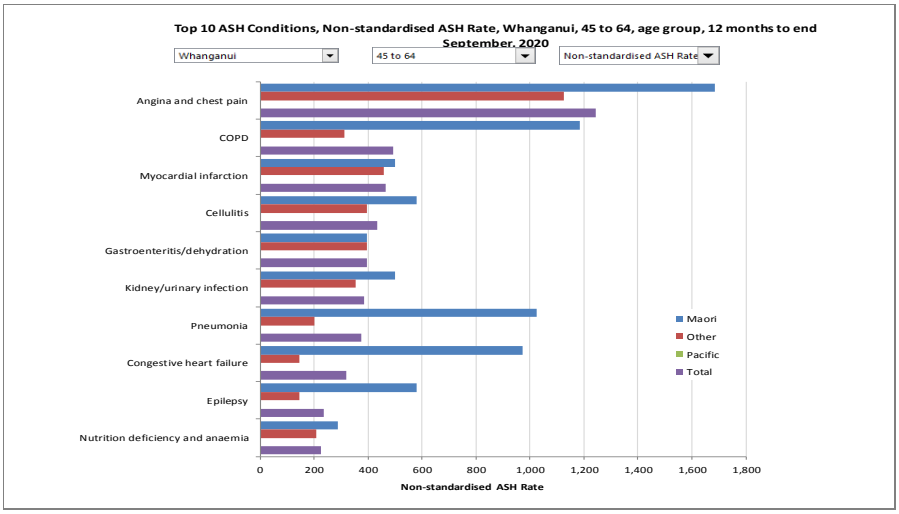
Report DHB activity to deliver on your regional commitment to a stocktake of dementia services, including:

2.a Implementation of the New Zealand Framework for Dementia Care

WDHB Response: the DHB actively supports the regional programme (report below) with local membership on the regional group. Addressing equity is a key DHB priority.

Implement regional priorities as identified from the 2019 / 2020 National Dementia Stocktake	Q1-4	The representation by Māori has been strengthened within the regional dementia reference group, with the addition of two new members who identify as Māori. Work continues to strengthen the governance by Māori. The regional health of older persons groups have begun defining and prioritising the actions that arose out of the Regional Dementia Equity Hui. The region continues to support the work of the National Dementia Framework Collaborative.

SS05: Ambulatory sensitive hospitalisations (ASH adult)

Summary information	
Data Source:	Ministry to provide data via NSFL web site and the DHB quarterly reporting website. https://nsfl.health.govt.nz/accountability/performance-and-monitoring/data-quarterly-reports-and-reporting/ambulatory-sensitive
• ***Target/expectation: as agreed in DHB Annual Plan*** • ***Please provide your standardised and non-standardised ASH rate result for the quarter***	**SI 1: Ambulatory Sensitive Hospitalisations (ASH)**  **DHB** / **Ethnic Group** / **12 months to September 2016** / **12 months to September 2017** / **12 months to September 2018** / **12 months to September 2019** / **12 months to September 2020** Whanganui / Maori / 9,407 / 8,311 / 10,880 / 10,132 / 9,737 Whanganui / Pacific / - / - / - / - / - Whanganui / Other / 4,862 / 4,954 / 5,230 / 5,197 / 4,759 Whanganui / Total / 5,784 / 5,647 / 6,407 / 6,226 / 5,798 National / Total / 3,809 / 3,966 / 3,951 / 3,938 / 3,660
Commentary on your latest 12-month ASH data including specific actions that supported Maori and Pacific* health:	

SS06: Better help for smokers to quit in public hospitals

2019/20 *Better help for smokers to quit* quarterly reporting template - Hospital (SS06)

DHB	Whanganui	*please select from the drop down box*
Reporting Quarter	Q2	*please select from the drop down box*

Results

	Events Coded	No. of people who smoke	No. of people given advice /support	Smoking rate	% of people who smoke given advice /support
ALL	2186	317	301.0%	14.5%	**95.0%**
Māori	497	145	139.0%	29.2%	**95.9%**
Pacific	28	4	4.0%	14.3%	**100.0%**

Name and contact details of person completing the report

Please answer ALL of the questions below	
If the DHB's result for this quarter are below 95%, for any of "All", "Māori" and/or "Pacific" people, if "Pacific" numbers are sufficient, please explain why.	N/A
Please identify what activities the DHB has undertaken this quarter to support this target?	I have tailored specific training to the core areas that have not been hitting target. I had meetings with smokefree champions and CNM's to work out the best approach to training staff. By listening to what works for the wards and their staff, I was able to train 70% of Medical and surgical ward staff over a one month period at the end of the year. All coders now have full electronic access to one of our recording systems rather than relying on paper print outs and we have made sure they all know where to find the information correctly for coding.
What are the barriers impeding the DHB ability reach the target and sustain it next quarter?	Sustainability, we need to keep up the momentum by making sure I'm a presence on ward as a reminder that smokefree is just BAU. CNM's and smokefree champions need to encourage and support staff.
Please note anything else you would like the Ministry to be aware of.	I'm proud of our staff, CNM's and smokefree champions for the hard work and coordination it has taken to hit target this quarter. We have gone from 85.9% in Q1 to hitting target at 95% this quarter.

SS07: Planned Care Measures

Please refer to the WDHB Planned Care Services 2020-2023 Three-Year Plan

SS09: Improving the quality of identity data NHI

No report received for the period (WALT)

SS09: Improving the quality of identity data NATIONAL COLLECTIONS

This measure is now managed and reported via TAS

SS09: Improving the quality of identity data PRIMHD

Focus area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)

Indicator 1: PRIMHD data quality

Please provide date(s) of routine data quality audits and corrective actions if any.

Dates(s) of routine audit(s)	Corrective actions (if no corrective actions please indicate – NIL)
Routine audits are completed weekly throughout the year	WDHB is fully PRIMHD compliant and all extracts sent to the ministry are now automatically automated into their production environment. Full quality checks and audits occur twice weekly to ensure accuracy of the data in the reporting of outcome measures, referrals, activity contacts, diagnoses, inpatient events and legal status. All PRIMHD errors are completed within a timely manner. Extracts are sent every two weeks; this allows time for clinicians to enter their data into the system and checking mechanisms are put in place to ensure accuracy using reports and cross referencing with the system. WDHB continue to achieve pass rates of 99% or more.

SS10: Shorter stays in Emergency Departments

2020-21 Quarterly Reporting for Acute Demand and Shorter Stays in Emergency Departments

Reporting sections: 1. Shorter Stays in ED data 2. Actions to improve SSED 3. Data on acutely admitted patients 4. Acute Demand actions from Annual Plans	**Guidance:**
DHB name: Whanganui	**Quarter: 2**

1. Shorter Stays in ED Indicator: 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.

Quarterly results *- Please use the ethnicity provided at the time of the ED presentation. Where that is not available, please use the ethnicity listed on the patient's NHI*									
	Total Population			**Maori ethnicity**			**Pacific ethnicity**		
Name of facility	Number stayed less than 6 hours	Total Presentations	% managed within 6 hours	Number stayed less than 6 hours	Total Presentations	% managed within 6 hours	Number stayed less than 6 hours	Total Presentations	% managed within 6 hours
Whanganui Hospital	5,522	6,007	92%	1,384	1,476	94%	143	147	97%
DHB total	5,522	6,007	92%	1,384	1,476	94%	143	147	97%

2. Actions to improve SSED - Please provide the Ministry of Health with further information on:

Measure	**Your actions, activities, issues**
1. Actions undertaken this quarter to maintain or improve the indicator	Development of ED "dashboard" to give data driven view of patient flow Understanding flow through the department for acute patients
2. Planned work for next quarter	Implementation of the Discharge Co-ordinator role – improving patient flow through services Ongoing work with Alliance leadership team on reducing acute demand for services
3. Barriers to achieving or maintaining the indicator	
What support can the Ministry provide	

3. Data on acutely admitted patients

4. Acute Demand actions from Annual Plans

Acute Data Capturing: Please provide an update on your plan to **implement SNOMED coding** in Emergency Departments to submit to NNPAC by 2021.
• Continuing to work with regional partners (sub-regional PAS) to develop implementation
To **improve Patient Flow**, please report on actions from your Annual Plan that: 1. improves patient flow for admitted patients 2. improves management of patients to ED with long-term conditions 3. improves wait times for patients requiring mental health and addiction services who have presented to the ED 4. improves Māori patients experience in ED
1 AND 2. ACTION: Other initiatives continue to further streamline patient flow of patients between ED presentations and lower acuity accident and medical patient are developing options for earlier identification and rapid connection with appropriate clinical teams and treatment. Long term conditions patients will be priorities for actue care and linked back to their community and primary care teams for ongoing care requirements through development of primary care pathways and the introduction of funded community options. Report due Q3. **3. Action**

Implement commitment to resourcing ED with a specialist mental health and addiction educator to build capability of front-line staff. Report due Q2.

Action

Support workforce development of the appropriate knowledge and skills to support people with mental health and addiction needs, including those with co-existing needs, for example, through the let's get real framework. Report due Q2-4.

4. Action

Continuing with the dedicated Haumoana (Family/Whanau Navigator) service in the emergency department. This serviced operates 24 hours each day to support Maori Whanau while they are in hospital from acute presentation to discharge. On site accommodation is available fo the family/Whanau of patients to enable them to be with patiens during their stay. **Met for Q1**.

SS11: Faster cancer treatment (62 days)

Report delayed- data due February

SS12: Engagement and obligations as a Treaty partner

Please refer to Quarter 2 AP updates

SS13: FA1 Long Term Conditions

Description	Specific actions including timeframe and milestones	Quarter 2
Actions with an equity focus to support people with LTC to self-manage Reference: https://www.health.govt.nz/publication/self-management-support-people-long-term-conditions	Review LTC approach, information and programs to ensure it supports whānau ora, meets health literacy guidelines, and best practice: (EF) - Consider proposal for Gout management programme combining culturally appropriate education along with a kaiawhina approach will support improved access to medication management and engagement with pharmacy and general practice - Implement programme across the region Chronic kidney disease Ruapehu project to reduce progression of CKD for identified patients with high BP, diabetes, uric acid:	The LTC Governance Group has considered the Ministry of Health Diabetes Team meeting feedback to inform review of the LTC approach and programme The Whanganui GOUT STOP Programme has been implemented across the region. This programme is a district wide collaborative between WDHB, Arthritis NZ and WRHN and involves the development and delivery of a new service involving Community Pharmacy, General Practice, Whanganui Accident and Medical (WAM) and a Kaiawhina, to decrease the high rates of poorly managed gout arthritis by improving awareness, health literacy, medication adherence and long term management. This collaborative and proactive gout arthritis management programme in primary care with an equity lens; • systematises easy access to gout arthritis medications • improves long term treatment and management within primary care with an equity focus • builds knowledge and skills in providers, self-

	(EOA) - Develop service model through a co-design approach with communities - Progress implementation of new service model	management skills in persons and their whanau, raise awareness in the communities • Increases self-management and control of the persons health and wellbeing. Barriers to optimal management are multifactorial and include; • Health system barriers • Patient barriers • Health literacy - both clinicians and patients • Lack of collaboration between healthcare providers One of the main barriers to good treatment and management of gout arthritis is that persons and their whanau have seldom been provided with the necessary tools to understand the condition and the medicines taken to control it. This can negatively affect self-management and adherence to appropriate treatment (BPAC 2014). This programme includes community pharmacists, general practice and a Kaiawhina who are well placed to provide advice and support clients to optimally manage their gout arthritis.
Actions with an equity focus to build health literacy Reference: https://www.health.govt.nz/publication/framework-health-literacy		A Gout equity workshop was held with Gabrielle Baker and Leanne Te Karu with funders, providers, and consumers. Workshop discussion informed changes to the programme's overarching goal that better reflects a pro equity approach. Participating consumers will be engaged in early 2021 to develop consumer information. A Cultural training programme is available for all community pharmacists and staff.
SPECIFIC SERVICES Gout: What specific services (if any) your DHB/PHOs are providing for gout in primary care and identify any barriers that prevent initiation or development of services. Chronic Kidney Disease (CKD): What specific services (if any) your DHB/PHOs are providing for CKD in primary care and identify: 1) any barriers that prevent initiation or development of services.2) actions with an equity focus to support people with CKD to self-manage		See above A Chronic Kidney Disease workshop has been held with consumers, providers and Iwi. A co-design approach has been agreed and group education sessions commenced

SS13: FA2 Diabetes services

Select DHB of Domicile:	Whanganui			Period	Q2 2020-21
SS13 *Improved management for long term conditions (Diabetes)*					
Please see the Instuctions tab and the Example Template tab					
Numbers of people with diabetes					
PHO register total (all PHOs)		***VDR estimate count of diabetes prevalence as at 31 Dec 2019***		***Estimated completeness of diabetes ascertainment by PHOs***	
Denominator					
	Ages 15-74 only	**All ages**	**Ages 15-74 only**	**All ages**	**Ages 15-74 only**	**All ages**
Maori	934	1,054	1010	1,142	92.5%	92.3%
Pacific	108	119	103	110	104.9%	108.2%
Other	1,762	2,495	2081	2,931	84.7%	85.1%
Total	2,804	3,668	3,194	4,183	87.8%	87.7%

HbA1c measurement data- for people aged 15-74 years inclusive						
Numerator						
	Number with HbA1c ≤ 64mmol	**Number with HbA1c ≥ 65mmol**	**Number with HbA1c ≥ 81mmol and ≤**	**Number with HbA1c ≥ 101mmol**	**Total number with any available**	**Total number with no available**
Māori	445	169	118	86	818	**116**
Pacific	47	20	7	13	87	**21**
Other	1,034	363	148	56	1,601	**161**
Total	**1,526**	**552**	**273**	**155**	2,506	**298**

Rate based on total PHO/practice count rate						
	% HbA1c ≤ 64mmol	**% HbA1c ≥ 65mmol and ≤ 80mmol**	**% HbA1c ≥ 81mmol and ≤ 100mmol**	**% HbA1c ≥ 101mmol**	**Percentage with any available HbA1c**	**Percentage with no available**
Māori	**48%**	**18%**	**13%**	**9%**	**88%**	**11%**
Pacific	**44%**	**19%**	**6%**	**12%**	**81%**	**18%**
Other	**59%**	**21%**	**8%**	**3%**	**91%**	**6%**
Total	**54%**	**20%**	**10%**	**6%**	**89%**	**8%**

SS13: FA3 Cardiovascular health

SS13 FA3 – Cardiovascular Disease Quarterly Reporting template 2021/21 – Quarter 2

Reporting requirements from two sources are included under this umbrella, from the quarterly non-financial reporting under SS13,Focus Area 3, and also from the *HEART HEALTH: previously known as More Heart and Diabetes* contracts, between the Ministry and the DHBs. Reporting is by narrative, with the questions from the two reporting requirements combined in the template below.

What, if any calculator, based on the 2018 algorithms, do you have available for use, or are you waiting for the national calculator solution?
• NZ Health Equation through the updated predict electronic tool
How was the funding provided under the "Heart Health contracts" used in the year 2019/2020.
• A designated nurse (.2FTE) to raise awareness of changes with practice teams and contribute to change in screening and assessment tool • Community health worker/ phlebotomist (.4 FTE) assists practices with capturing screening data and track and trace of hard to reach community • Contributing to annual costs of the electronic predict tool

How will the funding provided under the "Heart Health contracts" be used in the year 2020/2021
• Supporting practice facilitator role to undertake a CQI process to identify issues with the CVD recalls • Community health worker/ phlebotomist assists practices with capturing screening data and track and trace of hard-to-reach community • Contributing to annual costs of predict electronic tool
How are PHOs supporting practices to risk assess (for the first time) people in new groups that are now included in the denominator? e.g people with a severe mental illness, or younger aged Maori and Pacific patients.
Given the covid -19 lockdown and associated limited access to laboratory testing screening was not a priority for general practice teams during this period. • Raised awareness of equity at each primary care forum • Practices have been educated about change and expansion of recalls to include these groups • Raising awareness through planned training days with practice nurses • Education with health coaches and health improvement practitioners (Integrated mental health and addictions programme) to improve health literacy and self-management) • Clinical governance updates through e newsletter • Most practices have identified these new groups as a key focus area under their Services to Improve Access (SIA) quality plans.
How is annual recall of high-risk patients co-ordinated?
Recalls are coordinated at a practice level with teams encouraged to use population health reports (through powerBi) as well as Dr info to identify specific individuals. However, with the change in national guidelines the automated 5-year recall process has dropped off and there will be targeted work in 2021 to improve recall processes taking a person-centred approach verse a disease screening approach.

SS13: FA4 Acute heart services

PP20 FA4 - Acute Coronary Syndrome (ACS) Quarterly Reporting template 2020/21 – Quarter 2

Indicator 1: Door to cath - Door to cath within 3 days for ≥ 70% of ACS patients undergoing coronary angiogram**.**
Indicator 2a: Registry completion- ≥95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days of discharge and
Indicator 2b: ≥ 99% within 3 months.
Indicator 3: ACS LVEF assessment- ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (ie have had an echocardiogram or LVgram).
Indicator 4: Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance ≥ 85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge -

- Aspirin*, a 2nd anti-platelet agent*, and a statin (3 classes) and
- an ACEI/ARB if any of the following – LVEF <50%, DM,HT,in-hospital HF (Killip Class II to IV) (4

classes), and

- Beta-blocker if LVEF<40% ((5-classes).

* An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents.

Indicator 5a: Device registry completion ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS-QI Device PPM forms completed within 2 months of the procedure.

Indicator 5b: Device registry completion ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS-QI Device ICD forms completed within 2 months of the procedure.

Notes to indicators:

Indicator 2: *The requirement for ≥ 99% completion within 3 months added in 2018/19.*

Indicator 3: *new indicator in 2018/19.*

Indicator 4: *new indicator in 2018/19, and modified in 2019/20. Patients meet the indicator if they are recorded in the ANZACS-QI ACS form as either on the particular medication or recorded as having a known contraindication/intolerance to it. This is a "minimum" indicator. It may still be clinically appropriate to use a beta-blocker in the absence of LV dysfunction but this is not required to meet the indicator. Patients referred for in-patient coronary artery bypass grafts (CABG) are excluded because prescribing data is recorded prior to surgery when the second antiplatelet agent has been stopped. Patients are also excluded where no LVEF is recorded.*

Indicator 5a and b: *new indicators in 2019/20.*

Indicator measures: Each DHB must provide a percentage measure from the most recently available quarterly ANZACS-QI report for each of the indicators, and an ethnicity breakdown.

Note: Please either complete this template or add your report (including ALL the following points) to the website. All DHBs are expected to submit a report. DHBs meeting the target should highlight their approaches for success. Data for completing this report is available from the quarterly ANZACS-QI reports, and from 2018/19 should be provided by ethnicity.

Name of DHB: Whanganui

	TOTAL	**Maori**	**Pacific**	**Indian**	**Asian**	**Eur/Other**
INDICATOR 1 Quarterly percentage performance against indicator 1(use KPI December quarterly detailed report generated January 2021)	67%	50%	0%	100%	0%	69%
INDICATOR 2a Quarterly percentage performance against indicator 2, (use KPI quarterly detailed December report generated January 2021, and record Quarter 2 result):	97%	100%	-	100%	100%	96%
INDICATOR 2b Percentage performance against indicator 2, for 90 days prior (use December quarterly detailed report generated January 2021, and record Quarter 1, 2020/21 result)	89%	100%	100%	-	-	86%
INDICATOR 3 Quarterly percentage performance indicator 3 (use KPI December quarterly detailed report generated January 2021)	73%	60%	-	-	100%	74%
INDICATOR 4 Quarterly percentage performance indicator 4, (use KPI December quarterly detailed report generated January 2021)	44%	33%	-	-	100%	38%
INDICATOR 5a Quarterly percentage performance indicator 5a, (use KPI December quarterly detailed report generated January 2021) which reports registry completion in August, September, October.	N/A	N/A	N/A	N/A	N/A	N/A
INDICATOR 5b Quarterly percentage performance indicator 5b, (use KPI December quarterly detailed report generated January 2021) which reports registry completion in August, September, October.	N/A	N/A	N/A	N/A	N/A	N/A

Where the indicator has not been met, identify the indicator and provide narrative on any barriers/challenges to achieving the indicator and any mitigation strategies for these to be applied over the next quarter.	**DHB comments** Whanganui DHB is below the required levels for a number of indicators this quarter. As a DHB we are reliant on our tertiary partners for cardiology services, with only limited diagnostic services provided locally. We are active in our regional cardiology network, where recent developments include the cardiology service regional care arrangement map, and development of a focused workplan for the region.

SS13: FA5 Stroke services

DRAFT – SS13 Stroke Quarterly Reporting Template 2019/20 – Quarter 2

Indicator 1: 80% of stroke patients admitted to a stroke unit or organised stroke service, with a demonstrated stroke pathway **– Q1 confirmed data**
Indicator 2: 10% of potentially eligible stroke patients thrombolysed 24/7 **– Q1 confirmed data**
Indicator 3: 80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission – **Q1 confirmed data**
Indicator 4: 60% of patients referred for community rehabilitation are seen face to face by a member of the community rehab team within 7 calendar days of hospital discharge – **Q1 confirmed data**

Name of DHB: Whanganui

Confirmed result indicator 1 for Q1 **ASU 80%:** **Percentage: Total = 98%** **Māori = 100%** **Denominator: Total = 41** **Māori = 5** **Numerator: Total = 40** **Māori = 5**	**Confirmed result indicator 2 for Q1** **Reperfusion – Thrombolysis /Stroke Clot Retrieval 12% 24/7:** **Percentage: Total = 13%** **Māori= 20%** **Denominator: Total = 5** **Māori = 1** **Numerator: Total = 38** **Māori = 5**	**Confirmed result indicator 3 for Q1** **Inpt. Rehabilitation 80%:** **Percentage: Total = 69 %** **Māori = 20%** **Denominator: Total = 16** **Māori = 1** **Numerator: Total = 11** **Māori = 1**	**Confirmed result indicator 4 for Q1** **Community Rehabilitation 60%:** **Percentage: Total = 29%** **Denominator: Total = 28** **Numerator: Total =**

Indicator 1: ASU Numerator = number of acute stroke admissions admitted to an ASU or organised stroke service with a demonstrated stroke pathway within 24 hours of their presentation to hospital. Denominator = total acute stroke admissions (I61, I63, I64).

- Please provide narrative if any hospital in your DHB responsible for providing this service has not met this indicator, with your plan to achieve.
- Please include here a breakdown of: % numerator and denominator by hospital providing this service.

(See Minimal standards attached for guidance)

DHB Comments:	We have met this indicator – our acute stroke pathway is working very effectively. We often thrombolyse acute stroke patients in CT and then continue to the ASU unit exiting ED very efficiently. We are seeing significant improvement in NIHSS reduction using tenecteplase as our thrombolytic agent. We have been advised this supply chain is at risk and that we will need to return to using Alteplase in March 2021.

Indicator 2: Reperfusion – Thrombolysis /Stroke Clot Retrieval Service provision 24/7 Numerator = number of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval and counted by DHB of domicile. Denominator = number of stroke admissions eligible for thrombolysis or stroke clot retrieval (ICD Codes I63, I64)

- Please provide narrative if any hospital in your DHB responsible for providing this service has not met this indicator.

- Please include here a breakdown of each hospital providing this service: % numerator and denominator. - **NB: this is for the provision of a 24/7 thrombolysis service – if your DHB is not providing a 24/7 service please advise how/when you plan to achieve.**	
DHB Comments:	We have met this indicator, our in hours acute fast track pathway works very well, after hours the DTN times are protracted. We will start telestroke 24/7 in March. We are currently training ASU ward staff to attend CODE stroke, this will support the coordination of the code stroke and aimed at improving DTN times. We participate in the monthly acute stroke peer review regional meetings.
Indicator 3: Rehabilitation: Numerator = number of acute stroke admissions transferred to in-pt rehab within 7 days of acute admission. Denominator = number of stroke admissions eligible for rehabilitation (I61, I63, I64) – (see Minimum Expectations attached for guidance) - Please provide narrative if any hospital in your DHB providing this service has not met this indicator with your plan to achieve. - Please include here a breakdown of each hospital in your DHB: % numerator and denominator.	
DHB Comments:	This indicator was not met, we had 4 patients with prolonged acute stay waiting to stabilise and determine ability to participate in rehab. We are participants in the central regions stroke rehab sub-group. We are aligning our rehab service with the National Stroke Rehabilitation strategy KPI's. We have undertaken the research project via Otago University for the goal setting app. We participate in AROC data collection, FIM assessments, ANSANP calculation for LOS. Our service delivery is underpinned by Maori model of health "Te Whare tapa wha". We frequently hold whanau hui, collaborating with patient and whanau to provide care.
Indicator 4: Community Rehabilitation: Numerator = number of patients referred for community rehabilitation who are seen face to face by a member of the community rehab team within 7 calendar days of hospital discharge. Denominator = number of patients discharged from hospital with a primary stroke diagnosis (I61, I63, I64) who are referred within 2 weeks of discharge for community rehabilitation. **(See Minimum Expectations attached for guidance).**	
DHB Comments:	This indicator was not met. We have a very compromised community rehab allied health staffing capability impacting service delivery. Recent recruitment this week will support improving this outcome. The WDHB stroke nurse works across inpatient and the community, as well as provides telehealth services.

Other:
- Please indicate if you have a contact person in your local Iwi or Pacific Church who you could work with to support and promote the FAST message for this year's campaign. If not are these relationships that you could develop?
- Please comment on these services your DHB provides/participates in, either through services provided in your DHB or as part of an assisted regional service, or barriers that do not support your participation:
  - Telestroke activity
  - Stroke Clot Retrieval activity	

DHB Comments	We have strong links with local iwi and health promotion teams and actively promote the FAST message. We do not have established links with our small Pacific Island community. We will address this. We have telestroke services after hours via CCDHB, this will be 24/7 from March 1, 2021. We have established SCR pathway and send patients to both CCDHB and ADHB.

SS15: Improving waiting times for colonoscopies

Strong and equitable public health and disability system SS15: Improving waiting times for colonoscopies Partial Achievement.

The recommended urgent, non-urgent and bowel screening wait time targets were achieved this quarter, with results being 100%, 77.4% and 96% respectively. The recommended surveillance wait time target was not achieved, with results being 57.3%. We are working to increase the number of surveillance procedures that are being performed, with the aim of increasing this result in coming months.

The maximum urgent timeframe target was achieved this quarter, with result being 100%. The maximum non-urgent and surveillance timeframe targets were not achieved, with results being 91% and 68% respectively. The final version of our policy for management of our endoscopy waiting list that includes escalation process for patients at risk of exceeding maximum wait times has been reviewed and approved. We are confident that the percentage of non-urgent and surveillance patients that have their procedure completed within the maximum wait time will increase to the required level following implementation of this policy.

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WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	Item No. 3.2
Author	Kilian O'Gorman, Business Support Strategy, Commissioning and Population Health
Endorsed by	Paul Malan, General Manager Strategy, Commissioning and Population Health
Subject	Status update reporting- Actions Included in Annual Plans
Equity Considerations	The (EF) mark on some of the actions denotes "equity focused". These notations were included in the Annual Plan to highlight collective and sustained action focused on our pro-equity agenda. Similarly, (EOA) denotes "equity oriented activity".

Recommendations

Management recommend that the Combined Statutory Advisory Committee:

Receive the paper titled Status update reporting- Actions Included in Annual Plans

Note that while the Quarter 1 results are now final (section 1), Quarter 2 results are preliminary.

1. Purpose

This paper provides a comprehensive status update on Quarter 2 milestones against various initiatives within the 2020-21 Annual Plan. The table below shows the Ministry of Health's overall ratings for Quarter 1, and preliminary ratings for Quarter 2.

Not applicable	Other / Note	Achieved overall	Partially achieved	Not achieved

Status update reporting- Actions Included in Annual Plans	**Quarter 1 MoH Ratings**	***Preliminary* Quarter 2 MoH ratings**
Better population health outcomes supported by primary health care		
Better population health outcomes supported by strong and equitable public health services		No rating given yet
Give practical effect to He Korowai Oranga – the Māori Health Strategy		
Improving Child wellbeing		
Improving Mental wellbeing		
Improving Sustainability		
Improving wellbeing through Prevention		

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Better population health outcomes supported by primary health care				
Subsection	**Activity**	**Deliverable**	**Q_1**	**Q_2**
2.7.1 Primary health care integration	Better population health outcomes supported by primary health care	Improving patient flow through hospital services to allow a community focus with interprofessional practice as a priority (EF)		Work in progress
		Broadening use of the workforce in community settings (EF)		Work in progress
		Implementation of supported discharge, transition of care and coordination of home and community support services for older persons (disability) (EF)		Work in progress
		Develop understanding of, and develop strategies to address, barriers to broadening primary care workforce to reflect the population and create the conditions for equity of health outcomes for Māori. (EF)		Work in progress understanding the capacity and capability of the primary, allied health and community nursing teams for the provision of an integrated connected primary and community-based service (inclusive of NGOs and home health agencies). Networking with other providers nationally to gain an understanding of alternative delivery models.
		Review service models where appropriate to identify changes that would better serve the population and create conditions for equity including seeking opportunities for development of kaupapa Māori		Work in progress

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		services in consultation with Māori Health Outcomes Advisory Group (MHOAG) (EF)		
		Health Pathways supported by planned care and community care funding options (EF)		Community funding options programme contract agreed December 2020. A phased approach will taken with the initial phase being the implementation of IV therapy in the community. WRHN will administer for the district with expressions of interest sought from GP teams and Urgent care.
		Implement the RFP mental health services and addictions - See mental health section.		MH
2.7.2 Pharmacy	Implement community pharmacy component of MMR Campaign Strategy (EF)	Monitoring and MOH reporting requirements are met in line with WDHB Project Plan	Met	
		During COVID -19, relationships were developed across secondary and community services to support a whole of systems approach which will continue to be developed through the co design of a local pharmacy alert response framework. (EF)	Met	
		Review of current emergency planning completed to inform framework	Met	
		Framework developed and agreed	Draft completed	
		Implementation of health pathways and associated quality improvement activities for adult asthma and COPD	Stop Gout programme currently being implemented COPD Health Pathways under development	Adult asthma and COPD pathways currently under development (timelines have been delayed due to alignment with national guidelines by Lead pathways district DHB)
		Consider community pharmacy group respiratory health & gout proposals with an equity lens and identify equity outcomes. (EF)	*Gout Stop programme currently being implemented with an equity	Equity workshop held with Gabrielle Baker and Leanne Te Karu with funders, providers, and consumers.

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			lens as Maori experience higher prevalence of gout arthritis.	Workshop discussion informed changes to programme overarching goal that better reflect pro equity approach. Participating consumers will be engaged in new year to develop consumer information. Cultural training programme available for all community pharmacists and staff.
		Gout service model confirmed & establishment commenced	The Whanganui GOUT STOP Programme is currently being implemented. This programme is a district wide collaborative between WDHB, Arthritis NZ and WRHN and involves the development and delivery of a new service involving Community Pharmacy, General Practice, Whanganui Accident and Medical (WAM) and a Kaiawhina, to decrease the high rates of poorly managed gout arthritis within the Whanganui district, by improving awareness, health literacy, medication adherence and long term management.	**Completed**

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		Respiratory service model confirmed	COPD Health Pathways under development	Adult asthma and COPD pathways currently under development (timelines have been delayed due to alignment with national guidelines by Lead pathways district DHB)
		Explore the feasibility of establishing a mental health pharmacist to work across primary and secondary health (EF)		
		Complete consultation with psychiatric and pharmaceutical services and other relevant parties		
2.7.3 Long term conditions including diabetes	Chronic kidney disease Ruapehu project to reduce progression of CKD for identified patients with high BP, diabetes, uric acid: (EOA)	Develop service model through a co-design approach with communities		Workshop held with consumers, providers, and iwi. Co design approach agreed. Group education sessions begun.
	Explore the delivery of retinal screening in the community including identification of appropriate service model: (EF)	Implement new service model	See above *	
	Review LTC approach, information and programs to ensure it supports whānau ora, meets health literacy guidelines, and best practice: (EF)	Consider proposal for Gout management programme combining culturally appropriate education along with a kaiawhina approach will support improved access to medication management and engagement with pharmacy and general practice	See above *	
		Implement programme across the region		Completed

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Better population health outcomes supported by strong and equitable public health services				
Subsection	**Activity**	**Deliverable**	**Q_1**	**Q_2**
2.6.1 Delivery of Whānau Ora	Establish effective relationship with Te Puni Kokiri locally. (EF)	Support and explore collaborative opportunities with Te Pou Matakana and partners, and alignment of initiatives with local Whānau Ora initiatives. (EF)		Further progress required
	Implementing and monitoring whānau centred approaches to care and services.	Include whānau hui in service delivery with the support of Te Hau Ranga Ora Haumoana Service for DHB provided services. (EOA)	Met	Met
		Explore opportunity to partner with the PHOs to establish two whānau centred general practice and social service wrap around, one of which is kaupapa Māori, implemented through a whānau ora model of care. (EF)	Not met. In progress	Not met – yet to be formally considered due to other priorities
		Ongoing implementation and monitoring of Korero Mai (EF)	met	Met
		Korero Mai seeks to enable patients and whānau to communicate concerns about a patient's deteriorating condition	met	Met
		Reporting of results	met	Met
	Pro-equity priority areas:	Improve transparency in data and decision making: (EF)	met	In progress – more work required
		share equity analysis widely and include it in decision making		Needs more refining and consistency
		transparency in resource allocation, including equity analysis in all publicly reported data		In progress – further work required
		Support more authentic partnership with Māori: (EF)	Met	Met
		meaningful participation in the design of services and interventions to support Māori self-determination and whānau ora.		Met
		Ensure provision of information for Māori whānau meets the guidelines for health literacy. (EF)	Met	In progress - further education required and improved consistency in patient information
	Waimarino development	Co-develop design work and complete business cases (EF)	Met	

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2.6.2 Pacific health action plan	Pacific	Scope population profile and health needs to inform development of a Pacific Health Action Plan through a collaborative approach with the Pasifika community. (EF)		Initial research into Pacifica demographics completed, currently under discusion

2.6.3 Care Capacity Demand (CCDM)	Governance	There has been a change in the governance structure at WDHB. This includes a change in the chair for CCDM council, a change in the coordinator role to the ADON and a review of roles and responsibilities and systems and processes. This will strengthen the programme and support the 2021 deadline.		Met The governance and operational meetings are formalised and well attended.
	Activity	Ongoing monitoring of CCDM and TrendCare work plans through CCDM Council. (EF)	Met	Met
	Focus: Improved variance response management (VRM)	Operations centre is running and shift reporting done actively and in a 'live' manner. Live data is being used.	Met	Met
		Review analytics to ensure we are collecting the correct data to respond appropriately to staffing deficit.	Met	Met
		Align VRM to emergency response plans.	In Progress	Met
2.6.6 Planned Care	Strategic Priority 1 - Improve understanding of local health needs, with a specific focus on addressing unmet need, consumer's health preferences, and inequities that can be changed. (EF)	Analyse and benchmark intervention ratios to show potential focus areas	Met	
		Include equity analysis within intervention ratios	Not met	
		Use the results of the post-COVID consumer engagement surveys to highlight preference where applicable	Not met	
	Strategic Priority 2 - Balance national consistency and the local context	Maintain delivery rates that are consistent with national standard intervention ratios – this includes assessing models of care and how these are delivered in context of our local community.	Underway	See narrative reporting under SS08

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		Engage governance and clinical leadership on the potential impact of the national consistency approach	Met	See narrative reporting under SS08
		Define options for requisite adjustments	Underway	See narrative reporting under SS08
		Work with sub-regional partners to consider mutually beneficial approaches	Met	See narrative reporting under SS08
	Strategic Priority 3 - Support consumers to navigate their health journeys:	Review systems for booking and contacting patients regarding inpatient and outpatient events to ensure timely advice of pending treatment and reducing missed appointments (EOA)		See narrative reporting under SS08
		Review service models and identify potential services for change		See narrative reporting under SS08
		Review completion with recommendations		See narrative reporting under SS08
		Understand impacts and plan for implementation of accepted recommendations		See narrative reporting under SS08
	Strategic Priority 4 - Optimise sector capacity and capability	Review the process used to allocate operating times for surgeons. This will assist in list planning as one component of improving service delivery:	Underway	
		Develop Terms of Reference	Met	
		Agreed practices for surgeons and nursing perspectives completed	Met	
	Strategic Priority 5 - Ensure the Planned Care systems and supports are sustainable and designed to be fit for the future	Commission a comprehensive theatre productivity review to ensure theatre use is optimised and emerging opportunities for improved planned care can be implemented		Met
		Review throughput		Underway
		Reduce cancellations		Underway
		Develop robust production plan		Underway
		Consider flexible working arrangements and better integration with other hospital activity		Underway

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2.6.7 Acute Demand	69,000 beds	Streamline care across community health providers		Note: Reported 2.2.2 (Savings Plan)
		Enable community and Whānau centred care		
		Reduce "doubling up" of community services by stronger integration models		
		Enable faster access to services by reducing silos created between systems		
		Home and community support services review and redesign		
		Implement wellness/prevention model of care for reducing future costs		
		Enhance support for patient groups identified at risk of hospital admission/readmission		
		in the home models of care, partnering across social services and NGOs.		
	Acute data capturing	Switch over to SNOMED – still to be scoped as a regional project to meet 2020/21 timeframes.		Not met
	Patient flow activity	In the post-COVID environment we will continue to run an "influenza" clinic/workstream at the hospital front-door. This will be based on the CBAC model that existed through alert levels 2 – 4 and will ensure better streaming of patients, isolation of winter ills and the ability to re-establish a swabbing regime if necessary	Not met, CBACs remain in place	Not met – CBACs remain in place
		Continuing with the dedicated haumoana (family/whānau navigator) service in the Emergency Department. This service operates 24 hours each day to support Māori whānau while they are in hospital from acute presentation to discharge. On site accommodation is available for the family/whānau of patients to enable them to be with patients during their stay.	Met	Met
		Developing streamlined processes and protocols for early identification of those patients that are likely to be acutely admitted to hospital from ED and fast tracking those patients directly with the appropriate specialist team.	Underway	Underway

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	Understanding demand during COVID 19 and responding in new ways	Post-COVID 19, the district has embarked on an intensive community engagement process along with our recovery partners. Together we are asking the community for feedback on their experiences of the COVID pandemic across health, social and economic perspectives. The pandemic resulted in many acute services having a significant drop in attendance that we need	Underway	
		to understand. Alternative methods of serving that demand or of avoiding it altogether will be identified.		
		A significant amount of acute demand was responded to through virtual consultations – WDHB will be embedding the ability for DHB clinicians to safely deliver virtual consultations	Met – telehealth roll out across all services	

2.6.8 Rural Health	Telehealth for Rural communities	Develop new model of care to test with other services		CMAHS Psychologists are currently engaging with telehealth in the Marton and Taihape area. There is work underway to engage with the rebuild of the Waimarino Health Centre to create a telehealth space that allows for patient and Whanau centred care. Ongoing engagement with DN's, CNS's, community OT and physiotherapy is occurring to encourage services via telehealth to rural areas.
	Support community led consultation, and engagement with iwi, staff and community providers for the	Project Group Established		Met

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	redesign of the Waimarino Health Centre. The focus will be on identifying the needs of the Waimarino community, building on work undertaken as part of the Ruapehu Whānau Transformation Plan to develop a Wellness Centre that supports greater integration and enhanced models of care to improve access to health and support services for the Waimarino community – (see also section 2.6.1 Whānau Ora): (EF)			

2.6.9 Healthy Ageing	ACC Non-Acute Rehabilitation (EF)	Develop pathways/service for rehabilitation in the community and align with other community-based developments to encompass ACC non-Acute rehab (NAR).		Partial – work underway
	Addressing Frail and Vulnerable Older People (EF)	review with St Johns Ambulance service directly into ED by developing clinical pathways and models of care including home based support services, community providers and non-acute rehabilitation (supported discharge and transitions of care)		Partial – work underway
		implement Health Pathways supported by planned care and community care funding options		Partial – work underway
		continue to work closely with HQSC and support locally Advance Care Planning and Serious Illness Conversations		Met

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		Implement frailty health pathway		Not Met – Health Pathways being implemented as prioritized
		ensuring quality ethnicity data is included and results interrogated for equity in Māori Health outcomes		Met
	Carer Strategy (EF)	more accessible respite		Not Met – COVID
		management of continence		Not Met – COVID
		Funded Family Care		Met
	Home and community support – 69,000 beds (EOA)	Over the next two years partner with an inclusive range of representatives from our communities to redesign through co-design an integrated and coordinated community model incorporating home and community support, iwi providers, community NGOs, district nursing, specialist nursing and allied health, working in partnership with general practice teams focused on keeping people well in the community.		Partial – work underway
		The model will be informed by the Home and Community Support Service Framework and Service Specification outcomes from Live Stronger for Longer and Pressure Injury Review		Met
		Other funders such as ACC will be included. This work will also be a major contributor to assisting the DHB to address the drivers of acute demand for people aged 75 plus presenting at ED and urgent care services (including at lower ages for disadvantaged populations).		Met
		The approach will include a kaupapa Māori approach for kaumatua and includes working in partnership with interRAI NZ as they undertake a national review of interRAI by Māori and include other key stakeholders. (EF)		Not met – depends on interRAI NZ
		The first steps are to scope this commissioning project and agree the national standard bulk funding approach for home and community support services.		Met
	Implementing Dementia Framework (EF)	Support a regional approach to implementing the Dementia Framework locally.		Met

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	Live Stronger for Longer – Falls Prevention and Fragility Fracture Management (EF)	Continue to work with ACC, HQSC and the Ministry of Health to promote and increase enrolments in strength and balance programs and improvement in data driven osteoporosis management the as reflected in the 'Live Stronger for Longer' Outcome Framework, Healthy Ageing Strategy and DHB district whole of system approach.		Met
		The DHB in partnership with ACC and other key stakeholders will be undertaking an evaluation of the current programs for falls prevention and fragility fracture management. This evaluation will include identifying options for innovative delivery for community strength and balance and data driven bisphosphonate prescribing by primary care. This will be completed prior to December 2020 (EF)		Met
	Pressure Injury Prevention and Management (EF)	The DHB is working in partnership with ACC to progress pressure injury prevention and management programme across the WDHB district. This initiative includes linkages with age residential care, general practice and community providers.		Met
		The DHB in partnership with ACC and other key stakeholders will be undertaking an evaluation of the programs currently being offered. This will be completed prior to December 2020		Met

2.6.10 Improving Quality	Adverse events	Continue to undertake CSA/RCA/Case/London Protocol review for all SAC1/2 adverse events		Met
		Implement the national mental health adverse event template/process when this is available		Met
	Implement the new national inpatient survey once this is released by HQSC:	Implement the new national inpatient survey once this is released by HQSC:	Met	
		continue to engage with consumers and apply co-design principles in all service improvement activities. (EF)		Met
	Monitor all HQSC QSMs, including falls,	monitor ethnicity variations and develop plans to improve equity where inequities are identified (EF)		Met

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	pressure injuries and safe use of opioids and develop improvement plans where results are below the national average. HQSC QSMs are monitored and results are available on the national dashboard:			
	Reducing seclusion	Staff continue to work in a trauma informed way		Met
		Improve use of sensory modulation, as evidenced through increased episodes (EF)		Met
		Use of Māori sensory modulation kits (EF). Application of PDSA to implementation.		
		Continue to monitor the national KPI for seclusion hours and events		Met
	Service transition	Implement a discharge nurse position (general health)	FTE was disestablished by finance as part of the wash up last financial year; the fte was vacant.	
2.6.11 New Zealand Cancer Action Plan 2019-2030	Current Performance Actions	WDHB will continue the patient tracer audit programme and implementation of continual quality improvements identified in patient journeys that breach the 62-day target. (EF)	Met	Met
		WDHB has a Haumoana specifically to work with Māori and Whānau to provide support to assist them to navigate health services through their journey and to ensure equitable outcomes. This work will be led by a clinical team and include the cancer nurse coordinator and the Māori health team. (EF)	Underway	Underway
		Further planning initiatives will be developed in line with the National Cancer Action Plan and national cancer agency guidance.	Underway	Underway
	Local cancer services	Service business case completed	Underway	
		Facility business case completed		Met

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2.6.12 Bowel screening and colonoscopy wait times	In 2019/20 WDHB was allocated capital funding to develop a local chemotherapy and infusions unit. Planning is underway to have this established by 2021/22. It is anticipated that the current limited local chemotherapy options will be expanded significantly by having a local service and that this will reduce the need for WDHB residents to travel to Palmerston North for those procedures. Radiation oncology will continue to be based at the RCTS.	Continue to monitor and report on performance against urgent, non-urgent and surveillance colonoscopy waiting times (EF)	Met	Met Ongoing
		Discuss recommended and maximum wait time performance as standard agenda item at monthly endoscopy user group meetings. (EF)	Met	Met Ongoing
		Develop policy for management of endoscopy waiting list that includes escalation process for patients at risk of exceeding maximum wait time. (EF)	Draft policy developed and currently under review.	Met
		Develop report that identifies all patients that are waiting for colonoscopy by ethnicity and triage category. Include acuity index calculation, so that patients at risk of exceeding maximum wait time can be easily identified. (EF)	Met	Met
		Ensure 95% of bowel screening participants who return a positive FIT have a first offered diagnostic date that is within 45 working days of their result being recorded in the NBSP IT system, with no equity gap for Māori and Pacific populations (EOA)	Met	Met Ongoing
		Ensure at least 60% of eligible bowel screening population participate in the programme, with no equity gap for Māori and Pacific Island populations (EOA)	Met	Met
		Review and discuss bowel screening participation rates and bowel screening colonoscopy wait time results by ethnicity (Māori, Pacific Island, Asian, Other) at bowel screening equity working group meetings. (EF)	Met	Met Ongoing
		Facilitate the delivery of health promotion activities identified through the bowel screening equity working group, the bowel screening communication and engagement plan, and the bowel screening equity plan. (EF)	Met	Met Ongoing
2.6.13 Workforce	Align staff development with	Include health literacy as core component of staff training. (EF)		Not Met - Yet to be included in mandatory training and orientation

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	health gain areas for the district.			
	Be guided by the MoH Raranga Tupuake – Māori Workforce Development Plan. (EF)	Guidance is reflected in actions	Met	Met
	Continue to grow clinical leadership across medical, nursing and allied health, scientific and technical staff.	Complete Talent Mapping for WDHB tier 2 employees completed		Not Met - New Leadership group
	Continue with placing training interns at the WDHB.	Work with managers and executives to support expansion of the programme placing training interns at the WDHB.	Training interns in place. Expansion of the number of interns an ongoing process.	Met Ongoing
	Create environments where our people are well supported and enabled to thrive and deliver the best care to our patients, whānau and communities. (EOA)	Create environments where our people are well supported and enabled to thrive and deliver the best care to our patients, whānau and communities. (EOA)	Ongoing	Partial Ongoing
	Deliver on the WDHB pro-equity plan where the conditions for equity are created. (EF)	Equity KPIs agreed for all leadership / management roles	In progress	
		Agree equity targets to proactively grow Māori workforce across the health district that reflects proportionally for our Māori population by 2030	In progress – scoping underway to determine current status in district.	
		Use of Te Reo Māori reflected in all WDHB communication and formal interactions	In progress – ongoing work to further expand use of Te Reo.	
	Develop a retention and recruitment	Recruitment and Retention strategy for Māori staff developed		Partial - DHB recruitment Strategy revised and approved

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	strategy that includes health providers across the district that is focused on Māori staff. (EOA)			by executive Dec 2020- to be socialised with staff
		Implement the WDHB recruitment and retention strategy focused on Māori staff. (EOA)		Partial - DHB recruitment Strategy revised and approved by executive Dec 2020 - to be socialised with staff
		Increase number of Māori staff working in health across the district		Partial. Ongoing - Slow increase in number of Māori staff over past two quarters
	Develop a sustainable approach to nursing career pathways.	Equitable funding for professional development for nurse practitioners	In progress	In progress
	Development	Meet all of our training and facility accreditation requirements from regulatory and professional bodies, including New Zealand Nursing Council, Medical Council of New Zealand, New Zealand Dental Council, Pharmacy Council and Medical Colleges	Most areas comply. Awaiting confirmation following actions implemented.	Partial – Two corrective actions to be finalised
		Accreditation requirements met.		Partial
		Education committee actively leads training at all levels within the DHB.		Partial
	Expand Te Uru Pounamu to encourage connection between Māori health professionals. (EOA)	Three wānanga held for Māori staff per year		Not Met - Yet to be progressed - planning underway
	Gender Equity.	Implement equity and pay parity agreements as per the agreed settlement timeframes.	Bargaining / Negotiations continues	First equity settlement due in Q3 2020/21
	Make our environment conducive to greater uptake by Māori to improve recruitment and retention of Māori. (EOA)	Increased interview rate for Māori applicants – 100% of Māori applicants who meet the minimum eligibility criteria for any role are shortlisted for interview (EOA)	In progress – Final consultation on recruitment policy and procedure updated.	Partial - Recruitment policy and procedure approved. Roll-out and education plan for managers in Q3 2020/21
	Proactively promote Ministry of Health funding for Māori	Monitor awareness and uptake of Ministry of Health funding by kura kaupapa and kura auraki settings	In Progress - MOH funding is promoted, continues to be promoted	Partial

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	particularly in kura kaupapa and kura auraki settings. (EOA)		- building of awareness of funding available to rangatahi / tauira when they leave school. Data would be collected from KOH registrations	
	Provide tuākana tāina support for new graduate Māori nurses through Te Uru Pounamu programme. (EOA)	All new graduate Māori nurses receive formal support	Met	Met
	Realise cultural safety throughout the entire workforce. (EOA)	All staff, Board, management and leadership will continue to demonstrate participation in cultural competence training	Met Second phase of cultural training programme commenced.	Met
		Cultural safety monitored against changes to individual clinical practice which ensures Māori receive optimum care	Ongoing	Partial Ongoing
		Expand existing programmes that build on organisation culture and values to include action on racism and institutional bias	In progress	Partial
	Strengthen and maintain focus on Kia Ora Hauora. (EOA)	All Kia Ora Hauora graduates that wished to work in the WDHB are employed.	In progress	Partial
	Support and remind staff to update their ethnicity status. (EOA)	Review and update ethnicity collection so that the DHB has 0% employees who have their ethnicity recorded as unknown.	Met	Met
2.6.14 Data and digital	Alignment to regional strategy (ISSP) :	Contribute at workshop and executive level to optimise service delivery through a new regional operating model	Ongoing work by Central region DHBs with external consultants and TAS	Partial
		Have representation on regional clinical governance to ensure measurable clinical value	Met	Met

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		Involved in a refresh of the regional strategy with a modern digital context	Ongoing work by central region DHBs with external consultants and TAS	Partial
	Collaboration across community, primary and secondary care:	eReferrals will digitise, streamline and optimise the referral process between primary and secondary care	Generic referral form out for consultation. DXC system on the Service Now platform links to Medtech Evolution	Partial
		MS Teams supports greater collaboration with community and other external agencies	Continue to roll out teams aligned with hardware refresh	Partial
		Data sharing with main PHO generates shared insights	Ongoing	Partial
		Shared electronic health record makes primary care patient portal available to hospital clinicians	Access to manage my Health data available from CP	Met
	Consumer access to health information:	Deliver technology solution	No action	Not Met
	DHB ICT investment portfolio:	WDHB commit to providing quarterly reports to Data and Digital directorate	No action	Not Met
	Embedding gains from changes introduced during Covid-19:	Roll out of Microsoft Office and Teams	Follows roll out of new hardware	Partial
		Creating technical capability for roll-out of telehealth within DHB-provided services	Telehealth system utilised in some areas continuing with the roll out	Partial
	Fax machines. In removing fax machines WDHB will:	Provide secure email supported by SMS text messaging		Met
		Utilise secure links through MS teams to provide collaboration access to files	Follows roll out of teams	Partial
		Deconfigure fax access in multifunction printers with fax components.	Work underway	Partial
		Implement eReferrals to replace the current fax process.	Generic referral form out for consultation. DXC system on the Service	Partial

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			Now platform links to Medtech Evolution	
	IT security. To improve our security across digital systems:	Recommendations from Security Assessments will be reviewed and implemented where possible.		Met
		Enhanced security features available through our MS e5 licensing will be implemented	Some features turned on others require further testing	Partial
		Upgrade operating systems and replace aged hardware.	Follows roll out of new hardware	Partial
2.6.15 Implementing the New Zealand Health Research Strategy	Research and innovation, analytics and technology are all crucial for achieving an equitable, sustainable health system and better patient outcomes.	WDHB will identify regional networks to create research and analytics networks to support staff engaged with research and innovation and build capacity and capability. (EF)		Not met Research is being supported at a local level as per the WDHB research strategy
		Regional networks will report to ELT and Clinical Board		Not met

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Give practical effect to He Korowai Oranga – the Mâori Health Strategy				
Subsection	Activity	deliverable	Q_1	Q_2
2.1.1 Engagement and obligations as a treaty partner	Strategic	Maintain partnership and close working relationships between WDHB and Hauora Iwi (HAI), through:	Met	Met
		Regular joint hui (EF)	Met	Met
		Involvement of HAI members in all key DHB strategic discussions and decisions (EF)	Met	Met
		Consultation with HAI and joint board endorsement of the new WDHB He Hāpori Ora Thriving Communities Strategy Document 2020 – 2023 (EF)	Met	
		Message from HAI included in the foreword of the WDHB 2020/21 annual report (EF)		Met
		Joint board monitoring of equity measures in WDHB Annual Plan and pro-equity implementation work plan (EF)	Not met. Scheduled for next joint boards	Partial, preliminary work under way
		HAI representation on all interviews for executive positions (EF)	met	Met
		HAI representation on combined statutory advisory committees and performance review for chief executive (EF)	met	Met
		A follow-up facilitated partnership hui, with WDHB board and HAI, to further embed responsibilities under the Treaty, the five principles, pro-equity and monitoring processes. (EF)	Not met. COVID. To be actioned 2021.	
	Waitangi Tribunal	Plan and begin the roll out of embedding obligations under the five Treaty principles in updating key policies and procedures. (EF)	met	Met
		Continue to participate in the design and implementation of the proposed Ministry of Health Treaty framework, to be set out in the new Māori Health Action Plan, to ensure WDHB meets its statutory obligations, as prescribed by the Tribunal and its interpretation of the Treaty clauses under the NZ Public Health and Disability Act 2000. (EF)	met	Met
		Continue support for the Central Region's Iwi relationship boards Te Whiti ki te Uru forum and their alliance with the Central Region CEs and Chairs (EF)		Met

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		Continue participation in the Central Region GM Māori forum to influence across the region and share learnings and initiatives. (EF)	met	Met
		Continue participation in national Māori health leadership forum Tumu Whakarae. (EF)	met	Met
	Pro-equity	Continue to implement the WDHB Pro-equity Check-up Actions Implementation Plan 2019-21 report under 5 recommendations:		Met
		Strengthen organisational leadership and accountability for equity (EF)	met	Met
		Build Māori workforce and Māori health and equity capability (linked to workforce development) (EOA)	met	Met
		Improve transparency in data and decision making (EOA)	Not met. In progress.	Draft developed to be refined – in progress
		Support more authentic partnership with Māori. (EF)	Met	Met
	Leadership	Continue to provide professional development (training) for DHB leadership on the impact of racism, impact on colleagues and workforce, the impact on quality outcomes for patients and their whānau, and the use of equity tools and methodologies. (EOA)		Planning under way
		Introduce mechanisms that will be there to support Māori staff, if they have been victims of racism, as leadership and the organization addresses the impacts of racism (EF)		Current approach needs refinement in line with education programme
		Continue to support equity professional development to local provider partner leaders (EOA)	met	Met
		Apply equity methodology and monitoring to decision-making processes including commissioning, service delivery models and service changes (EOA)	met	In use – needs further refinement
		Continue to support development and provision of education for elected board and committee members in understanding the impact of racism and colonisation on health outcomes for Māori whānau and the use of equity tools and methodologies. (EOA)	met	Met
		Continue to provide cultural safety education as part of WDHB board member local induction programme (EOA)	met	Met

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		Continue to role model WDHB values and WDHB tikanga o Whanganui practices. (EF)	met	Met
2.1.2 Māori Health Action Plan (MHAP) - accelerate the spread and delivery of Kaupapa Māori services	Identify initiatives and opportunities to accelerate the spread of kaupapa Māori services and commissioning for whānau ora outcomes by:	applying equity methodologies to commissioning process across all new and expiring contracts for service and identify initiatives and opportunities to confirm and maximize investment that meets the needs of Māori (EOA)		In use – needs further refinement
		continuing to work in partnership with Iwi health organisations through the Māori Health Outcomes Advisory Group (MHOAG) to develop services that meet the needs of Māori whānau (EOA)	met	Met
		review (MHOAG) Terms of Reference (EF)		Met
		continuing to contract with kaupapa Māori service providers to maximise the use of whānau ora outcomes focused contracts:	met	Met
		maximise opportunities presented through the COVID -19 response to improve funding models and models of care and delivery (EF)		Met
		constantly seeking opportunities to provide a service in a kaupapa Māori setting/way, especially with any new initiative and funding opportunities (EF)	met	Met
2.1.3 MHAP – shifting cultural and social norms	Addressing bias in decision making:	include learnings from other DHBs on programmes, speakers and tools to support staff. (EF)	met	Met
	Enabling staff to participate in cultural competence and cultural safety training and development:	continue Hāpai te Hoe programme – WDHB policy confirms mandatory attendance for all WDHB staff and board members (EF)	met	Met
		enable the role of Kaitakitaki, Te Hau Ranga Ora (WDHB Māori health services team), in providing advice and support to executive leads and their teams (EF)	met	Met
		maintain the role of the Haumoana service (WDHB Māori health service) across all services to support whānau (Māori and non- Māori) and provide cultural support for staff 24 hours, seven days per week (EF)	met	Met
		ensure leaders 'walk the talk 'and more specifically addresses racism and discrimination within the frame of the	Not met. Education ongoing to support leaders	Planned approach – tested with staff – to be finalised

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		organisation's values and expectation that racism and discrimination of any sort is unacceptable. (EF)		
	WDHB Pro-equity Check Up implementation plan identifies a programme of work that builds on what the DHB is already undertaking to shift cultural and social norms.	continue to deliver Hapai te Hoe to all new staff prior to commencing work and as the first two days of the DHB orientation programme (EF)	met	Met
		continue to include key community partners and external agencies i.e. St John, Hospice Whanganui, UCOL Tutors Nursing Faculty, UCAL Nursing students, NZ Police, Coronial Transport Services and Local Funeral Directors (EF)	met	Met
		develop and implement Hāpai te Hoe extension course (Te Waka Hourua) that builds on orientation HTH and focusses on whānau ora models of care and DHB values (EF)	met	
		support the implementation of health discipline specific cultural frameworks to support professional development and best practice. (EF)	met	Met
2.1.4 MHAP – reducing health inequities – the burden of disease for Māori	Data	develop and implement pro-equity tools and methodology to guide decision making for investment and procurement (EF)		Needs more refining – in progress
		support development of a dashboard to monitor progress towards equity for Māori across priority indicators. (EF)	Not met. In progress	
	Reporting	reporting for equity to the statutory advisory committees and the Joint boards of WDHB and HAI. (EF)	Not met. Reporting tool to be developed	Draft developed to be refined – in progress
2.1.5 MHAP – strengthening system settings	Activity	Driving a commitment to pro-equity approach through governance support and executive leadership. (EF)	met	Met
		Development of clearer prioritisation frameworks that embed equitable outcomes actions, ethnicity in all data and equity in all data analysis which have governance endorsement and that inform annual prioritisation planning. (EF)		Work has started – needs refining
		Use contractual opportunities to increase equity-based reporting from contracted providers	Not met. To be progressed	Not met work will be progressed Q3 Q4 Check with Candace

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Improving Child Wellbeing				
Subsection	**Activity**	**deliverable**	**Q_1**	**Q_2**
2.3.1 Maternity and Midwifery workforce	Activity	Attract and recruit an appropriately skilled Director of Midwifery (DoM) to manage workforce development and drive governance across midwifery services.	Lucy Pettit , Director of Midwifery (DOM) was appointed on 20th July and is now in position.	
	The WDHB will support undergraduate midwifery students:	facilitate and support Otago Polytechnic's satellite midwifery school		Quarterly meeting commenced with Otago Polytechnic's satellite midwifery school Kaiako, CMM, DoM and Mid Ed. All midwifery students have a prepared roster with named preceptors. Successfully recruited one new grad midwife engaged in the MFYP. Currently advertising for a second new grad midwife. Only one Māori new graduate midwife qualified 2020 and she has chosen LMC practice.
		named preceptor for all midwifery student on placements		Met
		student offered equal opportunities to participate in any local midwifery education		Met
		employ at least one new graduate midwife from this programme (EF)		Met
		support and encourage participation in the Midwifery First Year of Practice programme (MFYP)		Met
		encourage Māori new graduate midwives to engage in Te Urupounamu, cultural Supervision. (EF)		Met
		Activities that address service delivery due to predicted seasonal changes in service demands:		LMC capacity and leave dates confirmed and DHB primary midwifery service recommenced in December 2020. This service is for re-evaluation after 6 months.

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				All women assisted to secure LMC postnatal care. Core midwifery staffing adequate.
		establish LMC capacity and leave dates for December/January/February		Met
		re-establish DHB primary midwifery service for women unable to secure LMC services		Met
		ensure maternity service staffing establishment is adequate for additional unit labours & births, using the CCDM framework		Met
		establish LMC capacity to provide postnatal care for women under the DHB primary service or establish a DHB postnatal service (EF)		Met
		communicate to the local community. (EF)		Met
	When the DoM appointment is in position (hospital and community) establish a project team to:	develop longer-term midwifery workforce plan that has an equity focus including cultural competency and increased Māori participation in the workforce (EOA)		Project team assembled and first meeting held
2.3.2 Maternity and early years	Activity	Implement the recommendations of the WCTO review. (EOA)	Still awaiting the feedback from MoH regarding the outcome o fthe review.	The MoH have not released any outcomes or recommendations from the WCTO review at this time.
	Develop and implement a Maternity and Early Years Key Stakeholder database (community and services) for the WDHB region :	develop baseline database that has ethnicity in all data and equity in all analysis including: (EOA)		Met, initial database underway.
		number of current stakeholders engaged with Maternity and early years		To be completed in Q3
		number of Māori and Non-Māori community stakeholders		To be completed in Q3
		number of Māori and Non-Māori service providers		To be completed in Q3
		number of kaupapa Māori services.		To be completed in Q3
		evaluate baseline database for gap stakeholders: (EOA)		To be completed in Q3
		identification and number of gap stakeholder.		To be completed in Q3

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	Provide intensive intervention to pregnant women and whānau with children under 3 years with co-existing alcohol and other drug issues with a using on a kaupapa Māori model: (EOA)	develop kaupapa Māori service model	WDHB is collaborating with MHOAG to develop, design and implement an iwi led kaupapa Māori service, delivered across the five iwi health providers. The development and design is almost complete and we are now beginning the implementation phase of the project. A service manager is in the process of appointment and advertising for the remaining FTEs will begin early October with their proposed start date in November/December 2020. Once all staff are appointed, they will complete inductions with their Providers as well as He Puna Ora and begin intense training with the aim to be fully operational by March 2021.	
		implement new service tranche 1		Met, team lead appointed, staff recruited.
		Implement safe sleep activities/strategies delivered through wānanga in alignment with the Whanganui Sudden Unexpected Death in Infancy (SUDI) Plan for the WDHB rohe. (EOA)		LMC and GP's encouraged to provide more smoking information and to refer whanau smoking to services rather then make it all about the hapu mama. John M & Quit Smoking Service met with

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				WRHN clinical team to look at options moving forward as part of service review which aims to ensure whanau needs are being met. Maori staff employed to improve engagement with whanau. Working to identify GP practice champions. WRHN have employed a Kaiawahina to work more closely with smoking Hapu mama to promote smoke free, safe sleep and support wrap around service engagement.
	Shaken Baby Prevention Programme (Power to Protect) (EOA)	Establish and document identified Power to Protect related activities including education, training, key messages and community programmes with a focus on Māori providers and working collaboratively with them on meeting their population's needs. (EOA)		WRHN - 97 Hapu Mama and significant others attended Antenatal classes and received Power to Protect video and discussion. 137 safe sleep spaces have been given who all received the education as well. (Some of these hapu mama both attended Antenatal classes and received safe sleep spaces.)
	increase number of pregnant women and/ their whānau referred to Stop Smoking Service	increase number of safe sleep devices distributed to Māori whānau with risk factors.		Met
2.3.4 Immunisation	COVID -19 Response	work alongside general practices to establish what the new normal is for COVID -19 level one for immunisation. (EF)		Met
		highlight safety of the new normal and communicate to whānau using multi media/joint communications (WDHB and PHOs) to encourage and have confidence in returning for immunisation and focus on priority population (complements the national campaign). (EOA)	Draft media plan developed.	Met, use of social media, weekly updates and practice visits

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		Te Oranganui that will include immunisation, though targeted for high needs populations and Iwi based, it is open to all. Includes a media campaign. (EOA)	Met, and on going	
	Provide HPV immunisation catch up for year 9-13 students in conjunction with the National MMR Campaign: (EOA)	develop and implement plan	Implementation plan approved and campaign underway	
	Regional immunisation communication plan aligns to Immunisation week 2020/2021 and influenza season. Protected Together #Immunise:	develop a joint health promotion and communication plan with the WDHB and the Whanganui Regional Health Network that covers Immunisation week and a long lead in time using various tech and channels to reach priority populations. (EOA)		In progress, working with team to develop awareness campaign, as well as MMR/HPV catch up programme.
		undertake review of media files including social media available for use in the regional communication plan (EF)		To be reported on in Q3, huge focus of work diverted to MMR/HPV catch up, COVID response
		evaluation use of social media in the community and views recorded. (EF)		To be reported on in Q3, huge focus of work diverted to MMR/HPV catch up, COVID response
		Conduct opportunistic childhood vaccination with a focus on Māori when they interface with community and secondary services. (EOA)		Met, pathway implemented
		Undertake a data review on the number of children under 5 years presenting at Whanganui Accident and Medical (WAM) and the WDHB emergency, paediatric and dental departments. (EOA)		Met, data review completed
	Work alongside interagency networks, communities, to support an increase in Māori	facilitate discussion between WINZ young parenting course and immunisation services to focus on the immunisation uptake of the young participants and their children	Initial discussions, on-going networking.	
		facilitate resources to support the implementation of this programme		Met, resources, information distributed as part of the programme.

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	childhood immunisation coverage. (EOA)	provide immunisation clinics between July-November 2020.		Met, weekly clinics are available.

Improving Mental Wellbeing				
Subsection	**Activity**	**deliverable**	**Q_1**	**Q_2**
2.4.1 Mental health and addiction system transformation	Establish the Whanganui Mental Health and Addiction Service Level Alliance to address challenges in mental health and addictions outcomes with a specific focus on Māori, by enabling a system-wide and multi-perspective approach to service design/redesign	build on the foundation set in Whanganui Rising to the Challenge, which outlined the future development of the district's whole-of-system mental health, addiction and wellbeing options	WORK IN PROGRESS	Met
		consider the full continuum of need for the Whanganui rohe		Met
		include participation and perspectives of people with lived experience	onging	Met
		enable co-design and iwi/community engagement from diverse communities	ongoing	Met
		provide recommendations to primary and secondary fund-holders.	ongoing	Met
	Placing people, whānau and	support mechanisms that enable real time feedback from tangata whaiora and their whānau into quality	Met	Met

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	tangata whaiora at the centre of all service planning, implementation and monitoring programmes:	programmes by improved utilisation and uptake of Marama Real Time Feedback and participation in the Conversation Cafe (EF)		
		ensure that individual care planning meetings involve a supported decision making focus which enables feedback from tangata whaiora and their whānau directly into their own care (EF)	WORK IN PROGRESS	Met
		focus on how we address equity for Māori, Pacific, young people, rainbow community and other population groups who experience disproportionately poorer outcomes (EF)	WORK IN PROGRESS	Partial – further education to raise awareness for clinicians has been scheduled
		actively partner with the Māori Health Outcomes Advisory Group (MHOAG) to facilitate efficacy of the Matauranga Māori qualitative research (EF)	WORK IN PROGRESS	Met
		development of a mental health and addiction measures dashboard to enable effective monitoring including of equity. (EF)	WORK IN PROGRESS	Partial – development of dash board continues
	Embedding a wellbeing and equity focus:	strengthen our focus on mental wellbeing through healthy active learning, (sleeping, physical activity and healthy food and drink) by health promotion, prevention, identification and early intervention (EF)	WORK IN PROGRESS	Met
		work with the Health Quality Safety Commission (HQSC), wellbeing focus for people with serious mental illness including the tangata whaiora in forensic units in our district inpatient unit and wider community (EF)	WORK IN PROGRESS	Met
		implement 'Supporting Parents, Healthy Children' to support early intervention in the life course (EF)	Met	Met
		collaborate and work with the Ministry, the Mental Health and Wellbeing Commission, the Suicide Prevention Office and other leadership bodies and key partners to drive transformation in line with He Ara Oranga. (EF)		Met
		Target people with low prevalence conditions to be a priority for DHBs funded employment, education and training resource (EF)	WORK IN PROGRESS	Met
		resuming the Equally Well project to improve the physical health outcomes for people with mental health and addiction conditions (EF)	To commence	Not met – project deferred by HQSC. To be reactivated 21/22

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		improving responses to co-existing problems via stronger integration and collaboration between other health and social services. (EF)	WORK IN PROGRESS	Met
	WDHB's Mental Health Service Level Alliance will: Increasing access and choice of sustainable, quality, integrated services across the continuum:	work in partnership with the Ministry, Māori, Pacific people, young people, rainbow community and people with lived experience, NGOs, primary and community organisations, and other stakeholders to review and strengthen the integrated approach to mental health, addiction and wellbeing	WORK IN PROGRESS	Met
		pass on maximum cost pressure funding to DHB funded mental health and addiction NGOs as of 1 July 2020	Met	Met
		enhance respite options to include an emphasis on therapeutic programs and smooth transitions of care	Met	Met
		support the roll out of new primary level responses (EOA)	Met	Met
		strengthen and increase focus on mental health promotion, prevention, identification and early intervention (EF)	WORK IN PROGRESS	Met
		support our Community Mental Health and Addictions Service (CMHAS) team to: (EF)	WORK IN PROGRESS	
		remodel crisis team to improve response time and enable service users direct and timely contact with a clinician	WORK IN PROGRESS	Met
		review the current delivery of home treatment and assertive outreach and consider day therapeutic programme options		Partial met – delays due to union involvement and late implementation of home care medical
		implement commitment to resourcing Emergency Department with a specialist mental health and addiction educator to build capability of front line staff		Met
		work alongside other colleagues to modify the Whakataketake combined risk assessment screening questions to incorporate mental health risk screening for depression and suicidality		Met
		in the Network model of care, clinical psychologists in each hub provide support to primary care clinicians in order to		

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		share knowledge and expertise and increase access.		Met
		will develop use of virtual consultations to expand access and to include the health improvement practitioners as these are appointed to primary provider practices, with effective triage through the SPOE (Single Point of Entry) matching tangata whaiora need and most appropriate level of service provision.		Met
	Suicide prevention	co-design high level action plans with community leaders and communities	WORK IN PROGRESS	Met
		implement from 1 July 2020 applying equity thinking and methodology at every touch point.	WORK IN PROGRESS	Met
	Workforce (note links to section 2.6.13 and 4.3):	work towards developing a workforce that reflects the community (EOA)		Met
		encourage the use of Supported Decision Making (SDM) principles by all mental health clinicians across all practice settings in preparation for the changes which are forecast in the Guidelines to the Mental Health Act		Met
		require all psychiatrists, psychiatry SMOs and trainees to improve their education and training in the use of SDM principles including consumer rights, to clearly identify differences between shared and supported decision-making either via the training package, online training module or other suitable training opportunities.		Met
		prioritise workforce education and upskilling of clinicians in psychological therapies as well as supporting primary care clinicians to upskill (EF)		Met
		continue to build the knowledge of all WDHB staff in Te Tiriti o Waitangi, pro-equity and impacts of racism (EF)	WORK IN PROGRESS	Met
		ensure all staff have completed the WDHB cultural education programme Hapai te Hoe (EF)	WORK IN PROGRESS	Met
		encourage participation in WDHB run Te Reo courses require all front-line staff to complete and implement learning on addressing bias in decision making. (eg via HQSC website) (EF)	WORK IN PROGRESS	Met
		enable staff to participate in cultural competence and cultural safety training and development, including		Met

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		supporting clinicians in the implementation of the Medical Council of NZ Statement on Cultural Safety (October 2019) and MCNZ He Ara Hauora Māori: A Pathway to Māori Health Equity (EF)		
		work in partnership with workforce centres to strengthen current workforces, including a focus on retention, recruitment, training, and wellbeing (EF)		Met
		support workforce development of the appropriate knowledge and skills to support people with mental health and addiction needs, including those with co-existing needs, for example through use of the Let's Get Real framework. (EF)		Met
	Forensics	Work with MOH and DHBs to improve and expand the capacity of forensic responses from budget investment.	WORK IN PROGRESS Not lead by WDHB	Met
	Commitment to demonstrating quality services and positive outcomes:	Explore options for health informatics using platforms such as Power BI or similar (Qliksense) to enable collection of data regarding practice and to permit the measurement of outcomes. (EF)	Work in progress	Met
		Develop new measures alongside providing reporting on priority measures, and addressing equity, including: (EF)	Work in progress	
		access	WORK IN PROGRESS	Met
		comparative data to allow for assurance of equity for Māori and youth		Met
		reducing waiting times	WORK IN PROGRESS	Met
		completion of transition/discharge plans and care plans	met	Met
		mental health and addiction service development	WORK IN PROGRESS	Met
		reducing inequities	WORK IN PROGRESS	Met
2.4.4 Maternal mental health services	Activity	Engage the Pasifika community especially, in rural areas, to improve their access to MH&A Services. (EF)		Not currently able to engage rural Pasifika community
	Develop intensive intervention for pregnant women and whānau with children under 3	develop kaupapa Māori service model	The WDHB is collaborating with MHOAG to develop, design and implement an Iwi led kaupapa	

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	years with co-existing alcohol and other drug issues using a kaupapa Māori model: (EOA) (Note: link to 2.3.1)		Maori service delivered across five Iwi health providers. The development and design is almost complete and we are now beginning the implementation phase of the project. A service manager is in the process of being appointed and advertising for the remaining FTEs will begin in early October with their proposed start date in November/December 2020. Once all staff are appointed, they will complete inductions their providers as well as He Puna Ora and begin intense training with the aim to be fully operational by March 2021.	
	Provide the Perinatal Ministry of Health report:	Provide the Perinatal Ministry of Health report:		
		collect ethnicity data to measure effectiveness of programmes targeted at equity (EF)		

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Improved Sustainability				
Subsection	**Activity**	**deliverable**	**Q_1**	**Q_2**
2.2.1 Improved out year planning processes	Improving sustainability	Development of clearer prioritisation frameworks that have governance endorsement and that inform annual prioritisation planning		Partial Prioritisation framework has been developed for certain class of assets. Needs to be enhanced for all asset classes. Prioritisation of new investments is embedded in the organisational strategy and implementation plan
		Prioritisation framework agreed		Partial See above
		Development of 3 to 5 year rolling operational plans that can inform integrated annual planning with clearer impacts on capital, workforce requirements and opportunities for service redesign		Partial Sustainability initiatives for cost savings have 3 year plans and targets and are tied into 20/21 annual plan. Capital planning takes a five year view of asset replacement and new capital asset purchases required to meet annal plan objectives.
		Quality review across Provider Arm service level agreement (price volume schedule) to confirm accuracy of data collections and better inform monitoring and planning		Partial Monthly reviews are completed of provider arm volumes but further work continuing to improve the robustness of the review process to improve the quality and reliability of data on an on-going basis across all parts of the provider arm.
		Enhanced senior management involvement to ensure planning assumptions are robust		Met

		and that executive leadership is clear on the business impact of outer year forecasts.		
		Co-ordinated project management for clearer alignment of strategic activity, improved allocation of resources and better monitoring of the strategic agenda		Parital WDHB has appointed a project manager to provide project management framework over strategic projects. BA has been seconded to support the project manager. The project management function is expected to be operating fully in Q3-4
2.2.2 Savings plans	"69,000 Beds"	Avoid unnecessary hospital admissions	On-going. A single team will be established to provide immediate assessment and intervention for the deteriorating patient	A system approach to strengthening primary care response proposal has been endorsed by key parties and successful in accessing DHB / MOH innovations funding
		Streamline line care across Community Health Providers to reflect patient and Whānau centred health care system	On-going. Referral pathway for frailty and deteriorating patients will be agreed and shared with all GP practises within the Whanganui region.	On-going. Referral pathway to identify frailty and deteriorating patients will be agreed and shared with all GP practises within the Whanganui region. Reshaping how at risk older people are managed, link with demand at the front door.
		Increase access to Community Care and reduce waitlist for community support	On-going. Increase of referrals from GPS for frailty/deteriorating patients will be observed. Increased use of telehealth to improve access.	Ongoing . Increased use of telehealth to improve access, roll out across rural areas.
		Implement wellness/prevention model of care for reducing future cost including those at risk of hospital admission/readmission	On-going.	A strategy has been endorsed by WDHB / WRHN PHO / Iwi stakeholders. Moving into development of operational measures and outcomes

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		Hospital in the home models of care, partnering across social services/NGOs other partners.	On-going. WRHN will report as per agreed contracting schedule to identify opportunities for primary community integration and establish models of care to reflect this.	Process has been confirmed for progressing joint initiatives and a focus will commence on Medical Skeletal presentations with primary care intervention engaging physiotherapy, urgent care and general practice working collaboratively
	FTE Management	WDHB has an average annual FTE turnover of 7.33%. By carefully managing the replacement of staff as they resign or retire, previous growth can be reversed. Target 2.5% in FTE management improvement per annum – adjust by 50% for timing. All staff appointments to be signed off by Finance, ELT member and Chief Executive. Opportunities will be sought for combining of roles & better use of technology to gain efficiency.	Ongoing. All staff appointments (new and replacements) are required to be justified with final approval to recruit signed off by Chief Executive. FTE reporting is being reviewed for Q1 to improve transparency and accountability through both cost centres and line of business.	Met The process is currently being followed with CE having final approval. However due to volumes, WDHB is having difficulty reducing FTE numbers. FTE reporting and review is occurring monthly through both cost centres and line of business.
	Intensive IDF Management	WDHB will intensively manage its IDF inflows and outflow to maximise the use of resources within the WDHB and minimise the cost of out of region care.	Met. A senior manager has co-ordinating responsibility for the IDF management across WDHB	Met
		Intensify management of monthly IDF results to ensure accuracy of in- & outflow monthly data and inform care decisions	Met. Monthly monitoring report is provided with financials	Met
		Reduce elective IDF net outflow & return care to WDHB in support of local surgical productivity	Met. 1. Communication to neighbouring PHOs on agreed referral pathways 2. Reduced elective outflow	Met
		Redesign community care & regional arrangements to reduce out of district travel where possible	Met. 1. Regular review of regional service discussed by COOs	Met

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			2. Funding models confirmed3. centralAlliance MOU updated to show overall agreement plus schedules	
		Enhanced planning of non-washed up elements with improved annual reconciliation, redesign and renegotiation	Met.	Met
	Radiology efficiencies	Reduce costs associated with out of hours radiology Monday-Friday by initially extending general x-ray on site hours to 11pm, and reducing out of hours CT examinations that are not considered urgent.	Met.	Met
		Streamline pathway for Community Radiology referrals by establishing joint service improvement groups between Radiology, Emergency department and community including GPs.	On-going. Reviewed and socialised community referred guidelines. All referrals received are appropriate and are triaged against criteria.	Met
		Reference to National Criteria to Access Community Radiology	On-going. Engaging with CMO to highlight variability and local use of CT compared to National rates	Met
	Theatre facility capacity management	Review acute theatre utilisation with a view to reduce cancellation and OT costs; includes reduce readmissions	Met. Engaged external subject matter expert to complete a site visit	Met
		Review throughput per session by speciality to maximise resources.	Met. Findings and actions included in completed action plan included	Met
		Preference standardisation	Met	Met
		Manage medical devices and consumables to budget	Met	Met

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		Complete a theatre production plan to ensure DHB drives efficiencies and meets compliance rates.	Met. Action plan and timelines developed, completed and circulated	Met
		Create a flexible workforce, and reconfigure the working day (activities, ie ward rounds/OP etc).	Met.	Met
2.2.3 Consideration of innovative models of care and the scope of practice for the workforce to support system sustainability	Dual purpose clinic supports winter plan and readiness for re-establishment of COVID testing capability	Continue to run the central community based assessment centre (CBAC) using primary care capacity at the hospital front door through to September 2020	Met	Met
		Clinic deals with all influenza-like illness as a pre-urgent care and pre-emergency department pathway	Met	Met
		Screening of patients in their cars before guiding to definitive treatment in the clinic or referral to urgent care or emergency department	Met	Met
		Provides capacity for ad hoc or regular COVID testing if necessary	Met	Met
		Re-evaluate for continuation and consideration of role in future winter plan		Met
	Establish kaupapa Māori service response for intensive pregnancy and parenting support	Using principles of Waitemata model of intensive outreach service for women (see mental health and addictions sections)	Met. Substantive progress has been made in line with MoH timelines and expectations	Met
	Establish peer support model to support a more sustainable and holistic response to tangata whaiora in acute and emergency	Respond to anticipated RFP for acute mental health solutions	Peer support does exist with a local provider. Te Awhina is looking to work in partnership with them to look at how peer support can be provided more effectively in a genuine manner.	MET

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	mental health settings			
	Expand regional telestroke service	In 2017, the Central Region established an after hours regional telestroke service whereby stroke physicians at Capital & Coast DHB were able to provide after hours clinical oversight remotely to local emergency departments to carry out thrombolysis on eligible stroke patients. The scheme has been so successful that currently rates of thrombolysis after hours are better than those in-hours. The Central Region is now expanding the service to cover all hours. This will increase the capacity of the sub-specialty at some hospitals in the region so that thrombolysis can be guided at all the region's hospitals at any time of the day or night using remote technology.	Met.	Met
	Introducing the role of Clinical Informatician to drive clinical engagement in informatics	Reallocation of resources to support a role that works between clinicians, data specialists and information technology to enhance clinical engagement and leadership in digital and data developments	Met	Met
	Partner with Arthritis NZ and the PHO to trial a kaiawhina role supporting a targeted approach to gout management	In 2020/21 we will progress a proposal for a gout management programme combining culturally appropriate education along with a kaiawhina approach that will support improved access to medication management and engagement with pharmacy and general practice	On-going. The Whanganui GOUT STOP Programme is currently being implemented. This programme is a district wide collaborative between WDHB, Arthritis NZ and WRHN and involves the development and delivery of a new service involving Community Pharmacy, General Practice, Whanganui Accident and Medical (WAM) and a Kaiawhina, to decrease the high rates of poorly managed gout arthritis within the Whanganui district, by improving	Met

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			awareness, health literacy, medication adherence and long term management.	
	Support the roll out of early responses to mental health needs in primary care settings	Our district mental health and addictions service level alliance co-designed a response to the primary mental health RFP in 2019 and were successful in gaining funding for an approach that will see two local general practices having health coaches and health improvement practitioners support enrolled populations	Providing liaison services from secondary heath care to assist with responding to people that present to GP practices. Anticipated they will be able to respond sooner to referrals that would not normally be accepted into secondary services thereby being able to respond in a more timely manner. Transition nurse from secondary care services is working alongside GP practices to strengthen primary and secondary working relationships around referrals and discharges.	Met
		Respond to any further RFPs and evaluate impact for consideration of expansion	On-going	MET No RFPs received

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Improving wellbeing through Prevention				
Subsection	**Activity**	**deliverable**	**Q_1**	**Q_2**
2.5.12 Cross sectoral collaboration including health in all policies (HiAP)	Development of more intensive support for HiAP will require professional development. In 2020/21 WDHB will investigate:	Increasing professional development of Public Health staff in Policy and Legislation	Delays due to Covid 19	Delays due to Covid 19 priority initiatives
		Identify and recruit a student undertaking current health policy studies	Delays due to Covid 19	Delays due to Covid 19 priority initiatives
		Scoping report completed for student Internship for a Policy Assistant position at Public Health (EF)	Delays due to Covid 19	Delays due to Covid 19 priority initiatives
		Approval of internship and criteria for Policy Assistant completed by January 2021 (EF)	Delays due to Covid 19	Delays due to Covid 19 priority initiatives
		Establish Student Internship for a Policy Assistant position at Public Health by June 2021 (EF)	Delays due to Covid 19	Delays due to Covid 19 priority initiatives
		Increasing expertise in the HiAP model and its applicability to other areas of WDHB activity	Delays due to Covid 19	Delays due to Covid 19 priority initiatives
		Identify subject matter expert	Delays due to Covid 19	Delays due to Covid 19 priority initiatives
		Scope relevant consultation and engagement pathways	Delays due to Covid 19	Delays due to Covid 19 priority initiatives
		Draft action plan	Delays due to Covid 19	Delays due to Covid 19 priority initiatives
		Facilitate the utilization of Health Equity Assessment Tool (HEAT) with HAL partners Ministry of Education and Sport Whanganui to prioritise schools/Early		Delays due to MoH resourcing other partners for our region

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		Learning Services (ELS), Kohanga Reo and Kura within deciles 1-4. (EF)		
2.5.2 Antimicrobial Resistance (AMR)	Activity	WDHB has a contract in place for infectious diseases support from CCDHB.		
2.5.5 Healthy food and drink	Across community settings:	We will work alongside a Kohanga Reo initiative creating supportive and enabling environments from a holistic approach that empowers and encourages the health and wellbeing of tamariki and whānau (EF)	Met	
		to develop a Results Based Accountability (RBA) pilot project. evaluation and communication plan	Met	
	Across contracted providers:	use contracting mechanisms to influence development of healthy food and drink policies amongst other health-related services (EF)		Partial
		identify those contracts that are relevant for a healthy food and drink clause.		Partial
		Ensure the next contract renewal date is noted and flagged for the change		Partial
		Report on percentage of contracts that have a healthy food and drink clause included.		Partial
	Implement Healthy Active Learning (HAL):	use the Health Equity Assessment Tool in collaboration with key stakeholders to determine which schools/Early Learning Services (ELS), Kohanga Reo and Kura they will engage with		Met
		identify what Healthy Food & Drink policies is already in place to support active and healthy food environments (EOA)		Met
		Determine baseline number of schools/Early Learning Services (ELS), Kohanga Reo and Kura with a policy within the Whanganui region (EOA)		Met
		To achieve a 10% increase in the number of Early Learning Services, Kura, Kohanga Reo and schools that have healthy food and water-only (including plain milk) policies (EOA)		Partial

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		provide specialist nutrition advice and support to enhance staff and caterers practice to increase the number of healthy food and drink environments and policies consistent with the Ministry of Health Healthy Food and Drink Guidelines (EF)		Partial
		partner with other key HAL providers to ensure a coordinated collaborative approach including with the HAL Evaluation provider (EF)		Met Ongoing
		provide health promotion support and guidance to the Regional Sport Trust HAL advisors (EF)		Not Met Sport Trust HAL advisor currently not operation due to funding allocation
		collaborate with other providers – NGOs, local government, Healthy Families, Heart Foundation that are working in schools and learning services (EF)		Met Ongoing
		leverage onsite health services such as Public Health Nurses and Community Oral Health services, to promote benefits of relevant policies in educational services (EF)		Met Ongoing
		work with and complete required reporting to the HAL National Coordination Service (EF)		Met Ongoing
	WORKWELL	review the WDHB Nutrition Policy to ensure WDHB is compliant with the National Healthy Food and Drink Policy and identify any opportunities to strengthening our local policy and make amendments		
		review and revise WDHB Workwell advisory group and programme and develop a Workwell action plan to progress from Bronze to Silver accreditation		Met Replacement of Workwell with Kahui Oranga HR approach driven by management
2.5.6 Smokefree 2025	Activity	To complete a Needs Assessment to inform Tobacco Control planning, investment and commissioning of new services and activities contributing towards achieving a Smokefree Whanganui and the Government Goal Smokefree Aotearoa 2025		Delays to ensure a collaborative approach and robust quantitative & qualitative analysis. A paper of recommended options to be tabled at next TAG meeting
		Needs Analysis Report completed and published by 31 December 2020		

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		To support regional and local stop smoking services to ensure an effective integrated approach for wrap around stop smoking services for Māori, Pacific people and hapū wāhine	Partial	Met Ongoing
		Increased engagement, referrals and outcomes for Māori, Pacific people and pregnant women	Partial	Met Ongoing
		Support priority settings where Māori live, learn, work and play to create supportive health promoting environments	Delays due to Parental Leave	Met Ongoing
		Advocate and support the development of healthy public policy that supports smokefree and vapefree environments	Delays due to Parental Leave	Met Ongoing
		To promote and raise the awareness and knowledge of a Smokefree Aotearoa 2025 goal	Partial	Partial
		Smokefree Aotearoa 2025 logo and messages included across Smokefree projects, communication and resources	Delays due to Parental Leave	Partial
		Review hospital based current services procedures all patients who smoke are Asked about their smoking status, given brief advice to stop smoking and are offered/given effective smoking cessation support.		Met
		Review Lead Maternity Carers (LMCs) procedure's that support a systematic process to ensure pregnant women who smoke are Asked about their smoking status, given brief advice to stop smoking and are offered/given effective smoking cessation support.		Met Ongoing
		Explore and agree options with the PHO to review current activities to achieve and maintain 'Better help for Smokers to quit'.		Met Tobacco Control Coordinator provides support identified by PHO
2.5.8 Cervical screening	Significant inequity in screening rates persist in Whanganui rohe. To	Identifying barriers and address the needs of Māori & Pacific women through: (EF)		**PARTIAL** ongoing work progressing
		data analysis of general practice registers, Trendly and Breast screen Coast to Coast data to identify Māori & Pacific women who need screening and identify focused approaches		**PARTIAL** Monthly electronic updates via national cervical screening have been occurring throughout this current quarter

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	improve equity we aim for a 10% increase in completed screens by priority populations on the previous 12 months by:			Breast screening Coast to Coast continues to be unable to data match general practice. A visit from the new equity breast screening person has acknowledged the barriers and is working to get data matching to commence
		proactive follow up by general practice, outreach service and Iwi health providers		Met
		Māori health providers located across the region to support women to screening including offering transport, information	Met	Met
		Improving access to Pacific women through community networks focused on Rangitikei population: (EF)	Met	Met
		consider Pacific 'kaiawhina role' including completing population profile and needs and scoping requirements with key stakeholders	Partial	**PARTIAL** Discussions have started with Te Kotuku Hauora and Breast Screen Coast to Coast to undertake a smear clinic in February while the breast screening unit is visiting. A Pacific employee is working with the local church groups
		Increase screening rates for Asian women through identification of practice registers and providing targeted outreach approach: (EF)	Partial	**PARTIAL** Discussion undertaken with nurses from the Asian community
		develop relationship with Asian nursing workforce to inform approach		**PARTIAL** Discussion undertaken with nurses from the Asian community
		Use population-specific health promotion approaches to encourage uptake of screening opportunities: (EF)		Met
		develop one communication flyer with key messaging in Te Reo, Pacific and Asian	Partial	**PARTIAL** A simplified smear communication flyer has been developed and currently being

				trialled by some practices currently this is only available in English
		Improving screening rates for Māori & Pacific women through: (EOA)		**PARTIAL** Monthly clinics at Rangitikei health centre gives us access to a number of Pacifica women who are offered a smear during their visit at the clinic
		data analysis of general practice registers, Trendly and NSU data to include age, ethnicity and location of women to inform targeted approaches for Māori & Pacific women	Partial	**PARTIAL** Discussion with one school community is progressing
		identification of appropriate screening venues e.g. workplaces, Marae & community settings		**PARTIAL** ongoing
		Develop / pilot an iwi led clinic (once a month over six months) including Māori smear takers as an alternative entry point for screening on weekends and after hours. Promoted widely across social/media and networks. (EOA)		**PARTIAL** Clinic undertaken with future clinics scheduled
		Develop Māori health professional smear takers to reflect GP population and increase number of Māori screen takers against baseline: (EF)	Work in progress	
		liaise with MOH & Family Planning NZ to identify and confirm educators to undertake accessible training sessions & confirm training calendar	Work in progress	
		engage with Māori nursing workforce including Te Uru Pounamu and other nursing roopu to support upskilling	Work in progress	
		Review investment into cervical screening against equity tool to inform development of appropriate model and align provider agreements with confirmed approach. (EF)		Work in progress
2.5.9 Reducing	Activity	Cohesive relationship between Public Health, Health Protection and the Alcohol Licensing Cluster Group for	Met ongoing	Met Ongoing

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alcohol related harm		monitoring and surveillance of the Whanganui District Alcohol Licensing accord and related activities		
		Quarterly monitoring and reporting surveillance of alcohol-related hospital presentations including improving maintaining the processes of data capturing within the DHB	Met ongoing	Met Ongoing
		Determine activities develop an action plan that aligned with the 5+ Solution approach to alcohol related harm within WDHB position statement on alcohol by 30 June 2020		Met
		In partnership with community probation service, community Mental Health & Addictions, Te Oranganui and WDHB develop a sustainable Brief Intervention Programme for Community Corrections (EOA)		Met
		To consult and co-design a Brief Intervention programme with key stakeholders and other interested parties		Met
	Raising awareness on preventing Fetal Alcohol spectrum disorder (FASD)	Public Health, Kaihoe-Health Promotion to Facilitate FASD) Network Group		Met Ongoing
		To deliver FASD Awareness presentations within the community for identified priority populations (EOA)		Met Ongoing
		In collaboration with partner's support FASD Awareness Day on the 9 September 2020		Met

February 2021 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Discussion Paper**
	Item No 3.3
Author	Paul Malan, GM Strategy, Commissioning and Population Health Louise Allsopp, Covid-19 Executive Lead
Subject	Covid-19 planning update
Equity Considerations	All planning is undertaken on the basis that any outcome be inclusive enough to incorporate all possible dimensions of equity

Recommendations

Management recommend that the Combined Statutory Advisory Committee:

a. **Receive** the paper titled Covid-19 planning update

b. **Note**

- Covid-19 testing continues to be available and responsive
- Contact tracing capacity is in place
- Covid-19 vaccination programme planning is underway

Appendix

- **Appendix 1**: Guiding documents for Covid-19 Testing
- **Appendix 2**: Vaccine rollout scenarios

1 Purpose

The purpose of this item is to provide the Committee with an update of the Whanganui DHB Covid plans and planning.

2 Overview

All of New Zealand remains on Alert Level 1. All DHBs are required to continue facilitating Covid-19 testing and to develop plans for the vaccination programme. Communications to our community rely on local and national resources. Nationally, HealthPoint (www.healthpoint.co.nz) is a central repository for up-to-date information. Providers of health services are able and expected to update details themselves. In addition, HealthLine (0800 611 116) is staffed 24/7 to answer queries, give advice and to triage people to relevant services.

Locally, we have established a Technical Advisory Group (TAG) to advise on testing, vaccinations and ongoing infection prevention. This group is chaired by the Chief Medical Officer and includes the Medical Officer of Health. In addition, we continue to provide media releases, updates on our Facebook page, provide information via contracted providers, run relevant campaigns in/on local media channels, etc.

3 Covid-19 Testing and Contact Tracing

The Ministry of Health Covid-19 Directorate retains overall responsibility for the national testing strategy and plans. Testing guidance for the health sector is regularly updated to reflect current conditions. The guidance reiterates key messages, takes into consideration any new surveillance findings and ensures the appropriate focus for our testing resources. The Testing Plan and the Testing Guidance are available on the Ministry of Health website.

Locally, implementation of testing follows the national guidance. Actual availability of testing does change from time-to-time with current information always available on HealthPoint and via HealthLine (0800 611 116). We also ensure that relevant DHB communications contain current information backed up with information shared widely across the sector.

We continue to provide testing via designated general practices in rural and urban settings and at Whanganui Accident & Medical. We are also supporting "pop-up" testing capacity to respond to directives from the Medical Officer of Health or other opportunistic testing where appropriate. Plans are in place to provide reactivate testing centres should the need arise.

Appendix 1 shows how the guiding documents for Covid-19 are linked to national strategy.

Whanganui DHB has a contact tracing plan, with resources on stand-by for dedicated work in the event of local case.

4 Covid-19 Vaccination Planning

The rollout of the Covid-19 vaccine for New Zealanders is one of the Government's top priorities for 2021, and there has been significant planning underway for some time already. The main issue for the sector is logistics – from supply of the vaccination into New Zealand through to administering to the population including sequencing, priorities, etc. The government is expecting enough vaccines for every New Zealander.

Medsafe granted provisional approval for one of the vaccines in early February and this has enabled the planning to advance. The amount of vaccine available will be limited initially and so sequencing has become the critical factor. Border and managed isolation and quarantine (MIQ) workers are the initial priority group and they (and their families) will be vaccinated first followed by high-risk frontline workforces. The general public vaccinations are expected to begin in the second half or 2021.

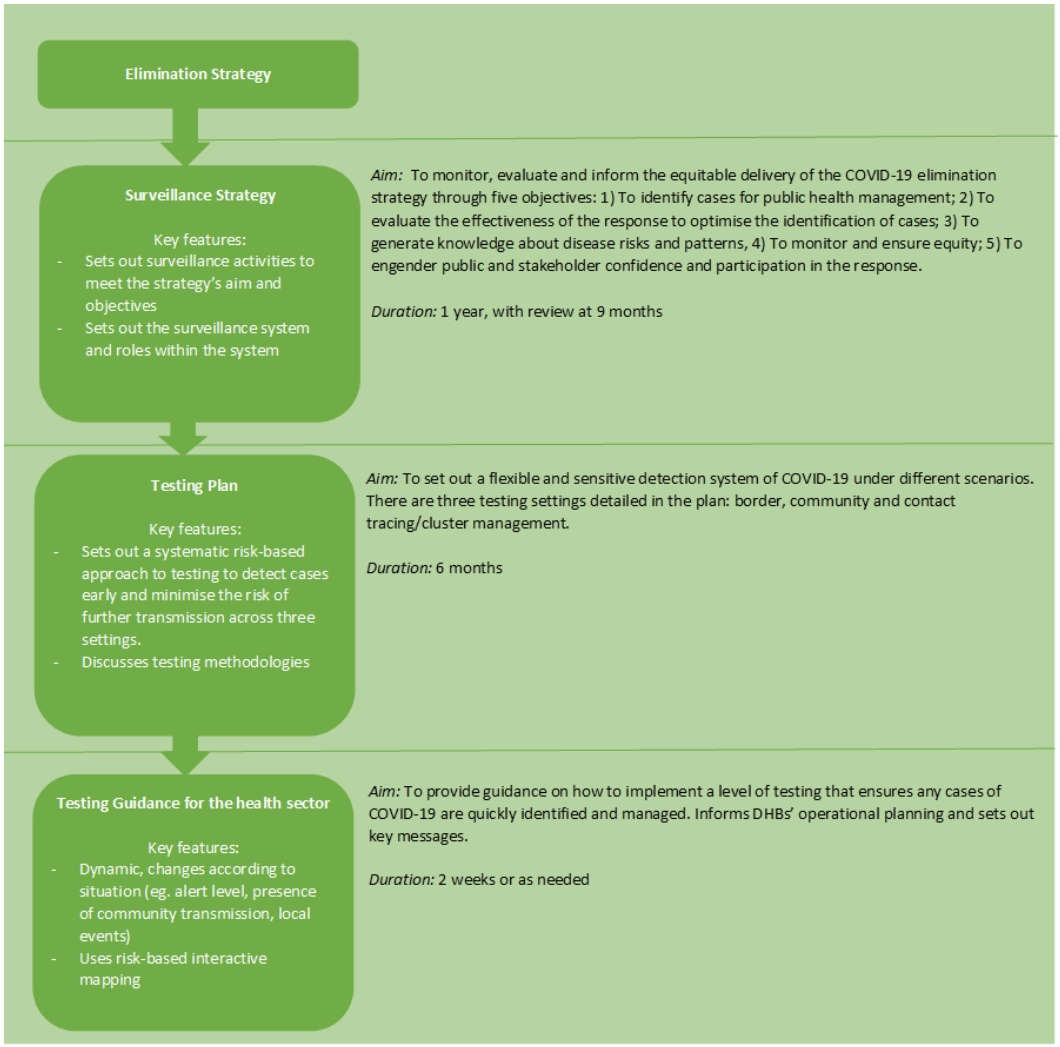
Ensuring equity of outcomes is a key measure of success. This includes protection for Māori, Pacific peoples and our most vulnerable population groups, such as older people and disabled people.

Three "roll-out scenarios" have been prepared, taking into consideration the groups of people who should receive the vaccine first under each scenario. The first scenario is "low/no community transmission"; scenario two is "clusters and controlled outbreaks"; and scenario three is "widespread community transmission". The sequencing of the vaccine programme will adapt should the Covid-19 environment change across the country.

Appendix 2 shows a high-level overview of proposed sequencing across the different scenarios.

Based on scenario 1, Whanganui DHB will not have local vaccinations in group 1. We are providing information on estimated numbers for group 2.

APPENDIX 1: 3.3.1 - Guiding documents for Covid-19 Testing



APPENDIX 2: 3.3.2 Vaccine rollout scenarios

	Scenario one: Low/no community transmission	**Scenario two: Clusters and controlled outbreaks**	**Scenario three: Widespread community transmission**
Aim	*Prevent transmission*	*Reduce transmission and protect people in close contact*	*Protect those most vulnerable to prevent illness and mortality*
Group one First group of people to receive the vaccine in each scenario	• Border and managed isolation & quarantine workforce • Health workforce at highest risk of exposure to COVID-19 • Household contacts of the above two groups	• Border and managed isolation & quarantine workforce • Health workforce at highest risk of exposure to COVID-19 • Population affected by the outbreak	• Older people (aged care residents, Māori and Pacific people, then others aged over 65 years) • People under 65 with underlying conditions • People living in long-term residential care settings
Group two Second group of people to receive the vaccine in each scenario	• High risk frontline health workforce • High risk frontline public sector and emergency services	• High risk frontline health workforce • High risk frontline public sector and emergency services	• High risk frontline health workforce • High risk frontline public sector and emergency services • Remaining frontline health workforce
Group three Third group of people to receive the vaccine in each scenario	• People in the community, including older people and those with underlying conditions • At risk health and social services workforce	• People in the community, including older people and those with underlying conditions • At risk health and social services workforce	• Remaining health and public sector workforce • Other population groups

February 2021 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Discussion Paper**
	Item No. 3.4
Author	Lucy Adams, Chief Operating Officer and Director of Nursing
Endorsed by	Ian Murphy, Chief Medical Officer Alex Kemp, Director Allied Health Scientific and Technical Services
Subject	**Provider Arm Services**

Recommendations

Management recommend that the Combined Statutory Advisory Committee:

a. **Receive** the paper titled 'Provider Arm Services'

b. **Note** comments around operational performance for Hospital and Clinical Services, Maternal, Child and Youth Services and Primary and Community Services

1 Purpose

To provide the Committee with a high-level overview of provider arm services; operational performance is noted for the months of December 2020 and January 2021.

2 Service Delivery Overview

2.1 Optimisation and Efficiency Programme

Theatre and Perioperative Services

The programme began in July 2020 and has been continuing, with good progress, against the milestones. Significant improvements in reporting and data collection relating to theatre metrics have enabled review of practices in theatre. TAS is conducting a nursing workforce roster review. It is envisaged that this will be conducted sometime in the next quarter.

Scheduling

A review of service efficiency is underway, and this piece of work will interface with the theatre and perioperative service project.

Patient Flow Programme

- Integrated Discharge Navigator

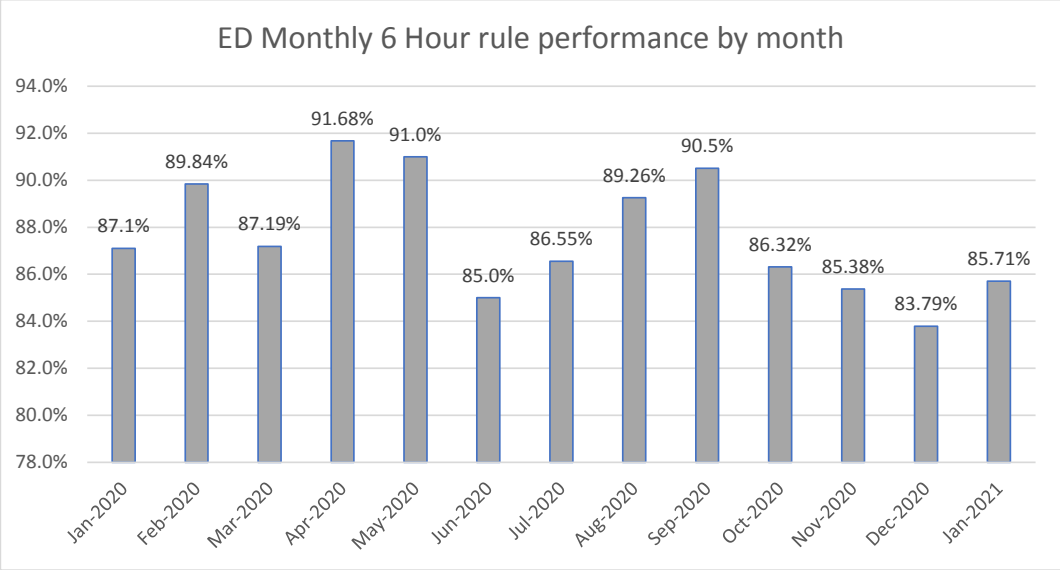
A one-year pilot role for integrated discharge navigator position has been recruited. The programme is aligned to the strategic focus on Healthy at Home: Every Bed Matters. The focus of the role will be ensuring systems and processes are in place to aid timely patient discharges, understanding and removing barriers to discharge and reviewing complex cases to support better health outcomes.

- Hospital Flow

There has been an increase in inpatient admissions and delays in discharges, which has contributed to a congested ED. This has generated discussions at all levels (medical, nursing, allied health, Maori health and patient safety). The solution will warrant a whole-of-system approach to which a workplan has commenced. An ED performance dashboard has been developed in PowerBI and is currently being socialised.

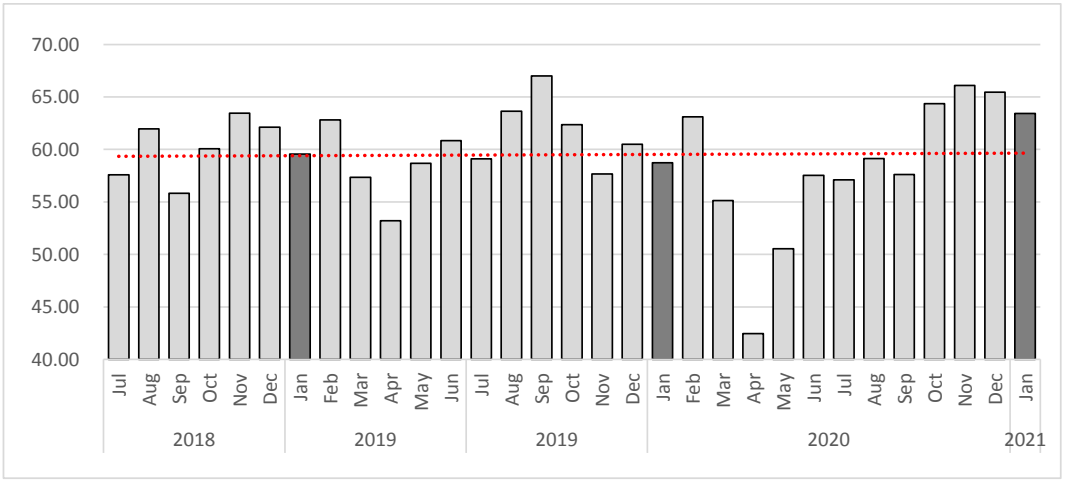
- ED Monthly 6 Hour rule performance by month

NZ government introduced a hospital emergency department (ED) target of 95% of patients seen, treated, or discharged within 6 hours. The aim was to alleviate crowding in public hospital EDs. January 2021 saw an increase in presentations, and this did impact on the 6-hour target. It is envisaged that the patient flow programme will support an improved metric.

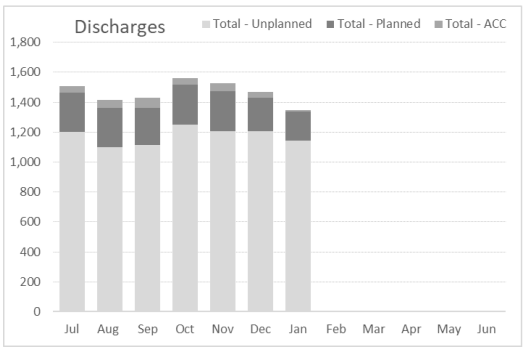


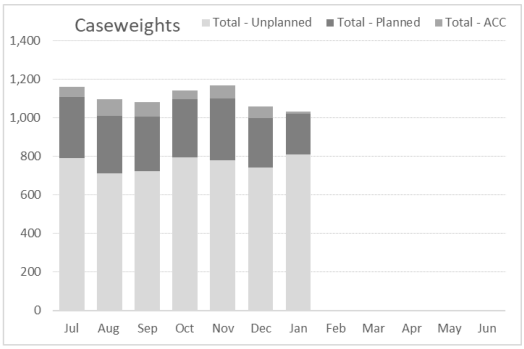
2.2 Hospital Throughput

Daily presentations to ED have been high over the summer months. Daily presentations are higher than the average for this time of year, with the daily average 8% higher than both summer in 2020 and 2019. The highest increase was in lower acuity patients, with a surge of 14% on normal volumes for the equivalent period in previous years. In discussions with our colleagues at other DHB's, it has been identified as a common trend across the country. We are continuing our discussions around management of acute demand across the sector, and where services are best delivered.



Overall hospital discharges and caseweight are lower than average months. This is in part due to the reduction of planned care services over the Christmas/New Year break. Acuity of unplanned care patients increased in January, with a spike to 0.71 caseweight per discharge, against the year to date rate of 0.64. This increase impacts on busyness of the hospital, with sicker patients requiring more care for each discharge.





2.3 Waiting Lists and Elective Services Productivity Indicators

Final ESPI results for December are now available and continue our overall trajectory towards compliance following COVID-19 service disruption. Results are:

- *ESPI2* - 7 out of 1612 (0.4%) of total patients waiting have waited longer than 120 days for a First Specialist Assessment, an improvement of 11 on the previous months results
- ESPI 5 – 46 out of 746 (6.2%) of total patients waiting have waited longer than 120 days for planned inpatient treatment. This was an expected deterioration with three main factors - a second "bubble" of orthopaedic patients post COVID disruptions, reduced planned services over the Christmas/New Year period, and delayed medical staff recruitment in ophthalmology.

Strategies are in place to mitigate impacts of reduced clinical capacity including additional theatre lists in some specialties and some service redesign.

We are making progress towards regaining compliance. The Ministry of Health has been advised of our expected non-compliance for ESPI5 and have agreed a 3-month improvement timeframe to March 2021.

2.4 Planned Care Programme

We have received approval of our three year planned care programme from the Ministry of Health and will be operationalising this through to July 2023. Our plan focuses on three phases:

1. Engaging with our community to fully understand health needs, community aspirations and how they contrast with the services currently delivered in our community (building on the work of the social governance model);
2. Implementation of changed service delivery models to meet community needs, delivering interventions at the lowest level – sooner and maintaining wellness;
3. Consolidation and ongoing focus on patient/whanau centred care, delivering equitable outcomes for our community.

We have received funding from the Ministry of Health for planned care projects and additional volumes as part of the post-COVID-19 service recovery programme.

- $50K for continuing with our development of patient focused booking systems, enabling access to services in a way that is easier to navigate and more convenient for our patients
- $1.28M for additional volumes for planned services (outpatients and inpatients), including $64K for system redesign for planned care. We are developing project plans for submission to the Ministry for this funding.

February 2021 **Public**

2.5 COVID Preparedness

Inpatient and ED Readiness

Hospital planning remains in place with CBAC/WAM continuing to screen for any COVID-19 like symptoms. 'FIT' testing has commenced with staff that work in clinical areas to ensure N95 masks fit correctly.

3 Hospital and Clinical Services (H&CS)

3.1 Nursing Workforce Development and Education

Role of the Nurse Educator at Whanganui District Health Board

Whanganui District Health Board employs 3 FTE and 2 .4 FTE Nurse Educators. These roles work collaboratively with our health care partners in both the community and hospital to facilitate the delivery of nursing workforce and development. This includes working with healthcare partners to identify learning opportunities, facilitate education days for staff across the region and have robust evaluation and reporting mechanisms. Nurse Educators also have at least one key portfolio to support national nursing programmes. These include but are not limited to:

- Nurse Entry to Practice Programme
- New Entry to Specialty Practice
- Professional Development and Recognition Programme
- Health Workforce New Zealand
- Acute Life Support
- Neonatal Life Support
- ACC Programmes
- Health Quality and Safety Commission Programmes
- Cardiopulmonary Resuscitation
- Safe Practice Effective Communication
- Sensory Modulation and
- Restraint Minimisation Safe Practice
- Infusion Therapy
- Nursing Care Sensitive Indicators
- Intravenous Therapy
- Nursing Competencies

These roles works collaboratively with schools of nursing and external providers to support students and nurses to meet Nursing Council of New Zealand competencies/requirements. They also align with the Patient Safety Quality & Innovation team to provide opportunities for education within each WDHB service continuum – Hospital, Community and Child and Adolescent services.

Nurse Entry to Practice (NETP)/New Entry Specialty Practice (NESP) - 2020/2021

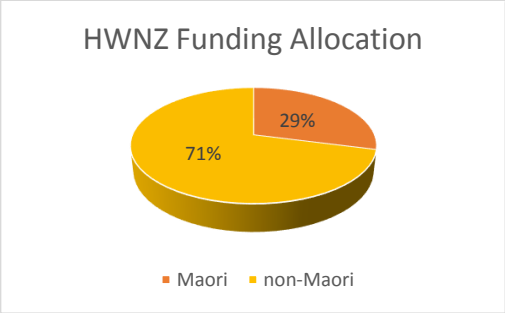
The following graph provides an overview of NETP/NESP recruited on the programmes, percentage of Maori versus non-Maori and whether they have been employed once they have graduated.

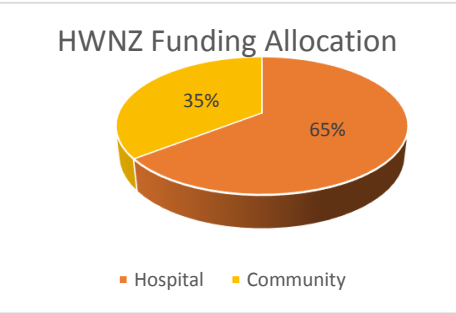
	Total NETP recruited	**WDHB**	**Expansion (primary)**	**NESP**	**Māori & Pacific Islander**	**Retained, end of NETP/NESP programme** **Across the WDHB Region**
2020	14	12	2	3	9	**NETP** To date, not all NETP have completed their NETP programme. Of those that have (7), all have permanent positions. One is on maternity leave and one is on a temporary contract. **NESP** All NESP gained permanent employment.
2021	11	7	2	2	7	

Health Workforce New Zealand (HWNZ) Funding 2021

HWNZ funding is provided yearly to support post graduate study for nursing. WDHB has funding criteria and this was utilised to determine who would be funded.

- Number applied: 88
- Number funded: 62
- Maori applicants: 100% of Maori applicants funded (n=18 → 29% of funded applicants)
- Non-Maori applicants funded: 44
- Community: 100% of community applicants funded (n=22 → 35% of funded applicants)





ACC Know Your IV Lines (KYIVL)

The ACC KYIVL program will be coordinated by a nurse educator and commenced on the 8th February. The initial point prevalence audit was completed in July 2020. The recommendations from the audit will be utilised to measure change in practice once the project has been implemented and embedded.

Once launched, a quarterly project progress and audit report will be submitted every 3 months from signing of the contract date. A final report inclusive of the results of the audit, and achievement of outcomes will be submitted.

3.2 Specialist Nursing

Whanganui District Health Board employs 20.7 FTE into the specialist nursing team. The team is employed into the following roles:

- 1 Nurse Practitioner and 1 Clinical Nurse Specialist – Renal
- 1 Nurse Practitioner, 1 Nurse Prescriber, 1 Clinical Nurse Specialist – Diabetes
- 1 Clinical Nurse Specialist working towards prescribing this year – Respiratory
- 1 Clinical Nurse Specialist working towards Nurse Practitioner this year – Cardiac
- 1 Clinical Nurse Specialist Ostomy
- 1 Clinical Nurse Specialist Continence
- 2 Clinical Nurse Specialist Tissue Viability
- 3 Clinical Nurse Specialist Cancer
- 1 Clinical Nurse Specialist Hepatitis and Rheumatology
- 1 Clinical Nurse Specialist Falls
- 1 Clinical Nurse Specialist Ophthalmology
- 2 Clinical Nurse Specialist Renal
- 1 Clinical Nurse Specialist Pain and Infusion Therapy

All specialist nurses have post graduate qualifications; many working towards prescribing. Some of the Nurse Practitioners and Clinical Nurse Specialist work alongside Senior Medical Officers and will often work in general practice to support their training and development.

3.3 Model of Care

Close Supportive Observation (CSO) Update

There has been a review of the care with dignity programme. The recommendations will go to ELT and will include cost avoidance strategies.

February 2021 **Public**

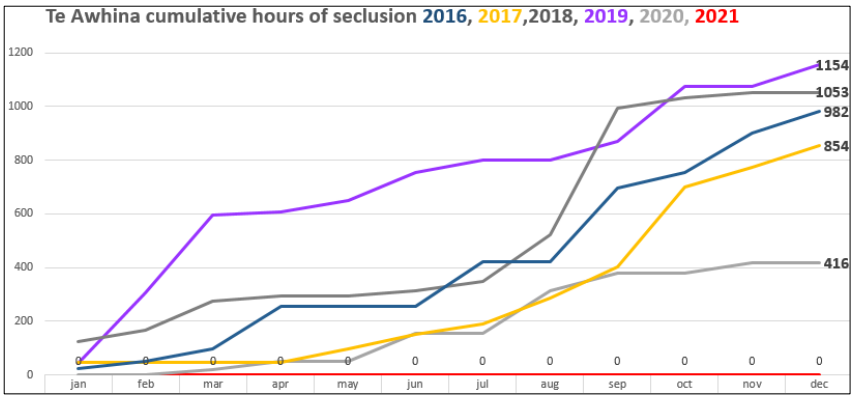
3.4 CCDM FTE Calculations

FTE calculations are well underway using the approved CCDM methodology. The calculations are being completed in partnership with the unions and CCDM advisors. The general wards are the priority with ED to follow. Outcomes are yet to be validated/understood. These are expected to be completed within the month and will be used to inform the budget process.

3.5 Seclusion Rates – Te Awhina

Seclusion rates continue to reduce with nil this year to date. The currently model of care shows signs of system improvement and staff morale appears to be improved.

The unit awaits the ombudsman report but we have been proactive in meeting the preliminary findings prior to its release. The windows have been tinted, security screens improved, pool table made usable and programmes being implemented/improved (to name a few). This all improves both staff and patient satisfaction.



4 Maternal, Child and Youth Services (MCYS)

4.1 General

Maternal Child and Youth Services (MCYS) have had a productive end to 2020 and start to 2021.

The Covid-19 pandemic remains a top-of-mind health issue for our WDHB staff, the wider DHB and our community. COVID 19 testing and contact tracing for resurgence and pop-ups for community events are currently at the forefront of planning. MCYS however, are committed to also continuing our business as usual to ensure we meet our MOH service requirements.

The MCYS leadership team ran the first quarterly Whanganui Maternal, Child and Youth Community Alliance meeting on 3 December 2020. It was well attended by both WDHB staff and our community partners. Our He Hāpori Ora – Thriving Communities strategy was presented, the scope of MCY services were outlined and feedback requested from attendees around the draft MCYS strategy plan diagram and MCY service improvements. Key feedback themes were:

- co-location, integration and access of services
- parenting support
- iwi-led/Māori specific services, approaches and Māori workforce
- coordination of services (e.g. navigator)
- health literacy

The maternal, child and youth team were pleased by the interest and enthusiasm that was shown by the participants of the meeting about the opportunity to engage. This will be central to our next meeting in February 2021.

February 2021 **Public**

4.2 Service Delivery

Maternity

The resignation of a permanent midwife in Waimarino means that after hours birthing will be carried out in Whanganui until further notice. Recruiting to this role is anticipated to take a significant amount of time.

The nationwide Lead Maternity Carer shortage remains a central issue. Regular maternity workforce planning meetings are being held to develop new initiatives in this area with mid to long term strategies their primary focus.

A primary antenatal clinic midwife has been appointed for 6 months at 0.2FTE starting in 2021 for the purpose of improving continuity of care for women unable to find an LMC.

A new graduate midwife started in the first week of February and we are currently recruiting for a second graduate midwife. Short term solutions are continually being monitored at an operational level.

The Primary Care and Maternity Service Interface Group has completed mapping work on the maternity service continuum from pre-conception through to birth, including discharge from the service. This meeting has a wide range of community and service representation, including Lead Maternity Carers (LMCs), TAS, Te Oranganui, He Puna Ora, Whanganui Regional Health Network (WRHN), GP representation, Plunket, etc. Service improvement and integration initiatives will be identified and initial workstreams commenced by the end of the financial year.

Paediatrics

Admission rates to the ward over Christmas and New Year were high. High birth rates continue to impact on the number of admissions to SCBU and in some instances it has been necessary to decline service for out-of-area babies due to lack of capacity. Skilled staffing shortage is also an issue in SCBU and a recruitment process is currently in place.

Child Development - additional funding was received from MOH for 3 years to reduce waitlists in CDS and we have reduced our wait times for cognitive assessment from over 3 years to now under 1 year.

Public Health

Immunisations will be at the forefront for the Public Health team for the next quarter. The school based programme has begun with the circulation of consent forms. Bruce Jones will lead the MMR campaign until the completion of the National Campaign at the end of August this year. He is working alongside the WRHN team and engaging particularly with Maori and Pacific Island providers and communities to ensure equitable access to the vaccine is offered.

The team are actively involved in the contract tracing resurgence plan and have undertaken training in the NCTS programme. Many of the team members are working with the Heath Protection team to provide an on- call roster for the contact tracing and CBAC services.

Maternal Infant Child Adolescent Mental Health and Addiction Services (MICAMHAS)

Massey Psychology have recently been engaged to provide psychology services to our MICAMHAS team in assessment and specialised therapy. This new relationship is going well.

MICAMHAS won the national competition for the best client focused child adolescent reception. The competition was run by Te Pou, the Ministry of Health and the Werry Workforce.

Oral Health

The digital radiography system is installed in all mobiles and fixed sites and training provided to staff, this will significantly improve service delivery. The next step, CT OPG dental imaging within the radiology department, is in progress.

School-based dental services will continue to work on arrears which accrued during Covid-19 pandemic due to reduced access to schools with lock-down directives in place and increased time to treat patients to Dental Council's prescribed infection control procedures once schools recommenced.

4.3 Future Focus

The second Whanganui Maternal, Child and Youth Community Alliance meeting is scheduled for 18 February 2021 and is focusing on two key areas: 1) pro-equity and 2) community engagement and feedback around MCY aspects of the WDHB Annual Plan.

The project to address Did Not Attend (DNA) appointments in specific MCY service areas is progress. Areas of focus have been identified as oral health, audiology and ophthalmology.

The Maternity Quality and Safety Programme (MQSP) Governance group work plan is close to completion. At least one new local project will be overseen by this group.

The Primary and Maternity Services Interface Group will be developing some workstreams to improve the continuum of care including care transitions and provide wrap-around care for mothers and babies.

5 Primary and Community Services

5.1 Service Delivery Overview

The vision of "healthy at home" continues to be socialised, with clinical teams, and embedded into new models of care and service delivery as opportunities for change in how services are provided are identified. Primary and Community Services have had a key role in the health partnership with the NZ Masters Games, promoting the message of Healthy Ageing as a key enabler of living better for longer at home. The initial feedback from community around the DHB involvement in this event has been overwhelmingly positive.

The contracted leadership position with Whanganui Regional Health Network, (WHRN), to build on collaborative initiatives across the sector is well established. This will be closely connected to the work around acute demand, but will focus on supported discharge and technology enablers for this. Shortage of Aged Residential Care beds in the community for those patient who require intermediate care has been improved with additional beds becoming available, which will support improved patient discharges.

Primary and Community services continue to use Telehealth across a range of services. There has been recent Ministry funding for a year for dedicated leadership for the telehealth initiative that is in the process of going to advert for recruitment. Many teams have increased their use of telehealth for meetings, increasing efficiency, with ongoing examples of changes to clinical care, such as Psychologists using telehealth in the Marton and Taihape areas. Work is underway to engage with the redesign of the Waimarino Health Centre to create a telehealth space that allows for patients and Whanau centred care.

Radiology service commenced a patient centred initiative in collaboration with MCDHB to offer Cardiac Angiography (CTCA), sessions at Whanganui hospital which commenced in December. This service has improved access, reduced unnecessary invasive tests, and the need to travel and costs associated for patients and Whanau. Feedback from patients and staff has been positive.

Access to mental health services for people in crisis has been improved with the establishment of a crisis telephone service resulting in a more responsive service. A Mental Health and Addiction Crisis Education role has been established to strengthen support and training for all staff working in mental health crisis within the DHB and across the rohe, initially working alongside emergency department staff.

The service as a whole is strengthening its work with community providers, for example the Te Oranganui Mental Health Service manager becoming part of mental health Clinical Governance, and Speech Language Therapy establishing group sessions for patients who are diagnosed with Parkinson's with the Parkinson's society.

IANZ completed the annual review in Radiology, two major non-conformities were identified which need to be completed by 17 March.

A new system to track and transfer equipment that enables discharge from hospital (e.g. walking frames) has been identified and agreed within the DHB for implementation, which will significantly reduce

resource currently used to track, swap and deliver equipment, as well as increase accuracy of follow up of equipment loaned within the community.

5.2 Workforce

The Dietitian Co-Ordinator role has been successfully recruited and due to commence in February.

The Physiotherapy department is fully recruited as of January. Overall, this will see a reduction in the number of referrals being outsourced as more will be able to be done in house. Social Work service has two vacancies and is actively recruiting.

Work is underway to establish therapy assistant roles which will be transdisciplinary and work across Occupational Therapy, Physiotherapy and Social Work. Once established this role will enable greater flexibility for these services to follow up patients discharging into the community.

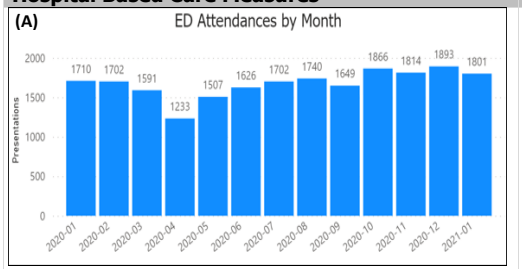
Sonography is now fully recruited to but positions will not be filled until July due to contractual obligations with locum staff.

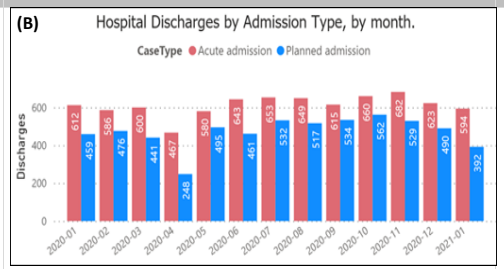
Appendix 1: 3.4.1 Provider Arm Report

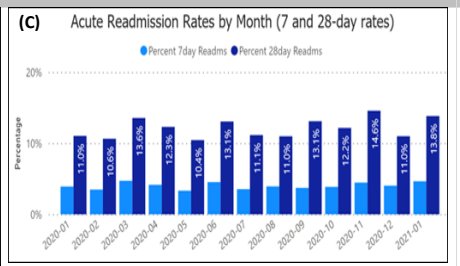
Whanganui DHB Performance Dashboard

(data extracted 16.2.21) January 2021

Hospital Based Care Measures

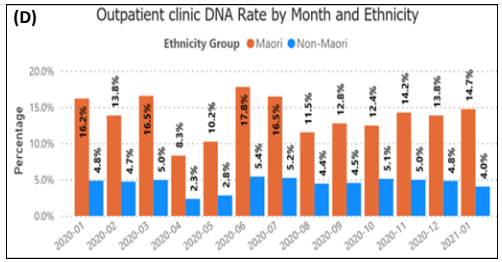


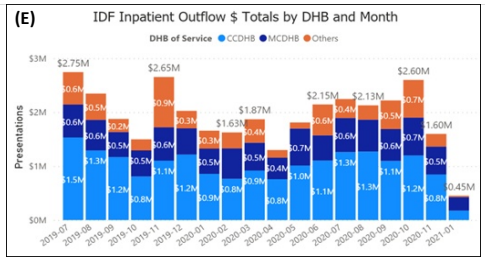


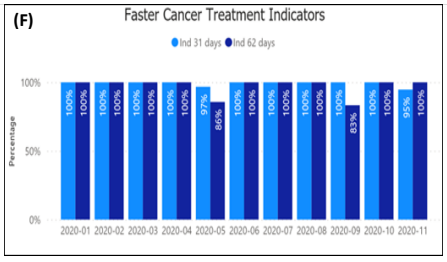


Commentary

ED commentary is within the body of the report.
(B) January saw an increase in admissions and delays in discharges; a whole of system plan is under development with the aim to address patient flow issues.
(C) Re-admissions remain high. A pilot introducing an Integrated Nurse Navigator will be introduced in March (1 year). Understanding readmission rates and barriers that are creating bottlenecks within the in-patient areas will be a focus area.



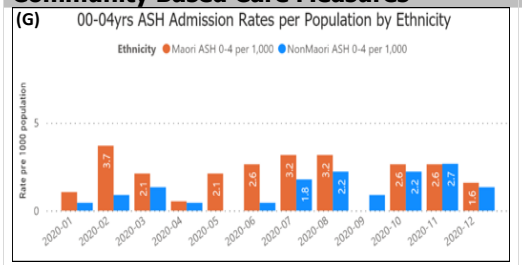


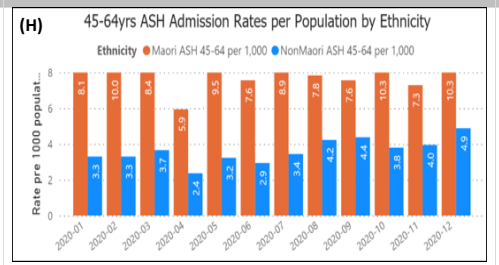


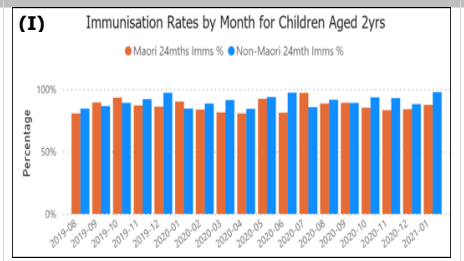
(D) Outpatient clinic DNA remain high for Maori whilst non Maori sits around 4-5%. Work is underway following up on children that have not presented to their audiology and opthalmoloy appointments.
(E) January data is not completed therefore metric is low.
(F) Faster Cancer Treatment 6 monthly report is separate.

Community Based Care Measures

Commentary







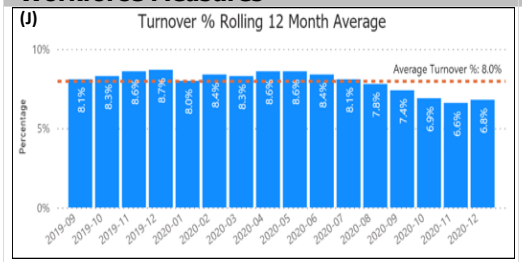
Commentary

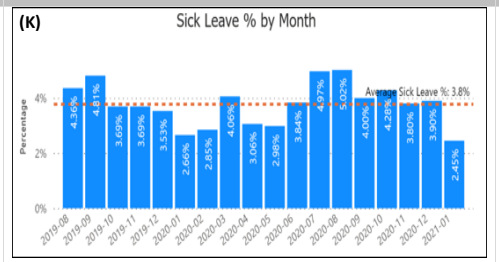
All Ambulatory sensitive hospitalisations (ASH) rates are for Whanganui Hospital. Maori are more likely to be hospitalised for ambulatory sensitive conditions compared to non-Maori.
(G) The top themes for 0-4 years are respiratory, dental, gastroenteritis and asthma.
(H) The top themes for 45-64 years are angina/chest pain, COPD, and pneumonia.
(I) Maori continue to be overrepresented in the overdue/decliners of immunisation outreach service numbers. Working with Iwi/Maori health providers to find solutions.

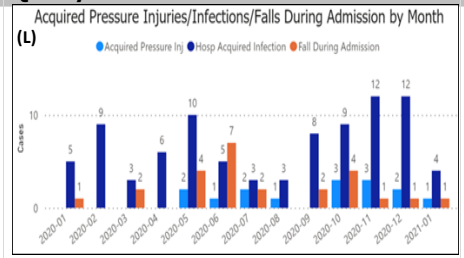
Workforce Measures

Quality

Commentary







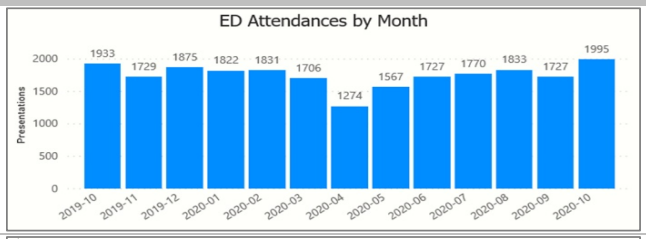
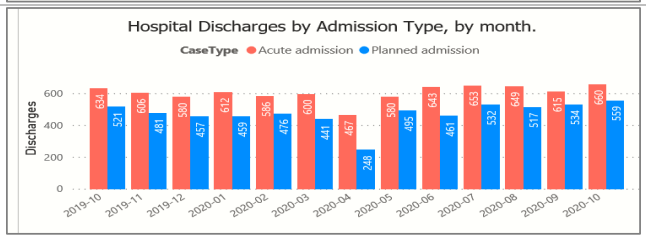
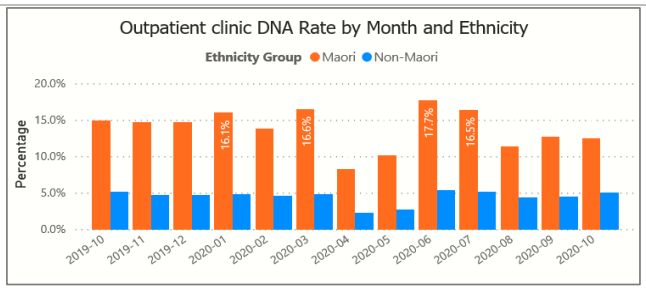
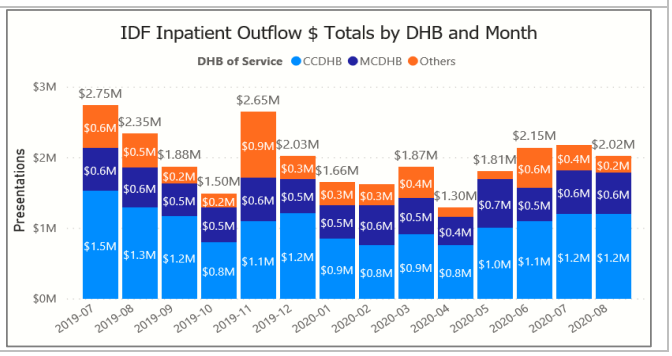
Commentary

(J) The average turnover at WDHB is 8 %; January was 3.8%.
(K) Prior to Xmas the sick leave was on the high side this has decreased. The in-patient ward areas have had a lens over sick leave, this includes reviewing processes for managing absenteeism. High sick leave impacts on over overall financials, of which this month the nursing workforce was favourable, against an unfavourable budget.
(L) Pressure injuries and falls were down this month, this is attributed to these quality indicators being targeted at the ward level, examples are education, documentation, and audits.
A whole of system review of the ACC funded Injury Prevention Programme has been conducted, recommendations will be released and used to inform interventions.

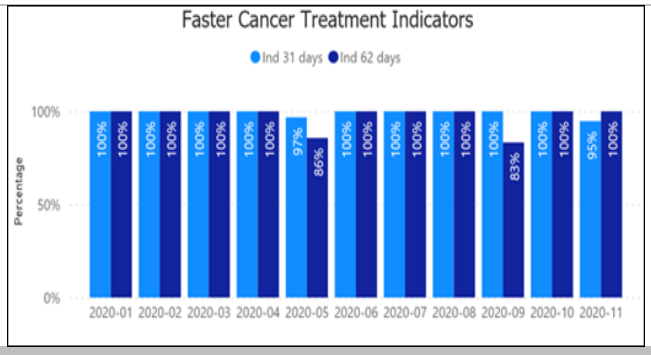
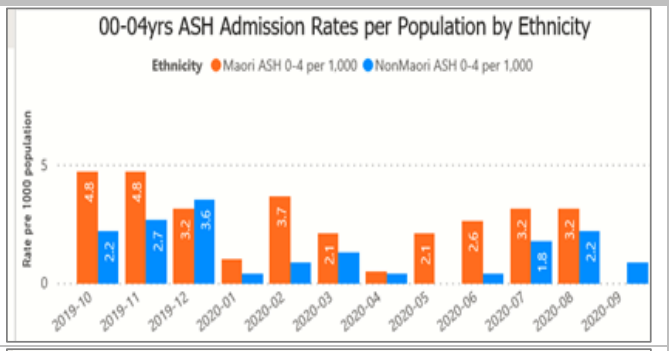
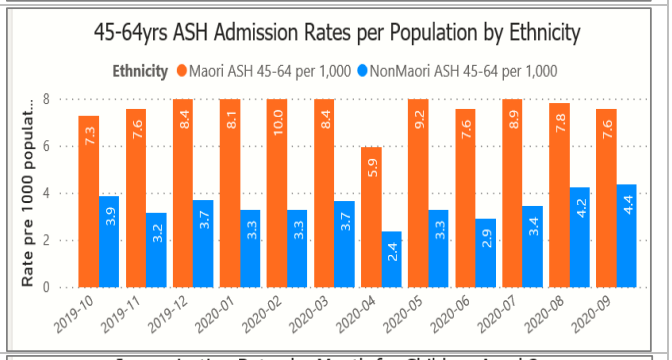
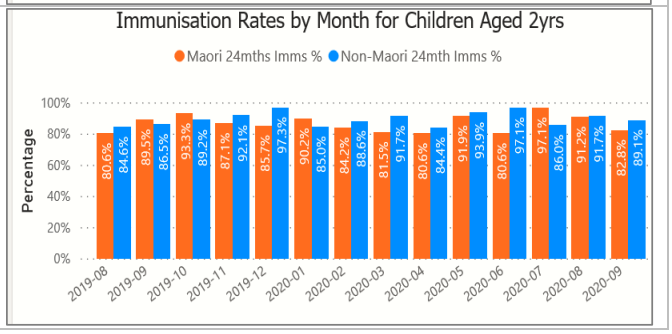
Appendix 1: 3.4.1 Provider Arm Report

Whanganui DHB Performance Dashboard definitions and glossary

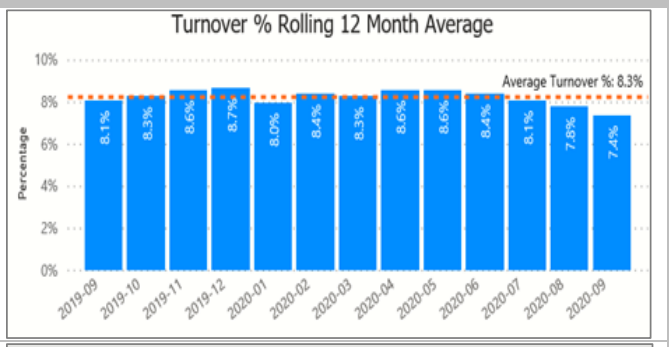
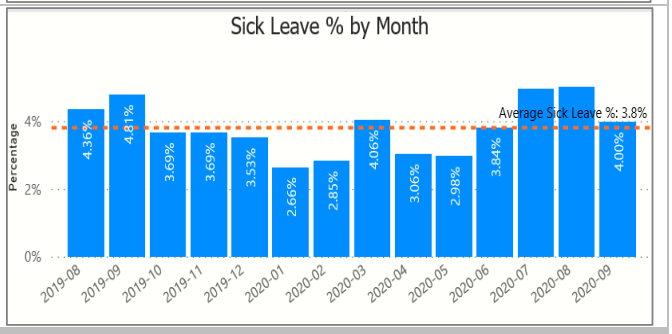
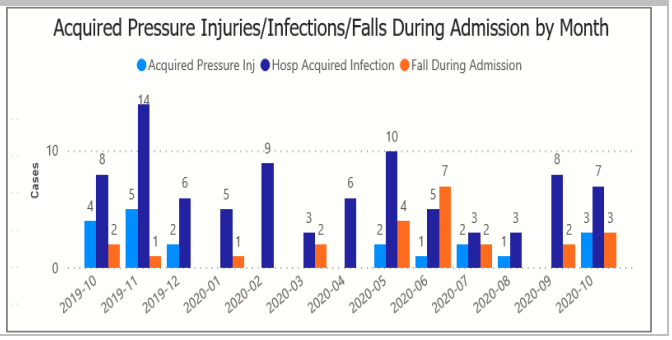
Note: The graphs below are for definitional purposes. The most up to date information is in the body of the main report.

Hospital Based Care Measures	
Graph A. ED Attendances ED attendances are an indicator of acute patient demand in the system, while also identifying issues in access to primary care and potential flow issues in secondary services. **Calculation**: count of attendances.	
Graph B. Hospital Discharges Throughput of hospital-based services. This is an indicator of patients through the system as opposed to occupied beds. **Calculation:** count of patients discharged from inpatient events, and includes day stay patients in all services.	
Graph C. Readmission Rates This is the percentage of all patient discharged that return to hospital acutely within 7 and 28 days of discharge. Readmissions can be for any reason, not exclusively related to the previous event. **Calculation:** Denominator = patients discharged Numerator = patients acutely re-admitted within 7/28 days	
Graph D. Outpatient DNA Rate DNA rates indicate where we have access issues to outpatient services. Significant disparities exist between rates for Māori and non-Māori indicating equity issues in access to services. **Calculation:** Denominator = total patients seen Numerator = missed appointments	
Graph E. IDF Outflows Total value of IDF outflows to main DHBs for each month. This is a dollar value, so increasing prices need to be considered when comparing years. **Calculation:** Dollar value of services provided by other DHBs to WDHB.	

Appendix 1: 3.4.1 Provider Arm Report

Graph F. Faster Cancer Treatment Patients identified as high suspicion of cancer on referral receiving treatment within 62 days (further information provided within the paper).	
Community Based Care Measures	
Graph G. ASH Rates 0-4 years ASH rates are a measure of avoidable hospital admissions (Ambulatory Sensitive Hospital admissions) per 10,000 population. Significant disparities exist between rates for Māori and non-Māori indicating equity issues in access to services. **Calculation**: admissions per 10,000 population for a range of standard conditions.	
Graph H. ASH Rates 45-64 years ASH rates are a measure of avoidable hospital admissions (Ambulatory Sensitive Hospital admissions) per 10,000 population. Significant disparities exist between rates for Māori and non-Māori indicating equity issues in access to services. **Calculation**: admissions per 10,000 population for a range of standard conditions.	
Graph I. Immunisation Rates for Children by ethnicity Percentage of children with up to date immunisation at the age of two years **Calculation:** Denominator = total children enrolled Numerator = total children with up to date immunisation	

Appendix 1: 3.4.1 Provider Arm Report

Workforce Measures	
Graph J. DHB Staff Turnover Rolling twelve month turnover rates is an indication of staff retention **Calculation:** Denominator = total staff numbers Numerator = new hires within the preceding twelve months	
Graph K. Sick Leave % Percentage of total paid hours taken as sick leave. This is an indication of illness levels and cost impacts when above average budgeted rates. Does not indicate where annual leave is used in place of sick leave **Calculation:** Denominator = total paid hours Numerator = hours paid as sick leave	
Quality	
Graph L. Pressure Injuries/Infections/Falls Patient safety and care indicators for key measures. **Calculation**: count of events each month (not individual patients)	

February 2021 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Discussion Paper**
	Item No 3.5
Author	Kath Fraser-Chapple. Business Manager Hospital and Clinical Services
Endorsed by	Paul Malan, General Manager Strategy, Commissioning and Population Health
Subject	Faster Cancer Treatment Targets
Equity consideration	Any breach of Faster Cancer treatment targets are investigated to consider equity impacts

Recommendations

Management recommend that the Combined Statutory Advisory Committee:

a. **Receive** the paper Faster Cancer Treatment Targets

b. **Note** that Ministry of Health Faster Cancer Treatment Health Target reporting is not yet available for Q2

Appendices

1. Ministry of Health Faster Cancer Treatment Report for Q1 20-21

1 Purpose

This paper provides an update on FCT Health Target Results for Q1 2020-21 and locally reported results for Q2.

2 Summary

Results for the Faster Cancer Treatment target for quarter one 20-21 are 95.5% of patients referred with high suspicion of cancer starting their treatment within 62 days of their referral.

3 Background

The Health Target reporting is compiled by the Ministry of Health on a DHB of domicile basis and returned to us quarterly, as an interim report followed by a final report. The information from the MOH SS-11 report is then used to fulfil our quarterly reporting obligations around the Faster Cancer Treatment 62 Day Target and 31 Day Target measures.

The 62-day target measures the time taken for a patient referred with high suspicion of cancer or a confirmed cancer diagnosis to receive their first treatment. This is expected to be approximately 25% of all cancer patients. Patients where treatment is delayed due to patient choice or clinical considerations (eg co-morbidities or staged treatment) are excluded from the target.

The 31-day target measures the time taken between decision to treat and the patient receiving their first treatment. Patients where treatment is delayed due to patient choice or clinical considerations are excluded from the target.

4 SS-11 Faster Cancer Treatment (62-day target)

Results received from Te Aho o te Kahu for quarter one 20-201 show that 95.5% of patients referred with high suspicion of cancer received their first treatment within 62 days of referral. A total of 47 patients were referred and 45 referrals were within the 62-day target cohort. Of these 42 received their treatment within the timeframe.

Of the total number of patients that were delayed in receiving their treatment 3 were for clinical reasons including staged treatment etc, 1 was due to patient choice and 1 was delayed due to clinical capacity.

We have local data collected for Q2, with results of 92% for the quarter. This is made up of 100% for October (10/10), 85% for November (17/20) and 100% for December 2020 (7/7). Of the delayed patients in November two were delayed for clinical staging and multi-disciplinary team requirements. The third patient was delayed for multiple reasons and this is being investigated for contributing system failures.

Due to the different collection methods of the MOH data (submitted nationally and calculated as a rolling 6-month quarter) and the local data collected by our cancer nursing team there are variances final numbers. For clarity we use the Ministry of Health reporting as our definitive results.

5 Faster Cancer Treatment (31-day target)

The results for Q1 have been received from the Ministry, for data collected up to 30 October 2020. We had a total of 199 patients in the FCT cohort for the reported timeframe with 176 receiving their treatment within 31 days of decision to treat, with a result of 88.5% against the target of 95%.

Local data for the 31-day target indicates results of 92% against the target. Of the delays experienced by nine patients, one was delayed 10 days due to operating capacity in general surgery (due to a large number of colo-rectal cancers) and eight due to surgical capacity in the Urology service. The average delay for those patients was 29 days. We continue to work with our sub-regional urology service to improve capacity in this area.

February 2021 **Public**

Appendix 1 3.8.1 – Faster Cancer Treatment.

Faster Cancer Treatment

Data submitted to the Ministry of Health as at **30 Oct 2020**)

This report provides preliminary achievement data for **quarter one 2020/21** (which is based on patients who received their first cancer treatment or other management) between **1 Jul 2020 and 30 Sep 2020**).

If you have any questions about this report, please contact Alex Dunn (Alexander.Dunn@Teaho.govt.nz)

62-day indicator achievement (Health Target)

		Adjusted number of records submitted *Patients within the 62-day FCT health target cohort (excluding patients breaching with a delay code of clinical consideration or patient reason), by month of first treatment*							Number of records within 62 days							Achievement 6-month quarter	Achievement 3-month quarter
DHB		Apr	May	Jun	Jul	Aug	Sep	Total	Apr	May	Jun	Jul	Aug	Sep	Total	Apr 2020 - Sep 2020 Tracking	Jul - Sep 2020 Tracking
Auckland		22	26	34	24	32	26	164	22	26	34	24	31	23	160	97.6%	95.1%
Bay of Plenty		19	12	13	10	12	12	78	18	12	13	10	12	12	77	98.7%	100.0%
Canterbury		56	39	55	52	44	40	286	54	36	54	51	42	40	277	96.9%	97.8%
Capital and Coast		24	14	14	18	29	16	115	22	10	12	17	24	14	99	86.1%	87.3%
Counties Manukau		38	21	37	34	32	31	193	32	16	34	31	31	29	173	89.6%	93.8%
Hawkes Bay		8	7	8	14	13	15	65	7	6	6	14	11	13	57	87.7%	90.5%
Hutt Valley		10	14	11	10	15	13	73	9	10	10	10	15	12	66	90.4%	97.4%
Lakes		8	4	4	6	2	9	33	8	4	4	6	2	9	33	100.0%	100.0%
MidCentral		7	7	4	4	10	8	40	7	7	3	4	10	8	39	97.5%	100.0%
Nelson Marlborough		33	16	21	32	28	22	152	32	15	17	31	25	21	141	92.8%	93.9%
Northland		24	27	28	22	30	25	156	16	14	21	18	22	15	106	67.9%	71.4%
South Canterbury		5	3	7	6	5	3	29	3	2	6	5	5	2	23	79.3%	85.7%
Southern		33	25	24	33	31	28	174	25	15	19	24	25	19	127	73.0%	73.9%
Tairawhiti		3	5	6	7	1	8	30	3	4	6	5	1	6	25	83.3%	75.0%
Taranaki		12	12	7	3	2	21	57	11	9	6	3	2	21	52	91.2%	100.0%
Waikato		31	17	25	23	22	28	146	29	16	25	23	22	28	143	97.9%	100.0%
Wairarapa		7	7	12	4	13	8	51	7	6	12	4	10	8	47	92.2%	88.0%
Waitemata		38	38	18	47	41	49	231	34	32	16	43	36	44	205	88.7%	89.8%
West Coast		6	5	5	4	1	4	25	5	5	4	4	1	3	22	88.0%	88.9%
Whanganui		9	8	6	10	6	6	45	9	6	6	10	6	5	42	93.3%	95.5%
National total		**393**	**307**	**339**	**363**	**369**	**372**	**2143**	**353**	**251**	**308**	**337**	**333**	**332**	**1914**	**89.3%**	90.8%

February 2021

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31-day indicator (policy priority)

DHB	Expected monthly cancer registrations	Number of records submitted *Patients within the 31-day FCT health target cohort, by month of first treatment*							Number of records within 31 days							Achievement
		Apr	May	Jun	Jul	Aug	Sep	Total	Apr	May	Jun	Jul	Aug	Sep	Total	Apr 2020 - Sep 2020 Tracking
Auckland	*161*	84	106	110	90	115	100	605	74	90	97	83	99	91	534	88.3%
Bay of Plenty	*115*	96	91	65	90	95	86	523	88	88	60	83	89	77	485	92.7%
Canterbury	*246*	139	116	108	124	121	94	702	127	97	106	116	115	89	650	92.6%
Capital and Coast	*107*	77	78	92	82	108	71	508	70	72	84	76	92	62	456	89.8%
Counties Manukau	*177*	162	127	134	143	139	158	863	151	113	120	129	124	135	772	89.5%
Hawkes Bay	*76*	61	44	68	92	67	60	392	54	37	60	85	63	53	352	89.8%
Hutt Valley	*60*	57	45	68	49	49	53	321	51	39	66	42	46	48	292	91.0%
Lakes	*47*	34	24	33	29	28	29	177	33	19	30	28	27	28	165	93.2%
MidCentral	*81*	55	62	72	70	85	73	417	53	49	67	66	78	63	376	90.2%
Nelson Marlborough	*74*	71	47	58	78	78	59	391	67	37	51	75	71	49	350	89.5%
Northland	*84*	76	72	69	59	67	57	400	68	55	55	52	59	49	338	84.5%
South Canterbury	*34*	17	16	31	24	21	19	128	16	12	28	22	20	17	115	89.8%
Southern	*136*	94	91	99	114	131	108	637	83	80	89	102	109	88	551	86.5%
Tairawhiti	*20*	8	11	19	18	10	19	85	6	10	14	17	10	19	76	89.4%
Taranaki	*57*	58	44	34	16	18	51	221	54	43	25	16	17	47	202	91.4%
Waikato	*161*	97	115	110	130	109	133	694	94	110	107	129	103	126	669	96.4%
Wairarapa	*22*	15	14	28	14	32	25	128	14	14	26	12	32	23	121	94.5%
Waitemata	*222*	164	159	139	160	167	159	948	153	143	129	148	150	142	865	91.2%
West Coast	*17*	11	12	14	18	14	9	78	10	11	14	18	14	7	74	94.9%
Whanganui	*34*	32	34	33	37	24	39	199	31	30	30	32	21	32	176	88.4%
National total	***1929***	**1408**	**1308**	**1384**	**1437**	**1478**	**1402**	**8417**	**1297**	**1149**	**1258**	**1331**	**1339**	**1245**	**7619**	**90.5%**

February 2021 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	Item No. 4.1
Author	Kath Fraser-Chapple, Business Development Manager
Endorsed by	Paul Malan, GM Strategy Commissioning and Population Health
Subject	Final Elective Services Productivity Indicator Results for December 2020

Recommendations

Management recommend that the Combined Statutory Advisory Committee:

a. **Receive** the paper titled Final Elective Services Productivity Indicator Results for December 2020

b. **Note** that the results for ESPI 2 is 0.4% non-compliance and ESPI 5 is 6.2% non-compliance

c. **Note** that the Ministry of Health has devolved $7M of funding nationally to improve waiting times and WDHB's share is $1.28M

d. **Note** this paper has also been provided to the Finance, Risk & Audit Committee

1 Purpose

This paper is for information only and shows the final Elective Services Productivity Indicator Results for December 2020. This information was discussed at the WDHB Finance Risk and Audit Committee on 17 February 2021.

2 Whanganui DHB Elective Services Productivity Indicator Results

Final ESPI results for December are now available and continue our overall trajectory towards compliance following COVID-19 service disruption. Results are:

- *ESPI2* - 7 out of 1612 (0.4%) of total patients waiting have waited longer than 120 days for a First Specialist Assessment, an improvement of 11 on the previous months results
- *ESPI 5* – 46 out of 746 (6.2%) of total patients waiting have waited longer than 120 days for planned inpatient treatment. This was an expected deterioration with three main factors - a second "bubble" of orthopaedic patients post COVID disruptions, reduced planned services over the Christmas/New Year period, and delayed medical staff recruitment in ophthalmology.

Strategies are in place to mitigate impacts of reduced clinical capacity including additional theatre lists in some specialties and some service redesign.

While the local outcome for ESPI 5 is disappointing, we are making progress towards regaining compliance. The Ministry of Health has been advised of our expected non-compliance for ESPI5 and have agreed a 3-month improvement timeframe to March 2021.

February 2021 **Public**

3 National Results and Ministry of Health Response to Increasing Waiting Times

In comparison against DHB's nationally we are ranked second for compliance following Wairarapa DHB for ESPI 5 and third for ESP1 2. The national picture of compliance with expected treatment timeframes shows deterioration, with ESPI 2 results at 12% waiting longer than 120 days, and ESPI 5 20% waiting longer than 120 days across all DHBs. Results for December 2019 were 10% for ESPI 2 and 17% for ESPI 5.

The Ministry of Health has invested significantly to improve waiting times for patients following COVID disruption. The Funding to Improve Waiting times programme distributed approximately $7m nationally based on population share.

Whanganui DHB's share of the funding is $1.28M, including $64K for service redesign. The majority of the funding is based on delivery of specified purchase units above agreed baseline volumes. While we have agreed additional volumes with the Ministry, there is a balance to be struck in delivering "more of the same" and the ability to change service delivery to meet the needs of our community. We are using the service redesign funding to align capacity and production planning models with patient focussed service delivery and improving access to services.

4 Summary

The Combined Statutory Advisory Committee note our results and ongoing progress in compliance and receive the final Ministry of Health Reporting for December 2020 is attached.

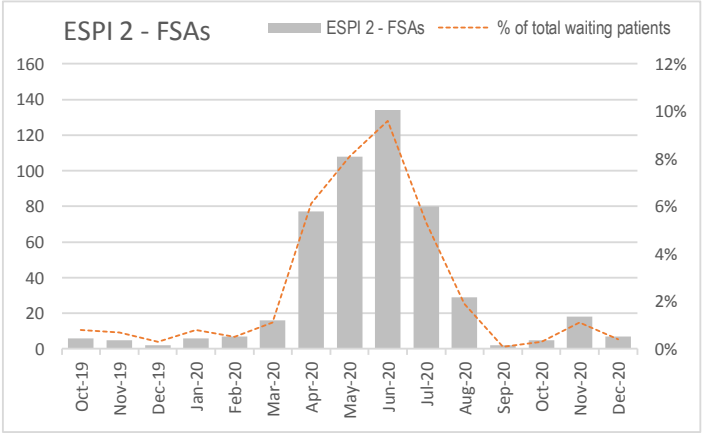
February 2021 **Public**

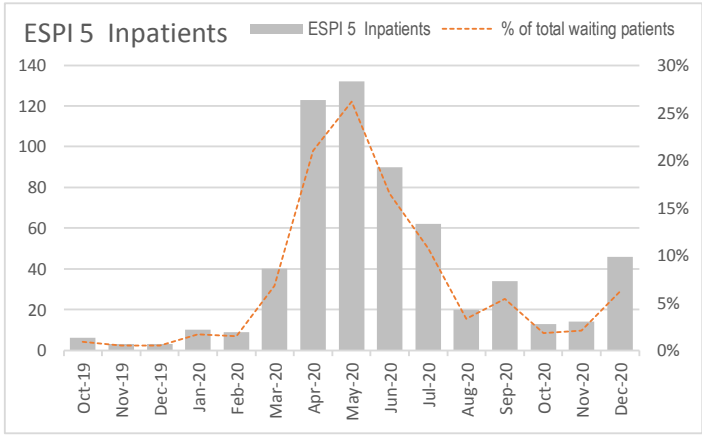
ESPI Results – Ministry of Health Reporting December 2020

MoH Planned Care Measurement

Summary of Patient Flow Indicator (ESPI) results
DHB: Whanganui

	Jan		Feb		Mar		Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec	
	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %
1. DHB services that appropriately acknowledge and process patient referrals within the required timeframe.	10 of 10	100.0 %	10 of 10	100.0 %	10 of 10	100.0 %	10 of 10	100.0 %	10 of 10	100.0 %	10 of 10	100.0 %	10 of 10	100.0 %	10 of 10	100.0 %	10 of 10	100.0 %	10 of 10	100.0 %	10 of 10	100.0 %	10 of 10	100.0 %
2. Patients waiting longer than four months for their first specialist assessment (FSA).	6	0.8%	7	0.5%	16	1.1%	77	6.1%	108	8.1%	134	9.6%	80	5.3%	29	1.9%	2	0.1%	5	0.3%	18	1.1%	7	0.4%
3. Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT).	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
5. Patients given a commitment to treatment but not treated within four months.	10	1.6%	9	1.5%	41	7.0%	124	21.2%	133	26.3%	90	16.8%	62	11.1%	20	3.3%	7	1.0%	13	1.8%	15	2.1%	46	6.2%
8. The proportion of patients treated who were prioritised using nationally recognised processes or tools.	0	100.0 %	0	100.0 %	0	100.0 %	0	100.0 %	0	100.0 %	0	100.0 %	0	100.0 %	0	100.0 %	0	100.0 %	0	100.0 %	0	100.0 %	0	100.0 %





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National comparison of DHBs for December 2020

	1. DHB services that appropriately acknowledge and process patient referrals within ten working days.			2. Patients waiting longer than the required timeframe for their first specialist assessment (FSA).			3. Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT).			5.Patients given a commitment to treatment but not treated within the required timeframe.			8. The proportion of patients who were prioritised using approved nationally recognised processes or tools.		
	Level	Status %	Imp Req.	Level	Status %	Imp Req.	Level	Status %	Imp Req.	Level	Status %	Imp Req.	Level	Status %	Imp Req.
Auckland	30 of 33	90.9%	3	935	5.56%	-935	0	0.0%	0	926	12.3%	-926	2,510	97.2%	72
Bay of Plenty	24 of 24	100.0%	0	504	7.82%	-504	0	0.0%	0	369	11.1%	-369	457	97.6%	11
Canterbury	28 of 28	100.0%	0	1,313	11.58%	-1,313	0	0.0%	0	1,034	20.0%	-1,034	1,417	100.0%	0
Capital and Coast	18 of 23	78.3%	5	314	4.69%	-314	95	0.9%	-95	307	8.8%	-307	1,120	100.0%	0
Counties Manukau	20 of 20	100.0%	0	1,133	9.19%	-1,133	103	0.8%	-103	202	6.3%	-202	1,533	100.0%	0
Hawkes Bay	15 of 19	78.9%	4	1,413	26.60%	-1,413	2	0.0%	-2	613	25.3%	-613	732	100.0%	0
Hutt Valley	15 of 15	100.0%	0	788	17.01%	-788	0	0.0%	0	1,092	41.0%	-1,092	523	100.0%	0
Lakes	8 of 16	50.0%	8	1	0.04%	-1	2	0.0%	-2	106	9.4%	-106	402	99.8%	1
MidCentral	10 of 23	43.5%	13	84	1.94%	-84	28	0.5%	-28	704	40.6%	-704	294	100.0%	0
Nelson Marlborough	20 of 20	100.0%	0	394	7.46%	-394	0	0.0%	0	166	12.5%	-166	306	100.0%	0
Northland	13 of 15	86.7%	2	1,957	28.28%	-1,957	0	0.0%	0	1,167	37.1%	-1,167	644	100.0%	0
South Canterbury	13 of 13	100.0%	0	3	0.24%	-3	0	0.0%	0	53	10.9%	-53	195	100.0%	0
Southern	28 of 28	100.0%	0	1,177	16.76%	-1,177	45	0.5%	-45	1,256	30.7%	-1,256	1,036	99.1%	9
Tairawhiti	17 of 17	100.0%	0	566	26.28%	-566	0	0.0%	0	78	16.3%	-78	199	100.0%	0
Taranaki	21 of 22	95.5%	1	2,455	42.61%	-2,455	2	0.0%	-2	652	30.0%	-652	515	100.0%	0
Waikato	3 of 27	11.1%	24	1,604	15.46%	-1,604	25	0.1%	-25	543	12.1%	-543	1,319	98.4%	22
Wairarapa	14 of 14	100.0%	0	6	0.48%	-6	0	0.0%	0	5	1.4%	-5	104	100.0%	0
Waitemata	20 of 20	100.0%	0	926	6.88%	-926	0	0.0%	0	1,073	20.2%	-1,073	1,610	100.0%	0
West Coast	18 of 18	100.0%	0	32	3.62%	-32	1	0.1%	-1	47	14.5%	-47	124	100.0%	0
Whanganui	10 of 10	100.0%	0	7	0.43%	-7	0	0.0%	0	46	6.2%	-46	188	100.0%	0
Total:				**15,612**			**303**			**10,439**			**15,228**		

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WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	Item No 4.2
Author	Paul Malan, GM Strategy, Commissioning and Population Health
Subject	Annual Plan 2021/22 update
Equity Considerations	The Annual Plan will include policy responses and actions relating to eliminating inequity in Whanganui DHB
Strategic alignment	The Annual Plan 2021/22 will be strongly aligned to He Hāpori Ora

Recommendations

Management recommend that the Combined Statutory Advisory Committee:

a. **Receive** the paper titled Annual Plan 21/22 update

b. **Note**

- The government's planning priorities have not changed
- The Ministry will not require a Regional Services Plan this year
- The contents of the Minister's Letter of Expectations
- The first draft will be submitted to the Ministry of Health on 5th March, 2021

Appendices

- **Appendix 1:** Planning package overview
- **Appendix 2:** Minister's Letter of Expectations

1 Purpose

The purpose of this item is to provide the Committee with an update of the developing Annual Plan 2021/22.

2 Background

A paper was presented to the November committee meeting outlining the Annual Plan timeline for 2021/22. As noted in that paper, some "pre planning-cycle" activities had already been completed and we would be receiving the guidance and commencing our plan well before the February meeting.

3 Update

We received the 2021/22 DHB planning package on 16th December, 2020. Some changes have been made to the planning processes with the aim of streamlining the annual planning for the coming year. These changes include:

- The focus of the annual plan guidance has been shifted away from business as usual to require DHBs to identify their most significant innovative activity to improve equity and to embed key COVID-19 learnings across the Government's planning priorities.
- Nationally directed regional planning will be paused for 2021/22 and no planning guidance for Regional Service Plans will be issued by the Ministry.
- The Ministry recommended to the Minister that refreshed DHB Statements of Intent should not be required for 2021/22 due to system level changes, including the Health and Disability System Review.

As expected, the government's planning priorities have not changed. An overview is provided in Appendix 1.

The second key input to the Annual Plan process is the Minister's Letter of Expectations. Addressed to our Chair, this was received by the DHB on 10th February, 2021. A copy is included as Appendix 2. Importantly, the Minister confirmed that he is not expecting a refresh of our Statement of Intent this year.

As soon as staff returned from the Christmas break, we commenced the process of responding to the guidance. Section leads have been assigned to planning priority areas and all executives have also been linked into the process. As usual, the timeframe is tight – especially with an expectation of some level of consultation with key stakeholders, such as the PHOs, Hauora providers and NGOs.

4 Next Steps

The first draft is due at the Ministry on Friday 5th March, 2021. By the next committee meeting we will have had the Ministry's initial response and will be almost due to submit our second draft.

Appendix : 4.2.1 : Annual planning update

Summary overview of the 2021/22 DHB planning guidance

Government's planning priorities.

Give practical effect to Whakamaua: Māori Health Action Plan 2020-2025
Engagement and Obligations as a Treaty partner
Whakamaua Objective: Accelerate and spread the delivery of kaupapa Māori and whānau-centred services
Whakamaua Objective: Shift cultural and social norms
Whakamaua Objective: Māori Health Action Plan 2020-2025 - Reduce health inequities and health loss for Māori
Whakamaua Objective: Strengthen system accountability settings
Improving sustainability
Short term focus 2021/22
Medium term focus
Improving maternal, child and youth wellbeing
Maternity Care
Immunisation
Youth health and wellbeing
Family Violence and Sexual Violence
Improving mental wellbeing
Kia Kaha, Kia Māia, Kia Ora Aotearoa
Improving wellbeing through prevention
Communicable Diseases
Environmental sustainability
Antimicrobial Resistance (AMR)
Drinking water
Environmental and Border Health
Healthy food and drink
Smokefree 2025
Breast Screening
Cervical Screening
Reducing alcohol related harm
Sexual and reproductive health

Cross Sectoral Collaboration including Health in All Policies
Better population health outcomes supported by strong and equitable public health and disability system
Delivery of Whānau Ora
Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025
Health outcomes for disabled people
Planned Care
Acute Demand
Rural health
Implementation of the Healthy Ageing Strategy 2016 and Priority Actions 2019-2022
Health quality & safety (quality improvement)
Te Aho o Te Kahu – Cancer Control Agency
Bowel screening and colonoscopy wait times
Health workforce
Data and digital enablement
Implementing the New Zealand Health Research Strategy
Better population health outcomes supported by primary health care
Primary health care
Pharmacy
Reconfiguration of the National Air Ambulance Service Project – Phase Two
Long-term conditions

Appendix 4.2.2: Annual Planning update

Hon Andrew Little
Minister of Health
Minister Responsible for the GCSB
Minister Responsible for the NZSIS
Minister for Treaty of Waitangi Negotiations
Minister Responsible for Pike River Re-entry

10 FEB 2021

Ken Whelan
Chair
Whanganui District Health Board
[redacted]

Tēnā koe Ken

Letter of Expectations for district health boards and subsidiary entities for 2021/22

This letter sets out the Government's expectations for district health boards (DHBs) and their subsidiary entities for 2021/22. As a DHB Chair you are accountable to me for meeting these expectations.

This government acknowledges the progress made to rebuild our health system, but there is still more to do. It is clear that COVID-19 will be placing a range of pressures on our health system for some time. We are well placed to continue to respond to resurgence as needed and to lock-in new ways of operating based on our COVID-19 response so that we retain and embed new and innovative approaches where possible.

A safe and effective vaccine for COVID-19 is an essential part of how we protect our communities, and this will be a key piece of work for the health system during 2021/22. Additional information will be provided when it becomes available.

As you know the Government has accepted the high-level direction of travel of the Health and Disability System Review (HDSR) and during this next phase we will roll out our plan to improve the public health system to ensure it delivers high quality services, improved equity for our vulnerable populations and supports better outcomes for all New Zealanders.

There will be uncertainty ahead, but I expect that this will not stop you from driving forward and continuing to deliver the improvements already underway. It is important that the sector continues to function at its best to provide health and disability services for New Zealanders while system changes are being confirmed and implemented. I also expect that you will begin to work together on further enhancements. The work we do now will ensure we have the right models of care to support longer term sustainability and to maximise outcomes through robust investment in primary and community care.

The priorities this Government has previously outlined to guide DHB planning will remain of critical importance for the coming year. Our wellbeing and equity system priorities together with a focus on giving practical effect to Whakamaua: the Māori Health Action Plan 2020-2025 and improvements to DHB sustainability, continue to provide a solid framework for planning and articulating the work DHBs are doing:

- giving practical effect to Whakamaua: the Māori Health Action Plan 2020-2025
- improving sustainability
- improving child wellbeing
- improving mental wellbeing including a focus on the transformational direction for our approach to mental health and addiction through the agreed actions from the Mental Health and Addiction Inquiry

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- improving wellbeing through prevention;
- better population outcomes supported by a strong and equitable public health and disability system
- better population health and outcomes supported by primary health care.

I would like you to continue to build on these areas of focus, so we improve equity for our vulnerable populations while also ensuring COVID-19 lessons and innovations are captured.

I expect all DHBs to deliver breakeven results by the end of 2021/22 and your annual plan will not be supported without this commitment. Strong fiscal management is critical to support our collective ability to invest more in new models of care and in primary care and population prevention approaches.

It is also imperative that the health system maintains and continues to strengthen our health capital planning, investment and delivery and as Chair you must have clear oversight of the DHB's annual plan to ensure it is sustainable, person centred and reflects Government expectations, including breakeven financial targets.

As you will be aware the Government will be implementing recommendations from the Health and Disability system review. This work will be undertaken alongside the work laid out in this letter. I expect that all DHB's will continue to provide the highest quality services to their populations while any changes are implemented across the system.

A number of DHBs will benefit from expert support across a range of areas and I understand that Chairs are working on an exemplars group. I expect you to seek the support of your colleagues and the Ministry where you need a lift in capability or support to navigate specific challenges.

This Government has provided specific sustainability funding for DHB led improvement projects. I expect to see tangible outcomes being delivered and implemented with this funding and reports on the impact it is having.

You will be aware that pay parity for workforces in the DHB-funded sectors is an issue. This is also an issue in other parts of the State sector, and it is important that a whole-of-Government approach is taken. This Government's position will be developed at a central agency level and I expect you to contribute to and act consistently with this approach. There are complex matters that need careful consideration, including whether DHB funding has flowed equitably to employees in the past and how this would be protected in the future.

I expect all DHBs to increase the pace and scale of implementation of the Care Capacity Demand Management Programme (CCDM) in 2021 to meet the expectations outlined in the 2018 NZNO DHB MECA. I want to be clear that full implementation of CCDM includes annual FTE calculations and ensuring agreed budgeted nursing and midwifery FTE are in place.

DHBs are responsible for the health outcomes for your population and it is important that DHBs and the Ministry continue to work together, and with primary and community providers, to ensure we have a strong and equitable public health system delivering better health outcomes for our most vulnerable populations who have long-standing health inequities.

Please ensure any approaches to a service reconfiguration support improved access to care and equity, and are financially sound. As you are aware any shifts or additions in workforce / FTE must be considered as a service change and follow service change processes. DHBs

must remain focused and prepared for increased pressure and ensure systems are in place to ensure COVID-19 innovations are used to avoid pressure building up on existing services.

DHBs are expected to support and contribute to the Ministry's National Asset Management Programme (NAMP), which will be used to assist the Capital Investment Committee and Ministers to make more informed decision on DHB capital expenditure. I expect DHBs to develop their own Asset Management Policy and Strategy and align their asset management practices with the Ministry of Health district health board sector Asset Management Framework.

Unlike previous years I have strong expectations that the annual planning process will be completed on time and as Chair it is your responsibility to meet all deadlines for this process. I expect a strong first draft annual plan will be provided to the Ministry for review in early March so that a robust final plan that meets all expectations will be able to be agreed with me as early as possible post Budget 21. If timelines are not met and robust and appropriate plans are not delivered I will not be able to sign them off for the year.

Please note that I do not require you to refresh your Statement of Intent for 2021/22.

We face complex challenges that require collective approaches and I am looking forward to working with you as we continue our efforts to improve outcomes for New Zealanders.

Thank you for the work you have been doing to provide strong governance within our health system. I remind you that in everything you do you are part of the system.

Ngā mihi nui

Hon Andrew Little
Minister of Health

Cc Russell Simpson
Chief Executive
Whanganui District Health Board

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WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	Item No 4.3

Author	Karmin Erueti, Kaitakitaki Health Promotion
Endorsed	Paul Malan, General Manager, Strategy Commissioning & Population Health
Subject	Public Health Covid-19 - Gatherings and Events
Equity Considerations	Work alongside community leaders, at events such as Ratana Church celebrations, will ensure correct messaging and adequate support is offered to reduce the risk of Covid-19 spread within the local community

Recommendations

Management recommend that the Combined Statutory Advisory Committee:

a. **Receive** the paper titled "Public Health Covid-19 - Gatherings and Events"

b. **Note** the MoH have established a voluntary code to support lowering transmission risk

c. **Note** the Health promotion team have provided support and guidance to event organisers over the summer period in line with the MOH "make summer unstoppable" campaign

1 Purpose

This paper will provide to committee an update from the Public Health/Health Promotion teams regarding local Whanganui initiative(s) for Covid-19 gatherings and events during the summer holiday period.

2 Background

On 10 December 2020 Public Health Units (PHU) were given a clear understanding of Ministry guidance around mass gatherings over the 2020/2021 summer holiday period in relation to the risk of Covid-19 infection.

During this timeframe a greater number of people travel throughout New Zealand and frequently outside the major population centres where much of the infrastructure and public health workforce are based. An outbreak in Whanganui would place a significant burden on the local PHU response. Due to the increase of inter-regional travel and gatherings both small (e.g. family events) and large (e.g. festivals), if an outbreak were to occur during this period there would be an increased likelihood of the disease spreading throughout New Zealand.

Under the current Alert Level system the risk of exposure to Covid-19 and transmission in the community remains. Events and gatherings could become a transmission risk if Covid-19 community transmission were to re-emerge.

- A Ministry of Health (MoH) events sector voluntary code has been developed to outline how to safely deliver events by following best practice expectations, guidance and behaviours to prevent/reduce Covid-19 related risks.

- The code enables events to appropriately support the MoH to contact trace if a community outbreak Covid-19 were to occur.
- The code does not replace existing systems and process that any event may have in accordance with existing legal obligations.
- The code is a non-legislative commitment and is not regulated or legally enforceable. However, to reduce the likelihood and impact of a Covid-19 outbreak, the code describes best practice processes which can be overlaid by an event organiser into existing systems and processes.

3 Public Health – Health promotion approach

Current Context: Covid-19
Aotearoa New Zealand has a strategy for the elimination of Covid-19. The aims are to eliminate transmission chains and to prevent the emergence of new transmission chains originating from cases that arrive from outside the country.

Maintaining current Pandemic Alert Level 1 with zero community transmission of Covid-19 is a national priority. Mass gatherings and festivals over the Summer period represent a potential source for disease outbreaks when a case has escaped detection through routine testing. The Ministry of Health has requested regional public health units assist with preparedness by liaising with local event organisers to ensure measures are in place both pre-event and during the event to minimise any potential spread of disease.

Public Health:
A focus on proven preventive measures and earlier intervention can result in significant health gains from a population approach. Covid-19 is deemed a public health emergency and global pandemic.

Covid-19 is fundamentally changing and challenging the way the New Zealand the public health system responds, especially in terms of what and how public health services are delivered.

The Covid-19 response and associated activities delivered by the DHB based public health units are now integrated with the Ministry of Health (led by the Covid-19 directorate). For example, the National Investigation and Tracing Centre and the use of a common ICT platform in the National Contact Tracing Solution.

Scope
Large gatherings in Whanganui region over the Summer Season from early December 2020 to 31 March 2021.

Objectives
- Health Promotion team to provide support and guidance for Covid-19 planning.
- Create an "Events Covid-19 checklist" ensuring consistent procedures to all first contact communications
- Create an information sheet to be emailed to all event organisers
- Determine main contact (including after hours) if a case is detected
- Contact event organisers within the Whanganui DHB region and complete the Covid-19 checklist raising the awareness of key preventative measures and communications. To include:
  - Key actions and how these can be facilitated
  - Public Health – Health Protection contact details
  - Location of testing services
- Determine if there is a Covid-19 response included within their Health & Safety/or pandemic Plans.
- Provide Covid-19 prevention guidance and support for key messages for event attendees aligning with "Ministry of Health Unite Against Covid-19: Make Summer Unstoppable" national communication campaign and resources
- Liaise and bridge the gap between Health Protection, Public Health Nursing, WDHB - Quality & Risk, Communication and Whanganui Regional Health Network on behalf of organisers if required.
- Liaise with and support Events communications leads and our DHB Communication Team to:
  - provide Toolkits with latest branding messages around the Covid-19 "Make Summer Unstoppable" campaign
  - offer digital toolkit to event organisers

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- inform and ensure messages around CBAC use/location and hospital services has been made available to event organisers

FIRST CONTACT BY KAIHOE – HEALTH PROMOTION- PREVENTION CHECKLIST

No	Action		To Facilitate this	Notes:
1	Contact Tracing	Scanning of COVID Tracer App QR Codes	▪ Important contact information is for all people who attend your event – this includes participants and their supporters, volunteers, paid staff, stall holders, first aiders, traffic control ▪ Should take steps to ensure everyone is checked-in ▪ QR Codes are easily visible and located in multiple places throughout your venue/event ▪ QR Codes should be consistent throughout the event (i.e. there should not be different QR codes posted around the event locations, they should be the same ▪ Unless people are having to move to completely different areas/locations then you can have separate QR Codes within different zones ▪ Access points in areas where people are likely to gather	Attendees should be advised that the purpose of recordings information is only for contact tracing purposes and will only be provided to Public Health if there is a case associated with the event
		Capturing key data via an Electronic register / or written	For attendees who do not have the COVID Tracer App or it is more reliable to capture attendees in a register ▪ The organiser should ensure the following information is captured (in an electronic format) With the following information: ▪ First Name / Last Name / Date of Birth / Mobile Ph Email ▪ Retain information for at least 4 weeks then you can delete your records/shred	Electronic registers should be readily available to Public Health Units should they be requested.
		Bluetooth Tracing	▪ This is optional but strongly recommended ▪ Ensure NZ Covid tracer mobile App is updated and turned-on Bluetooth tracing ▪ Still need to continue to scan QR codes ▪ Inform people Bluetooth tracing doesn't involve exchanging any identifying information ▪ Reminders: Turn on Bluetooth tracing on the NZ Covid Tracer App	If an App user is tested positive the contact tracing team, will ask them to upload their Bluetooth keys. If you have been at risk of exposure, you will receive a Bluetooth notification alert
2	If you are unwell stay home		▪ Ensure you continuously remind and motivate staff, volunteers, contractors, whanau and attendees before and during your event the importance of Stay home if you are feeling unwell and get advice about a COVID-19 test	On the Covid 19 government business and events toolkit you can download posters and social media posts

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No	Action		To Facilitate this	Notes:
			s	
3	Increased handwashing sanitising facilitates at the event		▪ It needs to be easily accessible ▪ Require regular checks to ensure they are kept clean and well supplies with soap and/or sanitiser ▪ Ensuring there are means to always dry hands as well	
4	High risk areas need to be cleaned frequently		Includes: Sanitary facilities and high use hand contact surfaces – Door handles – Counter tops/tables – Bench tops – Eftpos terminals	
5	Communication And Signage Raising awareness via Website & Facebook		Recommend they position throughout the venue/event reinforcing strengthen Public Health messages: – The importance of Contact Tracing (QR codes, Turning on Bluetooth, Electronic register) – If your unwell stay at home – Maintain good hygiene practices, including washing and drying your hands or use hand sanitiser if unable to wash your hands – Cough or sneeze into your elbow – Clean surfaces more frequently – Maintain physical distancing – Encouraging the use of face coverings – to get into the habit of carrying a mask or face covering at all times so that you can use it when needed	Face Coverings: Continuing good habits with face coverings will keep you and others safe, even at Alert level 1: It helps stop droplets spreading when someone speaks, laughs, coughs or sneezes

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WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	Item No 4.3
Author	Alex Kemp – Chief Allied Professions Officer and Dr Sarah Mitchell, Executive Director Allied Health Scientific and Technical, Bay of Plenty DHB
Endorsed by	Alex Kemp, Chief Allied Professions Officer
Subject	**The Life Curve**
Equity Considerations	The Life Curve is currently researched in its appropriateness for Māori through a Masters Project, supervised by Ngaire Kerse.

Recommendations

Management recommend that the Combined Statutory Advisory Committee:

Receive the paper titled "The Life Curve"

Note:

- The Life Curve is an evidence based tool that can indicate dependence on health and care systems and economic impact
- The Bay of Plenty DHB have purchased the right to the Life Curve app in New Zealand and are releasing a New Zealand version of this in March
- There is research occurring to ensure the life curve is appropriate for Māori, as part of the AWESSoM study headed by Professor Ngaire Kerse at Auckland University
- The Life Curve provides the potential to identify people who have not yet received support from health services
- The Life Curve has the potential to be used as a functional outcome measure across the health system

Support management to proactively promote and use the LifeCurve tool

1 Background

The Lifecurve is a simple multi-stakeholder concept developed at Newcastle University, and operationalised by ADL Smartcare in the UK, with the Bay of Plenty DHB (BOPDHB) holding the license for this in New Zealand. Lifecurve describes the hierarchical nature of function loss that occurs as we age. This is not based on chronological age as we all start the process of functional loss at different times in our lives, but has an average of 79 years as the starting point.

The Lifecurve provides the ability to map people on to their stage of functional decline, and provide an order of intervention approached to achieve best compression of this decline.

The hope is to use mapping of the lifecurve to extend 'years of able life' to improve a person's ageing journey and allow people to remain more independent from the health system, thus being more cost effective.

Professor Gore and colleagues from Newcastle University have developed the Model of Compressed Functional Decline – which is based on over 25 years of research on activities of daily living. Measures of Activities of Daily Living are often used to try and identify levels of dependency in order to match care and services.

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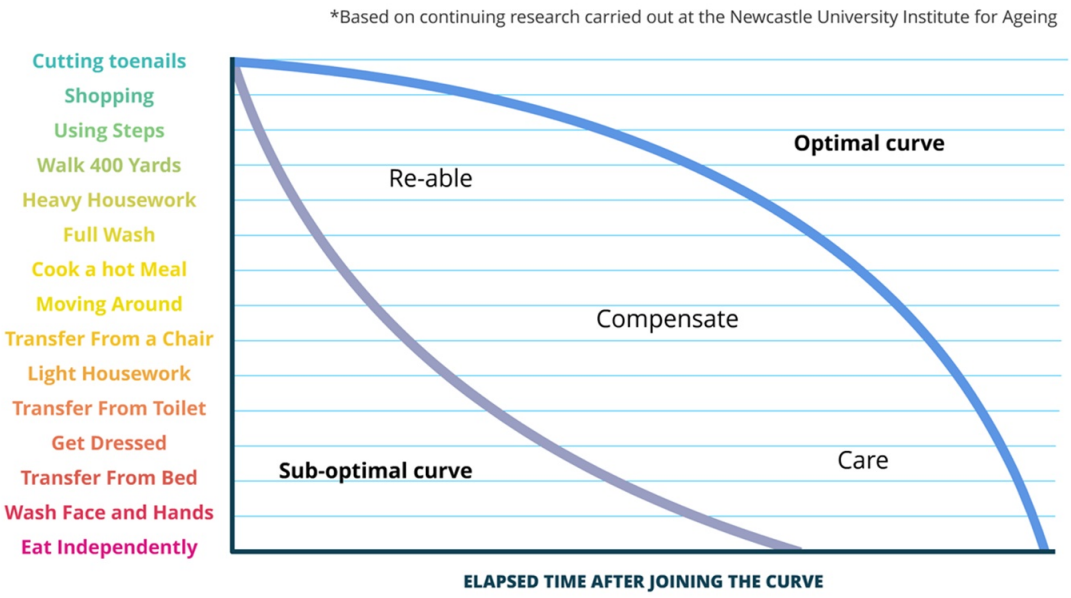
Age itself is easy to measure – but we know that how we age differs hugely dependent on many different factors - a range of social determinants – where we live, education, our mental health status, our housing circumstances, our early life experiences etc. We know we start to age (potentially) from around age 42 years – but those wide range of factors relate to what type of trajectory we are in terms of how age impacts on our ability to live independently and be independent of health services. So what does the term "elderly" mean? How useful is it? Research has now confirmed that people living in nursing care can improve their muscle strength by doing exercises – so what does aging mean?

Research findings have identified that there is a hierarchical order to functional loss – in other words there is a set order to how we all lose the ability to carry out our everyday activities. We can place people on their lifecurve by understanding what activities they can't do without help from a person or an assistive device and how long they haven't been able to do these activities for.

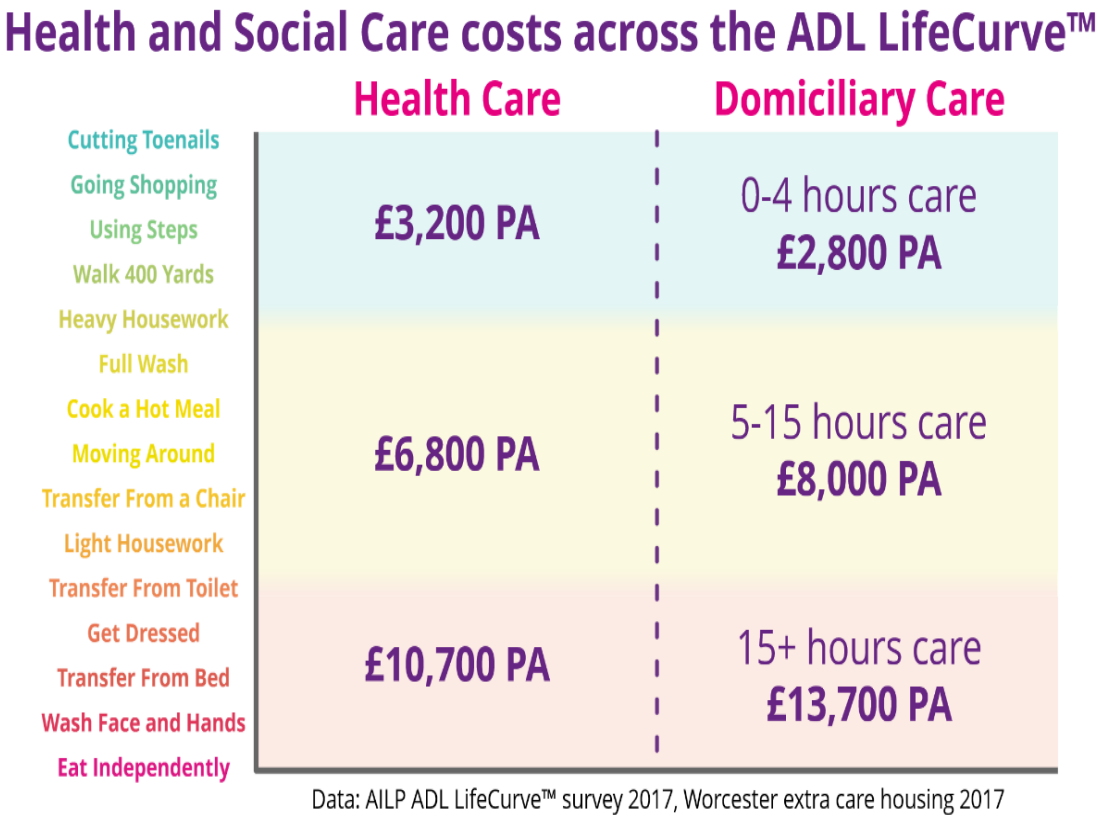
Listed below are the activities that we know lead to dependence on the health system and increase financial burden on support services.



In Mauve you will see the "sub optimal curve" – in that as we start to lose skills, the rate of deterioration and deconditioning that occurs means we start to lose other skills further down the curve more quickly. In blue, however, is the "optimal curve" - that we are able to slow down our rate of functional decline.

This research has also clearly identified the level of financial burden to the health system as we fall further down the life curve. Even though the figures presented are from the UK, they clearly show how significantly costs increase as a person moves further through the curve.

February 2021 **Public**

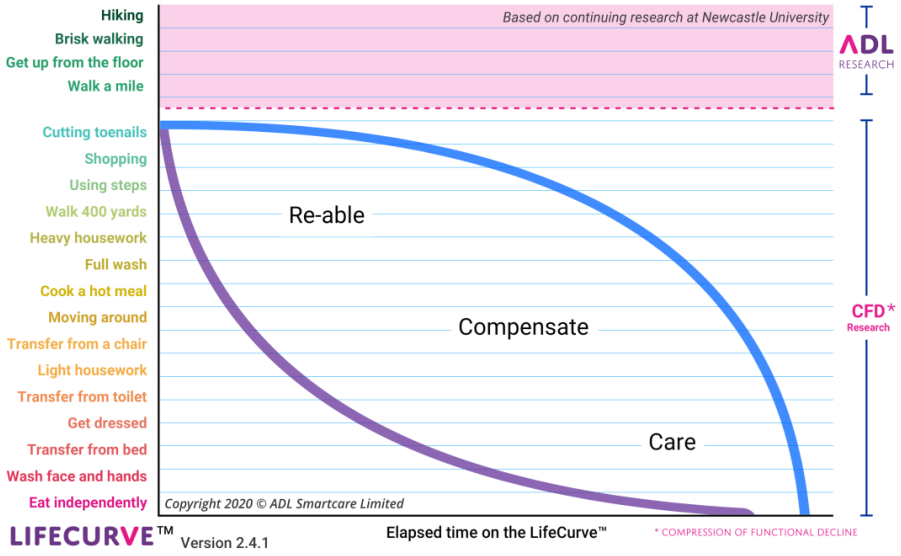


At each level of the care, there is research that identifies what kind of intervention works best. In our DHB and in clinical practise in general, we often decide whether we will offer direct services by using a screening or triage process – and usually this means that we focus on "greatest need" or "most vulnerable" – so we can leave off intervening directly until quite late in a persons' lifecurve trajectory.

February 2021 **Public**

1.1 Potential for Change through the use of the LifeCurve

In addition to the skills listed above, the research has also indicated 3 skills that we start to lose "pre life curve"

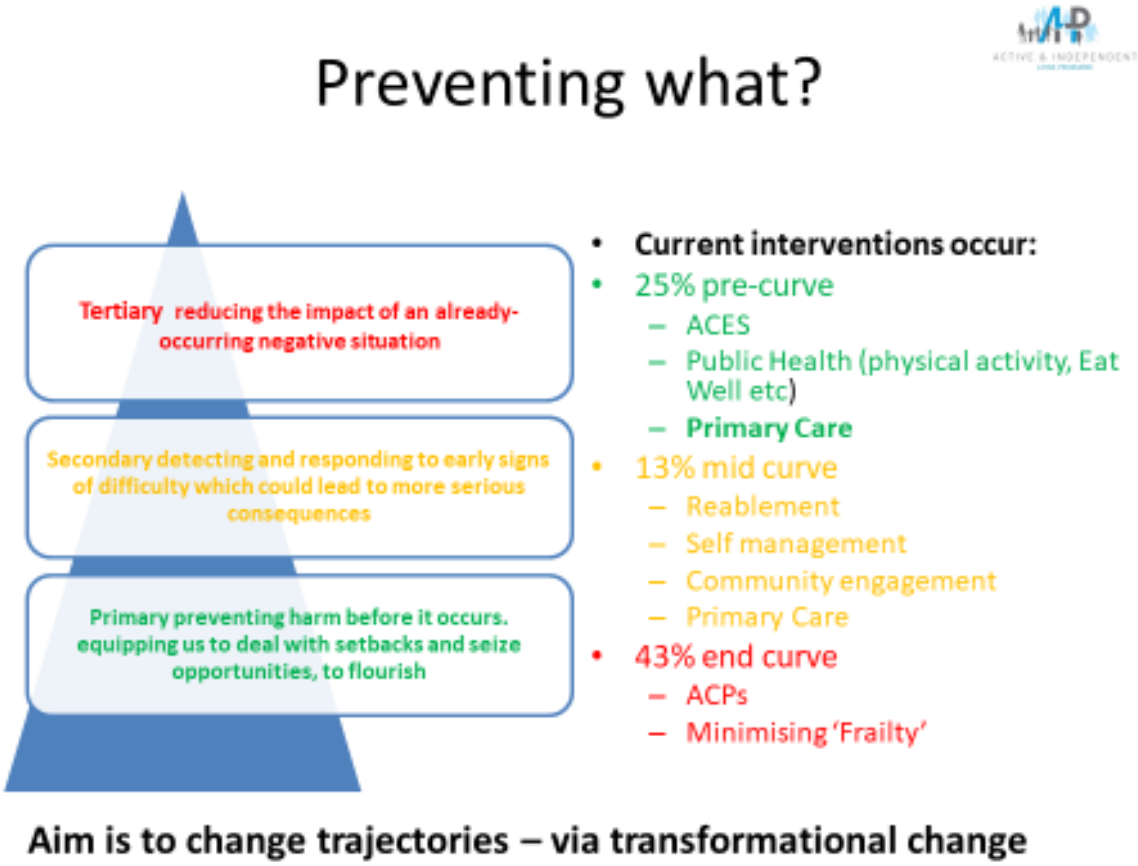


Trajectories of decline are affected by different types of interventions in different ways, and there is a best order:

1. 'Prehabilitation' (increase capability through *targeted* building of strength and muscle mass – ***before*** the particular ADL/IADL is lost e.g strengthening before a surgery such as joint replacement)
2. 'Reactivation' – (regain the lost ability through *targeted* building of strength and muscle mass – ***after*** the particular ADL/IADL is lost – possible for at least a while e.g. after some strokes, trauma)
3. 'Compensation' (the use of appropriate technology to supplement capability and keep the ADL/IADL ability that would otherwise be lost e.g after functional loss from stroke or trauma)
4. 'Care' – (this is necessary when the person has lost the ability – if introduced before the ability is lost, it can and typically does accelerate decline e.g. progressive degenerative disease)

(Note: general exercise and activity is good, but it won't necessarily delay particular muscle groups from declining and impacting your ADL/IADL ability)

February 2021 **Public**



The LifeCurve App will allow people to map their own position on the life curve and also provide them with evidence based interventions to, at best, reverse their progression on the curve, or at least slow down regression. It will also allow people to choose to connect with their local health partners – thus potentially opening up information to Whanganui DHB on people that have yet to connect with health services, and allowing us to intervene pre curve more often, saving on longer term costs to the health system.

February 2021 **Public**

2 The Lifecurve for Māori

In June 2019, $5 million funding was announced to the Ageing Well through Eating, Sleeping, Socialising and Mobility Programme (AWESSoM), headed by Professor Ngaire Kerse. Part of this funding is dedicated to a Masters Study by Leigh Haldane, looking at the appropriateness of the LifeCurve for Māori. The commitment from AWESSoM study is that "the LifeCurve app will be developed, tested and adapted for Māori, Pacific and Pakeha to assist in preventing the progression of disability by identifying older people" (www.ageingwellchallenge.co.nz/funding-announcement-health-and-wellbeing-in-ageing/)

3 Proposal for use in Whanganui

The potential use of the Lifecurve within Whanganui is

- Use as a functional measure of change in prevention and wellness interventions. Currently our measures of change are either system level measures (e.g number of ASH presentations) or count interventions (e.g. number of sessions, immunisations). The LifeCurve can allow us to measure functional change and related cost. This is currently being done in the BOPDHB in early studies.
- Use as a universal preventative tool at the primary care level which is person and whanau centred, and in the near future researched for Māori.
- Financial tool to enable predicted costs of care and change to costs based on earlier interventions

The tool can be used by any health partner and could be used across health and social systems within the rohe.

There will be a cost to each health provider to connect to information in their area, however this will be at a not for profit cost via BOPDHB.

Dr Sarah Mitchell, Executive Director of Allied Health, Scientific and Technical at the BOPDHB is one of the original researchers involved in the Lifecurve, and is one of the key organisers of bringing the knowledge, and technology, to NZ to allow us to learn from the UK experience. Whanganui DHB has been in regular contact with Dr Mitchell, who has acknowledged our desire to potentially be involved in any early rollout of the LifeCurve, and has committed to discuss next steps for this as they emerge.

Kathy Everitt, LifeCurve lead at BOPDHB, presented at the NZ Masters Games, and her presentation has been recorded.

It is recommended that Whanganui DHB proactively promote the use of the LifeCurve, with an active media and whole of system campaign, due to its significant benefit across the whole health system.

February 2020 **Public**

6 Exclusion of public

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

Agenda item	Reason	OIA reference
Combined Statutory Advisory Committee minutes of the meeting held on 13 November 2020 (public-excluded session)	For the reasons set out in the committee's agenda of 13 November 2020	As per the committee's agenda of 13 November 2020
Statement of Service Performance	Maintain the effective conduct of public affairs through the free and frank expression of opinions by or between or to Ministers of the Crown or members of an organisation or officers and employees of any public service agency or organisation in the course of their duty.	Section 9(2)(g)(i)

Persons permitted to remain during the public excluded session

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

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

WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

Terms of Reference

Combined Statutory Advisory Committee	
Applicable To: Whanganui District Health Board	**Authorised By:** Whanganui District Health Board
	Contact Person: Board Secretary

1. Committee of the board

The Combined Community and Public Health, Disability Support and Hospital Advisory Committee is a standing committee of the board, established in accordance with Section 34 of the New Zealand Public Health and Disability Act 2000 (the Act). These Terms of Reference are supplementary to the provisions of the Act and Schedule 4 of the Act.

2. Functions of the committee

- To provide advice to the board on the needs, and any factors that the committee believes may adversely affect the health status of the resident population of the district health board.
- To provide advice to the board on the disability support needs of the resident population of the district health board.
- To provide advice to the board on policy and priorities for use of the health and disability support funding provided.
- To ensure that all service interventions the district health board has provided or funded, or could provide or fund for the population, maximise the overall health and independence of the population whilst contributing to achieving equity of outcomes for all people.
- To promote, through its services and policies, the inclusion and participation in society, and maximise the independence of people with disabilities within the district health board's resident population.
- To advocate to external parties and organisations on the means by which their practices may be modified so as to assist those experiencing disability.
- To monitor and advise the board on the financial and operational performance of the hospital (and related services) of the district health board.
- To assess strategic issues relating to the provision of hospital services by or through the district health board.
- To recommend policies relative to the good governance of hospital services.
- To report regularly to the board on the committee's findings (generally the minutes of each meeting will be placed on the agenda of the next board meeting).

3. Delegated authority

The advisory committee shall not have any powers except as specifically delegated by the board from time to time. The following authorities are delegated to the Combined Statutory Committee.

- To require the chief executive officer and/or delegated staff to attend its meetings, provide advice, provide information and prepare reports upon request.
- To interface with any other committee(s) that may be formed from time to time.

4. Membership and procedure

Membership of the Committee shall be as directed by the board chairs (Whanganui DHB and Hauora A Iwi) from time to time. All matters of procedure are provided in Schedule 4 of the Act, together with board and committee Standing Orders.

Membership will consist of:

- Board appointments
  - The deputy chair of the board, who will be appointed to chair the committee
  - A minimum of five board members
- External (non-board member) appointments:
  - Up to two members of Hauora A Iwi board nominated by Hauora a Iwi board
  - At least three other members, nominated in consultation with Hauora a Iwi, and able to advise on matters relating to the DHB's functions and objectives.

5. Meetings

The Advisory Committee shall hold meetings as frequently as it considers necessary or upon the instruction of the board. It is anticipated that at least four meetings will be held annually, and that members will also attend any annual planning workshops.

Note
For the purposes of this document, the definitions of 'public health and disability support services' is incorporated in the Act, which means the health and disability support of all of the community in the district health board's region.

'Hospital' means all public health services owned by the Crown and previously known as 'Hospital and Health Services'.

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

AAU	Acute Assessment Unit
ACE	Advanced Choice of Employment
AH	Allied Health
AOD	Alcohol and Other Drugs
AoG	All of Government
APEX	Association of Professional and Executive employees
APC	Annual Practising Certificate
ASD	Autism Spectrum Disorder
ASMS	Association of Salaried Medical Specialists
AT&R	Assessment, Treatment & Rehabilitation
Capex	Capital expenditure
CAR	Corrective Action Request
CCU	Critical Care Unit
CMO	Chief Medical Officer
CSAC	Combined Statutory Advisory Committee
CSA	Critical Systems Analysis
CTA	Clinical Training Agency
CWD	Case Weighted Discharge
DNA	Did Not Attend
DSS	Disability Support Services
ED	Emergency Department
EN	Enrolled Nurse
ESPI	Elective Services Performance Indicator
FTE	Full Time Equivalent
GP	General Practitioner
HAI	Hauora a Iwi
HDC	Health and Disability Commission(er)
HPPPD	Hours Per Patient Per Day
HQPP	Hospital Quality and Productivity Programme
HQSC	Health Quality and Safety Commission
HRT	Health Round Table
HWNZ	Health Workforce New Zealand
IANZ	International Accreditation New Zealand
InterRAI	International Resident Assessment Instrument
LMC	Lead Maternity Carer
MERAS	Midwifery Employee Representation and Advisory Services
MERT	Medication Error Review Team
MHAHT	Mental Health Assessment Home Treatment
MHOAG	Maori Health Outcomes Advisory Group
MoH	Ministry of Health
MOoH	Medical Officer of Health
NASC	Needs Assessment Service Coordination Agency
NETP	Nurse Entry To Practice (Nursing)
NHC	National Hauora Coalition
NRT	Nicotine Replacement Therapy
NZHP	New Zealand Health Partnerships
NZNO	New Zealand Nurses Organisation
NZPHDA	New Zealand Public Health and Disability Act, 2000
NZRDA	New Zealand Resident Doctors' Association
OAG	Office of the Auditor-General
Opex	Operational expenditure
PACS	Picture Archive Communication System

PATHS	Providing Access To Health Solutions
PDRP	Professional Development and Recognition Programme (Nursing)
RAC	Risk and Audit Committee
RCA	Root Cause Analysis
RIS	Radiology Information System
RFI	Request for Interest
RFP	Request for Proposal
RMO	Resident Medical Officer
RN	Registered Nurse
RSP	Regional Service Plan
SAR	Severity Assessment Rating
SCBU	Special Care Baby Unit
SLT	Speech Language Therapist
SWIS	Social Workers In Schools
TAS	(Central Region) Technical Advisory Services
TOT (formally TOIHA)	Te Oranganui Trust (formally Te Oranganui Iwi Health Authority)
TOR	Terms Of Reference
VIP	Violence Intervention Prevention
WDHB	Whanganui District Health Board
webPAS	Web-based Patient Administration System
WRHN	Whanganui Regional Health Network

Kupu Māori	**English**
Aotearoa	Land of the long white cloud – New Zealand
Aroha	Love
Hapai te Hoe	Name of WDHB Education Programme
Hapū	Sub-tribe of a large tribe. It also means pregnancy or to be pregnant
Hariru/Hongi	Acknowledge (Pressing noses x2)
Haumoana	Family/whanau navigator
Hinengaro	Psychological realm, mental well-being
Hui	Meeting, gathering
Ipu Whenua	Container for placenta
Iwi	Tribe
Kai	Food
Kaiarahi	Clinical Management - Te Hau Ranga Ora Framework
Kaihoe	Frontline Staff - Te Hau Ranga Ora Framework
Kaikorero	Speaker (on behalf of group)
Kaitakitaki	Operational Management - Te Hau Ranga Ora Framework
Kaitiaki	Protector, caretaker
Kaitiakitanga	Protection, Guardianship
Kaihautu Hauora	CEO - Te Hau Ranga Ora Framework
Kaiuringi	Executive Management Team - Te Hau Ranga Ora Framework
Karakia	Blessings, incantations, prayer
Karakia tuku i te wairua	A prayer/incantation for the safe departure of the spirit from the deceased
Karanga	Calling (done by women)
kāumatua	Elder (usually male)
Kaupapa	Policy, protocol, theme, rule, topic. It also means a fleet (of ships)
Kia ora	Greetings
Kia piki te ora	Get well/May you be well

Kupu Māori	**English**
Koha	Gift
Koroheke	Elder (male)
Kotahitanga	Unity, cohesion, sharing vision, working together, trust, relationships
Kuia	Elder (female)
Kupu	Words
Mana	Status, standing, power, influence. The spiritual power/authority to enhance and restore tapu
Manakitanga	Ultimate respect and care
Manatangata	Dignity of relationships
Māoridom	Plural of Māori world
Māoritanga	Maori culture and perspective
Marae	Traditional meeting place
Mātua	Parents
Mauri	Life essence
Mauri Ora	Emergency Housing of families on WDHB Campus (Name of building)
Mihi or Mihimihi	Greeting/welcome, acknowledgement
Mihi Whakatau	Informal welcome
Noa	Free from tapu. Tapu and noa are terms used to describe a state or condition affecting both the animate and inanimate. Tapu denotes a state of restriction or sacredness. Noa is free from tapu
Pae Ora	Healthy Futures – Aim of the Ministry of Health Maori Health Strategy – He Korowai Oranga.
Pēpē	Baby infant
Pou tuara	Back bone
Pōwhiri	Formal Māori welcoming ceremony
Rangaimārie	Humility, peace
Rangatahi	Youth
Rongoa	Traditional Māori methods of healing
Take	Subject, topic, purpose
Tamariki	Children
Tāngata Whaiora	Māori mental health service user
Tangata Whenua	Local people Māori
Tangihanga	The mourning process before burial. Funeral
Tāonga	Treasure, valuables. Tāonga is interpreted to mean in its broadest sense an object or resource which is highly valued. Children and future generations are also regarded as tāonga
Tapu	Sacred. Tapu and noa are terms used to describe a state or condition, affecting the animate and inanimate. Tapu denotes a state of restriction or sacredness. Noa is free from tapu
Tapu o te Tinana	Respect for people
Te Hau Ranga Ora	WDHB Māori Health Services
Te Piringa Whanau	Building on WDHB campus under Tikanga of the Whanganui Iwi.
Te Puawai Arahi	Māori Mental Health Cultural Advisor
Te Reo Māori	Māori Language
Te Whare Whakatau Mate	Building on WDHB campus under Tikanga of the Whanganui Iwi – Temporary resting place for the deceased.
Tena koutau/koutou katoa	Greetings/to all

Kupu Māori	**English**
Tikanga	Customs, protocols or policies. Tikanga is used as a guide to moral behaviour and within a health context indicates the way resources, guardianship, responsibilities, obligations and future generations will be protected
Timatanga	Beginning
Tinana	The physical body
Tino Rangatiratanga	Māori chieftainship, self-determination, and absolute sovereignty
Toihau	Board/Chairperson – Te Hau Ranga Ora Framework
Tūpāpaku	Deceased person
Waiata	Song
Waiora	Health
Wairua	Spirit. Wairua refers to the spiritual element, an integral part of tapu and noa
Wairuatanga	Spirituality
Wananga	Place of learning
Whakamutunga	End
Whakanoa	Ceremony to make an area safe to use again
Whakapapa	Genealogy
Whakatauki	Proverb
Whakawhanaungatanga	Family/make connections
Whānau	Family. It also means to be born/give birth. Whānau in this document refers to Māori patients and their families and can include groups regarded as extended family as well as groups outside the traditional family structure
Whanaungatanga	Relationship
Whare	House, Building
Whenua	Placenta. Also means land

*The English definitions for Kupu Māori are reflective of the WDHB context.