WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

AGENDA

Combined Statutory Advisory Committee

Meeting date **Friday 15 May 2020**

Start time **9:30am**

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

Embargoed until Saturday 16 May 2020

Contact
Phone 06 348 3348
Fax 06 345 9390

Also available on website
www.wdhb.org.nz

CSAC

15 May 2020 09:30 AM - 11:30 PM

Agenda Topic			Presenter	Time	Page
PUBLIC					
1.	PROCEDURAL		Annette Main		3
	1.1	Karakia	Annette Main	09:30 AM-09:32 AM	
	Annette will ask a member of the committee to open the meeting				
	1.2	Apologies	Annette Main	09:32 AM-09:35 AM	
	This will record all apologies or absences for the meeting				
	1.3	Continuous Disclosure	Annette Main	09:35 AM-09:40 AM	4
		1.3.1 Interest Register Updates	Annette Main		4
		Members to advise of any additions or removals or changes to their listed interests on the register			
		1.3.2 Conflicts of Interest for items on this agenda	Annette Main		
	1.4	Confirmation of Minutes	Annette Main	09:40 AM-09:45 AM	
	13 March 2020				
	1.5	Matters Arising	Annette Main	09:45 AM-09:47 AM	7
	1.6	Chair report (verbal)	Annette Main	09:47 AM-09:52 AM	
2.	Chief Executive Report		Russell Simpson	09:52 AM-09:57 AM	8
3.	COVID-19 Presentation		Louise Allsopp	09:57 AM-10:17 AM	9
4.	DISCUSSION PAPERS				10
	4.1	Non-financial performance reporting	P Malan	10:17 AM-10:32 AM	10
	Quarter two results				
	4.2	Annual plan update	P Malan	10:32 AM-10:47 AM	20
	4.3	Aged residential care readiness assessment	P Malan	10:47 AM-10:57 AM	22
	4.4	Influenza Immunisation	P Malan	10:57 AM-11:07 AM	23
	4.5	Special funding for community responses	P Malan	11:07 AM-11:17 AM	25

5.	NEXT MEETING - Friday, 14 August 2020			
6.	EXCLUSION OF THE PUBLIC	Annette Main	11:17 AM-11:19 AM	28

Combined Statutory Advisory Committee member attendance schedule – 2020

Name	13 March	15 May	14 August	13 November
Annette Main (Chair)	✓			
Charlie Anderson	✓			
Christie Teki	✓			
Deborah Smith	✓			
Frank Bristol	✓			
Graham Adams	✓			
Heather Gifford	✓			
Josh Chandulal-Mackay	✓			
Ken Whelan	x			
Maraea Bellamy	✓			
Phillipa Baker-Hogan	x			
Sorya Peke-Mason	✓			
Te Aroha McDonnell	x			

Legend

✓ Present
× Apologies given
✦ No apology received
✸ Attended part of the meeting only
Absent on board business
⊙ Leave of absence

Interest Register

Name	Date	Interest
Annette Main *Chair CSAC*	18 May 2019	A council member of UCOL
Adams Graham	16 December 2016	▪ A member of the executive of Grey Power Wanganui Inc. ▪ A board member of Age Concern Wanganui Inc. ▪ The treasurer of NZ Council of Elders (NZCE) ▪ 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 20 September 2019	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. A director of The New Zealand Masters Games Limited.
Bellamy Maraea		
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	14 July 2017 1 September 2017 22 March 2019	Consultancy work for Capital and Coast District Health Board Appointed to the HQSC Board's Consumer Advisory Group Appointed to Te Pou Clinical Reference group.
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).
McDonnell Te Aroha		

Conflicts and register of interests up to and including 4 March 2020

Name	Date	Interest
Peke-Mason Sorya		
Smith Deborah		
Teki Christie		
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

1.5 Matters arising from previous meetings

Meeting Date	Detail	Response	Status
~~09/19-01~~	~~Update committee on car park strategy, challenges and learnings~~	~~As requested at the board meeting in April 2019 a consultation and implementation plan has been developed by management. This is expected to be in place by December 2019~~	~~Complete~~
~~09/19-02~~	~~Local Medical Officer of Health to provide an outline of the planning and process for such an event [epidemic management/public health in regions]~~	~~To be addressed: Item 7.2 on agenda 10/19~~	~~Complete~~
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	Carried forward	
11/22-01	Further detail to be provided in relation to performance measure BSS11 (Faster Cancer Treatment), to include ethnicity breakdown	Carried forward	
11/22-02	NZDSN 20/20 report to be distributed via email to Committee		Complete
11/22-03	Letter of thanks sent to presenter, Mr P Miller		Complete
03/13-01	Access and training to Diligent Board Books be arranged for committee members	Carried forward	
03/13-02	Previous conflicts declarations to be forwarded to committee members for whom information is held		Complete
03/13-03	New Committee members to provide secretariat with conflicts of interest	Carried forward	

Public

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Chief Executive Update**
	Item 2
Author	Russell Simpson
Subject	**Chief Executive Update**

Recommendations

Management recommend that the Combined Statutory Advisory Committee:

a. **Receive** the paper titled Chief executive update

b. **Note** the progress of the review for emergency and urgent care services being managed by the Whanganui Alliance Leadership Team

1 Purpose

This paper provides a brief progress update on the Sapere review.

2 Background

Whanganui DHB is unique in the running of both primary and emergency care at the front door. The review explores this business model and includes data obtained in earlier patient surveys.

The outcome of a review commissioned by Whanganui Alliance Leadership Team (WALT) using external health economics research company, Sapere, was expanded to provide further opportunities on models of care.

The subsequent report has been distributed to WALT and discussions on the models will be held at a future meeting.

May 2020 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Presentation**
	Item No. 3
Author	Louise Allsopp, General Manager Patient Safety, Quality & Innovation
Subject	**Covid-19: Recovery and beyond for Whanganui District Health Board**

Recommendations

Management recommend that the Combined Statutory Advisory Committee:

a. **Receive** the presentation titled "CoVid-19: Recovery and beyond for Whanganui District Health Board"
b. **Note** the intended framework, partnerships and processes that are planned
c. **Support** the proposal for the recovery framework

Appendix
3.1 "Change for Good - Please Press Pause": Wise Group Chief Executives, April 2020

1 Background

Since 19 March 2020, Whanganui District Health Board has been operating under an Emergency Operations Centre (EOC). Early in the process, the EOC invited participation from several community "partners in care" to meet to discuss our shared objectives and responsibilities in terms of the potential impacts of the Covid-19 pandemic. On 1 April 2020, the EOC shifted to the Whanganui District Council premises and became an integrated, community-wide, health-led EOC, with an Incident Management Team remaining at the Hospital to ensure a key link with DHB provider arm activity.

The EOC has continued to operate with core input from Iwi, Civil Defence, Whanganui District Council, WDHB, Whanganui Regional Health Network, Police, Fire Department and Spotless Services. The focus has recently turned to the recovery phase and the expectation is that this will continue to be a community-wide coordinated process.

2 Presentation

Louise Allsopp is the designated heath lead for the Whanganui recovery and she will provide an overview of the proposed framework for the recovery phase.

"Please press pause" is a framework that has recently been released by the Wise Group, imploring the government to ensure that the recovery phase is effective. The framework is included as appendix one and is provided for context to inform this discussion, noting that it comes from a specific NGO perspective.

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Discussion paper** **Item 4.1**
Author	Kilian O'Gorman, Business Support
Endorsed	Paul Malan – General Manager Strategy, Commissioning & Population Health
Subject	**Non-Financial quarterly performance reporting & progress reporting against the current annual plan (2019-20)**

Recommendation

Management recommend that the Combined Statutory Advisory Committee:

a. **Receive** the paper titled 'Non-Financial Performance Reporting' (NFPR)

b. **Note** the reduced Q3 reporting requirements from the Ministry of Health

1 Purpose

This paper presents a summary of the available Quarter 3, Non-Financial quarterly performance as published on the Ministry of Health performance website.

2 Background

Due to the current COVID-19 emergency, the Ministry has allowed for a greatly reduced suite of reporting this Quarter. Additionally, there is no requirement for WDHB to report on progress against initiatives within our Annual Plan 2019/20. The full suite of Q3 results will be reported, alongside Q4 results, within the Q4 MoH timeframe.

3 Preliminary summary of results

Ministry of Health Non–Financial Performance Reporting Feedback Quarter 3 2019/20			
	Q1	Q2	Q3
Improving Child Wellbeing			
CW01 Children caries free at five years of age 19/20	Not applicable	Not applicable	Achieved
CW02 Oral Health – Mean DMFT score at school Year 8 19/20	Not applicable	Not applicable	Achieved
CW03 Improving the number of children enrolled and accessing the Community Oral health service 19/20	Not applicable	Not applicable	Achieved
CW05 Immunisation coverage -FA1: 8-month-old immunisation coverage 19/20	Partial	Not achieved	Not achieved
CW05 Immunisation coverage -FA2: 5-year-old immunisation coverage 19/20	Partial	Not achieved	Not achieved
CW08 Increased Immunisation (at 2 years) 19/20	Partial	Partial	Not achieved

Better population health outcomes supported by strong and equitable public health services			
SS10 Shorter stays in Emergency Departments 19/20	Partial	Partial	Achieved

*Finalised results will be confirmed during 2nd week of May. At this time, changes to these ratings are unlikely.

	Q1	Q2	Q3
Care Capacity Demand Management Calculation19/20	not applicable	Achieved	Achieved

CCDM Calculations
The Director-General Health wrote to DHBs on 28 November 2019 to advise that information on completion and outcomes of annual CCDM FTE calculations would be requested as part of regular reporting processes from quarter two 2019/20.

Please provide your DHB's response to the questions below.

Questions	**DHB response QUARTER 2**	**DHB response QUARTER 3**
1. How many wards at you DHB are eligible for FTE Calculations? (ie how many wards are appropriate for CCDM methodology, please exclude EDs and outpatient units)	Eight (includes maternity and mental health inpatient areas).	Eight areas (awaiting presentation to executive leadership team and then CCDM governance)
2. How many FTE calculations have been **completed** since reporting to the Ministry in November 2019	nil The organisation believed that there were areas that required revisiting within the CCDM programme; mainly the accuracy of Trend Care data – including (1:1 observations, coordination hours and other variables). This recommendation was mirrored by SSHW during the recent standards assessment. FTE calculations were not completed until data improvements were made.	No further progress due to COVID-19.
3. What was the outcome of these calculations? ie # of additional FTE required, if any?	nil	As indicated in no. 1 above.
4. What number of these additional FTE have been recruited to?	nil	Nil Daily VRM report continues; improved daily operations meeting and reporting.
5. If FTE calculations have not been completed to date what is the plan and timeframe to complete these calculations?	FTE calculations for all areas scheduled in the CCDM work plan for August 2020.	Current situation and model of care has changed due to merging wards to create a COVID ward.

Ministry Feedback
Thank you for your update We acknowledge challenges associated with Covid-19. CCDM FTE calculation progress remains a priority.

	Q1	Q2	Q3

CW01 Children caries free at five years of age 19/20	Not applicable	Not applicable	Achieved

Age 5 children, 2019 calendar year

Dental Health Status	Number of Children Examined	Number of Children Caries-Free	Number of Decayed, Missing due to caries and Filled Teeth	% Caries Free	Mean dmft	Mean dmft
All 5-year old Children	887	520	1,763	59%	1.99	4.80
All Maori 5-year old Children	230	94	715	41%	3.11	5.26
All Pacific 5-year old Children	36	14	144	39%	4.00	6.55
All "Other" 5-year old Children	621	412	904	66%	1.46	4.33
All Fluoridated 5-year old Children	0	0	0			
All Non-Fluoridated 5-year old Children	887	520	1,763	59%	1.99	4.80
Maori Fluoridated 5-year old Children			0			
Maori Non-fluoridated 5-year old Children	230	94	715	41%	3.11	5.26
Pacific Fluoridated 5-year old Children			0			
Pacific Non-fluoridated 5-year old Children	36	14	144	39%	4.00	6.55
Other Fluoridated 5-year old Children			0			
Other Non-fluoridated 5-year old Children	621	412	904	66%	1.46	4.33

Ministry Feedback

Good result. The caries-free result of 59% exceeds the DHB's target of 57.5% and the 2018 result of 56.6%.

DHB comment: The Ministry feedback refers to the total target for WDHB. The target for Māori was also 57.5% and has not, therefore, been achieved. However, the Māori result has improved from 35% in 2018/19 and the non-Māori result has improved from 64% over the same time.

	Q1	Q2	Q3
CW02 Oral Health – Mean DMFT score at school Year 8 19/20	not applicable	not applicable	Achieved

School Year 8 (age 12/13) children, 2019 calendar year

Dental Health Status	Number of Children Examined	Number of Children Caries-Free	Number of Decayed, Missing due to caries and Filled Teeth	% Caries Free	Mean DMFT	Mean DMFT
All Year 8 Children	762	489	581	64%	0.76	2.13
All Maori Year 8 Children	237	135	230	57%	0.97	2.25
All Pacific Year 8 Children	36	21	45	58%	1.25	3.00
All "Other" Year 8 Children	489	333	306	68%	0.63	1.96
All Fluoridated Year 8 Children	0	0	0			
All Non-Fluoridated Year 8 Children	762	489	581	64%	0.76	2.13
Maori Fluoridated Year 8 Children			0			
Maori Non-fluoridated Year 8 Children	237	135	230	57%	0.97	2.25
Pacific Fluoridated Year 8 Children			0			
Pacific Non-fluoridated Year 8 Children	36	21	45	58%	1.25	3.00
Other Fluoridated Year 8 Children			0			
Other Non-fluoridated Year 8 Children	489	333	306	68%	0.63	1.96

Ministry Feedback

Good result. The average DMFT of 0.76 more than meets (i.e. is lower than) the DHB's target of 0.81 and the 2018 result of 0.82.

	Q1	Q2	Q3
CW03 Improving the number of children enrolled and accessing the Community Oral health service 19/20	not applicable	not applicable	Achieved

Ministry Feedback

A rating of 'achieved' has been provided based on the pre-school enrolment rates of more than 100 percent overall against the Statistics NZ denominator, and more than 100 percent for all population groups, and the excellent arrears result of 5.7 percent. The enrolment results over 100 percent may be due to:

- variation between the ethnicity recorded for children on enrolment with the COHS and the ethnicity captured for the same population cohort by Statistics NZ in Census 2013 and subsequent projections
- divergence between actual local population changes and the Statistics NZ population projections
- duplication of enrolment records for some children.

Any comment you have on these results greater than 100 percent would be welcome.

Measure 1 (PP13a): Number of pre-school children enrolled in DHB-funded oral health services, 2019 calendar year

Pre-school children
(age 0 - 4)

ALL ETHNICITIES			**MĀORI ONLY**		
Total Enrolled	Total Population	Percentage Enrolled	Total Enrolled	Total Population	Percentage Enrolled
5,501	4,320	127.3%	2,337	1,960	119.2%
PACIFIC ONLY			**OTHER**		
Total Enrolled	Total Population	Percentage Enrolled	Total Enrolled	Total Population	Percentage Enrolled
211	200	105.5%	2,953	2,160	136.7%

Measure 2 (PP13b): Number of enrolled pre-school and primary school children overdue for their scheduled examinations, 2019 calendar year

	ALL ETHNICITIES				
	Number of Children Overdue	Total Number Enrolled	Percentage Overdue	Longest waiting time	
				Duration (in months)	Number Affected
Pre-School Children (age 0 -4)	252	5,501	5%	4	3
Primary School Children (age 5 - Year 8)	511	7,855	7%	4	1
TOTAL	763	13,356	6%	4	3

	MĀORI ONLY				
	Number of Children Overdue	Total Number Enrolled	Percentage Overdue	Longest waiting time	
				Duration (in months)	Number Affected
Pre-School Children (age 0 -4)	129	2,337	6%	4	2
Primary School Children (age 5 - Year 8)	230	2,986	8%	4	1
TOTAL	359	5,323	7%	4	2

	PACIFIC ONLY				
	Number of Children Overdue	Total Number Enrolled	Percentage Overdue	Longest waiting time	
				Duration (in months)	Number Affected
Pre-School Children (age 0 -4)	11			3	2
Primary School Children (age 5 - Year 8)	33	498	7%	2	2
TOTAL	44	498	9%	3	2

	OTHER				
	Number of Children Overdue	Total Number Enrolled	Percentage Overdue	Longest waiting time	
				Duration (in months)	Number Affected
Pre-School Children (age 0 -4)	112			4	1
Primary School Children (age 5 - Year 8)	248	4,371	6%	3	3
TOTAL	360	4,371	8%	4	1

	Q1	Q2	Q3
CW05 Immunisation coverage -FA1: 8-month-old immunisation coverage 19/20	Partial	Not Achieved	Not Achieved
CW05 Immunisation coverage -FA2: 5-year-old immunisation coverage 19/20	Partial	Not Achieved	Not Achieved
CW08 Increased Immunisation (at 2 years) 19/20	Partial	Partial	Not Achieved

Note : In this instance, the Ministry Feedback is for all of the above measures

Ministry Feedback

Total immunisation coverage at two years has decreased by 0.2 percent this quarter and coverage for Māori children has decreased by 0.4 percent. National immunisation coverage at age 2 years is still below the 95 percent target and coverage for Māori is 6.3 percent lower than for non-Māori. Your DHB has total coverage of 87.4 percent, Māori coverage of 86.7 percent and Pacific coverage of 68.8 percent at 2 years.

Total immunisation coverage at eight months has decreased by 1.2 percent this quarter and coverage for Māori children has decreased by 1.9 percent. At age five years the total coverage has increased by 0.9 percent, coverage for Māori children has increased 1.1 percent. Your DHB has total coverage of 85.1 percent and Māori coverage of 78.7 percent at age 8 months and total coverage of 85.6 percent and Māori coverage of 85.1 percent at 5 years.

As with the previous quarter and for the quarters ahead, improving equitable immunisation coverage is a key priority. It is important that your DHB commits fully to the actions you have set to address the increasing inequities.

It is essential that Māori General Managers (Tumu Whakarae) and Pacific General Managers have oversight of all Māori-and Pacific focused work, respectively, in their DHBs. It is therefore the Ministry's expectation that your DHB Immunisation leads develop and maintain strong working relationships with your DHB's Māori and Pacific General Managers to ensure they have a clear line of sight into immunisation work.

We acknowledge the immense pressure DHBs are experiencing due to COVID-19, however, continuing to provide immunisation events on time, as per the National Immunisation Schedule, is critical for the health of our communities.

The Ministry appreciates the mahi you and your teams do to ensure the delivery of the National Immunisation Programme is to the highest standard. Thank you for your ongoing determination, innovation and perseverance.
B CW05 Immunisation coverage -FA1: 8-month-old immunisation coverage 19/20

Indicator: Increased Immunisation 8 months
DHB: Whanganui
Reporting period: Quarter 3
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 significant progress for the Māori population group (and where relevant) Pacific population group has been achieved.

Summary of results: coverage at age 8 months

Please complete the table (optional) and provide a brief summary of the DHB's performance in the Progress Report section.

Target: 95%	**Total**	**Māori**	**Pacific**	**Dep 9-10**	**Change: total**	**Change: Māori**
Q1 2019/20	**89.3%**	**85.1%**	**87.5%**	**89.9%**	**+2.3%**	**+3.1%**
Q2 2019/20	**87%**	**83.7%**	**100%**	**80.5%**	**-2.3%**	**-1.4**
Q3 2019/20	**85.1%**	**78.7%**	**83.3%**	**83.3%**	**-1.9%**	**-5%**
Q4 2019/20						

Progress report

18 children didn't get immunised in the correct timeframe

6 children were completed after turning 8 months
6 children remain with OIS
1 is GNA
3 are overdue but not referred to OIS
2 have declined OIS and remain over due
All but 3 are overdue for just 5 months event

Actions to address issues/barriers impacting on performance

Please provide a brief summary of any issues arising in the quarter that affected ability to meet the immunisation target and how these are being addressed

- 14 children had all their immunisations declined by whanau,5 Maori,4 European,5 other ethnic'
- January is always difficult to catch up with families due to holidays
- March has had lockdown occurring during the month and stopped OIS except for our clinics which have continued.

CW05 Immunisation coverage -FA2: 5-year-old immunisation coverage 19/20

Indicator: Increased Immunisation 5 years

DHB: Whanganui

Reporting period: Quarter 3 2019-20

Contact (role and name): Barbara Charuk, Portfolio Manager

Target definition

Percentage of eligible children fully immunised at 5 years of age for total DHB population, Māori and Pacific; achievement requires that the target is met for the total population and significant progress for the Māori population group (and where relevant) Pacific population group has been achieved.

Summary of results: coverage at age 5 years

Please complete the table (optional) and provide a brief summary of the DHB's performance in the Progress Report section.

Target: 95%	**Total**	**Māori**	**Pacific**	**Dep 9-10**	**Change: total**	**Change: Māori**
Q1 2019/20	**86.5%**	**82.8%**	**100%**	**81.1%**	**-2.5%**	**+3.8%**
Q2 2019/20	**88.2%**	**86.4%**	**87.5%**	**82.9%**	**+1.7%**	**+3.6%**
Q3 2019/20	**85.6%**	**85.1%**	**33.3%**	**87.5%**	**-2.6%**	**-1.3%**
Q4 2019/20						

Progress report
• **20 declined,8 declined all immunisations 1 opt off and 11 partial declines** • **10 children have not been immunised on time 2 were completed too late** • **1 is on catch up,2 are GNA** • **Only one of the 10 children completed their B4 School check**
Actions to address issues/barriers impacting on performance *Please provide a brief summary of any issues arising in the quarter that affected ability to meet the immunisation target and how these are being addressed*
• ***Lack of NIR administrator during the last 2weeks of quarter*** • ***Impact of school holidays in Jan*** • ***Impact of March COVID-19***

CW08 Increased Immunisation (at 2 years) 19/20

Indicator: Increased Immunisation 2 years CW08
DHB: Whanganui
Reporting period: Quarter 3 2019-20
Contact (role and name): Barbara Charuk, Portfolio Manager
Target definition Percentage of eligible children fully immunised at 2 years of age for total DHB population, Māori and Pacific; achievement requires that the target is met for the total population and significant progress for the Māori population group (and where relevant) Pacific population group has been achieved.

Summary of results: coverage at age 2 years

Please complete the table (optional) and provide a brief summary of the DHB's performance in the Progress Report section.

Target: 95%	**Total**	**Māori**	**Pacific**	**Dep 9-10**	**Change: total**	**Change: Māori**
Q1 2019/20	**85.3%**	**85.3%**	**100%**	**84.9%**	**-4.7%**	**+1.3%**
Q2 2019/20	**92.2%**	**91.5%**	**100%**	**92.1%**	**+6.9%**	**+6.2%**
Q3 2019/20	**88%**	**87%**	**71%**	**86%**	**-4.2%**	**-4.5%**
Q4 2019/20						

	Q1	Q2	Q3
SS10 Shorter stays in Emergency Department	Partial	Partial	Achieved

Ministry Feedback
Thank you for providing your Q3 SSED data. We greatly appreciate the effort that has gone into preparing for and responding to the COVID-19 pandemic.

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	**5005**	**5362**	**93.3%**	**1398**	**1477**	**94.7%**	**139**	**144**	**96.5%**
DHB total	**5005**	**5362**	**93.3%**						

May 2020 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Discussion Paper**
	Item 4.2
Author	Paul Malan – General Manager Strategy, Commissioning and Population Health
Subject	**Annual Plan 2020-21 Update**

Recommendations

Management recommend that the Combined Statutory Advisory Committee:

a. **Receive** the paper titled "Annual Plan 202-21 Update"

b. **Note** that there has been no feedback from CSAC members on the Draft Plan provided at the last meeting

c. **Note** the updated advice and timeline

Appendix

4.2.1 Ministers Letter of Expectations

1 Background

At the CSAC meeting of Friday 13th March 2020, the DRAFT Annual Plan and Statement of Performance Expectations for 2020-21 was provided in the public excluded section. It was noted that the DRAFT had already been submitted to the Ministry of Health on 2nd March 2020 and that feedback was expected in April. As many committee members had not had time to review the DRAFT, discussion ensued with further feedback being invited outside of the meeting.

The Minister's Letter of Expectations was sent on 10th March 2020 but, due to Covid-19 activity, there has subsequently been further amended guidance about expectations and timelines.

2 Impact of CoVid-19

The Ministry is adjusting 2020/21 annual planning processes and timelines in consideration of COVID-19.

Central Government Agencies have advised they are exploring a range of options, including potentially modifying legislative requirements to assist entities to manage legislative planning and reporting requirements and they expect to be in a position to provide updates later in April.

The Ministry is also considering how the impacts of COVID-19, the level 4 national lockdown and the future path to recovery are likely to impact on the planning advice previously provided.

This paper provides an overview of the updates for information of the committee.

May 2020 **Public**

2.1 Minister's Letter of Expectations

A copy of the Minister's Letter of Expectations is included as Appendix 2.

2.2 Annual Plan guideline

Feedback on first draft plans and advice on updated planning guidance that includes any new guidance/COVID-19 impacts will be issued mid-May – following the national budget. This date may extend depending on national lockdown period and/or state of emergency.

No revised sections/full drafts of 2020/21 annual plans or regional services plans or second draft financial templates will be expected at this stage until at least mid-June. Dates will be confirmed dependant on any legislative modifications that may occur.

The Ministry's financial monitoring team will continue to stay in contact during April regarding the financial templates provided to date.

2.3 Statement of Performance Expectations guideline

The SPE is required to be published by the start of the financial year to which it pertains, and tabled in Parliament within a set number of days after that. This is a requirement of the Crown Entities Act (2004). Part of the "legislative modifications" referred to above would include an amendment to this requirement for this financial year.

2.4 System Level Measures

The SLM plan is governed through Whanganui Alliance Leadership Team. There is no change to expectations of content, there is consistent change in the timeline and approval process.

2.5 Timeline

Activity	**Date: 2020**	**Revised timeline**
DHB strategic conversations	From February	From February
DHBs submit draft Annual Plans, Statement of Performance Expectations (SPE), financial templates, Regional Service Plans to the Ministry.	**2 March**	**2 March**
Feedback to DHBs on first draft Plans and release of guidance for any additional confirmed Government priorities	9 April	Mid May
Final draft SLM/annual plans/RSPs due to the Ministry	**NA**	**not before mid- June**
Final Plans due to the Ministry	**TBC**	**TBC**
DHB Board signed SPE to be published on DHB websites	Before end of June	TBC
Ministry approval of SLM plan	31 July	31 July
Any outstanding 2020/21 SPEs tabled with 2019/20 Annual Reports	December	TBC

MAY 2020 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Discussion Paper**
	Item 4.3
Author	Paul Malan - General Manager, Strategy, Commissioning and Population Health
Subject	**Aged Residential Care Readiness Assessments**

Recommendations

Management recommend that the Combined Statutory Advisory Committee:

a. **Receive** the paper titled "Aged residential care - readiness assessments"

b. **Note** the assessment results for aged residential care, disability support services and mental health & addictions facilities.

1 Purpose

This paper provides a summary of our aged residential care readiness assessment.

2 Background

On 15 April 2020 the National Emergency Coordination Centre asked all DHBs to assess the preparedness of their local residential services, including Aged Residential Care (ARC), Disability Support Services (DSS) and Mental Health & Addictions (MH&A) residential services. Locally we have twelve ARC facilities, five DSS facilities and three MH&A facilities. Capacity ranges from three (funded) beds to 89 (funded) beds.

Whanganui DHB responded very quickly and mobilised a team including primary care, infection prevention and control (IPC) and needs assessment services to oversee a co-ordinated effort. The approach was led by IPC whose staff visited or remotely assessed each facility using a framework covering, for example, capability to isolate, staff illness and absence, visitor policies, infection prevention and control policies, etc.

At the end of the exercise each facility was assessed and rated to indicate a level of support that may be needed to help in the case of a case of Covid19 in the facility. These assessments were reflected back to the facilities and our staff continue to work with those that welcomed the support to ensure a close understanding of risks.

3 Readiness assessment results

Support needs rating	Minimal	Low	Medium	High
Aged Residential Care	10	0	2	0
Disability Support Services	2	3	0	0
Mental health & addictions	0	2	1	0

As we move out of alert level 3, plans will be made to ensure that a response to any outbreak in a facility can be mobilised quickly and appropriately to support our community.

Public

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Discussion Paper**
	Item 4.4
Author	Katherine Harding, CNS Infection Control
Endorsed	Paul Malan, General Manager, Strategy, Commissioning and Population Health
Subject	**Influenza Immunisation**

Recommendations

Management recommend that the Combined Statutory Advisory Committee:

a. **Receive** the paper titled influenza immunisation

b. **Note** that Whanganui DHB is the highest performing DHB for influenza immunisation in the over 65 age group for Māori and non Māori.

1 Purpose

This paper provides a summary of our influenza immunisation programme.

2 Background

Our flu vaccination programme has provided the platform for the successful uptake of the influenza immunisation in our region. We have demonstrated the following key components:
- Strong leadership and commitment to equity
- Relationships and working together
- Focus on Māori
- Target high need discrete communities
- Healthy competition via a reporting league table
- Community walk-in and drive by clinics and home visits
- Combining with wellness check
- Preparation for COVID-19
- Opportunistic vaccinations
- Communications.

3 Results

Whanganui DHB's has the highest rate in New Zealand for Māori over 65 at 81% and total population at 74%. This has been achieved by the support of our iwi providers, taking a proactive approach and making contact with Māori whanau, and by the work of Whanganui Regional Health Network's outreach team which follows up on those hard-to-reach groups.

Public

IMMUNISATION COVERAGE BY PRIORITISED ETHNICITY - Aged 65+ years

DHB NAME	Total			Maori			Pacific			Asian			Other		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
Auckland	64,560	33,983	53 %	3,300	1,078	33 %	3,970	2,413	61 %	15,460	7,081	46 %	41,830	23,411	56 %
Bay of Plenty	49,050	32,537	66 %	4,770	2,895	61 %	320	146	46 %	2,020	457	23 %	41,940	29,039	69 %
Canterbury	94,750	63,008	66 %	3,720	1,635	44 %	870	482	55 %	5,150	1,997	39 %	85,010	58,894	69 %
Capital and Coast	44,900	27,072	60 %	2,020	1,065	53 %	1,640	1,180	72 %	4,970	2,021	41 %	36,270	22,806	63 %
Counties Manukau	70,090	37,071	53 %	5,180	2,314	45 %	8,410	4,921	59 %	16,490	6,994	42 %	40,010	22,842	57 %
Hawkes Bay	32,920	21,279	65 %	2,970	1,760	59 %	380	195	51 %	980	251	26 %	28,590	19,073	67 %
Hutt Valley	23,410	13,916	59 %	1,430	801	56 %	890	580	65 %	2,200	942	43 %	18,890	11,593	61 %
Lakes	18,710	11,099	59 %	2,680	1,685	63 %	160	112	70 %	740	171	23 %	15,130	9,131	60 %
MidCentral	33,530	20,686	62 %	2,410	1,191	49 %	390	182	47 %	1,600	511	32 %	29,130	18,802	65 %
Nelson Marlborough	34,550	20,976	61 %	1,170	596	51 %	180	66	37 %	690	121	18 %	32,510	20,193	62 %
Northland	37,490	19,704	53 %	5,300	2,466	47 %	370	120	32 %	740	169	23 %	31,080	16,949	55 %
South Canterbury	14,085	7,476	53 %	430	172	40 %	55	15	27 %	250	37	15 %	13,350	7,252	54 %
Southern	59,270	31,133	53 %	2,380	971	41 %	460	164	36 %	1,830	263	14 %	54,600	29,735	54 %
Tairawhiti	8,025	4,816	60 %	2,410	1,274	53 %	90	34	38 %	105	29	28 %	5,420	3,479	64 %
Taranaki	22,255	13,415	60 %	1,760	764	43 %	135	40	30 %	620	102	16 %	19,740	12,509	63 %
Waikato	70,330	44,116	63 %	6,420	3,427	53 %	1,050	476	45 %	3,550	1,387	39 %	59,310	38,826	65 %
Wairarapa	10,270	7,209	70 %	650	369	57 %	70	46	66 %	180	54	30 %	9,370	6,740	72 %
Waitemata	93,490	49,199	53 %	3,610	1,496	41 %	2,910	1,832	63 %	13,970	6,130	44 %	73,000	39,741	54 %
West Coast	6,415	4,454	69 %	350	197	56 %	45	8	18 %	90	19	21 %	5,930	4,230	71 %
Whanganui	13,295	9,822	74 %	1,290	1,040	81 %	135	63	47 %	340	78	23 %	11,530	8,641	75 %
National	**801,395**	**472,971**	**59 %**	**54,250**	**27,196**	**50 %**	**22,530**	**13,075**	**58 %**	**71,975**	**28,814**	**40 %**	**652,640**	**403,886**	**62 %**

IMMUNISATION COVERAGE BY DEPRIVATION - Aged 65+ years

DHB NAME	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Fully Immunised for Age	%
Auckland	64,539	33,983	53 %	18,186	9,900	54 %	14,863	7,728	52 %	11,892	6,003	50 %	10,283	5,000	49 %	9,315	4,079	44 %	1,273	2 %
Bay of Plenty	49,050	32,537	66 %	6,865	5,258	77 %	9,270	5,960	64 %	11,301	8,031	71 %	11,483	6,733	59 %	10,131	5,419	53 %	1,136	2 %
Canterbury	94,704	63,008	67 %	29,378	24,051	82 %	21,961	14,071	64 %	18,944	10,933	58 %	16,685	9,508	57 %	7,736	3,859	50 %	586	1 %
Capital and Coast	44,907	27,072	60 %	14,665	9,241	63 %	11,216	6,878	61 %	7,984	4,305	54 %	6,841	3,456	51 %	4,201	1,981	47 %	1,211	3 %
Counties Manukau	70,058	37,071	53 %	15,903	9,494	60 %	13,376	7,648	57 %	11,942	5,808	49 %	10,685	4,864	46 %	18,152	8,301	46 %	956	1 %
Hawkes Bay	32,927	21,279	65 %	5,917	4,577	77 %	5,400	3,658	68 %	7,245	4,571	63 %	7,664	4,441	58 %	6,701	3,786	56 %	246	1 %
Hutt Valley	23,436	13,916	59 %	5,293	3,222	61 %	4,670	3,425	73 %	4,946	2,727	55 %	4,656	2,577	55 %	3,871	1,922	50 %	43	0 %
Lakes	18,765	11,099	59 %	2,396	1,585	66 %	3,802	2,266	60 %	3,438	2,061	60 %	4,107	2,374	58 %	5,022	2,569	51 %	244	1 %
MidCentral	33,529	20,686	62 %	4,205	3,105	74 %	4,821	3,282	68 %	6,625	4,108	62 %	7,981	4,675	59 %	9,897	5,144	52 %	372	1 %
Nelson Marlborough	34,515	20,976	61 %	6,121	4,617	75 %	8,304	5,182	62 %	9,155	5,237	57 %	8,186	4,017	49 %	2,749	1,310	48 %	613	2 %
Northland	37,475	19,704	53 %	2,524	1,824	72 %	4,835	2,837	59 %	7,096	3,892	55 %	10,461	5,433	52 %	12,559	5,276	42 %	442	1 %
South Canterbury	14,125	7,476	53 %	2,451	1,517	62 %	2,937	1,525	52 %	3,711	2,003	54 %	3,614	1,750	48 %	1,412	604	43 %	77	1 %
Southern	59,228	31,133	53 %	12,560	7,634	61 %	14,073	7,486	53 %	13,756	7,028	51 %	12,433	5,902	47 %	6,406	2,766	43 %	317	1 %
Tairawhiti	8,034	4,816	60 %	1,178	1,042	88 %	825	542	66 %	991	578	58 %	1,913	997	52 %	3,127	1,637	52 %	20	0 %
Taranaki	22,239	13,415	60 %	2,742	2,101	77 %	4,621	2,885	62 %	5,084	2,922	57 %	6,178	3,355	54 %	3,614	1,892	52 %	260	1 %
Waikato	70,294	44,116	63 %	9,209	7,268	79 %	11,267	7,107	63 %	14,355	9,044	63 %	18,713	10,765	58 %	16,730	9,275	55 %	657	1 %
Wairarapa	10,254	7,209	70 %	1,346	1,112	83 %	2,193	1,618	74 %	1,745	1,346	77 %	2,948	1,894	64 %	2,022	1,227	61 %	12	0 %
Waitemata	93,527	49,199	53 %	24,284	13,655	56 %	27,095	14,315	53 %	20,198	9,880	49 %	15,770	7,133	45 %	6,180	2,649	43 %	1,567	2 %
West Coast	6,426	4,454	69 %	564	530	94 %	986	783	79 %	2,145	1,455	68 %	1,920	1,175	61 %	811	457	56 %	54	1 %
Whanganui	13,338	9,822	74 %	1,414	1,215	86 %	1,498	1,113	74 %	2,524	1,813	72 %	3,456	2,557	74 %	4,446	2,928	66 %	196	1 %
National	**801,370**	**472,971**	**59 %**	**167,201**	**######**	**68 %**	**168,033**	**100,309**	**60 %**	**165,077**	**93,745**	**57 %**	**165,977**	**88,606**	**53 %**	**135,082**	**67,081**	**50 %**	**10,282**	**1 %**

May 2020 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Discussion Paper**
	Item No. 4.5
Author	Paul Malan – General Manager Strategy, Commissioning and Population Health
Subject	**Special funding for community responses during COVID-19**

Recommendations

Management recommend that the Combined Statutory Advisory Committee:

a. **Receive** the paper titled "Special funding for community responses during COVID-19"
b. **Note** additional and rearranged funding that has been made available
c. **Note** there are other special funding arrangements anticipated and in progress

1 Background

In response to the COVID-19 pandemic, the government and DHBs have worked very closely to implement some significant funding and contracting changes that have enabled the system to respond appropriately.

This paper provides the committee with an overview of some of the key initiatives. Note that this excludes any packages that have not been channelled through DHBs.

1.1 Home and Community Support services (HCSS)

Whanganui DHB provides HCSS to approximately 550 - 600 customers at any time. HCSS includes personal care and household management for people who need that support to enable them to live safely in their own home. Typically HCSS is long term following needs assessment and may be caused by disabilities related to age, long-term chronic conditions or mental illness. We have four main providers who are contracted on a fee-for-service basis. At the beginning of the COVID-19 crisis, providers made arrangements to reduce visits to clients so as to ensure safety of clients and staff whilst balancing the need for in-person support. In order to keep the workforce employed in the face of significant change to volumes, DHBs agreed to bulk-fund providers based on recent averages.

1.2 Special funding for primary care, pharmacy and public health

At the end of March the Ministry of Health made special funding available for primary care, pharmacy and public health.

The primary care funding included:

- Direct funding to every general practice, based on enrolled service users (ESU) to enable enhance primary care responses including virtual consultations;
- Fee-for-service funding to general practice to deliver COVID-19 assessments based on 3 different levels of assessment (virtual, basic and full)
- Funding to support the local configuration of Community Based Assessment Centres (CBACs). Because each DHB district established CBACs in different ways, this fund was calculated based on

total ESUs but provided to the DHB to distribute in accordance with the actual costs of running the CBACs locally. In WDHB, the initial CBAC plan was based on the existing pandemic plan and this was updated and actioned by the Whanganui Regional Network taking the lead on CBAC set up with a Clinical Lead provided by Whanganui Accident and Medical (WAM). Staffing was made available from WAM, general practice, public health and dental therapists. The funding is expected to cover ongoing costs of delivering testing including mobile services, designated practices, community facilities, CBAC treatment, etc.

The pharmacy funding was channelled through DHB accounts to all holders of Integrated Community Pharmacy Services Agreements. The amount distributed was consistent nationally based on a set amount per pharmacy and an additional amount based on an algorithm that accounted for size through volumes of various services within the agreement.

The public health funding was provided to DHBs to boost public health capacity around contact tracing and can support health protection and health promotion measures.

1.3 Special funding for Māori health support

There are four funding lines focused on Māori health support released by the MoH for the Whanganui DHB area as follows:

- Infrastructure support total: distributed directly to Iwi health organisations by the MoH for infrastructure support to maintain viability, enable remoting working and enable organisations to respond to the needs of Maori whanau which may not be within current contracts.

- Maori Specific Initiatives: distributed through DHBs for specific initiatives to support Maori whanau i.e. wellness checks, medications, digital connectivity.

- Communications – messaging to Māori communities to support multimedia communication activities to produce information and messaging that will connect with and inform Maori whanau and Maori communities. Funded through DHBs.

- Focus on Maori Uptake for Flu Vaccinations: focuses on ensuring that Maori whanau who are eligible, receive flu vaccinations. This includes whanau over 64 years, hapu Mama and those with longterm conditions or are immune compromised including Tamariki. Whanganui Regional Health Organisation PHO, immunisation outreach services, Iwi providers and general practices across the WDHB are working together to maximise the uptake of flu vaccinations.

NOTE: Their efforts to date, lead the country for Maori over 64years and is well on the way to achieving an equally high uptake for other eligible Maori whanau. (See item 3.5)

1.4 Urgent dental services for community services card holders

This is a WDHB-specific initiative whereby we extended the scope of the Combined Dental Agreement (CDA) to temporarily included urgent care for community services card holders. An agreement on the ranges for services that could be provided and a process for claiming was set up with all existing holders of the CDA.

1.5 Aged Residential Care (ARC)

Government announced a support package for ARC on 18th April, amounting to $26 million nationally. There are negotiations underway with DHBs, Ministry of Health and sector representatives to agree on how this will be allocated.

Locally we have introduced some temporary changes to facilitate patient care through ARC:

- A payment to facilities to provide the wound care for people in short-term (intermediate care and non-weight bearing) care arrangements;
- Funding facilities to complete the interRAI assessments for changes in from short-term to long-term care, which previously required a DHB needs assessment services intervention; and
- Allowing facilities to use an interRAI assessment as the basis for a change in level of care for a long-term patient, rather than having to wait for DHB approval

1.6 Guaranteed funding for Non-government organisations (NGOs) on fee-for-service contracts

Similar to 1.1. above, this is a principles-based approach that opens the discussion with all NGOs on fee-for-service contracts to negotiate a bulk payment for a period of time. This would reduce the risk to the provider of a collapse of revenue and reduce the need to invoice for each transaction. An example in discussion at the time of writing is "In-between travel", which will be assessed to an average and paid in bulk for a period of time.

1.7 Other support packages anticipated

A number of other support packages have been touted. E.g. private hospitals, hospices, additional primary care, etc. It is expected that further advice will be given following any announcements in the national budget process.

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 March 2020 (public-excluded session)	For the reasons set out in the committee's agenda of 13 March 2020	As per the committee's agenda of 13 March 2020
April Financial Update	To enable the Combined Statutory Advisory Committee of the Whanganui District Health Board to carry out, without prejudice or disadvantage, commercial activities or negotiations (including commercial and industrial negotiations).	Section 9(2)(i) and 9(2)(j)

Persons permitted to remain during the public excluded session

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

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

PLEASE PRESS PAUSE

What are we rushing back to?
The non-government charitable sector request:
Please Press Pause before we lose everything we've discovered together through this crisis.

Government

	Our old normal	Level 4	Our new world
Prevailing attitude of Government	We need to manage risk and make sure we don't get in trouble for any decisions we make.	Deeper level of listening and mutual respect. Forget risk just do it. Non-Government sector at the front line knows what's going on. Ask them what they need and give it to them.	New rules and expectation of how Government operates with community are put in place. We keep being strong, kind and united. The community ecosystem flourishes when system constraints are removed.
Minister meetings	Half hour meetings at Beehive, many fly. Minister often late. Sit in the waiting room accompanied by Ministry staff. Distracted. Bells ring. Not a lot achieved.	Meetings via Zoom from home offices. Much more relaxed and very focused. No distractions. Feels more personal. Feels more equal. Decisions made.	Our flying footprint nationwide is reduced. People get to spend more time with their families and in their own communities. Acceptance that Zoom is our new tool for face to face meetings rather than our default. Face to face meetings that involve travel only when necessary.
Meetings with ministries and officials	In Wellington. Many Government employees commute weekly at high financial and personal cost, taking up valuable housing stock. Government staff turnover an issue. Meetings more process than outcomes focused and very time consuming. Providers have to travel to Wellington for meetings.	Meetings via Zoom from home offices. Much more relaxed and very focused. No distractions. Feels more personal. Feels more equal. Decisions made.	Our flying footprint nationwide is reduced. People get to spend more time with their families and in their own communities. Acceptance that Zoom is our new tool for face to face meetings rather than our default. Face to face meetings that involve travel only when necessary.
Decision making	Slow - can take more than a year. Often siloed. Often fiscally driven rather than meeting need.	Fast - takes less than five days. We get things done quickly together. Very satisfying for both parties. Move to whole of Government.	Agile Government. Negotiation timeframes become reportable KPI. Cross-sector collaboration harnesses our respective areas of expertise.
Contracts	One to two years. Multiple negotiations year on year waste both funder and provider time. Creates staff anxiety every year re job security. Paper copies have to be initialed on every page.	Existing contracts rolled over. Practical decisions made. More time able to be devoted to front line. More budget certainty, less staff anxiety. Electronic signing processes in place.	Five-year contracts. Electronic processes. Flexi-fund provided as core component of contracting, supported by smart systems to enable person-focused support.
Sustainability	Some ministries have no annual CPI in contracts. DHBs pay variable amounts from nil to passing on what they receive. Significant time with negotiation. Advice always late, making budgeting and salary raises for lower paid frontline staff an issue and increasing tension with unions. Financial and operational risk burden that often falls disproportionally on NGOs.	Indication that there may be a consistent nationwide CPI increase applied to all Health contracts including DHBs for the 2020-2021 year.	Annual consistent CPI increase agreed and signaled early across all Government contracts every year. Risk is explored and shared.
Clauses and outcomes	All contracts are different. Some have unrealistic wash up clauses like no time allowed to recruit a new staff member. Outcomes are often unrealistic and drive providers towards easy to reach clients. Providers have demonstrated that they achieve better outcomes with less constraint.	Outcome contracts and wash up clauses suspended. Staff able to be directed to need. Providers supporting the most vulnerable in a new way. Flourishing of provider relationships and innovation.	FTE funding. Outcomes are evidence-based, realistic and shaped between Government and providers together.
Reporting and audits	Onerous meaningless reporting. Some providers data-rich but this is not being utilised. Multiple audits from multiple ministries every year. Some every six months, auditing the same domains. Significant wasted time from senior management and frontline staff directed to meet with panels of auditors. Sector frustrated. Has continually raised issue, but little movement in 20 years.	No audits except PPE processes and systems. All hours devoted to frontline work. Some requests for onerous reporting as time elapses.	Funders and providers work together to measure what matters. One audit to cover all Government contracts. Mandate given to existing Government owned audit agency. Telarc to work with the sector and drive this. Onerous reporting removed.

Vulnerable Populations

	Our old normal	Level 4	Our new world
Homeless: Rough sleeper population	Live on the street. Poor. Have to go to places to receive food. High users of all services. Cost per person $65K per annum. Addictions and access to treatment an issue.	Rapid resolution in crisis. Moved into motels. Free Wi-Fi, Sky TV and food delivered. Cost per person $55K per annum. The experience has given people a sense of home. Some decrease in addiction and desire for help.	Empty housing stock is explored and becomes part of the supply chain. Housing stock is affordable. Homelessness is rare, brief and non-recurring. Clean slate of Government debt.
Long term motel population Transitionally homeless and those in emergency accommodation	Individuals and whānau placed in long term motel accommodation due to crisis. Does not meet need as not designed for long term living. Children dislocated from school. Increased social issues.	Situation exacerbated in lockdown as unable to escape unsuitable housing to attend school or work. Increased social issues.	Long term housing increased through Kāinga ora and community housing providers accessing required capital to develop and sustain stock over time. Clean slate of Government debt.
People with mental illness	Struggle with poverty and daily living. Requesting more contact with services but staff time pressures mean this can be difficult.	Evening cooked meal delivered. Significant increase in wellness with increased nutrition. Fifty percent increase in whānau connection as many system constraints removed and staff able to spend time contacting whānau.	Additional flexible funding allows providers to purchase and provide nutritious main meal. Addressing system constraints means gains under level four are sustained. Clean slate of Government debt.
Corrections population	Released from prison to often temporary accommodation and support situations. Benefit and ID often not in place.	Benefits in place. Green card pre-loaded. Accommodation seen as a priority.	No one leaves prison without a sustainable housing and income plan. More deliberate engagement in study and employment in prison.
Technology	No support for phones, technology or data for vulnerable populations. Under investment in e-therapy. Difficulty in accessing staff like psychiatrists when we need them face to face, and rarely able to access online. Multi party whānau Zoom meetings difficult as access issues for all parties.	Clients all given phones, data packages and training in technology use. Providers supply key agencies with serial numbers. Business support through not accepting goods for resale. E-therapy value realised in lockdown situation and rapidly deployed to meets needs of different populations. Virtual consults with psychiatrists talking directly to the client and support staff when we need them, in settings like respite facilities. Multi party/whānau supports possible via Zoom.	Access to Wi-Fi and a device that has speech and visual connectivity is seen as a critical part of support. All vulnerable clients have access to technologies and data packages. This is managed through non-government provider contracts and provision of a flexi-fund. Providers supply key agencies with serial numbers. Business support through not accepting goods for resale. Evidence based e-therapies are supported post crisis to ensure access and wellbeing gains are not lost. Virtual consults become part of BAU, specialist staff readily available.

Where and how we work

	Our old normal	Level 4	Our new world
Offices	Predominantly office based.	Many people working from home. Essential workers, mobile staff and frontline staff celebrated and recognised.	Increased working from home. Centralised hubs which support the community ecosystem.
Mobile outreach	Limited cars. Staff have to book availability. Often in larger centres have to travel miles to pick up a car from the office.	All cars diverted so essential workers delivering mobile support have a car. No need to come to the office to pick up. Car is their new office.	Transport is built into contract pricing for frontline workers. Support for non-government organisations to access electric vehicles through lease or purchase.
Use of technology	Government agencies receive technology funding. Non-government providers don't. Training predominantly face to face. Core professional development unable to be accessed online, so rural providers have to travel large distances.	Government agencies receive technology funding. Non-government providers don't. Working together highlights very big differences in access to technology between Government and providers. Face to face training rapidly transformed to online. Core professional development made available online.	Technology is recognised as a core tool and providers are able to access funds to support staff and system development. Blended models of training. Gains made in online learning continue to expand.
Providers	Siloed and competitive. Driven by contracting models that pit them against each other. Short term contracts. Competitive contracting affects collaboration.	Examples of providers rapidly coming together. Collaborating to meet the needs of the most vulnerable. New developments including joined up referrals and delivery of services.	Community ecosystem models are supported.
Data	Non-government rich in data but not always fully utilised across the system.	Examples of shared data emerging. Eg. Creation of Covid-19 view right across the Housing First and Motel utilisation.	Resources to access shared systems and people to support the work of the non-government sector.
Response	Locked into traditional roles and boundaries of contracts	It's all about coming together and meeting the needs of the most vulnerable in the most effective way. Explosion of creativity.	Resource and hardwire joined up models of delivery that have proved effective.

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

Ken Whelan
Chair
Whanganui District Health Board
kenwhelan57@outlook.com

Tēnā koe Ken

Letter of Expectations for district health boards and subsidiary entities for 2020/21

This letter sets out the Government's expectations for district health boards (DHBs) and their subsidiary entities for 2020/21.

DHBs make positive differences in the lives of New Zealanders and I look forward to working with you and your new Board to deliver the wider changes we need to improve outcomes. Strong and sustained leadership provides a foundation for high-performing DHBs and is critical to overall sector performance.

The Government intends to deliver long term, sustainable change to support improved wellbeing for New Zealanders. In the coming months we will receive the final report from the New Zealand Health and Disability System Review. Many of you have contributed to the review, and I thank you for that. The interim report aligned strongly with our Government's priorities and the changes we have underway to deliver better outcomes for Māori and improving equity and wellbeing. I expect you to be prepared and ready to implement Government decisions resulting from the review.

Wellbeing and equity underpin my priorities. Appendix one details expectations for the five system priorities:

- improving child wellbeing
- improving mental wellbeing
- 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.

This letter will outline my expectations for a range of matters that contribute to performance across these priority outcomes.

Governance

The DHB Board sets the direction for the DHB and rigorously monitors the DHB's financial and non-financial performance and delivery on the Government's priorities.

I expect you to hold your Chief Executive (CE) and senior leadership team to account for their financial performance and on the delivery of equitable health outcomes for your population.

+64 4 817 8709 Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand d.clark@ministers.govt.nz beehive.govt.nz

As Chair, you will need to provide leadership and direction to the Board, providing guidance and support to members to ensure they effectively govern the DHB. Please ensure that you have a process in place to review the performance of the Board on a regular basis.

Sustainability

Every DHB must clearly demonstrate how strategic and service planning will support improved system sustainability, including models of care and the scope of practice of the workforce. You should address how your DHB will work with sector partners to deliver the Government's priorities and outcomes for the health and disability system while reducing cost increases and deficit levels.

Please ensure that your 2020/21 planning documents clearly identify your DHB's approach to financial and clinical sustainability at both a strategic level and operationally across each of my priority areas.

Service performance

I expect you to challenge and support your CE and senior leadership team to identify ways to respond to the challenges the DHB faces, including timely, high quality delivery of planned care, reducing the length of emergency department stays and increasing immunisation coverage. You will oversee progress on the plans they develop to address these issues.

You need to ensure that workforce and delivery plans support innovative models of care and don't merely add FTE to maintain existing approaches. I expect this to be supplemented with other activities, such as managing annual leave liabilities and maximising productivity in theatres and wards.

Achieving equity

Achieving equity in health outcomes and ensuring fairness in access to and experience of care is essential. I will always expect you to consider equity as you develop plans across priority areas and to prioritise resources to achieve equity across population groups. This will include improving health outcomes for Maori and Pasifika, and an explicit focus on addressing racism and discrimination in all of its forms across all aspects of your operations.

Embedding Te Tiriti o Waitangi and achieving pae ora (healthy futures) for Māori

Māori-Crown relations are a priority for this Government, and I expect your DHB to meet your Te Tiriti o Waitangi obligations as specified in the New Zealand Public Health and Disability Act 2000. I expect you to develop your plans in partnership with your iwi/Māori partnership boards and include a statement from the Chair of the partnership board in your annual plan alongside statements from yourself and your CE.

Achieving pae ora (healthy futures) for Māori is an important goal for the entire health and disability system. While this includes achieving equity in health outcomes for Māori, responding to our obligations under the Treaty of Waitangi goes beyond that. A critical aspect is enabling iwi, hapū, whānau and Māori communities to exercise their authority to improve their health and wellbeing. I expect your plan to specify how you will work with iwi and Māori communities in your district to achieve this goal.

Financial performance and responsibility

The 2018/19 and 2019/20 budgets have provided the largest increases in funding that DHBs have ever had. To improve service and financial performance, you must focus on good

decision-making within your sphere of control and influence. Most of the issues driving costs are within the control of the DHB, including the number and mix of full-time equivalent staff.

A central challenge in the public health system is to deliver a wide range of quality health services to New Zealanders while remaining within budget. You will be aware of your DHB's financial position and my expectation is that you and your Board will deliver improved financial management and performance; this is especially true for those DHBs that have struggled in recent years.

The In-Between Travel (IBT) appropriation will be devolved from 1 July 2020. I expect you to work with the Ministry of Health (the Ministry) to ensure a seamless transition of responsibilities. The Ministry has an ongoing stewardship responsibility to ensure that all IBT obligations are met.

Capital investment

Timely delivery of the business cases prioritised for investment from the Budget appropriation should be a strong focus. You must comply with financial performance expectations for capital investments requiring Crown equity. You will also be expected to deliver a business case within the budget parameters set, and ensure all investments are procured in a timely manner.

Business cases for high priority projects should continue to be developed irrespective of their immediate investment status and I will seek your assurance that this work is progressing.

I expect all DHBs to follow the guidelines for construction procurement developed by the Ministry of Business, Innovation and Employment. I also expect DHBs to support the initiatives being developed under the Construction Accord. Information on these initiatives will be provided as the work develops.

The Government is supporting a range of capital infrastructure initiatives. The wider public good from our capital projects must be realised, which requires adherence to certain principles. An example is the NZ Green Building Council (NZGBC) Green Star rating for new building developments. Capital builds ought to meet a 5-star standard in the absence of any other mature standard, and this aim should be written into design thinking from the outset. This should result in longer term efficiencies, both financial and environmental. During 2020/21, you will need to engage with the Ministry and other partners as we continue to evolve approaches to sustainable facility design.

National Asset Management Plan

I would like to thank your DHB for supporting the first iteration of the National Asset Management Plan (NAMP) and ask that you continue to engage with the NAMP work as we develop and implement the next phases. Please continue to strengthen your DHB's asset management approach, including focusing on critical service assets, embedding asset management practices and ensuring you appropriately govern service improvement and asset performance.

Service user councils

Service user/consumer councils are key mechanisms through which service users can give feedback on how health and disability services are delivered in different communities. The Health Quality and Safety Commission (the Commission) has provided guidance to support an effective approach – 'Engaging with consumers: A guide for district health boards' and 'Progressing consumer engagement in primary care'. I am aware that many DHBs already

have strong service user councils and I want to strengthen this across all districts and regions.

The Commission, in partnership with the sector, has developed quality and safety markers for service user engagement and I encourage your DHB to participate in this.

My priority areas

I have clearly communicated my priorities for the health system. I expect your annual plans to address these priorities to meet the needs of all population groups, especially those groups that experience the most significant inequities. The actions you commit to in your plan must contribute to lasting equity and outcome improvements for Māori and for your Pacific population, including a strong focus on prevention. Appendix one details expectations for the five system priorities, which will be further described in the planning guidance your DHB receives from the Ministry.

I look forward to engaging with you on your planning intentions, receiving your planning documents for 2020/21 and working with you as your DHB delivers on your commitments. I appreciate you are receiving this letter at a time when our system is facing emerging pressures from COVID-19. I am pleased to see the way the sector has worked together during the early response phase and I know DHBs will continue to support our collective system response.

Thank you for your continued dedication and efforts to provide high quality and equitable health care and outcomes for New Zealanders.

Ngā mihi nui

Hon Dr David Clark
Minister of Health

Appendix one: Ministerial planning priority areas

Improving child wellbeing

The Child and Youth Wellbeing Strategy and Programme of Action (the Strategy) launched in August 2019 provides a clear pathway to ensuring New Zealand is the best place in the world for children and young people to live. I expect your annual plans to reflect how you are working to improve the health and wellbeing of infants, children, young people and their whanau. Your plans should focus on improving equity of outcomes (especially for Māori); on children and young people of interest to Oranga Tamariki; and children with greater need, including children and young people with disabilities.

I expect DHBs to increase childhood immunisation rates, especially for Māori. The recent measles outbreaks remind us of the impact of communicable diseases on our communities and the health sector and the importance of achieving full immunisation. I expect DHBs to work closely with their primary care providers to prioritise immunisation, including a renewed focus on robust pre-call and recall processes and immunisation outreach services.

I expect DHBs to focus on family and sexual violence screening, early intervention and prevention to ensure victims and families receive effective and timely health care and perpetrators are supported to break the cycle of family and sexual violence.

High quality maternity care is fundamental to ensure children get the best possible start in life. As part of their commitment to the Midwifery Accord signed in April 2019, I expect DHBs to implement a plan to improve recruitment and retention of midwives. You should use Care Capacity Demand Management (CCDM) work to ensure optimal staffing in maternity facilities.

Working with a full range of stakeholders, the Ministry has developed a comprehensive Maternity Action Plan to support a flexible, innovative and sustainable maternity system. I expect DHBs to work with all elements of the maternity system to ensure responsiveness to Māori and equitable access to quality maternity care, including maternal and infant mental health services.

Improving mental wellbeing

He Ara Oranga: Report on the Government Inquiry into Mental Health and Addiction and the Government's response, has set a clear direction for mental wellbeing in New Zealand. Supported by the investments announced in the 2019 Wellbeing Budget, we have a unique opportunity to improve the mental health and wellbeing of New Zealanders. Your leadership will drive system transformation in the mental health and addiction sector.

Collective action is needed to achieve equity of outcomes, in particular for Māori, as well as for other population groups who experience disproportionately poorer outcomes, including Pacific peoples, youth and Rainbow communities. You will work with the Ministry, the Initial Mental Health and Wellbeing Commission and the Suicide Prevention Office to support system transformation and the rollout of the Government's priority initiatives.

The mental health and addiction system must respond to people at different life stages and levels of need. I expect DHBs to work individually and collectively on mental health and addiction promotion, prevention and early intervention at the primary and community level. At the specialist end of the continuum you should ensure those with the most need have access to sustainable quality mental health and addiction services.

Improving New Zealanders' mental wellbeing will require collaboration with communities and non-government organisations (NGOs). I consider that DHBs have a social responsibility to

support the sustainability of NGOs and to empower communities to engage in the transformation of New Zealand's approach to mental health and addiction. This includes offering your expertise at no charge to NGOs and community organisations to support participation in new service delivery, particularly for communities who experience disproportionately poorer outcomes.

I expect you to contribute to the development of a sustainable and skilled workforce. You must invest to diversify, train and expand both the existing and new workforces. You should focus on training workforces to support the Government's primary mental health and addiction initiatives and communicate proactively with the Ministry about opportunities to expand coverage to reach underserved populations.

Improving wellbeing through prevention

Environmental sustainability

Ensure that you continue to contribute to our Government's priority of environmental sustainability, including green and sustainable facility design as noted above in the section on Capital Investment. I expect your annual plan to reflect your work to progress actions to mitigate and adapt to the impacts of climate change and enhance the co-benefits to health from these actions.

Antimicrobial resistance

I am concerned about the increasing threat of antimicrobial resistance (AMR) to our health security. DHBs have a key role in minimising this threat. The issues are systemic and require long-term planning and sustained actions.

I expect your annual plan to reflect actions that align with the objectives of the New Zealand Antimicrobial Resistance Action Plan and demonstrate you are working towards a sustainable approach to containing AMR.

Smokefree 2025

Smoking remains a major preventable cause of premature death, morbidity and health inequities. My expectation is that you work towards achieving Smokefree 2025. I expect to see effective community-based wrap-around interventions to support people who want to stop smoking, with a focus on Māori, Pacific people, pregnant women and those on a low income. The interventions should reflect your regional and programme provider collaborative efforts.

Bowel Screening

The National Bowel Screening Programme remains a priority for this Government. DHBs are expected to achieve national bowel screening targets (where applicable) and consistently meet diagnostic colonoscopy wait times. It is crucial that symptomatic patients are not negatively impacted by screening demand. DHBs must work individually and collectively to develop a sustainable endoscopy workforce, including support of training positions for nursing and medical trainees to meet growing demand in this area.

Better population health outcomes supported by a strong and equitable public health and disability system

National Cancer Action Plan

On 1 September 2019 the Prime Minister, Rt Hon Jacinda Ardern and I launched the National Cancer Action Plan and its four key outcomes. DHBs have an important responsibility to drive the necessary changes and deliver of these outcomes.

I have established a National Cancer Control Agency, which will report to me on the implementation of the Cancer Action Plan. You will work with and take direction from the Agency to reach national standards of care and improve quality.

Disability

Disabled people experience significant health inequalities and they should be able to access the same range of health services as the general population. Your DHB should look for opportunities to increase its employment of disabled people to improve the competency and awareness of your workforce in matters regarding disabled people and to advance social inclusion more generally.

Accessibility means that your DHB provides a barrier-free environment, including information and communications for the independence, convenience and safety of a diverse range of people. This includes people who may have access needs, including disabled people, older people, parents and carers of young children and travellers.

Enabling disabled people to access health services includes ensuring that all key public health information and alerts are translated into New Zealand Sign Language. It means consulting disabled patients (including people with sensory, intellectual or physical impairments) on their preferred means of communication for appointment notifications and the like.

As with previous years, your DHB must make progress towards, or fully implement, the United Nations Convention on the Rights of Persons with Disabilities. DHBs also need to implement policies and procedures to collect information about disabled people within your patient population. DHBs should also ensure contracts with providers reflect the requirement to either ensure accessibility or put in place plans to transition to a more accessible service.

Healthy ageing

If our ageing population continues to grow as current trends suggest, the number of people with dementia, and the associated financial and social consequences, will grow commensurately. This Government is determined to make a positive difference in the lives of people with dementia, their families, whānau, friends and communities. I expect your DHB to work with your region to implement the regional dementia priorities.

Please ensure the DHB develops models of care to identify frail and vulnerable older people in community settings, in particular Māori and Pacific peoples, and provides supports to restore function and prevent the need for acute care.

Workforce

I expect DHBs to develop bargaining strategies that progress the Government Expectations on Employment Relations in the State Sector.

I expect bargaining strategies to progress consistent employment arrangements and support agile, innovative workforces to deliver services. Employment arrangements should encourage people to grow, develop and thrive in a work environment that supports transdisciplinary teams and innovative models of care. I expect commitments made in bargaining to be met, including working party commitments, Accords or programmes, such as the CCDM programme.

DHBs have an essential role in training our future workforce and providing learning and development opportunities for current workforces. I expect you to continue to utilise current workforces to support innovative and transdisciplinary practice across models of care and enable people to work to their full scope of practice.

DHBs must create environments in which all health and disability workforces thrive. DHBs should facilitate healthy and culturally reinforcing working environments that support health equity outcomes for all.

Workplace violence

I am concerned about what appears to be increased levels of violence in the health workplace. In accordance with the Health and Safety Act 2016, DHBs are responsible for the health and safety of their staff, patients and visitors. I expect DHBs to keep staff, patients and visitors safe by implementing appropriate policies, procedures and training to maintain public trust and confidence in the health and disability sector.

Health Research Strategy implementation

Research and innovation, analytics and technology are all crucial to achieving an equitable, sustainable health system and better patient outcomes.

The New Zealand Health Research Strategy (2017-2027) is the key platform for us all and it is important to implement the strategic priorities. In the next year, we should focus on developing a flourishing research and innovation culture in our DHBs in both primary and secondary care.

I have asked the Ministry to work with you and other stakeholders to build up DHB people and resources to support and enhance research, innovation and analytics so the system can make better use of the evidence and innovation and contribute to the Health Research Strategy objectives. Please work with the Ministry to design and invest in the programme of work with a focus on creating regional research and analytics networks that support staff engaged with research and innovation.

National Health Information Platform (nHIP/Hira)

Digital health services are important to me and to all New Zealanders and I expect DHBs to ensure the digital services you use are safe, secure, integrated, reliable and provide appropriate access to data and information.

I also expect you to support the Ministry in developing and designing nHIP/Hira services and to prioritise nHIP/Hira implementation activities in your annual plan.

Planned care

The refreshed approach to deliver elective and arranged services, under a broader planned care programme, will build on the development of the three-year plan you started in 2019/20. Timely access to planned care remains a priority. I urge you to take advantage of the increased flexibility in where and how you deliver these services; to ensure improved equity

of access and sustainability of service delivery; and to provide services that meet your population's health care needs, support timely care and make the best use or your workforce and resources.

I am particularly concerned, across many DHBs, about the number of people waiting beyond expectations for first specialist assessments, planned care interventions, ophthalmology follow-ups and diagnostic radiology services. Please ensure you have appropriate plans in place to support timely care.

Measuring Health System Performance

The System Level Measures (SLM) programme provides a framework for continuous quality improvement and integration across the health system. I intend to build upon the SLM framework by publicising local progress in responding to my national priorities from quarter one 2020/21. I expect DHBs to work with all health system partners to agree local actions and the contributory measures needed to make a tangible impact on health system performance. This will require broadening of alliances to include partners beyond the primary health organisations (PHOs). Equity gaps are evident in all SLMs and in nearly all districts. Where equity gaps exist, I expect local actions and contributory measures to focus on addressing these gaps.

Care Capacity Demand Management

I continue to expect significant progress on implementing all components of the CCDM programme this year, including detailed plans for full implementation in all units in nursing and midwifery by June 2021. Full implementation includes annual FTE calculations and agreed budgeted FTE in place. I expect timely reporting, including your assessment on progress towards meeting the June 2021 deadline for full implementation of CCDM. It is vital that nurses and midwives see the impact of CCDM FTE increases and effective variance response management on safe staffing levels and that the core data set drives quality improvement. It remains my expectation that CE performance expectations include delivering CCDM expectations within agreed timelines.

Better population health outcomes supported by primary health care

Primary care

Primary care makes a significant contribution to improving health outcomes and reducing demand on hospital services. Continuing to improve primary health care remains a priority for this Government.

DHBs must work with their primary care partners and lead their alliance(s) to develop and implement models of care that improve equity for Māori and other high needs populations through services that target the needs of these populations. I expect these new models of care to use broader multi-disciplinary teams, strengthened inter-professional collaboration and improved integration between secondary, primary and community care. I expect high-quality information and data to be shared through formal agreements and used to support decision-making, particularly in improving outcomes for Māori.

Long-term conditions

As I have previously advised, I expect DHBs to explicitly require improvements in performance and reporting on long-term conditions in their contracts with PHOs. DHBs should incentivise PHOs to improve equity, reduce the burden of long-term conditions, demonstrate improvements in primary care settings and increase accountability for effectively managing long-term conditions, especially diabetes.

Pharmacy

Progress has been made on the strategic vision of the Pharmacy Action Plan 2016. I expect this progress to accelerate as you work with the pharmacy sector to develop funding models and models of care that are equity focused and centred on service users. Please ensure your DHB enables pharmacist vaccinators to deliver a broader range of vaccinations to improve access.

Rural workforce

DHBs with rural communities should build on 2019/20 and improve access to services for rural people. I expect you and your rural alliance partners, including rural hospitals, to explore the opportunities to use the Ministry's rural workforce initiatives to strengthen your rural workforce and improve the sustainability of rural services.

Supporting delivery of the Māori health action plan

The sector has recently engaged in the development of a Māori Health Action Plan to further implement He Korowai Oranga: the Māori Health Strategy and improve Māori health outcomes. I expect all DHBs to demonstrate delivery and implementation of this plan in 2020/21 planning documents.

Improving wellbeing through public health service delivery

Public Health Units (PHUs) are key to protecting and improving health and you should ensure that your DHB has strong and sustainable public health capability and capacity. I expect to see PHU plans integrated with DHB Annual Plans where appropriate in 2020/21.

Over the next year, a programme is underway to develop criteria and to confirm the accountability arrangements for public health service delivery. I encourage your PHU and DHB to get involved in this process and support the programme.