Public Board Meeting

03 March 2021 09:30 AM - 11:00 AM

March 2021 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Presentation** **3 March 2021**
Author	Wheturangi Walsh-Tapiata - Mātaiwhetū (CEO) Te Oranganui Trust
Endorsed by	Russell Simpson – Kaihautū Hauora Chief Executive
Subject	**Insights Report – approach to the prevention of suicide**

Equity Consideration

This paper and presentation present the Insights Report to suicide prevention. The methodology to undertaking the mahi has equity at its core and was enabled through a whole of community – whole of system approach.

Recommendations

It is recommended that the Board:

a. **Receive** the paper titled 'Insights Report – approach to the prevention of suicide'

b. **Receive** the presentation of the Insights Report from the Te Oranganui and Health Families Whanganui, Ruapehu and Rangitikei team.

1 Background

In 2019 the Whanganui District Health Board commissioned Health Families Whanganui, Ruapehu and Rangitikei to facilitate the co-design of a whole of community, whole of system approach to the regional suicide prevention strategy and action plan.

2 Purpose

The document and presentation is intended to provide an understanding of suicide and prevention of suicide by capturing the voice of whanau, communities and professionals.

We know that in order to be more effective and to accelerate success we will need to transform and change our approach to suicide prevention. This new approach moves toward a community-wide response that requires a multi-level and systematic change.

The insights and the hypotheses that have emerged from our community engagement are presented in the document, and have informed the co-design of a regional strategic approach and traction plan.

Interest Register

27 November 2020

Name	Date	Interest
Ken **Whelan** *Chair*	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
Annette **Main** *Deputy Chair* *Chair CSAC*	25 September 2020	Member of Whanganui Community Foundation.
Anderson-Town Talia *Chair FRAC*	2 June 2020	▪ A board member of Ratana Orakeinui Trust Incorporated ▪ A board member of Te Manu Atatu Whanganui Maori Business Network.
Adams Graham	16 December 2016	▪ A member of the executive of Grey Power Wanganui Inc. ▪ A board member of Age Concern Wanganui Inc. ▪ A trustee of Akoranga Education Trust, which has associations with UCOL.
Anderson Charlie	16 December 2016	An elected councillor on Whanganui District Council.
	3 November 2017	A board member of Summerville Disability Support Services.
Baker-Hogan Philippa	10 March 2006	An elected councillor on Whanganui District Council.
	8 June 2007	A partner in Hogan Osteo Plus Partnership.
	24 April 2008	Her husband is an osteopath who works with some of the hospital surgeons, on a non paid basis, on occasions hospital patients can attend the private practice, Hogan Osteo Plus, which she is a Partner at.
	29 November 2013	Chair of the Future Champions Trust, supporting promising young athletes.
	3 March 2017	A trustee of Four Regions Trust.
Chandulal-Mackay Josh	10 December 2020	An elected councillor on Whanganui District Council
	21 February 2020	A member of Aged Concern Deputy Chair for Whanganui Youth Services Trust
Hylton Stuart	4 July 2014	▪ Executive member of the Wanganui Rangitikei Waimarino Centre of the Cancer Society of New Zealand. ▪ The Whanganui District Licensing Commissioner, which is a judicial role and in that role he receives reports from the Medical Officer of Health and others.
	13 November 2015	An executive member of the Central Districts Cancer Society.
	2 May 2018	▪ The chairman of Whanganui Education Trust ▪ A trustee of George Bolten Trust
	2 November 2018	The District Licensing Commissioner for the Whanganui, Rangitikei and Ruapehu districts.
MacDonald Judith	22 September 2006	The chief executive of Whanganui Regional Primary Health Organisation
	11 April 2008	A director of Gonville Health Centre
	4 February 2011	A director of Taihape Health Limited, a wholly owned subsidiary of Whanganui Regional Primary Health Organisation, delivering health services in Taihape
	21 September 2018	A director of Ruapehu Health Ltd
	23 July 2020	A Board member of Aged Concern, Whanganui
	10 November 2020	A member of the NZ Rural General Practice Network Board
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

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WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**DRAFT MINUTES** Held on Friday, 27 November 2020 Boardroom, Level 4, Ward & Admin Block, Whanganui Hospital 100 Heads Road, Whanganui
Public Board Meeting	**Commencing at 9.30 am**

Present
Mr Ken Whelan, Board Chair
Ms Annette Main, Deputy Board Chair, Chair Combined Statutory Advisory Committee
Mr Graham Adams, Member
Mrs Philippa Baker-Hogan, Member
Mr Josh Chandulal-Mackay
Mr Stuart Hylton, Member
Mrs Judith MacDonald, Member
Mrs Soraya Peke-Mason, Member

Apologies
Mrs Talia Anderson-Town, Finance Risk and Audit Chair
Mr Charlie Anderson, Member

In attendance
Mr Russell Simpson, Chief Executive
Mrs Nadine Mackintosh, Executive Officer
Mr Ian Murphy, Chief Medical Officer
Mrs Rowena Kui, General Manager Māori Health and Equity
Mr Paul Malan, General Manager Strategy Commissioning and Population Health
Mr Andrew McKinnon, General Manager Corporate

1. Procedural

1.1 Karakia/reflection
The meeting was opened by G Adams reflecting on the supportive presentations at Porritt Lecture at the War Memorial on Thursday, 19 November 2020.

S Peke-Mason was welcomed back to our meetings with acknowledgment of the close results during the recent parliamentary elections.

1.2 Apologies
The board **accepted** apologies from T Anderson-Town and C Anderson.

1.3 Continuous Disclosure
1.3.1 Amendments to the Interest Register
P Baker-Hogan provided an update to the interest register advising she is no longer a member of the district licencing committee.

1.3.2 Declaration of conflicts in relation to business at this meeting
Nil

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1.4 Confirmation of minutes

1.4.1 25 September 2020

The minutes of the meeting held on 25 September 2020 were **approved** as a true and accurate record of the meeting.

Moved G Adams **Seconded** S Hylton **CARRIED**

1.5 Matters Arising

Nil

1.6 Board and Committee Chair Reports

1.6.1 Chair verbal report

The board chair highlighted the opportunity the board had received with the visit from S McKernan providing an opportunity to talk with him briefly about Thriving Communities and our point of difference.

Health reforms have been reduced from five years to two years.

The Government are committed to equity and will drive this hard and we need to ensure that all papers we present report on this commitment to equity.

1.6.2 Combined Statutory Committee report

The community chair reflected on the previous meeting and advised that the format of the future meetings will be focused on presentations and timelines of the meetings will align with Ministry reporting requirements.

1.7 Correspondence

The chair discussed some correspondence received from a member of the public in relation to views on systematic failure and recommended that we extend an invitation to attend the next board meeting to present her views. It was also suggested that due to the timing of our board meetings we provide an opportunity to meet with management in the interim.

The board members discussed the formal complaint process.

- Service and individual matters should go through the internal complaints process
- Policy and systematic matters can be discussed at the board.

Moved S Hylton **Seconded** G Adams **CARRIED**

2. Decision paper

3.1 Proposed Board and Committee Meetings for 2020/21

The board discussed the dates, noting that not all members may be able to attend. Zoom will be provided as an option to attend and if meetings need to be changed it should be done with as much notice as possible.

The Whanganui DHB Board

a. **Received** the paper '2021 Board meeting dates'

b. **Noted** the proposed meeting dates have been aligned to the timelines for approving key financial and ministerial reporting requirements

c. **Approved** the 2021 board and committee meeting dates.

Moved A Main **Seconded** J MacDonald **CARRIED**

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3. Chief Executive Report

The paper was taken as read.

The chief executive highlighted the success of the Porritt Lecture series and wanted to provide a special acknowledgement to the anesthetics team and Whanganui Events and Venue, both did a wonderful job to support our team to deliver the Porritt Lecture to the public with the special guest speaker, Director General of Health, Dr Ashley Bloomfield.

Rob Beglehole has been contracted by Safer Whanganui to address the matter of a water only policy so that the community can address the situation and then provide recommendations the board and through the combined statutory advisory committee. The recommendations to the board will be for services delivered by the DHB and services on DHB premises.

The violence intervention programme achievement of 56% is a new measure and training is continuing to be provided for staff with a goal to reach 100%.

The Māori Provider Development Funding scheme is direct funding from the Ministry of Health and is based on Māori population based funding for our community Maori health providers. The funding will be direct with the provider and the Ministry of Health.

Whanganui District Health Board members:

a. **Received** the paper titled chief executive report.

b. **Noted** that the anaesthetic department hosted this years 50th anniversary of the Porritt Lecture

c. **Noted** that a water only policy will be considered by the combined statutory committee with recommendations provided to the board

d. **Noted** that overdue check up dental rates for children at Whanganui District Health board are in the range of 2-3%

e. **Noted** that Whanganui District Health Board ranked number one nationally last year in the emergency department screening rate for intimate partner violence (IVP).

CARRIED

4. Information paper

4.1 Hospital and provider services operational overview

The paper was taken as read. The chief medical officer advised that the key theme for the service is workforce challenges. The DHB is fully recruited to senior medical officers which is a significant achievement with one exception. One locum contract is being utilised to offset SMO leave reduction.

On 3 December 2020 the Maternal and Child and Youth service will hold its first community forum.

The board discussed:

- System approach for NETP and placement of Māori graduates
- SMO and RMO overseas placements have had some challenges but not detrimental
- Volumes across the health system remain busy with high acuity and maintaining the elective surgery waitlist. There are a number of contributing factors and planning on alternative care is required.
- Pediatrics' have introduced telehealth opportunities supported by specialist nurses in the community. The pediatric service has been encouraged to contract an additional pediatrician.
- The DHB have plans in place to address the LMC shortages to ensure the community service is maintained.

Action:

The DON to provide overview of our system approach for NETP placements.

Management to provide a presentation on views to address the health system congestion and how we collectively reduce the pressures.

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The Whanganui District Health Board:

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

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

CARRIED

4.2 Whanganui DHB Organisational Dashboard

The paper was taken as read.

The board requested that the emergency department attendances to include triage categories, ie volumes by triage.

Readmission rates were discussed noting that we should aim to report on the same event rather than a separate event for the presentation.

The Board:

a. **Received** the paper titled Whanganui DHB Organisation Dashboard

b. **Noted** performance measures identified by ELT members

c. **Noted** further development required

CARRIED

5 Information paper

5.1 October 2020 Financial Update

The paper was taken as read. The primary driver relates to workforce and patient volumes noting that the busier we are the higher the consumables become.

The board were provided assurances that we do have a number of sustainability initiatives to assist with our financial position and that reporting will be continue via the finance risk and audit committee.

The board noted the increase in acuity and volumes and supported that management are maintaining efficiencies and encouraged a balance between financial pressures and staff wellbeing.

Whanganui District Health Board:

a. **Received** the report 'Detailed financial report – October 2020'.

b. **Noted** the October 2020 monthly result of a $665k deficit is unfavourable to budget by $325k. When including the increase in the Holiday Act Compliance provision this increases to $380k.

c. **Noted** the year-to-date result of $1,941k deficit is unfavourable to budget by $462k. Including the increase in the Holiday Act Compliance provision, the result is $643k unfavourable to budget.

CARRIED

5.2 Adult Inpatient Survey 2020/21 Quarter one results

The paper was taken as read acknowledging the reporting is new and that the data methodology is still being understood. The DHB will review and identify trends in future reporting.

Whanganui District Health Board:

a. **Received** the paper titled 'Adult Inpatient Survey 2020/2021 Quarter one results'

b. **Noted** the areas where WDHB has received a high percentage of positive feedback in comparison with other DHBs

c. **Noted** the identified areas for improvement

d. **Noted** the results for Māori respondents

e. **Noted** the results are not statistically significant

f. **Noted** that ELT are currently working on an action plan around these results

CARRIED

Action: Management will provide a plan on how we will address some of the areas in the report to ensure that an equity lens is included.

5.3 Health and Safety update

The paper was taken as read with management highlighting a reduction in aggression.

The board discussed infection control incidents noting that the increases are diverse with no patterns.

The board:

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

b. **Noted** there were no notifiable events reported to WorkSafe New Zealand in the 2017/18, 2018/19, 2019/20 financial years or 2020/21 year-to-date.

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

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

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

CARRIED

6. Resolution to exclude the public

The Whanganui District Health Board members:

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

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

Agenda item	Reason	OIA reference
Whanganui District Health Board minutes of meeting held on 25 September 2020	For reasons set out in the board's agenda of 25 September 2020	As per the board agenda of 25 September 2020
Chief executive's report	To protect the privacy of natural persons, including that of deceased natural persons	Section 9(2)(a)
Committee minutes	To avoid prejudice to measures protecting the health or safety of members of the public	Section 9(2)(c)
Clinical governance update	To protect information which is subject to an obligation of confidence or which any person has been or could be compelled to provide under the authority of any enactment, where the making available of the information would be likely to prejudice the supply of similar information, or information from the same source, and it is in the public interest that such information should continue to be supplied; or would be likely otherwise to damage the public interest.	Section 9(2)(ba)

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Agenda item	Reason	OIA reference
Radiology services contract Laboratory and Pathology services contract – negotiating plan Allied Laundry Strategic planning and investment for strong Primary Care infrastructure in Whanganui city to meet future population needs Waimarino Facility and Service Development	To enable the district health board to carry out, without prejudice or disadvantage, commercial activities or negotiations (including commercial and industrial negotiations	Section 9(2)(i) and 9(2)(j)
Draft Annual Report Regional Service Plan	To maintain the effective conduct of public affairs through the free and frank expression of opinions by or between or to Ministers of the Crown or members of an organisation or officers and employees of any department or organisation in the course of their duty	Section 9 (2) (g) (i)

Persons permitted to remain during the public excluded session

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

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

Moved G Adams **Seconded** S Peke Mason **CARRIED**

The public section of the meeting concluded at 10.55am

Signed K Whelan
Board Chair
Whanganui District Health Board

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WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	3 March 2021
Author	Russell Simpson – Kaihautū Hauora Chief Executive
Subject	**Chief Executive Report**

Recommendations

Management recommend that Whanganui District Health Board members:

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

b. **Note** the activities that have been undertaken around the rohe by members of the WDHB.

Appendix:

1. **Ministry of Health Vaccination Roll Out Guidance**

1 Background

It has been a while since we have been able to update the board of the various activities across the rohe which all link to achieving our He Hāpori Ora Thriving Communities strategic direction. The report aligns initiatives updates, by the DHB and our partners, across each of these strategic focus areas since the last board meeting.

1.1 End of year staff Christmas lunch



The end of 2020 was celebrated with staff at the end of year Christmas lunch. This gave the team the opportunity to farewell what was a challenging year with COVID-19. Members of executive leadership team, senior management and the board served the lunch and the sentiment around the event was resoundingly positive.

1.2 Stanford House Art Expedition

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The Stanford House Mahi Toi exhibition at the Community Arts Centre was on display during February 2021 on Taupō Quay featuring more than 40 artworks, including photography, flax weaving, drawings, paintings, graphic art and carvings created by the patients of Stanford House. The creation of works in a new exhibition are helping with the recovery of clients of Whanganui Hospital's medium secure forensic unit and exemplifies the DHB's values, with both staff and tangata whaiora/clients ensuring it was a success.

2 Pro Equity

2.1 COVID-19 local media

As a result of community feedback, the Whanganui District Health Board has undertaken a programme of work with Whanganui Mediaworks to localise the COVID19 messaging – in particular with respect to using the COVID19 Tracker app, staying home if you are unwell and that the hospital is open for visitors and patients. The campaign uses a mix of recorded messages, pre-recorded interviews and social media messages. This campaign has been offered to Awa FM and we are in the process of ensuring that these important messages are shared throughout the rohe.

Picture: Medical Officer of Health Dr P O'Connor with MoreFM's local presenter Sue Miller.

2.2 COVID19 Vaccine Roll Out

The Whanganui District Health Board in conjunction with the Whanganui Regional Health Network, Hauora ā Iwi and Te Oranganui have stood up a vaccination rollout planning and implementation group. Through this, in aligning with the Ministry of Health guidance (Appendix 1) on when and who can receive the vaccination, the DHB in conjunction with our partners in primary care and iwi health providers will ensure that the health workforce is enabled to administer the vaccines. Through the utilisation of pop-up's, GP clinics, secondary care facilities and the Health Bus, the communities within the Whanganui DHB will see vaccine administration in a place near them. This approach, should it be required, can also be utilised for increased community-based testing, should there be an outbreak of COVID-19 in our communities.

2.3 Measles Campaign Launched

In 2019 New Zealand experienced its largest measles outbreak since 1997. This was against a backdrop of increased reporting of measles cases worldwide and a declining immunisation rate in New Zealand.

The measles outbreak highlighted the need for New Zealand to strengthen its immunisation system and to improve measles immunisation rates. In particular, the immunity gap for Māori and Pacific adolescents and young adults needed to be urgently addressed. In response to these health risks, the Government approved funding in October 2019 to strengthen the immunisation system, improve public health, and respond to the measles outbreak. Strengthening the immunisation system and improving public health includes several initiatives, one of which is a measles immunisation campaign targeted towards people not already immunised.

The measles immunisation campaign was set out in four phases and began in 2019. Early activities included:

- maximizing the uptake of the first and second MMR doses at 15 months and four years, with an active recall for children under five years who have missed these two doses
- DHBs targeting vaccination of key groups relevant to their population demographics.

The last phase of the campaign will address the immunity gap as part of a nationwide 'Guardians of our Future' campaign. This will focus on closing the measles immunity gap by delivering the measles, mumps, rubella (MMR) vaccine for adolescents and young adults and achieving more equitable health outcomes for Māori and Pacifica peoples.

The Whanganui District Health Board is promoting this messaging through media, our onsite TV channels and our public health teams when they are at events. Recently, the WDHB and WRHN teams undertook a pop-up vaccination clinic at the Whanganui Rivers Traders Market – the team were able to offer measles vaccines free on the spot to anyone between the ages of 15-30 and were pleased that 13 people took up the offer.

2.4 He Puna Ora Launches

WDHB worked in partnership with the Māori Health Outcomes Advisory Group (MHOAG) to commission the design, development and implementation of a Pregnancy and Parenting Service – He Puna Ora. This collaboration has highlighted when Mana Whenua have the rangatiratanga to design a service model, born from a Māori world view, trust and relationships are strengthened and the foundations for improved equity are laid.

He Puna Ora will work assertively in our communities with whānau and others, using a whānau ora model to work with whānau to address their needs as identified by them, to strengthen their whānau environment. The service will be driven by mātauranga Māori to ensure an integrated service is established and implemented using a mix of wānanga and case management.

The Service is designed to serve hapū māmā, and/or whānau with pēpi/tamariki who have significant issues with alcohol and other drugs. The aim is to increase and facilitate their access to health and social support services and mitigate the harm to both themselves, their pēpi, future tamariki and whānau and in so doing to interrupt the potential for inter-generational damage.

Recruitment for the team began in late 2020 with the team coming on board January 2021 to begin intense training. He Puna Ora will start taking clients and referrals from 1 March 2021.

Picture: He Puna Ora Team, January 2021

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2.5 Pakaitore Day

The Whanganui District Health Board was represented at the Pakaitore Day Whanganui-tanga event held on the weekend of the 26th to the 28th of February 2021. A team from community mental health, public health, health promotion and Te Hau Ranga Ora teams were on site with the blow-up bowel and two gazebos to discuss all things health and health workforce, along with offering free MMR vaccination opportunities.

2.6 Fit for Surgery – Fit for Life

The Fit for Surgery, Fit for Life programme is to help patients with a BMI of 40 and over lose weight and improve their fitness levels before elective surgery. Fit for Surgery, Fit for Life supports clients to bring about a change that will see them reduce their weight and lift their fitness levels for surgery while continuing to maintain these changes for life.

Dr M Meijer, Whanganui DHB HoD Anaesthetics and C Taylor of Sport Whanganui were asked by the Australian and New Zealand College of Anaesthetists (ANZCA) to present the Fit for Surgery, Fit for Life programme to the ANZCA NZNC Cultural safety and leadership hui conference held on over 26th to the 28th of February 2021 at the Waitangi treaty grounds. This hui enables the programme that has a particular focus on Pro Equity to be on the national stage, as it looks towards expanding its reach into further surgical interventions.

3 Social Governance

3.1 Pack the Bus

The Whanganui District Health Board participated in the 'Pack the Bus' tour event prior to Christmas 2020. This saw a horizons bus being packed with children's toys to support the local Birthright Whanganui and the Whanganui City Mission. Donation boxes were located out the front of the main reception and on the fourth floor with staff donating goods.

The DHB further donated a signed Ashley Bloomfield T-Shirt for the auction, we support the collection day at Trafalgar Square and our Health Promotion team participated in the Majestic Square open day. This is the first year that the event has been run, with good participation across the community. The response to the DHBs participation was well received by both the organisers and the businesses that were donating to the cause.

3.2 Youth Employment Success Programme

The job profile videos have been filmed and it is currently in the postproduction phase before being launched on the website. These videos demonstrate the numerous opportunities for various careers within the Whanganui District Health Board. The team within People and Culture have worked through how the DHB can further support the programme, such as attending YES group programmes and work expos, offering on-site walk throughs and career opportunity discussions.

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3.3 Health Bus

The Whanganui District Health Board were proud to support the Robert Bartley Foundations Health Bus. In the aftermath of the COVID19 Level 4 lockdown, the Integrated Recovery Team (which the DHB was a participant in) engaged with a wide section of the community in Whanganui, Rangitikei, Ruapehu and South Taranaki about what could contribute to enabling resilient communities, empowering whanau and individuals to determine their own wellbeing. The most common form of feedback to help this was around the COVID-19 testing response and flu vaccine rollout - the 'Pop-ups' run by the Whanganui District Health Board, Whanganui Regional Health Network and Iwi Health providers. Through the generosity of the Robert Bartley Foundation, the DHB in conjunction with its health partners in care, will be able to operate screening, vaccinations, immunisations and health check clinics throughout the wider region by utilising the health bus. This will enable the team to support more of the community at a time and place that is more convenient for them to attend. It furthermore gives the DHB the opportunity to support health promotion activities at major events and can be involved in the roll out of the COVID-19 vaccine when this is available to the community. This is an encouraging project for the communities within the Whanganui District Health Board and supports our He Hāpori Ora Thriving Communities strategic direction.

3.4 Lived Experience Report – Finalisation of the IRT Covid-19 Reports

The final report in the Integrated Recovery Team series was released in January 2021.

The Lived Experience Report outlines some of the experiences of community members of South Taranaki, South Ruapehu, Whanganui and Rangitikei during the Level 4 lockdown. It further presents a sample of perspective on what is working in our communities, and what needs improvement. In terms of health, Mental Health and Addictions Service were identified as needing work, however, the push towards telehealth and the increasing use of technology were identified as positive steps for the DHB. This report is attached as an appendix to the paper titled 'Impact Collective – Whanganui, Rangitikei, Ruapehu and South Taranaki (Update)'.

4 Healthy at Home – Every Bed Matters (69,000 Beds)

4.1 Masters Games

The Whanganui District Health Board was pleased to be the Health Partner in Thriving Communities for the Downer New Zealand Masters Games 2021. The games was seen as an ideal local opportunity to launch the DHB "Healthy Ageing" campaign. The main message in this campaign is that only 25% of the ageing process is genetic, and the rest is often under your control. To support this kaupapa, we offered daily strength and balance sessions as well as health and wellbeing seminars in the Games Hub at the Whanganui War Memorial Centre. DHB physiotherapists also attended several the sports, giving assistance with injuries and injury prevention. Dr Martin Chadwick (Chief Allied Health Professions Officer – Ministry of Health) was amongst the VIPs to launch the Masters Games week. During the course of the day, Martin held a lecture for health professionals across the wider community on the impacts of Covid19 and the important role of Allied Health in healthcare of the future.

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Covid tracer compliance and education

With a recent Auckland based Covid19 community transmission case and an increase focus on the utilisation of the Covid19 Tracer App, the DHB worked closely with Sport Whanganui team to ensure that QR Codes were on display at all events across the region, and the sport leads were aware of the expectations around Covid at their events. Throughout the week, members of the DHB visited sporting locations and ensured continued displaying of QR codes, of which the compliance remained high at all events.

Technology as an enabler

The Masters Games indicated a real momentum towards the utilisation of technology as an enabler and presents opportunities for the DHB in the future. Some of these include the use of Apps to push notifications (Masters Games App), of social media to engage with community (Instagram Healthy.Ageing page) with information and exercise examples, and the creation of the Healthy Aging DHB page.

Launch of the DHBs Healthy Ageing messaging and introduction of "The Life Curve"

The Masters Games afforded the opportunity to launch the DHBs Healthy Ageing messaging as outlined above. The key message that a large amount of age related health conditions can be avoided, and even reversed, is key to this kaupapa. One of the key enablers of healthy ageing is the release of "The Life Curve app". This is being released by the Bay of Plenty DHB later this month. The app is free to download and allows any person in the community to find our how they are faring with functional independence compared to others of the same age, and provides targeted activities at each level designed to improve functional ability and reduce the cost of dependence on health and social services. This technology platform presents real opportunities going forward for our priority focus areas of Pro Equity, Social Governance and 69,000 beds.

The success of the Masters Games, and the recognition of the DHB staff in their green t-shirts did not go unnoticed by participants with organisers supporting partnering with the DHB as a Health Partner.

The DHB will now take the time to reflect on the learnings from the games and will begin approaching our external partners in care in advance of Masters Games 2023.

Picture: The WDHB Board member S Hylton and Chief executive R Simpson showing their form at the games.

4.2 ENT – WDHB to support Taranaki DHB with specialty

It was recently reported in the media about '*A shortage of ENT surgeons in Taranaki sees patients sent out of the region for surgery*'. This article outlined the experience of a patient who was required to be sent to MidCentral DHB for ENT surgery. Since January 2021, 20 patients from Central and South Taranaki have received their first specialist appointment in Whanganui DHB for ENT surgery, with a steady flow of patient referrals continuing as business as usual. This ensures continued support to our communities to enable them to remain healthy at home.

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4.3 Insights Report

February 2021 saw the release of the Suicide Prevention Insights Report for Whanganui, Rangitikei and Ruapehu. The document is intended to provide an understanding of suicide and prevention of suicide by capturing the voice of whānau, communities and professionals. This type of report, in conjunction with our Lived Experience Reports, seek to present community wide responses and support codesign work with our communities into the future, whilst acknowledging our Te Tiriti Commitments. It is pertinent to acknowledge the breadth of engagement undertaken by Te Oranganui and the Healthy Families Whanganui Rangitikei Ruapehu teams to produce a document of this calibre.

Operating Guidelines for DHBs & Providers

COVID-19 Vaccine Immunisation Programme

Version 1.0 – Tier 1 Go Live

Last Updated 18 February 2021

MINISTRY OF HEALTH
MANATŪ HAUORA

Document Version Control

Revision History

Version	Date	Section/Appendix	Summary of Changes
0.1	14/2/2021		Draft version for input issued to DHBs to support Tier 1 planning & operations
0.2	14/2/2021		Minor grammatical updates
1.0	18/2/2021		Significant changes including: • Addition of abbreviations table • Additional equity guidance • Additional clinical leadership guidance • Removal of 'Social distancing and consumer flow' section with detailed IPC section and guidance • Additional vaccine and on-site security guidance • Clarification of collateral available and purpose of each • Modified CIR access request process • Clarification of written consent process for Tier 1 cohort • Guidance for situations when consumers are not in CIR or do not have a NHI number • Addition of waste disposal process, vaccine quality control process and clarification of Credo bin return process • Additional detail on operational reporting that DHBs can request • Guidance on recording vaccine errors • Guidance on administering leftover vaccine

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Contents

1 Purpose

This document provides guidance on establishing and managing a COVID-19 vaccination site, including guidelines for the vaccination workforce. This document is designed to help District Health Boards and providers maintain public safety and ensure consistent and equitable COVID-19 vaccination practices are in place across New Zealand.

This version of the guidelines is specifically designed for Tier 1 vaccinations. This guide will be amended as needed and re-distributed to DHBs. We expect regular iterations based on learnings from the delivery of the COVID-19 vaccine programme. Please ensure you are always using the correct version of the guidelines.

1.1 Focus of current version

The guidance in this version focuses on delivery of the vaccine to Tier 1 of the Vaccination Programme, that is, the vaccination of Border and Managed Isolation and Quarantine Facilities (MIQF) workforces and their household contacts and the vaccination of high-risk healthcare workers.

The guidance in this document is designed for administering the Pfizer COVID-19 vaccine. This document will be updated as other vaccine types become available.

2 Abbreviations

Abbreviation	Full Name
BWTR	Border Worker Testing Register
CARM	Centre for Adverse Reaction Monitoring
CIR	COVID Immunisation Register
DHB	District Health Board
HCL	Healthcare Logistics
IMAC	Immunisation Advisory Centre
IPC	Infection Prevention and Control
MIQF	Managed Isolation and Quarantine Facility
MoH	Ministry of Health
NHI number	National Health Index number
ULT	Ultra Low Temperature(-90°C to -60°C)

3 Key Contacts

See also Appendix A for more information on the support organisation, noting that each region will have a dedicated MoH liaison/relationship manager.

Issue Type	When to Contact	Contact Details	Hours of Operation
IT hardware or non-COVID Immunisation Register (CIR) software issues	Logging technology hardware or software issues that *aren't* CIR-related	Contact your local IT ServiceDesk	Ensure after-hours support is available for sites operating outside business hours
COVID Immunisation Register Issues	For help on using CIR	For system help, contact your on-site Liaison Officer, or help@c-19imms.min.health.nz	8am-6pm, weekdays & weekend (TBC)
	Logging-in issues, password resets, or after hours help,	0800 223 987 or help@c-19imms.min.health.nz	
Vaccine or Consumables Supply Issues	To raise an issue with supplies	Covid-19.logistics@health.govt.nz or 0800 335 778	Email: 9am-5pm, weekdays Phone: 8am-8pm, weekdays & weekends
Clinical Vaccine Queries	To receive clinical advice on the vaccine or vaccination process	0800 IMMUNE	8am-8pm weekdays, available on weekends if requested
Order Vaccination Collateral	To request additional pamphlets or other collateral	Your DHB Comms Manager	
Privacy Incident or Concern	If you identify a known or suspected privacy breach	COVIDPrivacy@health.govt.nz	9am-5pm weekdays 24/7 Support TBC
Adverse Event Following Immunisation	If an individual has an adverse reaction to the vaccine	https://nzphvc.otago.ac.nz/report/ (03) 479 7247 carmnz@otago.ac.nz	

4 Roles and Responsibilities

Activity	Ministry of Health	DHBs	Tier 1 Employers	IMAC	CARM	HCL
Purchasing	• Purchase vaccine from Pfizer • Purchase consumables for vaccine delivery	• Purchase PPE through existing channels	N/A	N/A	N/A	N/A
Distribution	• Arrange distribution of vaccine and consumables to vaccination sites/DHB facilities	• If needed, arrange secure distribution from DHB facility to vaccination site	N/A	N/A	N/A	• Thaw and repack vaccine into sub-batches as needed • Distribute vaccine & consumables
Inventory Management	• Coordinate allocation schedule • Order vaccine and consumables for DHBs	• Plan vaccine demand to minimise wastage • Report stock on hand, stock movement & exceptions • Ensure vaccine handling & storage requirements are met	N/A	N/A	N/A	• Perform QA checks on receipt of vaccine from Pfizer • Ensure secure storage of vaccine prior to distribution
Workforce & Training	• Provide guidance on workforce model and training requirements • Provide access to CIR for vaccinators & admin staff • Provide CIR support/factsheets	• Hire and roster vaccinators and required site support staff • Provide info to MoH and IMAC for user on-boarding & provision of training • Ensure staff are appropriately trained	N/A	• Provide vaccine preparation & delivery training • Provide CIR training	N/A	N/A
Site Operations	• Provide guidance on preparing and running vaccination sites • Disseminate process improvements (e.g. via updated Operating Guidelines)	• Prepare and run vaccination sites, including providing IT equipment • Work with Tier 1 employers to schedule vaccinations of staff • Schedule appointments for household contacts • Engage with Māori & Pacific Island partners around vaccination of household contacts	• Liaise with DHBs if vaccination site is on employer premises to ensure site is set-up and secured	• Provide clinical support to vaccinators as needed	N/A	N/A
Post-Event	• Monitoring adverse event data	• Dispose of expired, empty or broken vaccine vials and used consumables • Pack down site as needed	• Where vaccination on employer premises, support pack down of site as needed • Provide employee support	N/A	• Receive and analyse adverse event reports	N/A
Comms & Engagement	• Coordinate national vaccine engagement campaign • Provide key messages to DHBs to share with Tier 1 employers • Provide collateral files to DHB Comms Managers & distribute banners/cards • Manage adverse event comms	• Engage with Tier 1 employers re: sites & schedule • Print and circulate collateral to vaccination sites as required	• Engage with employees re: vaccination plan	N/A	N/A	• Include 'Instructions for the Pfizer Vaccine - Preparation and Administration' info sheet in vaccine shipments
Reporting	• Produce programme and operational reporting	• Complete weekly stock on hand and stock movements reporting • Report exceptions to plan, as they occur	N/A	• Provide data on vaccinators trained to date	• Provide adverse event data to MedSafe	• Provide stock on hand and orders out reporting to MoH

5 Preparing a Vaccination Site

5.1 Equitable Access

You should ensure that your vaccination sites are accessible to all members of your community and ensure equitable opportunity for Māori and Pacific people, other ethnic communities, and disabled people. You should take reasonable steps to improve access and reduce potential inequalities. This may include:

- Providing access to translation and interpretation services to support the consent and immunisation processes. For more information on interpreter services see https://www.healthnavigator.org.nz/languages/i/interpreter-services/
- Actively incorporating Te Tiriti O Waitangi considerations, including:
  - making sure Māori are not disadvantaged
  - mitigating the impact to Māori as a result of COVID-19
  - establishing and maintaining effective partnerships with Māori stakeholders including iwi, hapu and whanau
  - seeking Māori specific advice from the outset
  - resourcing and investing where it is required the most
- Ensuring your site workforce reflects the demographic make-up of the likely consumer group or local area.
- Considering which site locations can best meet the community's needs in terms of both ease of access and comfort or familiarity with the location (e.g. marae, churches).
- Where drive-in sites are planned, ensuring consumers can either attend this site if they do not have a car or have access to a non-drive-in site.
- Providing supporting literature available in a range of languages and resources/support for those who have low health literacy. MoH is preparing translations of COVID-19 vaccine information (see section 'Ordering Site Collateral' below).
- Encouraging site staff to greet consumers in Te Reo or the language the consumer uses where possible
- Starting and ending the day with a karakia
- Ensuring key written material and any signage is in easy to read formats.
- Ensuring access for disabled people, including venue accessibility and accessible information. For more information on venue accessibility, see the Ministry of Health website.
- Building early and regular engagement with Māori and Pacific partners into your service delivery model to design for the community's needs.

5.2 Clinical Leadership

Every multi-vaccinator immunisation site should have a named lead clinician. The onsite lead clinician should be an appropriately experienced clinician (senior nurse/vocationally registered doctor) who is able to lead the vaccination team, manage adverse events, and provide onsite clinical advice.

5.3 Infection Prevention and Control (IPC)

The key IPC principles to consider and the precautions for safely delivering COVID-19 vaccines are described below. These principles and recommendations have been derived from the World Health Organisation (WHO) guidance.[1]

This guidance is intended for policy makers, immunisation programmes and IPC leads for vaccination delivery venues. This section covers the IPC measures required to support all vaccination activities, and as such, some aspects may also be covered in other sections of the operating guidelines.

5.3.1 Key IPC principles for COVID-19 vaccine deployment

- Standard precautions to be applied during any vaccination activity are also valid for COVID-19 vaccine delivery, considering that the population to be vaccinated consists of individuals **not** presenting signs and symptoms of infection.
- However, additional IPC precautions are necessary in the context of the COVID-19 pandemic to reduce the risk of SARS-CoV-2 transmission (e.g. mask use).
- It is critical to provide health workers with specific training and the public with targeted information regarding IPC measures for safe COVID-19 vaccine delivery.
- A clean, hygienic and well-ventilated environment, appropriate waste management and adequate spaces that facilitate best IPC practices (e.g. physical distancing) are necessary for COVID-19 vaccination activities.
- National guidance and protocols for IPC measures should be consulted and adhered to.

5.3.2 Preparation and planning phase

- Appoint a facility IPC lead for the planning, deployment and monitoring of the vaccination activities.
- Identify an adequate number of vaccinators to ensure there is sufficient staff and time to support correct implementation of the IPC practices required to safely administer the vaccine.
- Identify trained staff to deliver IPC training to those involved in vaccination activities (including managers, logistical support vaccinators, cleaners and health workers dedicated to screening) and to provide information for people to be vaccinated.
- Identify health workers for the supervision of vaccination activities and define a monitoring and evaluation process of IPC practices, including providing feedback to vaccinators and other staff as required.
- MoH recommends you create a vaccination site specific COVID Tracer App QR code posters. You can create QR code posters using the current self-service webform. More information about QR code posters is available on the Ministry of Health website.

5.3.2.1 Local IPC Guidance

- Develop local IPC guidance and standard operating procedures for COVID-19 vaccination, outlining the following:
    - screening policies for COVID-19 signs and symptoms of staff and individuals arriving for vaccination with clear exclusion criteria;
    - key IPC measures to be taken by anyone in the vaccination area or clinic
    - key IPC measures for safely administering COVID-19 vaccines;
    - cleaning and disinfection of the environment;

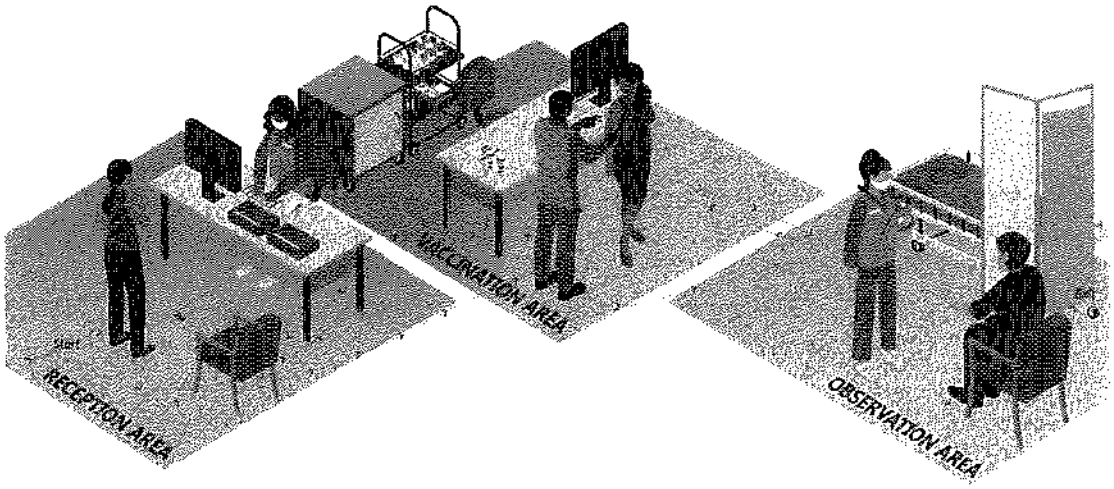
[1] Aide-Memoire Infection prevention and control (IPC) principles and procedures for COVID-19 vaccination activities, 15 January 2021. *https://apps.who.int/iris/handle/10665/338715*

- appropriate waste management taking in consideration the increase of waste associated with COVID-19 vaccination activities, and where possible include environmentally friendly approaches to manage both general and medical waste at point of use, segregation, disposal and collection;
- visual reminders emphasizing hand hygiene, safe injection practices, safe use of medical masks, respiratory hygiene, and other IPC measures;
- training materials for relevant staff and educational and informational materials for the public.

5.3.2.2 Environmental considerations and engineering controls at the vaccination venue

- Assess the layout of the building or area identified for vaccination delivery and ensure that the following features are in place to support appropriate IPC implementation:
  - clearly marked one-way foot traffic flow with clear entry and exit areas through the vaccination clinic; these should be separated when the vaccination area or clinic is located in a health care facility;
  - adequate screening area (ideally, private spaces) at the entry where people are assessed, including questioning for signs and symptoms of COVID-19 and other criteria for inclusion;
  - sufficient space to allow at least 1 metre physical distance between all individuals including between health workers at all stations (at the entrance, at the screening stages, while waiting to be vaccinated and during the observation period post-vaccination) and between staff;
  - adequate ventilation (mechanical, natural or hybrid) of all areas, including the screening, waiting, post-vaccination observation, and vaccination areas; if a mechanical ventilation system is operating in these areas, the ventilation rate should be 6 air changes per hour or according to national or local requirements for healthcare facilities;
  - medically equipped post-vaccination observation area for dealing with possible vaccine adverse reactions;
  - adequate number of hand hygiene stations in strategic areas to support appropriate hand hygiene for the public and staff (i.e., at the entrance and exit areas, in the waiting areas, and in each vaccination station);
  - laminated signage/posters to include reminders about:
    - reporting COVID-19 signs and symptoms;
    - medical mask wearing;
    - hand and respiratory hygiene;
    - physical distancing (e.g. floor markings, seating arrangements, tapes, ropes, and cones);
  - adequate space for vaccine storage and preparation (e.g. clean and hygienic environment, adequate ventilation and equipment to adhere to specific COVID-19 vaccine cold chain requirements);
  - vaccination stations a least 1 metre apart (ideally with installation of physical barriers between vaccination stations);
  - adequate 'cleanability' of screening areas, vaccination stations, waiting areas (e.g. removal of items that cannot be readily decontaminated and minimizing clutter to aid effective cleaning);
  - appropriate waste management system including safe disposal of waste (such as vials and masks) and sharps at each vaccination station.

Figure 1: Example consumer flow between site areas



5.3.2.3 IPC supplies

- Ensure that there is a continuous and sufficient supply of the following:
    - Medical masks
    - Other personal protective equipment (PPE) including eye protection, long-sleeve fluid resistant gowns and gloves, in case it is required for vaccination team's protection when dealing with a vaccine adverse event, to prevent exposure to non-intact skin to blood and body fluids or if a suspected case of COVID-19 is identified during the screening process.
    - Other supplies include; alcohol-based hand sanitisers, thermo-scans for temperature screening, tissues; waste bins and bin liners, sharp disposal bins, cleaning and disinfection products, visual reminders and signage and physical barriers to aid spatial separation.
- Identify a suitable area for storage of supplies.

5.3.3 Operational phase

- Use a daily checklist to monitor and ensure that the IPC and other safety measures are adhered to.
- Consider a daily 'huddle' to enhance teamwork and to highlight any IPC issues.
- Screen all staff for signs and symptoms of COVID-19 at the start of each shift.
- Screen all people arriving for vaccination for COVID signs and symptoms, especially those people who meet the New Zealand Government 'higher index of suspicion' (HIS) criteria.
- Ensure that the scheduling of vaccination appointments avoids over-crowding and allows for physical distancing and other IPC measures. Also, limit the number of accompanying people to only those who need assistance.

5.3.3.1 Key IPC measures to be implemented

- Hand hygiene
    - Vaccination team members to wash their hands with soap and water and dry thoroughly or use hand sanitiser at the start of the shift.
    - Facilitate hand hygiene by people attending for vaccination

- Vaccinators should perform hand hygiene before putting on and removing PPE, before preparing the vaccine and between each vaccine administration, preferably using alcohol-based hand sanitisers.
- Gloves are not required and, if used, do not replace the need for hand hygiene between each vaccine administration and for other indications. The use of alcohol hand sanitisers on gloves is strongly discouraged.

- PPE
  - Select PPE based on risk assessment as part of Standard Precautions
  - In the context of COVID-19 pandemic, vaccinators should wear a medical mask and the individual should wear a medical or non-medical/cloth mask
  - For pre-vaccination screening and vaccine administration PPE other than a mask is not indicated. Gloves are not indicated.
- Injection safety
  - Sterile, single use syringes and needles should be used.
  - Perform hand hygiene before preparing vaccine for delivery
  - Prevent contamination of the vials by wiping the access diaphragm (septum) with 70% alcohol (isopropyl alcohol or ethanol) on a swab or cotton wool ball before piercing the vial and allow to air dry
  - Adhere to IMAC guidance for the drawing up of vaccine and skin preparation at the site of injection
  - Discard used syringes and needles as a single unit into a sharps container immediately after administering the vaccine

5.3.3.2 Environmental cleaning and disinfection, waste management

- Prepare each injection in a clean, designated area.
- Perform regular environmental cleaning and disinfection of areas and sites where vaccination occurs at least twice daily with special attention to high touch surfaces. Use recommended detergent and disinfectant products.
- Seal and remove sharp containers when filled and stored in a secure area for transportation and final disposal
- Manage sharps waste as per the NZS 4304: 2002: Management of Healthcare Waste.

5.3.3.3 MIQF requirements

If the vaccination site is located within a Managed Isolation and Quarantine Facility (MIQF). In that instance, staff must abide by the IPC guidance set out for workers in MIQF in the MIQF Operations Framework.

5.4 Incident Management & First Aid

The site team should be trained and prepared to respond to three possible medical emergencies associated with COVID-19 vaccination: fainting, hyperventilation and anaphylaxis. The appropriate medication and equipment must be on site to manage these incidents.

Refer to section 2.3 of the Immunisation Handbook for guidance on emergency equipment required to manage post-vaccination medical emergencies.

5.5 Occupational Health Requirements

Ensure you have appropriate occupational health requirements in place for your site team, including an accessible needlestick injury protocol. Staff must understand what to do and who to contact if they experience a needlestick injury.

5.6 Business Continuity

Ensure you have a business continuity plan in place for your sites, e.g. to manage power failures.

Hard-copies of the following forms should be available on site in the event CIR is unavailable:

- Consent form (including all required consumer data fields that will need to be added to CIR)
- COVID-19 Vaccine Adverse Event Report. This is the form used to submit adverse event information to the Centre for Adverse Event Monitoring (CARM). If CIR is unavailable, you may use this form to capture relevant information, noting that on-site adverse events must be reported in CIR as soon as practicable (as distinct from submitting the form to CARM).

See 'Ordering Site Collateral' section below for information on obtaining these forms.

Any hard copy forms must be entered into CIR as soon as practicable. Make sure any printed copies of information are locked away when not in use.

5.7 Protecting Security and Privacy

The vaccination process will require personal, identifying information to be collected. In the health sector, NHIs are considered identifiable information as well as standard identifiers such as name, address and date of birth.

Health information can be sensitive so it's important that it is protected and treated with respect.

- All medical records (e.g. written consent forms) at immunisation sites will need to be securely stored out of the sight of patients (e.g. a drawer) and it is preferable that this drawer is in the constant presence of an authorised person (e.g. administrator, security guard or vaccinator) or alternatively it can be locked.
- At the conclusion of the immunisation event the personal information documentation needs to be taken directly (no transit points) by an authorised person (e.g. administrator, security guard or vaccinator) to the site where the record will be held.

In addition to ensuring the security of health records as per above, you should also consider the following security and privacy factors:

- Tell people why you're collecting their information and what it will be used for (e.g. that it will not be used for immigration or law-enforcement purposes)
- Think about who can see your computer screen if you're looking at personal information
- Keep your password and log-in details confidential
- If you spot something going wrong, let your DHB Privacy Officer or COVIDPrivacy@Health.govt.nz know as soon as possible
- Dispose of unnecessary duplicate information securely
- Be mindful about people overhearing confidential conversations in public places
- Use secure methods when transferring information outside of the core vaccine systems, e.g. when emailing or using USBs or online cloud storage password protect the data

5.8 Vaccine Security

To ensure the security of the vaccine, please ensure the following minimum standards are met:

- The vaccines must be stored in a work area that has the constant presence of an authorised person (e.g. administrator, security guard or vaccinator) during hours of operation.
- If the vaccine is to be stored overnight at the vaccination site, then the building should be in a controlled-access environment (e.g. Maritime Port or Managed Isolation and Quarantine Facility (MIQF)).
- If the building is not in a controlled-access environment (e.g. Community Hall), then the building should be able to be secured and have a monitored alarm.
- In the event the vaccines are stored at a vaccination site that does not have controlled access and is not a building (e.g. a tent) then an overnight onsite security guard should be present.

5.9 Site Physical Security

To ensure the safety of patients and staff all immunisation sites should have a security presence to control access to the site and be available to support in the event of attempted unauthorised access (e.g. public attempting to obtain a vaccination) or protest action.

Vaccinators will not require security to travel to the immunisation sites but secure parking and how vaccinators gain access to the site should be considered (e.g. separate access from the general public).

5.10 Site Security Assessment

All immunisation sites will need to be able to ensure the following:

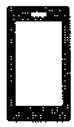
- Staff safety
- Patient safety
- Security of the vaccine (storage facilities, in-transit, at vaccination sites)
- Security of information – particularly paper-based information i.e. spreadsheets
- Confidence that contingency plans exist to deal with a 'disturbance'/potential protest event at a vaccination site.

A documented risk assessment should be conducted for every individual immunisation location. This should include, but is not limited to, the following considerations:

- How will staff travel to the immunisation location?
- Will secure parking be provided for vaccinators and administrators?
- How is access to the site controlled?
- How is the vaccine transported to and from the location?
- How is the vaccine securely stored at the immunisation location?
- How are consumables including needles securely stored at the immunisation location?
- How is hard copy information (if any) securely stored at the immunisation site?
- How will staff act if there is any disruption e.g. protest activity or if persons other than border workers or their household contacts turn up for immunisation?

5.11 IT Equipment

You'll need to cater for the following IT requirements at vaccination sites to ensure staff can access the COVID-19 Immunisation Register (CIR):

Network 	A secure network (Wi-Fi, hard wired, or 4G) with connectivity to the device running CIR and to the user's mobile phone or computer. Wi-Fi specifications: • Coverage ranging to reception, vaccination and waiting areas within the site • Highly available network (e.g. Fibre & 4G backup)
Internet Browser 	**Chrome** is the recommended internet browser; however, other browsers will support CIR. Internet Explorer is **not** supported (use Microsoft Edge if needed). For further information see: https://help.salesforce.com/articleView?id=sf.getstart_browsers_sfx.htm&type=5
Computer / Tablet Device 	Any laptop from the last 5 years should be compatible with CIR so long as it has browser access. For further information see: https://help.salesforce.com/articleView?id=sf.getstart_browser_recommendations.htm&type=5
Mobile Phone 	CIR users require an **iOS or Android** mobile phone to download the Salesforce Authenticator application. This can be downloaded from the App Store on iOS and the Play Store on Android. You can scan the QR code on the right to locate the Salesforce Authenticator app in the relevant App Store.

Prior to starting vaccination, make sure you have tested all IT equipment and that all staff have received the necessary training to use the devices and CIR.

Make sure you advise each site team where they can access additional IT support (i.e. for non-CIR issues such as hardware issues), including after-hours support if your vaccination site is operation outside standard business hours.

5.12 COVID-19 Immunisation Register (CIR)

The COVID-19 Immunisation Register (CIR) is a browser-based system where you'll record all vaccination details. CIR using email address, phone number and 6 identifiers to match consumer records with NHI records.

You will need to request access to CIR for your vaccinators and administrators following the process outlined below. This will also enable MoH to liaise with IMAC to ensure your vaccinators have access to IMAC training modules.

Note: CIR is not currently linked to the GP Practice Management System (PMS) to provide GPs notifications of who has received the COVID-19 vaccine. This linkage is expected to be live in mid-March. In the interim, consumers will need to advise their GP they have received the vaccine if it is relevant to do so.

5.12.1 Requesting Access to Training, CIR Classroom, and CIR

The DHB workforce lead needs to send a list of all staff requiring CIR access to MoH at covid-19vaccine@health.govt.nz. **Note:** MoH is developing a process to share these details via Microsoft Teams.

MoH will then liaise with the Immunisation Advisory Centre (IMAC), who will provide staff with CIR and/or Pfizer vaccine eLearning modules. CIR users will also be advised to attend a drop-in session, where the CIR drop-in team will set them up in CIR Classroom. This will allow the user to log into the classroom version of CIR and practice using the system.

Once staff have completed required training, the DHB workforce lead must confirm to MoH that the staff member is now 'approved' and MoH will then give them access to the live CIR environment.

5.12.2 New User Onboarding Support

For any questions or support on new user onboarding, please contact covid-19vaccine@health.govt.nz with the subject line: Vaccinator List Support.

5.12.3 CIR Support

If the site team requires CIR support, they should contact their support team liaison officer in the first instance. CIR ServiceDesk queries can be raised at 0800 223 987 or help@c-19imms.min.health.nz.

CIR eLearning modules and Quick Step Guides will be made available to all staff (see 'Staff Training and Reference Materials' section below).

5.13 Ordering Site Collateral

MoH has prepared the following collateral to support the vaccination programme. Files will be shared with DHB Comms Managers via an existing All of Government (AoG) Dropbox or via a MoH weblink and these can then be printed and supplied to sites.

MoH is arranging for consumer collateral to be translated into multiple languages. These versions will be made available as soon as possible. Translations will initially be available in the following languages, with additional languages to be added:

- Māori
- Hindi
- Samoan
- Simplified Chinese
- Tongan
- Cook Island Māori
- Fijian
- Tagalog
- Niuean
- Tokelauan

IMAC has prepared a consent video which can be displayed on sites in site reception areas if designed. MoH will provide a link to the final version of the video when it is available.

Purpose	Collateral	How to Order
To share with consumers on site or before attending the vaccination site	COVID-19 Vaccine Information & Consent Pack, which includes: • Getting your COVID-19 Vaccine: What to Expect • Consent form • After your immunisation • Privacy statement	Contact your DHB Comms Manager
	COVID-19 Vaccine FAQs	Available on MoH website
To provide after the consumer has been vaccinated	Vaccine record and appointment card	MoH will arrange distribution of physical cards to sites.
To collect household contact information on site *(only to be used if consumers cannot access the online form or 0800 number)*	Household contacts of Border Workers form	Contact your DHB Comms Manager
For use if CIR is unavailable	Consent form (which includes fields to capture required consumer data)	Contact your DHB Comms Manager
	COVID-19 Vaccine Adverse Event Report	Available on the Centre for Adverse Event Monitoring (CARM) website: https://nzphvc.otago.ac.nz/reporting/
To be displayed on site	Pull-up banners for site (2 designs: 'Vaccinations here' and 'Protecting our people')	MoH will arrange distribution of banners to sites.
	Teardrop flag for outside site	MoH will arrange distribution of flags to sites.
	COVID-19 vaccine posters (A3/A4 size)	Contact your DHB Comms Manager
	Large vaccination site poster (A0 size)	MoH will arrange distribution of these large posters to sites.
For vaccinators on site	Instructions for the Pfizer Vaccine - Preparation and Administration	Will be included in vaccine shipments; this will also be available on the IMAC website: https://www.immune.org.nz/
	Vaccine Error Reporting Form	Contact your DHB Comms Manager

5.14 Site Readiness Checklist

Complete the site readiness checklist included in Appendix B to assess whether the vaccination site is ready to commence vaccinations.

MoH recommends you complete a site trial or dry run before beginning vaccinations on site to ensure staff are familiar with their roles and consumer flow can be tested.

6 Preparing the Vaccination Site Workforce

6.1 On-Site Functions

MoH has identified the following functions for the site team. Note that someone with a clinical role (e.g. a vaccinator) may perform non-clinical functions, particularly in smaller sites.

This table is not intended to be a prescriptive list of all functions on site and expectations for different roles; rather, it outlines what likely functions will be required to aid in your workforce planning.

Non-Clinical Functions	Clinical Functions
• Greeting consumers and answering questions • Confirming consumer identity • Entering consumer information into CIR • Providing COVID-19 factsheets and FAQs • Directing the consumer to the Privacy Statement • Recording the vaccine details in CIR • Advising the consumer when they can depart the recovery room • Providing the vaccination receipt card • Capturing household contact information from Border and MIQF workers where this information has not already been provided • Completing or arranging daily cleaning of the site • Arranging collecting of medical waste • Decommissioning the site when it is no longer needed	• Preparing the vaccination dose • Obtaining consent to receive the vaccination • Asking health questions prior to administering the vaccine • Vaccinating the consumer • Monitoring consumers in recovery room for any adverse events • Attending to adverse events and recording them Staff performing clinical functions must have a valid Practicing Certificate and be appropriately trained to administer the Pfizer vaccine by the Immunisation Advisory Centre (IMAC).

6.2 Workforce Modelling

The size of the vaccination site and volume of vaccinations expected to be delivered on site will determine the size of the workforce required. The following tables outline staffing models for you to consider as you plan your vaccination workforce.

Note that the modelling below is only recommended and you should tailor your resourcing based on your expected site volumes, your service delivery model and your understanding of the needs of the consumers (for example, if the cohort being vaccinated is expected to have low health literacy or low English skills and may need more support throughout the process).

Please refer to Appendix 4 in the *Immunisation Handbook* for further guidance on criteria for authorised vaccinators and minimum staff and equipment requirements for the provision of vaccination services.

	Waiting Room	Immunisation Event	After the Event
Activity	Consumer will be checked in then watch a consent video in the waiting room (~10mins).	Consumer and vaccinator will have clinical conversation about the vaccination and consumer will provide consent. Immunisation occurs. Administrator will enter details into CIR as the vaccinator performs the vaccination	Consumers must remain onsite for 30 mins after the event for monitoring. Monitoring staff will ask consumers for their Household Contact information if this hasn't been provided before they arrived on site.
Staffing	1 x Administrator	1 x Administrator 1 x Vaccinator	1 x Registered/Practice Nurse 1 x support person with bystander CPR/first aid training as per minimum specifications in Appendix 4.2 of the *Immunisation Handbook*.

Based on the activities and staffing numbers above, MoH recommends the following site staffing numbers:

If 20 vaccinations per day	If 120 vaccinations per day	If 360 vaccinations per day
• 2 vaccinators working at the site who will undertake all roles	• 1 Admin in waiting room • 3 Vaccinators and 3 Admin support in Imms event • 1 Vaccinator drawing up the dose in Imms event • 1 Nurse and 1 support person monitoring after	• 1 Admin in waiting room • 9 Vaccinators and 9 Admin support in Imms event • 3 Vaccinators drawing up the dose in Imms event • 2 Nurses and 1 Support person monitoring after

Note: Given this is a new vaccine, DHBs will need to be prepared to adjust site staffing requirements as the reality of administering the Pfizer vaccine will likely vary from these assumptions as delivery progresses.

6.3 Staff Training and Reference Materials

Training will be provided to CIR users and Vaccinators through a combination of eLearning Modules and Quick Step Guides. The Quick Step Guides will be available within the eLearning system, as well as within the Knowledge tab of the CIR for continued availability and reference.

eLearning modules and Quick Step Guides include:

- Working with the COVID Immunisation Register (eLearning)
- COVID-19 Vaccinator Education Course (eLearning)
- CIR Quick Step Guides – Reception, Vaccination, Recovery, Quick Adverse Event, Adverse Event
- Inventory management (eLearning)

In addition to these training materials, staff will have access to a range of reference materials. These include:

- COVID-19 Vaccinator Guidelines: Paper-based (maybe laminated) reference information for vaccinators to use. Includes more detailed advice on health screening responses, informed consent. And vaccine preparation. (TBC if this will be available in Week 1)
- IMAC FAQs: These are available on the IMAC website: https://www.immune.org.nz/covid-19-vaccines

- Immunisation Handbook- COVID chapter: IMAC is preparing a COVID-specific chapter for this existing Ministry resource that will be available soon. https://www.health.govt.nz/publication/immunisation-handbook-2020
- Logistics training materials (TBC)

See 'Ordering Site Collateral' section above for detail on collateral available to be given to consumers.

7 Vaccinating Household Contacts

Household contacts of staff working in border or MIQF are eligible to receive vaccination in Tier 1.

7.1 Definition of a Household Contact

A household contact is defined as someone who usually resides in a household or household-like setting with a border or MIQ worker. Household contacts are eligible regardless of whether they are related or unrelated people and it includes people who may reside part-time in the household. Partners and dependents of eligible workers should be included (for dependents 16 years or older as per MedSafe approvals).

7.2 Collecting Household Contact Information – Direct Contact

7.2.1 Digital channel

In the first instance, MoH will directly contact staff with eligible household contacts using information in the Border Worker Testing Register. Contact will be made with eligible staff to invite them to provide details of their household contacts (this will include an approximate geographic location field to support delivery planning).

7.2.2 Non-digital channel

An 0800 phone line – 0800 2VAXCOVID – will also be available for workers with an eligible household contact to call. This will be operated from 8am to 8pm. Multiple language options will be available. Callers will be verified and asked to provide details for themselves and their household contacts. These details will be passed on to DHBs for scheduling per the following section.

Please provide the 0800 2VAXCOVID in your engagements with Border or MIQF workers so they can proactively supply household contact information.

7.2.3 Scheduling appointments

Responses will be compiled by MoH and subsequently shared with the appropriate DHB via a report. DHBs can then liaise with the household contact to schedule an appointment and complete the vaccination event.

MoH intends to move to a self-service reporting model to enable DHBs to generate the report with household contact details rather than MoH sending it out.

7.3 Collecting Household Contacts Information – At Vaccination

At the time of vaccination, the vaccination team should remind border and MIQ workers to submit the details of their household contacts. The first preference is for consumers to use the digital link to complete the online form. The hard copy form should only be provided as a back-up for completion if the consumer cannot access the online form or is unable to contact 0800 2VAXCOVID.

Where hard copy forms are completed, administration staff must transfer these details into an online form for MoH to collate. This will reduce the privacy risk associated with holding hard copy information and enables sharing of information about household contacts if they are living in different regions. Any hard copy forms must then be destroyed.

7.4 Vaccinating Household Contacts Without Appointment

There may be instances where household contacts accompany workers to their vaccination. If this happens, individuals should be provided with a digital or hardcopy form to complete in order to enable the scheduling of their vaccination. Note that household contacts will need to provide information that provides a link to an eligible worker (i.e. name and phone number) and be loaded into CIR manually.

In some cases, it may be possible to provide a vaccine in a 'walk-in' scenario. This will be at the discretion of the site manager based on their scheduled vaccine supply.

8 Running a Vaccination Site

8.1 Booking and Scheduling

Arrangements for the booking and scheduling of Tier 1 consumers, including household contacts, will take place at the DHB level. This will include booking and scheduling appointments for consumers to receive the second dose of the Pfizer vaccine. This should also include re-scheduling second dose visits if needed and providing a mechanism for people to reconfirm their appointment time (e.g. if they lose their appointment card).

At present, a national booking system is not available. MoH will provide more details about the national booking system as soon as possible. It will not be mandatory for DHBs to utilise this system.

8.1.1 Pre-loading consumers in CIR

Where consumers are in the Border Worker Testing Register (BWTR), MoH will extract that information so consumers can be preloaded in CIR to make the on-site administration process more efficient. However, MoH acknowledges that not all workers will be in BWTR or may not be in BWTR when the data is loaded in CIR. As such, MOH recommends you develop a local process for pre-loading consumers once a booking has been confirmed.

If consumers aren't preloaded before attending a vaccination site, they can be added to CIR on-site as needed.

8.2 Preparation of Doses

The Pfizer vaccine comes as a concentrate and **must be diluted on site** following the instructions provided by the Immunisation Advisory Centre (IMAC). These instructions will be included in vaccine shipments and will also be available on the IMAC website: https://www.immune.org.nz

Please note the Pfizer vaccine is fragile and **must not be shaken** during preparation.

Once the vaccine has been diluted, it **must be administered within 6 hours**. Any prepared doses not used within this time period must be discarded. Prepared doses cannot be transported to other sites.

You **must avoid exposing the vaccine to direct sunlight or UV light at all times** (when both a concentrate and prepared).

8.3 Pre-Vaccination Process

On arrival at the vaccination site, consumers will be greeted, and the site administrator/vaccinator will:

- **Verify identity:** Verify the individual's identity using name, DOB and address and locate their record in CIR. Note: Photo ID is not required to confirm the consumer's identity.
- **Provide collateral:** Provide the consumer with the COVID-19 vaccination information and consent pack, which includes the 'Getting your COVID-19 vaccine: What to expect' factsheet, consent form, privacy statement and 'After your immunisation' factsheet.
    - You may also choose to provide the COVID vaccine FAQs sheet, which is available on the MoH website.
    - You may also display the privacy statement in the reception area as well as supplying the information in hard-copy.
- **Complete a pre-vaccination clinical assessment:** Undertake a pre-vaccination clinical assessment to identify if the consumer has any COVID-19 symptoms or other medical reasons why they should not receive the vaccine. The outcome of this clinical assessment must be recorded in CIR. Please note:
    - People who have symptoms of COVID-19 should be advised to stay at home and get a test. They are able to be vaccinated once they have a negative test result and symptoms are mild only.
    - People who are significantly unwell are advised to wait until they are better before getting the vaccine, however, note that mild symptoms are not a contra-indication. People in this situation are advised to discuss their symptoms with their GP or vaccine provider.
- **Obtain informed consent:** The vaccinator must obtain the consumer's informed consent to receive the vaccine prior to the administering of the vaccine. Use the COVID-19 Vaccination form to obtain the consumer's written consent. **Written consent must be obtained for Tier 1 consumers.** Where appropriate, consent may be given by a proxy such as a guardian or person with power of attorney.
    - **Note:** IPC guidance must be observed around obtaining written consent. This may include, for example, the provision of single-use pens or encouraging consumers to bring along their own pen.
- **Record consent in CIR:** Record the consumer's consent to receive the vaccine in CIR. If the person does not wish to receive the vaccine, record their decline in CIR. See below for instructions on managing the written consent forms.

8.3.1 Uploading written consent forms

Written consent forms signed by Tier 1 consumers must be uploaded into CIR. This may be managed on-site or by a centralised administration team. Given the information on the written form contains personal information, **forms must be held and transported securely at all times** (e.g. in a locked cabinet or drawer or in a tracked courier bag or other secure container if transported between locations).

To upload the forms, the administrator must scan each form to their computer, locate the consumer's CIR record, and then upload the form to the consumer's CIR record. The administrator must then delete the local copy of the form on their computer and securely destroy the written form. If needed, the written form may be kept for a few days or weeks to check for inaccuracies in transcribing before they are destroyed.

Note: Instructions for uploading files to CIR are included in the CIR eLearning module.

8.3.2 Where the consumer is not pre-loaded in CIR

For the Tier 1a cohort (Border and MIQ workers), the Ministry is working to have their details preloaded into the CIR. There may be situations where a health consumer in this cohort arrives for their vaccination and their details are not loaded in CIR. In this situation, the site needs to confirm the consumer is in the eligible cohort and manually load their details into CIR prior to giving the vaccination.

Similarly, household contacts and consumers who are not in the Border Worker Testing Register (BWTR) will need to be manually loaded into CIR. This may be done at the time of booking or on site on the day.

8.3.3 Where the consumer has no NHI number

You will need to confirm that the consumer is in the eligible cohort and manually collect all required vaccination information to ensure the vaccination can take place that day. You can contact the MoH contact centre on 0800 855 066 to request a NHI number for the consumer. The consumer's record will be created in CIR overnight. You must then enter the vaccination data into CIR to ensure we can provide accurate reports of vaccination numbers.

8.4 Vaccination and Observation

Prior to administering the vaccination, the vaccinator must undertake final checks:

- Locate the consumer's record in CIR and confirm their name, address and DOB
- Confirm the consumer has completed their clinical assessment
- Confirm the consumer has received information about the vaccine, including aftercare information.

Once the vaccination is complete the vaccinator must update the consumer's record in CIR to note:

- The vaccine batch and expiry date
- Details of the injection site and the date and time of the vaccination event.

The consumer must remain on site under observation for 30 minutes. The vaccinator or site administrator will provide the consumer with a card recording the date/time of their vaccination and the date when they will be expected to receive the second dose of the Pfizer vaccine.

The time of the consumer's exit from the site must be recorded in CIR.

8.4.1 Adverse Events On Site

If the consumer has an adverse event on-site, appropriate medical attention must be provided. The on-site adverse event must be recorded in CIR to enable reporting on adverse reactions to the vaccine.

For more information on managing medical emergencies and anaphylaxis, please see section 2.3 of the Immunisation Handbook.

8.4.2 Adverse Events Off Site

If the consumer has an adverse event off-site, they will be advised (in the 'After your immunisation' flyer) to contact Healthline and submit an adverse reaction report to the Centre for Adverse Reaction Monitoring (CARM). A dedicated COVID-19 Vaccine Adverse Event Report is available on and can be submitted via the CARM website.

Note: Implementation of a national active monitoring process is being developed but is unlikely to be in place for Tier 1. Future active monitoring will likely consist of a text follow up with consumers a few days after receiving their vaccination asking if they have an adverse event and to report any symptoms to CARM. This will enable ongoing monitoring of adverse events and aid MedSafe's ongoing assessment of the vaccine. We will provide more information on this process is due course.

8.5 Recording Vaccine Errors

If a vaccine error occurs at any stage of the vaccination process (i.e. the vaccine cannot be used), the error must be recorded in using the Vaccine Error Reporting Form. You can record whether the error was the result of a:

- Storage issue
- Temperature issue
- Dose issue
- Dilution issue
- Vaccine issue

Once complete, the form must be submitted to the Centre for Adverse Event Monitoring (CARM). You can scan and email the form to carmnz@otago.ac.nz. Forms must be kept secure until they can be destroyed.

8.6 Administering Leftover Vaccines

To minimise wastage, MoH recommends you plan a back-up or stand-by list of consumers that aligns with the sequencing framework. This may include the Tier 2 cohort, but preferably not the Tier 3 cohort. If you have vaccine left at the end of the day/week (i.e. vaccine that will expire before the next clinic), we encourage you to administer these individuals on your stand-by list.

MoH does not require visibility of your stand-by list; you can manage this list as needed to align with the sequencing framework as best you can.

Individuals on your stand-by list will need to be manually loaded into CIR rather than being pre-loaded by MoH.

Please note that any unused vaccine cannot be returned to HCL for redistribution. It must be either used on site or disposed of following the disposal process below. Any vaccine that has already been drawn into a syringe must also be disposed of and cannot be stored or transported to another site.

8.7 Disposal of Consumables, Vaccine and Vaccine Packaging

eLearning modules will be available on vaccine disposal alongside other inventory management topics outlined below.

8.7.1 Disposal of consumables

Consumables should be disposed of according to existing procedures (e.g. disposal into sharps bin and/or biohazard bags). Follow your local procedures to arrange collection of the sharps bin.

8.7.2 Disposal of damaged, empty and expired vaccine vials

MoH is monitoring the number of all vials discarded. This includes all empty or damaged vials or vials that are full but the vaccine has expired.

Interwaste will provide vaccination sites with containers to in which to dispose empty, broken or damaged vials. When the container is almost full, sites must contact Interwaste on 0800 102 131 to arrange for pick-up (their call centre is available from 8am-5pm). Interwaste will deliver a new disposal container at the same time. Interwaste will destroy the vials in an appropriate manner.

Throughout the day, keep a count of the number of vials to be discarded and report this number at the end of every day to Covid-19.logistics@health.govt.nz.

Make sure you keep the lid of the Interwaste disposal container closer when not in use.

8.7.3 Disposal of vaccines drawn up but not administered & empty vaccine syringes

Vaccine doses that have been drawn up but not administered must be disposed of in the sharps bin provided. Similarly, empty/used vaccine syringes can be disposed of in the sharps bin.

8.7.4 Disposal of vaccine packaging

You must ensure the carton the vaccine is sent in is destroyed so packages cannot be replicated.

Once all vials in a carton have been used, black out all vaccine-related information on the label using a permanent marker. Place the carton in a biohazard bag for disposal in accordance with clinical facility waste management procedures. Cartons must not be disposed of in household waste collection or recycling centres. If you need additional biohazard bags, please advise MoH Logistics for your next consumables order.

8.8 Operational Reporting

Sites must ensure vaccination events are recorded in CIR at the time of administration to enable accurate data for operational reports (such as number of vaccinations completed and other trend data).

Sites will need to report to MoH:

- Number of vaccine vials disposed of (empty, damaged, intact but expired vials) (daily)
- Significant events on sites (e.g. significant adverse reaction, protest etc) (daily)
- Stock on hand (weekly)
- Stock movements (weekly)
- Demand allocation (weekly)

DHBs may wish to collate daily reporting back from sites on inventory and/or operations to aid in supply information back to MoH.

Feedback on the immunisation process or recommendations for operational improvements can be provided to help@c-19imms.min.health.nz.

8.8.1 Reports available to DHBs

COVID-19 vaccine reporting is linked to the NHI database, meaning you can request existing NHI data fields (e.g. ethnicity) to track vaccination rates and meet other reporting needs.

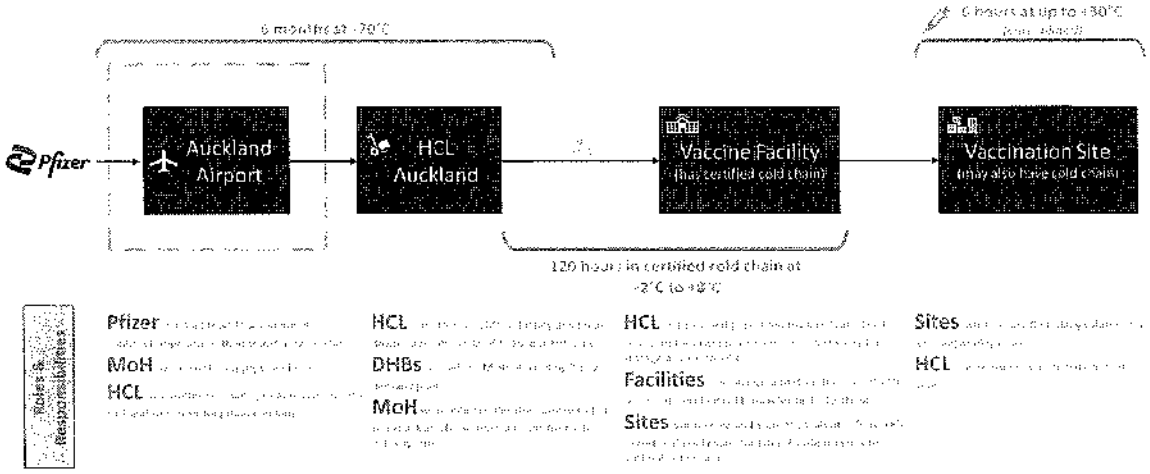
To request vaccine reporting, contact your DHB reporting team, who will then submit your request to the MoH reporting team. Once the report is prepared, it will be available in CIR as both a dashboard and downloadable report that will be updated in real-time. Note that if you need data for multiple DHBs, you must specify this in your request.

9 Inventory Management

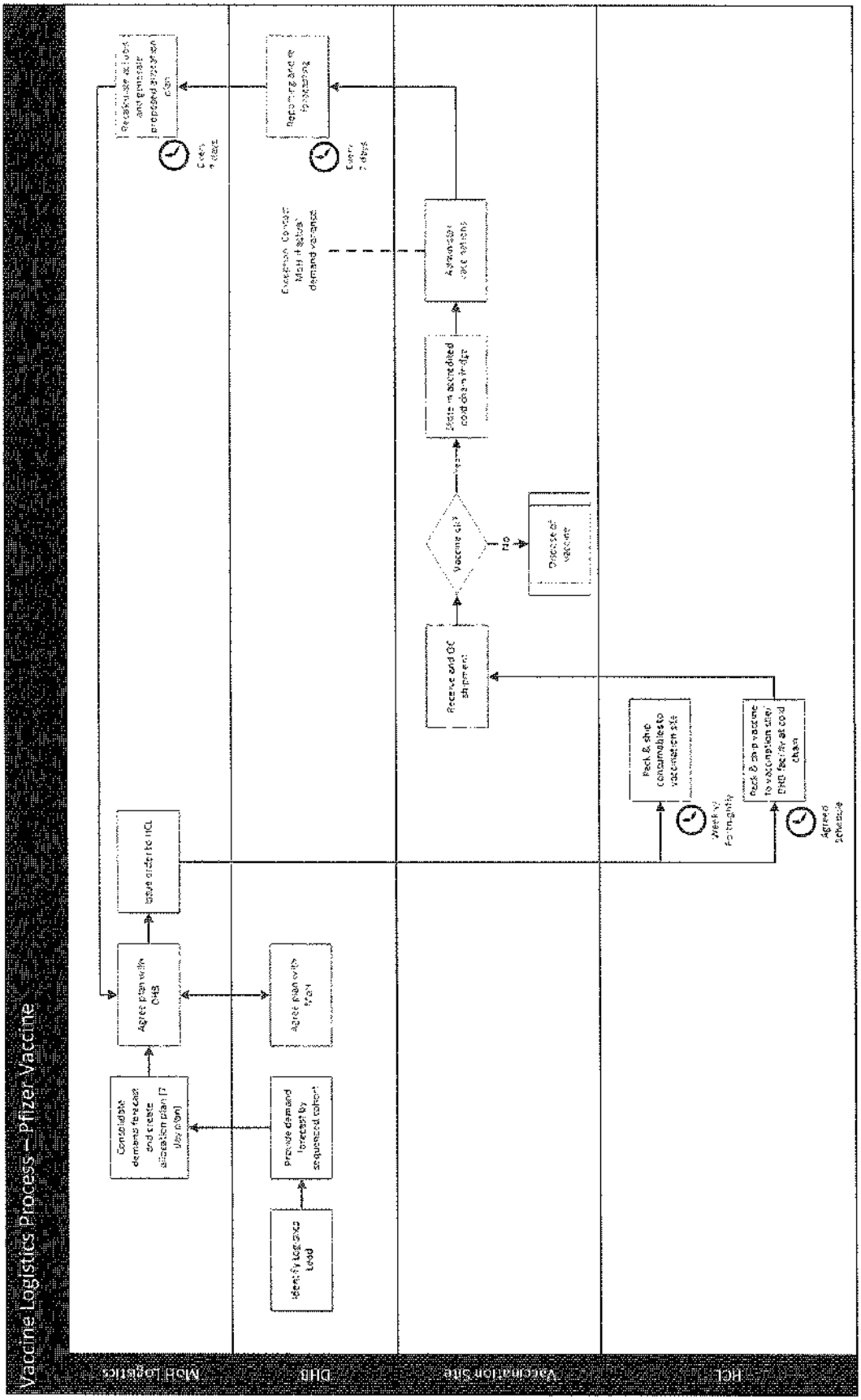
MoH will maintain a demand planning system to enable a centralised Logistics team to support ongoing monitoring of inventory and demand. The image below shows the current process for distributing the vaccine to vaccination sites.

Note that MoH will engage individually with DHBs in Tier 1 with respect to their specific requirements. Guidance in this section relates only to the initial 4-week period from the first receipt of vaccine in New Zealand and distribution to vaccinate Tier 1.

Distribution Map and Timeline



9.1 Vaccine Logistics Process Overview



9.2 Demand Planning and Vaccine Allocation

MoH will work with DHBs to create an agreed demand plan. This plan will provide detail for the upcoming 7-day period with forecast, higher-level detail up to 4 weeks out. A 3 days plan will remain fixed to enable deliveries to be packed and shipped efficiently.

The Logistics team will generate a national allocation plan that will cover both consumables and vaccine allocation. The national allocation plan will be re-planned on Day 6 of the weekly cycle. Vaccines are expected to be delivered to sites or DHB facilities twice a week.

MoH Logistics will liaise directly with DHB Logistic Leads to collect required demand plan and site delivery information.

9.2.1 Managing demand variances

If your actual demand changes by more than 20%, please contact MoH to directly to re-plan your upcoming shipment as needed. You can contact the Logistics team directly at Covid-19.logistics@health.govt.nz or 0800 335 778.

9.3 Provision of Consumables

The Ministry will provide consumables required to administer the Pfizer vaccine. As they do not require the same care in handling during transport and storage as the vaccine, consumables will be shipped separately to the vaccine itself.

Consumables will be shipped in quantities to supply approximately 2 weeks of stock, depending on the capacity to store consumables at DHBs.

MoH will calculate the volume of consumables shipped, including any safety margins, based on the amount of vaccine expected to be consumed. If additional consumables are required, you can order these by contacting Covid-19.logistics@health.govt.nz or 0800 335 778.

To administer 6 doses per vial under an Alert Level 1 setting, the Ministry will provide the following consumables:

Category	Description
Saline	Sodium chloride solution - saline 5ml (same quantity as the number of vaccines)
Disinfectant Wipe	Antiseptic Swab box of 200
Syringe & Needle	21-gauge needle (drawing needle) box of 100
Syringe & Needle	Prep 3ml syringe x 100
Syringe & Needle	Syringe 1ml Tuberculin box of 100
Syringe & Needle	Needle 25g 1in box of 100
Syringe & Needle	Low dead space (LDS) needle 1 box
Swab	Gauze swabs 5cm x 5 cm box 100
Container	Sharps Containers 1.4L
Waste Disposal	Bio Bags box of 50
Plasters	Box of 250

9.3.1 Personal Protective Equipment (PPE)

PPE will not be supplied by MoH. DHBs will continue to order PPE through existing channels.

9.4 Delivery to Sites

9.4.1 Delivery security

MoH will organise secure transportation of the large quantities of vaccine from HCL to the cold chain storage facility (e.g. DHB facility or vaccination site) using a MoH-contracted courier and security firm.

The secure transportation of the vaccines from the cold chain storage facility to the immunisation sites is the responsibility of the relevant DHB.

If you are transporting vaccine from a local facility to the vaccination site, the unique circumstances of these transportations should be considered in the site risk assessment. MoH recommends that if couriers or authorised persons (vaccinators, administrators or security personnel) are conducting the transport there should be direct (no transit points) to the immunisation site.

9.4.2 Delivery schedule

Vaccine will be shipped to DHB facilities or vaccination sites on a schedule agreed with DHBs. This means that a site with higher volumes can receive more regular shipments while lower volume sites or sites only operating on one day a week may choose to receive only one shipments per week.

Each site receiving shipments from MoH will receive a notification containing details of the amount of vaccine and/or consumables due to be delivered the following day. Delivery tracking will be managed centrally by MoH.

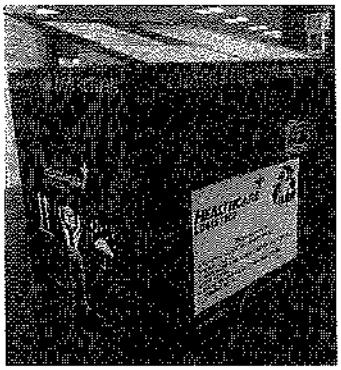


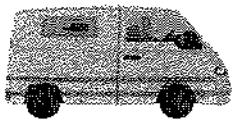
Figure 2: Credo bin

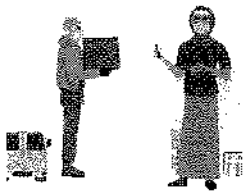
9.4.3 Delivery temperature

Vaccine will be shipped at under cold chain at +2°C to+8°C from HCL in Credo bins.

Vaccines will be labelled with a use-by date once they are removed from ULT -90°C to -60°C and begin thawing. This date will be 5 days/120 hours after removal from ULT. The use-by date/time will be on the vaccine carton.

9.5 Site Delivery and Receipt Process

Step	Action
 **DHB Logistics Lead provides site contact & delivery details**	The DHB Logistics Lead must provide MoH with the site contact and detailed delivery instructions, including address and any special instructions (such as separate entrances etc). The contact must be regularly available on site to accept deliveries to minimise the admin involved in changing the site contact person (Notify urgent site contact changes to MoH Logistics). MoH recommends that individuals handling vaccines are cold chain accredited; however, this is not a requirement.
 **HCL packs and ships vaccine**	HCL will pack and ship the vaccine under cold chain conditions in Credo bins at +2°C to+8°C.

Step	Action
 **Site contact receives the package**	The courier will hand the package to the site contact. Before signing for the package the site contact will: • Confirm the Credo bin is addressed to them/their site • Provide their identification to the courier for the courier's confirmation • Conduct a check of the order immediately while the courier is present (see below)
 **Site contact checks the temperature logger**	The site contact must check the temperature logger included in the Credo bin to confirm whether a temperature excursion has occurred in transit. The temperature logger will have a green light if the temperature has remained within limits or a red light if an excursion has occurred. Where an excursion has occurred the site contact must quarantine the shipment in cold chain conditions while the logger is returned to HCL for reading. The site contact must call the MoH Logistics team on 0800 335 778. The Logistics team will talk the site contact through the actions to be taken, such as urgent orders being placed and what will happen once the temperature data has been read. In this situation, the site contact will **not** sign for the package with the transport provider and it will be returned to HCL.
 **Site contact conducts visual check**	The site contact will open the Credo bin and the internal vaccine packaging and conduct a visual check of the vials in each package to ensure vials are intact. Where over 20% of the vials are broken or spoiled, the site contact must contact the MoH Logistics team on 0800 335 778. The Logistics team will talk the site contact through the actions to be taken (e.g. disposing of the vaccine and sending out an urgent replacement shipment).
 **Site contact signs for vaccine package**	Where over 80% of vials are intact and there are no concerns, the site contact will sign for the package.
 **Site contact stores vaccine in cold chain accredited conditions**	The site contact will then store the vaccine at cold chain conditions in the internal packaging carton it arrived in (not the Credo bin, but the white vaccine box) until the use-by date and time marked on the vaccine box is reached. Any vials that are not viable must be disposed of following the disposal process detailed above.

9.6 Vaccine Storage & Handling

9.6.1 Cold chain storage

Vaccine must be stored and transported in cold chain accredited conditions. MoH recommends that any individuals responsible for handling the vaccine have cold chain accreditation; however, this is not a requirement.

Further information on cold chain management is available in section 2.1 of the Immunisation Handbook. See also the manufacturer's specifications for approved product handling, available at: https://www.medsafe.govt.nz/profs/datasheet/c/comirnatyinj.pdf.

9.6.2 Vaccine quantities and package sizes

Unit	Size
Full tray	290 x 290 x 40 mm
15 vial pack	130 x 130 x 45mm
5 vial pack	130 x 65 x 45mm

9.6.3 Shelf-life of vaccine

Size	-90°C to -60°C	At +2°C to +8°C	At ambient temperature (up to +30°C)
Frozen Tray or Vial	**6 months** from date of manufacture	N/A	**Closed lid trays:** Up to **5 minutes** for transfer between ULT environments. **Open lid trays:** Up to **3 minutes** for transfer between ULT environments. **Note:** Following room temperature exposure, trays must be returned to the ULT -70°C freezer for 2 hours before they can be removed again.
Thawed Tray or Vial (undiluted)	N/A	**120 hours (5 days)** from time of removal from ULT. **Note:** Transportation time at +2°C to +8°C is included in the 5-day limit.	**2 hours**
Prepared Dose	N/A	**6 hours**	**6 hours**

9.7 Repacking Vaccine at DHB Facilities

If vaccine packages are delivered to a DHB facility (as distinct from a vaccination site), that facility **cannot** further break down the package size to redistribute it to vaccination sites in smaller quantities. This is to ensure traceability of the vaccine batches and sub-batches.

9.8 Transportation of Vaccine to Second Location

The DHB facility can transport the vaccine to a second location where the vaccine will be administered provided the vaccine is transported in cold chain and the pack remains whole. In this case, a pharmacist must oversee the process (i.e. it must be completed under a wholesale pharmacy license).

Similarly, DHBs may use vaccinators to go to discrete locations to deliver vaccines. In this case, the vaccine must be able to maintain cold chain conditions as required by the manufacturer's specifications.

9.9 Returning Credo Bins and Temperature Monitoring Equipment

Vaccination sites or DHB facilities must return the Credo bin and temperature monitoring equipment in a timely manner – preferably on the same day as receipt - to ensure there are no interruptions of subsequent vaccine deliveries. Pre-paid stickers will be included with the delivery for returns. Please call the number on the instructions to arrange collection.

You may need to remove/cross out the original courier label and original address details.

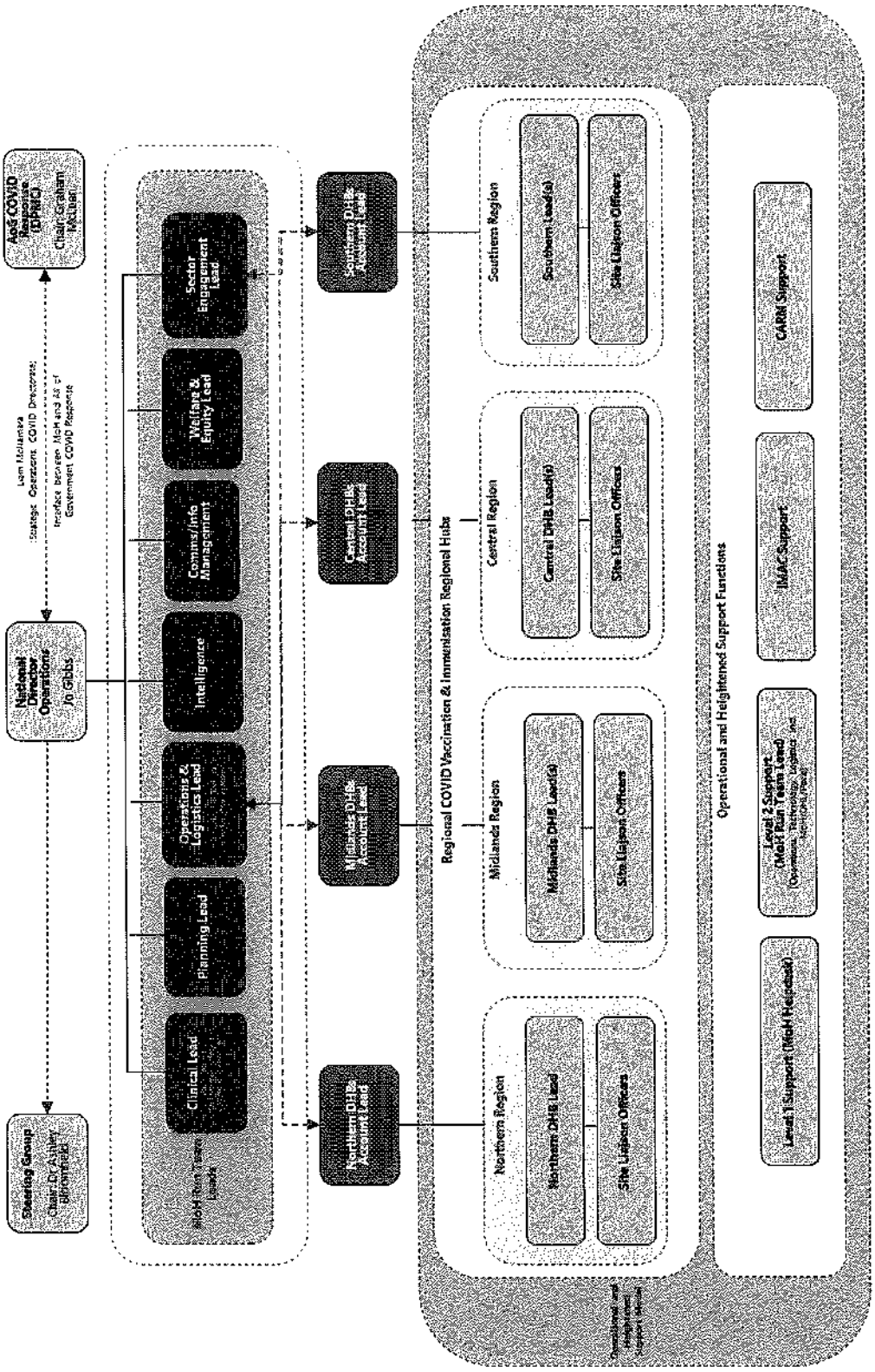
9.10 Inventory Reporting

The MoH Logistics team will continue to monitor demand and allocation using data from CIR and information from liaison with DHBs. DHB Logistics Leads must supply weekly reporting on:

- Stock on hand
- Stock movements

The MoH Logistics team will liaise with Logistics Leads to collect this information through an agreed mechanism.

Appendix A: Support Organisation



Appendix B: Site Checklist

The following list provides an overview of the minimum requirements that you need to consider and have in place to safely and efficiently deliver COVID-19 vaccinations.

As a general principle, the site and staff should be prepared and adhere to standard operating policies and standards, including clinical governance and health and safety, that are expected in a clinical environment to ensure staff and consumer safety.

Physical site	Yes / No	Comments
Adequate space and associated capacity for registration, vaccination (including drawing up and administering) and post vaccination observation area		
Appropriate cold chain provisions that are applicable for the site, including having: • An appropriate individual to receive the vaccine • Appropriate refrigerators and opaque containers to store material		
Equipment that is not provided in the consumable pack, including: • kidney dish • PPE		
Appropriate signage to identify as vaccination site for consumers and associated consumer collateral including: • Getting your COVID-19 Vaccine: What to Expect • After Your Immunisation • Vaccination receipt and second appointment card • Privacy statement • COVID-19 vaccination campaign posters/banners/flags • Hard copy form to collect household contacts		
Facilities and processes in place to safely dispose of unused, damaged or empty vaccine vials		
Appropriate protocols in place to safely manage waste		
Ability to maintain the room temperatures between 19-30°C		
Appropriate security provision to ensure vaccinator and consumer safety that is applicable and appropriate to the site context.		
Completed site risk assessment		
Appropriate emergency medication and equipment and protocol to respond to three possible medical emergencies associated with the vaccination (fainting, hyperventilation and anaphylaxis), as per IMAC guidelines and standard vaccination site protocol		
Information Technology	**Yes / No**	**Comments**
Sufficient tablets, laptops or desktop to access and operate CIR and complete inventory reporting requirements		
High speed wireless or 4G coverage		
Hard copy CIR form and associated secure storage in case of system disruption		
Booking mechanism to support scheduling (A national solution is being developed)		
Screen to display IMAC video (if applicable)		

Workforce	Yes / No	Comments
Staffing levels are appropriate for delivering the scheduled vaccination volume. At a minimum the following functions need to be allocated: • Consumer welcome • Preparation and administration of doses, including obtaining informed consent (these could be separate roles) • Event recording in CIR by a CIR-trained person • After-immunisation observation		
Staff have completed relevant training and accreditations, including cold chain and vaccine accreditation and training, adverse event accreditation and training, and CIR training.		
All staff on site are appropriately briefed on the site protocol including the Operational Guidelines and are clear on their respective roles and responsibilities for the shift		
Vaccination event	**Yes / No**	**Comments**
Procedures for identifying vaccine recipients		
Standardised screening process for contraindications, receipt of previous dose of COVID-19 vaccine or other vaccines, and COVID-19 symptoms		
Ability to monitor, manage and report adverse events following immunisation, including anaphylaxis		
Incident management procedures are in place and staff know how to report any clinical incident		
Other considerations		
If you are working in MIQ or other location that may require additional infection prevention controls, please adhere to the standard SOPs and associated protocols, including physical distancing requirements		
If there is change in Alert Level, please adhere to the relevant PPE SOPs and associated protocol required to operate under the Alert Level, including physical distancing requirements		
If you are operating a drive-in facility, please have an appropriate Traffic Management plan in place		

WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

COVID 19

COMMUNITY LIVED EXPERIENCE REPORT

Reflections from members of the communities of Rangitikei, Ruapehu, Whanganui and South Taranaki

ABSTRACT

There wasn't just one lockdown – we all had our own experience.

This report presents the lived experiences of the COVID-19 Level 4 lockdown for members of the Whanganui, Ruapehu, Rangitikei and South Taranaki regions. It serves to provide insights to members of the Impact Collective and our communities to our sense of wellbeing during our collective experience of lockdown.

Disclaimer:
As a result of the narratives being presented verbatim, some people may find the language and images contained within this report offensive or objectionable. Reader discretion is advised.

Report Author
Steve Carey

ACKNOWLEDGEMENTS

The team would like to thank the following organisations and representatives for taking the time to share your experiences of COVID-19 with the team. We have not listed the individuals who spoke to us 1-1 in this acknowledgement list for the purposes of anonymity.

60s Up Club
AccessAbility
Age Concern
Alzheimer's Whanganui
Aramoho Health Centre
Balance Whanganui
Birthright Whanganui
Brain Injury Association
Born and Raised Pasifika
Bulls Community Group
Bulls Medical Centre
Bulls RSA
Bulls Rural Women's Network
Cancer Society
Community Corrections
Community Education
Community House
Community Law Centre
Community Resilience Whanganui
Department of Internal Affairs
Family Harm Prevention Team
Fire and Emergency New Zealand
Fordell/Mangamahu Rural Women's Network
Geneva
Gonville Health Pharmacy
Hakeke St Library
Hakeke St Community Hub
Healthcare NZ
Healthy Families Whanganui, Rangitīkei and Ruapehu
Hunterville Community Group
Jigsaw Whanganui
Kaumatua Kaunihera
Kotuku Assistance Animals Aotearoa
Living Waters Medical
Love and Learn
Marton and District Budget Services
Marton Combined Churches
Marton Food Pantry
Marton Lions
MediaWorks Whanganui
MedLab Whanganui
Mental Health and Wellbeing Support
Ministry of Social Development
Mokai Patea
National Council of Women
National Hauora Coalition
Ngā Rauru-kitahi
Ngā Wairiki Ngāti Apa
Ngāti Rangi
New Zealand Police
Pathways
Positive Aging Forum
Prisoners Aid
Project Marton
Rangitīkei District Council
Rangitīkei Response Group
Rangitīkei Youth Council
Restorative Cities
Restorative Practices Advisory Group
Ruapehu REAP
Ruapehu Whānau Transformation Team
Ruapehu District Council
Safe and Free Whanganui
Safer Whanganui
Southern Rangitikei Networking Group
Sport Whanganui
Step Up Durie Hill
St John Ambulance
Stone Soup Kitchen
Sustainable Whanganui
Taihape Community Development Trust
Taihape Community Response Group
Taihape Health
Taihape Neighbourhood Support
Taihape older and bolder
TCLT
Te Kotuku Hauora
Te Ora Hau
Te Oranganui

Te Oranganui Rangatahi
Te Ranga Tupua Hub
Te Pae Tata Team
Te Taihāhā disability support services
Te Puke Karanga
Thrive Whanganui
Tupoho
Upokongaro School
Violence Intervention Network
Volunteer Whanganui
Whanganui Accident and Medical
Whanganui and Partners
Whanganui Budget Services
Whanganui Civil Defence
Whanganui Community Learning Centre
Whanganui Community Living Trust
Whanganui District Council Youth Committee
Whanganui District Council
Whanganui District Health Board
Whanganui NZDF
Whanganui Peoples Centre
Whanganui Prison
Whanganui Red Cross
Whanganui Regional Health Network
Whanganui Sleep Clinic
WIN1000
Women's Network
Workbridge
Woven Whānau
Youth Services Trust

A special acknowledgement must be made to the members of the public who provided their pieces of art, stories, videos and statements to the Bubble Korero - Whanganui Community Learning Centre and enabling these to be presented in this document – they are a powerful representation of the personal experiences of the COVID-19 lockdown on the members of Whanganui, Rangitikei, Ruapehu, and South Taranaki.

The Integrated Recovery Team who supported the gathering of the experiences presented in this report were comprised of members from the following organisations:

BACKGROUND

We are facing a global health crisis unlike any in recent history. One that is killing people, spreading human suffering, and upending people's lives and livelihoods. But this is much more than a health crisis. It is a human, economic and social crisis. COVID-19, which has been characterised as a pandemic by the World Health Organization (WHO), is attacking societies at their core. As of the 19th of January 2021, have been 2,262 coronavirus cases in New Zealand, out of which 85 are active. The total number of people who have died due to the virus nationally is 25. Worldwide, there have been 96,006,646 cases and 2,049,253 deaths.

The first confirmed case of COVID-19 in New Zealand (NZ) was reported on 28 February 2020. From this date, NZ joined the global effort to fight the rapidly spreading pandemic. In order to prepare for this unprecedented public health crisis, the NZ government announced a four-level COVID-19 alert system on 21 March 2020. The alert system provides escalating restrictions on human contact, travel, and business operations. This signposts in advance the changes our population of 5 million will be required to comply with at each level. In the early stages of the NZ pandemic response, the aim was to flatten the epidemic curve to avoid overburdening the NZ healthcare system and its available resources. It quickly became apparent, with evidence of community transmission and over 200 confirmed COVID-19 cases, that the NZ epidemic curve was following the same initial exponential acceleration seen in Asia and Europe. In response, NZ acted quickly moving to the highest alert level 4 at 11.59 pm on 25 March 2020 (lockdown). It restricted contact between people to the bare minimum. Interactions were limited to members of the same household and to use of essential service, decreasing the transmission of the virus among the population (McGuinness & Hsee, 2020).

The Integrated Recovery Team formed in the immediate aftermath of the nationwide New Zealand COVID-19 Level 4 lockdown. With representation from the Whanganui District Health Board, Whanganui, Ruapehu and Rangitikei District Councils, Whanganui Civil Defence, New Zealand Police, Ministry of Social Development and Whanganui & Partners, the team sort to understand the lived experience of members of our communities of the coronavirus disease (COVID-19) pandemic by undertaking more than 150 focus groups and 1 on 1 interviews. These stories and experiences tell a story of organisational boundaries being removed, of time for family, of instances of decreased access to necessary services, of joy and hope and of loneliness. This final report is the culmination of the last six months of rohe wide engagement with our communities and will form the beginning narratives of the next-normal.

METHODOLOGY

Following the final day of the nationwide level 4 lockdown, the Integrated Recovery Team set about engaging with as many iwi, community, government and non-government organisations as possible to get an understanding of their experiences of the COVID-19 pandemic and lockdown.

A minimum of two members from the team attended each community focus group and all sessions were recorded and then verbatim transcribed following the sessions. Alongside the focus groups, several 1-1 sessions with members of the community were also undertaken. These sessions were recorded and then verbatim transcribed following the sessions.

During the larger groups, the team utilised a duel moderator focus group methodology. This involved two moderators working together, each performing a different role within the same focus group. The division of roles ensured a smooth progression of the session and that all topics were covered.

Participants

All participants were contacted by either email or telephone to set up an appropriate time to hold the focus group. At the end of each focus group, participants were asked if there was anyone else that they believed we should reach out and contact – these leads were followed up and sessions set up where appropriate and agreed to.

At the beginning of every session, participants were advised that the sessions were being recorded for the purposes of transcription to inform this report on the communities lived experience of COVID-19. If anyone identified that they were uncomfortable with this, notes were instead taken, and the recorder turned off. However, throughout the extensive engagement, no members of the community requested the session not be recorded. As a result, the quotes contained within this document are unedited, however, we have ensured these have remained anonymous. Some of the images provided by the Whanganui Community Learning Centre were unable to be anonymised.

Throughout this engagement, we captured over 66 hours of focus group recordings which were transcribed into 612 pages of transcribed data. This transcribed data was then synthesized by way of thematic analysis to understand the detail amongst the diverse korero.


you are AWESOME Helping people. I really hope you...
don't got really SICK! ! !

LIVED EXPERIENCE REPORTS

SUMMARY

He aha te mea nui o te ao
What is the most important thing in the world?
He tangata, he tangata, he tangata
It is the people, it is the people, it is the people
Māori proverb

The biggest insight of the experience of COVID-19 Lockdown was that it is all about the people, the people, the people. When asked about the positive experiences– it was the connection with people. When asked about what we could do better – it was about the connections with the people that we need to improve. When asked about things that we cannot lose – it was about the newfound sense of connection and working together, as individuals, as whānau, as communities – as people.

The aspects that members of the community enjoyed the most were:

- *The slowing down of life – a time to reconnect*
- *Nature and the environment returning to equilibrium*
- *Support for one another – a sense of 'being kind'.*

The aspects of most concern during lockdown for members of our communities were:

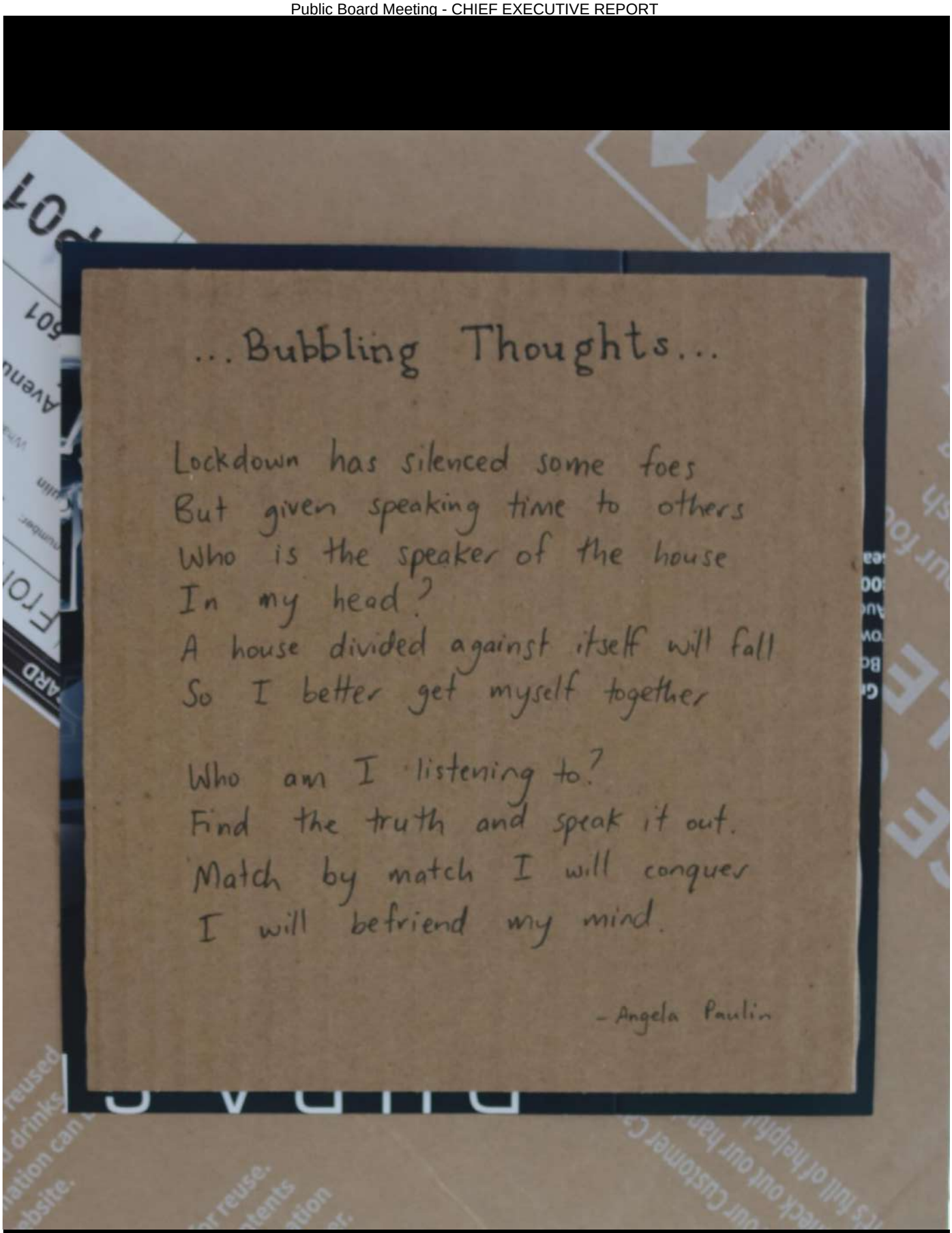
- *Mental Health and Addiction Services – availability and access*
- *Housing – Social Housing and Homelessness*
- *Organisations returning to how they operated in a pre-Covid environment.*

The aspects that were the most challenging for members of our communities were:

- *Loss of physical connection with friends and whānau*
- *Becoming workers, zoomsters, childminders and teachers all at once*
- *New ways of working – the same but different.*

The aspects that members of our communities want to keep the most in the future were:

- *Interconnection between agencies and the breaking down of barriers*
- *The sense of community kindness and connection*
- *Rapid support for the vulnerable and those in need in our community.*



...Bubbling Thoughts...

Lockdown has silenced some foes
But given speaking time to others
Who is the speaker of the house
In my head?
A house divided against itself will fall
So I better get myself together

Who am I listening to?
Find the truth and speak it out.
Match by match I will conquer
I will befriend my mind.

- Angela Paulin

LIVED EXPERIENCE REPORTS

Experience of COVID-19 Lockdown

Approximately nine months ago, the country was placed into full lockdown in response to the COVID-19 pandemic that was sweeping across the world. At 11.59pm on March 25, the country moved into alert level 4, introducing some of the strictest public health measures seen anywhere in the world.

Looking back at that one month when the country was at level 4, the curbs to personal freedom were unprecedented. Through this period:

- Everyone was staying in bubbles
- There was no inter-regional travel, no public gatherings and all public venues were closed
- Only essential services and businesses stayed open
- All educational facilities were closed for in person education.

However, it became clear that there wasn't just one lockdown – we all had our own experience. Throughout our engagement, each individual reflection on the lockdown varied and although there were a number of themes that began to emerge with no two stories of the experience being the same – even from members within the same bubble. Some people were forced into a month of unbroken solitude, others trapped for weeks on end with estranged partners. However, some saw it as a positive experience – a welcome opportunity to slow down, go for walks and relax with the family, or enjoy quality time with their children.

Whichever way the lockdown played out, there has been one near universal aspect to the past months – it abruptly disrupted our daily routines and living arrangements in ways that would not normally occur.

It was important for the Integrated Recovery Team to get an understanding of the personal impacts of lockdown on the individuals and whānau within our rohe. At each focus group and 1 on 1 session, the team asked the following questions:

- What was your experience of the COVID-19 level 4 lockdown?
- Have there been any unexpected positives as a result of the COVID-19 pandemic?
- Have there been any negatives/challenges as a result of the COVID-19 pandemic?
- Are there any changes that were made during COVID-19 that we should keep?
- Are there any changes that were made during COVID-19 that we should not keep?

Additional questions were asked around what contributes to the health and wellbeing of the community, which will form part of the narratives in the Community Equity and Wellbeing reports. These are being developed as part of the mahi by the Manu Taki – Impact Collective.

We heard stories of people saying it was fantastic and I had a holiday, to I didn't have enough money or I was really isolated or none of our street obeyed the rules and they were all just drinking and partying all the way through it and we were really frightened. We thought, 'Wow, there's such a diverse experience, the experiences that are happening out there.'

Through thematic analysis of the transcription data, 12 key themes emerged across the positive and negative experiences of COVID-19 and the Level 4 Lockdown in the wider Whanganui rohe. The following sections provide verbatim narratives from our communities which reflect upon their experiences and provide key insights into which we can draw critical learnings from to inform future community co-design opportunities.

The Slowing down of life – a time to reconnect

Prior to lockdown, our lives were characterised by speed. Hurrying around, carrying on with life at pace was the standard. Staying aware of work duties and our expanding social commitments was an endless accomplishment. Just an advantaged minority could stand to back off. Yet, in lockdown, the speed of life eased back significantly for the time being for everybody. Individuals in a real

sense quit hurrying to work and in life in general. The workplace, recreation centres, bars, clubs and eateries were shut. Worldwide travel shut down. Remaining at home turned into the new normal. Individuals started playing games, planting, zooming, taking walks and other simple pursuits with their recently discovered time (Eckhardt & Husemann, 2020).

Living in lockdown has given us an opportunity to reflect on ourselves, our connections and what's critical to us. For a few of us, that meant contacting old friends or whānau, or mending old relationships with individuals we once thought we'd never address again. Between more opportunity to think, dread around what's happening on the planet and the longing for significant association, the pandemic has moved a few people's points of view.

> *It was my sister's sixtieth birthday during that time. She lives in England. My nephew who stayed with us for a few months, so he's very close, he organised a Zoom meeting for her birthday and then we continued on that call by doing quizzes from England, Rotterdam and here. It was really fabulous. It was great being able to reconnect with them and have fun.*
>
> *I think too our pace of life got too busy. COVID slowed it down. COVID slowed it all down. That was a good thing. That was a good thing for everybody. I for one don't want to go back to that fast pace of life again.*
>
> *Our general feeling from touching base with a few was actually they really enjoyed just that whole being safe, being locked down, being okay to do what they needed to do; but, actually, just doing stuff together as a family, it was a joy.*
>
> *What else happened out of lockdown? More time talking with family; not just the family that are here, but all connecting.*
>
> *I was going to come to, because we do get quite a few calls from people, sometimes family/whānau and sometimes from others where the relationships were deteriorating and people actually had to get out of that bubble because it was becoming dangerous.*
>
> *On What's App we set up a family thing. We've got three kids and grandkids and every Sunday afternoon we all got on it and all the kids said what they'd been doing. We had never done that before and everyone was really looking forward to it. Everyone brought a cup of tea or cup of coffee and everyone sat down for an hour. That was a really positive and we'd do that again. Real connection instead of just the odd phone call to each other.*
>
> *I mean, with the COVID lockdown, like especially in level four, maybe one of the contributing factors to less criminal activity and the reduction in family violence, it could well be that, and in some sense, we were so secure in our lockdown. There was a lot of relief given for financial issues whether it was loans, mortgage, rent, and that security around the rent freeze as well. Possibly people actually had an opportunity to just dial*

back and appreciate time with family, rather than have all those money issues, and all the other bits and pieces…

Well, I led an ANZAC parade, straight opposite Kowhai Park, on that area, and what I was happy to see was the walks that people were allowed, was father and children. I mean, we see people walking up and down, and we know the kids go and play in Kowhai Park; but it was the walking and the family connection, in my opinion, in that; well, you know, if you're on your own and with husband, you might not want that! But families, and we see a lot of people taking the dog, but it was really, really interesting; and fathers and mothers on bikes, and the little kids on the pavements on bikes. You could feel that interconnection with families which normally back at work you don't see it, even at the weekend, because obviously families are busy at home at the weekend. So to me I just thought, 'well then it's good'. That was one thing I saw.

Yes, it is, generally speaking, it seems as though societies that reset, and they've gone back to discover family things, and they're actually the most important things, and the day to day grind of life generally has blinded them too.

On a personal level, I just noticed friends and family taking more time to prepare unprocessed meals, to actually eat better.

We live right by the cemetery, as you know like, when there was a tangi family couldn't attend it; but because the cemetery was in my neighbourhood, and through that Facebook thing; there was a lady that was posting about how stressed her friend was, she lost her mum and she couldn't attend the tangi or anything like that. I says, "Oh, I live right next door; its in my walking area. I can go in and video it for her," and tag you into it so that she can see it. So I'm sitting there like this weirdo at the cemetery, and me and Dempsey & Forrest; they were looking at me and I went, "I'm just here to video it for somebody on Facebook. I don't know who she is but that's her mum, and she can't be here." They said, "[whispers] let her be here." She goes, "Yeah." So that was nice for the rest of the family, I just carried on videoing and I thought, okay, take some flowers from the garden and do that. And then somebody else says, "Oh, can you go in and say hello to another family?" "Sure, no problem." I was running over and just put it on the headstone and I said, "Look, if you want to talk to her, talk to her; I'm just gonna put my phone down here and have a bit of a wander."

It was different and there were some positives, you know, the family connects and the connects with your neighbours seem to be more intensified because I suppose everybody's home.

I think you got a lot more quality family time, and a lot more of… People realised what was the most important thing I think, which was actually family or if not family, just having someone close, being able to talk to someone on the phone. Thank God we had the technology that we had.

So a lot of people around here really liked the work/life balance that happened in lockdown; the ability to spend more time with family; exercise was a huge one. You know you go to work, you rush around in the morning, and you get your kids to school and you go to work and then you come home and it's just about dark already, particularly at this time of year. It's like there's no opportunity to go for a walk or go for a bike ride or have quality time, so a lot of people moving forward are quite interested in making their hours a bit more flexible; maybe do a few hours in the weekend so they can finish a day early and go to their kids sport, or whatever, and I think that's huge. It's something that in this sort of sector, people are hardworking, and people put a lot of pressure on themselves to be perfect and work hard and whatever, and it sort of seems like you're letting the side down or it's a no, no if you try to do those things, whereas I think that it's changing, the attitude's changing and it's a bit more acceptable.

I was concerned it would start that and it would be hard for my husband and I to be there in the same… I wasn't worried about the kids but him and I, it actually brought us closer together as a family and as a couple personally.

It's been more family orientated as opposed to work orientated and it's not money orientated either. People have had to make do with limited means, but it's made them… even in the community, when we were going for walks the amount of food that people were putting out, fruit stalls and everything and just help yourself.

I like the fact that the world actually stopped for a while. After that fear of the unknown and that scary, scary oh my God, once it settled down a bit, it was really good to reprioritise and think what is the most important thing? It's like your family, your friends, people; looking after each other and just having that contact.

There was no one in my bubble, I talked with the neighbour once over the fence. I felt alone.

Shit.

I got to come back to Whanganui and spend time with my family. I was away from a very stressful job and it gave me a chance to reconnect, reflect and put some well needed plans in place. I also took the time to research some of our family recipes and learned how to bake a bread recipe from my great Grandmother.

I was so lonely.

My Mum died, I don't want to talk about it.

Great family time, we enjoyed it, love to happen every year.

I loved it, no visitors, time to rest, read books.

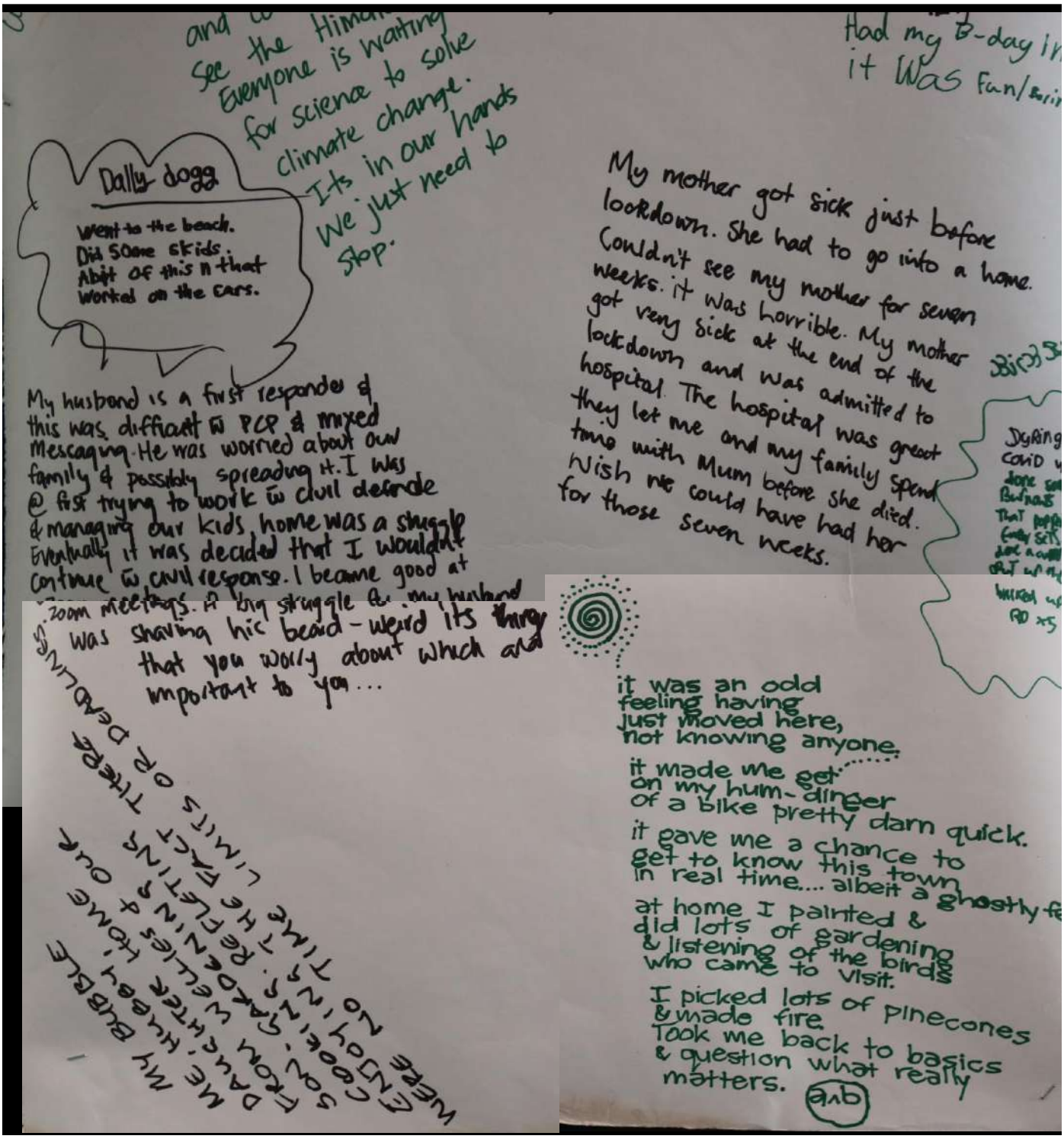
I feel guilty saying it was lovely.

It was special, I was able to pause and take time out.

I was a bit lonely.

We had bake offs with the neighbours.

It was amazing. Gave me time to actually take a break and reset. Realised I had been filling my life with so much "stuff". Was good to stop, spend time with my family and reflect on what was important.



Loved my Bubble by myself but I got bigger & bigger Rowi

My Bubble had the Best mother
Livi + mum/sark

I'm still Bubbling
Jacqui

The first few days were great - fun - relaxing but after that - not so much. I was in a bubble alone. I couldn't visit my friends but we drank beer over skype

Baking Bread
Growing a vege garden
Hardly ever going to town
Saving money

Maybe Longtime Sunshine Upon You
While Love Surrounds You
The Pure Light Within You
Guide Your way on. ♡

I loved this expression of creativity - Wonderful ♡
Marlene

I loved the friendliness of strangers out walking. It was nice seeing lots of bubble-groups out walking together. It was strange walking on the road to dodge other people's bubble.

Bubble was great!

The Global Great Reset

Nobody Knows
the bubble I've seen...
Justin Pappadom

Geez loise, I was scared but having fun. how does that work?!

Turn the news off!!

COVID-19 endless news confused lost feeling Sad Safe Bored Weird

Dads in the police and worked most of the time and Mum works at the hospital. It's Scary. I thought Mum might get COVID-19

Scared frightened nervous Helpless

...nako though ...s in a time-out!!

Nature and the environment returning to equilibrium

The worldwide spread of COVID-19 in a quite short time has brought a dramatic decrease in industrial activities, road traffic and tourism. Limited human association with nature during this pandemic has showed up as a gift for nature and the climate. Reports from around the world are showing that during the outbreak of COVID-19, natural conditions including air quality (figure 1), water quality in waterways are improving and untamed life is developing once again (Lokhandwala & Gautam, 2020). However, there are likewise negative consequences occuring, for example, the decrease in recycling and the large increase in waste, further exposing the pollution of actual spaces (water and land), and air (Zambrano-Monserrate, Ruano & Sanchez-Alcalde, 2020).

Figure 1: Comparison of air quality in worldwide major cities before the COVID-19 pandemic and during lockdowns

The sound of the bird life was amazing. Finally quiet enough to hear it in it's full chorus.

It was so calm and quiet. When I went for a walk I realized I could actually hear the sound of the sea from the end of my road in Whanganui East – I had never heard that before.

But we found that we were more sustainable in terms of whānau; empowering whānau to be able to move onto gardening and look at fishing and things like that; looking at recycling. It is just basic things like that and where does the waste go? It was around education. It was around sustainability. It was around environmental and all of that.

Most of them were environmental; like less rubbish and less cars on the road, and that made a healthy impact on the environment. And then all of a sudden COVID disappeared and everyone was just constantly on the road, going places, and then it just went down

again. I feel like something should happen with that, like just try and get more cars off the road.
Community gardens I think. We're running a few gardening courses and we've had a lot of interest in that. I think many people realised how important it was. People are talking a lot about sustainability and self-reliance and I think anything around that would be a really positive thing. There's a lot of fear about the environment. I think people had a lot of time to think.

That's a big one. I was really questioning our spot, what humans have done in the environment, and I think anything like that, all that sustainability stuff, gardening, cooking, things that don't cost money is really important, and things that you can do with your family, that you can do with your children. All those mums that are moving here with their children and their partners, but because that's an incredibly vulnerable spot to be in and if we can reach those families through their children, through their schools, it's really good.

Yeah, there's less rubbish. It was quite pleasant for a while there; the beach wasn't being torn up by four wheel drives and it was nice and didn't have loads of rubbish all over it and it was all pretty kind of quiet. If you're a local person it's quite pleasant to walk along the beach and things like that. Footsteps and paw prints. Nothing but footsteps and paw prints. That's right. It was quite pleasant. It was quite noticeable when the change came; it was quite a noticeable difference.

Being a society that now has technological capability; how can we work with nature and learn the lessons with nature rather than against it.

All going out on their bikes, all walking around, all being outside, less cars. It was beautiful weather as well, which helped.

The sense of community kindness and connection; support for one another – a sense of 'being kind'

He aroha whakatō, he aroha puta mai.
If kindness is sown, then kindness you shall receive.

Wilson (2020) outlines that recognising a pandemic creates multiple stressors for people, a further feature of the government's response has been a focus on *enabling kindness*. Jacinda Ardern specifically asked that all New Zealanders 'be kind' and offer support to one another when announcing the move to Level 4 (Arden, 2020). The government's key COVID website has resources reflecting an interest in kindness and in the lead up to Easter the Prime Minister confirmed that both the Tooth Fairy and the Easter Bunny were essential workers, thus demonstrating kindness to children and parents (Easter Bunny 'essential worker, says PM', 2020). When advised that some commercial landlords were increasing rents while under Alert Level 4, something the government was unable to prohibit, she condemned such actions as 'utterly unfathomable' and asked that landlords 'just be a good human being' (Molyneux & Lynch, 2020). The fantastic thing about kindness is that it benefits the *receiver*, and the *giver*. Being kind to others increases our own feelings of wellbeing – it makes us feel good about ourselves and improves our outlook on life. Kind and compassionate people tend to have more positive connections with their peers, higher academic achievement and a greater sense of happiness (Skinner, 2020).

> *I think it did make people stop and be kind and be considerate. I thought that was a real positive. I thought a lot more people actually stepped up and connected with their neighbours.*
>
> *Connected with… I mean, we ended up volunteering at the Foodbank and oh my God, the generosity of the community was amazing. It was huge. So yeah, that was really, really good. I think people did stop and take time to smell the roses, which was good.*
>
> *It was great just to see people's faces and just have that chat, talk about stuff and… One thing that I kept on pushing the whole time is that we've got to be kind.*
>
> *And one thing I reiterated was, "We actually need to be kind, because we don't understand the bubble that they are in."*
>
> *They'll have their own views on how they got through COVID and if there was kindness given to them.*
>
> *So it's that message, I think, for the community that, "Continue to be kind, because what you did was a beautiful thing. You don't have to stop just because the country's not in crisis anymore." That is the angle that I'm trying to give to people now and they go, "Oh I bet you it will all go away." "Well that's your responsibility."*
>
> *How amazing were we? But if we can keep it moving, keep putting it out there, I don't know, have a kindness day, I don't know. You see on people's windows, "Be kind," now.*

Like I never see that in Castlecliff, but to drive past and they've spray-painted it… That stuff. Wow.

Some of the locals that were down there were a bit more courteous than they had been in the past. I think everybody was just a little bit… That 'Be Kind' message did get across to a lot of people; even the more bolshy types that do live around here did button back a little bit

It was a mixture of concern for others and a relief to have some of the family home with me. We had two essential workers in the family so I was aware of the polar opposites of some sitting at home with not much to do while others were working long hours under the constant threat of the unknown.

I was acutely aware of the members of my extended family that were unwell or elderly and more vulnerable. It was a small sacrifice to make for them and the wider community.

Caring for your people, and that was one of our key messages, you know, check on your family and friends. Check on your neighbours. That's the best thing that you can do in this time. See those are the kind of message I think they should be all the time

That was the interesting thing; coming from the Prime Minister, who was having those 1pm briefings, with old Ashleigh stand aside, and she always ended hers with "be kind". And that was something, and especially in our community in Taihape; we took that really to heart, because that connection with the community; that connection we have with each other, and with our neighbours, was very very important.

And that's another thing that's come out of it, that I hope to see continue, the kindness and the acceptability for a range of people and abilities and all that kind of stuff. It was noticeable during lockdown, how kind people were, and I'd really like to see that keep… and be supportive and looking after neighbours and all that kind of stuff.

I think that all comes into the kindness thing, like people have to be kind, people haven't had to consider other people, and like suddenly they are, and I think that's huge as well.

There was a kindness during COVID which has stayed to some extent, but not to the full extent.

But people stop walking in the street. Even that man today. We were standing in the street like a bunch of wallies and he came out and he could see that we were there, and he just said, "Hey, you guys lost? What you after?" Would he have done that before COVID? Maybe. I'd like to think he would. He was a nice man. But everyone was saying hi to everyone even if they were crossing the street to be apart from everyone.

I think, from a community perspective some of the stuff that comes through the lockdown and things around being kind. I was gonna say, more understanding and people more kind I think; 'cause it was such a tough time, all over New Zealand. I mean, I just think people came out of it just more kind and understanding for each other.

The campaign's been there but it hasn't really continued, even if it was a Whanganui-centric kind of version of it, about being kind. And also, a couple of things on Facebook when they pop up every now and then; like, around being kind and you don't know what people are going through or what's behind closed doors. They were really strong things and its there, but its possibly could be ramped up a little bit more, or something like that perhaps.

Just amazing, you know. And that was way more than what we would normally see. Along with that was just the camaraderie, I guess. You know like people saying hello. Everyone said good morning. People were conscious of the social distancing but at the same time looked like a community that I don't think that I'd ever felt before. So, I think that was the biggest thing for me, if we could keep that. And already there's been a reduction in the likes of this. It's not helping that we're going into winter. But you know like as we transitioned down through the Levels it got less kind of thing.

It's real kindness. Yeah. People were nice to each other, much nicer to each other.

The aspects that were the most challenging for members of our communities were:

Loss of physical connection with friends and whānau

In response to the coronavirus pandemic, public health officials were asking us to do something that does not come naturally to our very social species: Stay away from each other. Such social distancing—avoiding large gatherings and close contact with others—is crucial for slowing the spread of the virus and preventing our health care system from getting overwhelmed.

But touch is "really fundamental" for humans, says Prof Robin Dunbar, evolutionary psychologist at the University of Oxford - and going without it weakens our close relationships. "The sort of more intimate touching - arm round the shoulder, a pat on the arm and these kind of things reserved for closer friendships and family members - are really important," he says. They make us feel happier, satisfied and trusting of others. Touch is our first sense to develop in the womb, and research has shown physical contact with others can reduce the effect of stress" (Gillett, 2020).

> *The Covid-19 pandemic has reshaped our personal relationships in unprecedented ways, forcing us to live closer together with some people and further apart from others. Life in lockdown has necessitated close, constant contact with our families and partners, but social distancing measures have isolated us from our friends and wider communities.*
>
> *My Mum was travelling to Palmerston daily to have radiotherapy treatment. We were being vigilant not to do anything that could compromise her health. We connected through video chats and once or twice my daughter and I arrived at her property to do a "flash mob" ABBA routine in her driveway as she watched through the window.*
>
> *I help quite a lot of elderly people, and I think the lockdown and families not being able to visit was hard for some people, and even people in the community too, and loss of all those fun things, like I go along and play table tennis, because there's quite some elderly people I discovered enjoy table tennis; and so, I've been losing all these activities that are really significant in those people's lives, and suddenly they couldn't do them was really upsetting.*
>
> *And physical contact is quite important. That's what people missed. That's what they all missed during lockdown was that physical contact - just a touch on the arm or just that simple thing. This is why I think drop-in centres would be really, really handy to have.*
>
> *I think that's really interesting isn't it, because during lockdown when we're thinking about the connects; like, I'm just thinking in my personal circles about people that I'm connecting with and then thinking about the parents that we had established some relationship.*

Becoming workers, zoomsters, childminders and teachers all at once; New ways of working – the same but different.

There is certainly one trait that became apparent during lockdown, the ability to multi-task and multi-skill. Non-essential workers went from working in office environments to working at home, we became proficient in the utilisation of video web-based technology (such as zoom), and for many, we became teachers and or childminders fulltime. However, despite NZEI president Liam Rutherford stating that 'parents shouldn't beat themselves up about it. Nobody is expecting them to be teachers ... instead, they should see it has an opportunity to make the most of the time and is important not to expect that learning from home would look the same as a standard school day' (Williams & Franks, 2020), and Jacinda Arden urging parents to not feel teaching pressures (Devlin, 2020), some parents felt the full weight of having their children at home full time learning – no more so than parents with children with special needs (Edwards, 2020 & Franks, 2020). These pressures were not only felt by parents, but also teachers and pupils who both reported working/studying for longer hours in order to undertake distance learning than normal school based sessions.

> *Schoolwork and working, you got like six hours of homework every day from five classes and then you'd be called into work and just don't have time to do that plus when you weren't sure when you're going back to school so you'd have to try and come up with the working with given what you couldn't do, and um, I think it really negatively affected my schoolwork because I'm so used to a set routine that I do every day and taking away that retain was really tough for me. And I felt as if I was actually given more schoolwork to do. It was a lot on all of us mentally being in the lockdown. So suddenly, then being piled up with lots of internals and things to do when you're not actually even given the chance to really go through it with teachers and get that help that you need. Yeah, that was definitely a struggle for me.*
>
> *My 5 year old grandson thought he was in a big time out.*
>
> *I hated it, the kids wanted out and I had to keep them in.*
>
> *I found it fucken scary, I got everyone in my office set up to work from home and it was full on. Once they had left and gone home, I realised that no one even thought about me, I went back to the office alone and bawled my eyes out. I hadn't even had time to get groceries for my family.*
>
> *Help us be creative aye? We were doing things that we never thought we could do. I don't even know how to be a teacher, but I tried during the lockdown and the kids were like, "I want to go back to the real teacher. This teacher is too crummy." So all those things that you learned as you stuck out with the kids.*
>
> *Most of them were relatively okay. It's like, we just hit our groove and we decided let's just flag the home schooling and just kind of go with the flow. And, yep, you have your chaotic days but that's okay.*

I guess the positive that came out of the COVID if you can call it anything positive about it was that the families that I knew and even my extended family; they had to work together. The kids benefitted from it because in most cases both parents were home. Both parents had to do things to occupy the kids that are normally out running all over the place and have a number of things to do at school; had to bring it home and do it there. They were quite innovative about things to the extent that when the COVID eased off and the return to school come about; a lot of the kids didn't want to go back to school because they had so much; well school entertainment during the day and taught them but doing it at home with the families; with their parents and the uncles and the aunties and stuff was hugely beneficial for them.

Pandemic stress, the pressures of working from home, school closures, social isolation…have caused a rise in abusive behaviours in families.

The road was empty it was like out of the movie apocalypse.

Because we work in the tertiary sector we weren't classed as essential workers – yet we often work with vulnerable people. The expectation from Govt was that we would work form home, but once we were locked out of our building we had no way to connect to our database and very few of our learners had the technology or capability to connect with us on-line. As a team we were concerned with how our families would cope. We knew that many were feeling stressed and would be completely isolated during lockdown. Sadly we did not have the means to alleviate that stress for them, stay connected or refer them to other organisations that may have been able to help.

And like people don't want to totally go online and they still like face-to-face and that, but it's nice to have options, and now we're set up so we do have options. For example, in the school holidays just been, normally I wouldn't be able to take time off because I can't not work. My job is such that I've got things that I have to do, and I was able to work from home. So I got a holiday, I got to be home with my son, I didn't have to shunt him off to school, I did the things that I had to do from home, so I'm now set up to work from home, and it was amazing. It was so much better, life was good, you know.

I actually struggle to get back into the zone, whereas that didn't happen at home and I absolutely agree. And I did, because my son was at home and working doing school from home, and so not motivated, I did basically hand-feed him through it. I did a lot of my work in the evenings and that suits me because I'm a night owl, and I'm super productive at night-times when I'm not interrupted and I loved the flexibility to be able to do that as well.

I guess with school and stuff back it would be a bit different now if we were to work. But I guess working from home was the dream. The reality isn't so.

Some employers are looking at things differently, they're allowing staff to work from home; they've got staff with mobility issues, that can be a really good thing.

I think I could concentrate a bit better at home, like I didn't have to work for two hours straight; I could work for an hour, have a 30 minute break, have some lunch, walk around the house, and then go back to work for another half an hour. I could do maths for an hour, or I could go out and cook something, as a hospitality assessment.

All the families were baking and everyone said to me, "Why are they running out?" And I said, "Think about it. They've all got their children home. What does a parent normally do if they've nothing to do, is they bake."

I like being at home because I can write my questions down, and my questions were down there, and I felt less of a barrier. You go into the doctor's surgery and you get all nervous and all up tight. You really want this, and you don't know if he's going to give it to you. But I had my cup of tea in my hand and my bits of paper down there, I'm going be relaxed with it because I work on computers all the time. That's probably why. Got nice big screen. He came up nice and big. I do think it depends on the technology and the experience of the person.

Our parenting groups – four of them wanted to continue as a Zoom group and they really appreciated… I think one of the things they appreciated was, when you're stuck at home with your kids, and actually to have sort of adult to adult conversations.

Personally, yes, I enjoyed working from home in the sense that you could work and we were so lucky with the weather, so we could get out and get some sunshine and exercise at the same time which now that you're back at work full-time, that's a negative. It's the lack of the exercise now.

The other thing about working from home I noticed… Well, I spent a lot more time with my partner. She actually said that she appreciated having me, even though she put me in the garage so I didn't distract her life. Because we went for a walk every lunchtime; we went for a for a good hour and a half's walk each day. It was pretty quiet around town and all that. Actually, the weather was quite good during it

Some said they were working far more efficiently from home.

Yeah. I think because we're all set up in the cloud and all got laptops and that too, I think working from home works. It's worked for a lot of people. It worked for me. I think working from home if you can do it is… yeah. Because I think you get a much better work/life balance when you're working from home and I think you structure your day better when you're working from home. I do. That's a big positive.

And my man-child husband. I was concerned it would start that and it would be hard for my husband and I to be there in the same… I wasn't worried about the kids but him and I, it actually brought us closer together as a family and as a couple personally. Even though it's difficult at times working from home, I think it's made a lot of people look at work situations differently.

I know a lot of people enjoyed working from home and they wanted it to carry on, whereas then there were other ones that didn't enjoy working from home and couldn't wait to get back.

I was surprised at the amount of work I did from home, even not having access to our computers because I thought that it was going to be cosy and it wasn't as cosy as I thought it was going to be. From a normal day, what was my productivity? I'd have to say it was probably only 50%. But personally I found that really difficult.

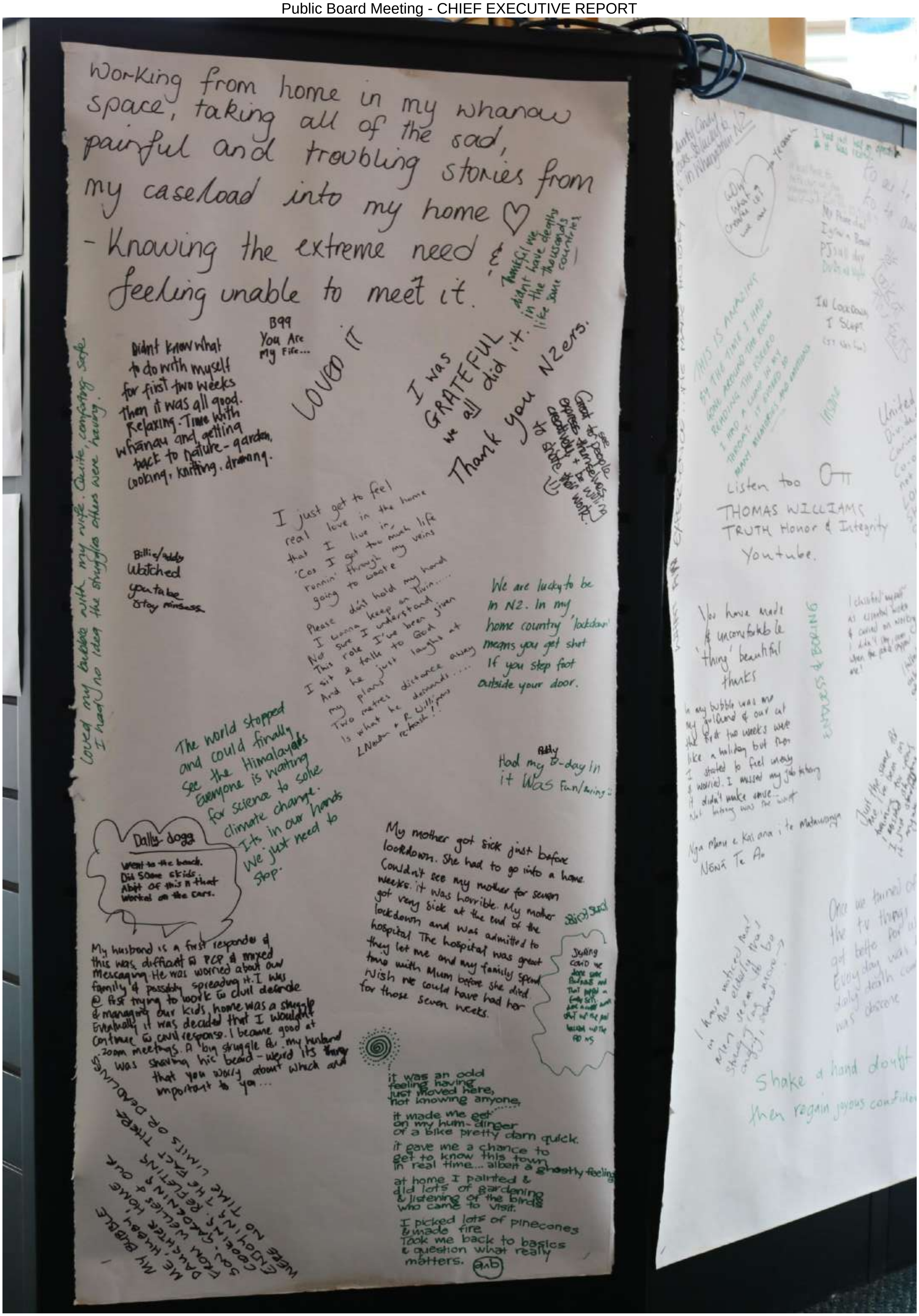
Yes, it was really nice working from home and to have good productivity when I was doing things.

You imagine being overseas in a country that there's no leadership, the virus is rampant, you're locked up in home with nobody to help you, nobody cares, no services, no resources, it must be petrifying. As hard as it was on some people, like we didn't have that.

I didn't enjoy working from home. Not because... in the beginning I thought perhaps I wasn't going to be disciplined enough and I've just gotta look for work. But I didn't do that. I think I worked harder. I think I worked harder over lockdown than I have in my whole entire life. Because I just, you know, like you would sit at your computer and then I'd just forget. I'd start at, I don't know, eight o'clock and I had to physically move myself from my kitchen table and move, and actually set myself up an office

Whilst it was great, one of the girls here, she's got a little baby who's two, one is two and another one who's turned four. She found it really, really difficult. Then she got the guilt because she wasn't spending time with her kids and things like that

Even the schooling was as big an issue I don't think as some had felt that it might be; but that would be the tip over was that they had to home school.


Working from home in my whanau space, taking all of the sad, painful and troubling stories from my caseload into my home
- Knowing the extreme need & feeling unable to meet it.
Didnt know what to do with myself for first two weeks Then it was all good. Relaxing - Time with whanau and getting back to nature - garden, cooking, knitting, drawing.
You Are my Fire...
LOVED IT
I was GRATEFUL we all did it.
Thank you NZers.
Billie/addy Watched youtube
We are lucky to be in NZ. In my home country 'lockdown' means you get shot if you step foot outside your door.
The world stopped and could finally see the Himalayas
Everyone is waiting for science to solve climate change. Its in our hands We just need to stop.
Dally-dogg
Went to the beach. Did some skids. Abit of this n that Worked on the cars.
Had my B-day in it Was Fun
My mother got sick just before lockdown. She had to go into a home. Couldn't see my mother for seven weeks. it was horrible. My mother got very sick at the end of the lockdown and was admitted to hospital. The hospital was great they let me and my family spend time with Mum before she died. Wish we could have had her for those seven weeks.
it was an odd feeling having just moved here, not knowing anyone,
it made me get on my hum-dinger of a bike pretty darn quick.
it gave me a chance to get to know this town in real time... albeit a ghostly feeling
at home I painted & did lots of gardening & listening of the birds who came to visit.
I picked lots of pinecones & made fire
Took me back to basics & question what really matters.
Listen too
THOMAS WILLIAMS
TRUTH Honor & Integrity
Youtube.
Shake a hand doubt
then regain joyous confiden

The aspects that members of our communities want to keep the most in the future were:

Interconnection between agencies and the breaking down of barriers

COVID-19 created a burning platform for change that required local organisations to think and act like a system, in ways we could have never before imagined. Things that were previously thought impossible were achieved in a matter of days or weeks, as people and organisations pulled together united in a new collective purpose, adopting radical new practice, and organising in new ways. One of the largest pieces of feedback that we received was that crown agencies, iwi and local government organisations cannot go back to operating in the manner that they were pre-COVID - because it was "never good enough for majority of our people" (Houpapa, 2020). The key theme that came out of the organisational and community engagement surveys was 'Together is Better' (Carey, 2020; and Carey, 2020b). As we collectively move forward it is important that we challenge traditional silos and work for the community. 'Community' in this sense is understood as a verb, not a noun; in other words, it is the state that is the consequence of our efforts, not a static thing at which we point or towards which we design services without our communities. If we do not directly invest in our community—its economy, ecology, and cultures— we may one day find there is no longer a community at all (Russell, 2020).

> *I've got four boxes of kai on my doorstep, you know? So, we actually had to talk about how we were distributing. You know? Who's on your database? Having those hard discussions and I think to be honest once we kind of let the egos go and that protection of I work for this, I work for that, actually I am you, you are me. We've got to help each other.*
>
> *And I think like you say, because of the COVID business, organisations here have talked to each other more. You saw a different side of people on Zoom meetings, because you see them at home, so it makes people more approachable.*
>
> *I was talking to my friends at Manchester House this morning and they were saying during the lockdown they gave 300 families food parcels at a value of about $100 each and that was a total of 30,000 and the Government gave them money like that. End of story. You need it you've got it. The Mayor organised for all of the swimming pool staff and the library staff to get in Council vehicles and deliver all the food parcels and there was a lot of collaboration here.*
>
> *It's got a whole lot better, but there still is very much the silo approach. There has been more collaboration that's happened over the years which is not rocket science. If you all work together, we will find that the sharing of resources, you're going to get more outcomes. But because we are still not doing that well enough, pre-COVID I was wondering how this was all sort of going to pan out. There's political stuff as well, there's iwi stuff, there's all the things, the things, the things that go on in this community. However, from my experience, I felt that actually when that happened*

there was… And I guess it does happen when there's a crisis – and only when there's a crisis – collaboration starts to happen. Why they can't keep that consistent, I don't know. So from what I saw between iwi, health and social service agencies, that collaboration was happening and it was happening really well.

The collaboration and the community, I think, was really, really good and really, really positive and it wasn't competitive because everybody united as one because everyone had a common cause, but we still had a common cause way before COVID came along, and post-COVID, so why can't we keep doing that stuff? During COVID Everybody did it together. It was amazing.

Absolutely but I mean that's just me just saying if we are going to move forward; collaboration and/or the most appropriate person doing the mahi; not the ones that are the ones left standing.

There was no such thing as a weekend, and the level of collaboration and cooperation to get a collective goal was just incredible. We don't do that on any other issue, and we've got some major, major entrenched social issues that we should be dealing with, but because they're not in our face, and they're not going to kill us tomorrow; we carry on and do like we used to do it, and it's the politics' step in. And the thing about this has to be about tino rangatiratanga in everybody… including my own iwi.

Two things for me have really stuck; the power of collaboration and the power of communication.

There's all these things which we already know about but I mean the power of the collaboration was that although numbers didn't increase in terms of family harm and that; it brought about change in terms of creating new relationships.

And there's a lot of collaborations that have come out of it like Volunteer and Age Concern is setting up together with the banks to help people that want to, especially elderly people get set upon online banking. And like that's amazing, like how cool's that, stuff like that to come out of it.

Communication, collaboration. It's really good working with other organisations; it's good when you have got that… You know other organisations, you know, other people you have that chat, you network.

I've seen amazing things happen when agencies work collaboratively. It's that really, because everybody's giving. No one agency is expected to go and fund the whole thing. If everybody sees that someone is putting in this and someone's putting in that then they don't feel like they're having to take responsibility. It's all come out that it's not fair that we have to do it and you don't have to do it. I've seen some amazing stuff like that. It's collaboration, and it works. Even in its most simple form.

Yeah, and if we do have a social governance model, and we do seriously have iwi at the table, and that's a big if we get them, and if they're willing to come and start, then that's an opportunity I think towards creating inclusiveness in terms of the whole city, but often iwi are focused on iwi, and that's okay, so long as they are taking care of everyone; and so, so long as everyone is connected somehow, but I don't think they are. That was the other thing I kept thinking after COVID; I was thinking we want to maintain this level of connectivity if you like, or collaboration.

So from what I saw between iwi, health and social service agencies, that collaboration was happening and it was happening really well.

Maybe a potential positive; the glass is half full. Is, from a major funder, a government agency; that they are starting to talk a little bit more, more flexible. I use the word flexible instead of being so structured. Yet to play out, but certainly, the right noises are coming our way.

That's one thing that's come out of that. Working together within the community was absolutely brilliant. It was amazing, and you just rung someone and something happened. That was really cool. We got stronger alliances and networks within other community agencies, and how we all just bandied together was just amazing. Well, I reckon anyway. The positives were that people were reassured.

I'm a big advocate for all the agencies working together so we're all on the same page, we're all on the same page. Doesn't matter what agency we are, we are all to be working for the same reason, is the health of our people, the health and mental.

When they set goals, and I think that's a different elective of that community approach; is all they wanted was a job, a house, and to be healthy, to look presentable so that they could get a job and have a family and a house. I guess, going forward, one of the things that came out of the work with them is; there was always something done to them, or a service or an agency working with them; but generally just doing things to them. They had an issue, they got moved to another service, another service; and often they just got moved on because it didn't meet the criteria - very strict criteria. I think if there were more places with more open criteria; I understand there needs to be criteria but it seems to be there's pockets of the community missing out all the time, and we're not taking a strengths-based approach; we're taking a needs-based approach.

How can we work together better? And there's a whole lot of stuff you guys do way better than we do because that's not our core business but it's your core business; and we're used to delivering food because actually when it comes to a flood we do that; we've been doing that for a while. So that's the stuff that we've got some systems that are quite good at that so, actually collectively can we do that better together? So we need to think about that.

"I'm sick of things being done to me." We ask them quite frequently, "What is it that brings you through our door? What is it that you get from coming into this space?" Time and time again we hear, "You guys actually listen, you actually give us a voice, we actually feel valued here and you don't try to fit us into a box." We had one woman that drew this fantastic picture of her family squashed into this box and trying to get out and she said, "This is what other agencies do to us." She said, "We go into WINZ and they say, "Yes we can help if you meet this criteria, this criteria, this criteria."" She said, "Nine times out of ten I don't." She said, "Whereas you guys just said, "How can we make that work?"

Rapid support for the vulnerable and those in need in our community.

"There comes a point where we need to stop just pulling people out of the river. We need to go upstream and find out why they're falling in." - Bishop Desmond Tutu

The New Zealand Government has announced a range of measures to support people and the economy with a $12.1 billion support package in response to the Coronavirus health crisis. From wage subsidies, to welfare packages, to kai packs and the homing of the homeless (Bay of Plenty Times, 2020; Graham-Mclay, 2020; and Small & Lynch, 2020). Engagement around how, as a community, we were able to break down 'bureaucratic barriers' and get people fed and homed were common – "It's those bureaucratic agencies; healthcare and education are not dissimilar, and council".

> *So it's very organic, I know it's not an answer, but if they were supported by the things they needed - an 0800 line or a reiteration of the COVID line, Kai Access, I don't know. Then if that kicked in you might have got neighbourhoods who were able to... and that we knew then that they were okay, rather than one house at a time.*
>
> *They care for the community. There are lots of little groups doing their work and yes most of us came together but there are still lots of groups doing their own work supporting their own individual communities and that's a really positive thing. We'd love them to be part of the wider network. I think that's what we're saying.*
>
> *So they had to access the supermarket; they still have to have their stuff. I'm part of neighbourhood support and we found people who had just had fireplaces installed but hadn't had them signed off, so they weren't allowed to use them, and there was a solo mum with two preschool kids living in this fridge, but the saving grace for that was when I rang all the plumbers and found all the houses that we had these fires; I was able to get hold of the Rangitikei District Council CE, and bang, he had it organised and had a building inspector come up in the first week of lockdown of level four and sign these off.*
>
> *Me personally, Taihape as a community really rose to the occasion. They were good – brilliant. We've got a great community here, great support system. Everyone was on board, there was no negativity at all, it was all positive.*
>
> *I think on a whole everyone worked well together, and everyone; well, as many people that needed support got in and find other people that asked us, were able to suggest a way that they can be assisted the same as the welfare centre would have done as well. I don't believe there was anyone that asked for food didn't get any food, or the help that they needed at that particular time, but there was also a big number of*

people who didn't ask for help either, that we actually didn't know about, because there's an assumption that we know all the older people.

And most of our member organisations were really impressed with how their clients managed the situation and were offering support on the phone and Zoom meetings and that sort of thing. I know Balance did a lot of Zoom support kind of meetings.

But they had a right to need support. So, we able to key them into support and that's having that wider network of us all working together. We were trying to only have a limited, you know, we were getting money given to us, how do we make that work?

She was referring a lot of our Samoan people, specifically from Marton and some around here in Whanganui. So, I was able to connect and ring the 0800 number so that they can get that support. It was great to actually see them utilise what we were trying to achieve here, to support our communities.

Because I think what we've highlighted through this process is that families are really vulnerable and the need to have easy access services, or ways that they can connect and feel supported in a way that's not threatening, is really, really important.

I think the way that Winz has restructured some of the ways that they do things; we need to keep that there. Because there are some parts of that that it's much easier now to access. That would be one thing I'd noticed. There seemed to be a dropping of the silos, which she's mentioned, and answers seem to be available quite quickly, which in the ordinary pre-Covid would have taken a very long time. You know, seem to be available almost instantly.

But that will only continue if we continue to have these conversations and continue to believe in a better tomorrow basically; and include the right people; have the right people. It's been done. It's been proven over the last you know. As some of the conversations we've had like just talking to your team. You've got a whānau here so sharing that. It didn't have to go by way of a big; there wasn't a lot of processes to go through; a lot of hoops to jump through in order to support this whānau. It was a conversation between two people or three people. We want those resources. At the end of the day the whānau were in a better space than they were that morning when they woke up basically. I think if we can use that as a starting point in terms of sustaining what's already happened and what's already taken place; then I think we're going to go a long way in terms of rebuilding or continuing to build on what we've started.

So obviously the current government's focus had a lot on mental health and resources for mental health, and I think that's huge in keeping people's wellbeing moving forward. There's a lot of resources around at the moment to help people with wellbeing, and to support people that need help there.

I think that's what I noticed was that people were able to access the help they actually need all the time. So, that extra pastoral support, that extra access to food. That extra access to money, that actually kind of helped them get across that threshold that is actually probably what they need all the time to be well. Was suddenly available. And it was like, oh, so we can do this.

So we transitioned our food delivery service through to them and I know Te Ranga Tupua have transitioned to them for food as well and so they'll get some extra support to provide additional support into the community from a food parcel perspective.

Also WINZ; I think WINZ impacted on the hub a lot, because the people that were ringing the beneficiaries, they talked about how the entitlements went out but it was very hard to make contact with WINZ. I know that one of our frontline said that one of her whānau had tried calling for hours to try and get a food entitlement. We did support that area, but she knew that because she was able to get those entitlements, tried ringing her on the phone and it was just chaos.

The bit that we saw that took really big hits were families where one income was lost, but they've got those fixed outgoings. That's where we've seen really big, big stress. It's been an interesting kind of, it's not been your average recipient of support. And they've found it quite hard to be recipients of support.

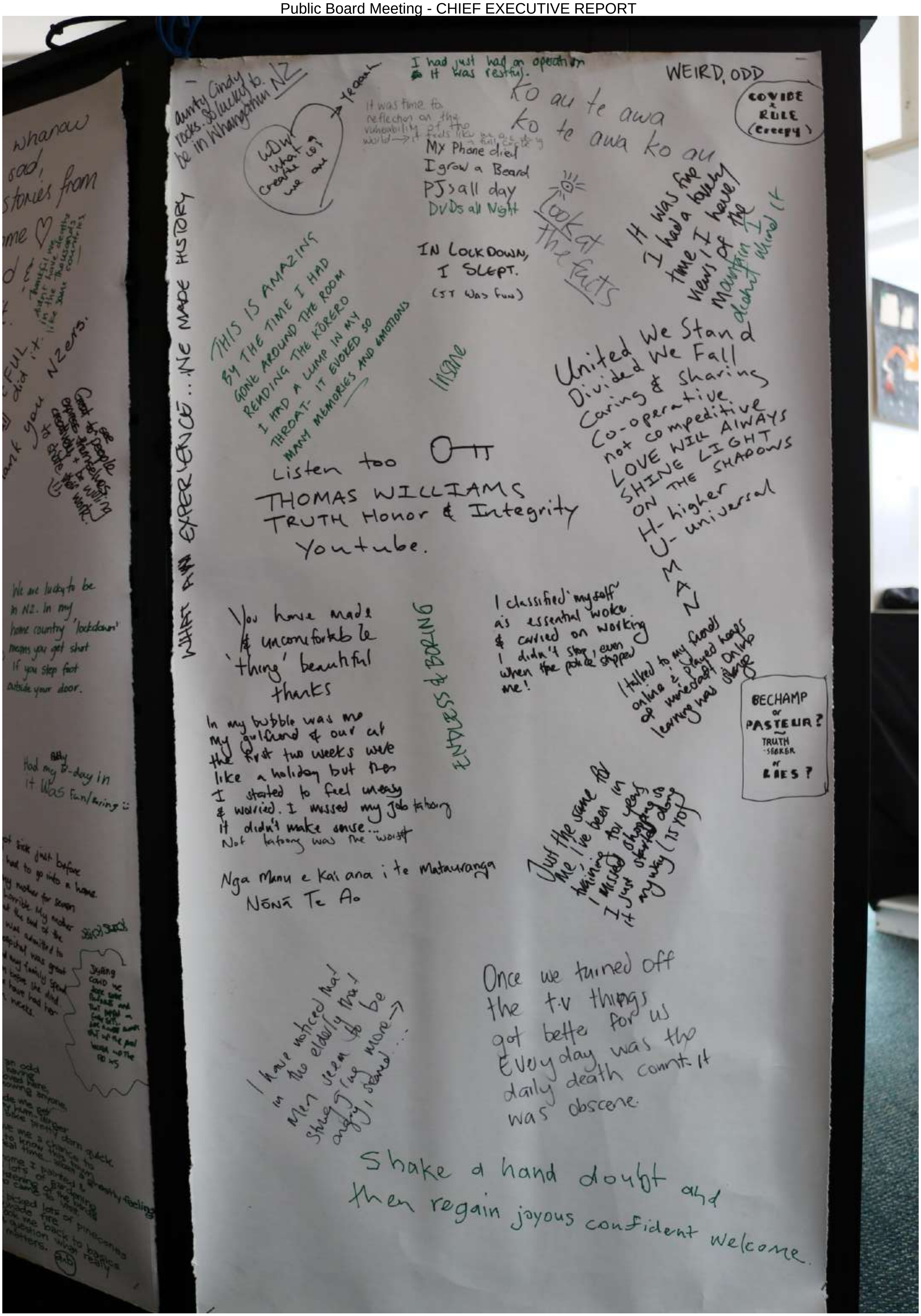
So failsafe support. I know you said outside COVID, but like was offered in COVID, like you're never going to get to rock bottom, we've got these systems in place.

They've got the help and support they need and medications

I mean, I suppose it's the same old issues isn't it; housing, mental health support is a big things that I notice.

I guess too, making sure that people are aware of the supports that are around; whether that be counselling, and again, the campaigns around that and what that looks like. So for the people who are struggling, they know its out there; and how to access it and make it easy, accessible.

That's huge because when I look around and see how much services there are in this area; I've said this before. There should be no one sick. There should be no one uneducated. There should be no one homeless when you look at the amount of money and resources that are poured in. If we could show over the COVID period how collaborative approach works best and go back to what was working and then look at that going forward; I'm sure we're going to get a whole lot of better outcomes. That may mean challenging some of these services that are funded to provide a service to engage with our family. A lot of people may feel uncomfortable about that conversation but I think it's a conversation that needs to be had.


WHAT AN EXPERIENCE... WE MADE HISTORY
aunty Cindy rocks. So lucky to be in Whanganui NZ
WOW what we created lol
I had just had an operation & it was restful.
It was time for reflection on the vulnerability of the world
My Phone died
I grow a Beard
PJs all day
DVDs all Night
WEIRD, ODD
COVIDE RULE (Creepy)
Ko au te awa
Ko te awa ko au
Look at the facts
It was fine I had a lovely time I have views of the Mountain I didn't mind it
IN LOCKDOWN, I SLEPT. (IT Was fun)
THIS IS AMAZING BY THE TIME I HAD GONE AROUND THE ROOM READING THE KORERO I HAD A LUMP IN MY THROAT - IT EVOKED SO MANY MEMORIES AND EMOTIONS
Insane
United We Stand
Divided We Fall
Caring & Sharing
Co-operative
not competitive
LOVE WILL ALWAYS SHINE LIGHT ON THE SHADOWS
H- higher
U- universal
M
A
N
Listen too
THOMAS WILLIAMS
TRUTH Honor & Integrity
Youtube.
You have made uncomfortable 'thing' beautiful thanks
ENDLESS & BORING
I classified myself as essential woke & carried on working I didn't stop, even when the police stopped me!
I talked to my friends online & played online & worried about learning was strange
BECHAMP or PASTEUR? TRUTH-SEEKER or LIES?
In my bubble was me my girlfriend & our cat the first two weeks were like a holiday but then I started to feel uneasy & worried. I missed my job tattooing it didn't make sense... Not tattooing was the worst
Just the same for me, I've been in training for years so I missed shopping & I just started doing it my way (15 YO)
Nga Manu e Kai ana i te Matauranga
Nōnā Te Ao
Once we turned off the t.v things got better for us
Every day was the daily death count. It was obscene.
I have noticed that in the elderly that men seem to be struggling more and angry, scared...
Shake a hand doubt and then regain joyous confident welcome.
whanau
sad,
stories from
We are lucky to be in NZ. In my home country 'lockdown' means you get shot if you step foot outside your door.
Had my Bday B-day in it Was Fun/boring

INSIGHTS

Throughout the community engagement, common experiences, stories and korero came to the fore that were of concern to many members of our communities. Through the thematic analysis, these were grouped into three core themes:

- *Mental Health and Addiction Services – availability and access*
- *Housing – Rentals and Home Ownership, Social Housing and Homelessness*
- *Organisations returning to how they operated in a pre-Covid environment.*

Other areas of concern were mentioned around education and the environment, however the narratives around these where specific and therefore have not been included to maintain the anonymity of the individuals and communities.

Whilst the narratives presented in this report are standalone to the narratives produced in the Integrated Recovery Team's previous reports, the themes are consistent with those found previously (Alexander, Almond & Carey, 2020; Carey, 2020a; and Carey, 2020b) in the immediate aftermath of the Level 4 lockdown.

In the following pages, narratives are presented to provide context to the concerns for our communities. These themes will be collated and presented with the 'stats' of each particular area in the Community Equity and Wellbeing reports.

Mental Health and Addiction Services – availability and access

Mental Health and Addiction Services were described throughout the engagement as dysfunctional. Unfortunately, to members of our community, their experience is one of not being able to get the help and support they need in a timely manner, of not having community connectors to support people through the system, of there being problems with access to services, and one of the system increasing health inequities.

> *A lot of mental health goes hand in hand with like social security. With energy poverty and healthy homes and social security; all these need resilient structures directly related to mental health. Then on top of it if you are in a cold damp home; you're probably miserable. You'll struggle about your power bill; you're miserable. If your children; if you're taking your children to hospital you're stressed out as well.*
>
> *Lake Alice which was the mental health institution. You've got, I guess, the historic hurts that have come from up the river and the Treaty claims mixed with all the social issues which impacts on the health of people which then impacts on the education of children and it all gets ugly. Like that, in a great big mucky ball, and it's the intergenerational stuff. It's just a constant flow on and trying to break those cycles. Can't break the cycles if you haven't got the resources; so it's very much… My*

colleagues work really hard – health, education, but we're just band-aiding what's happening and I just don't know… You know you can only put a plaster on it for so long and so there's a plaster that's been put on here sort of, with COVID. But you rip that off in a year's time and I just hate to see…

I don't even know where to start. I've been here 18 years, and for the most part I'm pretty good at de-escalation, but from time to time I will get someone who's really unwell, and it's not P, because I know what that looks like, but they are really, really unwell; and trying to get someone to help is forget it. I just don't even bother anymore. And how many times have we tried? Years and years and years… It is at all levels of mental health - All levels of mental health, it doesn't matter. I've even had people that I've kept in my office for two or three hours at a time, to try and calm them down enough just to feel okay about sending them out on the street, and then picking up the phone and ringing the Police and saying, "Hey look, I'm a little bit concerned about this individual."

It's what's not really working in a mental health team and all that kind of stuff and seeing some of the holes and going, "Oh." All that happens is that Police are called; it goes south and then if crisis isn't working but actually there's a whole heap of things that haven't worked way back here; that has enabled that to occur. The whole shift and focus around this is what is needed to empower our communities to put the barricades at the top of the cliff rather than seeking out the ambulances at the bottom which is Police pushing through doors or ambulances pushing through doors.

Yeah, so often in the NGO sector, I find people say, "Our contract doesn't allow us to do that." I'll say, "Bugger your contract. Your contract is you have to meet a certain thing or we'll deliver so many widgets or whatever it is. But that's all we do. The institution you have the contract with – it's not their job to tell you how to do it. That's your job, or how you best apply it." I get CAMHS. I get CAMHS saying, "Our contract with MOH, we can only work with the top three and a half percent of mental illness in children." I say, "How do you bloody work out if a kid fits the top three and a half percent." That's just ludicrous. Sometimes it is the way that money works. I've always made it our business here that we have a wide range of sources and the reason we do direct fundraising ourselves is because I always say to bureaucrats, "It's not your job to tell us how to do it and you're only partially funding this and people in our community are putting hands in their pockets."

They have felt left out through a lot of it. Even though they had contact with me, they still felt left out. Some of them felt very isolated. A lot of them, I thought that their mental health suffered. I was doing a lot more talking with them and just reassurance was desperately needed that they were going to be okay, that we're all going through this and just telling them it is okay to feel angry, it's okay to feel upset, it's okay to cry.

Mental health, old trust, and broken issues. It was a constant thing but he's just one of many, you know, we've got an old community of mental health people that went through Lake Alice, have gone through the systems when it wasn't right. So, their trust and anything medical or doctors is not okay.

I think that mental health is a really significant issues in our community, and mainly among young people. I think we definitely need to work on educating; and like educating our youth on different issues surrounding that and making them aware that they do have those options, and providing them with people you can go to so that you have that support system, because yeah, the amount of teenagers struggling is just crazy. The standards that many of us like are made to try and live up to, especially at our school. We've got mental health is really bad at our school.

But in terms of that, I think like community-wise, if we get more opportunities for mental health to be like communicated and stuff, and it helps, that'd be great.

So, those rural communities need to be a real focus, and I'd be interested to hear what that comes back. But also our young people, because we kind of think oh yeah they get on with it, but they worry about everything. You only need to look at the mental health statistics, and suicide, in our region is horrendous. We don't want that to increase.

I firmly believe that physical health goes into mental health, goes into this health and goes into this one. It's not just one small parcel; it affects every part of everybody's health.

Stemming from that as well, emergency accommodation for people with mental health. There are quite a few that come in here, and they're like simply just walking the streets because there's nowhere for them go, and there's no facility. I mean, there's a facility but there's no service to pick them up and guide them into a place. I mean, there's obviously a shortage of housing, and mental health workers as well.

There's enough money into the community that the services should be there, and that's the point that people who get the funding to help these people, do not have the skills, because you know people with mental health issues will scream and shout, and if you retaliate the same way you're just going to get one big hell of a fight, and then these poor people get banned and trespassed from an office, and it's how you deal with them, and of course they're not trained.

I mean, I suppose it's the same old issues isn't it; housing, mental health support is a big things that I notice.

Or maybe just break the ice, get them into community mental health, you know, where they build up a relationship with someone and they can keep it going. But when you've got a pandemic going, and you're locked down for two months, where do people go for that kind of support? Because they need support and can't get it.

What happened in my bubble was not a lot at all, well so I thought until I started to speak about it. I entered COVID unaware and a little relaxed not realising the extent of Fear out there. After all I just spent over a week organising and coordinating Race Unity week at UCOL, and rushing through our Women's Wellbeing workshops before lockdown, and making sure my tenants had heaters to stay warm.

Our household was well prepared with everything from new vege plants growing in the garden, to fully stocked cupboards, and sufficient toilet paper lol.
One of our whanau wouldn't lockdown so we had to ask him to leave. He felt shafted... didn't understand the safety factor.

Moving on, now there were two.
Imagine a big big house 180sqm, and just 2 people with a room each at the front of the whare, and the kitchen all the way down the back.
Communication is easy, just yell across the hallway.

I had a mission that I was going to do heaps of craft. Not even.
I became bored.. unmotivated.
I watched a lot of NETFLIX, 4 season marathons.
I joined a lot of new Facebook pages. My Favourite was Millar's Kitchen.
The first three weeks I cooked my little heart out. But then I started to gain weight.
I focussed on my sons' stomach happiness instead.
Before he finished his first meal, he was asking what's for the next meal.
He was surprised by all the flavours that came together in his mouth.
We ate simply, fresh vegetables and small amount of chicken and wraps and other child friendly food.
I was happy when I could finally cook us a roast. We also had homemade curry. And first-time making custard squares as I craved bakery food and home made KFC went down a treat in many households.
Supermarkets sold out of Celery salt and many other herbs and spices.

We burst our bubbles and celebrated mother's day at level 3
We celebrated 70 years for mums birthday at level 2
We celebrated my moko's 1st birthday by hanging out with him for the day. He didn't recognise us at first as it had been 6 weeks.

We lost loved ones too.

My 11yr old decided his hair was too long, so shaved the lot off. First home haircut.
Then he asked me to supervise him while he cooked us breakfast – hash browns, fish fingers, followed by steak, and conversation
I was looking a little grey, so gave myself a hair dye. Someone else usually did this for me.

Online shopping – lots of it, all essential, May birthday gifts sorted. Supplements sorted.

Learnt new skills – seed saving, garden tutorials, and crafting. Made Feijoa cake for first time and Feijoa Fizz. That was scientific. Even started learning a new LANGUAGE.

Group messaging with the whanau, with my mokos, with my children. There are many fun effects on messenger, I now have lots of funny pics.

Facebook challenges were plentiful, as were quiz games. I enjoyed the 10-day Nana challenge, posting photos of my beautiful mokos.

Support local – as we moved through the levels I enjoyed buying local organic and fresh hydroponic food, at the best prices, delivered to the door.

I enjoyed lockdown. The main thing I realised was my son ate three square meals, went to sleep on time, and woke early daily. Before he had difficulty sleeping, and gamed all night. COVID showed how erratic or unstructured our daily life was before.

My highlights – going to the supermarket as often as I could. Delivering kai to the vulnerable. Someone stealing lettuce from my garden twice, they must have been hungry.

Housing – Rentals and Home Ownership, Social Housing and Homelessness

The conversations that were had around housing were extensive and not limited to social housing or homelessness. The primary concerns around housing were:

- Availability of housing stock
- Availability of land to build on
- Affordability of existing housing
- Affordability of building materials
- The poor quality of the current housing stock

The primary concerns for rentals were:

- Availability of rentals
- Affordability of existing rentals
- The poor quality of the current rental stock
- The inability to address poor landlords due to the above concerns for fear of becoming homeless.

The accommodation situation is terrible and where do you put people? Particularly with sex offenders, child sex offenders in particular – they're the hardest to house and the Department have a policy of not putting sex offenders into hotels and motels which I think is ridiculous because one person stuffed up; you know, I don't know how many, hundreds. Homeless and sex offenders, they did put in hotels and motels, but in those situations it's about risk management, not about risk-adverseness. It's about managing the risk. When you've got a pandemic, part of that is being risk-adverse of course, it depends on how high the risk is, but someone actually has to determine whether it should be elimination or control and how that goes, because the Department were in the situation that if someone had a release date, they had to be released.

I think there is got a contract to put people into motels and hotels for a week and I think there might have been some extra provisions made during the lockdown. But that's something that must be taken into consideration moving forward; even whānau relationships break down, but particularly when… The housing crisis, we've got manufactured flats, not natural flats, where you're putting strangers in with each other and expecting them to get on

I think New Zealand has a major issue with inequality. It's growing. And I really think we've got an opportunity here to grow it further making sure that people have lovely large houses or we have an opportunity to ensure that our private people and the other people that they don't do the feeding of people

Yeah it is cold aye. It's freezing. Oh man, I hope you've got a warm house to go to." "Oh nah, not really." "Oh where do you live?" "Oh over Cliff. Having a few problems with the landlord."

It's hard to get food without food and housing to people.

The council with the hotline and everything made it quite clear for people where to go in the first instance, so most of our public inquiries came at the end of it, the fallout of it; so the housing issues, people that had issues during lockdown with housing, looking for housing and people wanting food.

When we talked about the P epidemic there was other things that were uncovered as well like financial issues; housing issues; domestic violence and all this other stuff.

One of the things that also stuck out was that there was an absence of some of the services. There was an absence. I mean to me it's not rocket science really. If we all have a passion for the people; then everything else will automatically guide you in terms of that. But if you are driven by a different kaupapa then you're going to be led by that kaupapa which doesn't trickle down to the whānau that we're here to serve in terms of power for the education, employment, housing, social.

Germany got well over a million people within a very short period of time and I actually wanted, just out of pure interest… I've got a housing interest anyway, but how did they cope with it? Because I knew that they were in church halls, gymnasiums, anywhere where they could put a sleeping bag and a bed and how did they do that? They prefabricated houses – three storey, four storey – and they prefabricated them for cheap but adequate, you know? No leaky homes. They made communities. They looked at the social structure of the people that were coming and they built it around communities, and they had social workers and language specialists and health professionals going into the community so that they weren't isolated. They did a marvellous job.

Also we had like emergency housing available during COVID which disappears once the crisis is over. Our people continue to suffer.

I mean we still don't have enough housing by a long shot, and we still do not have decent housing either.

So some of the problems were there before COVID and the housing issue is our biggest. In fact, I did a submission to the Department about the housing issue with some solutions to it because I had the time to do that.

As a landlord with the new government regulations coming in, I am going to leave my properties vacant. Why would I enable people in them to have more rights than myself as the owner? Do I feel sorry for those that cannot get into a house and I have houses empty? Sometimes, but then I realise that this has only occurred due to the government

imposing this on landlords. Stop picking on those that have got ahead in life and can provide a roof over people's head – how about the government builds the houses they promised to build? How about that?

Housing.

Housing is huge.

We had a few people ringing, but they'd never had a fixed abode for food packages and stuff. So yeah, housing.

A big part is housing for our men folk. Not-so-great places like Bignell and they're getting charged $320 for a one bedroom including power. And they've got no money left over each week. They're not safe and they've got virtually nothing left over for food. And it's not great. But there's nowhere else for them to go. It's like what's the option.

We need to increase our housing rapidly. I think youth housing is an easy one and I know Oranga Tamariki are talking about the possibility of youth transition housing here.

As a community, Waimarino have already identified housing as a really big issue; that some of the houses aren't actually liveable but people are still living in them because that's all they have.

And I'm finding it more and more frustrating when all this monies coming out for the emergency housing, and I know there's an issue, totally know there's an issue, but they're not looking where the money is going to, and they're not contracting for that money, they're just giving it out, because somebody's got the biggest mouth.

There's a lot of money going into emergency housing, a heap of money, but it's not been given to the right people, because we know who the people are now

Focus on housing.

Housing's a huge one obviously.

Yeah, but you know, does the council want to get into housing? That's a whole other big, big, big thing.

You know the people that are hard to house and that are the people who have all the issues and have burnt their bridge and blah, blah, blah, if they got help sooner, they might not get there.

And a lot of that is outside of our localized control in central government policy, or there's not enough housing, there's not enough builders, there's not enough resource.

The clear link between housing and respiratory health. We're looking at somewhere around 800 preventable emergency room visits of children in Whanganui every year which is costing a lot of money. It's really stressful to parents and families and the issue isn't being addressed significantly but it can be. It can be; that's one really good example where the DHB can be out working proactively in the community to promote and guide people towards healthy housing.

The amount of under-utilised housing in Whanganui is incredible in terms of just old people who can't afford to move but have these houses that aren't being lived in. I think that's another opportunity in terms of planning.

Can I just throw it out there. You know it's great that we've got all this development and housing and stuff going in. But none of that is going to be suitable for first homeowners or for people that are struggling.

Financially I mean the house prices. House prices are ridiculous. They are. And at the moment we've got families that are being shunted out of their houses because the house is sold and they cannot afford to get into anywhere and there's no rentals and the prices of these new places is not going to be achievable. It's the same everywhere. Also we've got an awful lot that the town isn't growing or anything because all the buildings here have got to be made earthquake proof. And I mean it's like our church. It's going to cost us about 300,000 to do a church that's 130 years old. It's never had a shake. Made of wood. Happy as a lark. But it's going to cost us that to put it back in. So we're in the church hall at the back.

I know a lot of families that, even though they don't have insulation, they're too scared to talk about it because then the house will be condemned and then they'll be homeless. I also know there's millions of homeless families right now.

They need more Housing New Zealand homes. At one point, sorry T, they did sell a lot of their houses because there was no need for them and now all of a sudden there's been a change. Because they've sold all their houses they've got a huge waiting list for whānau, so it's real hard. A lot of whānau can't get private rentals because of their backgrounds. People don't want them in their houses which is sad. The prices are ridiculous. Especially for Whanganui. I've got clients in those units where there's four two-storey units. You know how crappy they are? Mouldy everything. $320-$350 a week out of a benefit. How does that even work? I don't understand how they can put people in motels and that though for like $700 a week. They can't put them in a house but you can put them in a motel for double the price – triple for some. Temporarily, so still got to live out of bags and unsettled. It's a lot of money.

We also don't truly know the urgency aye? I know families where they've got mum, dad and two children in one room because they're in with another family. So even

though they're in a home, it doesn't mean it's… Can you imagine the dynamics and the raru that comes out of having no space? Children and adults.

There's definitely need there but this is a particular gap that does have... it's a bit of a rabbit hole and people just can't get on to the ladder of rentals and so to try and avoid that kind of couch sort of thing.

Organisations returning to how they operated in a pre-Covid environment.

Outlined previously in this report is a section on the positive aspects of the inter-agency connections (*see: Interconnection between agencies and the breaking down of barriers*). It articulates that the communities and organisations represented in the narratives in this report seek a future whereby organisational silos and a lack of communication and collaboration is a relic of the pre-Covid era. They have challenged the way that iwi, crown organisations, local government and non-government organisations have traditionally operated. When development of new, or redesigning of old services are tabled, that collectively across the sectors the question is asked as to 'who should be at the table' and then ensuring that the design work is operationalised in a true codesign methodology. The long term success of intersectoral collaboration and cooperation is dependent on each sector committing to not reverting to a pre-Covid model of operating – the proof will be mutual trust and formation of authentic partnerships, a sharing in power, and in a joint understanding of the importance of lived experiences shaping our future.

> *It did. I think that's the way forward actually is you come to the table for the community and you check your ego at the door. You check your organisation at the door and you come in with that collective sense of responsibility.*
>
> *But also at that table were community members; not community representatives. We had people; we had people on employment benefit. We had solo parents. We had scrub cutters; we had shearers; we had part-time workers. Then on the other side we had business owners; it gave a bigger and broader perspective around the functions of the community but more importantly; communities come up with solutions to some of the 23 points that they had. The whole conversation changed completely. It wasn't the same old conversation. It was empowering.*
>
> *It's got a whole lot better, but there still is very much the silo approach. There has been more collaboration that's happened over the years which is not rocket science. If you all work together, we will find that the sharing of resources, you're going to get more outcomes. But because we are still not doing that well enough, pre-COVID I was wondering how this was all sort of going to pan out. There's political stuff as well, there's iwi stuff, there's all the things, the things, the things that go on in this community. However, from my experience, I felt that actually when that happened there was… And I guess it does happen when there's a crisis – and only when there's a crisis – collaboration starts to happen. Why they can't keep that consistent, I don't know.*
>
> *So from what I saw between iwi, health and social service agencies, that collaboration was happening and it was happening really well.*

That would be one thing I'd noticed. There seemed to be a dropping of the silos, which she's mentioned, and answers seem to be available quite quickly, which in the ordinary pre-Covid would have taken a very long time. You know, seem to be available almost instantly.

But they do. They work in silos. They're separate. But then when this happened they've come back together. I don't want to see them splitting again. This will happen if we don't get in there and say start pulling back and do it.

It was like, yeah, no, we need to do that a lot more. And there were different services up at the hospital that we didn't normally have and say, oh, my gosh they're really cool. I have to say and this is nothing to do with COVID, but pre-COVID we were already starting to find some really good relationships up, you know, like apparently up until recently we've not had very good relationships with the social workers. But just before COVID, during COVID, and even now, awesome. Awesome. Yeah, I think there is some good relationships that have been built and it will be a shame to let everything go back to the way that it used to be, if we let it.

UNITED IN RECOVERY
He waka eke noa

A new way forward

The transition has now occurred to shift us from working together under the collective banner of 'United in Recovery' to operating under the Impact Collective. This collective marks our new way forward, working in collaboration between iwi, local and regional organisations and private and social enterprise, whose leaders are collectively providing leadership to enable community led commissioning for services and supplies. Extending on from the work of the COVID-19 Integrated Recovery Team, through community and sector engagement, the community will identify their aspirations in order to live a more meaningful and healthy life in our thriving communities. The Impact Collective's aim is:

To enable regenerative systems within a thriving community that creates wellbeing for all people, our places and the planet. This will ensure that our resources, our services and our collective wellbeing is equitably shared across our rohe, founded in the principles of Mātauranga Māori.

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March 2021 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Decision paper**
	3 March 2021
Author	Nadine Mackintosh, Executive Officer
Endorsed by	Ken Whelan, Board Chair
Subject	**2021 Hauora A Iwi and District Health Board Joint Meetings**

Recommendations

Management recommend that the board

a. **Receive** the paper

b. **Note** the dates of the Hauora A Iwi Board meetings

c. **Note** that Hauora A Iwi have proposed the joint board meeting dates be aligned to alternatively follow set dates for the individual boards on a quarterly basis

d. **Approve** the 2021 joint meetings dates as

i. Wednesday, 21 April 2021, following the Whanganui DHB Board meeting

ii. Tuesday, 29 June 2021, following the Hauora A Iwi Board meeting

iii. Wednesday, 1 September 2021, following the Whanganui DHB Board meeting

iv. Tuesday, 14 December 2021, following the Hauora A Iwi Board meeting

1 Purpose

This report seeks the board's support of the 2021 meeting schedule for the Hauora A Iwi and Whanganui DHB Joint Board sessions.

2 Summary

The Hauora A Iwi Board met on Tuesday, 23 February 2021 and set the 2021 dates for their meetings. It has been proposed that Whanganui DHB consider the joint board meetings endorsed at their meeting on 23 February 2021 which have been alighted to alternative follow individual board meetings.

The board may wish to consider realigning the meeting of 30 June 2021 to 29 June 2021 to reduce meeting commitments.

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

March 2021 **Public**

3. 2021 Proposed Meeting Schedule **Endorsed HAI 23.02.2021**

Dates for the Joint Board meetings with Hauora A Iwi are to be confirmed.

2020 MEETING SCHEDULE FOR WDHB BOARD & COMMITTEES					
Meeting **Time**	**FRAC** **1pm-3pm**	**CSAC** **9am-1pm**	**Board** **9am-1pm**	**Joint Boards WDHB / HAI** **1pm – 3pm**	**HAI Board** **10am-12pm**
Date of meeting	**17 February**	**26 February**			**23 February**
Deadline for reports	3 February	12 February			
Published	13 February	19 February			
Date of meeting			**3 March**		
Deadline for reports			17 February		
Published			24 February		
Date of meeting	**14 April**		**21 April**	**21 April**	**6 April**
Deadline for reports	30 March		7 April		
Published	7 April		14 April		
Date of meeting		**28 May**			**18 May**
Deadline for reports		14 February			
Published		21 February			
Date of meeting	**16 June**		**30 June**		
Deadline for reports	2 June		16 June		
Published	9 June		23 June		
Date of meeting				**29 June**	**29 June**
Deadline for reports					
Published					
Date of meeting	**18 August**	**27 August**			**10 August**
Deadline for reports	4 August	13 August			
Published	11 August	20 August			
Date of meeting			**1 September**	**1 September**	**21 September**
Deadline for reports			18 August		
Published			25 August		
Date of meeting	**20 October**	**28 October**			
Deadline for reports	6 October	Annual Planning			
Published	13 October				
Date of meeting	**17 November**	**26 November**			**2 November**
Deadline for reports	3 November	12 November			
Published	10 November	19 November			
Date of meeting			**1 December**	**14 December**	**14 December**
Deadline for reports			17 November		
Published			24 November		

March 2021 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Discussion Paper**
	3 March 2021
Authors	Rowena Kui, Kaiuringi GM Maori Health and Equity Andrew McKinnon, GM Corporate Alex Kemp, Chief Allied Professions Officer Louise Allsopp, GM Patient Quality, Safety and Innovation Steve Carey, Integrated Community Impact Strategist Paul Malan, Kaiuringi GM Strategy, Commissioning and Population Health
Subject	He Hāpori Ora Thriving Communities Progress Report 1

Equity consideration

Our strategy includes utmost commitment to equity and this progress report shows how that is being advanced across the system as well as highlighting some gaps and opportunities.

Recommendations

Management recommend that the Whanganui District Health Board:

a. **Receive** the paper titled He Hāpori Ora Thriving Communities Progress Report 1
b. **Note** the progress supporting implementation and success of the strategy.

Appendices

1. He Hāpori Ora Thriving Communities Progress Report for the Six Months to December 2020

1 Purpose

This paper is provided to the Whanganui District Health Board for information.

2 Summary

The He Hāpori Ora Thriving Communities Progress Report has been developed to report on actions in support of the implementation and sustained long-term success of the strategy. The intention of the report is to provide Members of the Whanganui District Health Board with an overview of WDHB activity in alignment with the strategic focus areas.

The following information is included in the report:

1. Introduction
2. Detailed actions completed and in progress against each of the strategic focus areas
3. A brief summary with key steps for quarters three and four.

It is intended to provide the report semi-annually and to develop our annual plan to be a fully aligned action plan.

He Hāpori Ora Thriving Communities

Supporting the implementation and sustained long-term success of the Whanganui District Health Board and Hauora ā Iwi He Hāpori Ora Thriving Communities Strategy

Progress Report for the Six months

To

December 2020

1 CONTENTS

2 INTRODUCTION

Whanganui District Health Board (WDHB) is committed to delivering 'thriving communities' as outlined in our He Hāpori Ora Thriving Communities strategy endorsed by Hauora ā Iwi and the WDHB Board in August 2020. Ultimately the success of He Hāpori Ora Thriving Communities will be evidenced by the impact on our strategic drivers and enablers. Our strategic focus areas deliver the strategy and provide the 'what does this look like' to the strategic drivers and enablers outlined in the strategy.

Strategic Focus Area One: Mana Taurite – Pro-equity

Inequitable difference in health status can be by age, gender, socioeconomic position, ethnicity, impairment, and geographical locality. We are committed to achieving equity of health outcomes, across all population groups, with a view of eliminating disparity, particularly for Maori.

Strategic Focus Area Two: Kāwanatanga Hāpori – Social Governance

Across the Whanganui rohe there are a range of organisations and government agencies working on outcomes and delivering services for the health and wellbeing of our communities. Traditionally, community organisations and government agencies, including district health boards, have worked in isolation. The challenge laid down by the government is for these organisations to work in a more integrated and collaborative way. In response to this challenge we are championing social governance as a model to harness the collective power of these organisations to better serve the people of our rohe.

Strategic Focus Area Three: Noho Ora Pai I tōu ake Kāinga – Healthy at Home: Every bed matters

Using a social governance model where iwi, communities and agencies work together, we can make 'every bed matter' by focusing on the transition to and from the hospital or community care settings and enabling people/whānau to be directly involved in decisions about their care. Being healthy at home means the wider social determinants of health (such as housing, education and employment) are addressed through a social governance model, where community, social and government organisations work together on health and wellbeing outcomes for our communities.

This progress report details actions and activity completed in quarters one and two of 2020/21 in alignment with our strategic focus areas. Note that our strategic focus areas are woven together – we cannot achieve one without the other and so some activity may appear more than once or may be cross-referenced to another section.

It is intended to produce this report semi-annually.

3 Focus Area Actions Q1 and Q2

The following sections provide details of some of the activity that has been completed in Q1 and Q2 in support of our He Hapori Ora strategic agenda.

3.1 Mana Taurite - Pro-equity

Pro-equity requires concerted effort and rethinking of some of the approaches we have taken over decades in the health and disability system. We are committed to partnering with Māori as the foundation for success. This includes building on our relationship with Hauora a Iwi, working in partnership with Māori and iwi providers in the community, and further exploring and supporting Māori models of care and Whānau Ora approaches.

3.1.1 Strengthen leadership and accountability for equity

Publicly committing to an equity goal

We are updating public messaging and developing district wide policy in alignment with this commitment. In the first half of 2020/21 we can report the following progress:

- Media releases and reporting on performance include references to equity and ethnicity comparators (as available).
- Māori media is utilised for health promotion messaging and messages from the Kaihautū Hauora, chief executive.
- Web page in the process of updating – includes information such as Māori workforce funding and supports, services and kaupapa Māori services
- Revised WDHB vacancy advertisements (supported by updated recruitment policy and procedure) states the following: Whanganui DHB is committed to increase the diversity of our workforce, and actively focus on employing and building a sustainable Māori workforce which supports our pro-equity commitment.

To ensure greater visibility of WDHB's activities and performance, both as a funder and as a provider of services. The following documents are publicly available:

- WDHB Pro-Equity Check Up Report
- Central Region Equity Framework
- Te Tumu Whakarae Position Statement on Māori Workforce
- Nationally agreed targets to reduce Māori health inequity
- Annual Plan and Regional Service Plan
- Annual Report

There is ongoing activity to develop district-wide policy that links to and strengthens Whānau Ora service delivery and supports our commitment to achieving equity in health outcomes for Māori. This activity includes:

- Central Region Equity Tool developed and utilised in regional workplans – ongoing training provided
- GM Māori participating in Central Region Partnership Planning Group – focused on regional Services Plan – Central Region
- GM Māori Health and Equity chairs Te Koro Matua ki Ikaroa (CR GM Māori Forum, regular attendance and shared learning i.e Flu vaccination exemplar.
- GM Māori Health and Equity, regular participation in national Māori health leadership forum Tumu Whakarae
- Te Whiti ki te Uru forum has not been meeting over the past 9 months

Creating a learning environment and building leadership commitment

To increase knowledge of organisational decision makers to drive annual plans and service improvements, we are providing mentorship and coaching for equity champions, leaders and Māori health leaders using independent expert advice. Actions completed and underway include:

- Board and committee local induction programme includes cultural safety and supports members impact of racism and colonisation on health outcomes for Māori whānau and the use of equity tools and methodologies.
- Baker Contracting available to DHB and community partners leaders
- MoH training available for board and Committee members with more equity focused approach being developed by the MoH Māori Directorate to be rolled out nationally in Q3.

Further focus on building knowledge and capability of teams has been effected through:

- Revision of the recruitment Policy, with procedures underway
- Revision of cultural and equity competencies, with KPIs underway
- Equity training and coaching is ongoing for executives and leaders
- Kaitakitaki (Te Hau Ranga Ora leaders) continue to provide advice and support across all service and enabler groups.

In the medium term we are creating a culture of accountability across the organisation by revising job descriptions, which will be progressed along-side the roll out of the revised recruitment policy, and developing dashboards of service performance. The first phase of development has been completed with trialling and refinement in progress.

Committing to a training budget to support equity skill development

Activity in the first half of the year includes:

- Training budget has been identified and ringfenced
- Workforce planning underway includes refresh of orientation, mandatory training and leadership programmes
- Hāpai te Hoe continues as part of the organisation welcome and orientation programme. 90+ % of existing and all new staff have completed the programme.
- Equity tools and methodologies training programmes are ongoing. 2020-21 the programmes are more focused on specific initiatives and activities eg. WRHN Gout Programme analysis, Annual Planning – equity KPI development, Maternal Child and Youth Health Alliance development
- HEAT Tool utilisation staff have been trained – further work to build competency and consistency is ongoing.

3.1.2 Build Māori workforce and Māori health and equity capability

Recruitment and retention strategy focused on Māori staff

Existing recruitment policy is being reviewed to ensure appropriate support for Māori applicants.

- Work continues to strengthen the workplace environment and recruitment pathway (Te Ara Ki Te Mahi Hauora) for Māori into Health. Currently 13.0% staff that are employed within the Whanganui DHB workforce identify as Māori, this is an increase of 12.28% from 2020. Annual planning for 2020/21 highlights the focus of growing the Māori health workforce by 2030 to proportionately reflect the Māori population we serve across the region, enablers to achieve this have been the focus for the first half of the year (Q1-Q2), this includes establishing accurate data to capture ethnicity across the workforce and also at the point of application for vacant roles within the organisation.

- Recruit advertisements – refreshed to include DHB vision and values as described in He Hāpori Ora, whānau centred approach to care and service delivery

- The review and ratification of the Recruitment Policy and Recruitment Procedure and Guidelines sets foundations to enable growing the Māori health workforce through recruitment efforts and will strengthen the development of the Workforce Development Plan.

- Workforce development plan- initial stages of developing by the newly established Education and Professional Development Operational Group. The group has DHB and community partners membership, terms of reference agreed alongside the scope and purpose of the group. This will be ongoing through Q3&4.

We are developing a recruitment and retention strategy that includes talent mapping; partnering with Māori providers, community providers and NGOs; strengthening links with training providers and programmes including Kia Ora Hauora; and ensuring regional links to support the wider health workforce

In line with the strategy, activity underway includes:

- Our focus on Te Ara Ki Te Hauora (pathway to health for Māori), where we have sought to understand this pathway and barriers in this space. Work with Kia Ora Hauora to engage Māori onto the health pathway continues and provides opportunities to work closer with Māori from our DHB district who are Kia Ora Hauora registered. Although data for Kia Ora Hauora reflects the Central Region, we can see 3 new Māori registered for the programme in quarter 2, and of the total 792 Māori in the Central Region currently registered, 81 identify as from the WDHB district.

- Revising the Recruitment Policy and Recruitment Procedure and Guidelines, which will enable:
  - Prioritisation of Kia Ora Hauora graduates who wish to work in the Whanganui DHB
  - Increasing the interview rate for Māori applicants where all Māori applicants who meet the minimum eligibility criteria for any role are shortlisted for interview
  - Consistent use of the new advertising format to raise the interest of Māori to work in our DHB

- Continuing to increase awareness of the availability of the HWNZ funding across the WDHB district. There was a small increase in applicants for HWNZ Hauora Māori Training Fund and Māori Support Fund 2020.

<u>Strengthening the role and size of the Te Hau Ranga Ora/Māori health services team</u>

Supporting the Te Hau Ranga Ora and Māori Health Services team to maintain and strengthen their roles in the first half of the year has included:

- Te Hau Ranga Ora Kaitakitaki leaders being appointed to all teams (three clinical and four enabler teams). They provide cultural expertise, advice and mentorship, equity expertise and training, participate in development of policies and procedures, provide education sessions, advise on development of service initiatives, commissioning and service planning. The team leads cultural practices and events, provides te reo sessions, cultural training and translations, advice on patient information and media releases and support whānau to access the Whare Wakatau Mate, lead and support the Haumoana service and role model whānau centred care and DHB values. They facilitate whānau hui following complaints and incident reviews and restorative practice for staff members.

- Māori staff can access cultural supervision although there is only one Māori clinical supervisor in the WDHB supervision pool.

- Te Hau Ranga Ora staff can access external cultural supervision

- Both Te Hau Ranga Ora Cultural Advisors are available to staff for cultural supervision and advice.

- The Kaitakitaki, Māori Health Workforce Development will be more focused in Q3 & 4 to support community partners and organisations

Developing a health equity competency

In order to set a base level of expectation for new recruits, job descriptions are being updated to include equity expectations for the organisation. This includes:

- Revision of job descriptions to be progressed alongside the roll out of the revised recruitment policy
- Hāpai te Hoe and Te Waka Hourua cultural education programmes are ongoing.
- Training and support of staff in the use of equity tools and methodologies is ongoing.
- A programme that specifically focuses on the impact of racism, impact on colleagues and workforce, the impact on quality outcomes for patients and their whānau is being developed.

Plans for Q3 &4 include:

- Further refining of the WDHB value-based interviewing approach
- Research and development of alternative dispute resolution approaches that better align with WDHB tikanga, focus on early intervention and support restorative practices.
- Disability awareness training for staff.

In order to set expectations of pro-equity action by staff across WDHB, we will continue to refine and develop more detailed health equity competencies with staff and develop training for front line staff that focuses on pro-equity, anti-racist approaches. Linked activity includes:

- Revision of job descriptions to be progressed alongside the roll out of the revised recruitment policy
- Development of KPI's once staff get to a level of competency that is consistent and can be measured. This is in progress to be completed in Q4.
- Planning for the roll-out of unconscious bias awareness training to support appointments and training and development decisions. This is in progress and planned to roll out in Q3-4. Training will include learning and toolkits for staff and leaders ranging from assessment tools, self-reflection, in practice examples, webinars for personal or team reference etc.

Continued strengthening and extension of Hāpai te Hoe.

Hāpai te Hoe and Te Waka Hourua (part two) focus on living our values, promoting whānau centred care in practice and extending staff knowledge of local Māori and tikanga. These programmes are ongoing. Staff attend Hāpai to Hoe as part of orientation and attend Te Waka Hourua every three years.

We continue to develop Hāpai te Hoe programme and enable participation by external agencies where possible.

- A tikanga guide 'flip chart' is being developed for each service and department to support staff in their day to day mahi and an individual booklet for staff once they complete the education sessions will be developed by Q4.
- The Te Reo programme is very popular with over 160 staff having completed the course. Some staff have gone on for further study at the Wananga.

3.1.3 Improve transparency in data and decision making

Building capability in equity data analysis

We are aiming to improve the presentation of statistics and stories relating to health need so as to enable more informed decision making. We are working to include narratives that support data and analytics in Board decisions. To-date, local provider partner leaders and staff have participated in equity education sessions and are able to access advice as required. Actions to be progressed and continued include:

- equity reporting will be integrated into service provider contracts.
- commitment to the five principles of the Te Tiriti o Waitangi will be integrated into service provider contracts.
- Ongoing support of training and development of equity approaches and use of tools (such as the HEAT tool).

We continue to work with staff and local health partners in care to include equity focused data analysis in all information presented to the Board and Hauora ā Iwi to inform all decision making.

- Training in equity analysis is ongoing. Consistent use of equity tools and methodologies is improving.
- Dashboards to monitor performance continue to be developed, including equity ratio and ethnicity data.

Share equity analysis widely and include it in all decision making

The objective is to share information in a way that is easily understood and helps the Board and Hauora ā Iwi to get a full picture of WDHBs performance and the tradeoffs that may need to be made.

We have introduced a requirement for equity impacts to be explicitly included in all papers to ELT, committees, the Board and Hauora ā Iwi. To-date we have tried different approaches and these will be aligned and progressed in Q3.

In order to build experience in using equity tools and frameworks, we are supporting the development of base knowledge and use of tools.

- Training and support of staff in the use of equity tools and methodologies is ongoing.
- Training in equity analysis is ongoing. Consistent use of equity tools and methodologies is improving.
- Competency and consistency is building across teams – more focus to be applied in Q3 & 4
- Equity methodology being used to set annual plan targets – equity orientated actions (EOA)
- Equity dashboard – under construction
- Staff and teams are using internal and external equity expertise.

Transparency in resource allocation - include equity analysis in all publicly reported data

To advance transparent decision making and funding allocation that meet the needs of our communities, we are:

- Gathering information on approaches and methodologies to review all spend for impact on achieving equity for Māori,
- enhancing commissioning approaches to enable provision of services that meet the needs of Māori communities in their localities and ensure that Māori communities have a range of services available including kaupapa Māori services.

3.1.4 Support more authentic partnership with Māori

Strengthening partnership with Hauora ā Iwi

Resigning of the MoU between Hauora ā Iwi and the board is underway with a Draft Manatu Whakaaetanga Memorandum of Understanding developed for endorsement in March / April 2021.

Increasing use of Māori health and community expertise by the DHB

In order to demonstrate the principles of partnership in health and to amplify the voice of Māori consumers, we are committed to having 50 percent Māori representation on Te Pukaea. Progress to date:

- Consumer engagement review has been completed
- Recommendations have been endorsed by executive leadership and joint boards
- Implementation of the recommendations is in progress.

Meaningful participation in the design of services and interventions to support Māori self-determination and Whānau Ora

Activity in this domain links to community engagement and requirements for community-led programmes.

Kaupapa Māori providers and DHB partnership continues to be strong. Notable activity in the first half of the year include:

- Ongoing relationship between Māori Health Outcomes Advisory Group (MHOAG) and DHB through monthly hui. MHOAG is made up of leaders of the five kaupapa Māori services in our rohe/district.
- Development of He Puna Ora, a kaupapa Māori service was led by MHOAG in partnership with DHB. This service is funded by MoH across five DHBs to focus on Māori wahine (who are hapū/ pregnant and or have children under the age of three) and their whānau who are affected by addiction to alcohol and other drugs. This service commenced in Q2 and is unique in NZ.
- Discussions underway to strengthen the relationship between WDHB and MHOAG to alliancing and partnership approach to commissioning equity-focused service outcomes for Māori.

We are engaged with strategic partnerships in this domain too. Key activity to-date includes:

- Strategic and Planning Workshop co-led by Chair of Hauora ā Iwi. Hauora ā Iwi are engaged and advise the Board on all strategic decisions and planning processes.
- Regular hui – joint boards and chair to chair
- Revised Manatu Whakaaetanga Memorandum of Understanding strengthens partnership and engagement

3.2 KĀWANATANGA HĀPORI - SOCIAL GOVERNANCE

The people of Whanganui rohe will see community leaders and support services working towards the same social, health and wellbeing outcomes, with regular input and collaboration from our communities. Services for individual and whānau will 'wrap around' and support people across all aspects of wellbeing: mental and physical health, education, employment and housing – to support them to thrive.

3.2.1 Addressing social determinants of health

We are working collectively to address inequities caused by poor health and wellness beyond physical ill-health. This will enable and empower communities, neighbourhoods and whānau to thrive now and into the future.

Taking a holistic approach to health and wellness by including physical and mental health, wairua and whānau health into our services.

The aim is to promote whānau centred methods and enable more community-centric options. Some examples of work underway include:

- Following the launch of He Puna Ora, Hauora providers have accessed "Supporting Parents Healthy Children" (SPHC) training. The "Keeping Families and Children in Mind" module was presented in Whanganui in September 2020, and in Taihape in October as part of regular updates, with a facilitated full day 'Let's Talk' workshop in Taihape in November 2020.
- There is further interest in the "Single Session Family Consultation" in the rural sector. Further SPHC training has been booked to take place in January 2021 for all He Puna Ora staff orientation.

Mental health and addictions services have a focus this year on improving physical wellbeing and employment opportunities for tangata whaiora.

- 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
  -

Building capability across sectors, organisations and community leaders

By participating in a district-wide approach to social governance that focuses on community wellbeing, we will be strategically aligned with other social sector agencies and stakeholders.

- WDHB are participating in the Impact Collective Whanganui, Rangitikei, Ruapehu and South Taranaki. A charitable foundation is in the process of being developed to ensure that there can be an operational funding vessel from crown agencies. The purpose of the Impact Collective is to nurture a regenerative economy within a thriving community that creates wellbeing for all people, our whenua and the planet.

Committing to working alongside existing organisations and communities to provide housing, employment opportunities, social support and education.

The broad range of economic, environment and social issues that contribute to health outcomes are part of the social governance agenda. WDHB staff across the organisation will work throughout the system with intersectoral and community agencies.

- We have gone live on the YES – Youth employment success (a programme that encourages NEET and school aged children into employment) with a video outlining the various opportunities afforded at the District Health Board.
- WDHB remains a partner in the Safer Whanganui programme.
- 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.

Ensuring partners are committed to the five principles of Te Tiriti o Waitangi and assisting and guiding them on Te Tiriti when necessary.

We aim to have clear expectations of acceptable behaviours and commitment to Te Tiriti o Waitangi.

- Training across the organisation has been highlighted in the Pro-equity section above and will be extended to contracted and other community partners where possible.
- We are aligning contracting and human resource processes to reflect obligations in respect of Te Tiriti o Waitangi.

3.2.2 Collective action and shared intelligence

The objective is to work collaboratively with Iwi, community and government partners on outcomes that increase the health and wellness of our communities.

Working in collaboration with social governance partners on projects and plans which emphasise health, wellness and self-determination sharing information and data appropriately across government organisations and community groups to meet the health and disability needs of our communities.

We aim to engage with partners in care, and intersectoral and community organisations around information sharing agreements and shared planning where appropriate.

- The Impact Collective are currently working through a process of formalising the charitable foundation which will operate an operational arm. Through this, information sharing and the shared portal (located on the Impact Collective website) will be enabled.
- The child health team is continuing to network and share information between agencies and communities such as Plunket, Pasifika church groups, Iwi organisations, and general practices to locate transient children that fall within our priority groups to help reduce inequities.
- 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.

Developing systems for decision making underpinned by evidence and focused on equitable outcomes.

Effective commissioning requires decision support systems that provide population level intelligence. Across the district, a community equity and wellness profile is being developed. Linked in will be a health needs assessment to ensure WDHB's statutory obligations are met.

- The Impact Collective have identified an external partner (Dot Loves Data) to support the analysis of the data streams which will form the 'stats' portion of the Community Equity and Wellness Profiles. The external partner has extensive experience in delivering interactive data analysis to a SA2 level

(smallest mesh block under the census data). Dot Loves Data will be engaged once the foundation is formalised.

- WDHB have initiated the health needs analysis. This will be progressed in modules and includes:
  - Understanding changing demographics – analysis of the results of Census 2018
  - Understanding health service utilisation: access, growth and equity
  - Understanding mortality and morbidity variation across our population

3.2.3 Authentic partnerships and connections

We are committed to integrating our work with Iwi and communities through authentic partnerships and connection.

Understanding what challenges communities have and supporting them with health and wellbeing services and initiatives strengthening existing partnerships with iwi, communities and organisations and developing new partnerships to ensure participation and engagement across services and initiatives.

The first step is to ensure the formation of an authentic collective approach to be followed by the co-developed community needs assessment.

- The Action Plan for the Impact Collective has been presented to the Board. This outlines the timeframes for the Community Equity and Wellbeing Profiles.

Supporting initiatives already in our communities which contribute to wellbeing by sharing and contributing to successful models and developing new ones where needed.

We aim to identify existing community plans and support groups and to work with these to achieve the aspirations, where appropriate. This work is ongoing and will use the background research work referred to in other parts of this report to ensure that health participates in the development of wellness plans for our varied communities.

3.2.4 Strengthening integrated social governance leadership

We will develop our leaders to deliver and support health and wellbeing initiatives for our communities and lead the health and wellness aspect of social governance work across our rohe by bringing our partners together.

Fostering relationships, protocols and systems to support social governance

Our objective is to participate in groups and alliances that support community-led co-design.

- WDHB are participating in the Impact Collective Whanganui, Rangitikei, Ruapehu and South Taranaki.
- Ruapehu Whānau Transformation is leading co-design of the wellness facility in Raetihi
- A number of cross-sector and service-level alliances are in place or in establishment phase. These groups provide support for community-led co-design by bringing networks together:
  - Mental health and addictions service level alliance – in place
  - Maternal, child & youth service level alliance – in place
  - Māori health outcomes advisory group – in place
  - FLOW - the family harm initiative led by the Police and incorporating the children's team – in place
  - Healthy Ageing service level alliance – to be established

Maintaining a high level of strategic leadership to enable our organisations to work 'on the system' rather than 'in the system'.

We are maintaining participation at national and regional forums to enable the organisation to work on the system and working across the health system to support our partners in care.

- WDHB are participating in the Impact Collective Whanganui, Rangitikei, Ruapehu and South Taranaki.
- WDHB are participating in the Manawatu-Whanganui Regional Leads Group – the Impact Collective is to be presented as a priority work programme.
- Executive participation in Health and Disability System planning, regional planning, and local responses to new and redesigned initiatives is ongoing.

Challenging the confines of regional and organisational borders and delegations to ensure we work effectively across the system.

The aim is to support commissioning of services that take cognisance of economic, social, environmental and health imperatives.

- WDHB are participating in a review of WAM.
- WDHB are participating in the Ruapehu Wellness Centre project. Further discussions are being held as to how closer links with the community and its service providers can work together to create a 'community hub'.
- WDHB and MidCentral DHB (MCDHB) have a formal alliance known as the centralAlliance. The purpose of the centralAlliance is to work together where appropriate to co-develop, co-fund and/or co-operate on clinical and non-clinical service delivery.
- WDHB works closely with Taranaki DHB to provider some service coverage to people resident in South Taranaki

Collectively lobbying central government on behalf of our communities

Wherever inequitable outcomes for our communities occur, we will challenge those decisions.

- A collective voice from the WDHB rohe supported representation by WDHB Chief Executive to the Ministry of Health, asking for permission to offer bowel screening to Māori at a younger age than is currently offered by the national programme. Unfortunately, this has not been able to progress.
- Our Social Governance intentions have been shared with the Ministry of Health.

Challenging the status quo and traditional ways of working and creating new projects and ideas for long-term community benefit

Over the medium-term, we expect to be working across the system, with our partners in care and social governance partners on community-focused, sustainable solutions.

- WDHB are participating in the Impact Collective Whanganui, Rangitikei, Ruapehu and South Taranaki.
- The community equity and wellness profiles will inform the prioritisation of community-focused, sustainable solutions.

3.3 Noho Ora Pai i tōu ake Kainga - Healthy at Home: Every Bed Matters

The people of Whanganui rohe will se an increasing number of services delivered in the community in collaboration with primary healthcare providers, kaupapa Māori health providers and other social and government agencies.

3.3.1 Empowering whānau -centred care

Health care should be accessible in the right setting and environment, including within communities and homes.

Investigating and implementing new ways of delivering services to enable consumer choice, including different locations, opening times and virtual services.

The following are some of the actions completed or underway to underpin provision of a suite of services that support whanau-centred care.

- WDHB has been implementing the roll out of telehealth using Microsoft Teams, as the preferred method due to its security settings and ability to connect with other IT systems WDHB uses. There is a steady increase in the number of clinicians who are offering this to patients, and also an increase in staff using this as an alternative to in person meetings, saving WDHB both in travel time for staff and in fleet car costs.
- Use of telehealth options saves consumers in cost of travel and in time off work.
- Community Mental Health and Addictions Services 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 whānau -centred care. Ongoing engagement with district nurses, clinical nurse specialists, community occupational therapists and physiotherapy is occurring to encourage services via telehealth to rural areas.
- The Ruapehu wellness centre development continues to progress, with architect plans being considered and a business case being presented to the ministry in March.
- The Community Mental Health crisis team have embarked on a change to improve access to a crisis response at all hours. Home Care Medical (HCL) are a telephone crisis triage service that went live on the 9th December 2020. The local team switches over to HCL from 1630 to 0700 hrs in the morning. Evaluation is ongoing.
- The Whanganui "GOUT STOP" Programme has been implemented across the district. Development was led by a collaborative between WDHB, Arthritis NZ and WRHN and the programme is delivering a new service involving community pharmacy, general practice, Whanganui Accident and Medical (WAM) and a Kaiawhina. The aim is to decrease the high rates of poorly managed gout arthritis by improving awareness, health literacy, medication adherence and long term management.
- New model for assessment of child behavioural issues introduced in Q1 using a range of clinical expertise has reduced the time from referral to diagnosis and definitive treatment commencing. New process engages whānau and other stakeholders much earlier reducing whānau stress. Treatment assists with individuals attaining better academic achievements.

Using the Whānau Ora model to develop services which are tailored to individuals, whānau and communities

Work to integrate the Whanau Ora model includes:

- WDHB has been working with services that provide kaupapa Māori service. He Puna Ora, (explained in more detail under Pro-equity above) has been established. The service was designed and by all of the Hauora providers. The service is a kaupapa Māori response to support, for whānau where there are alcohol and drug issues preventing access to services.
- Te Whare Tapa Wha has been implemented as a model of care in Te Awhina mental health unit with positive results. There has been zero seclusion for Māori since this change was initiated.

We have an ongoing commitment to review existing services to identify areas where a whanau ora approach is appropriate and we are reviewing and redesigning kaupapa commissioning approaches.

Catering to the diverse health needs in our communities by intensifying high needs care where appropriate and encouraging self-management and autonomy where suitable

The intention of this activity is to provide better support for self-management and to allocate more intensive support in alignment with need.

- WDHB has recently begun roll out of a "Healthy Ageing Strategy", to highlight ageing as a lifelong process that begins in our 20's and 30s, and promote the message that 75% of health related conditions associated with ageing are potentially preventable or reversible.
- 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.
- Acute demand pressures continue to be a focus with work underway to:
  - Improve access to urgent care outside of the hospital
  - Improve and integrate hospital discharges to reduce readmissions and increase flow through acute services
  - Redesign community transitional and support services

3.3.2 Empowering consumer engagement

Communities are an integral part of the health system and we want to improve our understanding of what our diverse communities need through regular and meaningful engagement.

Engaging with our diverse communities about what health, disability and wellbeing services will make a difference to them and regular feedback helps create new services

Closely linked to the Social Governance agenda and better understanding of holistic community need, we are directly and indirectly improving our approaches to consumer engagement. Foundation work completed to-date include:

- Hauora ā Iwi commissioned a piece of research to find out about our people's experience during the COVID-19 lockdown and response. Hauora ā Iwi has been sharing this research with respective Iwi and also presented it at the International Indigenous Research Conference in November 2020. The Research Report has been shared with WDHB for information, noting that the research is being used to inform an independent piece of Covid research for Te Ranga Tupua. Learnings are being used to inform Annual Planning for 2021/22.
- The Integrated Recovery Team, formed in the immediate aftermath of the nationwide Covid-19 lockdown, also conducted local research on the lived experience of members of our communities of the pandemic. More than 150 focus groups and 1-to-1 interviews were conducted. The final report outlines stories and experiences of organisational boundaries being removed, of time for family, of instances of decreased access to necessary services, of joy and hope and of loneliness. The findings of the report are informing the work of the Social Governance Impact Collective and the Annual Planning for 2021/22.
- WDHB has collated community feedback and experiences on telehealth. This is being used to ensure that telehealth options continue to be promoted and enhanced.
- A consumer engagement strategy has been developed, linked to He Hāpori Ora

Engaging with our communities to reduce inequities and ensure our Te Tiriti obligations are upheld

WDHB must ensure that engagement for service design honours our commitment to Pro-equity and to Te Tiriti o Waitangi. This involves policy work to ensure procedures aligned to national mandates is in place as well as practical commitment that tests different approaches.

- Policy work is outlined in the Pro-equity section above.
- WDHB continues 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 Waitangi Tribunal and its interpretation of the Treaty clauses under the NZ Public Health and Disability Act 2000.
- The first "Growing Collective Wellbeing" insight report on suicide prevention has been released, and continues to be supported by WDHB in next stage of service design. The process included significant, in-depth community-based conversations with tangata whaiora, whānau /families and community stakeholders.
- The community insight reports on COVID-19 and Telehealth have all specifically looked at responses from Māori.
- A facilitated gout equity workshop was held in October 2020 with funders, providers, and consumers to review the GOUT STOP programme. Workshop discussion informed changes to the programme's overarching goal that better reflects a pro equity approach.

Ensuring iwi and consumers are part of developing and advising on services

Formal activity that is ongoing includes:

- WDHB engages regularly with the Māori Health Outcomes Advisory Group, and Te Pukaea consumer group.
- Service Level Alliances (SLAs) include Hauora provider perspectives in the membership. SLAs are established for mental health and addictions and for maternal, child & youth services. MHOAG serves as a SLA for Hauora providers/kaupapa services and a "healthy ageing" SLA is to be established. These SLAs are "networks of networks" and use a "perspectives" approach to membership where members bring a specific perspective (rather than a service provider interest) to the alliance. This formalises a wide consultative forum for input into service design and development.

3.3.3 Communities have input into how services are funded to address their needs

We expect a pro-equity and community-led social governance model with shared intelligence to result in funding being more closely aligned to the and wellness aspirations of our communities.

Strengthening community participation and influence in the commissioning process.

Activity to-date that has fostered participation in groups and alliances that support community-informed co-design includes:

- 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.
- 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. In addition, networks are being developed with the District Council youth committee to determine how we can better reflect youth voices in health services.
- Suicide prevention strategy development ("Growing collective wellbeing"):
  - 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.
    - 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.
- Community Health Pathways programme is active across primary and secondary care, developing best practice pathways for referrals between providers.

Transforming the funding system and aligning funding models to collectively tackle complex problems, including exploring co-funding options and more options to fund directly to or with iwi

We are supporting commissioning of services that work across the system and shifting service delivery settings where inequities of access can be addressed. Some work to-date includes:

- The local youth one-stop shop (Youth Services Trust) has recently received 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.
- To underpin the Suicide Prevention strategy, a "Growing Collective Wellbeing Insights Report" was produced, with ten key themes for future decision-makers and community leaders to consider.
- A community funding options programme has been agreed. This provides funding direct to primary care for treatments aimed at avoiding hospital-based intervention. Initial stage (Jan-June 2021) will focus on IV therapy in the community aligning with community health pathways.
- Through WRHN programmes in Q2, 97 Hapū Mama and significant others attended Antenatal classes and participated in Power to Protect videos and discussions. 137 safe sleep spaces have been given to all who received the education as well.
- Supporting the roll out of early response to mental health needs in primary care: our district mental health and addictions service level alliance (SLA) 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. Expansion of this programme is anticipated in Q3 or Q4.

Strengthening prevention services which support our most vulnerable communities

WDHB partners across the system to encourage a shift of focus from an illness model to a wellness model. Primary prevention activity to date includes:

- Child wellbeing for Q2:
    - 173 children had received their scheduled immunisation 8 months.
    - 167 children had received their scheduled immunisation at 2 years
    - 198 children had received their scheduled immunisation at 5 years
    - Rates of coverage and declines are inequitable and work is ongoing with Hauora providers and advisers to find solutions
- Help for smokers to quit
    - Maternity: work with DHB midwives and Lead maternity carers to identify smokers and offer support to quit
    - Primary care: results below target due to post-Covid increased acute demand at general practice leading to less time to screen for smoking status and offer advice. PHO is initiating remote access to a centrally based kaiawhina resource to specifically target enrolled smokers plus social medial promotion of the kaiawhina role.

    - Hospital: target met in Q2 for all populations.
- Raising healthy kids: the before school check (B4SC) programme identifies children who are obese and offers referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions. Local decline rate of 13% is significantly lower than national rate showing willingness of families to accept support. More programmes are needed, discussions about a broader approach with Sport Whanganui and other stakeholders have been initiated.
- Mental wellbeing:
    - School based health services covering all deciles 1 – 5 schools, teen parent units and alternative education facilities. "Youth Health Care" programme rolled out in secondary schools.
    - Youth mental health: increased funding to youth one-stop shop to support a more appropriate response
    - Introduced health improvement practitioner programme in two general practices. Expected to be expanded in Q3 or Q4
- Suicide prevention work advanced – Growing Collective Wellbeing insights report released. Strategy to be finalised in Q3
- Screening programmes:
    - Breast screening: coverage for Q2 is below target reflecting impact of Covid-19. Outreach was delayed to August 2020. Work underway to address barriers and improve support for underserved populations.
    - Cervical screening: similar to breast screening. Mitigations planned for Q3
    - Bowel screening: continuing to exceed anticipated numbers, indicating early uptake by those invited to screen. Good equity results reflect promotional activity undertaken and continuing.
- Healthy ageing: a review of the falls prevention programme (in-home and community-based strength and balance training) and of the pressure-injury prevention programme (hospital based) has been completed. Opportunities for improvement will be developed in Q3.

3.3.4 Informed communities

We want information about health, disability and wellbeing to be easy to access. People should have autonomy about their own health and wellbeing and more health services should be delivered in non-traditional health settings.

Ensuring information and resources, including patient and health information, is easy to access, appropriate, user-friendly, timely and meaningful

An objective for this year is to review resources to ensure that we are providing resources that encourage self-management, taking consideration of health literacy.

- Existing brochures are being aligned and updated to align with He Hapori Ora and ensure ease of reading.
- HealthPoint is being promoted as the single source of trusted information for Covid-19. Services are responsible for their own entries so it is difficult to control the accuracy of some entries.
- Community health pathways developments typically include resources for patients, which clinicians can print or email to consumers. Each pathway being developed considers the associated resources. To-date, 65% of the planned pathways work for the year had been completed.

Using appropriate and contemporary technology to develop channels, communications and resources for information and support about health, disability and wellness

We would like to integrate whanau ora plans and other care plans across the system.

- A programme of work, Kotahitanga, is underway with kaupapa Māori services from around the district exploring sharing of information across providers.
- We are currently implementing the recommendations from Gabrielle Baker's 'Review of Consumer Engagement' at WDHB. This includes the membership of Te Pukaea changing to 50% Māori.

Targeting health promotions to those who need them in a meaningful and regionally appropriate manner

A wide programme of health promotion partners with stakeholders across the system to relentlessly promote wellness. Completed and ongoing activity includes:

- Using healthy food and drink as a platform to work alongside a Kohanga Reo initiative creating supportive and enabling environment that empowers and encourages the health and wellbeing of tamariki and whanau.
- As contracts with providers have been renewed, we have included an expectation of adherence to the national guidelines on healthy food and drink for those that provide/vend food and drink as part of their services.
- Commenced implementation of the "Health active learning" programme promoting a water-only policy in learning environments.
- Commenced a community-wide needs assessment to inform tobacco control planning, investment and commissioning of new services and activity contributing towards achieving the government's goal of Smokefree Aotearoa 2025.
- District-wide stop-smoking services focus activity on service availability for Maori, Pacific and hapū mama. Expectations of hospital services, Lead maternity carers, and PHO services have been reviewed to ensure quit support is being offered to smokers.
- Population-specific health promotion approaches are employed locally to encourage uptake of cancer screening opportunities (bowel, breast and cervical).
- Hauora providers across the system promote and support participation in cancer screening programmes.
- Cohesive relationship between Public Health, Health Protection and the Alcohol Licensing Cluster Group for monitoring and surveillance of the Whanganui District Alcohol Licensing accord and related activities are in place. Health promotion activity supports reducing alcohol related harm.
- Public Health, Kaihoe-Health Promotion have established and continue to facilitate a fetal alcohol spectrum disorder (FASD) network group. The network delivers FASD awareness presentations within the community for identified priority populations
- The Healthy Ageing strategy will be developed and rolled out across the community, with presence at the NZ Masters Games in February 2021, and a range of social media platforms including a webpage and an Instagram account.
- In preparation for the national "Make summer unstoppable" campaign, Health Promotion activity will support events such as Vintage Weekend, Ratana celebrations, the NZ Masters Games, Pakaitore, etc. There will be a "wellbeing" focus, with COVID-19 prevention messaging a key part of this.
- A health promotion programme is running to raise awareness of the catch-up campaign for immunisation of young people against measles.

Ensuring our communities are part of developing information and resources about health, disability and wellbeing

Continuous improvement activity relating to information resources:

- Te Pukaea work with us on patient documentation and information. The mental health and addictions and maternal, child and youth service level alliances are in place to gather and share system wide feedback.

Ensuring clinicians and the wider health workforce understands, promotes and leads health literacy.

Activity relating to cultural training is detailed above in the Pro-equity section. We are committed to being a health literate organisation, which requires us to ensure that our own resources recognise health literacy issue and that our staff are trained to deliver information in a way that people can understand. Health literacy education resources are available for clinicians via the HQSC website. (See Pro-equity section).

4 Summary and Next Steps

This progress reports highlights the inter-dependency of each strategic focus area along with the complexity of activity across the work of the DHB and its key partner agencies and organisations. It is clear that significant progress has been made in support of our He Hāpori Ora Thriving Communities strategy. Actions in the 2020/21 Annual Plan are well-aligned to the strategic focus areas and progress is largely in line with expectations. There has been some delay due to the impact of Covid-19 and this is highlighted in relevant sections within the progress report.

A number of actions and activity have been reported as 'ongoing' or 'in progress'. These will continue to be advanced during quarters three and four and into the two remaining years of the strategy. Annual Planning for 2021/22 commences in Q3 and will provide an opportunity to more firmly align the annual plan activity to the strategy as well as considering the core next steps for the following year (2022/23). This will reinforce achievement of the strategic agenda.

March 2021 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	3 March 2021
Author	Raju Gulab, Finance Manager
Endorsed by	Andrew McKinnon, General Manager Corporate
Subject	**Detailed financial report – January 2021**

Recommendations

That the Board:

a. **Receive** the report 'Detailed financial report – January 2021'.

b. **Note** the January 2021 monthly result of a $132k surplus is favourable to budget by $420k. When including the increase in the Holiday Act Compliance provision and one-off facility contract mobilisation costs, the result is $357k favourable to budget.

c. **Note** the year-to-date result of $3,102k deficit is unfavourable to budget by $448k. Including the increase in the Holiday Act Compliance provision and one-off facility contract mobilisation costs, the result is $942k unfavourable to budget.

Financial Overview – January 2021

YTD Performance
Actual deficit $3.1m (excluding Holiday Act Compliance provision and one-off facility contract costs)
Against budgeted deficit of $2.7m, $0.4m unfavourable to budget.

YTD IDF Net Flow
$23.8m expenditure
Against budgeted expenditure of $23.7m, in line with budget.

YTD CWDs
Estimated CWDs 7,344
Against 7,060 budgeted CWDs; 284 CWD or 4% ahead of budget (IDF CWDs excluded).

YTD FTE
Actual FTE 946
Budgeted FTE of 934, acuity running 4% above target and added pressure on nursing resource.

YTD Capital Expenditure
Actual spend $4.0m
Against budgeted expenditure of $3.1m, $0.9m unfavourable, due to timing of expenditure.

March 2021 **Public**

Consolidated Statement of Financial Performance for the period ended 31 January 2021

	Month				Year to Date				Annual	Annual
$'000	Actual	Budget	Var		Actual	Budget	Var		Budget 2020-21	Actual 2019-20
Revenue	24,830	24,963	(133)	U	172,531	172,373	158	F	294,806	272,259
Revenue- COVID-19	207	-	207	F	2,195	-	2,195	F	-	3,931
Total Revenue	25,037	24,963	74	F	174,726	172,373	2,353	F	294,806	276,190
Less:										
Provider Health Service	(12,104)	(12,366)	262	F	(88,650)	(87,457)	(1,193)	U	(148,803)	(143,995)
Corporate Service	3	(67)	70	F	(457)	(854)	397	F	(1,221)	(1,990)
Governance	(81)	(76)	(5)	U	(511)	(551)	40	F	(950)	(722)
DHB Funder Division (exl IDF outflow)	(8,443)	(8,742)	299	F	(57,896)	(58,217)	321	F	(99,201)	(91,641)
Inter-district Outflow	(4,145)	(4,016)	(129)	U	(28,302)	(28,110)	(192)	U	(48,189)	(45,247)
ACC Contract (net)	9	16	(7)	U	253	162	91	F	309	265
COVID-19	(144)	-	(144)	U	(2,265)	-	(2,265)	U	-	(5,444)
Total expenditure	(24,905)	(25,251)	346	F	(177,828)	(175,027)	(2,801)	U	(298,055)	(288,774)
Net Surplus/(Deficit) before HolidayPay	**132**	**(288)**	**420**	**F**	**(3,102)**	**(2,654)**	**(448)**	**U**	**(3,249)**	**(12,584)**
Holiday Act Costs	(40)	-	(40)	U	(333)	-	(333)	U	-	(2,820)
One-off Facility contract	(23)	-	(23)	U	(161)	-	(161)	U	-	-
One-off	(63)	-	(63)		(494)	-	(494)		-	(2,820)
Net Surplus / (Deficit)	**69**	**(288)**	**357**	**F**	**(3,596)**	**(2,654)**	**(942)**	**U**	**(3,249)**	**(15,404)**

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

Overview

The operating result for the month of January 2021 was favourable to budget by $420k. When including Holiday Act Compliance provision and one-off facility contract mobilisation costs, the result is $357k favourable to budget.

Revenue

Revenue was $133k unfavourable to budget due to the capital charge rate being reduced from 6% to 5%. This reduction in the rate resulted in a lowering of the base line funding (offset by an equal amount of costs). Also contributing to lower revenue was lower ACC home base nursing, ACC non-acute inpatient rehabilitation revenue and not meeting the ACC additional revenue target.

Revenue- COVID- 19

Covid-19 revenue was $207k favourable to budget due to additional funding received to cover increased pharmaceutical drug costs and surveillance testing costs.

Provider health service (Appendix 2)

Provider division was $262k favourable to budget due to lower personnel costs arising from improved management of workforce during the holiday period. This favourable variance is partly offset by high building facility maintenance costs and high depreciation costs.

Inpatient volumes were 110% to target in January 2021 with unplanned (acute) at 108.4% and planned (elective and arranged) at 117.3% of budget for the month. The value of this increased volume is approximately $516k.

Corporate service (Appendix 2)

Corporate was $70k favourable to budget due to the capital charge rate reduction from 6% to 5% (offset by lower capital charge revenue), lower fuel cost and lower staff costs.

Governance

Governance was $5k unfavourable to budget.

DHB Funder division (exl IDF outflow) (Appendix 3)

Funder division was $299k favourable to budget due to lower health of older people costs and correlation of incorrectly charged of in-between travel costs, this favourable variance is partly offset by higher pharmaceutical costs.

Inter-district flows (Appendix 4)

Inter-district flows were $129k unfavourable to budget. Auckland DHB acute general surgery 46 CWD, patient required Tracheostomy with Ventilation.

COVID-19 expenditure

COVID-19 expenditure was $144k unfavourable to budget with costs incurred mainly in operating CBAC facilities and pharmaceuticals.

Year-to-date January 2021 operating result was unfavourable to budget by $448k; when including Holiday Act Compliance provision and one-off facility contract mobilisation costs, the result is $942k unfavourable to budget.

Revenue (Appendix 1)

Revenue was $158k favourable to budget, due mainly to service changes for inter-district inflow revenue, student replacement revenue, health work-force clinical training revenue (one-off), outpatient clinic revenue and non-resident patient revenue. These increases in revenue were partly offset by a reduction in capital charge funding due to the rate reduction from 6% to 5% (this reduction resulted in a lowering of the base line funding, offset by a reduction of equal amount of costs), lower ACC non-acute inpatient rehabilitation and not meeting the ACC additional revenue target.

Revenue- COVID- 19 (Appendix 1)

Covid-19 revenue was $2,195k favourable to budget due to additional funding received for ongoing support of operating CBAC facilities and COVID-19 testing. However, this funding was offset by COVID-19 related costs of $2,265k.

Provider division (Appendix 2)

Provider division was $1,193k unfavourable to budget due to increased nursing costs high acuity, medical locum cost to cover vacancies, increased pharmaceutical (mainly EYE drug costs), and an unmet clinical savings target. These increases were partly offset by lower outsourced service costs for radiology and unattended courses/conferences due to the COVID-19 pandemic.

Inpatient volumes were 104% to target year to date with unplanned (acute) 103.1% and planned (elective and arranged) 106.5% of budget year-to-date. The value of this increased volume is $1.6m.

Corporate (Appendix 2)

Corporate was $397 favourable to budget due to the capital charge rate reduction from 6% to 5% (offset by lower capital charge revenue). These lower costs were partly offset by higher IT-related costs, depreciation on IT capitalised projects bought into production and building depreciation costs relates to increased building valuations.

Governance

Governance was $40k favourable to budget due to lower other operating expenses, outsourced costs and democracy.

DHB Funder division (exl IDF outflow) (Appendix 3)

Funder division was $321k favourable to budget due to an in-between travel refund, lower short-term home-based support, and higher pharmaceutical rebate. This favourable variance was partly offset by higher pharmaceutical costs, travel and accommodation costs and mental health costs.

Inter-district flows (Appendix 4)

Inter-district flows were $192k unfavourable to budget mainly due to general surgery (Tracheostomy with Ventilation), neurosurgery, specialist neonates, acute cardiology, acute cardiothoracic and acute plastic and burns.

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COVID-19 expenditure

COVID-19 expenditure was $2,265k unfavourable to budget mainly due to other public health service operation costs of $1,299k, pharmaceutical costs of $732k (assume equal amount of expenditure occurred to offset the revenue), and personnel payroll cost of $234k.

Holiday Act provision

A $333k provision was made to accommodate any ongoing impact on accumulated leave in the 2020-21 financial year.

Facility contract one-off

A one-off cost of $161k for new facility contract mobilisation cost, anticipated full year costs will be $280k.

Appendix 1 - Revenue

	Month				Year to Date				Annual	Annual
$'000	Actual	Budget	Var		Actual	Budget	Var		Budget 2020–21	Actual 2019–20
Ministry of Health	23,847	23,904	(57)	U	164,823	164,541	282	F	281,284	259,121
Inter–district inflow	618	637	(19)	U	4,508	4,458	50	F	7,643	7,764
Other District Health Board (DHB)	66	37	29	F	590	340	250	F	560	612
Accident Compensation (ACC)	166	262	(96)	U	1,654	2,122	(468)	U	3,687	3,317
Other Government	31	3	28	F	141	79	62	F	197	145
Patient consumer sourced	11	30	(19)	U	199	204	(5)	U	353	371
Other income	91	90	1	F	616	629	(13)	U	1,082	929
COVID–19	207	–	207	F	2,195	–	2,195	F	–	3,931
Total revenue	25,037	24,963	74	F	174,726	172,373	2,353	F	294,806	276,190

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

Month comments

Ministry of Health

Revenue was $57k unfavourable to budget due to a reduction in capital funding (offset by an equal amount of costs) and various side contract funding.

Accident Compensation (ACC)

Revenue was $96k unfavourable to budget due to lower ACC non-acute inpatient rehabilitation and not meeting the additional ACC revenue target.

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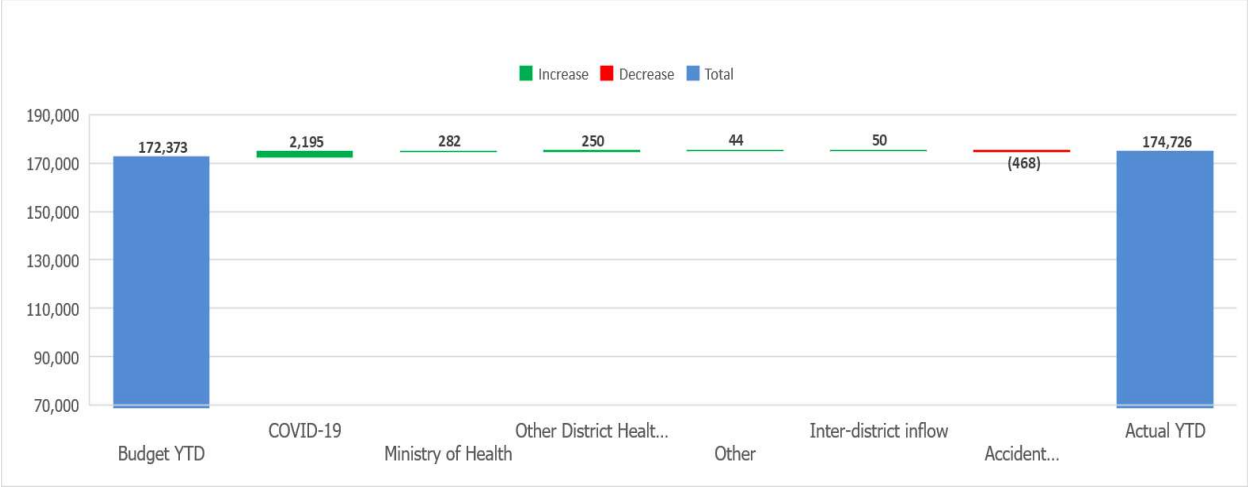
COVID-19 revenue

COVID-19 revenue was $207k favourable to budget due to Ministry of Health funding for COVID-19 related pharmaceuticals and testing and surveillance funding.

March 2021 **Public**

Year-to-date comments



COVID-19 was $2,195k favourable to budget due to Ministry of Health funding for:

- CBAC establishment $30k
- GP based easements $62k
- Surveillance plan and testing strategy $710k
- Public health unit $450k
- HOP support $29k
- Digital enablement $182k
- Pharmaceuticals $732k

This revenue passes on to various community health providers.

Ministry of Health

Revenue was $282k favourable to budget due to one-off health work-forced clinical training revenue, an increase of primary care revenue and funder division side contract revenue (This increase in funding was passed on to PHO and other health providers). This was partly offset by a reduction in capital charge funding due to the rate reduction from 6% to 5%.

Other District Health Board (outpatient Clinics)

Other District Health Board was $250k favourable to budget due to the increase of other District Health Boards (DHBs) outpatient clinics revenue.

Other

Other revenue was $44k favourable to budget due to the increased patient consumable revenue.

Inter-district inflow

Inter-district inflow was $50k favourable to budget due to service changes with other DHB and inpatient service revenue.

Accident Compensation (ACC)

Revenue was $468k unfavourable to budget due to lower ACC non-acute inpatient rehabilitation $290k and not meeting the ACC revenue target of $292k. This lower funding was partly offset by additional revenue from ACC radiology $52k, ACC home base nursing $32k, ACC injury prevention $25k and other $5k.

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Appendix 2 - Provider Health and Corporate Services

	Month					Year to Date					Annual	Annual
	Actual	Budget	Variance		Var %	Actual	Budget	Variance		Var %	Budget 2020-21	Actual 2019-20
Expenditure												
Medical Personnel	1,897	2,080	183	F		13,732	14,558	826	F		25,259	22,696
Nursing Personnel	3,862	3,957	95	F		25,951	25,061	(890)	U		42,796	42,778
Allied Personnel	1,002	1,075	73	F		7,336	7,883	547	F		13,545	12,346
Support Personnel	94	83	(11)	U		613	628	15	F		1,080	934
Management & Admin Perseonnel	820	977	157	F		6,880	7,178	298	F		12,270	12,061
Total Personnel(Exl other & outsourced)	**7,675**	**8,172**	**497**	**F**		**54,512**	**55,308**	**796**	**F**		**94,950**	**90,815**
Personnel Other	175	191	16	F		1,117	1,281	164	F		2,355	1,737
Outsourced Medical Personnel	372	326	(46)	U		3,725	2,253	(1,472)	U		3,883	6,433
Outsourced Allied Personnel	58	32	(26)	U		572	321	(251)	U		492	704
Outsourced Manag & Admin Personnel	44	7	(37)	U		289	46	(243)	U		78	59
Total Personnel outsourced	**649**	**556**	**(93)**	**U**		**5,703**	**3,901**	**(1,802)**	**U**		**6,808**	**8,933**
Total Personnel Expenditure	**8,324**	**8,728**	**404**	**F**		**60,215**	**59,209**	**(1,006)**	**U**		**101,758**	**99,748**
Outsourced Clinical Service	470	469	(1)	U		3,121	3,468	347	F		5,915	6,015
Clinical Supplies	1,282	1,304	22	F		10,527	10,258	(269)	U		17,300	16,107
Infrastructure & Non Clinical Supplies Costs	1,281	1,199	(82)	U		10,175	10,308	133	F		16,171	15,540
Capital Charge	187	202	15	F		1,384	1,497	113	F		2,505	2,748
Depreciation & Interest	542	517	(25)	U		3,589	3,486	(103)	U		6,193	5,563
Internal Allocation	15	14	(1)	U		97	85	(12)	U		182	264
Total Other Expenditure	**3,777**	**3,705**	**(72)**	**U**		**28,893**	**29,102**	**209**	**F**		**48,266**	**46,237**
Total Expenditure	**12,101**	**12,433**	**332**	**F**		**89,108**	**88,311**	**(797)**	**U**		**150,024**	**145,985**
Expenditure												
Medical personnel and Locum	2,269	2,406	137	F		17,457	16,811	**(646)**	U		29,142	29,129
Nursing Personnel	3,862	3,957	95	F		25,951	25,061	**(890)**	U		42,796	42,778
Allied Personnel	1,060	1,107	47	F		7,908	8,204	**296**	F		14,037	13,050
Othe Personnel costs	1,133	1,258	125	F		8,899	9,133	**234**	F		15,783	14,791
Clinical Supplies	1,282	1,304	22	F		10,527	10,258	**(269)**	U		17,300	16,107
Outsourced Clinical Service	470	469	(1)	U		3,121	3,468	**347**	F		5,915	6,015
Infrastructure & Non Clinical Supplies Costs	1,468	1,401	(67)	U		11,559	11,805	**246**	F		18,676	18,288
Depreciation & Interest	542	517	(25)	U		3,589	3,486	**(103)**	U		6,193	5,563
Internal Allocation	15	14	(1)	U		97	85	**(12)**	U		182	264
Total Expenditure	**12,101**	**12,433**	**332**	**F**		**89,108**	**88,311**	**(797)**	**U**		**150,024**	**145,985**
FTEs												
Medical	112.3	109.4	(3.0)	U		106.1	109.9	3.8	F		111.5	112.5
Nursing	495.6	490.1	(5.4)	U		482.8	460.5	(22.3)	U		460.8	462.2
Allied	146.0	159.4	13.5	F		152.4	160.3	7.9	F		160.3	153.4
Support	19.2	17.9	(1.3)	U		17.9	18.0	0.1	F		18.0	16.8
Management & Admin	146.8	169.0	22.2	F		171.2	169.5	(1.7)	U		170.5	177.9
Total FTEs	**920**	**946**	**26.0**	**F**		**930**	**918**	**(12.2)**	**U**		**921**	**923**
Case Weighted Discharges (CWD)												
Unplanned (Acute)	810	748	(61)	U	-8.2%	5,353	5,191	(163)	U	-3.1%	8,836	8,528
Planed (Elective & Arranged)	211	180	(31)	U	-17.3%	1,991	1,870	(121)	U	-6.5%	3,227	2,968
Total CWD	**1,021**	**928**	**(93)**	**U**	**-10.0%**	**7,344**	**7,061**	**(284)**	**U**	**-4.0%**	**12,063**	**11,496**
Further information												
General Medicine	305	295	(10)	U	-3.6%	2,398	2,043	(355)	U	-17.4%	3,478	3,728
General Surgery	246	184	(63)	U	-34.1%	1,559	1,454	(105)	U	-7.2%	2,488	2,582
Orthopaedics	189	162	(27)	U	-16.7%	1,320	1,393	73	F	5.2%	2,390	1,897
Gynaecology	32	22	(9)	U	-42.9%	243	203	(39)	U	-19.2%	350	388
Emergency Medicine	109	114	5	F	4.1%	676	788	113	F	14.3%	1,342	1,096
Othter	140	152	12	F	8.1%	1,149	1,179	29	F	2.5%	2,015	1,805
Total CWD	**1,021**	**928**	**(93)**	**U**	**-10.0%**	**7,344**	**7,061**	**(284)**	**U**	**-4.0%**	**12,063**	**11,496**

Month comments

Inpatient volumes were 110% to target in January 2021 with unplanned (acute) at 108.4% and planned (elective and arranged) at 117.3% of budget for the month. The value of this increased volume is approximately $516k.

The overall expenditure for the month of November was $332k favourable to budget.

Personnel

Total personnel costs were $404k favourable to budget mainly due to improved management of workforce during the holiday period with staff heavily utilised annual leave.

Clinical supplies

Clinical supplies costs were $22k favourable to lower usage of blood product, lower pharmaceutical costs, lower dental supplies and lower wards consumables. These lower costs were partly offset by orthotics and surgical footwear costs and patient travel costs.

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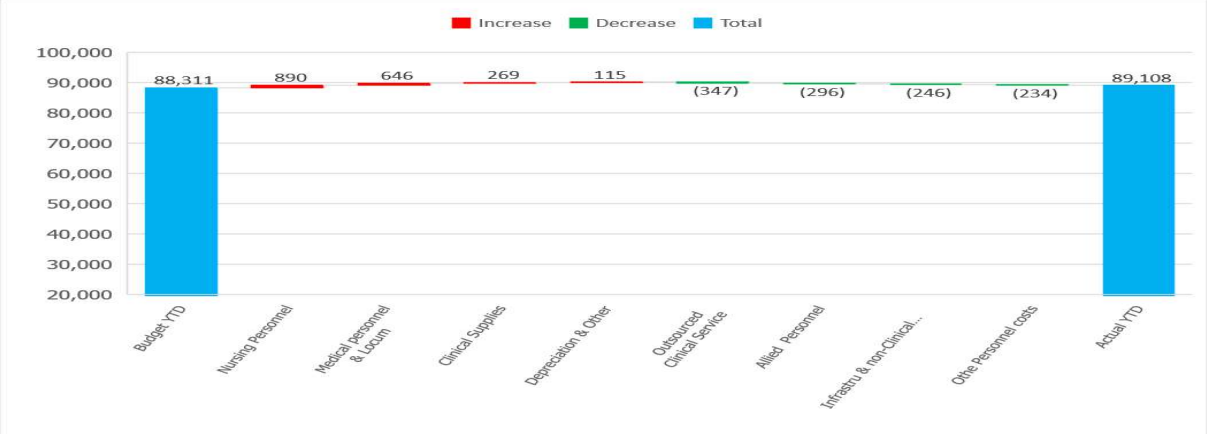
Infrastructure and Non-Clinical supplies

Infrastructure and non-clinical supplies cost were $82k unfavourable due increased building maintenance costs.

Capital charges

Capital charges were $15k favourable to budget due to the rate reduction from 6% to 5% (offset by an equal amount of funding reduction).

Year-to-date comments



The overall year-to-date expenditure $1,127k unfavourable to budget.

Nursing personnel

Nursing personnel was $890k unfavourable to budget due to high nursing costs in the medical ward, surgical wards, ATR ward, mental health inpatient units (Te Awhina), ED, theatre, forensic service (Stanford House), ATR community service and community mental health. The staffing levels were particularly high due to clinical need.

Medical personnel

The medical personnel net unfavourable variance of $646k was mainly due to use of locums to cover vacancies. Unfavourable locum costs of $1,461k were partly offset by savings in payroll costs of $826k due to unfilled vacant positions. Locum costs were made up of ophthalmology $131k, orthopaedics $15k, RMOs $345k, anaesthetics $147k, mental health $366k, gynaecology $414k and dental and other units $53k.

Clinical supplies

Clinical supplies costs were $269k unfavourable to budget due to high orthotics and surgical footwear costs, wards pharmaceutical costs, theatre consumables and high eye drug costs. These higher costs were partly offset by lower dental, radiology and district nursing consumable costs.

Deprecation other costs

Deprecation costs and other costs were $115k unfavourable to budget due to clinical equipment, IT projects bought into production and the impact of deprecation for 30 June 2020 land and building valuation increases (anticipated full year unfavourable impact of $60k).

Outsourced clinical and other services

Outsourced clinical and other services were $347k favourable to budget, mainly due to radiology service costs $286k, lower CCDHB infectious disease costs $34k and various other $27k.

Allied personnel

Allied personnel costs net favourable variance of $296k favourable to budget was mainly due to vacancies in audiology, dental, physiotherapy, speech therapy, pharmacy, community mental health and health promotion. Favourable payroll savings of $547k were partly offset by outsourced costs of $251k mainly orthotics, speech therapists and radiology locum.

Infrastructure and Non-Clinical supplies

Infrastructure and non-clinical supplies costs were $246k favourable due to the capital charge rate reduction from 6% to 5% (offset by an equal amount of funding reduction) $113k, building insurance savings of $80k, transport $17k, corporate training $20k, IT software licences $40k, facility and hotel service costs $48k. These lower costs were partly offset by high security service to the mental health inpatient unit, A&R wards and medical ward $32k, professional fees relating to facility contract $25k and other costs $15k.

Other personnel

Other personnel costs were $234k favourable to budget mainly due to unattended course and conferences as a result of the COVID-19 pandemic.

Case Weighted Discharges

Year to Date estimated case weighted discharges (CWD) were 284 CWD, 4% higher than target. General medicine 355 CWD, 17.4% higher than planned.

Note that CWD above includes services provided at Whanganui Hospital. This CWD does not include IDF outflows and means it is not the complete result in relation to the Planned Care Target.

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Appendix 3 - DHB Funder Division

	Month				Year to Date				Annual	Annual
	Actual	Budget	Variance		Actual	Budget	Variance		Budget 2020-21	Actual 2019-20
Expenditure by type										
Pharmaceuticals	1,590	1,430	(160)	U	9,942	10,128	186	F	17,173	16,052
Primary Health Organisation (PHO)	1,500	1,501	1	F	10,589	10,375	(214)	U	17,763	16,941
Home Based Support (short Term)	141	218	77	F	1,401	1,523	122	F	2,610	1,766
Other Personal Health	1,059	1,121	62	F	7,800	7,843	43	F	13,452	12,440
Health of Older People	2,794	3,089	295	F	18,359	18,517	158	F	31,472	30,236
Mental Health	971	939	(32)	U	6,749	6,555	(194)	U	11,215	9,085
Public Health	66	85	19	F	633	633	–	F	1,057	976
Maori Services	137	136	(1)	U	915	1,037	122	F	1,719	1,602
Total Other provider expenditure	**8,258**	**8,519**	**261**	**F**	**56,388**	**56,611**	**223**	**F**	**96,461**	**89,098**
Funding Admin	185	223	38	F	1,508	1,606	**98**	F	2,740	2,543
Total funder expenditure	**8,443**	**8,742**	**299**	**F**	**57,896**	**58,217**	**321**	**F**	**99,201**	**91,641**
	–	–	–		–	–	–		–	
Expenditure by service										
Personal Health	4,290	4,270	(20)	U	29,732	29,869	137	F	50,998	47,199
Health of Older People	2,794	3,089	295	F	18,359	18,517	158	F	31,472	30,236
Mental Health	971	939	(32)	U	6,749	6,555	(194)	U	11,215	9,085
Public Health	66	85	19	F	633	633	–	F	1,057	976
Maori Services	137	136	(1)	U	915	1,037	122	F	1,719	1,602
Funding Admin	185	223	38	F	1,508	1,606	98	F	2,740	2,543
Total Expenditure	**8,443**	**8,742**	**299**	**F**	**57,896**	**58,217**	**321**	**F**	**99,201**	**91,641**

Month comments

The overall expenditure for the month of January 2021 was $299k favourable to budget.

Pharmaceutical

Pharmaceuticals were $160k unfavourable to budget due to higher drug cost (budget was based on Pharmac August 20 forecast), which was partly offset by higher Pharmac Rebate.

Health of older people

Health of Older People was $295 favourable to budget, largely due to one-off in-between travel reimbursement relates to prior year.

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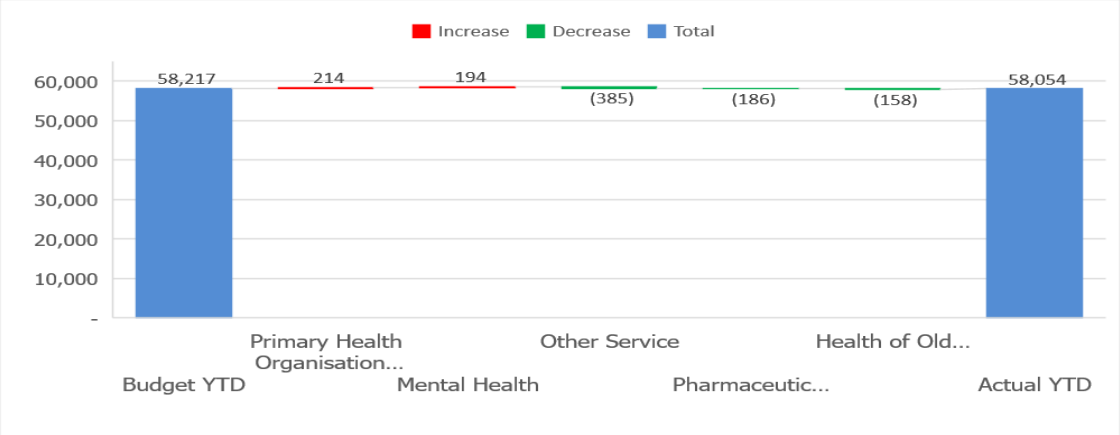
Year-to-date comments

The overall year-to-date expenditure was $23k favourable to budget.



Primary Health Organisation

The Primary Health Organisation (PHO) was $214k unfavourable to budget, largely due to an increased capitation first contact service payment which indicates increases in enrolment, and the timing of the PHO system level measure capability payment. This was partly offset by increased in primary care funding.

Mental Health

Mental Health service was $194k unfavourable to budget largely due to increase in number of mental health contracts. This is partly offset higher revenue.

Other service

Other service was $385k favourable to budget due to lower short term Homebase support, lower other personal health costs and lower funding and admin management costs.

Pharmaceutical

Pharmaceuticals were $186k favourable to budget, due to a higher rebate (based on Pharmac forecast), this was partly offset by increased drug costs (core pharmacy service costs increased by $1.8m, 16% compared to prior year).

The table below indicates actual payment data, paid though HealthPac, overall costs increased by $1.8m (16%) for six months. Pharmaceutical cost increases will significantly impact the WDHB bottom line going forward.

Pharmaceutical expenditure trend (Health Pac data)

$'000	2019-20 Actual	2020-21 Actual		% increased
Jul	1,880	2,183	(303)	16%
Aug	1,849	2,211	(362)	20%
Sep	1,866	2,189	(323)	17%
Oct	1,949	2,140	(191)	10%
Nov	1,851	2,256	(405)	22%
Dec	2,011	2,255	(244)	12%
	11,405	13,234	(1,829)	16%

Health of older people

Health of Older People was $158k favourable to budget, largely due to one-off in-between travel reimbursement relates to prior year.

March 2021 **Public**

Appendix 4 - Inter-district flows (IDFs)

	Month				Year to Date			Annual	Annual
	Actual $000	Budget $000	Variance $000		Actual $000	Budget $000	Variance $000	Budget 2020-21 $000	Actual 2019-20 $000
Expenditure									
Outflow inpatient	$2,204	$2,031	($ 173)	U	$14,840	$14,216	($ 624)	$24,371	$24,073
Outflow other	$1,941	$1,985	$44	F	$13,462	$13,894	$432	$23,818	$21,174
Total outflow	**4,145**	**4,016**	**(129)**	**U**	**28,302**	**28,110**	**(192)**	**48,189**	**45,247**
Inflow inpatient	($ 247)	($ 277)	($ 30)	U	($ 1,912)	($ 1,942)	($ 30)	($ 3,329)	($ 3,269)
Inflow other	($ 371)	($ 360)	$11	F	($ 2,596)	($ 2,516)	$80	($ 4,314)	($ 4,495)
Total inflow	**(618)**	**(637)**	**(19)**	**U**	**(4,508)**	**(4,458)**	**50**	**(7,643)**	**(7,764)**
Total IDF net flow	**3,527**	**3,379**	**(148)**	**U**	**23,794**	**23,652**	**(142)**	**40,546**	**37,483**

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

Year-to-date comments

Year-to-date IDF net flow was $142k unfavourable to budget.

Year-to-date outflow IDF expenditure was $192k unfavourable to budget

Inpatient IDF outflow

Inpatient IDF outflow was $624k unfavourable to budget due to an anticipated saving target only partially achieved. Costs reflect payments made in accordance with the national plan. Specialities running over budget were acute general surgery, neurosurgery, specialist neonatal, acute cardiology, acute cardiothoracic, and acute plastic and burns.

Other IDF outflow

Other IDF outflow was $432k favourable to budget due to prior year PCT, community pharmaceutical washup $132k and service changes. (The IDF's for any year are set based on historical services provided and historical volumes, if there is a change in the services delivered by another DHB for Whanganui DHB population, this could be that a service is stopped, or volumes significantly change. This will only be required for IDF categories that are not washed up at the end of the year).

Year-to-date inflow IDF revenue was $50k favourable to budget.

Inpatient IDF

Inpatient IDF inflow was $30k unfavourable due to a slight under-delivery of the inpatient volume for other DHBs.

Other IDF

Other IDF inflow was favourable $80k service changes. (The IDF's for any year are set based on historical services provided and historical volumes, if there is a change in the services delivered by another DHB for Whanganui DHB population i.e. if a service is stopped or volumes significantly change). This will only be required for IDF categories that are not washed up at the end of the year).

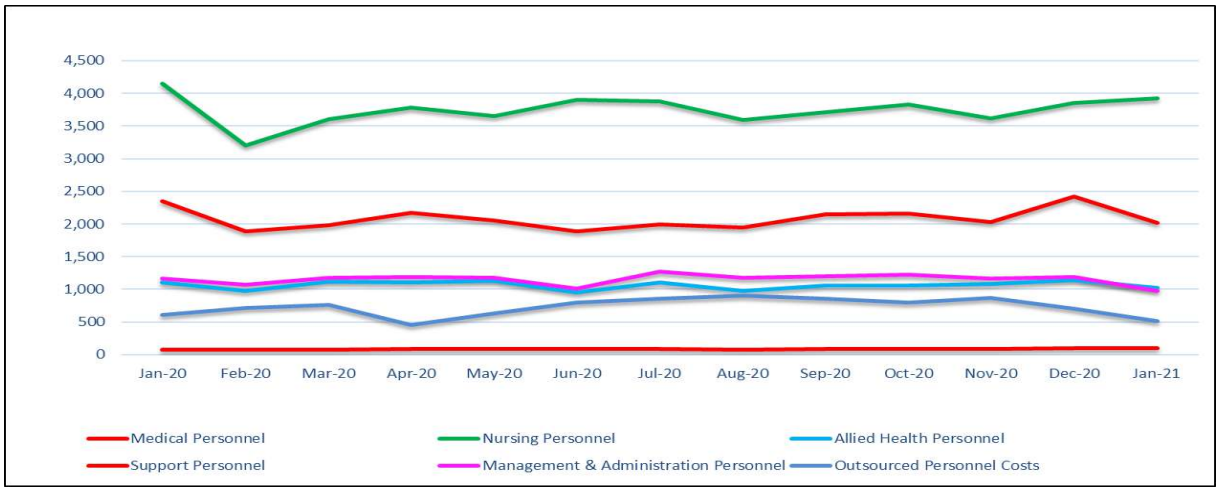
Other IDFs are made of General Medical Service (GMS), Immunisation, Laboratory, Personnel Health – NGO, - Outpatients, Pharmaceutical Cancer Treatment (PCT), Pharmacy, Primary Health Organisation (PHO), Tertiary Adjuster (TDDJ), Long Term Conditions (LTC), Health of Older People Aged Residential Care (ARC), Health of Older People Non-Inpatient AT&R, Health of Older People NGO, Health of Older People Inpatient AT&R, Health of Older People Mental Health NGO, and Mental Health Provider Arm.

March 2021 **Public**

Appendix 5 - Other information

Supplementary information on costs

Personnel cost trends

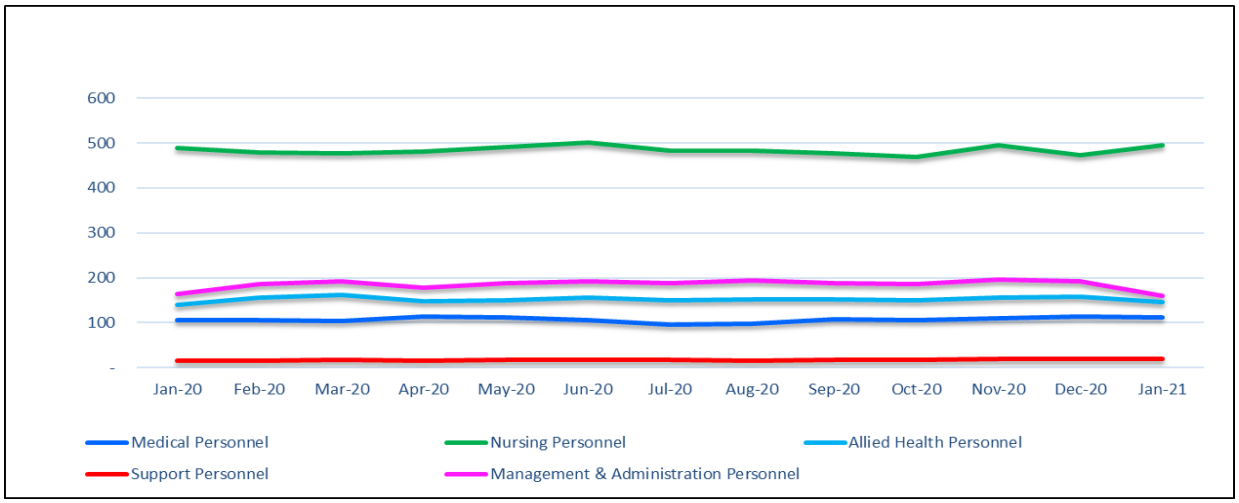


Overall, the personnel costs downward trend in January compared to prior month is due to two less working days in the month.

Nursing personnel costs slightly upward trend in January reflect high acuity.

Outsourced personnel costs downward trend in January compared to prior month is due to lower ACC contract costs (offset by lower revenue)

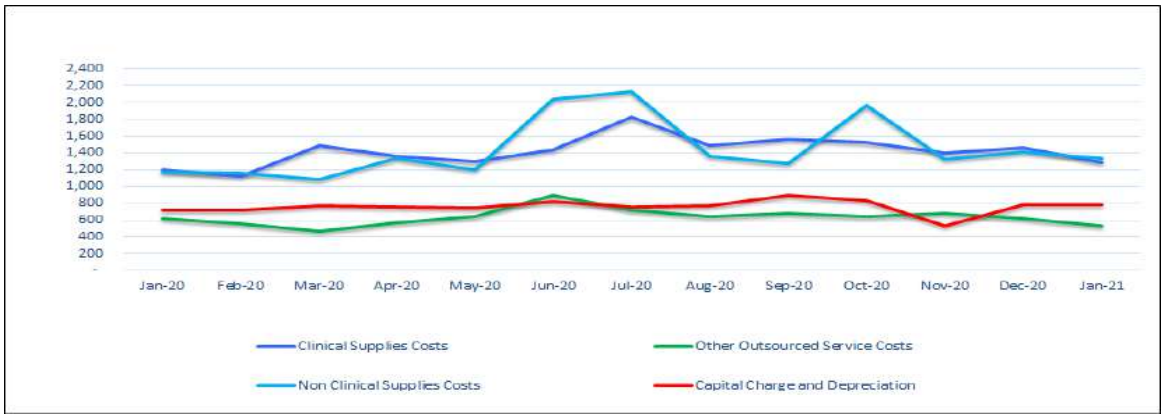
FTE trends



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

March 2021 **Public**

Other operating costs



Clinical supplies downward trend in January compared to prior month is due lower theatre consumable costs.

Non-clinical supplies downward trend in January compared to the prior month is due to timing of IT and profession fees costs.

Other outsourced service downward trend in January compared to prior month is due to ACC contract costs.

Capital charge and depreciation downward trend in January is comparable to prior month.

March 2021 **Public**

Appendix 6 - Statement of financial position

	Actual 2019 $000	Actual 2020 $000	Budget 2020 $000	Varinace to Budget	Annaul Budget 2019 $000
Assets					
Current assets					
Cash and cash equivalents	3,813	713	5	708	5
Receivables & Prepayments	6,275	8,118	5,949	2,169	5,492
Investments	–	–	–	–	–
Inventories	1,617	1,601	1,617	(16)	1,617
Trust /special funds	190	191	189	2	189
Patient and restricted trust funds	4	3	4	(1)	4
Total current assets	**11,899**	**10,626**	**7,764**	**2,862**	**7,307**
Non current assets					
Property, plant and equipment	79,602	80,282	75,052	5,230	78,310
Intangible assets	11,741	11,475	12,049	(574)	12,640
Investments in associates	1,185	1,185	1,077	108	1,102
Total non current assets	**92,528**	**92,942**	**88,178**	**4,764**	**92,052**
Total assets	**104,427**	**103,568**	**95,942**	**7,626**	**99,359**
Liabilities					
Current liabilities					
Bank Overdraft	–	(11)	(11,203)	11,192	(9,199)
Payables	(20,535)	(22,573)	(17,125)	(5,448)	(17,235)
Borrowings	(198)	(131)	(133)	2	(100)
Employee entitlements	(21,920)	(22,738)	(15,475)	(7,263)	(19,265)
Provisions	–	–	–	–	–
Total current liabilities	**(42,653)**	**(45,453)**	**(43,936)**	**(1,517)**	**(45,799)**
Non-current liabilities					
Borrowings	(486)	(429)	(430)	1	(385)
Employee entitlements	(839)	(830)	(851)	21	(805)
Total non current liabilities	**(1,325)**	**(1,259)**	**(1,281)**	**22**	**(1,190)**
Total liabilities	**(43,978)**	**(46,712)**	**(45,217)**	**(1,495)**	**(46,989)**
Net assets	**60,449**	**56,856**	**50,725**	**6,131**	**52,370**
Equity					
Contributed Capital	(112,409)	(112,409)	(112,409)	–	(114,651)
Accumulated surplus / (deficit)	82,698	86,294	85,752	542	86,349
Property revaluation reserves	(30,551)	(30,551)	(23,881)	(6,670)	(23,881)
Hospital special funds	(187)	(190)	(187)	(3)	(187)
Total equity	**(60,449)**	**(56,856)**	**(50,725)**	**(6,131)**	**(52,370)**

Total assets increased by $7.6m compared to budget due to impact of increased land and building valuation and actual 2019-20 lower capital expenditure than forecast position included for 2019-20 in annual plan 2020-21.

Total liabilities increased by $1.5m compared to budget due to accounts payable-related accrual provision and employee entitlement which was partly offset by a budgeted overdraft that was not needed.

March 2021 **Public**

Appendix 7 - Cashflow

Consolidated Summary Statement of Cash Flows for the period ended 31 Jan 2021 ($000)

	Actual 2018-19	Actual 2019-20	Actual YTD 2020-21	Budget YTD 2020-21	Variance		Annual Budget 2020-21
Net surplus / (deficit) for year	(13,654)	(15,404)	(3,596)	(2,653)	(943)	U	(3,250)
							–
Add back non-cash items							–
Depreciation and assets written off on PPE	5,417	**5,566**	3,588	3,489	99	F	6,201
Revaluation losses on PPE	–	–	–	–	–	F	–
							–
Total non cash movements	**5,417**	**5,566**	**3,588**	**3,489**	**99**	**F**	**6,201**
							–
Add back items classified as investment Activity							–
(loss) / gAmn on sale of PPE	15	5	3	–	3	F	–
Profit from associates	(95)	(108)	–	–	–	F	(85)
GAmn on sale of investments				–	–	F	–
Write-down on initial recognition of financial asset	1,048	–	–				–
Movements in accounts payable attributes to Ca	268	(127)	4	–	4	F	–
							–
Total Items classified as investment Activity	**1,236**	**(230)**	**7**	**–**	**7**	**F**	**(85)**
							–
Movements in working capital							–
Increase / (decrease) in trade and other payables	**4,312**	**2,301**	**2,038**	(4,017)	6,055	F	(3,907)
Increase / (decrease) employee entitlements	**3,907**	**5,173**	**809**	(6,433)	7,242	F	(2,689)
				–	–	F	–
(Increase) / decrease in trade and other receivable	2,555	123	(1,843)	733	(2,576)	U	1,275
(Increase) / decrease in inventories	(15)	(190)	16	–	16	F	–
Increase / (decrease) in provision	–	–	–	–	–	F	–
							–
Net movement in working capital	**10,759**	**7,407**	**1,020**	**(9,717)**	**10,737**	**F**	**(5,321)**
Net cash inflow / (outflow) form operating activ	**3,758**	**(2,661)**	**1,019**	**(8,881)**	**9,900**	**F**	**(2,455)**
	–	–	–	–			–
Net cash flow from Investing (capex)	(4,572)	(3,110)	(4,009)	(3,136)	(873)	U	(9,697)
Net cash flow from Investing (Other)	(65)	(48)	3	1	2	F	(24)
Net cash flow from Financing	(385)	(388)	(124)	(121)	(3)	U	2,043
Net cash flow from deficit support	–	7,000	–	–			–
							–
Net cash flow	(1,264)	793	(3,111)	(12,137)	9,026	F	(10,133)
Net cash (Opening)	4,284	3,020	3,813	939	2,874	F	939
Cash (Closing)	**3,020**	**3,813**	702	**(11,198)**	**11,900**	**F**	**(9,194)**

Closing cash is better than budget due to a delay in Holiday Act Compliance payment and receiving additional $1m deficit support in 2019/20.

March 2021 **Public**

Capital expenditure as at 31 Jan 2021 ($000)

	Actual 2019 000	Actual 2020 $000	Budget 2020 $000	Variance to Budget	Actual 2019 000
Buildings & Plant	702	989	675	(314)	4,825
Clinical Equipment	1,247	1,527	1,505	(22)	2,537
Other Equipment	46	41	70	29	210
Information Technology	239	930	149	(781)	230
Purchase of software	838	522	737	215	1,895
Motor Vehicles	38	–	–	–	–
Total capital expenditure	**3,110**	**4,009**	**3,136**	**(873)**	**9,697**

Capital expenditure is $873k higher than plan, due to Lambie ground floor refurbishment (project was delayed), IT infrastructure is mainly due to PC and laptop purchased (relying on remote working and new way interacting with employees and customers). Switching IT infrastructure to cloud service would add significant new costs to WDHB.

General Manager Corporate

10 February 2021

March 2021 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	3 March 2021
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 Board:

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

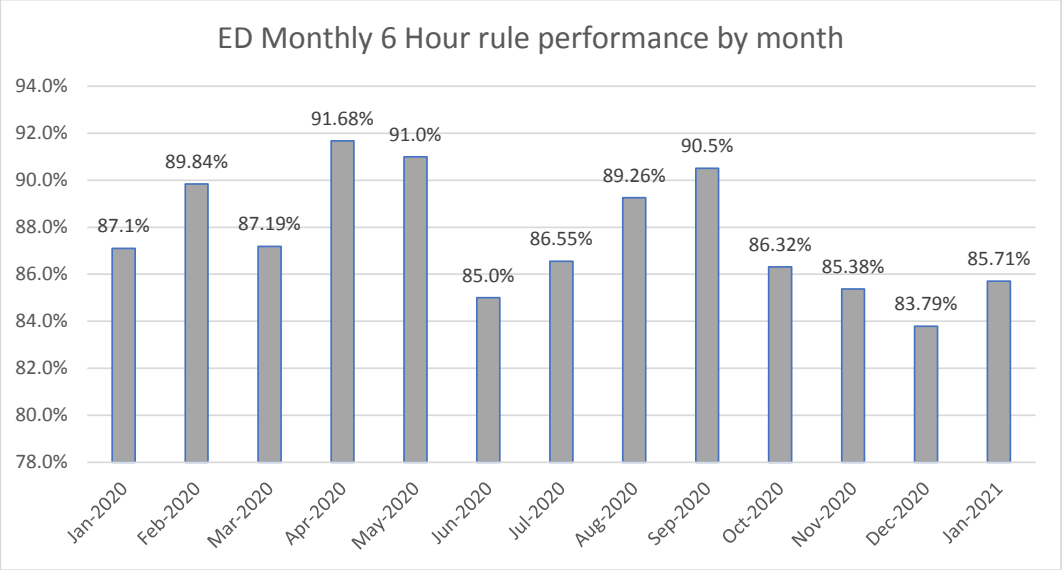
A one-year pilot role for integrated discharge navigator position has been recruited. The programme is aligned to the strategic focus on Healthy at Home: Every Bed Matters. The focus of the role will be ensuring systems and processes are in place to aid timely patient discharges, understanding and removing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

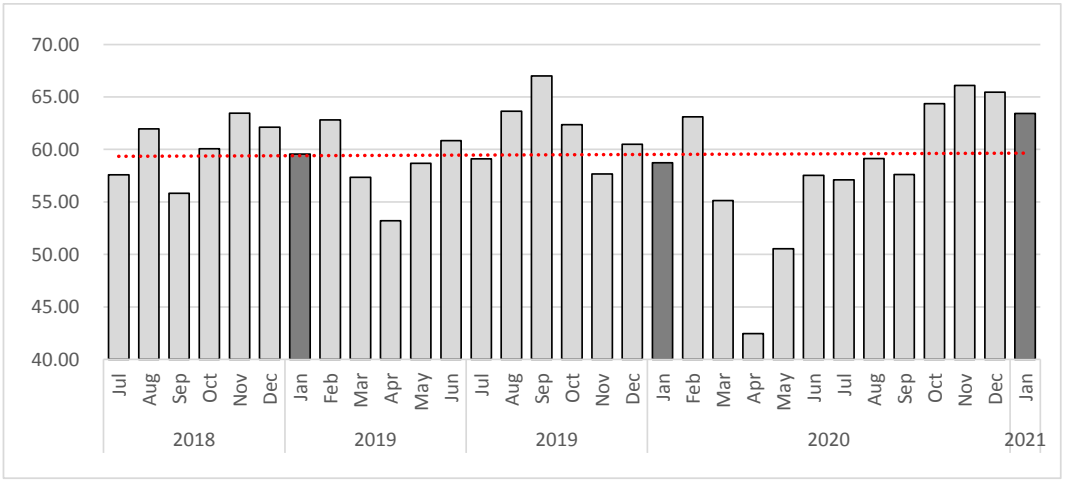
- ED Monthly 6 Hour rule performance by month

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.

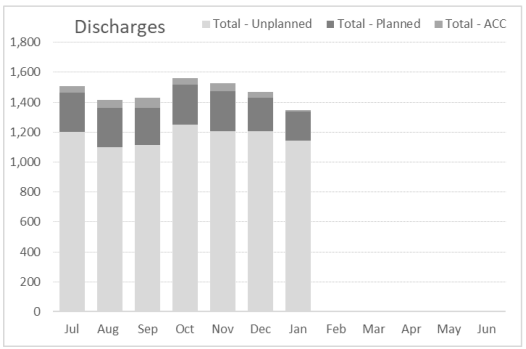


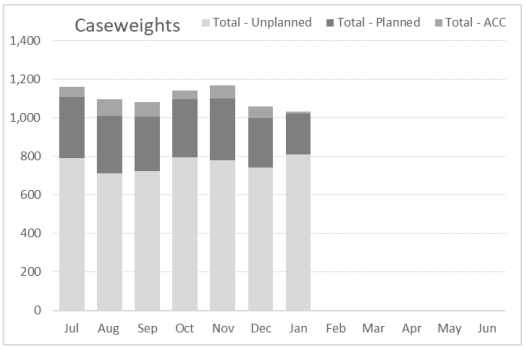
2.2 Hospital Throughput

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.

March 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

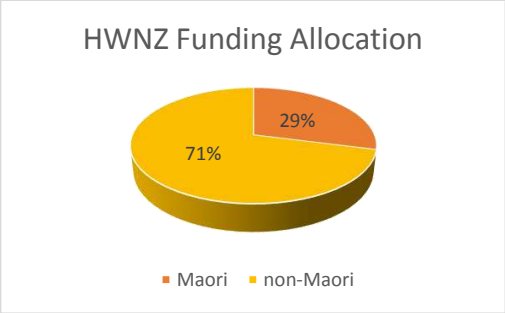
The following graph provides an overview of NETP/NESP recruited on the programmes, percentage of Maori versus non-Maori and whether they have been employed once they have graduated.

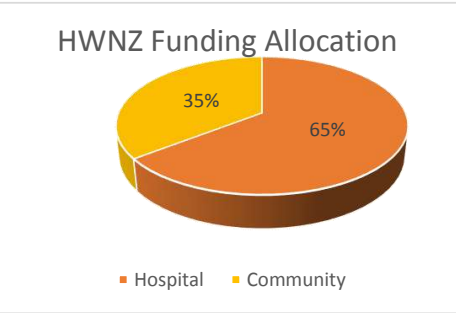
	Total NETP recruited	**WDHB**	**Expansion (primary)**	**NESP**	**Māori & Pacific Islander**	**Retained, end of NETP/NESP programme** **Across the WDHB Region**
2020	14	12	2	3	9	**NETP** To date, not all NETP have completed their NETP programme. Of those that have (7), all have permanent positions. One 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.

March 2021 **Public**

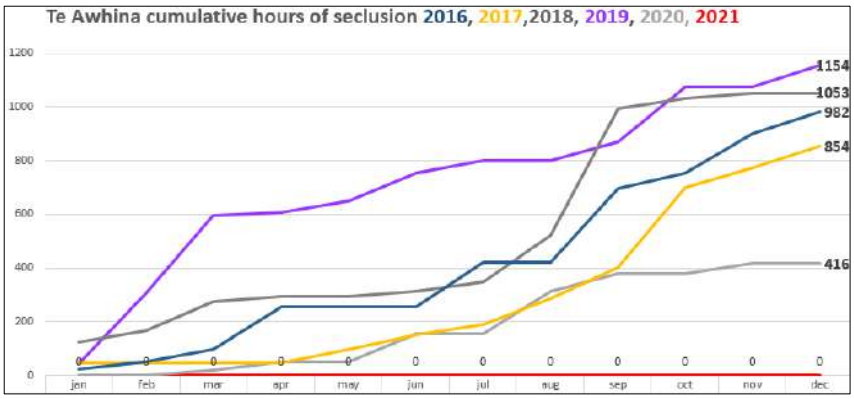
3.4 CCDM FTE Calculations

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.

March 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 was 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.

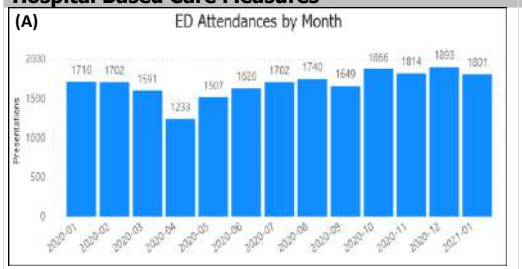
Work is underway to establish therapy assistant roles which will be transdisciplinary and work across Occupational Therapy, Physiotherapy and Social Work. Once established this role will enable greater flexibility for these services to follow up patients discharging into the community.

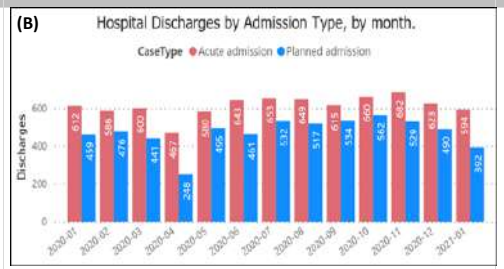
Sonography is now fully recruited to but positions will not be filled until July due to contractual obligations with locum staff.

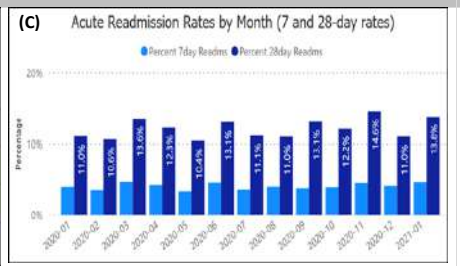
Whanganui DHB Performance Dashboard

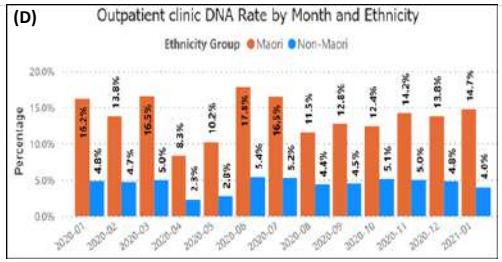
(data extracted 16.2.21) January 2021

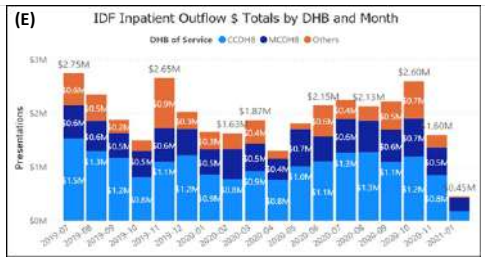
Hospital Based Care Measures

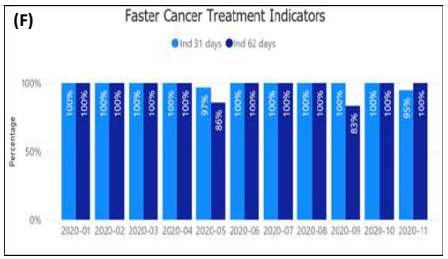










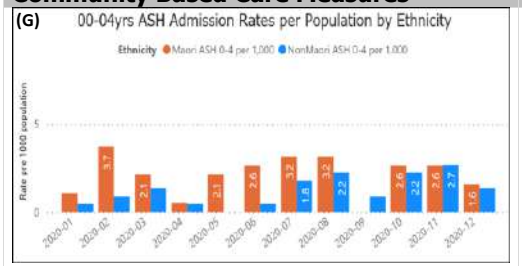


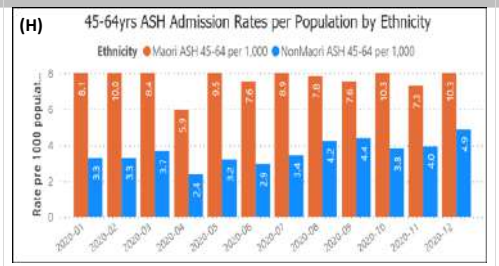
Commentary

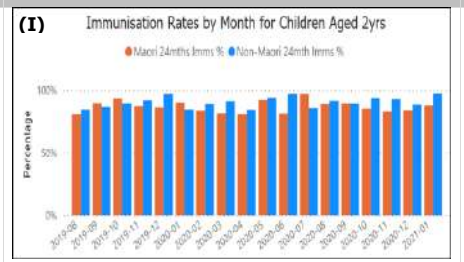
ED commentary is within the body of the report.
(B) January saw an increase in admissions and delays in discharges; a whole of system plan is under development with the aim to address patient flow issues.
(C) Re-admissions remain high. A pilot introducing an Integrated Nurse Navigator will be introduced 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



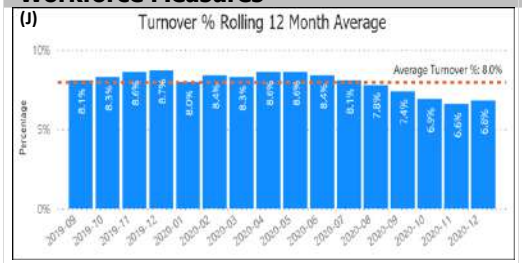




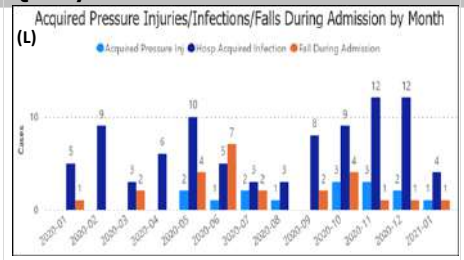
Commentary

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



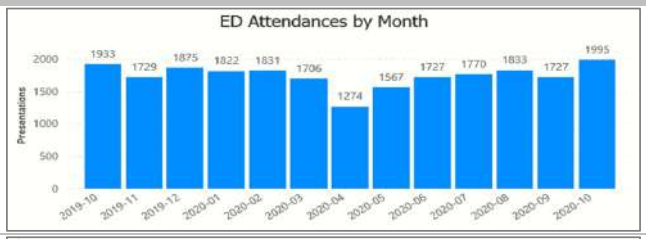
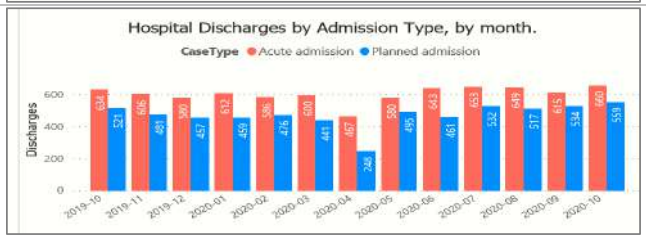
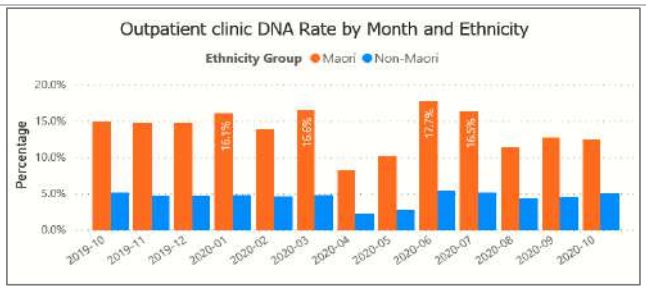
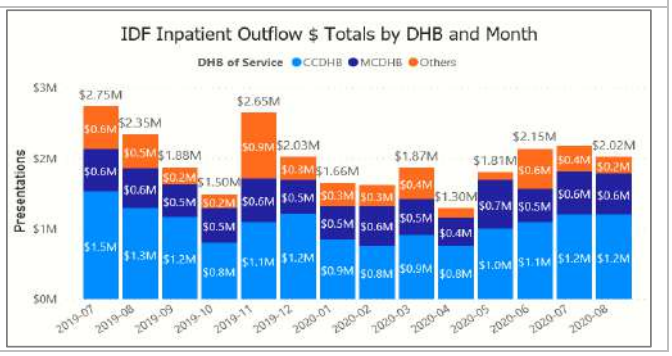
Quality

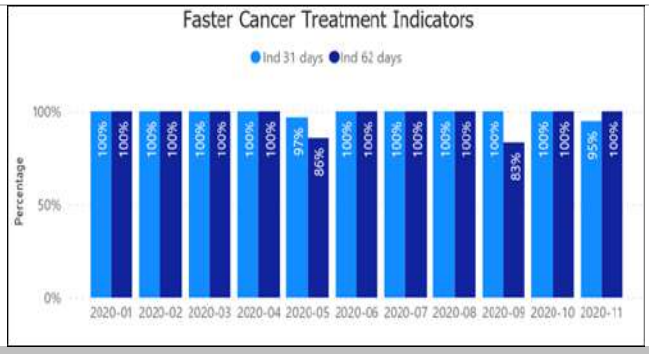
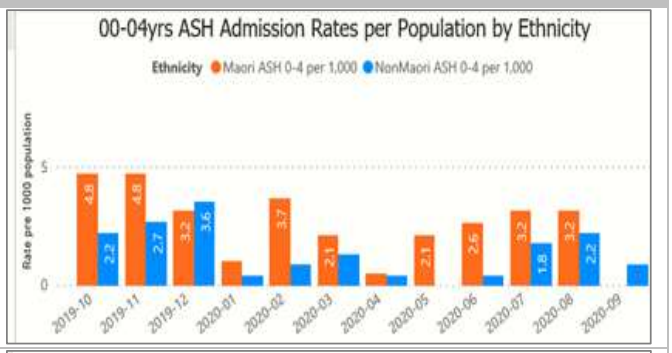
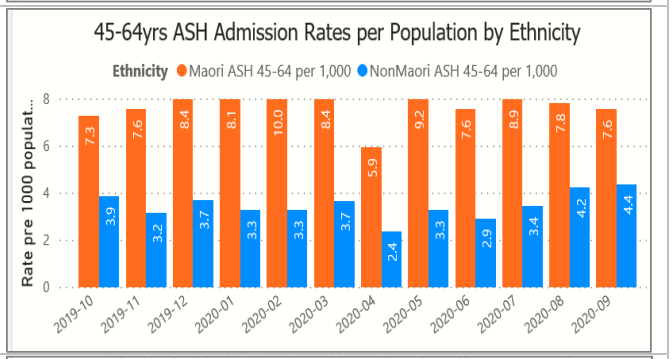
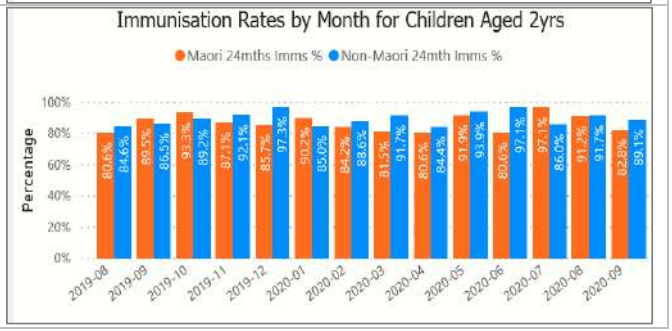


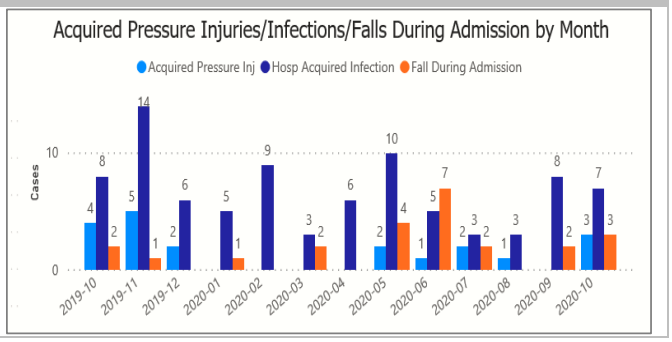
Commentary

(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.

Whanganui DHB Performance Dashboard definitions.

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.	

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	

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)	

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WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper** **3 March 2021**
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
Recommendations Management recommend that the Board **receive** the paper titled Status update reporting- Actions Included in Annual Plans	

1. Purpose

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

Not applicable	Other / Note	Achieved overall	Partially achieved	Not achieved

Status update reporting- Actions Included in Annual Plans	Quarter 1 MoH Ratings
Better population health outcomes supported by primary health care	
Better population health outcomes supported by strong and equitable public health services	
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**
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
	Provision of education and process links to general practice to develop the capacity of community pharmacies for gout, COPD, MUR and vaccination (EF)	Online Gout training course completed by participating pharmacies	
		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
	Review community pharmacy facilitation roles to ensure alignment with identified priorities including: (EF)	Ensuring Aged Residential Care have access to medicines optimization expertise of pharmacists	
		Recommendations agreed and updated service agreement completed	
		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 lens as Maori experience higher prevalence of gout arthritis.
		Gout service model confirmed & establishment commenced	The Whanganui GOUT STOP Programme is currently being implemented. This programme is a district wide collaborative

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			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.
		Respiratory service model confirmed	COPD Health Pathways under development
		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	
		Develop job description	
		Complete recruitment process	
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	
		Progress implementation of new service model	
	Explore the delivery of retinal screening in the community including identification of appropriate service model: (EF)	Consider use of other staffing groups (e.g. non-regulated) to undertake parts of the screening	
		Consider use of artificial intelligence to identify those screenings that require secondary reading from an Ophthalmologist.	
		Implement new service model	See above *

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	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	

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Better population health outcomes supported by strong and equitable public health services			
Subsection	**Activity**	**Deliverable**	**Q_1**
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)	
	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
		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
		Ongoing implementation and monitoring of Korero Mai (EF)	Met
		Korero Mai seeks to enable patients and whānau to communicate concerns about a patient's deteriorating condition	Met
		Reporting of results	Met
	Pro-equity priority areas:	Improve transparency in data and decision making: (EF)	Met
		Share equity analysis widely and include it in decision making	
		Transparency in resource allocation, including equity analysis in all publicly reported data	
		Support more authentic partnership with Māori: (EF)	Met
		Meaningful participation in the design of services and interventions to support Māori self-determination and whānau ora.	
		Ensure provision of information for Māori whānau meets the guidelines for health literacy. (EF)	Met
	Waimarino development	Co-develop design work and complete business cases (EF)	Met
		Establish project group	
		Service redesign and models of care completed	
		Facility design completed.	

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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.	
	Activity	Ongoing monitoring of CCDM and TrendCare work plans through CCDM Council. (EF)	Met
		WDHB is employing an allied health informatics role which will be the key link to advance allied health CCDM further.	
	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
		Review analytics to ensure we are collecting the correct data to respond appropriately to staffing deficit.	Met
		Align VRM to emergency response plans.	In Progress
		WDHB has a programme (Health Careers Day) to educate and enhance nursing/midwifery/allied and medical as a career. The focus is particularly for Māori as we recognise that the percentage of Māori clinical staff employed does not reflect our population.	
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
		Engage governance and clinical leadership on the potential impact of the national consistency approach	Met

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		Define options for requisite adjustments	Underway
		Work with sub-regional partners to consider mutually beneficial approaches	Met
	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)	
		Review service models and identify potential services for change	
		Review completion with recommendations	
		Understand impacts and plan for implementation of accepted recommendations	
		Collaborative Community Health Pathways	
		Localise 70 pathways for use in general practice	
	Strategic Priority 4 - Optimise sector capacity and capability	Deliver services in least intensive setting – continue to review what procedures can be undertaken in outpatient and community settings where patients have fewer barriers to access: (EF)	
		Work with secondary services, general practice and community providers to shift volumes	
		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
		Plan for implementation from Q3 2021/22	
	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	
		Review throughout	
		Reduce cancellations	
		Develop robust production plan	
		Consider flexible working arrangements and better integration with other hospital activity	

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2.6.7 Acute Demand	69,000 beds	Streamline care across community health providers	
		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	
		Develop hospital 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.	
	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
		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
		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

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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

2.6.10 Improving Quality	Adverse events	Continue to undertake CSA/RCA/Case/London Protocol review for all SAC1/2 adverse events	
		Implement the national mental health adverse event template/process when this is available	
	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
		action plans are developed where results are below the national average (EF)	
		action plans have been developed to address inequities identified in the survey returns and results. (EF)	
	Service transition	Continue to implement connecting care projects	
		Transition role from CMHAS to GP is in place	
		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	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

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Plan 2019-2030		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
		Further planning initiatives will be developed in line with the National Cancer Action Plan and national cancer agency guidance.	Underway
	Local cancer services	Service business case completed	Underway
		Facility business case completed	
		Tender for build	
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
		Discuss recommended and maximum wait time performance as standard agenda item at monthly endoscopy user group meetings. (EF)	Met
		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.
		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
		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
		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
		Review and discuss bowel screening participation rates and bowel screening colonoscopy wait time results by ethnicity (Māori, Pacific	Met

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		Island, Asian, Other) at bowel screening equity working group meetings. (EF)	
		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
2.6.13 Workforce	Be guided by the MoH Raranga Tupuake – Māori Workforce Development Plan. (EF)	Guidance is reflected in actions	Met
	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.
	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
	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.
		Implement the WDHB recruitment and retention strategy focused on Māori staff. (EOA)	
		Increase number of Māori staff working in health across the district	
	Develop a sustainable approach to nursing career pathways.	Equitable funding for professional development for nurse practitioners	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.

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		Accreditation requirements met.	
		Education committee actively leads training at all levels within the DHB.	
	Gender Equity.	Implement equity and pay parity agreements as per the agreed settlement timeframes.	Bargaining / Negotiations continues
	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.
	Proactively promote Ministry of Health funding for Māori particularly in kura kaupapa and kura auraki settings. (EOA)	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 - 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
	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.
		Cultural safety monitored against changes to individual clinical practice which ensures Māori receive optimum care	Ongoing
		Expand existing programmes that build on organisation culture and values to include action on racism and institutional bias	In progress
	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
	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

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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
		Have representation on regional clinical governance to ensure measurable clinical value	Met
		Involved in a refresh of the regional strategy with a modern digital context	Ongoing work by central region DHBs with external consultants and TAS
	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
		MS Teams supports greater collaboration with community and other external agencies	Continue to roll out teams aligned with hardware refresh
		Data sharing with main PHO generates shared insights	Ongoing
		Shared electronic health record makes primary care patient portal available to hospital clinicians	Access to manage my Health data available from CP
	Consumer access to health information:	Deliver technology solution	No action
		Change management completion	
	DHB ICT investment portfolio:	WDHB commit to providing quarterly reports to Data and Digital directorate	No action
	Digital Maturity Assessment programme	WDHB commit to commence taking part in this programme at the earliest opportunity.	
	Embedding gains from changes introduced during Covid-19:	Roll out of Microsoft Office and Teams	Follows roll out of new hardware
		Creating technical capability for roll-out of telehealth within DHB-provided services	Telehealth system utilised in some areas continuing with the roll out
	Fax machines. In removing fax machines WDHB will:	Provide secure email supported by SMS text messaging	
		Utilise secure links through MS teams to provide collaboration access to files	Follows roll out of teams
		Deconfigure fax access in multifunction printers with fax components.	Work underway

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		Implement eReferrals to replace the current fax process.	Generic referral form out for consultation. DXC system on the Service 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.	
		Enhanced security features available through our MS e5 licensing will be implemented	Some features turned on others require further testing
		Upgrade operating systems and replace aged hardware.	Follows roll out of new hardware

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Give practical effect to He Korowai Oranga – the Māori Health Strategy			
Subsection	**Activity**	**Deliverable**	**Q_1**
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
		Regular joint hui (EF)	Met
		Review Memorandum of Understanding (MoU) between WDHB and HAI boards in 2020 (EF)	
		Involvement of HAI members in all key DHB strategic discussions and decisions (EF)	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)	
		Joint board monitoring of equity measures in WDHB Annual Plan and pro-equity implementation work plan (EF)	Not met. Scheduled for next joint boards
		HAI representation on all interviews for executive positions (EF)	Met
		HAI representation on combined statutory advisory committees and performance review for chief executive (EF)	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
		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	Met

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		the Treaty clauses under the NZ Public Health and Disability Act 2000. (EF)	
	Partnership	Implement recommendations from the WDHB consumer involvement review 2020, including Te Pukaea and grow the number of Māori members to 50% of the total membership (EOA)	
		Implement Term of Reference for a Māori reference group to provide Māori community and health expertise advice to key service developments, service improvements, development of Māori health policy and frameworks to ensure that we have a wider Te Ao Māori lens applied to our work (EF)	
		Develop a work programme between the WDHB and HAI boards to measure improvement in equity for Māori across annual plan equity-oriented activity indicators and the WDHB pro-equity work programme (EF)	
		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)	
		Continue participation in the Central Region GM Māori forum to influence across the region and share learnings and initiatives. (EF)	Met
		Continue participation in national Māori health leadership forum Tumu Whakarae. (EF)	Met
	Pro-equity	Continue to implement the WDHB Pro-equity Check-up Actions Implementation Plan 2019-21 report under 5 recommendations:	
		Strengthen organisational leadership and accountability for equity (EF)	Met
		Build Māori workforce and Māori health and equity capability (linked to workforce development) (EOA)	Met
		Improve transparency in data and decision making (EOA)	Not met. In progress.
		Support more authentic partnership with Māori. (EF)	Met
	Leadership	Continue to provide professional development (training) for DHB leadership on the impact of racism, impact on colleagues and	

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		workforce, the impact on quality outcomes for patients and their whānau, and the use of equity tools and methodologies. (EOA)	
		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)	
		Continue to support equity professional development to local provider partner leaders (EOA)	Met
		Apply equity methodology and monitoring to decision-making processes including commissioning, service delivery models and service changes (EOA)	Met
		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
		Continue to provide cultural safety education as part of WDHB board member local induction programme (EOA)	Met
		Continue to role model WDHB values and WDHB tikanga o Whanganui practices. (EF)	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)	
		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
		Review (MHOAG) Terms of Reference (EF)	
		Continuing to contract with kaupapa Māori service providers to maximise the use of whānau ora outcomes focused contracts:	Met
		Maximise opportunities presented through the COVID -19 response to improve funding models and models of care and delivery (EF)	
		Implement any changes (EF)	

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		Constantly seeking opportunities to provide a service in a kaupapa Māori setting/way, especially with any new initiative and funding opportunities (EF)	Met
2.1.3 MHAP – shifting cultural and social norms	Addressing bias in decision making:	Initiate a more focused programme on biases in best practice that affects patient outcomes – building on the examples from medical bodies and programmes in other DHBs. Establish an ongoing forum for Māori staff to meet and feedback on activities that achieve equity in health outcomes for Māori whānau, WDHB Māori health strategy and policy initiatives and whānau focused models of service delivery – monitoring and audit (EF)	
		Continue to provide a professional development (training) for DHB leadership and staff on the impact of racism, impact on colleagues and workforce, the impact on quality outcomes for patients and their whānau (EF)	
		Include learnings from other DHBs on programmes, speakers and tools to support staff. (EF)	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
		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
		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
		Ensure leaders 'walk the talk 'and more specifically addresses racism and discrimination within the frame of the organisation's values and expectation that racism and discrimination of any sort is unacceptable. (EF)	Not met. Education ongoing to support leaders
	WDHB Pro-equity Check Up implementation plan identifies a programme of work that builds	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

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	on what the DHB is already undertaking to shift cultural and social norms.	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
		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
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)	
		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
2.1.5 MHAP – strengthening system settings	Activity	Driving a commitment to pro-equity approach through governance support and executive leadership. (EF)	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)	
		Use contractual opportunities to increase equity-based reporting from contracted providers	Not met. To be progressed

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Improving Child Wellbeing			
Subsection	**Activity**	**Deliverable**	**Q_1**
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.
		Develop a plan for the Whanganui rohe recruitment and retention of Lead Maternity Carers with a focus on recruiting Māori LMCs. (EOA)	
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 of the review.
	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

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			the aim to be fully operational by March 2021.
		Implement new service tranche 1	
		Implement new service tranche 2 & 3.	
		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)	
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)	
		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.
		Work with general practices to identify, trial, pilot innovative approaches to reaching target populations, ie different places, times. etc. Review and evaluate success of approaches. Feedback data in a responsive way via practice facilitators (EF)	
		Whanganui Regional Health Network and Te Oranganui health provider are trialing Saturday wellness clinics at	
		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 ongoing
	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
	Work alongside interagency networks, communities, to support an increase in Māori	Undertake review of participants immunisation status	
		Provide onsite immunisations when able	
		Provide statistics for both WINZ and WDHB.	

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	childhood immunisation coverage. (EOA)	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	
		Provide immunisation clinics between July-November 2020.	

Improving Mental Wellbeing			
Subsection	**Activity**	**Deliverable**	**Q_1**
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
		Consider the full continuum of need for the Whanganui rohe	
		Include participation and perspectives of people with lived experience	Ongoing
		Enable co-design and iwi/community engagement from diverse communities	Ongoing

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		Provide recommendations to primary and secondary fund-holders.	Ongoing
	Placing people, whānau and tangata whaiora at the centre of all service planning, implementation and monitoring programmes:	Support mechanisms that enable real time feedback from tangata whaiora and their whānau into quality programmes by improved utilisation and uptake of Marama Real Time Feedback and participation in the Conversation Cafe (EF)	Met
		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
		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
		Actively partner with the Māori Health Outcomes Advisory Group (MHOAG) to facilitate efficacy of the Matauranga Māori qualitative research (EF)	Work in progress
		Development of a mental health and addiction measures dashboard to enable effective monitoring including of equity. (EF)	Work in progress
	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
		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
		Implement 'Supporting Parents, Healthy Children' to support early intervention in the life course (EF)	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)	
		Target people with low prevalence conditions to be a priority for DHBs funded employment, education and training resource (EF)	Work in progress

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		Resuming the Equally Well project to improve the physical health outcomes for people with mental health and addiction conditions (EF)	To commence
		Improving responses to co-existing problems via stronger integration and collaboration between other health and social services. (EF)	Work in progress
	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
		Pass on maximum cost pressure funding to DHB funded mental health and addiction NGOs as of 1 July 2020	Met
		Enhance respite options to include an emphasis on therapeutic programs and smooth transitions of care	Met
		Support the roll out of new primary level responses (EOA)	Met
		Strengthen and increase focus on mental health promotion, prevention, identification and early intervention (EF)	Work in progress
		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
		Review the current delivery of home treatment and assertive outreach and consider day therapeutic programme options	
		Implement commitment to resourcing Emergency Department with a specialist mental health and addiction educator to build capability of front line staff	
		Work alongside other colleagues to modify the Whakataketake combined risk assessment screening questions to incorporate mental health risk screening for depression and suicidality	
		In the Network model of care, clinical psychologists in each hub provide support to primary care clinicians in order to	
		Share knowledge and expertise and increase access.	

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		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.	
	Suicide prevention	Co-design high level action plans with community leaders and communities	Work in progress
		Implement from 1 July 2020 applying equity thinking and methodology at every touch point.	Work in progress
	Workforce (note links to section 2.6.13 and 4.3):	Work towards developing a workforce that reflects the community (EOA)	
		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	
		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.	
		Prioritise workforce education and upskilling of clinicians in psychological therapies as well as supporting primary care clinicians to upskill (EF)	
		Continue to build the knowledge of all WDHB staff in Te Tiriti o Waitangi, pro-equity and impacts of racism (EF)	Work in progress
		Ensure all staff have completed the WDHB cultural education programme Hapai te Hoe (EF)	Work in progress
		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
		Enable staff to participate in cultural competence and cultural safety training and development, including supporting clinicians in the implementation of the Medical Council of NZ Statement on Cultural	

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		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)	
		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)	
	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
	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
		Develop new measures alongside providing reporting on priority measures, and addressing equity, including: (EF)	Work in progress
		Access	Work in progress
		Comparative data to allow for assurance of equity for Māori and youth	
		Reducing waiting times	Work in progress
		Completion of transition/discharge plans and care plans	Met
		Mental health and addiction service development	Work in progress
		Reducing inequities	Work in progress
		Continue engagement with the regional MMH team for ongoing training and knowledge sharing opportunities e.g. via Perinatal Anxiety and Depression Aotearoa (PADA) (EF)	
2.4.4 Maternal mental health services	Develop intensive intervention for pregnant women and whānau with children under 3 years with co-existing alcohol and other drug	Develop kaupapa Māori service model	The WDHB is collaborating with MHOAG to develop, design and implement an Iwi led kaupapa Maori service delivered across five Iwi health providers. The

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	issues using a kaupapa Māori model: (EOA) (Note: link to 2.3.1)		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.
		Implement new service tranche 1	
		Implement new service tranche 2 & 3	
	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)	
		Support development of the new Pregnancy and Parenting service by reporting on specific activities undertaken and evidence to develop integration and referral pathways across both areas of the new service with a focus on equity. (EOA)	

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Improved Sustainability			
Subsection	**Activity**	**Deliverable**	**Q_1**
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
		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.
		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.
		Implement wellness/prevention model of care for reducing future cost including those at risk of hospital admission/readmission	On-going.
		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.
	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	Ongoing. All staff appointments (new and replacements) are required to be justified with final

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		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.	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.
	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
		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
		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
		Redesign community care & regional arrangements to reduce out of district travel where possible	Met. 1. Regular review of regional service discussed by COOs 2. Funding models confirmed 3. Central Alliance MOU updated to show overall agreement plus schedules
		Enhanced planning of non-washed up elements with improved annual reconciliation, redesign and renegotiation	Met
	Radiology efficiencies	Reduce costs associated with out of hours radiology Monday-Friday by initially extending general x-ray on site hours to 11pm	Met

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		and reducing out of hours CT examinations that are not considered urgent.	
		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.
		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
	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
		Review throughput per session by speciality to maximise resources.	Met. Findings and actions included in completed action plan included
		Preference standardisation	Met
		Manage medical devices and consumables to budget	Met
		Complete a theatre production plan to ensure DHB drives efficiencies and meets compliance rates.	Met. Action plan and timelines developed, completed and circulated
		Create a flexible workforce, and reconfigure the working day (activities, ie ward rounds/OP etc).	Met
2.2.3 Consideration of innovative	Dual purpose clinic supports winter plan and readiness for re-	Continue to run the central community based assessment centre (CBAC) using primary care capacity at the hospital front door through to September 2020	Met

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models of care and the scope of practice for the workforce to support system sustainability	establishment of COVID testing capability	Clinic deals with all influenza-like illness as a pre-urgent care and pre-emergency department pathway	Met
		Screening of patients in their cars before guiding to definitive treatment in the clinic or referral to urgent care or emergency department	Met
		Provides capacity for ad hoc or regular COVID testing if necessary	Met
		Re-evaluate for continuation and consideration of role in future winter plan	
	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
	Establish peer support model to support a more sustainable and holistic response to tangata whaiora in acute and emergency mental health settings	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.
	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

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	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
	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 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

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			secondary working relationships around referrals and discharges.
		Respond to any further RFPs and evaluate impact for consideration of expansion	Ongoing

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Improving wellbeing through Prevention

Subsection	Activity	Deliverable	Q_1
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
		Identify and recruit a student undertaking current health policy studies	Delays due to Covid 19
		Scoping report completed for student Internship for a Policy Assistant position at Public Health (EF)	Delays due to Covid 19
		Approval of internship and criteria for Policy Assistant completed by January 2021 (EF)	Delays due to Covid 19
		Establish Student Internship for a Policy Assistant position at Public Health by June 2021 (EF)	Delays due to Covid 19
		Increasing expertise in the HiAP model and its applicability to other areas of WDHB activity	Delays due to Covid 19
		Identify subject matter expert	Delays due to Covid 19
		Scope relevant consultation and engagement pathways	Delays due to Covid 19
		Draft action plan	Delays due to Covid 19
		Develop a strategic analysis by 31 March 2021 to highlight the opportunities for supporting inclusion of HiAP across the public sector.	
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

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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	
		Needs Analysis Report completed and published by 31 December 2020	
		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
		Increased engagement, referrals and outcomes for Māori, Pacific people and pregnant women	Partial
		Support priority settings where Māori live, learn, work and play to create supportive health promoting environments	Delays due to Parental Leave
		Advocate and support the development of healthy public policy that supports smokefree and vapefree environments	Delays due to Parental Leave
		To promote and raise the awareness and knowledge of a Smokefree Aotearoa 2025 goal	Partial
		Smokefree Aotearoa 2025 logo and messages included across Smokefree projects, communication and resources	Delays due to Parental Leave
		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.	
		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.	
		Explore and agree options with the PHO to review current activities to achieve and maintain 'Better help for Smokers to quit'.	
2.5.8 Cervical screening	Significant inequity in screening rates persist in Whanganui rohe.	Identifying barriers and address the needs of Māori & Pacific women through: (EF)	

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	To improve equity we aim for a 10% increase in completed screens by priority populations on the previous 12 months by:	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	
		Proactive follow up by general practice, outreach service and Iwi health providers	
		Māori health providers located across the region to support women to screening including offering transport, information	Met
		Improving access to Pacific women through community networks focused on Rangitikei population: (EF)	Met
		Consider Pacific 'kaiawhina role' including completing population profile and needs and scoping requirements with key stakeholders	Partial
		Increase screening rates for Asian women through identification of practice registers and providing targeted outreach approach: (EF)	Partial
		Develop relationship with Asian nursing workforce to inform approach	
		Use population-specific health promotion approaches to encourage uptake of screening opportunities: (EF)	
		Develop one communication flyer with key messaging in Te Reo, Pacific and Asian	Partial
		Improving screening rates for Māori & Pacific women through: (EOA)	
		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
		Identification of appropriate screening venues e.g. workplaces, Marae & community settings	
		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)	

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		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)	
2.5.9 Reducing alcohol related harm	Activity	Cohesive relationship between Public Health, Health Protection and the Alcohol Licensing Cluster Group for monitoring and surveillance of the Whanganui District Alcohol Licensing accord and related activities	Met ongoing
		Quarterly monitoring and reporting surveillance of alcohol-related hospital presentations including improving maintaining the processes of data capturing within the DHB	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	
		In partnership with community probation service, community Mental Health & Addictions, Te Oranganui and WDHB develop a sustainable Brief Intervention Programme for Community Corrections (EOA)	
		To consult and co-design a Brief Intervention programme with key stakeholders and other interested parties	

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WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	3 March 2021
Author	Kilian O'Gorman, Business Support Strategy, Commissioning and Population Health
Endorsed by	Paul Malan, General Manager Strategy, Commissioning and Population Health
Subject	Final Ratings Quarter 1 Non-Financial Performance Framework Measures

Recommendations

It is recommended that the Board **receive** the paper titled Final Ratings Quarter 1 Non-Financial Performance Framework Measures

1. Purpose

This paper provides Ministry of Health final ratings on the quarter 1 *(July/Aug/Sept 2020)* non-financial performance framework results.

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Measure	Q-1
Ratings confirmed?	✓
Key Achieved / Partial / Not achieved / Not req'd / Update due	
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	
CW08: Increased immunisation 2 years	
CW09 Better help for smokers to quit (maternity)	
CW10: Raising healthy kids	
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	
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	
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)	

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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	
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	

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WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Decision paper**
	3 March 2021
Author	Nadine Mackintosh, Board Secretary
Endorsed by	Russell Simpson, Chief Executive
Subject	**Resolution to exclude the public**

Recommendations

Management recommend that the Whanganui District Health Board:

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

Agenda item	Reason	OIA reference
Whanganui District Health Board minutes of meeting held on 27 November 2020	For reasons set out in the board's agenda of 27 November 2020	As per the board agenda of 27 November
Chief executive's report	To protect the privacy of natural persons, including that of deceased natural persons	Section 9(2)(a)
Committee minutes	To avoid prejudice to measures protecting the health or safety of members of the public	Section 9(2)(c)
Sustainability Reporting	To protect information which is subject to an obligation of confidence or which any person has been or could be compelled to provide under the authority of any enactment, where the making available of the information would be likely to prejudice the supply of similar information, or information from the same source, and it is in the public interest that such information should continue to be supplied; or would be likely otherwise to damage the public interest.	Section 9(2)(ba)
Laboratory and Pathology services contract MOH Infrastructure Programme updates Māori Partnership Board MoU	To enable the district health board to carry out, without prejudice or disadvantage, commercial activities or negotiations (including commercial and industrial negotiations	Section 9(2)(i) and 9(2)(j)
Draft Annual Plan	To maintain the effective conduct of public affairs through the free and frank expression of opinions by or between or to Ministers of the Crown or members of an organisation or officers and employees of any department or organisation in the course of their duty	Section 9 (2) (g) (i)

Persons permitted to remain during the public excluded session

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

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