MidCentral District Health Board

Te Pae Hauora o Ruahine o Tararua

Part One HDAC Papers

1 March 2022 HDAC

Printed from Stellar by
Margaret Bell <margaret.bell@midcentraldhb.govt.nz>

Contents

Agenda

1 March 2022 HDAC

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MidCentral District Health Board

Health and Disability Advisory Committee Meeting

Venue: via Zoom (due to COVID-19 restrictions)

When: Tuesday 1 March 2022, from 9.00am

PART ONE

Members

John Waldon (Committee Chair), Heather Browning, Vaughan Dennison, Lew Findlay, Norman Gray, Muriel Hancock, Materoa Mar, Karen Naylor, Oriana Paewai, Stephen Paewai, Jenny Warren.

Apologies

Brendan Duffy (Board Chair)

In attendance

Kathryn Cook, Chief Executive; Kelvin Billinghurst, Chief Medical Officer; Debbie Davies, Interim General Manager, Strategy, Planning and Performance; Celina Eves, Executive Director, Nursing and Midwifery; Gabrielle Scott, Executive Director, Allied Health and Interim General Manager, Quality and Innovation; Tracee Te Huia, General Manager, Māori Health; Emma Horsley, Communications Manager; Margaret Bell, Board Secretary.

In attendance (part meeting)

Item 3	Operations and Clinical Executives: Scott Ambridge, Dr Jeff Brown, Debbie Davies, Sarah Fenwick, Dr Claire Hardie, Lyn Horgan, Dr Syed Zaman
Item 4.1	Dr David Peel, Radiation Oncologist; Dr Claire Hardie, Clinical Executive and Sarah Fenwick, Operations Executive, Te Uru Mātai Matengau
Item 5.1	Michelle Riwai, General Manager, Enable New Zealand
Item 6.1	Scott Ambridge, Operations Executive, Te Uru Rauhī
Item 6.2	Keyur Anjaria, General Manager, People and Culture
Items 7.1 and 7.2	Angela Rainham, Locality and Intersectoral Development Manager

Please contact the Board Secretary if you require a print copy – email boardsupport@midcentraldhb.govt.nz before noon on the working day prior to the meeting

1. KARAKIA 9.00

He Karakia Timata
Kia hora te marino — May peace be widespread
Kia whakapapa pounamu te moana — May the sea be smooth like greenstone
He huarahi ma tātou I te rangi nei — A pathway for us all this day
Aroha atu, aroha mai — Give love, receive love
Tātou I a tātou I ngā wa katoa — Let us show respect for each other
Hui e taiki e

2. ADMINISTRATIVE MATTERS 9.05

2.1. Apologies
2.2. Late items
2.3. Register of Interests Update
2.4. Minutes of Health and Disability Advisory Committee meeting – 23 November 2021, Part One
2.5. Matters arising

3. DIRECTORATE WITH CLUSTER FUNCTIONS REPORTING 9.10

3.1. Directorate Dashboard
3.2. Te Uru Mātai Matengau – Cancer Treatment, Screening and Support
3.3. Te Uru Pā Harakeke – Healthy Women, Children and Youth
3.4. Te Uru Rauhī – Mental Health and Addiction Services
3.5. Te Uru Arotau – Acute and Elective Specialist Services
3.6. Te Uru Whakamauora – Healthy Ageing and Rehabilitation
3.7. Te Uru Kiriora – Primary, Public and Community Health

4. STRATEGIC FOCUS 10.00

4.1 Regional Cancer Services and Te Aho o Te Kahu

REFRESHMENT BREAK 10.15

5. PERFORMANCE REPORTING 10.30

5.1. Enable New Zealand Report

5.2. Pae Ora Paiaka Whaiora Report

5.3. Quality and Safety Dashboard

6. DISCUSSION/DECISION PAPERS 10.50

6.1. Māori Health Equity Dashboard – Mental Health Indicators

6.2. Māori Health Equity Dashboard – Workforce Indicators

7. INFORMATION PAPERS 11.10

Information papers for the Board to note

7.1. Regional Services Plan – Quarter One and Quarter Two

7.2. Locality Plan Progress Report – Manawatū

7.3. Committee's Work Programme

8. GLOSSARY OF TERMS

9. LATE ITEMS

10. DATE OF NEXT MEETING – Tuesday 24 May 2022

11. EXCLUSION OF THE PUBLIC

Recommendation

That the public be **excluded** from this meeting in accordance with the Official Information Act 1992, section 9 for the following items for the reasons stated.

Item	Reason	Reference
'In committee' minutes of the previous Health and Disability Advisory Committee meeting	For reasons set out in the agenda of 23 November 2021 meeting held with the public present	
Serious Adverse Events (SAC 1) Report	To protect patient privacy	9(2)(a)

PART ONE TO FINISH BY 11.40am

Administrative matters

1 March 2022 HDAC

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Apologies

Any apologies to be noted?

Late items

Opportunity to advise any late items to be discussed at the meeting

Register of Interests: Summary, 25 February 2022
(Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)

Board Members		
Name	**Date**	**Nature of Interest / Company/Organisation**
Browning, Heather	4.11.19	Director – HB Partners Limited
		Member – MidCentral Governance Group Mana Whaikaha
		Board Member and Chair, HR Committee – Workbridge
	26.7.20	Director and Shareholder – Mana Whaikaha Ltd
	23.10.20	Member – Te Aho o Te Kahu (Cancer Control Agency) Consumer Reference Group
	9.2.21	Project Manager to lead Mana Whaikaha out of the Ministry of Health; stood down from appointed role of Deputy Chair of the MidCentral Governance Group for the MidCentral prototype
		Resigned as Director of Mana Whaikaha Ltd – effective from December 2020
	12.7.21	Appointed to the Support and Consultation for End of Life Choice in New Zealand (SCENZ) Group – a statutory part-time role within the Ministry of Health.
Duffy, Brendan	3.8.17	Chair and Commissioner – Local Government Commission
		Member – Representation Commission
		Chairperson – Business Kapiti Horowhenua Inc (BKH)
	17.8.21	Trustee – Eastern and Central Community Trust
	16.12.21	Chairperson – Horowhenua Health and Wellbeing Hub Stakeholder Advisory Group
Dennison, Vaughan	4.2.20	Councillor – Palmerston North City Council
	9.2.21	Member of Palmerston North City Council Infrastructure Committee
	14.9.21	Employee – Homes for People, Kaitiaki, Public Relations
		Director – Social Impact Property, Property and Support Services
		Partner – Dennison Rogers-Dennison, Accommodation Services
		Trustee – Manawatū Whanganui Disaster Relief Fund
		Chair – Camp Rangi Woods Trust
		Board Member – Softball New Zealand
		Patron – Manawatū Softball Association
		Wife is a Partner – Dennison Rogers-Dennison, Accommodation Services
		Wife is an employee – Homes for People, Kaitiaki, Support Worker
		Wife is an employee – Healthcare NZ, Community Support Worker
		Father is Managing Director, Exclusive Cleaning Services
Findlay, Lew	1.11.19	President, Manawatu Branch and Director Central District - Grey Power
		Councillor – Palmerston North City Council
		Member – Abbeyfield
	16.2.21	Vice President Manawatū Branch and Board Member of Grey Power New Zealand
Gray, Norman	10.12.19	Employee – Wairarapa DHB
		Branch Representative – Association of Salaried Medical Specialists

Register of Interests: Summary, 25 February 2022 (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)		
Hancock, Muriel	4.11.19	Sister is casual employee (Registered Nurse, ICU) – MidCentral DHB
		Volunteer, MidCentral DHB Medical Museum
	30.9.20	Sister-in-law is employed as a registered nurse at Whakapai Hauora
	19.11.21	Sister-in-law works as a COVID-19 vaccinator for MidCentral DHB
	1.2.22	Sister-in-law no longer works for Whakapai Hauora
Mar, Materoa	16.12.19	Upoko Whakarae Te Tihi O Ruahine Whānau Ora Alliance
		Chair – EMERGE Aotearoa
		Matanga Mauri Ora Ministry of Health Mental Health and Addiction
		Chair, 'A Better Start – E Tipu Rea', National Science Challenge, Liggins Institute, University of Auckland
	11.2.20	Member of MDHB Cluster
		Member of local Child and Youth Mortality Review Group (CYMRG)
	5.8.20	Member of MDHB's Māori Alliance Leadership Team (MALT)
	13.7.21	Member – Te Ahu Whenua Māori Land Trust
	17.8.21	Member, Māori Provider Expert Reference Group for Transitional Health Unit
Naylor, Karen	6.12.10	Employee – MidCentral DHB
		Member and Workplace Delegate – NZ Nurses Organisation
	9.10.16	Councillor – Palmerston North City Council
Paewai, Oriana	1.5.10	Member – Te Runanga o Raukawa Governance Group
		Chair – Manawhenua Hauora
	13.6.17	Co-ordinating Chair – Te Whiti ki te Uru (Central Region DHB MRBs)
		Member Nga Manu Taiko, a standing committee of the Council – Manawatū District Council
		Member – Te Tihi o Ruahine Whānau Ora Alliance
		Board Member – Cancer Society Manawatū
	30.8.18	Appointed Member – Massey University Council
	13.4.21	Trustee – Manawatū/Whanganui Children's Health Charitable Trust Board
	27.7.21	Member – Governance Board, Mana Whaikaha
	9.11.21	No longer a Board Member – Cancer Society Manawatū
		No longer a member of Nga Manu Taiko, a standing committee of the Manawatū District Council
	9.2.22	Co-Chair, Regional Skills Leadership Group, Manawatū-Whanganui
Waldon, John	22.11.18	Co-director and co-owner – Churchyard Physiotherapy Ltd
		Co-director and researcher – 2 Tama Limited
		Manawatu District President – Cancer Society
		Executive Committee Central Districts (rep for Manawatu, 1 of 2) – Cancer Society
	9.2.21	Has a contract with UCOL
	14.12.21	No longer contracted to UCOL
		Appointed as Research Advisor Māori to Massey University (commencing 17 January 2022)

Register of Interests: Summary, 25 February 2022 (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)		
Warren, Jenny	6.11.19	Team Leader Bumps to Babies – Barnardos New Zealand
		Consumer Representatives National Executive Committee – National On Track Network
		Pregnancy and Parenting Education Contractor – Palmerston North Parents' Centre
	12.2.21	Member of Locality Advisory Group for both Tararua and Ōtaki/Horowhenua for the Primary Maternity Project
	1.7.21	Enhancing NZ Clinical Trials – member of Consumer Focus Group (run by the Liggins Institute with funding from the Ministry of Health and Health Research Council)
		No longer Team Leader Bumps to Babies – Barnados New Zealand
	15.10.21	No longer Pregnancy and Parenting Education Contractor – Palmerston North Parents' Centre
	4.11.21	No longer a member of the Locality Advisory Group for Tararua and Ōtaki/Horowhenua for the Primary Maternity Project
	9.11.21	Contract with Horowhenua Life to the Max
	19.11.21	Contract with The Horowhenua Company
Committee Members		
Allan, Simon (FRAC)	2.6.20	Deputy Chair – Manawatu Branch of Cancer Society
		MDHB Rep – THINK Hauora
		Palliative Care Advisory Panel (Ministry of Health advisory body)
		Director of Palliative Care – Arohanui Hospice
		Chair of Board – Manawatu Badminton Association
Hartevelt, Tony (FRAC)	14.8.16	Independent Director – Otaki Family Medicine Ltd
	14.8.16	Elder son is Director, Global Oncology Policy based at Head Office, USA – Merck Sharpe & Dohme (Merck) (NZ operations for Global Pharmaceutical Company)
	14.8.16	Younger son is news director for Stuff.co.nz – Fairfax Media
	7.10.19	Independent Chair, PSAAP's Primary Care Caucus – Primary Health Organisational Service Agreement Amendment Protocol (PSAAP)
	14.10.21	Resigned as Independent Chair of the Primary Care Caucus for PSAAP negotiations
Paewai, Stephen (HDAC)	24.11.21	Trustee – THINK Hauora
		Member of MDHB's Consumer Council (Interim Chair from November 2021)
		Member of THINK Hauora's Clinical and Digital Governance Committee
		Beneficiary of Rangitane o Tamaka nui a Rua Inc Society
		Trustee – Te Tahua Trust
		Trustee – Te Ohu Tiaki o Rangitane Te Ika a Maui Trust
		Director – Rangitane o Te Ika a Maui
		Board member – Tararua REAP
		Member – Lottery Community Manawatū/Whanganui
		Wife is an employee of MCI and Associates, accounting practice
		Brother-in-law is a senior manager, ACC

Register of Interests: Summary, 25 February 2022 (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)		
Management		
Cook, Kathryn	13.4.21	Nil
Ambridge, Scott	20.8.10	Nil
Amoore, Anne	23.8.04	Nil
Anjaria, Keyur	17.7.17	Wife is a user of the Needs Assessment and Service Co-ordination Service – MDHB
Bell, Margaret	28.7.20	Nil
Billinghurst, Kelvin	6.8.20	Fellow of the Royal College of Medical Administration (RACMA) Coordinator for the Indigenous Health Programme – RACMA Member of the Rural Policy Advisory Group – RACMA Fellow of the Australasian College of Health Service Managers (ACHSM)
Brogden, Greg	16.2.16	Nil
Brown, Jeff		TBA
Davies, Deborah	18.5.18	Member, Alliance Leadership Team – Central PHO Daughter is an employee and works within hospital services – MidCentral DHB
Eves, Celina	20.4.20	Trustee – Palmerston North Medical Trust
Fenwick, Sarah	13.8.18	Nil
Free, Jennifer	6.8.20	Nil
Hansen, Chiquita	9.2.16 3.3.21	Employed by MDHB and seconded to Central PHO 8/10ths – MidCentral DHB CEO – Central PHO Employed by THINK Hauora as Chief Executive and seconded to MidCentral DHB as Interim General Manager, Strategy, Planning and Performance 6/10ths Husband is employed by MidCentral DHB Executive member of General Practice New Zealand (GPNZ) Executive member of Health Care Home Collaborative
Hardie, Claire	13.8.18 13.8.18 13.8.18	Member – Royal Australian & NZ College of Radiologists Trustee – Palmerston North Hospital Regional Cancer Treatment Trust Inc Member, Medical Advisory Committee – NZ Breast Cancer Foundation
Horgan, Lyn	1.5.17 18.5.18	Sister is Coroner based in Wellington – Coronial Services Member, Alliance Leadership Team – Central PHO
Miller, Steve	18.4.17 26.2.19 6.3.19 1.10.19	Director. Farming business – Puriri Trust and Puriri Farm Partnerships Board Member, Member, Conporto Health Board Patient's First trading arm – Patients First Member, Alliance Leadership Team, Member, Information Governance Group – Central PHO Chair – National DHB Digital Investment Board
Ratana, Darryl	29.5.19	Nil

Register of Interests: Summary, 25 February 2022 (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)		
Russell, Greig	3.10.16	Minority shareholder – City Doctors Member, Education Committee – NZ Medical Council
Scott, Gabrielle	Dec 2019	Son is a permanent MDHB employee and works within Digital Services
Tanner, Steve	16.2.16	Nil
Te Huia, Tracee	13.7.21	Member of the No Ngā Hau e whā branch of the Māori Women's Welfare League
Wanden, Neil	February 2019	Nil
Williamson, Nicki	March 2020	Nil
Zaman, Syed	1.5.18	Nil

Resolution

That the Part One minutes of the 23 November 2021 Health and Disability Advisory Committee meeting be approved as a true and correct record.

MidCentral District Health Board

Health and Disability Advisory Committee Minutes

Meeting held on 23 November 2021 from 9.00am
Board Room, Gate 2, Heretaunga Street, Palmerston North
(and via Zoom due to COVID-19 restrictions)

PART ONE

Members

John Waldon (Committee Chair), Brendan Duffy (Board Chair), Heather Browning, Vaughan Dennison, Lew Findlay, Norman Gray, Muriel Hancock, Materoa Mar (Deputy Committee Chair), Karen Naylor, Oriana Paewai, Jenny Warren.

Apologies

Stephen Paewai.

In attendance

Kathryn Cook, Chief Executive; Dr Kelvin Billinghurst, Chief Medical Officer (and Clinical Executive, Te Uru Kiriora); Judith Catherwood, General Manager, Quality and Innovation; Debbie Davies, Interim General Manager, Strategy, Planning and Performance (and Operations Executive, Te Uru Kiriora); Emma Horsley, Communications Manager; Tracee Te Huia, General Manager, Māori Health; Margaret Bell, Board Secretary.

In attendance (part meeting)

Scott Ambridge, Operations Executive, Te Uru Rauhī; Dr Jeff Brown, Clinical Executive, Te Uru Pā Harakeke; Sarah Fenwick, Operations Executive, Te Pā Harakeke and Te Uru Mātai Matengau; Dr Claire Hardie, Clinical Executive, Te Uru Mātai Matengau; Lyn Horgan, Operations Executive, Te Uru Arotau; Angela Rainham, Locality and Intersectoral Development Manager; Michelle Riwai, General Manager, Enable New Zealand, Gabrielle Scott, Executive Director, Allied Health; Dr Syed Zaman, Clinical Executive, Te Uru Whakamauora.

THINK Hauora – Chiquita Hansen, Chief Executive; Nicola Russell, General Manager, Clinical Quality; Kylie Faas, General Manager, Knowledge and Insights, Dr Bruce Stewart, Board Chair.

Media – 1 Public – 2

1. KARAKIA

The meeting opened with the organisational karakia.

2. ADMINISTRATIVE MATTERS

2.1. Apologies

The apology from Stephen Paewai, the Interim Chair of the Consumer Council (following resignation of Gail Munro) was accepted.

2.2. Late items

No late items were advised.

2.3. Register of Interests Update

The following updates to the Register of Interests were advised.

Jenny Warren

Add – Contract with The Horowhenua Company.

Muriel Hancock

Add – Sister-in-law is employed as a COVID-19 vaccinator for MidCentral District Health Board.

2.4. Minutes of the 14 September 2021 meeting, Part One

It was resolved that:

> *the Part One minutes of the 14 September 2021 Health and Disability Advisory Committee meeting be approved as a true and correct record.*
>
> *(Moved Brendan Duffy; seconded Heather Browning)*

2.5. Matters arising from previous minutes

No discussion.

3. STRATEGIC FOCUS

The meeting agreed to re-order the Strategic Focus items.

The Locality and Intersectoral Development Manager joined the meeting.

3.2 Population Profile Update – with a future focus

The Locality and Intersectoral Development Manager presented this report, which was taken as read.

Committee members noted the need to use the data to improve services, particularly for Māori and Pacific people. A breakdown of ethnicity for Territorial Local Authority (TLA) data was needed to ensure data was used appropriately.

The Locality and Intersectoral Development Manager noted that the population was growing faster than predicted by Statistics New Zealand in each locality within the MDHB region. Further work would be done to ensure health services met the needs of the population, including refugees who often had complex health needs.

The Chief Executive responded to concerns raised about the different population numbers used by TLAs and District Health Boards (DHBs). As a Government agency, MidCentral DHB (MDHB) was obliged to use data provided by Statistics New Zealand. Following the establishment of Health New Zealand and the Māori Health Authority in July 2022, DHB boundaries would no longer exist. People could choose where they received their health care and funding would be based on services provided rather than population numbers.

It was resolved that the Committee:

note the detailed work being carried out to understand the differences between data used by MidCentral DHB and local authorities in the region

note the special needs of Māori, Pasifika, refugee and other population groups; and that the current population profile gives statistics for these groups but does not identify how that information needs to be utilised in service provision

note the current population profile for the district; and recognise that in planning future services, population projections from a variety of sources should be considered, as Statistics New Zealand projections have under-estimated the actual population in recent years.

(Moved Vaughan Dennison; seconded Brendan Duffy)

The Locality and Intersectoral Development Manager left the meeting.

The THINK Hauora Chief Executive; the Board Chair; the General Manager, Clinical Quality; and the General Manager, Knowledge and Insights joined the meeting.

3.1. Primary Care Access and Affordability Update

The THINK Hauora representatives presented this report, which was taken as read. They noted that the population in the district continued to grow and that General Practice Team enrolment numbers for Māori continued to increase.

THINK Hauora noted that the comparison of consultation rates between 2020 and 2021 had been affected by COVID-19 lockdowns, testing and the vaccine rollout. The number of patients redirected through the Emergency Department Redirection to General Practice programme was increasing. Analysis showed the number of Māori and Pacific people was higher than non-Māori and also showed lower deprivation scores. Data would continue to be monitored through Primary Options for Acute Care and more detail would be included in the next report to the Committee.

The Committee noted that a new GP practice would open in Ashhurst in April 2022.

It was resolved that the Committee:

note the update of various activities contributing to primary care access and affordability.

(Moved John Waldon; seconded Jenny Warren)

The THINK Hauora Chief Executive; the Board Chair, the General Manager, Clinical Quality; and the General Manager, Knowledge and Insights left the meeting.

The Clinical and Operations Executives joined the meeting.

4. DIRECTORATE WITH CLUSTER FUNCTIONS REPORTING

4.1. Directorate Dashboard

The Operations Executive, Te Uru Pā Harakeke, Healthy Women, Children and Youth presented this report, which was taken as read.

A Committee member noted the impact of occupational therapy vacancies on discharge planning and length of stay for patients. The Executive Director, Allied Health advised that the community wait list was being reviewed and that MDHB was working with a contracted provider and Whanganui DHB to support the service.

The Clinical Executive, Te Uru Pā Harakeke noted that GPs had been encouraged to diagnose asthma in children so they could access the Community Child Health Team's Child Health Asthma Service. The DHB, in conjunction with THINK Hauora, had held education sessions on managing respiratory difficulties without needing hospital level care.

4.2. Te Uru Rauhī – Mental Health and Addiction Services

The Operations Executive, Te Uru Rauhī presented this report, which was taken as read. He noted the significant decrease in occupancy of inpatient beds, with 18 people in the unit today.

The Adult Integrated Model of Care, Te Mātāpuna o te Ora, was expected to be fully deployed from April 2022. COVID-19 had impacted the timeframes and a 'signpost check in' would be carried out in February 2022.

4.3. Te Uru Arotau – Acute and Elective Specialist Services

The Operations Executive, Te Uru Arotau presented this report, which was taken as read. She noted that MDHB was one of five DHBs taking part in the Ministry of Health's (the Ministry) weekend discharge pilot. Community infusion sites were being set up – two in Palmerston North and one in Tararua.

4.4. Te Uru Whakamauora – Healthy Ageing and Rehabilitation

The Operations and Clinical Executives, Te Uru Whakamauora presented this report, which was taken as read.

Committee members raised concerns around the waiting list for non-urgent Occupational Therapy referrals. The Operations Executive advised that a pilot was about to begin, where SupportLinks would carry out assessments outside of the hospital.

4.5. Te Uru Pā Harakeke – Healthy Women, Children and Youth

The Operations and Clinical Executives, Te Uru Pā Harakeke presented this report, which was taken as read. In response to a question, she advised that only one permanent midwife had indicated she would not be vaccinated against COVID-19. Due HR processes related to the COVID-19 Vaccination Order were being followed.

A Committee member raised a question about the software to facilitate the process of fast and efficient referral, data gathering and whānau ora outcomes approach for the Child Development Service Referral Integration Project. The Clinical Executive advised that the project brought the education, Child, Adolescent and Family Services and the health sector together to provide wrap-round care. The focus was on getting an improved outcome for children.

4.6. Te Uru Mātai Matengau – Cancer Screening, Treatment and Support

The Operations Executive and the Clinical Executive, Te Uru Mātai Matengau presented this report, which was taken as read.

4.7. Te Uru Kiriora – Primary, Public and Community Health

The Operations and Clinical Executives, Te Uru Kiriora presented this report, which was taken as read. As at 22 November, 91 percent of the eligible population had received their first dose of the COVID-19 vaccine and 82 percent were fully vaccinated. There

was now around 11,000 people unvaccinated in the district. Ten Supported Isolation and Quarantine (SIQ) facilities were now available in the region if required.

It was resolved that the Committee:

note the areas highlighted in the dashboard and associated commentary.

(Moved John Waldon; seconded Muriel Hancock)

The Clinical Executives and Operations Executives left the meeting.

The General Manager, Enable New Zealand joined the meeting.

5. PERFORMANCE REPORTING

5.1. Enable New Zealand Report

The General Manager, Enable New Zealand presented this report, which was taken as read. She noted that the Managed Rehabilitation Equipment Services (MRES) contract with ACC was launched last week. Since then, 270 pieces of equipment had been processed each day.

The Committee Chair asked that percentages be added to the ethnicity data charts in future reports.

It was resolved that the Committee:

endorse the Enable New Zealand Report to 31 October 2021.

(Moved John Waldon; seconded Muriel Hancock)

The General Manager, Enable New Zealand left the meeting.

5.2. Pae Ora Paiaka Whaiora Report

The General Manager, Māori Health acknowledged the passing of Delwyn Te Oka's husband and said it was fitting that the Pae Ora report started with Te Ohu Auahi Mutunoa (TOAM smoking cessation service), as this service is led by Delwyn. No reira, moe mai, moe mai, moe mai ra e te Rangatira. The report was then taken as read. She noted that Blair McKenzie, Regional Commissioner for Social Development, Ministry of Social Development, had been appointed as the Regional Partnership Services Leadership (RPSL) Chair.

It was resolved that the Committee:

note the progress update for the Pae Ora Paiaka Whaiora Māori Health Directorate.

(Moved Materoa Mar; seconded Vaughan Dennison)

5.3. Quality and Safety Dashboard

The General Manager, Quality and Innovation presented this report, which was taken as read. In response to a question about whether the increase in complaints from Māori patients related to specific issues, she agreed to include narrative in future reports.

Committee members asked that concerns highlighted through inpatient surveys regarding the cleanliness of rooms and wards be addressed.

It was resolved that the Committee:

note the content of the Quality and Safety Dashboard

endorse the improvement activities planned for the next quarter.

(Moved Karen Naylor; seconded Vaughan Dennison)

6. DISCUSSION/DECISION PAPERS

6.1. Quality Account – Quarter One 2021/22

The General Manager, Quality and Innovation presented this report, which was taken as read.

In response to comments from Committee members, it was agreed that future reports would include more input from Pae Ora Paiaka Whaiora and the Consumer Council,consumer stories; and that readability would be improved.

It was resolved that the Committee:

note the Quarter One 2021/22 Quality Account.

(Moved Vaughan Dennison; seconded Muriel Hancock)

7. INFORMATION PAPERS

7.1. MidCentral District Health Board Position Statement on Alcohol

The Clinical Executive, Te Uru Kiriora presented this report, which was taken as read.

The Chief Executive advised that the National Chief Executives and Chairs had committed to having an alcohol statement that was consistent with the national policy statement on alcohol. Each DHB would have a local statement.

The Committee asked that the statement includes a reference to the principles of Te Tiriti o Waitangi and notes that alcohol is a carcinogen.

It was resolved that the Committee:

endorse the Alcohol Position Statement for submission to the Board.

(Moved Karen Naylor; seconded Jenny Warren)

The Clinical Executive, Te Uru Kiriora left the meeting.

The Clinical Executive, Te Uru Pā Harakeke joined the meeting.

7.2. The 15th National Child and Youth Mortality Data Report 2015-2019

The Clinical Executive, Te Uru Pā Harakeke presented this report, which was taken as read.

Committee members expressed concern and sadness at the suicide rate. A large percentage of these young people had no prior engagement with mental health services, so agencies including education, Police and Oranga Tamariki needed to work together to identify and support young people at risk. It was suggested that the issue be discussed at a Regional Interagency Network meeting.

It was resolved that the Committee:

note this report on the deaths of pēpi, tamariki and rangatahi aged from 28 days to 24 years in Aotearoa

note that this brief review of data provides a link to part of the roadmap to reducing the number of deaths and disproportionate outcomes across ethnicities, age groups, gender identity and deprivation levels.

(Moved Heather Browning; seconded Muriel Hancock)

The Locality and Intersectoral Development Manager joined the meeting.

7.3. Locality Plan Progress Report – Tararua District

The Locality and Intersectoral Development Manager presented this report, which was taken as read. She noted that as at 22 November, 88 percent of the eligible Tararua population had received their first dose of the COVID-19 vaccine; and 77 per cent were fully vaccinated. There were 1776 people eligible who had not received any vaccination.

It was resolved that the Committee:

note the progress that has been made in relation to Tararua Te Mahere Hauora (Health and Wellbeing Plan).

(Moved Muriel Hancock; seconded Karen Naylor)

The Locality and Intersectoral Development Manager and the Clinical Executive, Te Uru Pā Harakeke left the meeting.

7.4. Committee's Work Programme

The report was taken as read.

It was resolved that the Committee:

note the update on the Health and Disability Advisory Committee's work programme.

(Moved John Waldon; seconded Karen Naylor)

8. GLOSSARY OF TERMS

No discussion.

9. LATE ITEMS

No discussion.

10. DATE OF NEXT MEETING

Tuesday, 1 March 2022 – Board Room, MidCentral District Health Board, Gate 2 Heretaunga Street, Palmerston North

11. EXCLUSION OF PUBLIC

It was resolved:

that the public be excluded from this meeting in accordance with the Official Information Act 1992, section 9 for the following items for the reasons stated:

Item	Reason	Ref
'In committee' minutes of the previous Health and Disability Advisory Committee meeting	For reasons set out in the agenda of the 14 September 2021 meeting held with the public present	
Serious Adverse Events (SAC 1)	To protect patient privacy	9(2)(a)

(Moved John Waldon; seconded Jenny Warren)

Part One of the meeting closed at 11.45am

Confirmed this 1st day of March 2022

……..

Committee Chair

Health and Disability Advisory Committee – MidCentral DHB

- Schedule of Matters Arising, 2021/22 as at 26 November 2021

Matter	Raised	Scheduled	Responsibility	Form	Status
Provide an update on colonoscopy wait times for the next quarter, particularly for non-urgent and surveillance colonoscopies	Sept 21 Board	May 22	D Davies J Long	Report	Scheduled
COMPLETED					
Strategic discussion on the national policy around primary care costs, availability and timeliness of appointments with GPs, and GP workforce recruitment issues	October 20	November 20	D Davies	Strategic discussion as required	Completed and ongoing
Future reports on midwifery workforce to include more information around clinical risk and observations from the external advisor	Feb 21	April 21 and ongoing	S Fenwick	Report	Completed and ongoing
Invite THINK Hauora to future meeting to discuss GP availability	July 21	Nov 21	D Davies	Strategic discussion	Completed
Provide details of unmet need/Did Not Waits in the Emergency Department	July 21	Sept 21	L Horgan	Report	Completed
Advise the number of responses to online survey – Mental Health and Addiction Services Adult Indicators, Te Ara Angitū Report	July 21	Sept 21	S Ambridge	Report	Completed
Report on MDHB's preparation for implementation of the End of Life Choice Act	July 21 Board	Sept 21	C Hardie	Report	Completed
Ask Board to consider writing to the Ministry of Health to highlight issues faced by migrant GPs in gaining residency	July 21	August Board meeting	J Waldon	Resolution passed at August Board meeting	Completed
Provide more detail on the increased Mental Health Client DNAs in next HDAC cluster report	Feb 21 – Board mtg	~~April 21~~ July 21	V Caldwell S Ambridge	Report	Completed

Directorate with cluster function reporting

1 March 2022 HDAC

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For:

	Approval
	Endorsement
X	Noting

Key questions the Committee should consider in reviewing this paper:

- Does the dashboard provide insight and a helicopter view on key areas of Directorate performance?
- Are there areas of opportunity/risk that the Committee would like more focus on?

To	Health and Disability Advisory Committee
Author	Scott Ambridge, Operations Executive, Te Uru Rauhī
Endorsed by	Kathryn Cook, Chief Executive
Date	10 February 2022
Subject	**Directorate Dashboard**

RECOMMENDATION

It is recommended that the Committee:

- **note** the areas highlighted in the dashboard and associated commentary.

Strategic Alignment

This report is aligned to MidCentral District Health Board's (MDHB) strategy and the implementation of its Annual, Operational and Sustainability Plans, Locality and Directorate Health and Wellbeing Plans.

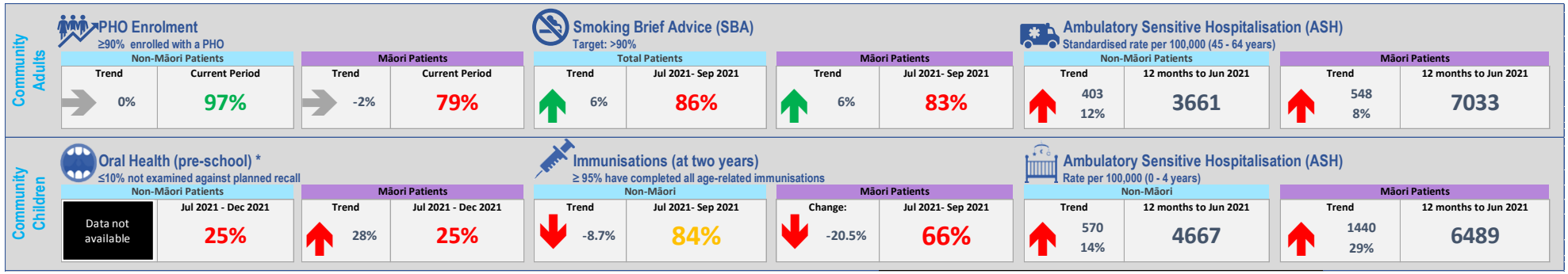
1. PURPOSE

To provide the Committee with a regular overview of key performance metrics, applying a Māori health equity perspective to all measures (where appropriate). The dashboard is provided with a combined directorate view demonstrating the system performance of activity provided or commissioned by MDHB. Unique priorities and associated performance measures specific to an individual directorate can be found in the individual directorate reports following the dashboard commentary.

2. COMBINED DIRECTORATE VIEW

The metrics follow the same format as outlined in previous reports and cover the period 1 October to 31 December 2021. They are compared to the same period in the last reporting year, unless specified differently within a particular metric.

2.1. Primary and Community



Data from the reporting period shows a similar trend for Māori patients enrolling with a primary health organisation. As previously reported, the issue of enrolment pressures continues. Some whānau do have the means and ability to enrol and travel to Palmerston North for their vaccinations and primary health care, the most vulnerable populations are impacted most from this situation, which includes enrolment for newborns. General Practitioner (GP) workforce shortages continue to impact enrolment capacity and service delivery in the Horowhenua locality. The opening of Managed Isolation and Quarantine (MIQ) places for essential workers has resulted in a further three GPs being recruited into two practices – due to start by end of Quarter Three.

Data over the reporting period, although still below target, shows a significant positive trend for both Māori and non-Māori. THINK Hauora continues to assist the general practice network with their efforts to increase Smoking Brief Advice (SBA) completion rates. Comparison with the starting baseline at Quarter Two 2021 of 67 percent shows a significant improvement over the past year. General Practices Teams (GPT) administrators provide SBA during any call/contact with a patient who is recorded as a current smoker, regardless of the status of SBA in the PMS (Patient Management System). This will reduce the burden of 'chasing' overdues to just those that are infrequent/non-users of GPT services.

When examining hospitalisations for potentially avoidable conditions, known as Ambulatory Sensitive Hospitalisations (ASH) 45-64 years, the standardised rate for both non-Māori and Māori has remained the same as the previous report. For non-Māori the rate is 3661 per 100,000 and for Māori the rate is 7033 per 100,000. The rate for Māori continues to be almost double that of non-Māori with a clear equity gap remaining evident.

Planned Care that had been delayed from COVID-19 lockdown periods over 2019/20 and 2020/21 may still be continuing to impact on ASH, although there may be some improvement given that the population has increased over this time.

ASH presentations for 0-4 years for the period July 2020 to June 2021 have now been confirmed by the Ministry of Health and are unchanged. The apparent change compared with the previous report is due to the 2019/2020 numbers being adjusted down. An increase in the standardised ASH rate for both non-Māori and Māori for 2020/2021 was expected – very few winter illnesses in 2019/20 due to border closures and increased COVID-19 alert levels, then an outbreak of Respiratory Syncytial Virus (RSV) and winter illnesses in 2021 with borders opened and reduced COVID-19 restrictions.

The reporting of immunisation rates for Māori and Non-Māori shows a further decrease compared to the last report. Over the reporting period, restrictions continued to significantly impact the vaccinating workforce across all service providers. The drive for increased COVID-19 vaccinations remains and places pressure on childhood vaccination efforts.

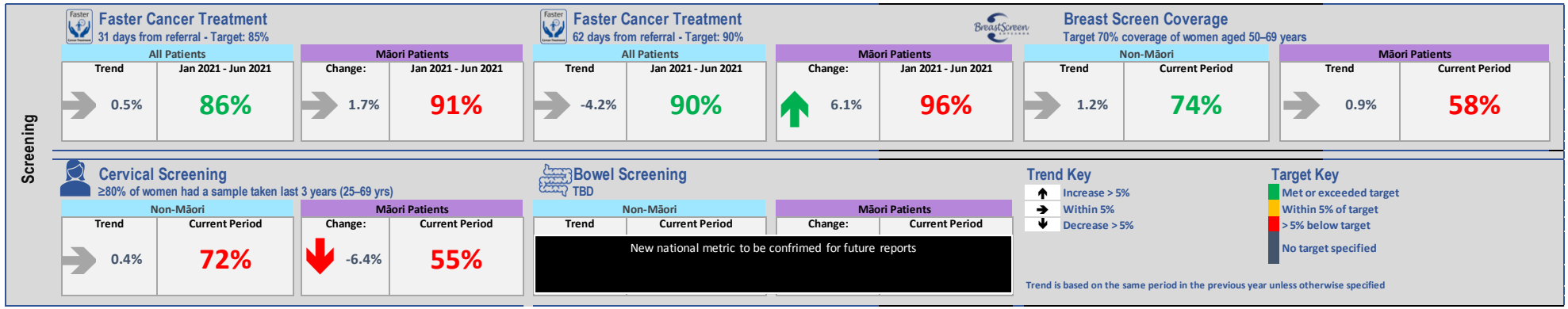
Considerable efforts of THINK Hauora's immunisation team, supporting staff and general practice network, continue to work with whānau to improve immunisation rates. The THINK Hauora immunisation team provided home visits and targeted community vaccination clinics. The demographic profile of the target population is either likely to decline or be represented in the 'hard to reach' COVID-19 vaccination cohort. There continues to be the same distrust of the healthcare system and a lack of resources/ planning to invest in services to go directly to where these communities live/work/play.

Data issues continue to impact the integrity of the completion rates recorded in the National Immunisation Register (NIR) system and wherever possible the THINK Hauora immunisation team assist practices with this activity. As previously reported, staff are required to spend considerable amounts of time identifying and correcting errors in messaging between the PMS and the NIR system. This impacts on available workforce to support community vaccination clinics.

The ongoing threat of community spread of COVID-19 is likely continue impacting vaccination declines and vaccine hesitancy (delayed acceptance). Whilst it is difficult to accurately quantify the degree to which the Quarter Two lockdown, ongoing saturation of COVID-19 publicity and vaccine mandate anxieties have impacted childhood vaccination rates, narrative from General Practice and other vaccinating staff reinforces the fact that ascertaining 'true declines' from those 'actively delaying' (either all or some, of the scheduled vaccination series) remains difficult in the current NIR system. There is some evidence that vaccine delayers will decline immunisations as a method of blocking constant contact by health services whilst taking their time to decide.

It is to be noted that business as usual (BAU) activities from Public Health were ceased during Quarter Two to concentrate all efforts on the COVID-19 pandemic. The expected nationwide Omicron outbreak will significantly impact on all other BAU activity.

2.2. **Screening**

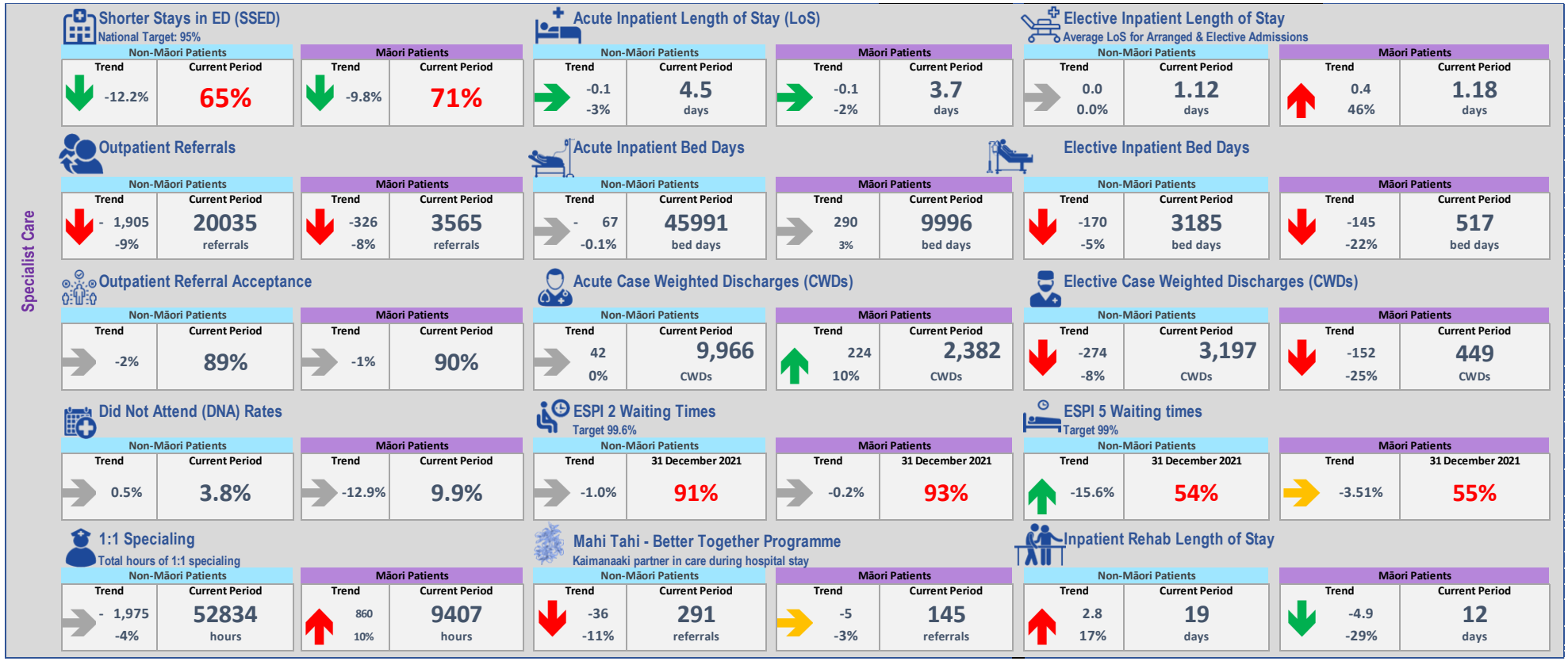


Data to December 2021 shows similar low cervical screening rates for both Māori and non-Māori to the previous report. The screening rates for Māori decreased from 56 percent to 55 percent. The continuing low screening rates are likely due to the ongoing threat of community spread of COVID-19 and the impacts of the access changes with restrictions. Providers acknowledged that there has been an increased reluctance from many women to attend cervical screening appointments in the practice post this lockdown period.

The Cervical Screening Action Group continues to work across the screening pathway to identify and promote service improvement opportunities across the region.

Breast Screen Coast to Coast (BSCC) has reviewed and updated their 'Engaging with wāhine Māori' process over this reporting period to ensure prioritisation of wāhine Māori in response to the clearly persistent equity gap. There was a slight increase in Māori participation at 58.6 percent compared to 57 percent at the close of the previous quarter.

2.3. **Specialist care**



Shorter Stays in Emergency Departments (SSIED) remains below target at 63 percent in December. SSIED was 62 percent for non-Māori and 67 percent for Māori. There were 3969 presentations to the Emergency Department in October, 4018 in November and 3995 in December. This is similar to the same period last year.

During October to December 2021, of the patients in the Emergency Department (ED) who were not admitted, 24 percent waited over six hours. Of the patients in ED who were admitted, 64 percent waited over six hours.

Road trauma presentations has increased above the baseline of 33; with 32 in October, 58 in both November and December. Fifty-eight is the highest number in the last 18 months.

Overall performance in the ED continues to be impacted by high occupancy, with adult inpatient wards at 105 percent. This restricts effective patient flow. The acute inpatient length of stay and acute inpatient bed days remained steady for both non-Māori and Māori patients when compared with the same period last year.

Ward 24 was closed for a period of four weeks mid-November to mid-December 2021. This closure was required to upgrade oxygen supply capacity to the identified COVID-19 ward. Mitigations were put in place to support patient flow however, this ward closure had an impact on both acute and planned care activity.

Elective Services Patient Flow Indicators (ESPI) 2

MDHB continues to work towards the achievement of ESPI 2. In October, 10 of the 21 services were compliant. November saw this increase to 14 services compliant. At the end of the quarter (December 2021) this reduced to 11 of the 21 services achieving the agreed trajectory. At the end of December 2021 there were three services with less than five patients exceeding the four-month target. The recent decline in compliant services can be attributed to the rescheduling of patients required following the national COVID-19 Level Three and Four lockdowns in August and September 2021.

ESPI 5

ESPI 5 remains an area of challenge. MDHB continues to work in partnership with Crest Hospital to provide outsourced and outplaced surgical procedures to further improve performance in this area. MDHB is working with clinicians on prioritising Māori and Pasifika in planned care scheduling to ensure there are no unintended consequences. Planned care waiting lists are produced by ethnicity with regular monitoring to ensure a greater focus on improving Māori timeframes from referral to treatment. There were eight out of nine services non-compliant at the end of December.

Acute Inpatient Length of Stay

The OPAL Unit cumulative average length of stay (ALOS) was 8.83 by the end of December, which is an increase from 8.39 in August. This reflects a small increase in accumulating ALOS for OPAL compared to 8.00 at end of July 2021. Increased length of stay (LOS) is due to patients requiring Protection of Personal Property Rights (PPPR) application and greater challenges for timely discharge to aged residential care (ARC) in relation to COVID-19 protection measures. In this quarter a higher proportion of OPAL patients had a LOS of two or less days; with the proportion of long stay patients (4+ days) continuing to reduce. Availability of ambulance patient transportation services is impacting on both LOS and rate of discharges/transfers before noon. Several initiatives to reduce LOS such as the OPAL Discharge Lounge and Discharge to Short Term Care pilot are detailed below.

Specialling

The level of combined specialling hours required per month across the Healthy Ageing and Rehabilitation (HAR) wards continued to reduce this quarter (prior to December) and by October was at the lowest level in 16 months and 62 percent lower than the month of October 2020. HAR ward combined specialling hours increased from 2819 (October) and 2625 (November) to 4411 hours in December. Of note, December 2020 also had a quick increase in specialling hours (increasing to 5640 hours). Despite this sudden increase in December and through into January 2022, the current months levels remain below those of July 2020 to June 2021. This could be evidence that the new nursing clinical risk assessment tool and model of care for specialling introduced mid-2021 across all wards is having a positive impact.

Inpatient Rehabilitation Length of Stay

Both STAR 2 and STAR 4 continue to show an increase in cumulative ALOS however, the ALOS trend line is showing a slight improvement. Transfers to ARC, particularly in the Horowhenua region has had an impact on achieving timely discharge (due to ARC staff shortages), as has the impact of vacancies across several Allied Therapist roles in STAR 2. Allied Health vacancies have been advertised and are being actively recruited to. STAR 2 bed occupancy increased to 124 percent for four weeks over November and December 2021, increasing bed capacity by five daily as part of the Ward 24 decant for oxygen supply infrastructure work.

Mahi Tahi – Better Together programme

The number of patients with Mahi Tahi indicated as part of their care on the MIYA board is at a much lower level than previous years, this decline is particularly noted in the adult general medical wards. Charge Nurses are actively encouraging nurses to promote Mahi Tahi in their wards. Education tools and resources to support staff to invite and encourage whānau to be involved in the safety companion role for at risk whānau in hospital were introduced across all adult service wards including OPAL.

OPAL discharge lounge

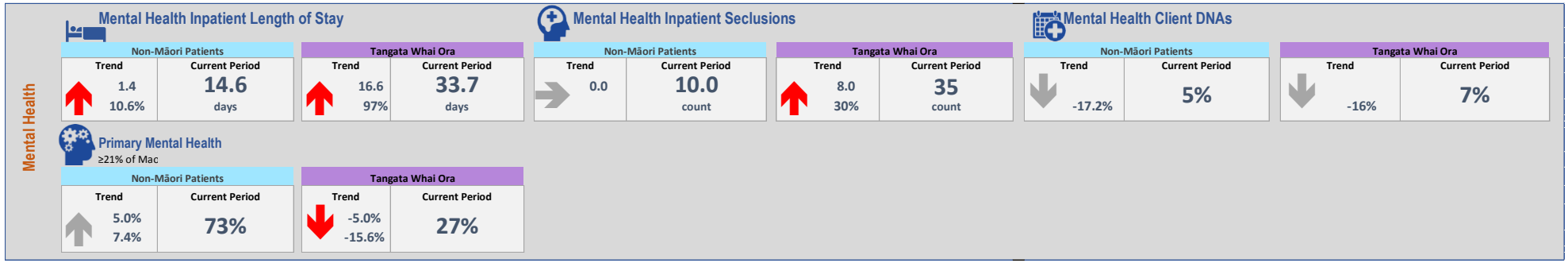
A second (six-week) pilot of the OPAL discharge lounge concluded in early November 2021. Although not able to operate every business day during that period due to staffing gaps, 23 patients were able to be transferred to the OPAL discharge lounge to await discharge, releasing bed space earlier by a total of 58.7 hours and enabling ED patients to move directly to OPAL. The OPAL discharge lounge will be re-established in March once the OPAL patient flow nurse and lounge health care assistant are in post.

Discharge to Short Term Care Pilot

Over this quarter HAR developed and in late December 2021 commenced piloting an initiative focused on promoting timely and well supported inpatient discharge. This is aimed at patients clinically and functionally cleared for discharge but requiring additional recovery time and support to be ready to return home, or before long term support needs assessment should occur and permanent support arrangements implemented. The 'Discharge to short term care service' initiative is focused on supporting people wherever possible to return to their prior home, and support arrangements coordinated by Supportlinks delivers planned and goal orientated support in an aged care facility for up to six weeks on discharge from hospital (as an alternative to return home) to help the person

regain their optimal achievable level of independence. Over the Christmas and New Year period timely discharge for eight patients was enabled through this pilot.

2.4. **Mental health**



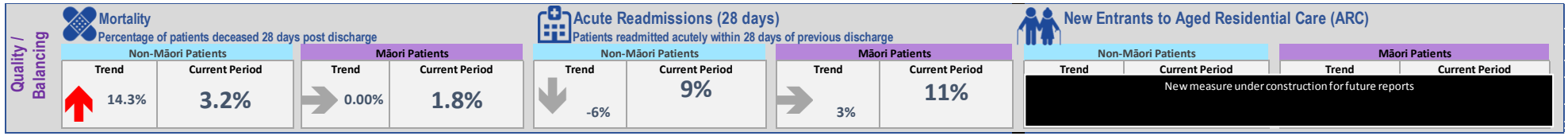
The ALOS is calculated as the total number of acute inpatient bed nights occupied for referrals that closed during the reference period (in this case the month). The current result of 35 days is being influenced by three discharges of tangata whai ora that occurred in October and November, each had a length of stay greater than 100 days.

The sub-acute/extended care service based in Palmerston North is operational to help support those complex patients that require long term rehabilitation and recovery support.

The quarter saw an increase in seclusion events for tangata whai ora, there were two very complex individuals who were admitted in November and accounted for 64 percent of the seclusion events. The focus remains on least restrictive practices and de-escalation, including the establishment of a sensory modulation room in the high needs unit.

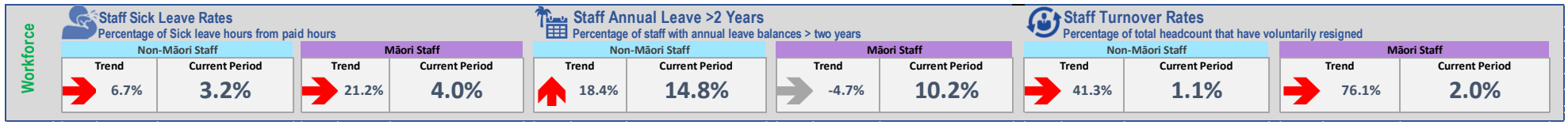
Did Not Attends (DNAs) have remained consistent compared to the previous reporting period and over the past 12 months DNAs have reduced by 25 percent for Māori and 40 percent for non-Māori. Further work is underway to explore the reasons behind DNAs with a particular focus on how Māori engage with secondary mental health and addiction services.

2.5. **Quality/Balancing**



The re-admission rate for Māori year to date (YTD) remains stable at 11 percent and non-Māori YTD is nine percent, a slight reduction on the previous year. Re-admissions continue to be monitored monthly to review potential trends or opportunities for improvement. Where possible, patients are assigned to the previous admissions team. This assists in ensuring consistency for review and highlights any significant issues with the re-admission for the patient.

2.6. **Workforce**



Sick leave rates remain stable, with continued emphasis on staff not coming to work if they have any cold or flu symptoms, even if mild.

Annual leave balances greater than two years have increased year to date above the target of nine percent and remained static at this rate. Individual leave plans are actively managed. The current percentage of staff with annual leave balances over two years is 11.3 percent. Vacancies and inability to plan and undertake overseas travel is likely to have continued impact on leave build up.

APPENDIX ONE: SUMMARY OF THE SIX HEALTH AND DISABILITY SERVICE DIRECTORATES

A SUMMARY OF THE SIX HEALTH AND DISABILITY SERVICE DIRECTORATES		
Te Uru Arotau **Acute and Elective Specialist Services**	**Te Uru Kiriora** **Primary, Public and Community Health**	**Te Uru Mātai Matengau** **Cancer Screening, Treatment & Support**
Te Uru Arotau is responsible for the planning, funding, commissioning and provision of secondary care (hospital level) services: • Medical services and subspecialties • Surgical services and subspecialties • Anaesthetics and Intensive Care Unit • Medical/Surgical inpatient wards • Medical Imaging and Hospital Pharmacy • Emergency services. • Integrated Operations Centre • Specialist Sexual Health services	Te Uru Kiriora is responsible for the planning, funding, commissioning, and provision of: • Primary and community-based services via a range of contracted partners • Public health services spanning health promotion, protection, regulation, and clinical care delivery • Community based nursing services including District and Primary Health Care nursing.	Te Uru Mātai Matengau is responsible for the planning, funding, commissioning, and provision of: • Prevention and early detection (screening) programmes • Cancer diagnostic and treatment services • Cancer support services • Palliative care services • Non-malignant haematology services • Regional services for treatment and screening.
Te Uru Pā Harakeke **Healthy Women Children and Youth**	**Te Uru Rauhī** **Mental Health and Addictions**	**Te Uru Whakamauora** **Healthy Ageing and Rehabilitation**
Te Uru Pā Harakeke is responsible for the planning, funding, commissioning and provision of: • Primary and secondary maternity care • Secondary Obstetrics and Gynaecology services including antenatal day unit, inpatients, outpatient clinics, community midwifery services and lactation services • Family centred inpatient, outpatient and community care for neonates (including neonatal intensive care), children (including high dependency care) and young people – up to their 16th birthday as inpatients and until end of school for ongoing ambulatory care • Child and Adolescent Oral Health Service • The commissioning of appropriate services to help improve the local population's health needs with a particular focus on the first 1,000 days and youth oriented care.	Te Uru Rauhī is responsible for the planning, funding, commissioning and provision of: • General adult mental health in community • Primary Mental Health and Addictions • Mental Health Acute Inpatient services • Eating disorders • Maternal Mental Health • Community Rehabilitation • Child Adolescent and Family • Alcohol and Other Drug Specialist Services • Māori Mental Health • Older Adult Mental Health Services • 24 hour Mental Health Acute Care Team.	Te Uru Whakamauora is responsible for the planning, funding, commissioning and provision of specialist services for people over the age of 65 years (55 years for Māori) and those between the ages of 16 and 64 with a physical disability, with a focus on assessment, treatment and rehabilitation. Services are structured into: • ElderHealth • Rehabilitation • Therapy Services • Supportlinks.

APPENDIX TWO: DIRECTORATE VIEW METRIC DEFINITIONS

METRIC	DEFINITION	EXCLUSIONS
THINK Hauora Enrolment	Percentage enrolled with THINK Hauora of MDHB population.	
Smoking Brief Advice (SBA)	Percentage of current smokers (or recent ex-smokers) who have received brief advice to quit smoking or an offer of cessation support in the last 15 months.	Patients not enrolled with THINK Hauora; non-coded smoking status and SBA; smokers under the age of 16 years.
Ambulatory Sensitive Hospitalisation (ASH)	As per the Ministry of Helth definition used in the non-financial metrics.	Standardised rate/100,000.
Oral Health (pre-school) *	All 0 to 4 years Oral Health Arrears.	Only have Māori back to October 2019, so missing the first quarter of financial year 2020 (for last YTD). For all ethnicities only December 2020 to February 2021 (three months).
Immunisations (at two years)	As per the Ministry of Health definition used in the non-financial metrics.	Note: Methodology for reported counts now changed to include all vaccinations in schedule due for children aged up to two years, not just count at 'final dose', which is rate (%) reported for period ending 30 September 2019. Has the effect of dropping percentages by about one percentage point when comparing to 2019/20 results.
Ambulatory Sensitive Hospitalisation (ASH)	As per the Ministry of Health definition used in the non-financial metrics.	Standardised rate/100,000.
Faster Cancer Treatment – 31 days from referral	Percentage of patients referred with a high suspicion of cancer waiting 31 days or less to receive their first treatment.	
Faster Cancer Treatment – q2 days from referral	Percentage of patients referred with a high suspicion of cancer waiting 62 days or less to receive their first treatment [sco219].	
Breast Screen Coverage	Percentage Coverage of all enrolled (?) women for Breast Screen Coast to Coast (BSCC) screening.	
Cervical Screening	Percentage coverage National Screening Unit (NSU) National Cervical Screening Programme	

Shorter Stays in ED (SSIED)	Ministry of Health definition – patients discharged from the ED within six hours of arrival in the department.	Excluding Mental Health
Acute Inpatient Length of Stay (ALOS)	The ALOS for acutely admitted patients discharged during the reporting period with an admission type of (AC).	Excluding Mental Health
Elective Inpatient Length of Stay	The ALOS for elective admitted patients discharged during the reporting period with an admission type of (WN).	
Outpatient Referrals	Number of outpatient referrals received.	Excluding where Ministry of Health reported = Not required/null/blank
Acute Inpatient Bed Days	Total number of acute inpatient bed days.	
Elective Inpatient Bed Days	Total number of elective inpatient bed days.	
Outpatient Referral Acceptance Rate	Number of outpatient referrals received that were accepted.	Excluding where Ministry of Health reported = Not required/null/blank
Acute Case Weighted Discharges (CWDs)	The case weight derived from eligible coded planned care acute inpatient discharges.	
Elective Case Weighted Discharges (CWDs)	The case weight derived from eligible coded planned care elective inpatient discharges.	
Did Not Attend (DNA) Rate	Patients who did not attend their booked outpatient appointment.	Last YTD under the non-Māori column is actually all patients as ethnicity was not pulled back with snapshots at that point
ESPI 2 Waiting Times	As per the Ministry of Health definition used in the non-financial metrics.	Last YTD under the non-Māori column is actually all patients as ethnicity was not pulled back with snapshots at that point
ESPI 5 Waiting times	As per the Ministry of Health definition used in the non-financial metrics.	
1:1 Specialing		
Mahi Tahi – Better Together Programme	Count of referrals to Mahi Tahi programme.	
Inpatient Rehab Length of Stay	The average length of stay for elective admitted patients discharged during the reporting period with all admission types and Specialities D01 & D41.	
Mental Health Inpatient Length of Stay	The ALOS for mental health admitted patients discharged during the reporting period.	
Mental Health Inpatient Seclusion rate	The number of seclusion events in the reporting.	
Mental Health Client DNAs	The number of unattended booked appointments.	
Primary Mental Health		

Mortality	Number of patients deceased 28 days post discharge.	
Acute Readmissions (28 days)	Percentage of patients who were acute readmissions within 28 days of previous discharge.	Acute Readmission Rate KPI – one-month lag due to late coding.
Staff Sick Leave Rate	Staff sick Leave hours as a percentage of staff paid hours.	
Staff Annual Leave >2 Years	Percentage of employees with an Annual Leave balance in excess of two years' worth of their current annual entitlement.	
Staff Turnover Rate	A rate-based measure of staff turnover within the DHB.	

SERVICE	Te Uru Mātai Matengau – Cancer Screening, Treatment and Support
FOR PERIOD	October, November, December 2021
PREPARED BY	Sarah Fenwick, Operations Executive Dr Claire Hardie, Clinical Executive

1. PERFORMANCE OVERVIEW

The following table provides a summary of the progress to date against the equity outcome, sustainability and other actions in the 2021/22 Annual Plan. Te Uru Mātai Matengau is generally on track, with those actions behind plan discussed in the section below.

	Initiative	**Rating & Trend**	
A-E	Implemented whānau centred care guidelines within tumour streams	G	•
A-E	Establish a Māori Cancer research strategy	A	•
A-E	Achieve equity for screening programmes	A	•
A-E	Review pathways for populations at high risk of cancer	G	•
A-E	Increase referrals to Iwi Cancer Co-ordinators	G	•
A-E	Implement Cancer Prevention / Early Detection Governance framework	G	•
A	Develop a cancer workforce strategy	A	•
A	Deliver to tumour stream work plans	G	•
A	Commission LINAC replacements in Palmerston North	G	•
A	Continue to collaborate on projects to establish Outreach Radiation Treatment	A	•
A	Minimise breaches of the 31-day and 62-day Faster Cancer Treatment waiting times	G	•
A	Continue to collaborate to ensure outreach chemotherapy availability at Whanganui Hospital	A	•

A	Refresh Te Korowai O Rongo, the district Palliative Care Strategic Plan	A	•
A	Deliver year three of the Regional Cancer Treatment Service Plan 2020-2025	G	•
A-E	Identify opportunities to include traditional Māori forms of healing in patient care	G	•
A-S	Improve the sustainability of the Regional Cancer Treatment Workforce	G	•

Rating & Trend Legend							
G	On track, progressing as planned.	A	Behind plan – remedial action plan in place.	R	Behind plan – major risks and exception report required.	D	Not completed as planned.
↑	Improved from last report.	↓	Regressed from last report.	•	No change from last report.		

Plan Legend	A	Annual Plan	S	Sustainability Plan	E	Equity Indicator

The comments below relate to Performance Overview initiatives that have not already been covered under the Directorate Dashboard commentary.

The Māori Cancer Research Strategy has been aligned with Te Tiriti o Waitangi and the Wai 2575 principles. Final sign off was expected by the end of 2021, however this has been delayed to ensure alignment with the organisational research and audit strategy. Sign off is now expected by June 2022.

The Bowel Screening Team has seen an increase in the equity gap through this reporting period, with an average Māori participation of 40.91 percent compared to 51.48 percent at the close of the previous quarter. This data is in line with previous years' reporting which show a reduction in December, as this is when the new invitations are sent out to eligible participants across the rohe. The team has recently recruited a new Māori bowel screening promoter as part of Te Uru Mātai Matengau's commitment to achieving equity across the screening programme. This role has recruited new kaitautoko (bowel screening champions), and with the communications team captured new images for promotions. A Facebook promotional campaign is planned for the coming months.

BreastScreen Coast to Coast (BSCC) has reviewed and updated their 'Engaging with wāhine Māori' process over this reporting period to ensure prioritisation of wāhine Māori. This is in response to the clearly persistent equity gap, with a slight increase in Māori participation at 58.6 percent compared to 57 percent at the close of the previous quarter.

The recent recruitment of the Operations Lead and Associate Director of Nursing to the Te Uru Mātai Matengau Senior Leadership Team will ensure a strong focus on the cancer nursing workforce strategy, which is a priority to ensure a safe and sustainable oncology nursing workforce.

The outreach radiation project remains behind schedule. The business case for Taranaki District Health Board is now signed off, with the detailed design stage of the project progressing well. Due to a change in the location requirement, Hawke's Bay District Health Board's project has been significantly delayed. MidCentral DHB (MDHB) continues to contribute to the project as subject matter experts as the service provider.

The outreach chemotherapy solution at Whanganui Hospital remains behind schedule. Whanganui District Health Board is now pursuing alternative solutions for service provision via an integrated day stay unit. Te Aho o Te Kahua is providing programme management for this project.

Work to refresh Te Korowai O Rongo, the District Palliative Care Strategic Plan, remains on hold due to the resignation of the project lead late last year. Due to the recent COVID-19 Omicron outbreak in the community and subsequent service resources impacted by this outbreak, it is likely this project will continue to remain on hold until later in the year.

2. SIGNIFICANT MATTERS

2.1. Medical Workforce

The Regional Cancer Treatment Service (RCTS) continues to experience vacancies at Senior Medical Officer (SMO) and Medical Officer of Specialist Scale (MOSS) level. The situation is now more critical due to the recent resignation of a Radiation Oncology SMO, who will cease employment in April 2022. Whilst the current SMO workforce in Radiation Oncology will continue to proactively manage the workload to help mitigate any delays in patients' treatment, there remains a significant risk that the service will be impacted, as referrals into the department continue to exceed previous year's numbers. Active recruitment is underway to fill these positions and there is regular liaison with Te Aho o Te Kahu on waiting times to determine if support from other centres should be activated.

The Medical Oncology workforce is currently working at reduced capacity due to the retirement of one of the senior SMOs in December 2021, an existing SMO vacancy and another SMO commencing maternity leave early 2022. In addition, the service also has a MOSS vacancy. Active recruitment continues to fill these positions and a new Medical Oncology SMO will commence in March 2022 and a six-month locum SMO position has been appointed who will commence in April 2022.

2.2. BreastScreen Coast to Coast (BSCC)

Radiologist support continues with outsourced provision following the resignation of the Clinical Director in 2021. Negotiations for a permanent outsourced solution have not progressed and active recruitment for a Radiologist continues.

2.3. Oncology Outpatients

Active recruitment to the permanent position of Charge Nurse, Oncology Ambulatory Care is currently underway as the temporary secondment for this role has now come to an end. The newly appointed Associate Director of Nursing Te Uru Mātai Matengau will temporarily cover this role until a permanent candidate has been selected.

2.4. Mosaiq

The Mosaiq business case to move Mosaiq from the current MDHB Information Technology servers to a cloud-based solution has now been approved. The expected installation to the cloud is on track to be completed by August 2022.

2.5. Radiation Therapist (RT) Led Discharge Protocol

The RT led discharge protocol is now live. This protocol enables patients who have completed either a course of radiation therapy for Dupuytren's disease; a superficial course of radiation therapy for skin cancer; a single palliative dose of radiation therapy; or those patients who have completed a course of breast/chest wall radiation therapy for breast cancer; to have their discharge appointment completed on their treatment machine by one of the radiation therapists who delivered their treatment. This appointment is followed by a Radiation Therapist led phone call one to two weeks later as a supportive care initiative to ensure these patients are continuing to manage side effects post treatment, are aware of their ongoing follow up plan and to advise of where further support can be sought if required.

2.6. COVID-19 Omicron

The Te Uru Mātai Matengau Business Continuity Plan has been reviewed in response to the current COVID-19 Omicron community outbreak, to ensure critical service functions are maintained if case numbers rise and staffing is impacted.

SERVICE	Te Uru Pā Harakeke – Healthy Women, Children and Youth
FOR PERIOD	October, November, December 2021
PREPARED BY	Sarah Fenwick, Operations Executive Dr Jeff Brown, Clinical Executive

1. PERFORMANCE OVERVIEW

The following table provides a summary of the progress to date against the equity outcome, sustainability, and other actions in the 2021/22 Annual Plan. Actions behind plan are discussed in the section below.

	Initiative	**Rating & Trend**	
A-E	Reduce equity gap between Māori and non-Māori babies who are exclusively or fully breastfeeding at three months of age.	**A**	•
A-E	Babies who live in smoke free household at Well Child Tamariki Ora (WCTO) first core contact.	**A**	•
A-E	Complete Tūngia Te Ururua community engagement	**A**	↓
A-E	Deliver district wide breast-feeding strategic plan	**G**	•
A-E	Develop a regional first 1000 days strategy	**G**	•
A-E	Develop equity leadership across Te Uru Pā Harakeke	**G**	•
A-E	Reduce the number Ambulatory Sensitive Hospitalisation (ASH) events	**G**	•
A	Support a sustainable midwifery workforce	**R**	•
A	Increase engagement and visibility of the Family Violence Intervention Programme across the DHB	**G**	•
A	Increase clinical procedures in the outpatient setting and explore opportunities alongside primary care for services closer to home.	**G**	•
A	Implement the Planned Care Waiting List Improvement Plan - Elective Services Performance Indicator 2 (ESPI 2)	**A**	•
A	Implement the Planned Care Waiting List Improvement Plan - Elective Services Performance Indicator 5 (ESPI 5)	**A**	•
A	Improve shorter stays in the Emergency Department	**A**	•

Rating & Trend Legend							
G	On track, progressing as planned.	A	Behind plan – remedial action plan in place.	R	Behind plan – major risks and exception report required.	D	Not completed as planned.
↑	Improved from last report.	↓	Regressed from last report.	•	No change from last report.		

Plan Legend	A	Annual Plan	S	Sustainability Plan	E	Equity Indicator

The comments below relate to Performance Overview initiatives that have not already been covered under the Cluster Dashboard commentary.

Data for reducing the equity gap between Māori and non-Māori babies who are exclusively or fully breastfeeding at three months is reported six-monthly, so will be reported to the next Health and Disability Advisory Committee (HDAC) meeting. However, the use of donor milk through the Whāngai Ora milk bank has contributed to improving the exclusively breast-fed rate on discharge from hospital, with 89.7 percent achievement in December 2021. It is hoped that the three-month breastfeeding rate will improve over the coming months, noting this will be a measure of support in the community following discharge.

Data for babies who live in smokefree households is provided six-monthly and therefore will be reported to the next meeting.

Independent analysis of the approximately 220 consumer surveys and 25 provider surveys received as part of the Tūngia te Ururua, first thousand days Tararua, Ōtaki and Horowhenua community engagement is underway. A draft report has been received and feedback provided, with the final report expected within the next four weeks. The full report will be shared with the Committee and with the communities involved.

As highlighted in previous papers, the national shortage of midwives, increasing acuity and handover of care are all factors impacting on the ability to recruit and retain midwives at MDHB. A robust action plan is in place to mitigate the workforce risk, with Te Papaioea Birthing Centre staffing still limited, to ensure safe staffing at Palmerston North Hospital. MDHB remains fully committed to resuming 24-hour staffing at the Birthing Centre as soon as safely possible. In addition, a staffing escalation plan has been developed in consultation with union partners and staff to mitigate and manage the staffing risk.

Local recruitment efforts continue with three new graduate midwives, commencing on 31 January 2022. The graduates will follow a three-month supernumerary orientation. Two external recruitment companies are engaged to recruit midwives internationally, with one candidate from the United Kingdom successfully recruited and due to arrive in New Zealand in March 2022.

Recruitment to an Associate Director of Midwifery role is underway as recruitment to the Director role was unsuccessful. An appointment has been made to the Secondary Care Midwifery Manager role and a Clinical Midwifery Coach commenced on 10 January 2022. As part of Te Uru Pa Harakeke's commitment to Te Tiriti and equity of outcomes for Māori, recruitment has commenced for a Kaiaraara Tu Ora – Primary Midwife Specialist. This multidisciplinary role will work closely with Pae Ora Paiaka

Whaiora Hauora Māori to enhance the experience and outcomes for wāhine and whānau Māori across the rohe. Recruitment to the Equity Lead role has not been successful to date. Further advertising is in progress.

2. SIGNIFICANT MATTERS

2.1 MDHB Child Development Service (CDS) Referral Integration Project

The CDS Referral Integration Project focuses on developing an integrated health and education referral pathway for children with additional needs, developmental delays or disabilities requiring multi-agency or specialist services across the MDHB region. Phase One of the project was completed in February 2021.

Phase Two of the project focuses on piloting the integrated model, with a multi-agency system to trial the new model and ways of working. Child Hub Collaborative branding, with gifted te Reo Māori name, Kia Kotahi te Tamaiti (coming together for the children), is in place. The working group begins trialling end-to-end across agency case examples through the foundational pilot system, before inviting live participants from each service area to participate in the pilot. These live examples will enable us to ensure processes are in place for each of the pilot services before implementing wider use.

2.2 Child Development Service (CDS) Psychology

A change paper released in March 2021 proposed moving to a fully outsourced arrangement for neuropsychological assessments, currently performed by psychologists in the CDS. A decision document was released on 28 June 2021 confirming the decision to proceed with the model proposed. Work to progress this decision with staff and union partners has resulted in definitive changes in February 2022. The outsourced tender will be released upon completion.

2.3 Colposcopy Audit

The National Cervical Screening Programme run by the Ministry of Health commenced their three-yearly audit of colposcopy screening and treatment processes at MDHB on 17 August 2021. The audit was paused due to the increase in COVID-19 alert levels, however, has since been completed virtually. The final report has yet to be received.

2.4 First 1000 Days Strategy

MDHB has been successful in securing sustainability funds to develop a strategy for the first 1000 days for the MidCentral DHB region. Learnings from the Tūngia te Ururua community engagement will help inform the project, which will be led as a partnership between Te Uru Pā Harakeke and Pae Ora Paiaka Whaiora Hauora Māori. A joint Synergia and Francis Health bid to lead the project was successful. Terms of reference have been agreed and the programme has commenced.

2.5 **Recruitment**

The Obstetrics and Gynaecology team has recruited a Senior Medical Officer (SMO) who commenced in November 2021, reducing their vacancies to two full time equivalent Senior Medical Officers. A further SMO has been recruited with a March 2022 start date predicted. A locum has been secured for a six-month period commencing in April 2022 to bring the team to full staffing. Recruitment efforts will continue until a final permanent SMO is secured.

The Paediatric team is now fully staffed with SMOs. However, RMO vacancies are impacting staffing provision with limited availability of locums. The SMO workforce is covering RMO roster gaps where no locum can be secured.

2.6 **Antenatal Clinic**

The Antenatal Clinic will permanently relocate to premises beneath the Birthing Centre, previously known as the 'The Salt Rooms', following the recent signing of a lease. Some building work is required prior to the relocation and the Antenatal Clinic will remain at Te Papaioea Birthing Centre until this work is complete.

2.7 **Ultrasound**

Maternity, Radiology and local private radiology providers met in November 2021 to agree a local plan regarding obstetric ultrasound that ensures best outcomes for wāhine and pēpi across the rohe. A further meeting will be held in February 2022 to review the plan and make any required changes or additions.

2.8 **Francis Health**

Following a Request for Proposal (RFP) process, Francis Health was commissioned to support a programme of work to improve the culture across the maternity service. The team leading this work has extensive experience working in culture, leadership and organisational development. After individual interviews with a wide breadth of the team, a whole of service representative steering group was established, with Pae Ora Paiaka Whaiora Hauora Māori supporting Te Uru Pā Harakeke. Two workshops were held exploring how the service can thrive and staff can work cohesively, consistently and help others do the same across the service. A maternity culture survey was conducted in July 2021, with 41 percent of the team completing the survey. Face-to-face feedback sessions and culture workshops planned for August 2021, were postponed and revised due to COVID-19 Delta national Alert Level Four, and held via Zoom in September 2021. Outcomes of these sessions were sent to staff in October 2021. A wider leadership hui was held on 8 December 2021. Further staff engagement workshops are planned for March 2022.

SERVICE	Te Uru Rauhī – Mental Health and Addiction Services (MHAS)
FOR PERIOD	October, November, December 2021
PREPARED BY	Scott Ambridge, Operations Executive

PERFORMANCE OVERVIEW

The following table provides a summary of the progress to date against the equity outcomes, sustainability, and other actions in the 2020/21 Annual Plan. Te Uru Rauhī is generally on track, with those actions behind plan discussed in the section below.

Delivering on Equity Outcome Actions	**Status**	**Change**
Increase access and equity of care for Māori whānau engaging with Mental Health and Addiction Services.	G	↑
Partner with THINK Hauora to implement the Access and Choice initiative within Primary Care.	G	•
Increase the participation of iwi, people and whānau in the development and design of services.	G	↑
Develop initiatives to increase the diversity and cultural competency of the workforce.	G	•
Develop a responsive, innovative and flexible workforce that supports people and whānau across the continuum of care.	G	•
Delivering on the Sustainability Plan		
Implement mental health service changes aligned to enhanced models of care.	G	•
Delivering on Annual Plan Actions		
Expand capability and capacity in suicide prevention, develop high profile campaigns and training focused on prevention.	G	•
Develop and pilot community-based services that expand access in the Horowhenua and Tararua areas.	A	↑
Work with THINK Hauora to improve physical health outcomes for whānau with mental health and addiction conditions.	G	•
Deliver clinically safe and effective health care in a less restrictive environment.	G	•
Improve equity of access to alcohol and drug addiction services across the district.	G	•
Progress key capital work (i.e., new inpatient redevelopment).	G	•
Progress digital enhancements to support integrated models of care and improve workforce effectiveness and mobility.	G	↑
Work in conjunction with Te Uru Pā Harakeke to develop and improve access for hapu mama.	G	•
Work with Te Uru Arotau, support the Emergency Department for people presenting with mental health needs.	R	•

Rating & Trend Legend							
G	On track	**A**	Behind plan – remedial action plan in place	**R**	Behind plan – major risks, exception report required	**D**	Not completed as planned
↑	Improved from last report	↓	Regressed from last report	•	No change from last report		

Request for Proposal (RFP) – Horowhenua community based acute alternative service

The RFP closed for the Horowhenua service in December 2021. A response was received by a consortium made up of Muauapoko Tribal Authority, Raukawa Whānau Ora Services, Mana o te Tangata Trust, Whaioro with Emerge Aotearoa. Evaluation of this proposal included a presentation from the joint parties. Recommendation documents are being prepared for next steps.

Support the Emergency Department for people presenting with mental health needs

An agreement has been reached with Te Uru Arotau to appoint a clinical specialty role that will be based within the Emergency Department but will be positioned within the hospital based mental health liaison service. This sees no change to the responsibilities and expected outcomes of the role, but ensures the role has good, strong clinical and professional links with the Mental Health and Addiction Service. As recruitment to this position has been challenging, a recruitment agency will be engaged to identify applicants.

SIGNIFICANT MATTERS

1.1 Inpatient bed occupancy

From October to December the average number of patients on the ward has been 24 (total including those on leave is 27). Whilst the current budget provides safe staffing levels up to 28 beds, recruitment continues to be a challenge. The Charge Nurse position remains vacant; however, a temporary appointment was made in December. The Acting Charge Nurse is an experienced Associate Charge Nurse within Ward 21 and will support the leadership of the team whilst recruitment is underway. In addition to this, an additional role, Service Lead Inpatient Services, has been created to strengthen the clinical and operational leadership of Ward 21.

Management, staff, and unions continue to meet regularly to oversee a range of agreed actions relating to staff welfare, recruitment, facility improvements, clinical and cultural practice. The Operations Lead and Medical Director remain actively involved in clinical oversight and in particular the complex care coordination. The Patient and Bed Flow Manager position continues to focus efforts on people who have been an inpatient for 30+ days, as well as overseeing allocation of community bed resources, ensuring these are appropriately utilised and used to their fullest potential.

The readmission rate and length of stay for the ward are included below:

KPI #	Description	Target	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	vs. Last Month
KPI 2	28 day acute inpatient readmission rate	0-10%	18%	16%	20%	11%	14%	9%	11%	13%	16%	13%	19%		↑
KPI 8	Average length of acute inpatient stay (days)	14-21 days	14.8	31.0	10.8	15.4	20.4	12.0	31.1	19.4	14.2	27.5	21.9	9.7	↓

LEGEND
Meets Ministry of Health Target
Does not meet Ministry of Health Target
Ministry of Health Alert or Significantly below target

1.2 **Workforce**

A consultation process was undertaken on the future medical leadership model. The paper set out a future direction aimed at strengthening medical leadership within Te Uru Rauhī that included the reinstatement of the Clinical Executive position and the establishment of two Medical Lead roles within each speciality area - Acute and Specialist Services and Specialist Community and Primary Services. The changes were supported by the medical staff and unions and recruitment is underway.

A review of the leadership structure within Ward 21 was undertaken. Its intent was to review the current leadership model and to provide recommendations around alternatives. The work involved consultation with staff, unions and included benchmarking with other DHBs. The proposal (that was endorsed and approved) established a Service Lead, Inpatient Services position that will work in partnership with the Charge Nurse to lead the effective and efficient clinical delivery of inpatient services. The Charge Nurse position remains vacant (an Acting Chare Nurse is in place), recruitment to both positions is underway.

Te Uru Rauhī is experiencing a high level of vacancies across all services and professional groups. In total Te Uru Rauhī is carrying 52 vacancies (total establishment of 325). The table below shows the vacancies by professional group:

Professional Group	Budget	Actual	**Variance**
Medical Staff	26.90	19.3	**-7.60**
Registered Nurse	99.68	87.90	**-11.78**
Health Care Assistants	27.70	16.80	**-10.90**
Addictions Practitioner	14.00	8.00	**-6.00**
Occupational Therapist/Employment Support	7.00	3.80	**-3.20**
Psychologist	11.50	6.05	**-5.45**
Social Worker	13.40	9.70	**-3.70**
Administrator	20.55	16.85	**-3.70**

The vacancies for medical staff are all Senior Medical Officers and the main vacancies in Ward 21 are Health Care Assistants. The balance of vacancies sits across community services and in particular the impact of the changes from Te Mātāpuna o te Ora, such as increasing addictions and allied health capacity. The team is actively recruiting across all roles.

Whilst demand across services has stabilised the high vacancy rates, coupled with the change programme underway is placing significant pressures on services.

1.3 Child and Adolescent Mental Health and Addictions Services (CAFS)

Over the past 12 months CAFS has seen a steady increase in referrals. CAFS have been running the ALERT programme for almost three years and have currently seconded a member of staff to the Ministry of Education to set up the ALERT programme in Early Childhood Centres in Palmerston North – 0.5FTE (one of only three pilot sites in the country). The ALERT programme is an evidence-based approach to assist children with self-regulation so that they can better handle life's challenges. The pilot is planned to run for 11 months. CAFS continues to provide this program for 5-12-year-olds. CAFS has completed a procurement process to contract Youthline to provide brief interventions to young people (teens) who are no longer acutely unwell but require follow up support and to offer a stepdown service for teens transitioning from CAFS. The service continues to have the lowest waitlist in the country.

1.4 Inpatient facility rebuild

The entranceway has been redesigned, led by iwi in partnership with the clinical team to ensure this a welcoming and culturally responsive space for all. As some time was lost through this process, the decision was made to split the package of works. This means that the concrete slab and civil engineering works will take place first, followed by the remainder of the build. This split package approach enables work to take place whilst other processes are occurring and has reduced the timeframe to ensure that the build is still delivered by the end of 2023.

Developed design is coming to a close, which will followed by a short, detailed design phase. The completion of developed design will be marked by presentations from the design team, which include a 3D walkthrough. These workshops will be scheduled to engage our wider stakeholders, including Manawhenua, union partners, and neighbours.

1.5 Adult Integrated Model of Care – Te Mātāpuna o te Ora

In the last quarter the expressions of interest process with impacted staff concluded. All staff were offered positions, although a small number opted to look at other options outside of the DHB. Recruitment has commenced across all vacant positions.

Significant work in the quarter involved developing the professional development programme to support the implementation of Te Mātāpuna o te Ora. The programme is focused on team development and will take place over three days. The training programme commenced in late January 2022.

Communication with service users and whānau has commenced. There will ongoing engagement and ongoing consultation with service users and whānau throughout this period. We are also leveraging off existing networks such as locality groups and will be establishing regular locality-based forums to keep service users and whānau updated on the changes and what will look different for them.

Collaborative design

Funding received from the Ministry of Health (the Ministry) enabled MDHB to engage an external contractor to design what kaupapa Māori mental health service would look like with a particular focus on the Horowhenua locality. Described as the "Kaupapa Māori Collaborative Design Program" it has extensive support through the established Te Roopu WAIORA governance group which includes all iwi and Māori providers delivering mental health and addiction services including Mana o te Tangata – a Māori peer led organisation. The collaboration plan has two discrete components focusing on Horowhenua kaupapa pathway design and Te Papaioea – Manawatu pathway design with an interacting pathway across the MDHB rohe.

Cultural support

The implementation of Te Mātāpuna o te Ora significantly increased access to cultural supports through the appointment of additional Whānau Ora Kaitautoko and Tikanga and Cultural Competency Facilitator positions (an increase from two to seven). Working within kaupapa services the Whānau Ora Kaitautoko positions will focus on whānau connectivity and community support and the Tikanga and Cultural Competency Facilitator will lead the integration of cultural (Māori worldview) understanding across all aspects of clinical service delivery and skill development in cultural responsiveness and tikanga within kaupapa services. Recruitment is underway for these positions.

Digital enhancements

The first sprint is underway with the connected care record (Whānau Tahi). This includes the preparation of user stories for the Specialist Primary service, which will guide the basic programme build and the set-up of the infrastructure. Data mapping has also taken place to understand the integration requirements.

A demonstration for a new 'soft' telephony system was held and development of the system is underway.

Facilities

An architect has been engaged to develop a preliminary design for the Horowhenua facility that has been identified (the old hospital). A preferred building for Manawatū has also been identified and we are currently working through the funding implications. It is planned to have terms of lease signed by 30 June 2022.

SERVICE:	Te Uru Arotau – Acute and Elective Specialist Services
FOR PERIOD:	October, November, December 2021
PREPARED BY:	Lyn Horgan, Operations Executive

1. PERFORMANCE OVERVIEW

The following table provides a summary of the progress to date against the equity outcome, sustainability and other actions in the 2021/22 Annual Plan. Te Uru Arotau is generally on track, with those initiatives behind plan discussed in the section below.

	Initiative	Status	Change
A	Progress the Surgical Procedural Intervention Recovery Expansion (SPIRE) programme	G	↑
A	Progress the acute capacity and assessment (EDOA/MAPU)	G	↑
A-E	Progress development of Hospital Health Pathways	G	↑
A	Progress the Community Infusion Service Pilot	G	↑
A	Progress the implementation of the ScOPe – Theatre Flow and Clinical Audit	G	↑
P	Improve clinical documentation and coding to capture appropriate data and revenue	G	↑
A-P	Progress the Acute Demand programme to improve patient flow throughout the hospital	A	•
A-P	Progress the Planned Care Waiting Trajectories – Elective Services Performance Indicator 2 (ESPI 2)	A	•
A-P	Progress the Planned Care Waiting Trajectories – Elective Services Performance Indicator 5 (ESPI 5)	A	↓
E	Advance the Central Region Equity framework in relation to Planned Care	G	↑

Rating & Trend Legend

G	On track	**A**	Behind plan – remedial action plan in place	**R**	Behind plan – major risks, exception report required	**D**	Not completed as planned
↑	Improved from last report	↓	Regressed from last report	•	No change from last report		

Plan Legend

A	Annual Plan	**P**	Performance Improvement Plan	**O**	Operational Plan	**EOA**	Equity of Outcomes

The comments below relate to Performance Overview that have not already been covered under the Directorate Dashboard commentary.

The contract has been signed with the vendor for the delivery of the Performance Indicators for Coding Quality (PICQ) audit tool. The PICQ audit tool is undergoing test data extracts. It is expected to be fully implemented by the end of February 2022. The coding quality tool objectively assesses all records in a data set according to clinical coding standards and coding conventions. The audit information will identify targeted areas for improvement.

Unplanned Care – Shorter Stays in Emergency Department (SSIED)

Acute flow continues to be a challenge for the organisation and this is reflected in the SSIED results. High acuity and high occupancy in the hospital has continued to be pressure on this target. This is a priority focus for MDHB. The Directorate continues to progress work across the system to improve the flow of patients from presentation to ED to discharge.

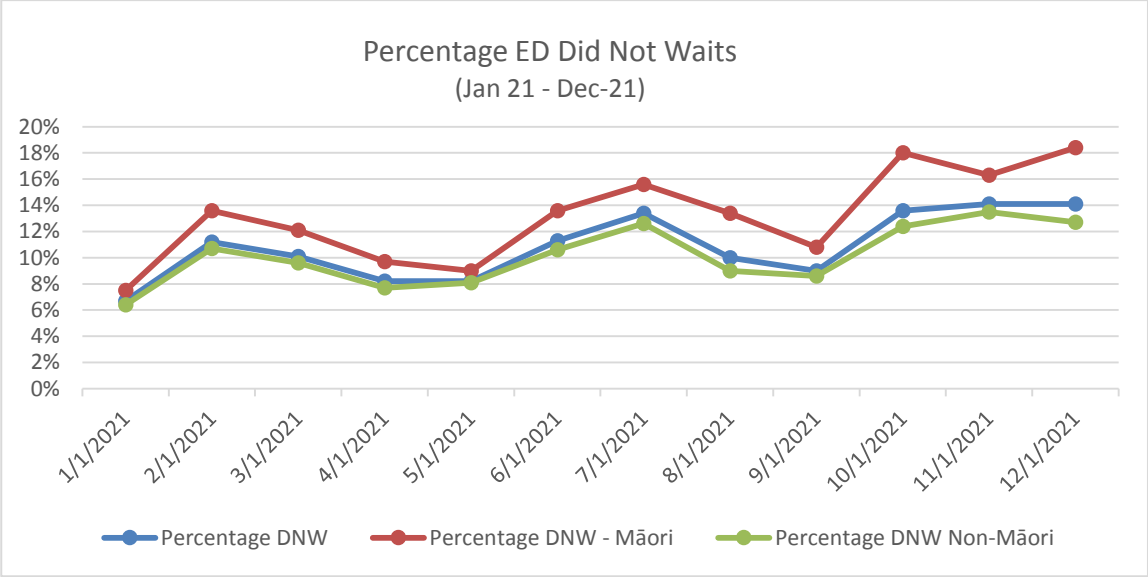
In response to the increasing wait times through the ED a number of additional initiatives are underway to improve whole of system patient flow:

- MidCentral District Health Board (MDHB) is participating in a Ministry of Health (the Ministry) sponsored pilot focused on weekend discharging of patients. Three areas have been identified with the Ministry which include a Package of Treatment Support (PoTS) service as an extension of the Post Emergency Department Assessment Liaison (PEDAL) service, weekend and extended hours for Allied Health Therapies and a Patient at Risk (PAR) nurse role.
- Establishment of a dedicated Patient Flow Nurse to focus on system flow of patients from decision to admit in ED through to the wards. This role will start in early February 2022.
- Establishment of a dedicated Complex Nurse Coordinator role to support the discharge of patients with complex needs. Recruitment to commence in February 2022.
- An additional all day Saturday acute theatre list to improve the flow of acute surgical patients and reduce deferred planned care surgeries on Mondays.
- Te Uru Arotau is working in partnership with Pae Ora Paiaka Hauora Māori to progress the establishment of an Equity Coordinator to be based in the ED.
- New Nursing Entry to Practice Programme Nurses commenced in early 2022. This has reduced the number of nursing staff vacancies in the wards.
- The ED POAC (Primary Options for Acute Care) redirection continues and there is good uptake of this ongoing initiative.

Emergency Department – Did Not Waits (DNW) 12 months ending December 2021

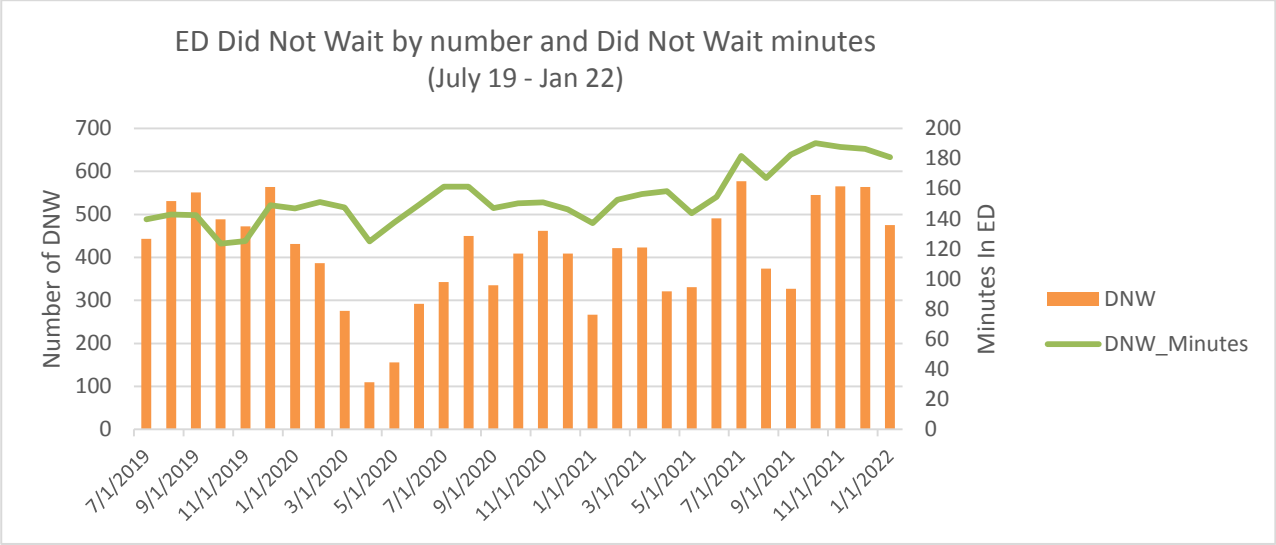
Month	Total Presentations	Total DNW	Percentage DNW	Māori Presentations	Total DNW Māori	Percentage DNW – Māori	Non-Māori Presentations	Total DNW Non-Māori	Percentage DNW Non-Māori
January 2021	3,945	263	6.7%	851	64	7.5%	3,094	199	6.4%
February 2021	3,730	417	11.2%	863	117	13.6%	2,805	300	10.7%
March 2021	4,218	429	10.1%	925	112	12.1%	3,293	317	9.6%
April 2021	3,895	318	8.2%	822	80	9.7%	3,073	238	7.7%
May 2021	4,020	333	8.2%	927	83	9%	3,093	250	8.1%
June 2021	4,354	493	11.3%	1,006	137	13.6%	3,348	356	10.6%
July 2021	4,293	574	13.4%	1,071	167	15.6%	3,222	407	12.6%
August 2021	3,762	376	10%	856	115	13.4%	2,906	261	9%
September 2021	3,606	327	9%	777	84	10.8%	2,829	243	8.6%
October 2021	3,958	540	13.6%	877	158	18.0%	3,081	382	12.4%
November 2021	4,021	568	14.1%	906	148	16.3%	3,115	420	13.5%
December 2021	3,994	562	14.1%	927	171	18.4%	3,067	391	12.7%

Emergency Department Percentage – Did Not Waits (DNW) Trend Graph



The percentage of DNW is increasing. Māori and Pasifika ethnicities are considered priority flags as part of the ED triage process.

Emergency Department Did Not Waits (DNW) by Number and Minutes Graph



There has been an increase in the DNW time which could mean more people might be leaving because they are waiting longer.

MDHB is planning with the Ministry's System Flow team to visit, following their offer of support last year, as part of wider discussions to improve performance.

Planned Care and ESPIs

MDHB is progressing well towards the achievement of ESPI 2.

ESPI 5 remains an area of challenge. MDHB continues to work in partnership with Crest Hospital to provide outsourced and outplaced surgical procedures to further improve performance in this area. Senior Medical Officers continue to be involved with planning surgery based on those with greatest clinical urgency and long waiting times.

Planned Care Improvement Action Plan

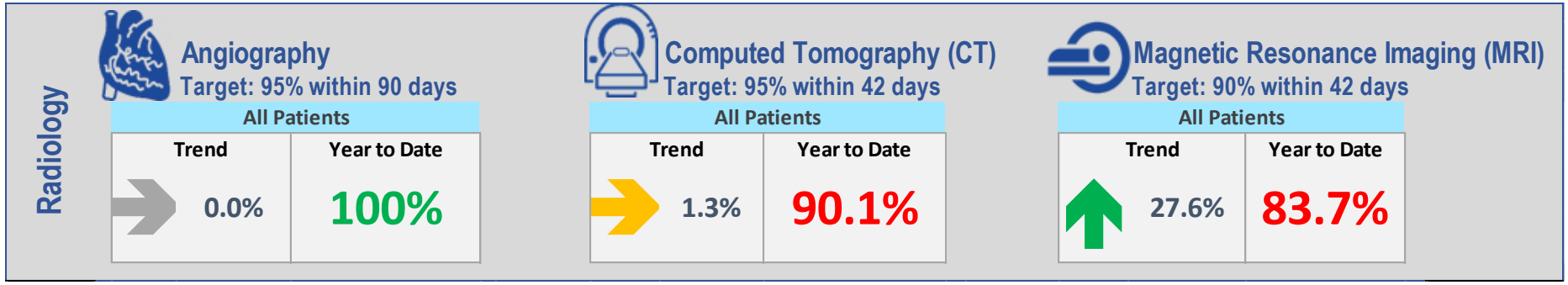
The Ministry has further allocated additional funding for District Health Boards for short term initiatives to improve Planned Care and diagnostics. MDHB has submitted additional initiatives for 2022 which includes six options to improve waiting lists and system flow. These are listed below. MDHB expects to be notified in early 2022 the outcome for the proposals.

- Acute theatre capacity (additional acute theatre on Saturdays)
- Outsourced complex Otorhinolaryngology surgeries
- Outsourced Audiology
- Additional fortnightly Saturday Gastroenterology lists
- Flexible Acute Flow Unit
- Outsourced Medical Imaging (CT, MRI and US).

Community Infusion Service Pilot

The Community Infusion Service Pilot has commenced with three General Practice sites. This pilot provides equipment, training and support for patients who would normally receive their infusion at Palmerston North Hospital, to be delivered at a local General Practice site. The feedback from the patients who have had their infusion provided at a General Practice site is extremely positive. This is an example of an integrated and partnership approach between secondary and primary care.

1.1 Performance Indicators – December 2021



Computed Tomography (CT) performance increased to 95.1 percent in December following recovery from the National COVID-19 Level 3 and Level 4 lockdowns. Demands for service continue to increase and acute demand impacts on planned CTs. Planned volumes and acute demand is such that the CT machine is being used 24 hours.

Magnetic Resonance Imaging (MRI) performance improved by almost 10 percent to 93.2 percent in December.

Outsourcing as part of Planned Care trajectories for both CT and MRI continues to support service delivery and performance.

The Angiography performance target remains at 100 percent.

2. SIGNIFICANT MATTERS

2.1 Major Facility Projects

2.1.1. SPIRE (Surgical Procedural Interventional Recovery Expansion)

Stage 1 construction is underway and involves the establishment of a new Day of Surgery Admission and Recovery area and the expansion of the Endoscopy Unit on the first floor of Block A.

Stage 1 also includes the upgrade and expansion of the Staff Change area within the theatre suite and the development of the shell of a Procedure Room within the current theatre staff room. These two pieces of work had to be done over the Christmas/New Year period and are now largely complete. As expected, some issues were encountered when the walls and ceilings were opened up. The theatre suite is within Block B which is an older building. The issues identified are being rectified but due to their nature have caused delays. The work is now expected to be completed by mid-February, not 31 January as originally scheduled.

Similar issues have been identified in the Block A component of work and the potential impact on the programme is being explored.

The detailed design for Stage 2 is on track for completion of documentation in February 2022. The design has been issued to MDHB for review and this is underway.

2.1.2 Medical Assessment Planning Unit (MAPU)/Emergency Department Observation Area (EDOA) Unit

Construction work is underway and includes the building foundation and the establishment of disability car parks. The delays experienced are challenging the target of completing the facility this year.

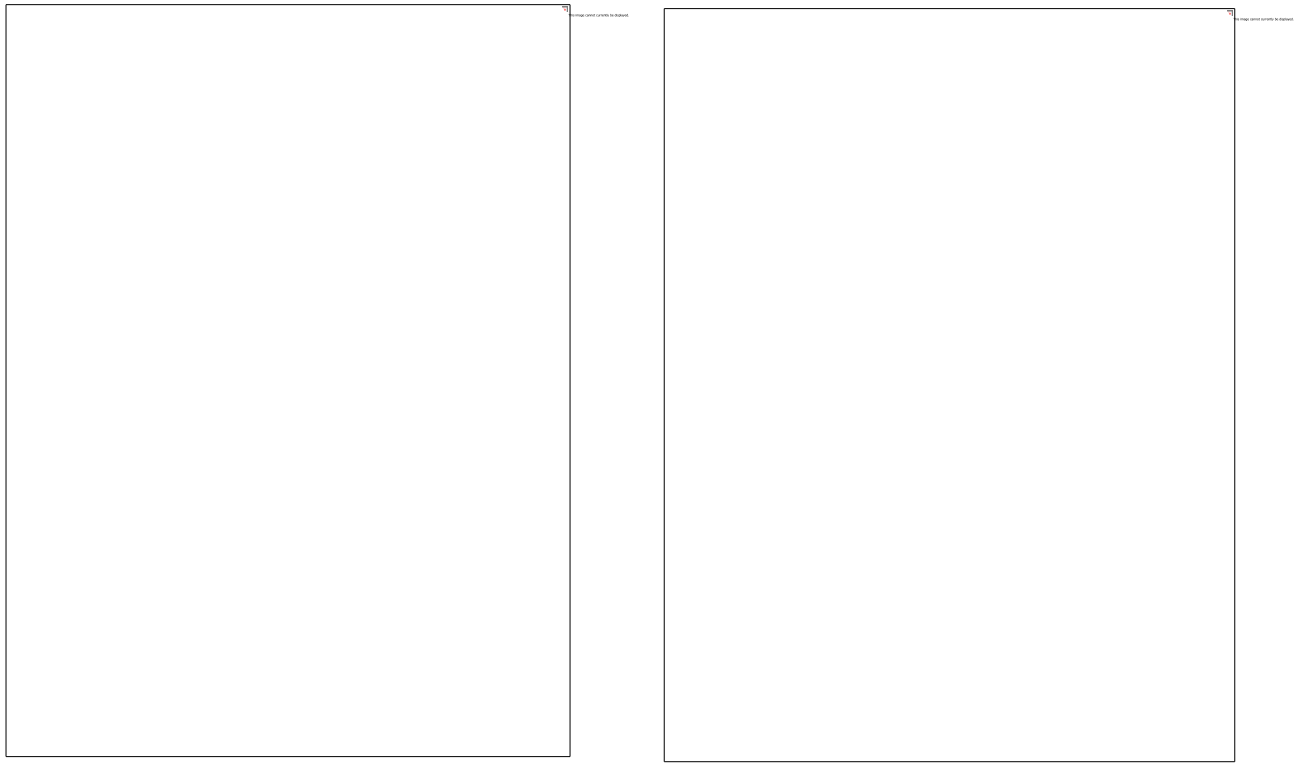
A water pipe and fibre optic cables have been re-routed away from the building site and work on excavating the foundation and establishing foundation walls and beams is now occurring.

New accessibility parks are being created, replacing those previously located in Car Park C. Meantime, temporary accessibility parks have been created. New signage and temporary walkways have been established to support public and staff access the hospital from Car Park C and the southern end of the campus.

From a service perspective, planning continues to ensure everything is ready and in place to enable a smooth commissioning process, including pre-ordering of equipment.

2.1.3 Fluoroscopy

The new fluoroscopy machine has been installed and is now undergoing final commissioning testing.



2.2 Medical Imaging Clinical Services Plan

MDHB has been successful in securing sustainability funding (round two) from the Ministry to support the completion of a Medical Imaging Clinical Services Plan. The scope of this initiative is two-fold; to ensure medical imaging diagnostic services are meeting community and clinician needs and are delivered in the right place at the right time, and maximum value from the available resource is realised for Māori and vulnerable populations. The desired outcome of the project is to have a road map that will consider the short, medium and long future environment. MDHB has a contract in place with an external provider to support this mahi and this is now progressing.

2.3 Echo Image Vault

The MDHB Echocardiography Image Vault was replaced in December 2021. Echocardiography is specialist ultrasound (medical imaging) of the heart. It is routinely used in the diagnosis, management and follow-up of patients with any suspected or known heart diseases and is one of the most widely used diagnostic tests in Cardiology.

The new system includes the ability for Cardiologists and Echosonographers to retrieve the images and reports on their own desktops and additional stations have been added in the Coronary Care Unit and the Emergency Department. Previously all reporting was done from one station in the Cardiology Department.

2.4 Omicron Planning

The impact of COVID-19 response for the new variant Omicron planning dominates our thinking, confirming plans for service delivery alongside our COVID-19 reality. Planning is well in place to support a coordinated response to the Omicron variant of COVID-19. The focus is on identified critical and vulnerable services.

SERVICE	Te Uru Whakamauora – Healthy Ageing and Rehabilitation
FOR PERIOD	October, November, December 2021
PREPARED BY	Lyn Horgan Operations Executive Syed Zaman, Clinical Executive

1. PERFORMANCE OVERVIEW

The following table provides a summary of the progress to date against equity outcomes, sustainability and other actions in the 2021/22 Annual Plan. There are no emerging risks or areas of concern for this reporting period.

	Initiative	**Rating & Trend**	
A-E	Increase access and equity of care for Māori kaumātua and whānau to enhance Māori health gain across the district	**G**	•
A-E	Increase uptake of integrated falls and fracture liaison service	**G**	•
A-E	Develop a more responsive and effective rehabilitation model	**G**	•
A	Improve models of care for the older person with frailty	**G**	•
A	Support regional improvements for all people and whānau living well with dementia prioritising support and education for Māori kaumatua and whānau	**G**	•
A	Improve patient flow throughout the hospital, reducing barriers and delays	**G**	•
A	Support aged residential care preparedness with COVID-19 aligned to the New Zealand Aotearoa Pandemic response policy for aged residential care	**G**	•

Rating & Trend Legend							
G	On track	**A**	Behind plan – remedial action plan in place	**R**	Behind plan – major risks, exception report required	**D**	Not completed as planned
↑	Improved from last report	↓	Regressed from last report	•	No change from last report		

Plan Legend							
AP	Annual Plan	**P**	Performance Improvement Plan	**O**	Operational Plan	**EOA**	Equity Outcome Action

The following comment relates to Performance Overview that has not already been covered under the Cluster Dashboard commentary.

2. SIGNIFICANT MATTERS

2.1. Omicron Planning

Te Uru Whakamauora has identified critical services and enablers that may be impacted with the Omicron variant. An action plan is in place to mitigate workforce issues and other issues impacting on service delivery. The Directorate has also been working closely with Aged Residential Care (ARC) and Home and Community Support (HCSS) providers to identify vulnerable service users when workforce issues may impact on service delivery. Regular meetings are being held between Directorate representatives and ARC/HCSS providers to provide ongoing support and reassurance. ARC providers have plans in place to mitigate a reduced workforce which include extended shifts, use of volunteers and whānau. HCSS provider mitigation plans include prioritising complex clients that require a higher level of support and reducing or suspending non-urgent services, such as home management.

2.2. Care in the Community

A business case has been developed for investment into post-acute community rehabilitation delivered by allied health and endorsed by the Organisational Leadership Team (OLT). A number of initiatives are covered in the proposal including Rehabilitation in the Home (Accident Compensation Corporation Non-Acute Rehabilitation), community stroke rehabilitation, enhanced allied health support and coordination of Health Recovery beds, transitional care beds to support the Protection of Personal and Property Rights process outside of the inpatient setting and Voice Therapy to support stroke rehabilitation and gender affirming intervention.

Approval has been given for OPAL Community Service (CS) implementation planning to proceed. A project manager commenced in November and a Model of Care working group and a Governance group are meeting regularly to progress planning for implementation of OPAL CS teams across the MidCentral DHB region. Horowhenua is being prioritised for implementation of a service by July 2022. A phased approach is being undertaken to implement services in all other localities by September 2023.

2.3. Community Capacity

For this period all therapy services (Occupational Therapy, Physiotherapy, Social Work, Speech Language Therapy and Dietetics), have remained within the Ministry of Health's (the Ministry) guidance for clients referred for urgent or semi-urgent assessment.

Community Occupational Therapy non-urgent referrals has remained at 433 and all areas have wait times greater than 12 months. The level of urgent cases in addition to current caseloads has reduced the team's ability to pick up cases, contributing to the high non-urgent waitlist numbers and wait times. The Occupational Therapy leadership team continues to work on a plan to mitigate the risks associated with the high wait list numbers and wait times. This has included contracting private providers to assist the team with inpatient service provision until the end of November 2021 and prioritising referral criteria for the community. A triage tool in the form of a risk matrix is being applied to all new referrals by a triage team and the current waitlist reviewed to determine the level of ongoing need for Occupational Therapy services.
The loss of a long-term staff member has been a factor in delivery of services and recruitment is underway. Recruitment remains a challenge with reduced numbers of applicants for positions advertised.

The Hand Therapy service waitlist for Priority 2 patients has reduced from 60 to 50 as the Hand Therapist remains part-time and on light duties. All ACC patients and Ministry patients that are Priority 1 are being sent through to the private sector. A temporary contract with an Occupational Therapist has assisted our Hand Therapist to manage the Burns and Scar management patients.

The Dietetics Service has encountered a nationwide shortage of Nutricia-branded oral nutritional supplements as well as enteral feeds. The Clinical Dietetic team worked with the national Dietetic Professional Leads to address this issue with PHARMAC in order to ensure that all patients reliant on such feeds were not at risk of going without. Nutricia airfreighted various feeds from Europe in order to meet the demands of our population. The service worked closely with Compass Food Services to ensure that all nutritional stocks were available throughout the critical December/January period although ongoing issues with supply chain disruptions are being experienced.

The waitlist for Supportlinks has reduced from 352 to 222 during this reporting period. Mitigation of client risk continues with Packages of Temporary Care (PoTS), providing respite and carer relief packages prior to assessment if required, applying a proactive assessment approach based on risk and urgency for vulnerable client groups and assessment by telephone. Two staff members have resigned and recruitment is underway.

MidCentral District Health Board (MDHB) has received formal notification from BUPA, an aged care provider, that Gardenview, a 41 bed dementia facility in Levin, is to close with an effective date of 6 March 2022. There are currently 23 residents to relocate. The Needs Assessment and Service Coordination (NASC) service Supportlinks will be working closely with the Gardenview team and families to identify potential new facilities. A Palmerston North BUPA facility is to hold 10 beds in the dementia unit to assist with this transition. Some families have indicated that they are wanting to move their family member out of the area. Another MDHB ARC provider has been approached to certify four additional beds that have not been used previously.

Supportlinks have commenced a review of all residents in dementia units to ensure they continue to be appropriate for this level of care as availability of beds is critical. Out of area transfer requests for dementia level of care placements are managed on a case-by-case basis.

The health and disability sector continues to experience significant service coverage challenges due to an inability to recruit to existing vacancies for both registered nurses (RNs) and community support workers. Locally, MDHB ARC providers have reported issues with recruitment and covering rosters in times of sickness and vacancies. Mitigation plans that have been implemented in ARC include RNs working longer shifts, clinical managers working on the floor and using senior caregivers with an RN on call. HCSS providers are experiencing recruitment issues across all localities. There has been an impact on timely discharges for all levels of care for new residents into ARC and for complex support packages in the community.

The COVID-19 mandatory Vaccination Order for frontline staff impacted on two of the three MDHB HCSS providers who applied to the Minister for COVID-19 Response for an exemption. Approval for two extensions to the mandate were granted to enable their staff to be vaccinated. The providers completed risk assessments for all clients who could be impacted across all the funding

streams including the Ministry, Accident Compensation Corporation and MDHB. MDHB worked closely with the providers through this period to ensure there was no service disruption.

2.4. Equity

The Paediatric Dietitian for the Dietetics Service began providing outpatient appointments from Health on Broadway. There has been an improvement in attendance of patients and their whānau. This is not only because the appointment is not based at the hospital, but also means the Clinical Dietitians have direct access and support to the Community Child Health Nursing team with shared patients. This has improved the understanding of the patient and their whānau regarding the child's health and wellbeing. This Dietetic Service has increased from one half-day a month to two half-days a month.

SERVICE	Te Uru Kiriora – Primary, Public and Community Health
FOR PERIOD	October, November and December 2021
PREPARED BY	Deborah Davies, Operations Executive Kelvin Billinghurst, Clinical Executive

1. PERFORMANCE OVERVIEW

The following table provides a summary of the progress to date against the equity outcome, sustainability and other actions in the 2021/22 Annual Plan. Te Uru Kiriora's leadership team have continued to respond to the Ministry of Health's (the Ministry) direction for COVID-19 community surveillance testing, the ongoing COVID-19 vaccination programme and have been heavily involved in the preparatory work for the Omicron variant. COVID-19 has continued to impact on some initiatives, with those actions behind plan discussed in the section below.

	Initiative	Rating & Trend	
A-E	Enable service users to access a health service associated with their place of learning, to improve health outcomes and reduce health inequities	G	•
A-E	Promote and enable wellbeing in communities through health policy initiatives	A	•
A-E-S	Improve management of Long-Term Conditions (Chronic Pain, Diabetes and Respiratory Care) with a focus on improved outcomes for Māori	A	•
A	Drive effective integrated Locality based care delivery through locality team prototype development and workforce planning	G	↑
A	Strengthen community based Acute and Urgent Demand model of care and delivery	G	•
A	Improve patient health care outcomes and experience in primary care and community settings through scaling of Health Care Home	G	•

Rating & Trend Legend							
G	On track	A	Behind plan – remedial action plan in place	R	Behind plan – major risks, exception report required	D	Not completed as planned.
↑	Improved from last report	↓	Regressed from last report	•	No change from last report		

Plan Legend	A	Annual Plan	S	Sustainability Plan	E	Equity Indicator

1.1. Key progress commentary

1.1.1 Improve management of Long Term Conditions (LTCs)

THINK Hauora and MidCentral District Health Board's (MDHB) progress in the integrated Horowhenua locality-based service model development has continued to progress this quarter. While General Practitioner (GP) workforce shortages continued to impact enrolment capacity and service delivery in the Horowhenua locality, the opening of Managed Isolation and Quarantine (MIQ) places for essential workers has pleasingly resulted in a further three GP's being recruited into two practices; due to start by end of Quarter Three.

Several key LTC service delivery innovations in the Horowhenua locality commenced at the end of Quarter Two, including a shared appointment self-management pilot for patients newly diagnosed with Type 2 diabetes along with a follow up support group in partnership with the Manawatū Diabetes Trust. Early work has commenced on a pilot in one practice to identify all enrolled patients with indications of pre-diabetes and plan a work programme to provide group-based interventions. In the Palmerston North locality, a partnership with Massey University has commenced to embed tikanga principles into the Heart Health Group (Cardiac Rehabilitation) service, to increase participation rates and self-management confidence of Māori whānau.

The THINK Hauora Primary Health Organisation (PHO) LTC service specifications have been reviewed and updated to align with the commissioning for outcomes framework and reflect the changing workforce requirements for locality based LTC services (the 'Transdisciplinary LTC team'). This allows greater flexibility to shape service delivery within each locality and ensure efficient distribution of the skilled workforce to best meet the needs of individuals living with LTC.

Community based integrated care for whānau with heart failure continues in five sites across the region. The Nurse Practitioner Cardiology aligned with the newest area Horowhenua, continues to undertake shared collaborative clinics and provide education, support and mentorship to the Primary Health Care (PHC) teams. In addition to scheduled clinics, the support continues virtually as required in between times.

The transition of care programme for post-discharge management of people with Chronic Obstructive Pulmonary Disease (COPD) continues from both the Emergency Department (ED) and inpatient settings. Whilst volumes through this pathway remain extremely low due to a range of factors (reported last quarter), inpatient referrals have increased to match referrals out from ED with Māori representing 70 percent of the cohort and no representations to hospital reported. The arrival of the Omicron variant is anticipated to have an impact on this pathway.

2. SIGNIFICANT MATTERS

2.1 Smokefree 2025

New Zealand/Aotearoa's Smokefree 2025 Action Plan was launched in December 2021. Guided by the principles of Te Tiriti o Waitangi, and the culmination of many years of hard mahi, the plan will accelerate progress toward a smokefree future and tackle the harm smoked tobacco products cause. MDHB's Public Health Team, working with our local communities and as part of Aukati Tupeka Aotearoa (ATA) have been amongst the many and diverse groups who have played a part in getting the country to this point. The action plan reflects the understanding that no one single intervention will help us to achieve a Smokefree 2025. It will take a multi-faceted approach and evidence-based measures to stamp out smoking. Focus areas include:

- ensuring there is Māori leadership and decision-making across all levels of the action plan
- funding more health promotion and community activities to motivate and mobilise people across the country to get behind the smokefree goal and to signpost support for people on their quit journey
- giving people the wrap-around support they need on their quit journey by investing in more tailored help such as a stop smoking service for Pacific communities.
- making it easier to quit and harder to become addicted by only having low-level nicotine smoked tobacco products for sale and restricting product design features that increase their appeal and addictiveness
- making smoked tobacco products harder to buy by reducing the number of shops selling them and kickstarting a smokefree generation.
- making sure the tobacco industry and retailers follow the law.

Under the second focus area, Public Health has received new funding (approx. $9000) from Te Hiringa Hauora (Health Promotion Agency) to promote the new Smokefree and Vapefree cars law that came into effect in November 2021. The project is being carried out collaboratively with Regional Public Health (who provide public health services to Hutt Valley, Capital and Coast and Wairarapa DHBs). This has involved the development of promotional notice boards including local kuia and their mokopuna. The boards are placed at different locations throughout the MDHB rohe including the large billboard at MDHB. One of the kuia was also interviewed and featured on Te Karere. Car seats and smokefree car resources were given to three Pasifika Early Childhood Education and three Kohanga Reo. An excellent video was developed at Foxton Beach which featured local Foxton Beach tamariki and highlighted the Smokefree car law change.

This was just one of many health promotion projects that are being run in collaboration with local networks including promotion of smoking cessation at local events, supporting retailers who choose not to sell tobacco and assisting with workplace/council policy development.

The planned Smokefree Position Statement will be presented at the next HDAC Meeting on 24 May 2022 (capacity allowing).

2.2 Fluoridation Bill

Recent changes to the Health (Fluoridation of Drinking Water) Amendment Bill, which has now passed through the parliamentary process, gives the Director-General of Health the power to issue a direction to local authority water suppliers (including bulk water suppliers) to fluoridate a public drinking water supply.

This obviates the need for DHBs to become involved in the decision making with respect to drinking water supplies within their respective rohe. There are a number of unfluoridated supplies within the MDHB rohe, many of which are in the Tararua and Horowhenua Districts.

It is expected that once the directions are in place and implemented, there will be a gradual improvement in oral health status of children in the affected areas.

2.3 COVID-19 vaccination programme

The COVID-19 vaccination programme continues to adapt to the Ministry's requirements and public demand. The focus from late 2021 into this year has been the delivery of boosters and the commencement of the 5 to 11-year-old vaccination programme.

The distributed model with multiple vaccination providers, General Practice Teams (GPTs), THINK Hauora, iwi providers, independent vaccinators and pharmacies continues and supports a good reach across the rohe. All providers are delivering the boosters although due to space constraints and other factors some community providers will not be delivering the child vaccinations. The DHB team is delivering child doses in all static sites and working towards further sites and increased school and kura delivery in Term One.

At time of writing, the vaccination rates for total eligible population are 84 percent, Māori at 72 percent and Pasifika at 80 percent. This percentage includes the child doses therefore total population percentage is lower than adult percentage.

Negotiations are underway to have a vaccination team back at the Plaza in Palmerston north. The team is also responding to requests to have kanohi to kanohi (face-to-face) korero with whānau. In the past month, the Clinical and Operations Executives have engaged with groups such as the Rotary Club in Palmerston North, and with whānau in the Manawatū and Tararua. Queries regarding multiple COVID-19 related issues are being received and responded to across the broader team(s).

A Super Saturday style event, named Whānau Weekend was held on 5 and 6 February 2022. This included activity in the Arena and an iwi-led drive through on the Saturday night. This provided an ideal opportunity to further engage with whānau and increase coverage of boosters, although first and second doses were also available. Child vaccinations were also available to enable a whānau experience.

2.4 COVID-19 case investigation and contact management

The COVID-19 Protection Framework has been introduced. It minimises the impact and provides protection from COVID-19 through three settings – Green, Orange and Red.

The whole country is currently in the red setting. We are currently in Phase One of the government's Omicron response which involves continuation of the 'Stamp it out' approach. Public Health Service staff continue to investigate each case as it is notified, advising the person that they have tested positive, ensuring that they go into isolation, and ascertaining the details of their contacts and locations of interest.

Since the start of January 2022 there have been six cases within the MDHB rohe, involving three households. All of these are the Omicron variant. While the six cases include family members who have been isolating with the initial cases, there appears to have been no further spread.

Other areas of the country, particularly the top half of the North Island are seeing rapid increases in daily case numbers. In several areas' numbers have surpassed local PHU capacity for case investigation and contact management. In those areas the simple to moderate complexity cases are being investigated by Reach Aotearoa, a central case investigation resource.
Despite our early success in managing our Omicron cases in the MDHB rohe, we expect that we will shortly reach a similar point, where our low complexity cases are managed by Reach Aotearoa. This will free PHU staff to focus on the higher complexity cases, which may involve high risk sectors of the community such as people in transient housing, aged residential care or Department of Corrections facilities.

With national case numbers increasing and placing pressure on health and community services, the country will transition to Phase Two of the plan. Here the focus will no longer be stamping COVID-19 out, but rather on minimising and slowing further spread and assisting vulnerable communities. Cases will be identified by PCR testing and notified via text message. They will receive a link to a self-investigation tool via which they will input the requisite information. Phone interviews will continue as required.
Symptomatic household contacts will become probable cases. At this point, the public health role will be to focus on management of significant exposure events rather than individual case management. This will help protect the more vulnerable sectors of the community who are either more at-risk of contracting COVID-19, or more at-risk of poor outcomes.

2.5 Supported isolation and quarantine implementation

The COVID-19 Community Supported Isolation and Quarantine (SIQ) programme has been replaced with the Care in the Community (CitC) programme. This programme will still provide wrap-around services to support community cases and close contacts to appropriately self-isolate. Isolation may be in their home environment, or in alternative facilities for cases and close contacts who are unable or unwilling to isolate in their own home.

The two most significant changes are:

- the establishment of a Central Coordination Hub by five Locality Hubs: Tararua, Palmerston North, Manawatū, Horowhenua and Ōtaki
- the shift of responsibility for addressing welfare needs to the Ministry of Social Development (MSD).

This is a rapidly changing environment with processes and practices evolving daily.

The Locality Hub operations are being co-designed with the hub members which include Māori health and welfare providers alongside primary care providers. Locality Hubs will coordinate and deliver all health and welfare needs to people isolating in their locality.

The shift to CitC means that whānau need to prepare for isolation ahead of time as we know there will not be enough alternative accommodation, previously known as SIQ facilities, for everyone who wants it as opposed to needs it. We continue to have 14 secured accommodation bubbles. MIQ is also an increasingly unavailable resource.

2.6 COVID-19 surge testing

Over time, the general public response to COVID-19 threats in the community has been less urgent, resulting in shorter queues for testing. However there has been a slow creep of demand over the last few weeks. The central testing site now completes approximately 300 tests a day, compared with about 80 a day in December 2021. There is also increased demand at the weekends which has been met through extended weekend hours.

In terms of surge capacity, Te Uru Kiriora continue to link with THINK Hauora to ensure increased testing capacity is provided through GPTs across the rohe during the surge. Work is also underway to develop the iwi provider capacity to be able to step into this space. A recruitment drive is currently in place to ensure we have staff available to maintain capacity in the DHB team.

Border workers and Defence Force personnel who cycle through the MIQ facilities in Auckland also provide peaks of time sensitive activity, which to date the team have managed well.

The rollout of electronic ordering of laboratory tests has been very successful. It has resulted in more efficient processing of tests and improved the time it takes to complete the test. Potential gaps in the ordering pathway have also been closed, with time spent following up on missing information or results.

2.7 COVID-19 Care in the Community

The development of the MDHB Clinical and Services Operating Framework, and the MDHB Enabler Framework to support COVID-19 Care in the Community (CiTC) with associated 'pillar leads' complete this quarter, and covers the following areas in line with the Ministry's operational guidelines:

- Coordination – governance oversight, logistics and planning
- Care – both clinical and welfare
- Connectedness – connecting all key role players across welfare and clinical domains to include primary, public and specialist care
- Communication – communication and information for the public, whānau and stakeholders alike.

Focused planning is in place at the local and regional level as we move into the response of managing Omicron in the community. Detailed planning in the latter part of December 2021 positioned the MDHB to move into the response phase of increasing cases in the rohe.

Locally the Central Coordination Hub (CCH) has been activated in partnership with local iwi providers and the MSD. This hub is being tested and adjusted to comply with the Government's phases of response to Omicron (Stamp it out, Flatten the curve, and Manage it). With small case numbers to date this further supports the ability to confirm processes across health and social care services. In January 2022 the MDHB resilience checklist was refreshed to incorporate the additional requirements to respond to Omicron. This is being supported by regional level planning as Omicron cases increase, with a focus on identifying known risks and issues related to the primary care, public health and welfare responses.

Strong partnerships are in place at the leadership and operational interface with MDHB as an active member of the Regional Leadership Group, and operational relationships are well established to support the CCH and localities. The MDHB CCH for CiTC has been established and a number of key priorities addressed with regard to membership, purpose and functions of the hub. Prior to Christmas, members tested processes based on scenarios for potential cases with a focus on early identification, information flow, role delineation and timely provision of care (clinical and welfare). Since the new year, the CCH has further refined processes based on small local COVID-19 Omicron cases.

Strategic focus

1 March 2022 HDAC

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For:

	Approval
	Endorsement
X	Noting

Key questions the Committee should consider in reviewing this paper:

N/A

To	Health and Disability Advisory Committee
Author	Sarah Fenwick, Operations Executive, Te Uru Mātai Matengau Dr Claire Hardie, Clinical Executive, Te Uru Mātai Matengau, Cancer Treatment, Screening and Support
Endorsed by	Kathryn Cook, Chief Executive
Date	22 February 2022
Subject	**Regional Cancer Services and Te Aho o Te Kahu**

RECOMMENDATION

It is recommended that the Committee:

- **note** the update regarding the Advisory Oncology Service.

Strategic Alignment

This report is aligned to the DHB's strategy and the strategic imperatives within it. It is particularly aligned with 'Partner with people, whānau and communities to support health and wellbeing'.

1. PURPOSE

To provide a progress update on the Regional Cancer Services and Te Aho o Te Kahu. No decision is required.

2. SUMMARY

A 12-month pilot Advisory Oncology Service (AOS) Primary Care was established in 2019. This was the result of identifying that 50 percent of cancer patients have non-specific symptoms and therefore did not present through standard referral pathways. As a result, these patients often experienced significant delays and morbidity.

The AOS provides support and advice for non-oncological teams in primary care where a cancer diagnosis is suspected but without a clear pathway being identified for the patient. The General Practice Team and Nurse Practitioners can request Computed Tomography (CT) for patients if specific criteria are met. Although there were initial concerns that opening CT to primary care may create increased pressure on the service, this did not happen.

There were 30 referrals during the 12-month pilot, with 30 percent of the scans undertaken indicating the presence of a cancer. This is a high proportion of cases and indicated the need for the pilot to be continued.

The Te Uru Mātai Matengau Governance Group reviewed the pilot programme and agreed to continue with it due to the positive outcomes for local communities. This service is therefore now business as usual.

The following presentation provides information on the benefit the programme has provided to primary care teams and the community.

MidCentral DHB

Advisory Oncology Service

Primary Care

(AOS)

Dr David Peel, Radiation Oncologist

Background

- 50 percent of cancers present through standard referral pathways, the remainder have non-specific symptoms
- Patients experience significant delays and morbidity (physical and psychiatric)
- Often present via acute / inpatient settings with advanced non-curable conditions
- GP perspective: a time consuming and professionally difficult group of patients
- Under supported by secondary care.

AOS Primary Care

- Following a model used in Europe, a pilot AOS – Primary Care was established at MDHB in August 2019
- The support and advice for non-oncological teams in Primary Care relating to patients where there was a suspected cancer diagnosis and there was no clear pathway for patient management
- Enables GPs or NPs to request cross-sectional imaging (CT) for their patient if they meet clear criteria
- Does not replace the on-call services for Clinical Hematology, Medical Oncology or Radiation Oncology.

Patient eligibility criteria

- Unexplained weight loss after history, examination and investigation (including blood panel of CBC, renal function, liver function, thyroid function, CRP, calcium and plasma electrophoresis).
- New unexplained pain present for at least 4 weeks, together with GP / NP suspicion of malignancy.
- New palpable mass.
- GP “gut feeling” following 3 repeat consultations with patient.

Patients who were over 50, were current or ex-smokers, a previous history of cancer, or who identified as Māori should have a higher index of suspicion for referral for CT.

CT Imaging

- Initial concern that this could “open the floodgates” to CT from primary care
- This did not happen – GPs are extremely good gatekeepers
- Patients would have got the scan anyway, usually during ED attendance as their condition worsened
- Referral process was straightforward with medical imaging accepting referrals if they met the eligibility criteria
- Results of the CT scan returned to the GP or NP to action through established pathways
- Oncology clinic available for disseminated disease with out a clear pathway.

Result of 12 month pilot (August 2019 – August 2020)

- During the 12 month pilot period there were 30 referrals from primary care via AOS pathway for a CT.
- Nine of these scans indicated the presence of a cancer and a tenth scan indicated suspicious liver lesions that required further investigation.
- Te Uru Mātai Matengau governance agreed this pilot should continue as business as usual.
- Continued efforts to educate to primary teams to raise awareness of the service and its eligibility criteria.
- Subsequently placed on Primary Care Health Pathways website by Dr Andy Williams.

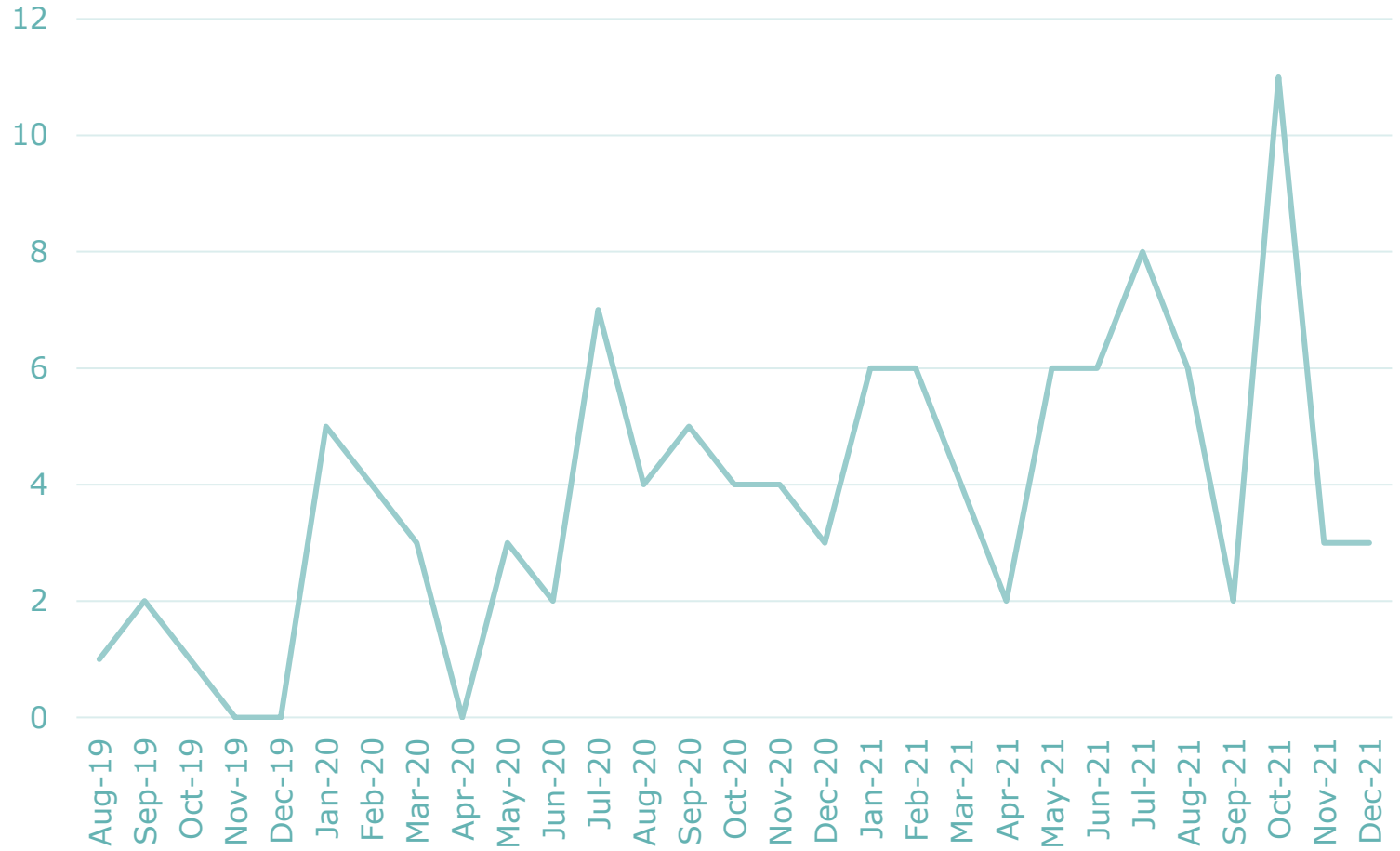
Results of AOS pathway referrals to date

- Since August 2019 there have been 111 referrals for CT on the AOS pathway
- Women are more commonly referred (77/111 = 69.4%)
- Average age at referral for total population = 68.2 years
- Average age at referral for Māori = 63.2 years.

Ethnicity Data

Ethnicity	Number of referrals	Percentage
Māori	9	8.1%
New Zealand European	86	77.5%
Pacifika	1	0.9%
Asian	5	4.5%
Other	8	7.3%
Unknown	2	1.8%

Referrals



Source of Referral

The top 3 referring practices were:

- Feilding Health Care (42.3% referrals)
- Kauri Health Care (29.7% referrals)
- Sydney Street Health Centre (5.4% referrals)
- A further 13 practices have referred patients, including Horowhenua Community Practice, Otaki Medical Centre and Whakapai Hauora Best Care.

Cancer Detection Rate

- 24 of the 111 referrals resulted in a cancer diagnosis (21.6%) International range 7.7- 17%:
  - Do we have a different population?
  - Are we too stringent in our criteria?
  - Is there sufficient GP access?
- 20 of the 24 patients were New Zealand European (83.3%).
- None of the patients with a confirmed cancer diagnosis on the AOS pathway identified as Māori.
- Average wait time for a CT scan after referral on the pathway was 15 days.

Cancers detected

Most commonly, a diagnosis of diffuse metastatic cancer was confirmed.

Cancer Type	Number of cases (n = 24)	Percentage
Metastatic	8	33.3%
Pancreas	4	16.7%
Lung	3	12.5%
Bowel	2	8.3%
Testis	1	4.2%
Thymus	1	4.2%
Hodgkin's Lymphoma	1	4.2%
Ovarian	1	4.2%
Liver	1	4.2%
Stomach	1	4.2%

Outcomes of cancers detected

8/24 (33.3%)	Palliative Care service only
5/24 (20.8%)	Medical Oncology referral
5/24 (20.8%)	Surgical referral
3/24 (12.5%)	Radiation Oncology referral
2/24 (8.3%)	Missing data - no subsequent referral found
1/24 (4.2%)	Referred to Respiratory Department

Results generally acted upon, appropriate referrals.

The Future

AOS pathway is acceptable to GPs and is now in use across the district and across practices

Need to continue to raise awareness, particularly ensuring that Māori patients presenting with non-specific symptoms are considered for this pathway if applicable

The AOS pathway may still result in a cancer being diagnosed when only palliative treatment options are possible but these patients:

- Have cancers are detected earlier when treatment options are potentially increased
- Are informed of their diagnosis by their GP in the GP practice not in an ED cubicle
- Have more time to plan around their cancer and inform family and whānau

Te Uru Mātai Matengau will continue to support the delivery of this service.

Performance reporting

1 March 2022 HDAC

Printed from Stellar by
Margaret Bell <margaret.bell@midcentraldhb.govt.nz>

For:

	Approval
X	Endorsement
	Noting

Key questions the Committee should consider in reviewing this paper:

- Are there any specific areas of performance the Committee would be interested in hearing more about?

To	Health and Disability Advisory Committee
Author	Michelle Riwai, General Manager, Enable New Zealand
Endorsed by	Kathryn Cook, Chief Executive
Date	10 February 2022
Subject	**Enable New Zealand Report**

RECOMMENDATION

It is recommended that the Committee:

- **endorse** the Enable New Zealand Report to 31 December 2021.

Strategic Alignment

This report is aligned with MidCentral District Health Board's (MDHB's) strategy, specifically to achieve equity of outcomes, and sets out performance results for Enable New Zealand (Enable). The report also aligns to all three of the strategic goals embedded in Enable's Operational Plan.

1. PURPOSE

To provide an update on Enable's performance against its Operational Plan and advise of any current and emerging matters.

2. PERFORMANCE OVERVIEW

At year-end, overall performance across Enable continues to track well with most performance measures being met. Considerable effort in planning for and resourcing of projects, while maintaining momentum in operations, has been a significant focus for the team.

	Initiative	**Rating**
	Strengthen and enhance existing services to provide a quality customer experience	
O	Develop a quality driven practice model to drive service excellence	G
O	Deliver responsive and accessible customer services across all areas of the organisation aligned to the customer's requirements	G
O	Partner with key stakeholders to deliver long term sustainable outcomes for the customer	G
	Employ efficient delivery practices and maintain a culture of effectiveness and responsiveness in all areas of work	
O	Develop a responsive, innovative, and flexible workforce that supports people and whānau across the continuum of care.	G
O	Our infrastructure is healthy, and our technology drives enhanced performance in the delivery of services to our customers	G
O	We nurture a positive and diverse workforce culture and a healthy workplace that reflects our values and respects the dignity and privacy of all stakeholders	G
O	We cultivate competency and capability in our workforce that is flexible and responsive to the current and future needs of the business and service requirements	G
	We aggressively pursue opportunities to grow and develop sustainable services	
O	Meet a broader range of customer needs to remain competitive in the changing market	G
O	Increase the total number of customers that purchase services directly from Enable New Zealand	G
O	Increase the number of primary customer contracts	G
O	Grow diversified revenue streams	G
O	Ownership and Governance	G

Rating Legend							
G	On track, progressing as planned.	A	Behind plan – remedial action plan in place.	R	Behind plan – major risks and exception report required.	D	Not completed as planned.

2.1. Performance indicators

A high-level breakdown of Enable's performance indicators is shown in Appendix One: Performance Indicators. Performance across all measures is being achieved and/or is within acceptable levels of tolerance. There continues to have been some impact on measures due to COVID-19 service restrictions, and global and domestic supply chain issues outside our control.

3. SIGNIFICANT MATTERS

3.1. New contracts

Hire Service – District Health Boards (DHBs)

The hire service contract with South Canterbury DHB will be commencing mid-March 2022 under the wider Southern DHB hire agreement. Conversations and initial scoping meetings are taking place with Waikato DHB to evaluate whether they would like to adopt this system.

This hire service results in DHB patients receiving equipment upon release from hospital that is in good condition, and that is delivered, tracked, collected and maintained by Enable for reissue/disposal.

3.2. Community update

EASIE Living Retail and Demonstration Centre

Due to COVID-19 Alert Level 2, activities planned through October to December were impacted; seeing the Sensory Room close and all scheduled workshops/talk series postponed.

However, Disability Information Advisory Service (DIAS) functions continued as normal with customers still seeking information by visiting the EASIE Living store, phone calls and emails.

Sales continued to perform well, with EASIE Living achieving a 38 percent revenue growth in 2021 compared to 2020. This was due to increased sales of beds, scooters and lift-chairs.

Under the Government's new COVID-19 Protection Framework (traffic light system), the Sensory Room will be reopened in early 2022 and the workshops/talk series will also recommence. These workshops/talk series are hosted by a variety of organisations, such as Mana Whaikaha, Manawatū Community Law; covering wills and enduring power of attorney, and the New Zealand Heart Foundation; covering heart health for Heart Awareness month.

3.3 **General**

Enterprise Resource Planning (ERP) update

The design phase of the new financial system, replacing the currently used JD Edwards (JDE) financial system, is underway with many internal workshops being held throughout December 2021, and continuing into the start of 2022. This is a project within the Enablement Programme to ensure that current process pain points impacting on efficiency are captured and addressed in the Minimum Viable Product Plan.

Joint Government Initiative - Housing Modifications Process

Kāinga Ora is leading a joint Government initiative to discuss and agree a cross-agency approach to housing modifications in public housing, that will improve customer equity and service. This joint initiative includes the Ministry of Health, Accident Compensation Corporation (ACC), Ministry of Social Development and Kāinga Ora. Enable was invited as a key stakeholder to the initial Zoom meeting held in November 2021 and will attend the first face-to-face workshop, scheduled tentatively for February 2022 in Wellington. This is an opportunity for Enable staff to share their expertise and experience in providing this service, and to network with the various Government agencies.

COVID-19 Response Plan

An internal working group of Enable staff from the Operations team was led to develop, finalise and implement an Enable COVID-19 Response Plan, that aligns with the COVID-19 Protection Framework and the MDHB approach, to ensure business continuity.

ACC

The co-design stage of the ACC Managed Rehabilitation Equipment Service (MRES) contract commences early in 2022. Enable and ACC will work together to design a new operating model for this service. In the meantime, we are still working through day-to-day issues/expectations that were not identified during the eight-week implementation.

Work is also underway with ACC about service options in response to the potential issue of ACC and/or Enable staff being required to self-isolate due to COVID-19, to ensure service delivery continues with limited resources.

Appendix One: Performance Indicators

This report relates to the reporting period from 1 October to 31 December 2021.

National volumes

The following chart is a high-level snapshot of the volume of work Enable has achieved during this reporting period. The nationwide MRES contract with ACC commenced on 15 November, which resulted in a significant increase to the number of customers Enable services, as reflected in the November and December figures (below).

Regional results

This reporting period saw a high volume of equipment requests, reflecting a nationwide trend of increased volumes in the supply of simple and complex equipment.

There was a decrease in the client numbers for December, mainly due to the Christmas holiday period. Other lines in the table below reflect similar volumes to previous months.

Table 1: Volume/demand of customers accessing Enable New Zealand within MDHB region for October to December 2021

Client Volumes by Service	MDHB Region October	MDHB Region November	MDHB Region December
Equipment	249	311	226
Hearing	119	116	129
Housing	18	16	13
Spectacles	145	115	104

Performance indicators against contractual agreements

The Key Performance Indicators (KPIs) continue to consistently track above target for Band 1 equipment and Complex Housing Modifications. However, these KPIs are potentially under threat for the first time due to the increase in online purchasing and logistics demands, resulting in bulk freight and courier networks struggling to maintain timely deliveries, and modification quotes taking longer to come through due to the current constraints within the construction sector. We are preparing for further impacts in 2022, including ongoing discussions with the Ministry and ACC to understand and address these challenges and the impact they have on service outcomes.

Non-urgent ACC grabrails remain lower against target, largely due to COVID-19 lockdowns in Waikato and ongoing delays in the supply of materials, especially for the month of December.

The level of equipment being written off continues to be high compared to last year, which has an ongoing, but slight, negative impact on equipment reissue percentages.

Table 2: Performance against contractual measures

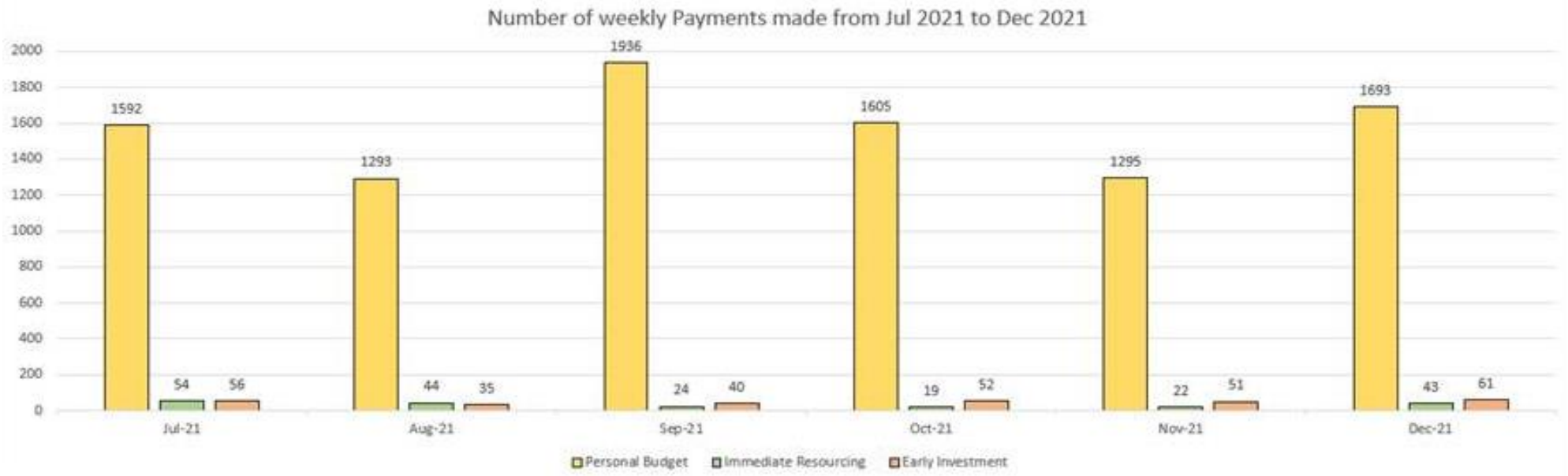
Key Performance Indicator (KPI)/Measure	Target	Achieved October	Achieved November	Achieved December
Percentage of Band 1 equipment delivered within five working days	90%	93.6%	96.2%	91.8%
Percentage of Complex Housing Modifications completed within 120 working days (Ministry of Health)	60%	82.1%	85.7%	75.0%
Percentage of Equipment provided to Service Users supplied from refurbished stock (Ministry of Health)	35%	32.4%	31.6%	28.9%
Grabrails Installation Non-Urgent (ACC) installed within five days	95%	71%	95%	50%

Mana Whaikaha

All the measures across the Mana Whaikaha Prototype have increased. Additional Connector and Connector Support roles are being currently advertised, which will increase capacity for engagement with disabled people currently on the waitlist. Enable continues to support the Ministry to embed its new model of service delivery.

Table 3: Volume/demand for Mana Whaikaha services

Mana Whaikaha Regional Results	Launch of Prototype to December 2021
Total disabled people active in the database	2495
People allocated to a Ministry of Health Connector (and are still allocated to a Ministry of Health Connector)	1423
People allocated to their own/Independent Connector	187
People in queue (awaiting allocation to a connector)	272
Total number of individuals under the age of 21 years	991

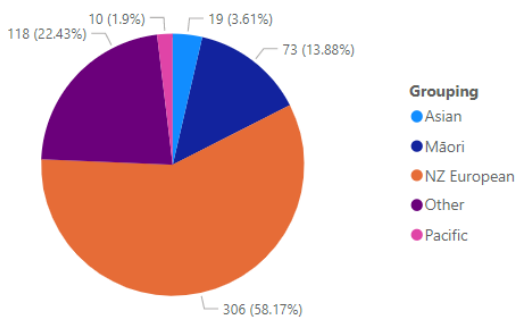


NB: The increase in personal budget payments in September is due to the Ministry increase in payments.

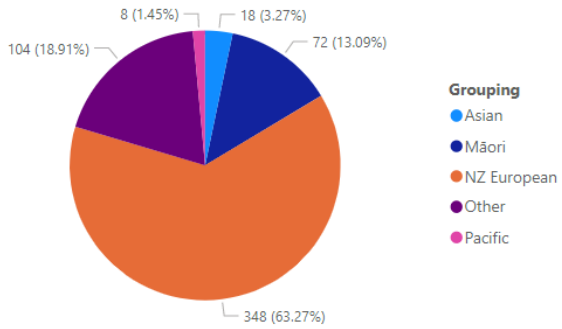
Ethnicity data

The following graphs represent the ethnicity data for the MDHB region for the months October to December 2021.

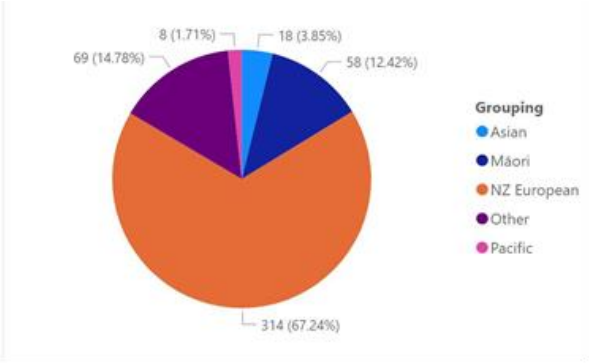
October Overall



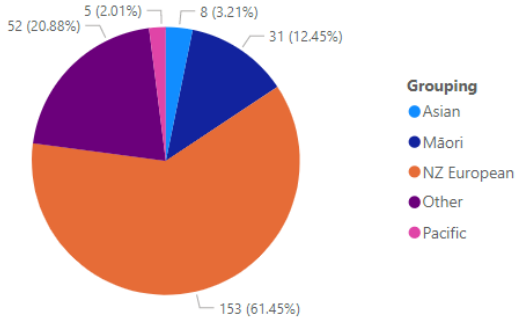
November Overall



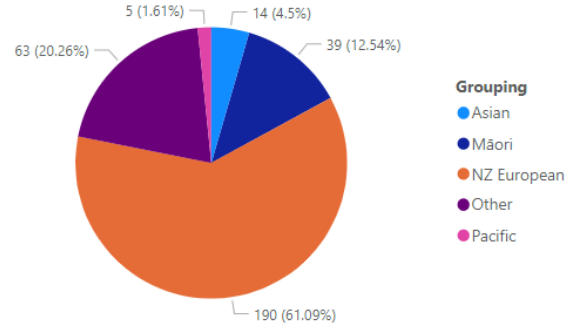
December Overall



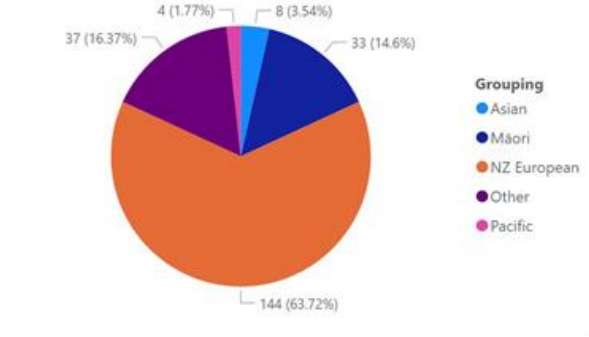
October Equipment



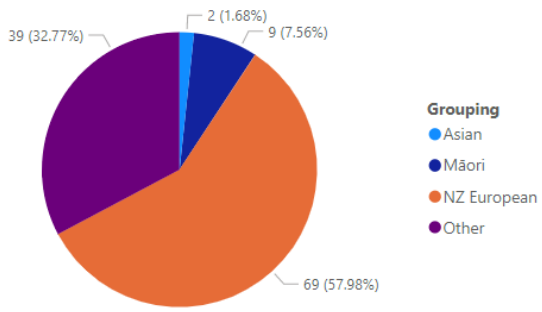
November Equipment



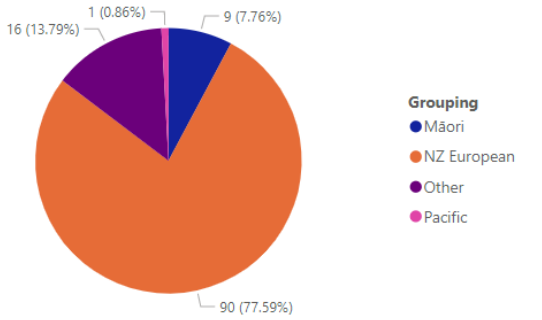
December Equipment



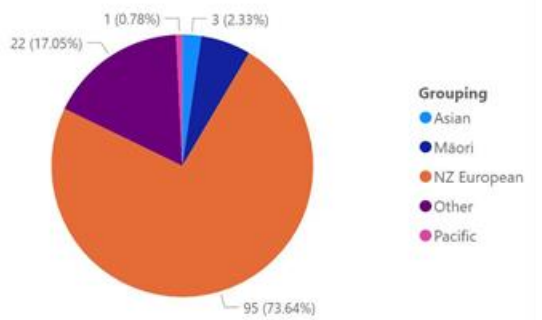
October Hearing



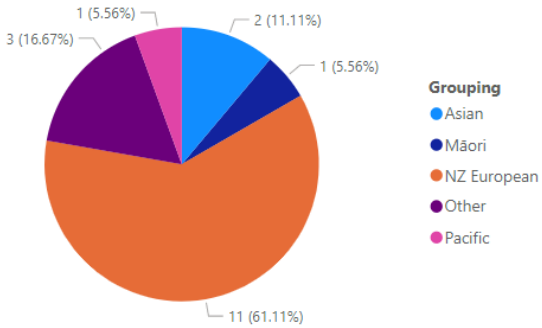
November Hearing



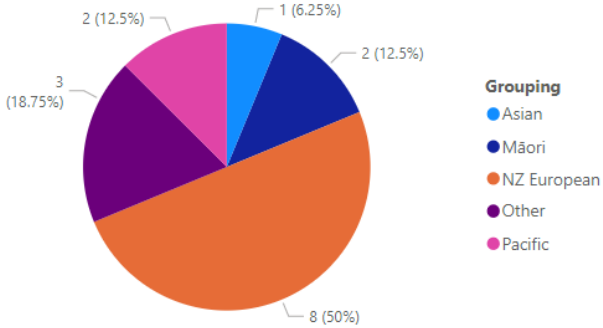
December Hearing



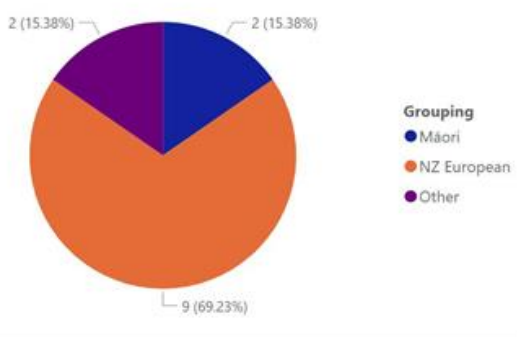
October Housing



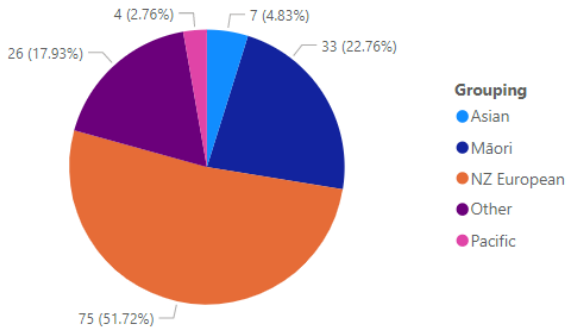
November Housing



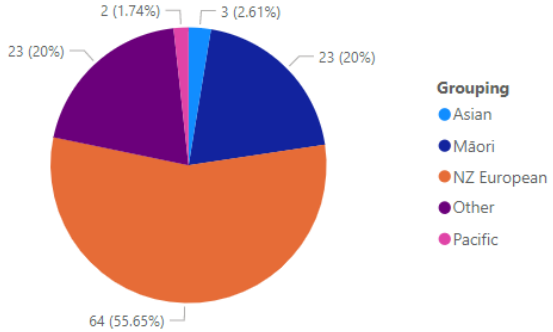
December Housing



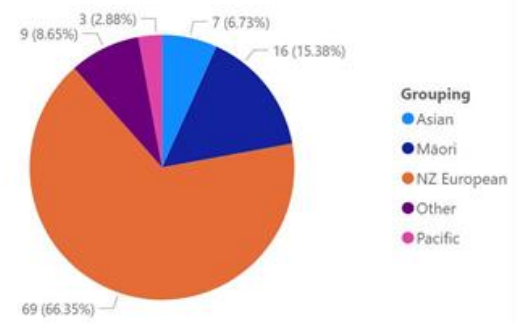
October Spectacles



November Spectacles



December Spectacles



For:

	Approval
	Endorsement
X	Noting

Ki a wai | To	Health and Disability Advisory Committee
Ngā Kaituhi | Authors	Tracee Te Huia, General Manager Māori Health Marcy Williams, Senior Māori Workforce Development Manager
Kaiwhakamana | Endorsed by	Kathryn Cook Chief Executive, Te Tumu Whakarae
Te Rā | Date	8 February 2022, Te Waru o Huitanguru, Rua Mano, Rua Tekau ma Rua
Te Kaupapa | Subject	**Pae Ora Paiaka Whaiora Māori Health Directorate report** **Te rīpoata mo Pae ora Paiaka Whaiora Hauora Māori**

Key questions the Committee should consider in reviewing this paper:

- Is the current work focus for Pae Ora meeting the expectations of HDAC?
- *Kei te pae te mahi kua mahia e Pae Ora ki te HDAC ae rānei, kāo rānei?*
- Is the performance against the Annual Plan actions for Māori Health, performing to the Committee's expectations?
- *Kei te whakatūtuki pai mātou o Pae Ora, te mahi mo ngāi Māori e pā ana ki te Mahere-a-tau?*
- Is there anything Pae Ora needs to include into our work focus moving forward?
- *E hiahia ana koutou o te Komiti HDAC ētahi atu mahi hei tāpiri atu ki ēnei mahi?*

RECOMMENDATION

It is recommended that the Committee:

- **note** the progress update for the Pae Ora Paiaka Whaiora Māori Health Directorate.

Strategic Alignment

This report is aligned to the MidCentral DHB's strategy, the Ka Ao, Ka Awatea Māori Health Strategy 2020-2022, and the Strategic Imperatives, particularly Achieving Equity of Outcomes Across Communities. This document also aligns to the Pae Ora Paiaka Whaiora Hauora Operational Plan; of which the areas of focus have been identified and approved in principle.

1. OVERVIEW

Pae Ora Paiaka Whaiora Hauora Māori Directorate			RATING	
SP	**Driving the health system to improve Māori inequity**			
AP	1.	Progress through Māori Health equity dashboard Te Ara Angitū, is reported quarterly to Board through HDAC and Manawhenua Hauora EOA		↑
O	2.	Increase investment and prioritise initiatives, which are aimed at reducing health disparities for Māori EOA		↑
AP	3.	Develop a prioritisation process that includes Māori Health as a key priority for new investment into kaupapa Māori service delivery and monitor progress through the established Māori health equity dashboard Te Ara Angitū		•
O	4.	Deliver a primary care gout improvement programme targeting male Māori in localities.		•
AP	5.	Partner with Te Ohu Auahi Mutunga (TOAM Stop Smoking Service), and Community Pharmacy to embed the processes to deliver Nicotine Replacement Therapy (NRT) EOA		↑
SP	**Enabling iwi and Māori to reach Pae Ora**			
AP	6.	Partner with iwi partners, commencing with Rangitāne o Manawatu, to co-design an integrated whanau ora commissioning framework that incorporate Rangitāne expectations and aspirations and give effect to Rangitāne o Manawatū Treaty Pathway EOA		↑
O	7.	Embed the MDHB Whānau Ora Position Statement and Implementation Framework into the planning and prioritisation material for 22/23. EOA		↑
O	8.	Ensure quarterly MDHB Board to Manawhenua Hauora Board engagement meetings are getting timely and consistent advice. Meetings are to be held in August, November, February, and May of each year EOA		↑
	9.	Māori Board members and Manawhenua Hauora to attend Ministry of Health governance training as and when these are available EOA		↑
O	10.	Provide services and support for whānau to give every child the best start to life EOA		↑
SP	**Growing the Maori Workforce across the sector**			
O	11.	Continue to drive the implementation of MDHB Māori Health Workforce Development Implementation Plan 2017-2022 EOA		↑
O	12.	Implement MDHB Board Treaty training package; Te Hikoi Maumahara: Connecting people to the past (wall walk training developed by Dr Simone Bull) by December 2021 EOA	**D**	•
O	13.	Swabbing and vaccinator workforces: Work with Māori Health Providers, Māori wardens and MSD to recruit, train and maintain a COVID-19 immunisation team, including support and administration roles; Offer specific return to nursing and new graduate opportunities for new vaccinators to join the COVID-19 immunisation team EOA	**G**	↑
O	14.	Employ a workforce that is reflective of our population, prioritising Māori participation in the workforce EOA		↑

SP	**Tackling social determinant factors that impact on Māori communities**		
O	15. Embed the use of iwi plans into MDHB's planning and prioritisation process for investment decision-making and/or service design by July 2021 EOA		•
O	16. In collaboration with the Regional Interagency Network (RIN) develop a regional plan and work programme with clear health actions for relevant agencies to progress EOA		↑

Rating & Trend Legend							
G	On track, progressing as planned.	**A**	Behind plan – remedial action plan in place.	**R**	Behind plan – major risks and exception report required.	**D**	Not completed as planned.
↑	Improved from last report.	↓	Regressed from last report.	•	No change from last report.		

Plan Legend							
SP	Strategic Plan	**AP**	Annual Plan	**O**	Operational Plan	**EOA**	Equity Outcome Action

2. PURPOSE

To provide the Health and Disability Advisory Committee (HDAC) with an update on progress for the work programme for Pae Ora Paiaka Whaiora Māori Health Directorate from November 2021 to January 2022.

3. SUMMARY

This report provides the Committee with an update on the following:

- Performance monitoring review – Te Ara Angitū
- Equity lead for the Emergency Department
- Pae Ora workforce capacity increased
- Rongoa services establishment
- Whanau Care Facilitation services
- Iwi Māori Partnership Board developments
- Equity funding progress
- Kaimahi Ora Whānau Ora Māori Workforce Development.

4. DRIVING THE HEALTH SYSTEM TO IMPROVE MĀORI EQUITY

The equity monitoring framework Te Ara Angitū has been revised alongside all other performance reporting to ensure there is no duplication moving into the reforms. Equity monitoring across the system using Te Ara Angitū, will continue with the next report focusing on mental health and addictions. This is until new reporting frameworks for Health New Zealand and the Māori Health Authority are established into the sector. Manawhenua Hauora endorses that MidCentral District Health Board (MDHB) continues Te Ara Angitū in the meantime as they work to consider their requirements for health sector reporting into the future.

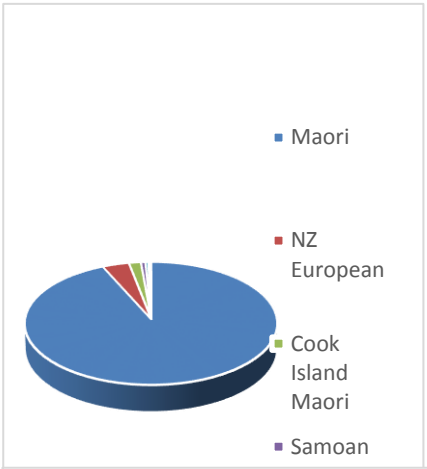
Agreement has been reached between Te Uru Arotau and Pae Ora to establish an equity lead into the Emergency Department to reduce equity issues identified by the team. Initially it will focus on the reasons for Māori arriving at the Emergency Department where they could be seen in primary care and Did Not Waits. Other issues of rurality, poverty and poor access to services will be worked through with patients to ensure these barriers are dealt with consistently and effectively so as not to see these patients displaced in the system.

Pae Ora has had to prioritise its mahi due to the workload, lack of capacity and COVID-19 demands. Meeting the needs of whānau is our number one priority across all services. We are trialling after hours services both at nights and in the weekends. To date this has worked well although we haven't advertised the services as yet. We are working to increase capacity in the tikanga team, the facilitation services and the clinical team. The Whānau Care Team has been working at capacity with complex case reviews and complex referrals for some time. Increased FTE derived from the equity funding last year has led to the recruitment of 4 FTE Kaituitui Whānau Ora Tapuhi nursing roles – one in Horowhenua, one in Tararua and two in Palmerston North. We have recently reconfigured a role to enable a role for Manawatū. These roles will have key working relationships with GP practices, iwi and Maori providers in their localities and whānau. We expect to finalise the recruitment and have these roles in place at the end of February.

Rongoa or traditional healing services have now been contracted out to four iwi and Māori providers this quarter with recruitment underway by the providers. These services will be delivered in the home, hospital and community. The Ministry of Health has been contracting for Rongoa services for over 17 years however, no contracts have been awarded to this district. With the approved equity funding for Māori health last year, we have now been able to establish these services across localities. An agreement has been reached with He Puna Hauora, the Māori health provider in Palmerston North, to deliver rongoa into Ward 21 as well as community. The Associate Director of Nursing and Operations Lead met with the provider to understand their needs as part of the Acute Mental Health Inpatient Unit build which has now been incorporated into the planning. Additional clinical roles have been increased into iwi and Māori provider services in line with their requirements.

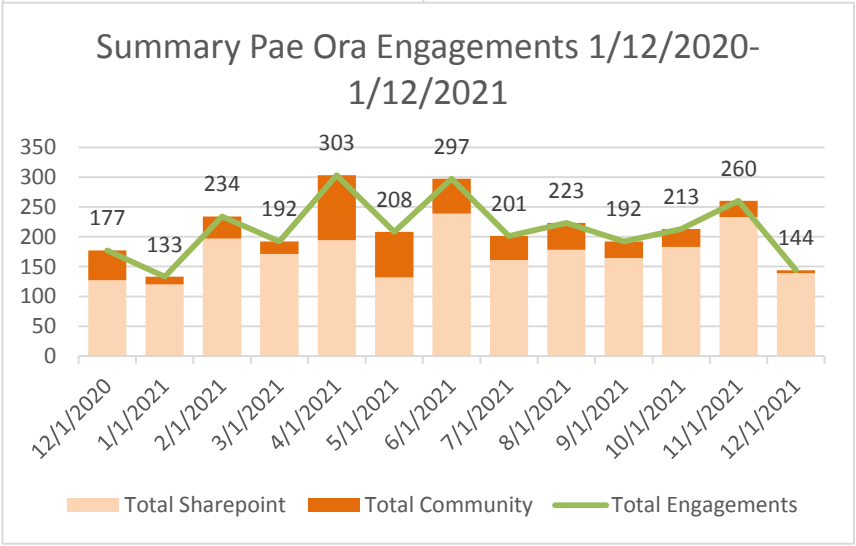
Over 93 percent of individuals engaged by Pae Ora identify as Māori. The age-gender diagram illustrates the cohort distribution of Māori inpatients referred into the Whanau Care Facilitator team. Gender split is slightly higher for males with a 47 percent (female), 53 percent (male). Nearly half of the inpatients are 55 years or older (49 percent) with approximately 42 percent of the individuals in the 20-54 age range.

Referrals were taken from inpatient wards, Department of Corrections, iwi and kaupapa services, Youth justice, Police and other DHBs.



The main reasons for referrals into the Whānau Care Facilitator team were:

- Advocacy and support with inpatient services
- Support for appointments for services
- Orthopaedics and child health services
- Cultural support
- Death and dying pathways support and
- Connector/navigation services



From 1 December 2020 to 1 December 2021, the Whānau Care team (2 FTE in total) have engaged 2777 inpatients. This equates to around six patients and their whānau per day. Children's Ward and Orthopaedics were identified as the areas where Pae Ora has had the majority of their whānau engagements. Other highly engaged areas by Pae Ora ranked in order from highest number of engagements were:

- Medical Assessment Planning Unit
- Surgical Services
- Maternity Services
- Women's Health Services
- Cancer Treatment Services

5. ENABLING IWI AND MĀORI TO REACH PAE ORA

Manawhenua Hauora is preparing for the transition to the new health structure from 1 July. Iwi have reviewed the current Manawhenua Hauora structure and terms of reference to prepare for the new requirements for Iwi Māori Partnership Board establishment by March 2022. This includes having Taurahere (Māori who don't whakapapa to this district) representation on the Board. A new entity is currently being established with Charitable Trust status. Offices for the new entity has been secured at 35 Victoria Avenue, Palmerston North for a three-year period commenced from 1 February 2022. Trevor Shailer, currently the Chief Executive for Sport Manawatū, has been seconded into the Project Manager Transition role for a six-month period, tasked with the establishment of the Iwi Māori Partnership Board as per the Establishment Plan submitted to the Transition Unit in November 2021. Resourcing for the establishment of Iwi Māori Partnership Boards is funded through the Transition Unit initially.

New equity investment is now contracted out to providers with only two providers yet to complete the signing off process. The activity for new services relates mainly to recruitment into new roles and programme development. Pae Ora is close to completing the new co-designed contract with Rangitāne o Manawatū that relates to their Treaty pathway presented to DHB in March 2021. Due to Sector Services advising DHBs cannot change the wording content of the head agreement of contracts, the DHB is working on ensuring core Treaty responsibilities and the Whānau Ora Commissioning Outcomes Framework, is incorporated into Section E of the contract to acknowledge our Treaty partnership. Once this is agreed we will meet with other iwi providers with sizeable contracts to discuss and agree these changes or similar.

6. GROWING THE MĀORI WORKFORCE ACROSS THE SECTOR

Overall, it is pleasing to see an increase of Māori staff within DHB by 55 FTE in the last 12 months, taking our representation rate to 10.27 percent, which is above the national average for other similar sized DHBs. This is a phenomenal effort and the work services are doing to support this increase is evident. Thank you to the hiring managers.

Future pipeline development and improving cultural responsiveness training is projected to meet the anticipated target percentage within excess of 500 or more spaces for staff in Te Tiriti o Waitangi training confirmed and 160 spaces in the Māori Cultural Responsiveness training available over the next 12 months. There has been an excellent response to the tikanga roles currently being recruited to with all four applicants being qualified te reo Kaiako (teachers) alongside many other qualifications. This is an outstanding response and should be acknowledged given people of this calibre are choosing to work for MDHB. *Ka mau te wehi!*

Following the HDAC report provided in November 2021, this report covers the activity against the Kaimahi Ora, Whānau Ora Implementation Plan refresh for the period from November 2021 to January 2022.

- The Steering Committee has been established with lead executives engaged
- Visibility of all Māori applicants across MDHB is being reviewed monthly

- Pae Ora Paiaka Whaiora Hauora – Māori Health Directorate equity scholarship programme designed and released December 2021. To date, nine applications have been and 15 enquiries across the following areas:
    - Allied Health – Medical Imaging Technology, Health Science Psychology
    - Nursing and Midwifery – Clinical and community based
    - Social Work and Child, Youth and Family Therapy
    - Professional services – Māori and Indigenous Leadership

- Partnership formalised with Pūhoro – STEM Academy, Māori Education Trust, Young Enterprise, Ministry of Social Development and CEDA (Central Economic Development Agency) to assist with workforce pipeline networks, and attraction strategies to encourage tauira to enter health (regulated and non-regulated workforces) within our rohe
- Tuakana Tēina Programmes are being established across various services and networks starting with the PGY1 doctors.

TITLE: Kaimahi Ora, Whānau Ora Implementation report	**REPORT PREPARED BY:** Marcy Williams
DATE OF REPORT: 9 February 2022	

PURPOSE:

To provide the Health and Disability Advisory Committee with an update on the implementation of Kaimahi Ora Whanau Ora, Māori Workforce Development strategy from November 2021 to January 2022.

Pou		Focus	Completion Date	Actions	Status
1	*Build capacity and capability of the Māori workforce across MDHB*	Workforce pipeline strategies EOA	Jul 22 – ongoing	Partnering with services to understand their workforce needs	↑
				Māori NETP graduates are employed and supported	
				Māori Midwifery graduates are employed and supported	
				Māori Allied health graduates are employed and supported	
				Māori Doctors are employed and supported	
				Supporting Iwi and Māori providers workforce pipeline	
				Understanding drivers for exit from services	
		Performance development EOA	March 22	Performance plans in place and supported	↑
				Bi-Cultural competencies are established within performance development processes and systems	
				Training needs are reviewed with services established	
		Cultural strengthening EOA		Mentoring and cultural support is encouraged, visible and accessible	
				Cultural supervision is encouraged	
		Professional development EOA	Jun 22	Career coaching suite and support is accessible	↑
				Scholarship approach and programme established to support professional development and growth	
				Localised talent and succession strategies completed as appropriate	
		Performance & Evaluation EOA	Jan 22	Health workforce funding centralised, and annual plan and budget established	**Completed – ongoing**
				Enhance meaningful analysis and reporting on Māori workforce statistics	
				Monitoring and evaluation completed.	

Pou		**Focus**	**Completion Date**	**Actions**	**Status**
2	*Pipeline Development – increasing our Māori workforce in the future*	Workforce pipeline strategies EOA	Mar – Jul 22 – phased approach	Formalise relationships with external organisations (including local schools, education providers and Iwi and Māori providers, government bodies) to support entrance into Health	↑
				Understanding the unique needs of our Iwi/Māori providers	
				Establish internships and summer school placement opportunities across the sector	
		Performance & Evaluation EOA	Mar 22 – ongoing	Create short, medium, and long-term measures to support the success of the programme aligning it with future developments across the sector and with Iwi	↑
				Continued evaluation of approaches and mechanisms to ensure we are reaching our targeted audiences, establishing ideas and initiatives to support the work programme	
3	*Improve cultural responsiveness of the workforce*	Cultural strengthening EOA	Mar - Jun 22 phased	Review training approaches, and provide options for consideration and review by relevant teams	↑
				Quarterly Te Ara Kotahitanga hui for all Māori staff	
				Lifting cultural responsiveness through services delivery incorporating a cultural competency framework	
		Professional development EOA	Jun 22	Targeted increase in training support to Iwi/Māori providers based on their requirements	↑
				Scholarships administered in areas where more Māori are needed	
		Performance & Evaluation EOA	Mar 22 – ongoing	Workforce monitoring and reporting is consistent and relevant – Te Ara Angitū	↑
				Ongoing monitoring and promotion of training initiatives reviewed with support	

Rating & Trend Legend							
G	On track, progressing as planned.	**A**	Behind plan – remedial action plan in place.	**R**	Behind plan – major risks and exception report required.	**D**	Not completed as planned
↑	Improved from last report.	↓	Regressed from last report.	•	No change from last report	**P**	Pending / To be started
EOA	Equity Audit Outcome						

For:

	Approval
	Endorsement
X	Noting

To	Health and Disability Advisory Committee
Authors	Susan Murphy, Manager, Quality Assurance Mariette Classen, Manager, Consumer Experience
Endorsed by	Gabrielle Scott, Executive Director Allied Health and Acting General Manager, Quality and Innovation
Date	10 February 2022
Subject	**Quality and Safety Dashboard**

Key questions the Committee should consider in reviewing this paper:

- Does the dashboard provide clear trend-based reporting?
- Is current compliance with quality and safety markers explained sufficiently?
- Are there any concerns about quality and safety of patient care measures which require more explanation?

RECOMMENDATION

It is recommended that the Committee:

- **note** the content of the Quality and Safety Dashboard
- **endorse** the improvement activities planned for the next quarter.

Strategic Alignment

This report is aligned primarily to the MidCentral District Health Board's (MDHB) strategic imperative of committing to quality and excellence in everything we do.

1. PURPOSE

To provide the Committee with the Quality and Safety Dashboard reflecting organisational performance on the quality and safety of patient care, including the Quality and Safety Markers (QSMs), adverse events, incidents and consumer feedback.

2. BACKGROUND

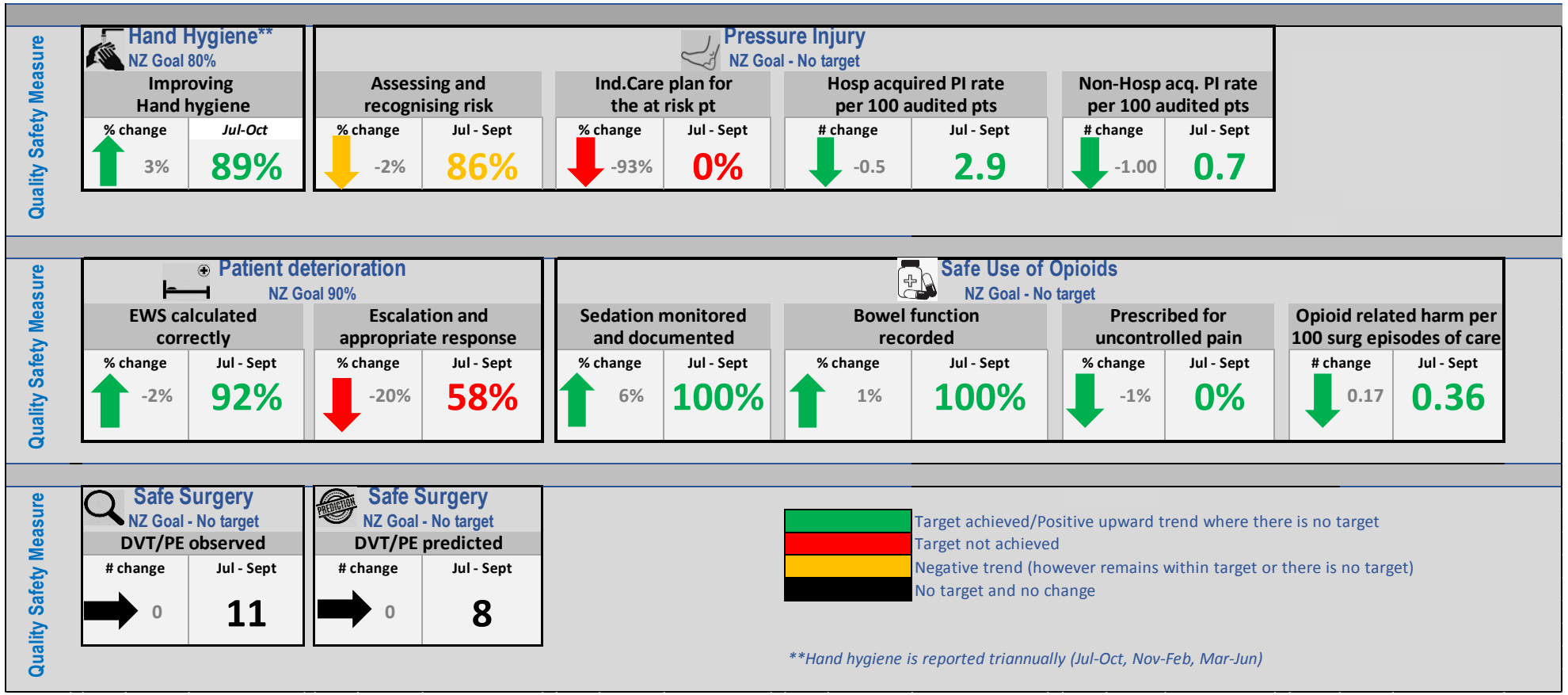
MidCentral District Health Board (MDHB) developed its Clinical Governance Framework (The Quality Agenda) in 2018. This sets the framework through which quality, safety and clinical risk is managed, embracing a shared governance model. A strong clinical governance system requires a robust quality and safety measurement system with trend-based analysis. It also requires clinical teams to have access to the clinical outcome, quality and safety data appropriate to their service or population group.

This dashboard provides an 'at a glance' approach and is inclusive of ethnicity breakdown, summary narrative on compliance, achievements and actions being taken for improvement. Further information about the current and historical performance of all DHBs on the QSMs is available on the Health Quality and Safety Commission (HQSC) website. The revised MDHB clinical governance structure has been implemented.

The Committee should note that the dashboards use percentage changes to provide trends from period to period. While the percentage change may appear significant, the actual numbers driving the change are small. Variances which are significant will be identified in the narrative.

This report will be modified to apply rolling averages or a suitable alternative to reduce the quarter-to-quarter variation. This will be progressed once sufficient historical data has been collected to support robust and consistent reporting of all indicators. Trends in the statistical process control (SPC) graphs for several indicators are provided in Appendix One.

3. QUALITY AND SAFETY MARKERS DASHBOARD (HQSC LATEST DATA JULY 2021 TO SEPTEMBER 2021)



3.1. Quality and Safety Markers Background

Quality and Safety Markers (QSMs) were designed by the HQSC in partnership with DHBs, to evaluate the success of its quality improvement programmes and determine whether the desired changes in practice and reductions in harm and cost have occurred. The following link is for further information and data about the QSMs: https://www.hqsc.govt.nz/our-data/quality-and-safety-markers/

All DHBs submit data to HQSC for the QSMs. Since the initial set of indicators was developed in 2013, further indicators have been designed – from outcomes from adverse events or where benchmarking indicates scope for improvement.

Some of these indicators are in a development phase and have no set target at present. As more information is gathered, the HQSC will adapt the QSMs, which will result in an enhanced and increased set of measures.

3.1.1. Quality and Safety Marker Performance

The Safe Use of Opioids looks at three markers: Sedation, Bowel Screening and prescribed medication for uncontrolled pain. MDHB has achieved 100th percentile in all three markers.

The Patient Deterioration QSM measures patients with cardiopulmonary arrests or rapid response escalations. Early Warning Scores (EWS) calculated correctly, shows no change. This QSM remains within normal variation at 92 percent, which is above the target of 90 percent.

The escalation and appropriate response marker measures whether an escalation of care was triggered and the patient received the appropriate response to that escalation. Performance in this latest quarter has deteriorated to 58 percent. Actual audit numbers are small, therefore a deep dive into patient records is being conducted to identify if the decline is due to the auditing process and compliance with our recognition and response guidelines. The Deteriorating Patient Governance Group is progressing the establishment of a Patient at Risk service that could address early deterioration identified in patients and alleviate the number of escalated response calls and Medical Emergency Team (MET) calls.

The Hand Hygiene QSM measures the five moments of hand hygiene (before touching a patient, before clean/aseptic procedures, after body fluid exposure/risk, after touching a patient and after touching patient surroundings). MDHB has consistently achieved the target (89 percent) over the last quarter through improvement activities undertaken. The quality improvement work includes learning and applying successful approaches to improvement from other DHBs.

The Pressure Injury QSM aims to reduce the occurrence of and harm from pressure injuries. This QSM has no target. There continues to be a very slight decline in the rate of assessment in the last quarter. This outcome remains near or above the New Zealand average. The 'Assessment' QSM is 86 percent in MDHB and 88 percent in New Zealand.

The 'plan' data is not available this quarter. There has been a change in collection approach to include ethnicity which requires individual data collection across all the markers. This has now been addressed and all future collections will be included in this report.

To improve this marker, the Pressure Injury Working Group continues to focus on compliance education. The number of reported hospital and non-hospital acquired pressure injuries has continued to increase over the last two quarters. More information about the improvement initiatives to address this are provided in section 4.2.4.

3.1.2. The Consumer Engagement QSM

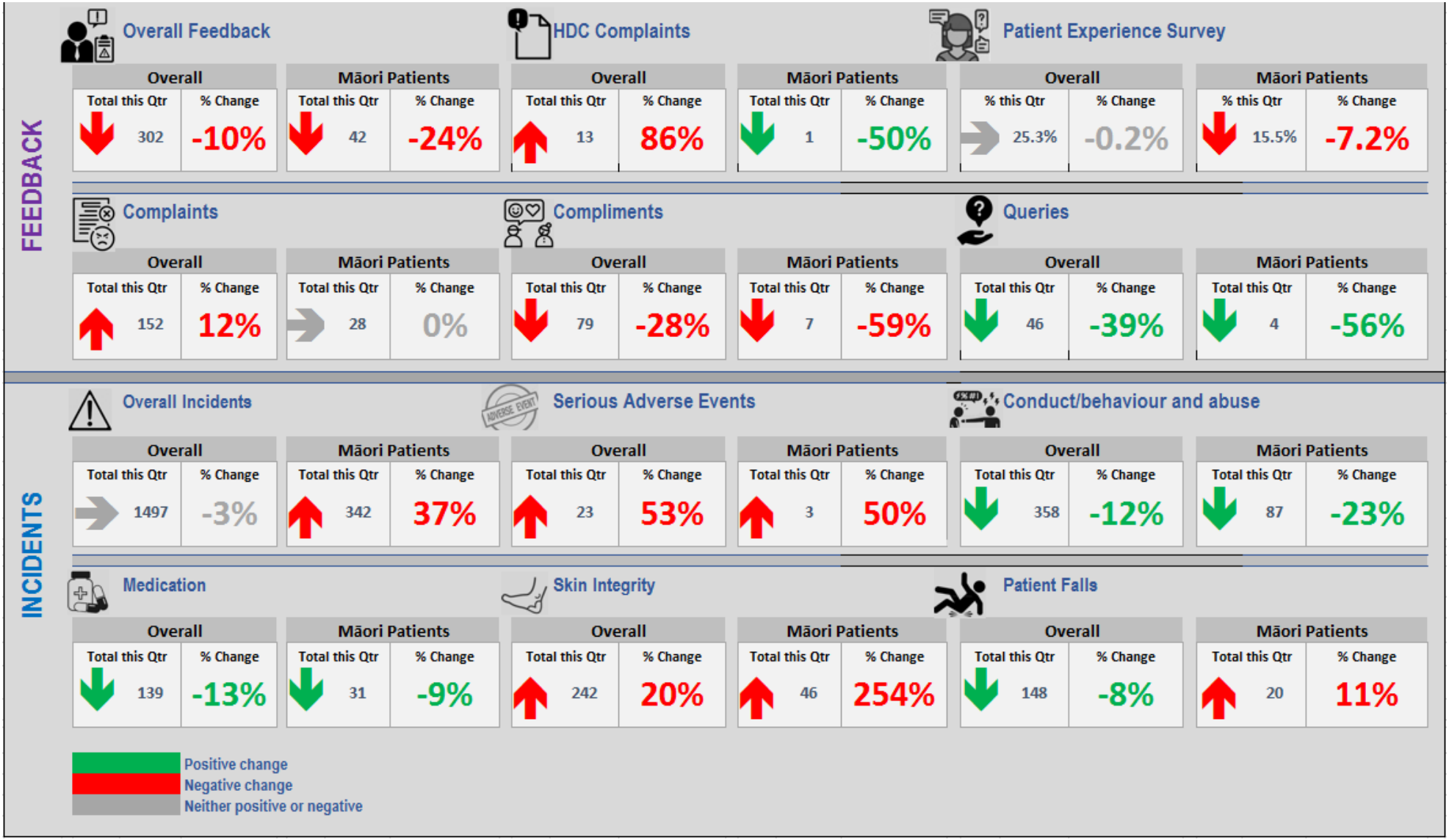
The third round of the national self-rating submissions for this QSM is due in March 2022. The Oversight Group's workplan actions to improve identified focus areas are progressing.

The data for all DHBs will published on the Commission's website and all ratings and examples across the DHBs, as well as some key questions linked to this QSM will be available to view.

All ratings and examples across the DHBs, as well as some key questions linked to this QSM, will be available view on the HQSC website.

4. QUALITY AND SAFETY DASHBOARD

(Quarterly comparison between July to September 2021 and October to December 2021)



4.1. **Feedback**

Overall, the number of complaints received remains within normal variation compared to the previous quarters (Appendix One, Fig 4.1.3). However, there was an increase in complaint numbers for November 2021 that normalised again in December 2021. There has been a decrease in the number of compliments as well as queries received for this reporting period. Overall compliment rates remain slightly lower than expected but within normal variation (Fig 4.1.4). An overall decrease of ten percent in feedback received was noted for this reporting period. This is expected due to the December holiday period.

There has been a noticeable increase in complaints received from the Health and Disability Commissioner (HDC). MDHB received 86 percent more complaints from the HDC compared to the previous reporting period. However, 23 percent of these complaints were referred back to MDHB for resolution with the consumer directly. This trend is being closely monitored.

Thirty-eight percent of complaints received required an extension (Fig 4.1.2). This is an increase from the previous reporting period, however, is expected due to the corporate closure period in December. The number of queries received decreased by 39 percent and the rate is within normal variation (Fig 4.1.5).

Feedback metric definitions and/or exclusions have been included in Appendix Three.

MDHB did not receive any breach findings from the Health and Disability Commissioner during this quarter.

4.1.1. Inpatient experience survey

A highlight of the five highest and lowest performing areas for MDHB in comparison with national results is provided in Appendix Two – Patient Experience Survey November 2021. The results indicate where MDHB is performing well and where there are opportunities for improvement. MDHB's results remain comparable to other DHBs.

Survey results show that 100 percent of Māori patients and 94.9 percent of all patients surveyed did not perceive any unfair treatment and 94.9 percent of patients felt their cultural needs were met. However, during this survey period, there was a decline in the number of patients who felt that they were told of the possible side effects of the medicine they left hospital with, in a way they could understand. MDHB's rating of 59.7 percent is significantly lower than the national score. It is however positive to note that 82.6 percent of Māori patients definitely felt that they were told of the possible side effects of medication in a way they could understand.

The Consumer Experience Team will support services to utilise the information from the survey to develop actions that will support improved consumer experience. This will be achieved with the facilitation of training interventions led by the Consumer Experience Team and will empower service leaders and staff to create a positive consumer experience for patients and their whānau.

4.2. **Incidents and adverse events**

4.2.1. Incidents

Overall, reported incidents have remained the same this quarter. Reported rates appear to be normalising back to baseline levels (Appendix One, Fig 4.2.1). The rate of reported incidents remains within the upper and lower control limits and are similar when compared to the same quarter in 2020. MDHB has encouraged staff to report incidents in RiskMan to support a culture of safety and in response to staffing shortages under the Variance Response Management (VRM).

4.2.2. Serious Adverse Events

There were 23 new Serious Adverse Events (SAC 1 and 2) in this quarter, an increase from last quarter. Three events were SAC 1 and the remaining were SAC 2 events and included 14 pressure injuries, two suspected suicides, two falls with fractures and two clinical process events. One being an unexpected death and the other a fourth degree tear.

A review of trends in the reported Serious Adverse Events (SAE) was reported to the Serious Adverse Events Governance Group in September. A comparison of MDHB data with the national HQSC data indicates MDHB was not an outlier in the number of SAEs reported over the 2020/21 year. This includes all subsets of events (mental health, clinical process, always report, review and falls).

During this quarter, 15 SAE reviews were concluded (Fig 4.2.2). This is a decrease of three compared to the last quarter. The total average number of days to complete the reviews remains under the target set by the HQSC of 70 working days. Four case reviews have taken longer due to their complexity and the lack of staff availability. This is a decrease from the previous quarter. All other reviews are taking well below the 70-day timeframe to complete. Further training to increase the number of SAC 1 events is occurring in early March 2022, with 15 staff on the training which is planned over five days. SAC 2 event reviewer training has been added to the education calendar for 2022 and will be available every month for staff to attend.

Two new action plans have been created this quarter as an outcome of SAE reviews. Six action plans were completed and closed this quarter. All recommendations have been actioned.

4.2.3. Patient falls

The number of patient falls has remained relatively stable since November 2020, with an average rate of 55 falls per month (Fig 4.2.4). This dipped in June to a total of 34 falls. There were two falls resulting in significant harm this quarter. Both reviews have commenced and will be completed in March.

4.2.4. Pressure injuries

There has been an increase in reported skin integrity incidents (stage 1 and 2) (Fig 4.2.6) in the month of December. These are newly-formed lower severity pressure injuries. Twenty significant pressure injuries were reported and classified as SAC 2 events (Stage 3 and 4 skin integrity incidents) for the October to December period.

The Pressure Injury Working Group have identified a trend of increasing SAC 2 pressure injuries. Detailed reviews indicate multifactorial issues including patient comorbidity and acuity, as well as significant staff turnover. Following their findings and discussions, the group's members included a new initiative of increasing the number of ward nurses with specialised wound care knowledge as well as all new nursing staff having specific training in pressure injury assessment and management to reduce the number of pressure injuries being reported.

4.2.5. Incident rates for Māori

The incident rates for Māori this quarter have increased compared to the previous quarter. Of the 23 SAE reported this quarter, three were reported as Māori. This figure remains stable given the increased number of SAEs. Rates for Māori decreased for conduct/behaviour/abuse and medication incidents. There has been no trends or themes found from these reviews that relate to Māori. Training of staff in the review of incidents will incorporate cultural responsiveness. This includes timely reviews and the opportunity to have meetings with patients, family and whānau to identify what is needed to better support Māori patients. Training has been provided since January 2022 with a good uptake of staff registering for this training.

It is important to acknowledge that the hospital is seeing increasing patient occupancy and acuity, which adds pressure to the overall system. This has resulted in an increase in the number of incidents reported.

Incident metric definitions and/or exclusions are provided in Appendix Three.

APPENDIX ONE – TREND DATA FOR FEEDBACK AND INCIDENTS

Figure 4.1.1

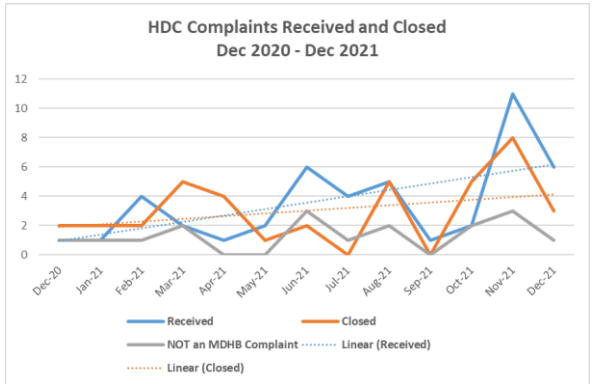


Figure 4.1.2

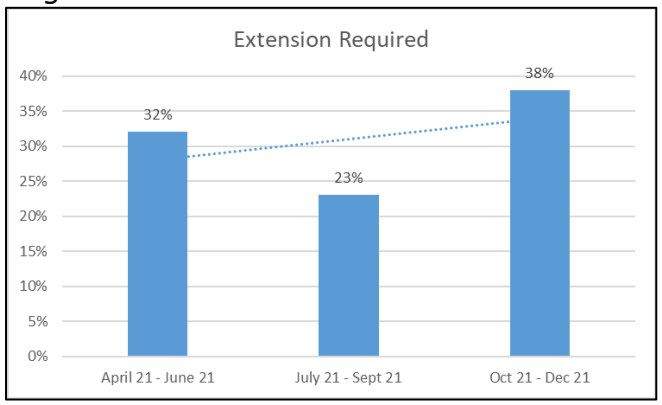


Figure 4.1.3

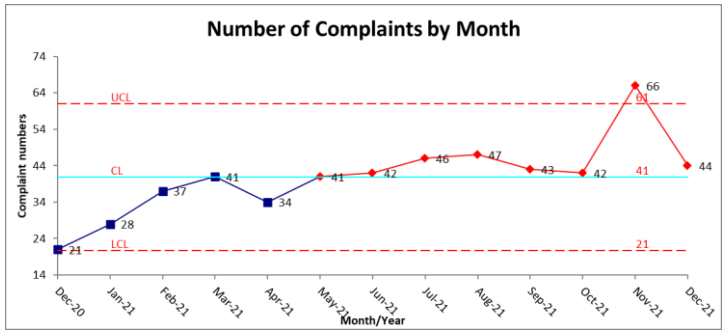


Figure 4.1.4

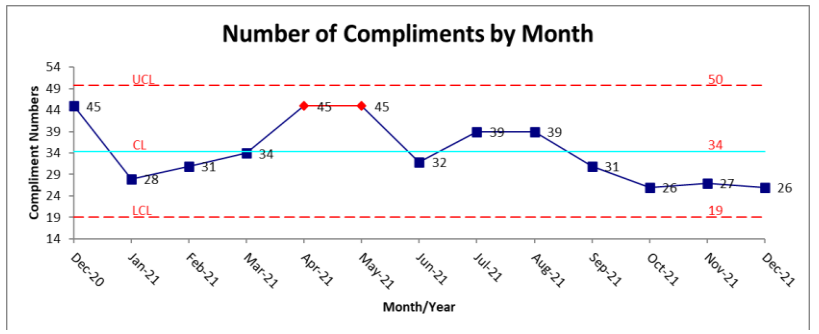


Figure 4.1.5

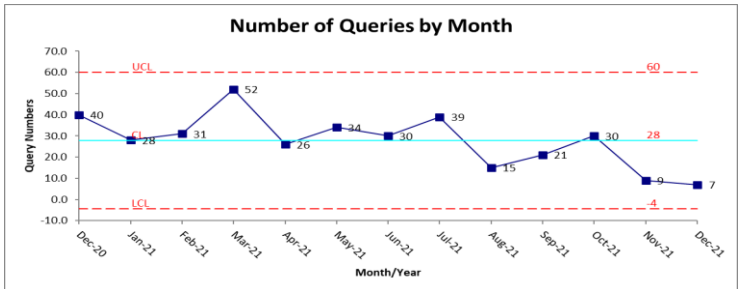


Figure 4.2.1

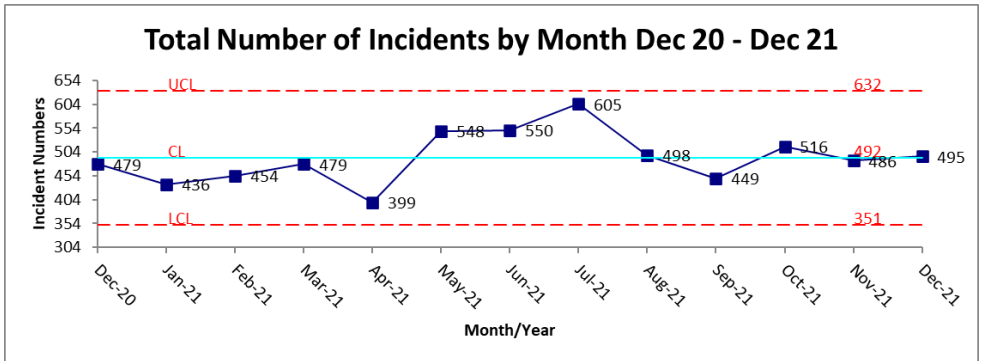


Figure 4.2.2

Figure 4.2.3

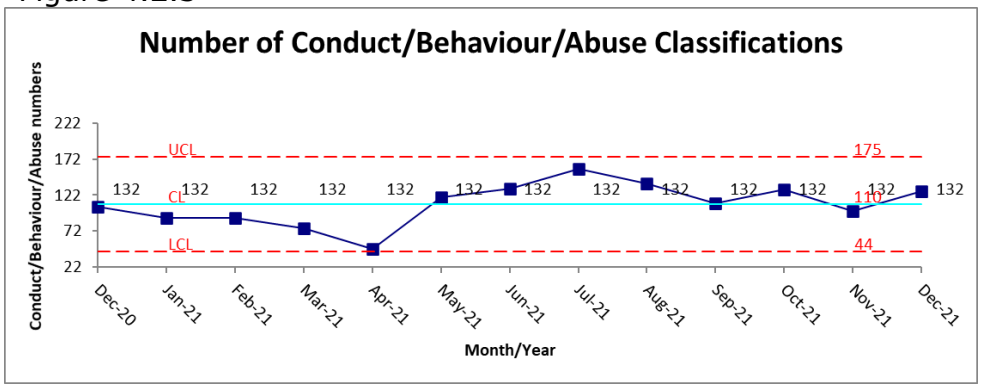


Figure 4.2.4

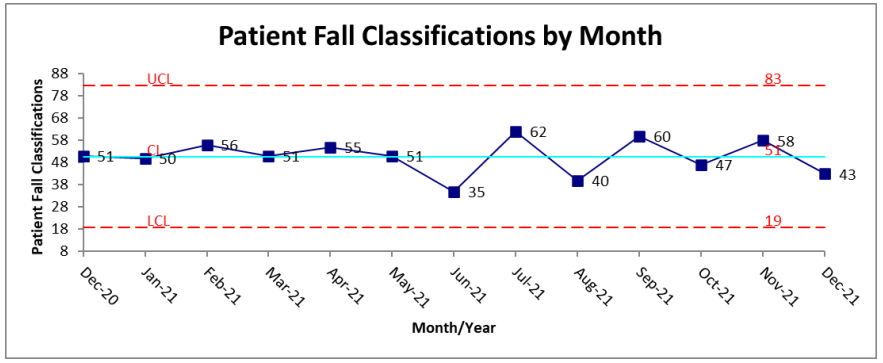


Figure 4.2.5

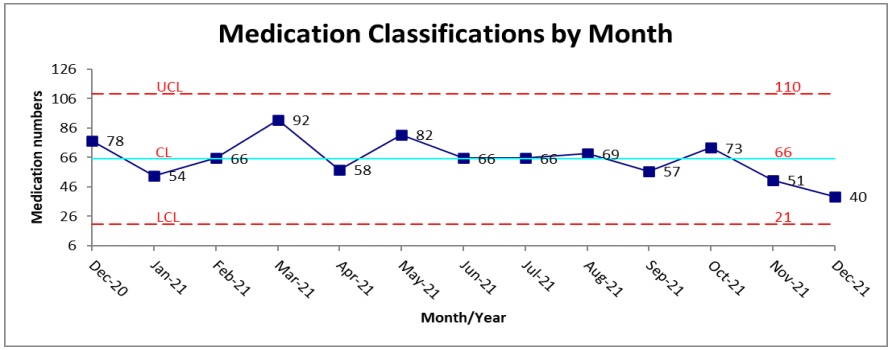
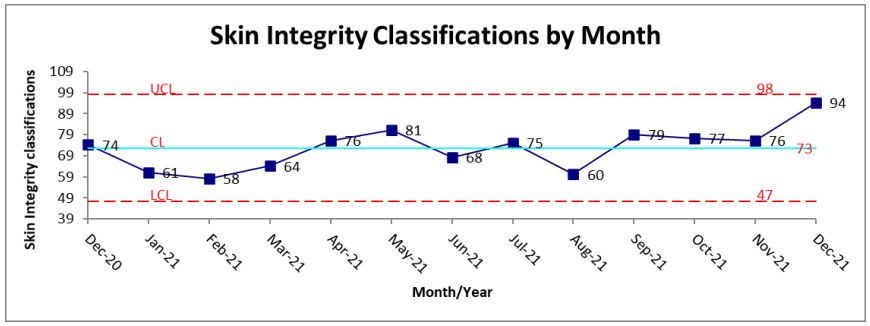


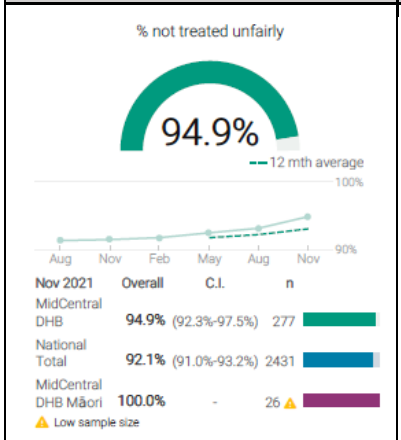
Figure 4.2.6



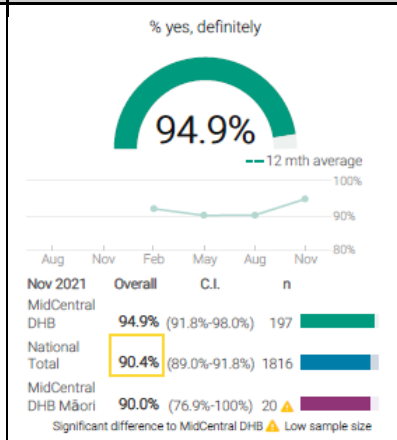
APPENDIX TWO – PATIENT EXPERIENCE SURVEY RESULTS (November 2021)

HIGHEST PERFORMING

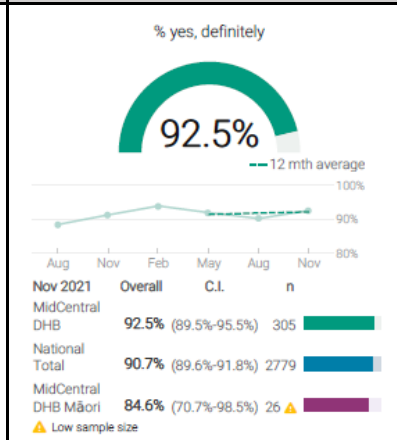
Patient did NOT identify perceived unfair treatment



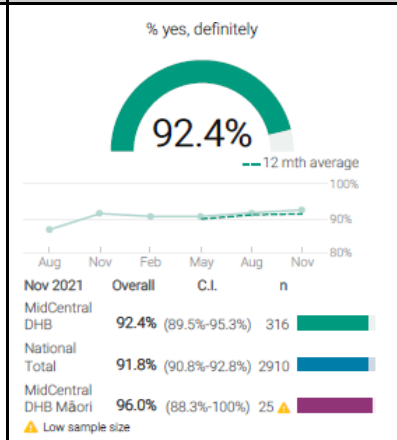
Patient definitely felt cultural needs were met.



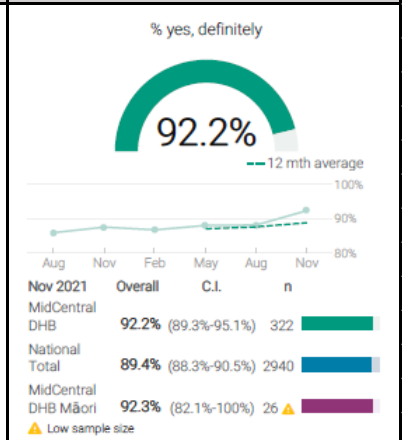
Patient definitely treated with respect by other members of health care team.



Patient definitely treated with respect by doctors.

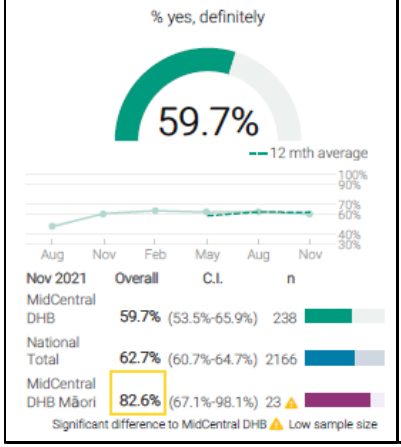


Patient definitely treated with kindness and understanding by doctors whilst in hospital.

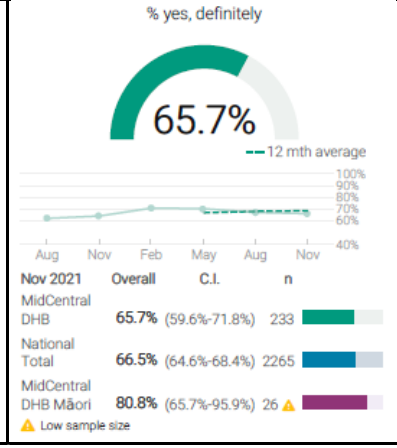


LOWEST PERFORMING

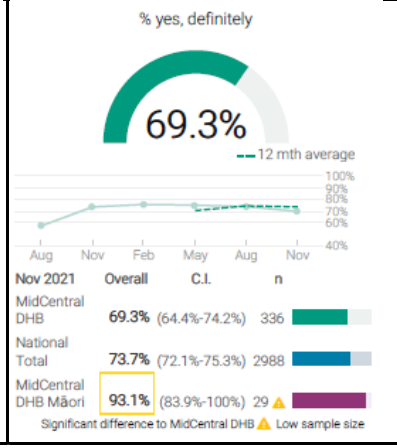
Patient was told the possible side effects of the medicine they left hospital with, in a way they could understand.



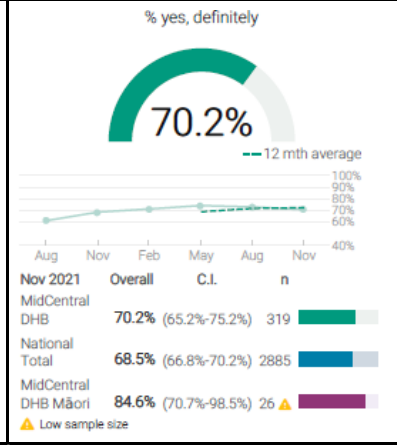
Staff talked with the patient about whether they would have the help they needed when they left the hospital.



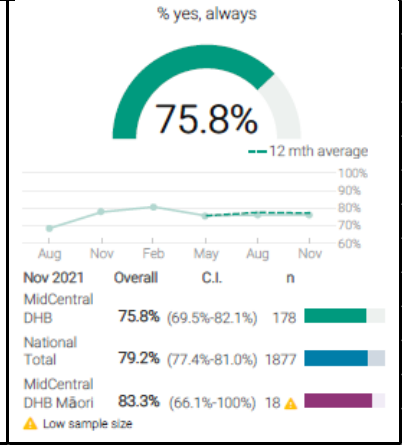
Patient definitely given enough privacy when talking about treatment or condition.



Patient definitely had enough information about how to manage their condition or recovery after they left hospital.



Hospital staff always helped patient to get to the bathroom or to use a bedpan as soon as desired.



APPENDIX THREE – METRIC DEFINITIONS

Quality Safety Markers metric definitions

Metric	Definition	Exclusions
PREVENTING PATIENT FALLS	In-hospital falls causing fracture neck of femur	
% with Risk Assessment	Percentage of patients over 65 assessed for the risk of falling	
% with care plans	Percentage of patients assessed as at risk of falling who received an individualised care plan that addresses these risks	
Per 100,000 admissions #NOF	In-hospital falls resulting in a fracture neck of femur per 100,000 admissions	
SAFE SURGERY		
SAFE SURGERY ALL COMPONENTS OF THE CHECKLIST WERE REVIEWED (sign in, time out, sign out)	Measures levels of teamwork and communication relating to the paperless Safe Surgery checklist.	
SAFE SURGERY - ENGAGEMENT SCORES OF >=5 (sign in, time out, sign out)	A minimum of 50 observational audits per quarter per part is required before the observation is included in uptake and engagement assessments.	
SAFE SURGERY - # OBSERVATIONAL AUDITS CARRIED OUT	Direct observational audits used to assess the use of the three surgical checklistparts (sign in, sign out and time out).	

Metric	Definition	Exclusions
REDUCING SURGICAL SITE INFECTIONS		
>=2g cefazolin given	Percentage of procedures with the right antibiotic in the right dose cefazolin 2g or more or cefuroxime 1.5g or more	
Antibiotic <1hr knife to skin (KTS)	Percentage of primary procedures with the antibiotic administered in the right time.	
PATIENT DETERIORATION	Patients with Cardiopulmonary arrests or Rapid response escalations	
EWS calculated correctly	Percentage of audited patients with an early warning score calculated correctly for the most recent set of vital signs	
Escalation and appropriate response	Percentage of audited patients that triggered an escalation of care and received the appropriate response to that escalation.	
IMPROVING HAND HYGIENE	Percentage of opportunities for hand hygiene taken	
PRESSURE INJURY		
Assessing and recognition risk	Percentage of audited patients with a documented and current pressure injury risk assessment	
Independent Care plan for at risk patients	Percentage of at-risk audited patients with a documented and current individualised care plan.	
Hospital acquired PI rate per 100 audited patients	Percentage of audited patients with a hospital-acquired pressure injury.	
Non-Hospital acquired PI rate per 100 audited patients	Percentage of audited patients with a non-hospital-acquired pressure injury.	
SAFE USE OF OPIOIDS		
Sedation monitored &and documented	Percentage of patients whose sedation levels are monitored and documented following local guidelines.	
Bowel function recorded	Percentage of patients who have had bowel function activity recorded in relevant documentation.	
Prescribed for uncontrolled pain	Percentage of patients prescribed an opioid who have uncontrolled pain.	
Surgical admission with opioid related harm	Opioid-related harm per 100 surgical episodes of care.	

Metric	Definition	Exclusions
FEEDBACK	Views and opinions of service users (ie. patients and their family or whānau) on the care they have experienced.	
Health and Disability Commissioner complaints	Any expression of dissatisfaction by a patient/consumer or their family/whānau or support person regarding health care service provided received by theHealth and Disability Commissioner and sent to MidCentral District Health Board for formal investigation and response is required.	
Patient Experience Survey	A survey designed to find out about the experience of patients aged 15 and older with at least one night's overnight stay, where the hospital event ended with a routine discharge or self-discharge. The survey aims to find out whether patientsfelt they had their physical and emotional needs met and received the right level of communication.	Specific exclusions are patients admitted to amental health specialty, patients who were transferred to another health facility, and patients who died in hospital.
Complaints	Any expression of dissatisfaction by a patient/consumer or their family/whānau or support person regarding any aspect of the service offered or provided by MidCentral District Health Board where a formal responseto the expressed dissatisfaction is required.	
Compliments	All expressions of satisfaction regarding any aspect of the service provided by MidCentral District Health Board and staff and acknowledged as appropriate to the provider.	
Queries	Any expression of concern by a patient/consumer or their family/whānau or support person regarding any aspect of the service offered or provided by MidCentral District Health Board where an immediate response and resolution, and acknowledgement if appropriate can be gained.	

Metric	Definition	Exclusions
INCIDENTS	An event or circumstance which could have or did result in unintended or unnecessary harm to a person, and/or loss or damage.	Risks and hazards are not included in thesefigures.
Serious Adverse Events	Events with a negative reaction or result that are unintended, unexpected or unplanned that have had serious consequences for the patient/consumer/whanau as defined by the severity assessment code (SAC 1 and 2).	Severity ratings of 3 and 4
Conduct/Behaviourand abuse	An event where a patient/consumer behaves in a manner thatis deemed inappropriate. This may be situations of verbal or physical abuse, aggression, harm to self, leaving the hospital without agreement by the treating team.	
Medication	Any event where medication was involved where it was inappropriately/incorrectly stored, administered, dispensed, prescribed, transported or where an incorrect counting of medication has occurred.	
Skin Integrity	Any event where the skin integrity of a patient/consumer has been compromised such as tears and pressure injuries.	
Patient Falls	Any event where a patient/consumer has fallen to the ground with or without harm having occurred.	

Discussion/Decision papers

1 March 2022 HDAC

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Margaret Bell <margaret.bell@midcentraldhb.govt.nz>

For:

	Approval
X	Endorsement
	Noting

Key questions the Committee should consider in reviewing this paper:

- Is there any key equity information which is required for governance that is not included in the report and should be?
- Do the next steps adequately reflect the expectations of the Committee?
- Are there any changes suggested for future reports?

To	Health and Disability Advisory Committee
Author	Scott Ambridge, Operations Executive Te Uru Rauhī, Mental Health and Addiction Services
Endorsed by	Manawhenua Hauora Kathryn Cook, Chief Executive
Date	10 February 2022
Subject	**Māori Health Equity Dashboard - Te Ara Angitū Report - Mental Health and Addiction Adult Health Indicators**

RECOMMENDATION

- **note** the equity position for each of the indicators
- **note** the analysis, discussion and proposed next steps to improve Māori health equity and further strengthen MidCentral District Health Board's commitment to Te Tiriti o Waitangi
- **endorse** the Te Ara Angitū report.

Strategic Alignment

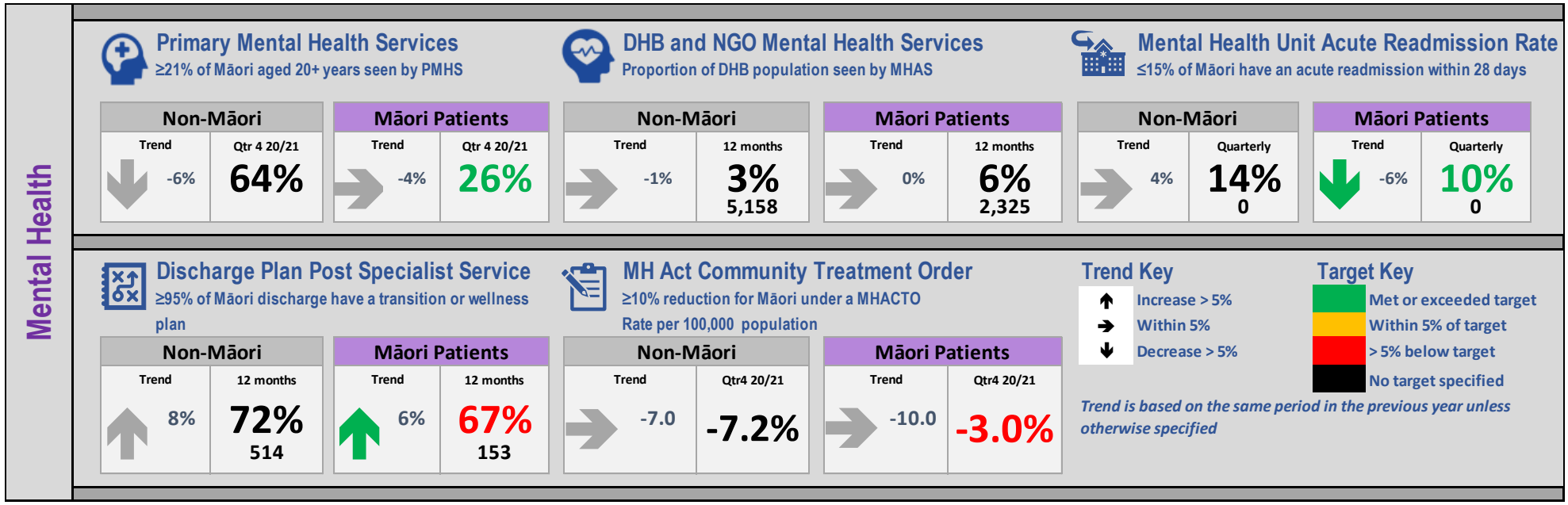
This report is aligned to the DHB's Strategic Plan and Ka Ao, Ka Awatea, the Māori Health Strategic Framework.

1. PURPOSE

This Te Ara Angitū report, provides an analysis of equity indicators across adult mental health. The priority indicators were agreed by both MidCentral District Health Board (MDHB) and Manawhenua Hauora at their respective meetings in June and July 2020. They are consistent with the MDHB health outcomes framework, Whānau Ora, MDHB's commitment to Te Tiriti o Waitangi and deployment of the MDHB Strategy. Detailed reports can be found on the Stellar platform (MDHB/HDAC/HDAC Reports and Documents).

Three indicators have shown improvement, one is no change, and one shows a slight decline.

2. INDICATOR OVERVIEW



3. WHAT THIS TELLS US

3.1. Primary Mental Health and Addiction Services

Providing increased access and choice is the goal for whānau whaiora. The Integrated Primary Mental Health and Addiction Programme (IPMHA) services continue to promote engagement and enhance strengths through services being delivered in accordance with whānau whaiora preference either face-to-face, by telephone or through virtual mediums. The data for December demonstrates a decrease of Māori over 29 accessing the programme. This decrease may be secondary to the current COVID-19 Omicron pandemic with tāngata whaiora limiting attendance at health care and/or iwi and Māori organisations; Kaimahi leave and the mandatory two week stand down period for THINK Hauora over the festive period; and limitations in the ability to provide Rongoā Māori during December following venue unavailability. The Mātanga Whai Ora providing Rongoā Maori is now based at Muaūpoko Tribal Authority and expansion to Ōtaki is planned for March 2022. Positively there has been an increase in Māori whānau whaiora under the age of 29 accessing support via the IPMHA programme this past quarter. Ongoing collaboration between Mātanga Whai Ora (Health Improvement Practitioners) and Kaiwhakapuaki Waiora (Health Coaches) has led to 24 percent of whānau whaiora seen under the IPMHA Programme being actively engaged with Kaiwhakapuaki Waiora. Further strengthening of these relationships is occurring in General Practice Teams (GPTs) and iwi and Māori organisations throughout the rohe with regular huis utilising a whānau whaiora centric approach for enrolled and non-enrolled whānau whaiora.

The challenges for the programme remain as previously reported with the IPMHA Programme and Te Pou HIP training being developed and designed for implementation and delivery within GPTs and not transferring well into iwi and Māori and Non-Government Organisations where no general practice is employed. This is a nationwide challenge faced by many DHBs at present and discussions are underway with Ministry of Health (the Ministry) to explore options to adapt the programme to meet the needs of Aotearoa. An avenue under exploration with the Ministry at present is Nurse Practitioner led clinics being an alternative to GPTs for the IPMHA Programme. Shortage of Specialist Providers of Brief Therapy within rural localities remains an area of concern. There is a high demand for therapeutic interventions within the community and avenues are being explored to increase provider resource through an EOI process. Removal of criteria that excludes kaupapa Māori providers not registered under the HPCA Act enables partnership with a wider range of providers to occur.

3.2. Service Access

Whilst the numbers indicate that access is relatively stable, we know that there are significant challenges for Māori in accessing services.

Te Mātāpuna o te Ora sets out a programme of transformational change that provides for increased investment in kaupapa Māori service offerings and choice with a particular focus on our localities where there is high health need. This creates an opportunity to think differently about how to design and deliver services by Māori for Māori and from this several initiatives are underway as outlined below.

Collaborative Design

Funding received from the Ministry enabled MDHB to engage an external contractor to design what kaupapa Māori mental health service would look like with a particular focus on the Horowhenua locality. Described as the 'kaupapa Maori Collaborative Design Programme' it has extensive support through the established Te Roopu WAIORA governance group which includes all iwi and Māori providers delivering mental health and addiction services including Mana o te Tangata – a Māori peer led organisation. The collaboration plan has two discrete components focusing on Horowhenua kaupapa pathway design and Te Papaioea – Manawatu pathway design with an interacting pathway across the MDHB rohe.

Building on the work during the last quarter Te Roopu WAIORA also requested that the implementation of Te Ara Totika – the kaupapa Māori Mental Health RFP to the Ministry be included as a joined-up menu of options for the rohe. This component is being undertaken in partnership with Te Tihi o Ruahine Whānau Ora Alliance under the mantel of Te Roopu WAIORA governance. Te Ara Totika is focused on increasing access and choice to Rongoaa services across the rohe and involves several of the same iwi and Māori providers. This work is progressing well as part of the overarching development of a menu of kaupapa service offerings.

Acute Alternative – Horowhenua

During the last quarter MDHB released an RFP for a four bed Acute Community Response. This saw Muauapoko Tribal Authority, Raukawa Whānau Ora Services, Mana o te Tangata Trust, Whaioro invite a partnership with Emerge Aotearoa to develop a joint response that was consistent with the collaborative design principles and approach that has been outlined above.

The approach was endorsed by MDHB and represents a fantastic opportunity for MDHB clinical services and the Iwi Māori Partnership to develop the service together utilising the shared co-design approach.

Increasing access to Cultural Supports

The implementation of Te Mātāpuna o te Ora significantly increased access to cultural supports through the appointment of additional Whānau Ora Kaitautoko and Tikanga and Cultural Competency Facilitator positions (an increase from two to seven). Working within kaupapa services the Whānau Ora Kaitautoko positions will focus on whānau connectivity and community support and the Tikanga and Cultural Competency Facilitator will lead the integration of cultural (Māori worldview) understanding across all aspects of clinical service delivery and skill development in cultural responsiveness and tikanga within kaupapa services. Recruitment is underway for these positions.

3.3. Acute Re-admission Rate

The table below shows the 28-day acute readmission rate and length of stay for Māori and non-Māori for the last 12 months:

28-Day Acute Inpatient Readmission Rate Ward 21	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Chng
KPI 2 - All	18%	16%	20%	11%	14%	9%	11%	13%	16%	13%	19%		↑
KPI 2 - Māori			21%	13%	0%	10%	0%	14%	36%	7%	25%		↑
KPI 2 - Non-Māori			19%	11%	33%	8%	15%	12%	4%	16%	15%		↓

The increase in readmission rate for the quarter was due to four clients with very challenging and complex needs. These individuals had a brief readmission (less than five days) before being discharged. Whilst the quarter increased the average length of stay for Māori (for the last six months) was 16 percent versus non-Māori at 12 percent. Work continues on whānau involvement in care planning, improving discharge and service planning.

3.4. Seven Day Follow up Post Discharge

KPI 19	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Chng
KPI 19 - All	74%	75%	78%	80%	73%	81%	89%	96%	92%	85%	90%	73%	↓
KPI 19 - Māori				81%	82%	64%	86%	100%	93%	81%	80%	50%	↓
KPI 19 - Non-Māori				79%	67%	90%	90%	92%	92%	88%	96%	83%	↓

The reduction in the December result is largely down to the Christmas period. Of five Māori clients not contacted within seven days, two were 'out of area' transfers who could not be contacted by the relevant DHB and three did not respond to contacts by the community teams. All five have now been followed up (NB: the January result for Māori was 93 percent).

Work continues to consolidate and bed down the changes, in particular:

- Day six reminders to all clinicians responsible for a seven-day follow up
- Daily distribution of a discharge list with traffic lights to highlight urgency of follow up
- Month-end audit of reasons for clients not seen
- Inclusion of follow up status in community team huddles.

Ongoing communication with the Ministry and partners has also been required to overcome coding and reporting system barriers to performance.

3.5. **Community Treatment Orders (CTOs)**

Whilst the quarter has seen a reduction in the CTOs rate for Māori there is still a significant equity gap between Māori and non-Māori.

The Quality Action Group implemented a project to reduce the number of Māori on CTOs. The project is led by the Whānau Equity Lead and has set a target reduction of 10 percent in the overall number of Māori on CTOs by 30 June 2022.

A review of data across all services has identified the areas of focus and a further deep dive analysis (25 service users) is underway to better understand the reasons (and barriers) for applying indefinite CTOs. The analysis will also include linking with THINK Hauora to look at other indicators that also may be relevant (registered with General Practitioner (GP), deprivation index). The review will provide useful insights into the reasons, rationale and behaviours that sit in behind the use of CTOs and will inform the next phase of action planning.

Changes to Compulsory Treatment Orders

In line with the national shift away from coercive care and toward a recovery focus, the Ministry has announced an amendment to the Mental Health (Compulsory Assessment and Treatment) Act 1992, commencing in October 2023. This replaces the use of indefinite compulsory treatment with the option to extend an order by 12 months, after review by the Responsible Clinician and only after submission to the Family Court. This means all service users currently on indefinite compulsory care will need to be reviewed before this time. We are currently scheduling reviews to stagger the workload before the commencement date and, importantly, assessing the implications for increasing community and whānau supports sufficiently to reduce the use of CTOs in more stable clients, compliant with necessary community treatment.

The legislative changes will be socialised with tangata whaiora, a proactive communication and engagement campaign is currently being developed.

4. DISCUSSION

Whilst access for whānau whaiora to the IPMHA programme is delivering above target the challenges for the programme remain. The delivery model within GPTs is not transferring well into iwi and Māori and Non-Government Organisations where no GP is employed. Discussions are continuing at a national level with the Ministry.

Work is continuing across several initiatives aimed at improving access for Māori. This work is aligned with Te Mātāpuna o te Ora and demonstrates in practical terms the partnership between Te Uru Rauhī and Pae Ora Paiaka Whaiora. This mahi will take time but is crucially important to ensure sustainable services are implemented.

The indicators within Secondary MH&A services show a clear equity gap between Māori and non-Māori. This confirms that the current traditional "medicate and manage" approach is not working for Māori that that this population is being disadvantaged by the lack of culturally appropriate options available to them. Consolidating kaupapa Māori health with the amalgamation of Oranga Hinengaro and Pae Ora Paiaka Whaiora in July 2020 was an important first step. However, there is still significant work required within secondary services to address the current equity gaps.

The results over the past six months for seven-day post discharge follow up for Māori is very pleasing. Current focus is on consolidating the gains made and to ensure ongoing monitoring and review is in place.

While the number of Māori on CTOs remains a significant inequity, it is pleasing to see a positive improvement across the quarter. The disparities seen provide strong evidence that the current approach is not working for Māori. Improvement work is underway, led by Pae Ora Paiaka Whaiora in partnership with Te Uru Rauhī and is grounded in Kaupapa Māori principles. The legislative changes will also provide much needed impetus, in line with the stated objective to drive improvement in the next six months.

5. NEXT STEPS

Individual indicator analysis notes the current range of improvements that are focused on improving Māori health equity the bullet points below summarise the next steps within each indicator.

Primary care

- Continue to build on the current collaboration within the IPMHA programme to further improve access to Kaiwhakapuaki Waiora (Health Coaches)
- Continue to work with the Ministry to provide other options for kaupapa providers to participate in the IPMHA programme.

Service Access

- Continue collaborative design work with iwi in the Horowhenua region
- Progress the next phase of the RFP for the Horowhenua Acute Alternative service
- Continue recruitment of Whānau Ora Kaitautoko and Tikanga and Cultural Competency Facilitator to support Kaupapa services.

Seven-day post discharge follow up

- Consolidate the gains made
- Incorporate changes into clinical practice, monitor and continue to report progress.

28-day Acute Readmission Rate

- Continue to monitor and incorporate changes into clinical practice.

Community Treatment Orders

- Finalise the deep dive review and identify next steps
- Contact other DHBs who have made progress with this objective to capture any insights
- Finalise communication and engagement plan.

For:

	Approval
	Endorsement
X	Noting

To	Health and Disability Advisory Committee
Authors	Marcy Williams, Senior Māori Workforce Development Manager Keyur Anjaria, General Manager, People and Culture
Endorsed by	Kathryn Cook, Chief Executive
Date	9 February 2022
Subject	**Māori Workforce Indicators Identified for 2021/2022**

Key questions the Committee should consider in reviewing this paper:

- Does the report provide sufficient, detailed information on identified workforce measures?
- Are there any key risks which the Committee would like oversight of?
- Does the commentary and 'next steps' within this report provide assurance on meeting workforce targets for the 2021/22 year?
- Are there any changes or amendments suggested by the Committee for future reports?

RECOMMENDATION

It is recommended that the Committee:

- **note** the progress made on workforce indicators identified for the 2021/22 year
- **note** the analysis, discussion and proposed next steps to improve the current workforce indicators.

Strategic Alignment

This report is aligned to MidCentral District Health Board's Strategic Plan and Ka Ao, Ka Awatea, the Māori Health Strategic Framework. The report also draws on the People Plan, '*He kura te Tāngata, A plan for our people'*, especially the action plan for the 2021/22 performance year.

1. PURPOSE

To provide the Committee with an update on key workforce measures identified within the People Plan, *He kura te Tāngata, A plan for our people*, as identified for the 2021/2022 performance year. The indicators have been agreed by both MidCentral District Health Board (MDHB) and Manawhenua Hauora at their respective meetings. They are consistent with the MDHB's health outcomes framework, Whānau Ora, MDHB's commitment to Te Tiriti o Waitangi and deployment of the MDHB Strategy.

The data and information in this report is as at 3 February 2022. Data, insights, and commentary for each indicator have been provided.

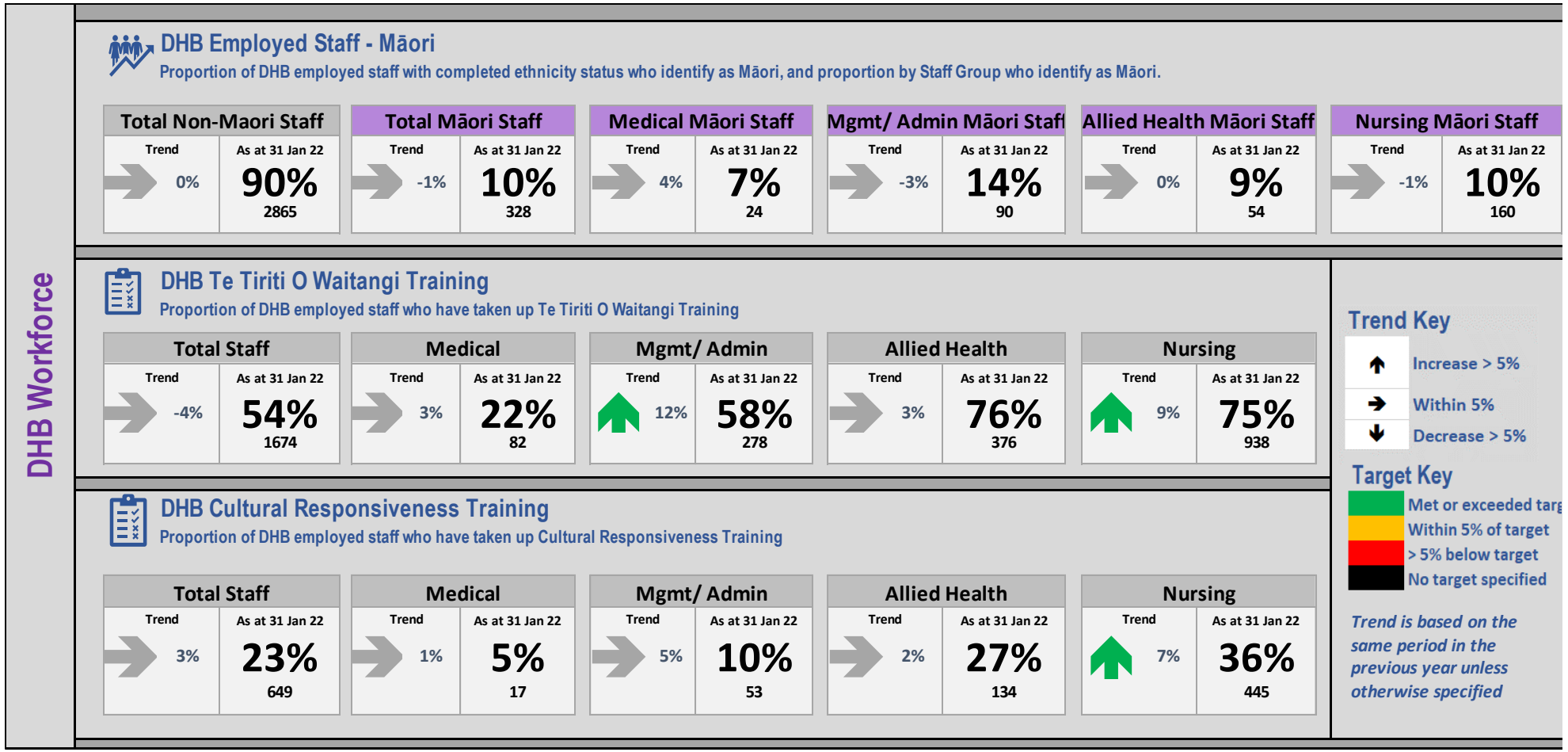
2. BACKGROUND

He kura te Tāngata, A plan for our people was developed in 2019, following a refresh of the previous Organisational Development Plan of 2017. The plan was developed following consultation with staff, and input from the staff engagement survey conducted in 2018. Five strategic areas of focus were identified within the plan:

- Our commitment to Te Tiriti o Waitangi – inspire our people toward enhanced cultural responsiveness.
- Our culture – support a healthy and productive workplace culture which enables excellence.
- Our capability – empower an increased capability of our people.
- Our ways of working – encourage our people to be agile, innovative and respond effectively to our patients, whānau and community.
- Our environment – design a work environment which delivers an exceptional employee experience.

The People Plan is supported by an action plan which identifies key performance indicators (KPIs) and markers across the strategic areas of focus for four years. This report provides an update on the actions identified for the strategic area – 'Our Commitment to Te Tiriti o Waitangi for the 2021/2022 year'. The relevant section of the action plan for the 2021/2022 year is attached as Appendix One which indicates areas of focus moving forward as a guide to our key activities.

Information is provided in the dashboard below, followed by commentary against these measures.



3. COMMENTARY ON PROGRESS AGAINST KPIS

3.1. A pro-equity approach is applied to the Māori workforce

One of the key workforce measures for MDHB is to have a workforce which is reflective of the ethnicities within the community.

As at 3 February 2022, an increase of 0.27 percent has been achieved – taking our overall Māori representation of 10.27 percent employed across the MDHB workforce (the numbers are inclusive of casual staff, but excludes Māori workforce employed by our contractors such as Ventia, Compass, Allied Laundry etc). This movement is a positive sign given current employment market conditions such as low employment rates, competition for Māori kaimahi, mandated vaccination orders and a skill shortage across the sector, coupled with the pandemic and the health reform, creating a layer of uncertainty across the sector.

Other key steps which have been undertaken and supported an increase of Māori kaimahi into the sector include:

- Appointment of the Senior Māori Workforce Development Manager in August 2021.
- Affirmative action statement incorporated into all advertisements.
- All Māori identified kaimahi are interviewed for roles applied for, provided they meet the requirements of the position competencies.
- Recruitment metrics are tracking, enabling trend analysis from attraction to offer.
- Recruitment review undertaken across various roles and services, with recommendations provided to People and Culture for enactment.
- The recent Nursing Entry to Practice (NETP) and Nursing Entry to Specialist Pratice (NESP) recruitment process has resulted in recruitment of 14 Māori staff. These staff will commence employment in February 2022.

3.2. **Our employment processes are inclusive of Te Tiriti knowledge and Tikanga Māori**

The following key activities have been undertaken to support this initiative.

- Pae Ora Paiaka Whaiora Hauora – Māori Health Directorate has increased resourcing across their team and continue to support whānau throughout the services, supporting the service offerings with an intent of providing support to its whānau, and being accessible to develop non-Māori kaimahi kite of knowledge and cultural responsiveness and understanding support.
- NETP Nursing process enabled the Senior Māori Workforce Development Manager to assess and apply best practice approach into other areas.
- Focused collaboration of MDHB communication approach where MDHB's Communications Team has partnered with Pae Ora Paiaka Whaiora Hauora to share whakaaro and kōrero around initiatives within the Māori Health sphere.
- Refreshed performance plans and framework have been rolled out across the system which incorporates Te Tiriti o Waitangi and cultural responsiveness developmental goals.

3.3. **MDHB's employees demonstrate cultural competence**

The DHB continued to enhance cultural competency requirements for its staff through focused Te Tiriti o Waitangi and Cultural Competency programmes in line with its Te Tiriti o Waitangi policy as well as agreed completion targets for the next three years.

	YTD completion percentage	2022/23 goal percentage	Comment
Te Tiriti o Waitangi and Equity in Health (ToW)	53.5	70	Tracking well with scheduled trainings
Māori Cultural Responsiveness in Practice (CRIP)	22.8	45	
Year 3 total % completion rate	76.3	70	Achieved

Further detail of the professional groups who have completed this training is provided in the dashboard. Significant investment in these service offerings by MDHB has meant that it has 10 courses booked for Treaty of Waitangi training and 10 courses booked for Māori Cultural Responsiveness in Practice. Despite delivering high numbers of CRIP and ToW training programmes, the percentage of staff who have completed this training, especially in the Nursing and Medical professional groups, continues to vary. This variance is mainly because of the new staff intake especially into House Officers, Registrars and NETP roles, thereby continually changing the denominator of these professional groups. These staff members joined the DHB in late January and will be scheduled to undertake this training as it becomes available to them, during the year.

Additional activities underway include:

- Considering other public sector training resources which can be complementary to the DHB's training programmes. The Pae Ora Paiaka Whaiora Hauora – Māori Health Directorate leadership and Tikanga is currently reviewing these offerings. If these are considered appropriate, People and Culture will consider rolling them into the training schedules as part of the induction/ orientation programme.
- Pae Ora Paiaka Whaiora Hauora, alongside supporting services, are working with education providers to create a cultural supervisor database, which would make cultural supervision more accessible for Māori kaimahi.
- Wellbeing approach has been partnered with Pae Ora Paiaka Whaiora Hauora to ensure that Te Ao Māori is incorporated and woven into the plan, which is being finalised for release for Manawhenua endorsement and support in March 2022.

4. NEXT STEPS

Reports in the dashboard indicate continued progress across the workforce initiatives which have been identified. Over the next six months, the following key activities are planned to accelerate the workforce performance indicators.

- Developing cohorts across the MDHB to support cultural strengthening and more diversity inclusive practices. Three are currently being conceptualised within the Medical Administration Unit, Māori Midwifery Team and Scholarship Programme (designed by the groups and supported/facilitated by Pae Ora Paiaka Whaiora Hauora).
- Inception of various working groups and ensuring there is appropriate representation.
- Further communication and approaches to assist with normalising Māori pro-equity practices.
- Partnering with Pae Ora Paiaka Whaiora Hauora and services to review processes, as and when appropriate.
- Establishing pipeline support and visibility through tailored communication and workforce development activities through a variety of partnerships, to create pathways more accessible for MDHB's rangatahi.

Appendix One: Year Three activities of the People Plan, *He kura te Tāngata*

Year 3 | 2021/2022

Enable our People

Our Commitment to Te Tiriti o Waitangi Kia ū ki te tika
Our systems and practices ensure that Māori needs are met. • Implement action plan which ensures that karakia, waiata, whakawhanaungatanga, pōwhiri, and Te Reo Māori are embedded into all DHB practices. **A pro-equity approach is applied to Māori workforce.** • Targeted development practices are embedded for Māori workforce. **We drive and measure the progress of Māori health gains.** • Report progress on Māori workforce development. **Our employment processes are inclusive of tikanga Māori.** • Implement project plan to ensure inclusivity of organisational people processes. **Our employees demonstrate cultural confidence.** • 70% of the workforce has completed at least one cultural competence training programme. **Apply Māori values into an integrated Leadership development programme approach.** • Integrate cultural competence as a part of performance conversations across the organisation.

Information papers

1 March 2022 HDAC

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Margaret Bell <margaret.bell@midcentraldhb.govt.nz>

For:

	Approval
	Endorsement
X	Noting

Key questions the Committee should consider in reviewing this paper:

- Does this paper provide the Committee with sufficient information and line of sight on progress with delivering the annual planning priorities for the central region?

To	Health and Disability Advisory Committee
Author	Angela Rainham, Locality and Intersectoral Development Manager
Endorsed by	Deborah Davies, Interim General Manager, Strategy, Planning and Performance
Date	8 February 2022
Subject	**Regional Services Plan Implementation, Quarter One and Quarter Two – 2021/22**

RECOMMENDATION

It is recommended that the Committee:

- **note** there is no requirement to have a Regional Service Plan presented to the Minister of Health for the 2021/22 year
- **note** the progress made on implementing the central region's national and regional priority programmes for Quarter One and Quarter Two of 2021/22.

Strategic Alignment

This report concerns the collaborative programme of work undertaken as a region and is consistent with the District Health Board's (DHB) Strategy and the central region's strategic objectives.

1. PURPOSE

To provide an update on delivering the Central Region 2021/22 Regional Services Plan (RSP) for Quarter One and Quarter Two (1 July to 31 December 2021). It is for the Committee's information only and no decision is required.

2. KEY POINTS TO NOTE

- There is no requirement to present a Regional Service Plan to the Minister of Health for 2021/22.
- Technical Advisory Services (TAS) prepares and submits RSP reports on behalf of the six central region DHBs.
- Single System of Care and Mental Health and Addiction programmes were deferred between November 2021 and January 2022. Two FTE programme managers are now in place to progress those programmes.
- A key focus for the central region during this period has been on progressing the regional resilience programme and supporting the region with planning for the Omicron variant of COVID-19.

3. BACKGROUND

The RSP articulates the central region's strategic direction and provides a high-level overview of the priority programmes with actions to be undertaken by the six DHBs over the planning year. These actions are aimed at advancing the region's three strategic objectives:

1. Equitable access and outcomes across the region.
2. Financial sustainability for all services in the region.
3. Clinical sustainability to ensure patient safety and quality of care.

To achieve the region's three strategic objectives, the six central region DHBs have identified the following three strategic initiatives.

1. Building regional partnerships with Māori.
2. Implementing a networked approach to specialist service delivery.
3. Enabling the system.

These are linked to four agreed priority areas to be progressed in the 2021/22 year:

1. Developing regional single systems of care by prototyping orthopaedics.
2. Developing a plan for regional specialist mental health and addiction services.
3. Developing a regional frailty model of care.
4. Health emergency and resilience planning.

These are all underpinned by the commitment to equitable access and outcomes across the region, Te Tiriti o Waitangi and implementation of the regional equity framework, with particular focus on Māori health and wellbeing.

The RSP also includes the following clinical network focus areas.

- Cardiology
- Radiology
- Stroke
- Major Trauma
- Child Wellness Tamariki Ora.

4. DELIVERY OF THE 2021/22 REGIONAL SERVICES PLAN

TAS prepares reports regarding the regional services programme on behalf of the six DHBs and the table below provide a summary of progress over Quarter One and Quarter Two.

4.1 Definitions of ratings

All health targets/deliverables/milestones have been tracking to plan.	Achieved
Health targets have been achieved; some indicators/deliverables/milestones are not tracking to plan but an adequate resolution plan is in place, more clarification required.	Partially achieved
One or more health targets/indicators/deliverables/milestones have not been achieved; no adequate resolution plan is in place; there are delays in the implementation of the plan.	Not achieved

4.2 Regional Priority Programme Reporting Dashboard

An update on progress for the regional priority programmes is summarised below. These programmes are not subject to an assessment and rating by the Ministry.

Regional priority programmes	Comment/Summary of progress	Q1	Q2	Q3	Q4
Single System of Care (SSOC)	The programme has been on hold since November 2021 to enable redeployment of resourcing to focus on COVID-19 resilience planning. A programme manager has been recruited and commenced on 31 January 2022 and is now connecting with the clinical lead and SSOC steering group members	●	●		
Mental Health and Addiction	The programme was on hold between November 2021 and January 2022; however, a 1 FTE programme manager is now in place to progress the programme of work. The focus in January 2022 has been on establishing readiness and response to managing tangata whaiora who are acutely unwell (MH&A); and impacted by COVID-19 (requiring isolation).	●	●		
Frail Elderly/Health of Older People	A time limited Frailty Programme Steering Group (FPSG) has been established to make regional implementation recommendations from Achieving Kaumātua Ora. Progress has occurred across all the regional older persons programmes; however some activity did get slowed down due to COVID-19 restrictions with some meetings cancelled and group members being re-directed to support local responses.	●	●		
Health Emergency and Resilience Planning	A regional resilience workshop in Palmerston North on 4 February 2022 involving the Health Emergency and Resilience Planning Steering Group and the programme executive and workstream leads developed an action plan for the short and medium term across the primary care, workforce, hospital and equity streams of work. Additional resourcing is now in place to rapidly progress the establishment of the Central Region Coordination Centre.	●	●		

Clinical Networks

Cardiology	• Regional CEs have requested that an external consultant be contracted to develop a future whole system model of care for cardiac and implementation plan. Synergia have been approached to do this work in December 2021 and are currently developing a project scope for Regional CEs approval. • Heart Failure data has been analysed by TAS and the decision by the Cardiac Network has been to carry out a clinical audit. • Echo cardiography Working Group – A Working Group has been set up that will focus on consistent training, registration, reporting and clinical governance. The group plan to begin meeting in February. • Equity – The TAS Senior Equity Consultant met with the Regional Clinical Lead for Cardiac in December. The outcome of this meeting was that TAS will develop a document that provides guidance to DHBs on how to improve access to cardiac services.				
Radiology	Progress includes: • Regional Workforces – A meeting was held late last year with Regional COOs to agree total investment of the Radiology RMO training programme. Regional COOs agreed to this investment, subject to an updated funding paper. An updated paper has been completed and will be presented to Regional COOs and GMs Planning and Funding in the next few weeks. • An Allied Health Workforce Group has been set up and is currently carrying out a stocktake of training initiatives occurring in each DHB. Regional Radiology Information System – RRIS Working Group continues to meet regularly and work through onboarding and BAU challenges. Regional DHB approval for CCDHB onboarding March 2022 achieved in December. Go Live date 18/03/2022.				
Stroke	The region is prioritising a focus on progressing work in the rehabilitation space and is planning regional roadshows to support DHBs. A number of FAST initiatives are underway, and equity and Treaty of Waitangi training is being arranged for Stroke Network members. Progress with the work programme has slowed as a result of the sector focus on planning for, and response to, COVID-19.				

Major trauma	The major trauma work programme is on track. A significant achievement in Q1/Q2 was the establishment of the cross sector Strategic Trauma Network the subsequent development of the Central Region Strategic Trauma Plan 2021 to 2024, which was agreed by the Central Region CEs in December.		●		
Child Wellness Tamariki Ora	Additional Ministry funding received to support Regional CDS Innovations. Projects on track. Whakapakari Hunga Tautoko has been endorsed by Te Koro Matua ki Ikaroa rōpū – GMs regional Māori. A letter advocating for funding to support the proposed solution has been received by the Ministry of Health – Population Health and Prevention directorate. Whakapakari Hunga Tautoko is a regional project partnering with iwi/Māori WCTO providers to develop a solution for workforce clinical support and professional development.	●	●		

For:

	Approval
	Endorsement
X	Noting

Key questions the Committee should consider in reviewing this paper:

- Does the report provide a useful update on progress in the Manawatū District?
- Is the Committee satisfied with current progress?
- Are there any additional matters that should be included in future locality updates?

To	Health and Disability Advisory Committee
Author	Angela Rainham, Locality and Intersectoral Development Manager
Endorsed by	Deborah Davies, Interim General Manager, Strategy, Planning and Performance
Date	10 February 2022
Subject	**Locality Plan Progress Report – Manawatū District**

RECOMMENDATION

It is recommended that the Committee:

- **note** the progress that has been made in relation to Manawatū Te Mahere Hauora (Health and Wellbeing Plan).

Strategic Alignment

This report is aligned to the DHB's strategy and the strategic imperatives within it. It is particularly aligned with 'Partner with people, whānau and communities to support health and wellbeing'.

1. PURPOSE

To provide an update on progress with MidCentral District Health Board's (MDHB) locality approach in the Manawatū District and recent feedback from the community regarding health and wellbeing issues. No decision is required.

2. SUMMARY

The paper provides a summary of:

- progress in relation to the current plan
- current key issues affecting the health and wellbeing of residents and points of note
- upcoming locality work in the Manawatū District.

3. BACKGROUND

The Manawatū Locality Plan was completed in 2018 and was one of five plans created for the different localities (Territorial Local Authority areas) across the MDHB rohe. The current plan provides information about the community, including a demographic profile, community priority areas and focus areas within these as identified by the community. There is also a plan of actions that MDHB and partner organisations committed to undertaking to make progress in the identified priority areas.

The current plan (along with the other four plans for Ōtaki, Tararua, Horowhenua and Palmerston North) can be found at: http://www.midcentraldhb.govt.nz/Planning/localPlan/Pages/LocalityPlanning.aspx.

The three focus areas within each of the four community priority areas are shown in the table on the following page.

Access to Health Care	Mental Health and Addiction	Healthy Living	Better Communication and Connections
People are able to get help when they need it (improving access to primary care)	People are able to find help when they need it locally	Quality living for older adults	Improving communication
Improving people's access to hospital and specialist care	Support for our youth	Wider determinants of health	People are aware of their choices and what's available
Health working together as one team (improving people's experience)	Rural Mental Health	Link local people to local activities	Increasing engagement and visibility

4. PROGRESS IN RELATION TO THE CURRENT PLAN

The plan has 53 actions in total and the reporting template has had 10 further actions added to it. Sixty-one of these 63 actions are progressing well or have been completed. Appendix One summarises the action plan progress in each focus area.

4.1. Examples of progress being made in community priority focus areas

4.1.1. Providing COVID-19 vaccinations in different ways (Access to Health care)

The delivery of COVID-19 vaccination clinics outside of regular hours, 'by Māori for Māori', where people are gathering or having drive-through options are all examples of changing the way we do things to break down barriers to accessing services. The Ngā Kaitiaki o Ngāti Kauwhata Iwi Partnership Clinic held in Feilding from 1 to 7pm on Wednesday 9 February is a good example of providing an option 'by Māori for Māori' and where people can attend outside of their normal working hours.

4.1.2. Success of Specialist Women's Health Services being delivered locally (Access to Healthcare)

Weekly gynaecology/obstetrics clinics have been held in Feilding for over a year now. Having these clinics enables local people to access specialist health practitioners within their community, saving the need to travel to Palmerston North Hospital for appointments.

Dr Philip Suisted delivers clinics in Feilding and has noted the following benefits.

- Attendance is better. Most patients acknowledge the ease and the convenience. Many will walk to the clinic and others appreciate the free parking.
- The clinicians (Dr Suisted and the registrar) have a sense of the community, having travelled to get there.
- The easy access to multiple other health services is useful.
- The nurses are very helpful and can check contact details/vaccinations/screening/etc for patients as they arrive. If patients don't attend, the nurses will find out why and make other arrangements.
- Women can be walked to the lab to schedule their glucose blood test (for example), to get buy in, when otherwise they may not have attended.
- It is useful to have smoking cessation in the office next door.

4.1.3. Kaiwhakapūaki Waiora (Health Coaches) working in the community (Mental Health and Addiction Services)

The two Kaiwhakapūaki Waiora (Health Coach) roles that work within this locality provide a great service for local people. They are based at Nga Kaitiaki o Ngāti Kauwhata and Whaioro Trust and they receive referrals from the Mātanga Whaiora (Expert in the Art of Wellbeing) based at Feilding Health Care as well as through their base organisations.

These non-clinical roles work alongside whānau with mental health, addiction and other wellbeing challenges, coaching them to build their own skills, knowledge and confidence to manage their health and wellbeing. The Kaiwhakapūaki Waiora roles also provide a useful bridge to primary care services.

The service is free and there are no criteria to access the service.

4.1.4. Local organisations working on the wider determinants of health (Healthy Living)

- Ngā Kaitiaki o Ngāti Kauwhata have been undertaking a 'Nga Kainga Kawariki' project to improve the health of homes for Ngāti Kauwhata whānau in Feilding. They have upgraded the homes of 25 whānau and have a list ready for the next tranche of the programme.
- The local Work and Income office are working with clients and local doctors to ensure those who are eligible for a Disability Allowance are accessing it.

5. CURRENT HEALTH AND WELLBEING ISSUES AND POINTS OF NOTE IN MANAWATŪ

5.1. Health and wellbeing issues raised by Ngā Kaitiaki o Ngāti Kauwhata

Late last year we visited Ngā Kaitiaki o Ngāti Kauwhata who highlighted the following challenges affecting the health and wellbeing of local whānau.

- Growing incidents of family harm – exacerbated by pressure created through COVID-19.
- Waiting times for health services.
- Access to warm and affordable housing.
- Rangatahi not engaged in education and no local provider of alternative education.

5.2. Health and wellbeing issues highlighted at Farmers Market feedback tent

In December 2021 we set up a tent adjacent to the Farmer's Market in Feilding one Friday morning and gathered the following feedback from the community regarding *What are the key issues/challenges affecting the health and wellbeing of your community?* The majority of people spoken to were older adults and it is notable that many of the issues raised were related to COVID-19.

COVID-19 related:

- Concern for mental health of people being isolated at home due to lockdowns or fear of going out
- COVID-19 processes and requirements can be confusing – rules of the traffic light system, mandates
- Masks provide difficulties for some people, such as: those with respiratory issues, PTSD, deaf people who need to lip read
- Some people expressed frustration about COVID-19 and restrictions
- Differences of opinions regarding vaccinations is causing stress and conflict within families
- People are so fearful of COVID-19 some tend to overlook other health issues (anxiety, depression, the common cold).

Other main issues raised:

- Waiting times to access healthcare
- Frustration with getting different nurses/doctors every time and information is not consistent.

5.3. Impacts of poverty on people's health

The November 2021 Health and wellbeing Group meeting focused on the impacts of poverty on people's health in the Manawatū District. The following points were noted:

- Feilding Health Care did a customer survey which highlighted that many people struggle to pay for prescriptions.
- Manchester House reported that many of their transient clients use the emergency department for healthcare and are not registered with a practice.
- Ngā Kaitiaki o Ngāti Kauwhata highlighted that some whānau do not access healthcare or medications because of the cost.

5.4. What is being done to address some of these issues

- **Family harm** - late last year MDHB established the Family Protection team with a vision to make a positive contribution to the prevention of family harm and child abuse within our rohe by working with our wider staff to educate and support them. The long term goal is that each patient presenting to MDHB facilities will be screened for family harm and for the Family Protection team to subsequently provide the appropriate action and support.

- **Housing** – As mentioned above in 4.1.4 Ngā Kaitiaki o Ngāti Kauwhata have a Nga Kainga Kawariki programme of work to help whānau to improve their housing conditions. Our Child Health Community team also work with whānau to provide education and access to some community based interventions related to healthy homes. A RFP has recently been completed to deliver the Ministry of Health's Healthy Homes Initiative across our rohe and this is an exciting opportunity to partner with Ngā Kaitiaki o Ngāti Kauwhata and the Child Health Community team (amongst others) to build on the existing mahi in this area. This programme will enable us to identify eligible whānau/aiga and then ensure they are supported through the journey of having a housing/whānau assessment and then accessing appropriate interventions to support them in creating a warm, dry and healthy home environment to live in.

- **Expanding primary care options** – Feilding Health Care are always looking at ways to offer services differently to meet patient needs. Recently they have partnered with Practice Plus to offer virtual, after hours GP consultations from 5 – 10pm weekdays and 8am – 8pm weekends. People choosing this option should reduce the overall number seeking appointments during standard business hours which may result in reduced waiting times for appointments.

- **Reducing waiting times for hospital care in the Emergency Department** –Te Uru Arotau are acutely aware that people are often faced with very long waiting times to be seen in the Emergency Department and that the number of people who leave before being seen is increasing. The Te Uru Arotau update within this meeting's agenda papers highlights work currently being undertaken to improve these Emergency Department waiting time issues.

- **Minimising waiting times for surgery –** The SPIRE project will result in two new theatres and increased surgical capacity. While the building work is taking place surgical capacity on-site has been reduced so, to mitigate the impact of this, outsourcing and outplacing of surgery to CREST hospital is taking place.

5.5. Other points of note

- Ngā Kaitiaki o Ngāti Kauwhata have identified three areas of focus in their 'post-COVID-19' report:
  - Housing
  - Employment
  - Māori business

- YouthLine are seeing a heavy demand for their services.

6. COVID-19 READINESS AND VACCINATION ROLLOUT IN MANAWATŪ

The COVID-19 vaccination programme within the Manawatū District has resulted in 98 percent of the population 12 years and over being fully vaccinated. As at 8 February 2022, 9,325 people in the locality had also had their booster shots (of the 14,129 eligible).

Ngā Kaitiaki o Ngāti Kauwhata and Feilding Health Care have been running regular clinics and delivering vaccinations to people and whānau within the Manawatū District throughout the time vaccinations have been available. Both organisations must be recognised for their efforts to ensure there are good vaccination rates within this locality.

The MidCentral DHB vaccination teams were also active in 2021 in providing bespoke clinics at places throughout the locality (including saleyards and some of the more rural communities) to reach groups who may not have otherwise been vaccinated.

Regular testing has been available through Feilding Health Care and other testing sites are ready to be stood up by MDHB, in partnership with iwi, as required – in line with the COVID-19 surge plan.

When active cases of COVID-19 arise in the Manawatū District, there is a locality hub set up to manage care in the community in line with the central hub. This hub includes local iwi, health and social service providers.

7. UPCOMING WORK IN NEXT SIX MONTHS

- Developing and distributing of the March and June 2022 community e-newsletters.
- Continuing community engagement and feedback to MDHB executive members. There will be a focus on hearing the voice of rangatahi over the next six months.
- Refreshing the demographic profile information for the Manawatū District (alongside the other localities) to provide more population information about the community that can be utilised by services. 'Assessing individual, whānau, community aspirations and health needs' is important in planning for the provision of quality health services and the refreshed locality profiles will provide key information.

Appendix One: Progress in each community priority focus area

Access to Health Care	Mental Health and Addiction	Healthy Living	Better Communication and Connections
People are able to get help when they need it (improving access to primary care) = nine actions 100 percent progressing well	People are able to get help when they need it = eight actions 88 percent complete or progressing well, 12 percent behind/challenges	Quality living for older adults = five actions 100 percent complete or progressing well	Improving communication = four actions 100 percent complete or progressing well
Improving people's access to hospital and specialist care = eight actions 88 percent complete or progressing well, 12 percent behind/challenges	Support for our youth = three action 100 percent progressing well	Wider determinants of health = seven actions 100 percent complete or progressing well	People are aware of their choices and what is available = five actions 100 percent complete or progressing well
Health working together as one team = five actions. 100 percent complete or progressing well	Supporting rural communities = one action 100 percent completed or progressing well	Link local people to local activities = three actions 100 percent complete or progressing well	Increasing engagement and visibility = five actions 100 percent complete or progressing well

Just two of the 63 actions are classed as 'Behind/challenges' or 'yet to start':

Focus area	Action	Comment
Access to health care - Improving people's access to hospital and specialist care	People's circumstances (such as locality and family/ whānau responsibilities) will be taken into consideration by more flexible hospital booking systems.	This project has been deferred. The focus remains on seeing patients at a facility closer to home where possible. The use of telehealth is being encouraged, where appropriate, making it easier for patients to access a secondary care assessment. A number of electronic initiatives are underway to streamline the flow of referrals into the organisation.
Mental Health and Addiction – People are able to get help when they need it	Better support for communities locally by having a Suicide Prevention Local Response team in place in the district. This will involve local agencies working collectively as one team.	This development has been put on hold due to staffing changes and Public Health staff being redeployed to COVID-19 work.

For:

	Approval
	Endorsement
X	Noting

Key questions the Committee should consider in reviewing this paper:

- Does the work programme include the topics needed to confidently govern?

To	Health and Disability Advisory Committee
Author	Margaret Bell, Board Secretary
Endorsed by	Gabrielle Scott, Interim General Manager, Quality and Innovation
Date	9 February 2022
Subject	**Committee's Work Programme**

RECOMMENDATION

It is recommended that the Committee:

- **note** the update on the Health and Disability Committee's work programme.

Strategic Alignment

This report is aligned to the DHB's strategy and key enabler 'Stewardship'. It discusses an aspect of effective governance.

1. PURPOSE

To provide an update on the Health and Disability Committee's (HDAC) work programme. This is for information only and no decision is required.

2. COMMITTEE'S WORK PROGRAMME

The Committee's work programme was approved in November 2020.

The Strategy, Planning and Performance and Pae Ora Paiaka Whaiora Directorates are working on aligning reporting with the transition to the new health system indicators. The six-monthly reporting on Te Ara Angitū (the Māori Health Equity Dashboard) reporting is critical to this alignment. However, the reduced number of HDAC meetings has impacted the timeliness of data. The child and youth indicators will now be provided at the May 2022 meeting.

At its meeting in July 2021, the Committee agreed that Clinical Governance and Quality Improvement Framework reports were no longer required. Instead, this information would be provided via the quarterly Quality Accounts, Quality and Safety Dashboard and the Directorate reports. Reporting on the Clinical Governance and Quality Improvement Framework has therefore been removed from the work programme.

Items on the work programme that are scheduled after the Committee's disestablishment on 30 June 2022 have been noted in a column headed 'Not required'.

The Consumer Story workshop has been deferred until the COVID-19 situation in the community allows a face-to-face meeting to be held.

All other reporting is occurring in line with the work programme.

Health and Disability Advisory Committee Work Programme	Frequency	Feb	May	Not required	Responsibility
Key updates					
Health Needs Assessment and Equity Snapshot to consider the health needs assessment of the district and sub-region	Triennial Nov 21			**X**	**GMSPP**
Ka Ao, Ka Awatea – Māori Health Strategic Framework review/refresh the strategy to ensure it remains relevant and reflects the DHB's strategy	Triennial Oct 23			**X**	**GMM**
Disability Roadmap to determine a disability strategy and roadmap for the district, and thereafter how it has been advanced, changes, and priorities/investments for the future (three to five years)	Triennial Aug 22			**X**	**GMENZ and EDAH**
Locality Health and Wellbeing Plans to determine how the locality plans have been advanced, what's changed and priority initiatives/ investments for the future (three to five years) and to receive community feedback	Triennial Apr 21		**X**		**OEs and CEs and SPP**
Cluster Health and Wellbeing Plans to determine each cluster's planned outcomes, priorities and targets for the next three years, and the roadmap for achieving these, including required investment and resources	Triennial TBC			**X**	**OEs and CEs**
Quality Improvement					
Quality and Safety Dashboard/Online Quality Report to monitor the quality and safety of healthcare services in the district, including trends, performance against dashboard and markers, and confirm the adequacy of the programme planned or established in advance or address issues to monitor serious and sentinel events and HDC complaints includes information from the quality plans developed by clusters with system wide improvement activities that align with The Quality Agenda	Four times a year	**X**	**X**		**GMQ&I**
Consumer Stories (workshop) to hear direct from consumers of health and disability services about their experience	Three times a year	**X**	**X**		**GMQ&I**
Quality improvement					
Cluster Reports, including Health and Wellbeing Plans to monitor each Cluster's performance, including the implementation of their Health and Wellbeing Plans, including progress against key targets, initiatives and outcomes	Each meeting	**X**	**X**		**OEs and CEs**
Cluster Deep Dive reports (presented under Strategic Focus – rotated between Clusters) to monitor current and emerging matters, including quality and safety, opportunities and challenges, and the adequacy of any mitigations	Each meeting	**X** Regional Cancer Services	**X** Acute Demand and Flow		**OEs and CEs**
Locality Health and Wellbeing Plans to determine how the locality plans have been advanced, what has changed, and priority initiatives/investments for the future (three to five years), and to receive community feedback	Annual	Manawatū	Palmerston North		**OEs and CEs and SPP**
Regional Services Plan (implementation) to monitor the implementation of the Plan and achievement of stated outcomes	Four times a year	Q1	Q2		**GM SPP**
Disability					
Disability Strategy to monitor progress in implementing the Disability Strategy, including opportunities and challenges, and confirming the priorities and initiatives/investment for years ahead	Annual			**X**	**GM ENZ and EDAH**
Governance					
Policies to determine governance and significant quality and improvement policies	As required				

Health and Disability Advisory Committee Work Programme	Frequency	Feb	May	Not required	Responsibility
Equity					
Ka Ao, Ka Awatea – Māori Health Strategic Framework to monitor progress being made in achieving the Framework, including the appropriateness of initiatives and investment planned/established	Annual		**X**		**GM M**
Te Ara Angitū – Equity Dashboard – Māori Health Indicators ('Deep dive' reports) to monitor progress being made in achieving the national Māori health targets, including the appropriateness of initiatives planned/established	Six-monthly for each group				
Child and Youth indicators			**X**		**OEs and CEs**
Adult indicators			**X**		**OEs and CEs**
Mental Health indicators		**X**			**OEs and CEs**
Workforce indicators		**X**			**OEs and CEs**

Key:

CEO	Chief Executive Officer
ED N&M	Executive Director, Nursing and Midwifery
GM F&CS	General Manager, Finance and Corporate
GM M	General Manager, Māori Health
CMO	Chief Medical Officer
FRAC Chair	Chair of the Finance, Risk and Audit Committee
Chair	Board Chair of the MidCentral District Health Board
GM P&C	General Manager, People and Culture
GM Q&I	General Manager, Quality and innovation
GMSPP	General Manager, Strategy, Planning and Performance
EDAH	Executive Director, Allied Health
GM ENZ	General Manager, Enable New Zealand
HDAC Chair	Chair of the Health and Disability Audit Committee
CDO	Chief Digital Officer

Glossary of terms

1 March 2022 HDAC

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Glossary of Terms

AC	**Assessment Centre**
ACC	**Accident Compensation Corporation** The New Zealand Crown entity responsible for administering the country's no fault accidental injury compensation scheme.
ACCPP	**Accident Compensation Corporation Partnership Plan**
ACE	**Advanced Choice of Employment**
ACT	**Acute Crisis Team**
ADL	**Activities of Daily Living**
ADON	**Associate Director of Nursing**
AESS	**Te Uru Arotau Acute and Elective Specialist Services**
ALOS	**Average Length of Stay**
AMHU	**Acute Mental Health Unit**
Anti- VEGF	**Anti-Vascular Endothelial Growth Factor**
AoG	**All of Government**
AP	**Annual Plan** The organisation's plan for the year.
APEX	**Association of Professional and Executive Employees**
API	**Application Programming Interfaces**
ARC	**Aged Residential Care**
ASH	**Ambulatory Sensitive Hospitalisations**
AS/NZS ISO 31000	**2018 Risk Management Principles and Guidelines**
AWS	**Amazon Web Services**
B Block	**Wards, Laboratory, Admin and Outpatients**
BAG	**Bipartite Action Group**

BAPSF	**Bereavement leave, Alternative days, Public holidays, Sick leave, Family Violence leave**
BAU	**Business as Usual**
BN	**Bachelor of Nursing**
BSCC	**Breast Screen Coast to Coast**
BYOD	**Bring Your Own Device**
CAG	**Cluster Alliance Group** A group or 10-12 members from across the health and wider sector supporting the Cluster Leadership Team to identify population health needs, planning, commissioning and evaluating services and developing models of care. Members include consumer and Māori representatives.
CAPEX	**Capital Expenditure**
CBAC(s)	**Community Based Assesment Centre(s)**
CCDHB	**Capital and Coast District Health Board**
CCDM	**Care Capacity Demand Management** A programme that helps the organisation better match the capacity to care with patient demand.
CCTV	**Closed Circuit Television**
CCU	**Critical Care Unit**
CDO	**Chief Digital Officer**
CDS	**Core Data Set**
CE	**Clinical Executive** (of a service)
CE Act	**Crown Entities Act**
CEO	**Chief Executive Officer**
CFIS	**Crown Financial Information System**
CHF	**Congestive Heart Failure**
CIMS	**Coordinated Incident Management System**
CIO	**Chief Information Officer**

CLAB	**Central Line Associated Bacteraemia**
CME	**Continuing Medical Education**
CMO	**Chief Medical Officer**
CN	**Charge Nurse(s)**
CNGP	**Carbon Neutral Government Programme**
CNM	**Clinical Nurse Manager**
CNS	**Clinical Nurse Specialist**
COI	**Committee of Inquiry**
ComM	**Communications Manager**
COPD	**Chronic Obstructive Pulmonary Disease** A common lung disease which makes breathing difficult. There are two main forms, Chronic bronchitis - a long term cough with mucus. Emphysema - which involves damage to the lungs over time.
COVID-19	**Novel Coronavirus**
CPAC	**Prioritisation scoring system code table**
CPB	**Combined Pharmaceutical Budget**
CPHO	**Central Primary Health Organisation**
CPI	**Consumer Price Index**
CPOE	**Computer Physician Order Entry**
CRM	**Cyber Risk Monitoring**
CSB	**Clinical Services Block**
CT	**Computed Tomography** A CT scan combines a series of X-ray images taken from different angles around your body and uses computer processing to create cross-sectional images of the bones, blood vessels and soft tissues inside your body.
CTAS	**Central Technical Advisory Services** (also TAS)

CTCA	**Computed Tomography Coronary Angiography** A CT scan that looks at the arteries that supply blood to the heart. Can be used to diagnose the cause of chest pain or other symptoms.
CVAD	**Central Venous Access Device**
CWDs	**Case Weighted Discharges** Case weights measure the relative complexity of the treatment given to each patient. For example, a cataract operation will receive a case weight of approximately 0.5, while a hip replacement will receive 4 case weights. This difference reflects the resources needed for each operation, in terms of theatre time, number of days in hospital, etc.
DCFO	**Deputy Chief Financial Officer**
DDIGG	**Digital and Data Informatics Governance Group**
DHB	**District Health Board**
DIVA	**Difficult Intravenous Access**
DNA	**Did Not Attend**
DNW	**Did Not Wait**
DoN	**Director of Nursing**
DS	**Digital Services**
DSA	**Detailed Seismic Assessment**
DSA	**Digital Subtraction Angiography**
DWP	**Digital Workplace Programme**
DX	**Data Exchange** A data exchange software mechanism developed with the Social Investment Agency (SIA) to support encrypted data sharing between public services.
EAP	**Employee Assistance Programme**
EBITA	**Earnings Before Interest, Taxes and Amortisation**
ECM	**Enterprise Content Management**
ED	**Emergency Department**

EDAH	**Executive Director Allied Health**
EDG-VPSR	**Electrocadiograph – Visual Positioning System Rhythm**
EDN&M	**Executive Director, Nursing & Midwifery**
EDOA	**Emergency Department Observation Area**
EDON	**Executive Director of Nursing**
EECA	**Energy and Efficiency Conservation Authority**
ELT	**Executive Leadership Team**
EMERGO	**Emergo Train System**
EMR	**Electronic Medical Record**
EN	**Enrolled Nurse**
ENT	**Ear Nose and Throat**
ENZ	**Enable New Zealand**
EOC	**Emergency Operations Centre**
EP	**Efficiency Priority**
EPA	**Electronic Prescribing and Administration**
EPMO	**Enterprise Project Management Office**
ERCP	**Endoscopic Retrograde Cholangio Pancreatography**
ERM	**Enterprise Risk Management**
ESPI	**Elective Services Patient Flow Indicator** Performance measures that provide information on how well the District Health Board is managing key steps in the electives patient journey.
ETA	Energy Transition Accelerator
EV	**Electric Vehicle**
EWS	**Early Warning System**
EY	**Ernst & Young**

FACT	**Flexible Assertive Community Assessment Team**
FHC	**Feilding Health Care**
FHIR	**Fast Healthcare Interoperability Resources**
FIT	**Faecal Immunochemical Test**
FM	**Facilities Management**
FM Services	**Facilities maintenance and hotel services required by the DHBs**
FPIM	**Finance and Procurement Information Management System**
FPM	**Financial Planning Manager**
FRAC	**Finance, Risk and Audit Committee**
FSA	**First Specialist Appointment**
FSL	**Fire Service Levies**
FTE	**Full Time Equivalent** The hours worked by one employee on a full-time basis.
FU	**Follow Up**
Gap	**Analysis used to examine current performance with desired, expected performance**
GETS	**Government Electronic Tenders Service**
GHG	**Greenhouse Gases**
GM	**General Manager**
GMFCS	**General Manager, Finance and Corporate Services**
GMM	**General Manager, Māori Health**
GMPC	**General Manager, People and Culture**
GMQI	**General Manager, Quality and Innovation**
GMSPP	**General Manager, Strategy, Planning and Performance**
GP	**General Practitioner**
GST	**Goods and Services Tax**

H&S	**Health and Safety**
HaaG	**Hospital at a Glance**
HAI	**Healthcare Associated Infection**
HAR	**Te Uru Whakamauora, Healthy Ageing and Rehabilitation**
HBDHB	**Hawke's Bay District Health Board**
HCA(s)	**Health Care Assistant(s)**
HCSS	**Home and Community Support Services**
HDAC	**Health and Disability Advisory Committee**
HDU	**High Dependency Unit**
HEAT	**Health Equity Assessment Tool**
HEEADSSS	**Home, education/employment, eating, activities, drugs, sexuality, suicide and depression, safety (wellness assessment)**
HIP	**Health Infrastructure Programme**
Hira	**National Health Information Platform**
HISO	**Heath Information Security Framework**
HQSC	**Health, Quality and Safety Commission**
HR	**Human Resources**
HRC	**Health Research Council**
HRIS	**Human Resources Information System**
HROD	**Human Resources and Organisational Development**
HSWA	**Health and Safety at Work Act**
Hui	**Formal meeting**
HV	**High Voltage**
HVAC	**Heating, Ventilation and Air Conditioning**
HVDHB	**Hutt Valley District Health Board**

HWIP	**Health Workforce Information Programme**
HWNZ	**Health Workforce New Zealand**
IA	**Internal Audit**
IAAS	**Infrastructure as a Service**
IAP	**Incident Action Plans**
ICNet	**Infection Control Surveillance**
ICPs	**Incident Control Points**
ICPSA	**Integrated Community Pharmacy Services Agreement**
ICT	**Information and Communications Technology**
ICU	**Intensive Care Unit**
IDF	**Inter-district Flow** The default way that funding follows a patient around the health system irrespective of where the are treated.
IEA	**Individual Employment Agreement**
IFHC	**Integrated Family Health Centre** General practice teams with the patient at the centre, providing quality health care when, where and how patients need it.
IFM / IFM20	**Integrated Facilities Management**
IL	**Importance Level** Seismic assessment rating
IMAC	**Immunisation Advisory Centre**
IMT	**Incident Management Team**
Insourced	**Delivered directly by the DHBs via its staff**
IOC	**Integrated Operations Centre**
IOL	**Intraocular Lens**
IOT	**Internet of Things**

IPSAS	**International Public Sector Accounting Standards**
IS	**Information Systems**
ISM	**Integrated Service Model**
ISP	**Internet Service Provider**
IT	**Information Technology/Digital Services**
ITSM	**Integrated Service Module**
IV	**Intravenous**
IVP	**Improving Value Programme**
JDE	**JD Edwards** Name of software package
Ka Ao Ka Awatea	**Māori Health Strategy for the MDHB District**
KPI(s)	**Key Performance Indicator(s)** A measurable value that demonstrates how effectively an objective is being achieved.
LAN	**Local Area Network**
LDC	**Local Data Council**
LED	**Light Emitting Diode**
LEO	**Leading an Empowered Organisation**
LMC	**Lead Maternity Carer**
LOS	**Length of Stay**
LSP	**Leadership Success Profile**
LTC	**Long Term Condition(s)**
LV	**Low Voltage**
MALT	**Māori Alliance Leadership Team**
MAPU	**Medical Assessment and Planning Unit**
MBIE	**Ministry of Business, Innovation and Employment**

MCH	**MidCentral Health**
MCIS	**Maternity Clinical Information Service**
MDBI	**Material Damage and Business Interruption**
MDHB	**MidCentral District Health Board**
MDM	**Master Data Management**
MDT	**Multi-disciplinary Team**
MECAs	**Multi Employer Collective Agreements**
MEED	**Midwifery External Education and Development Committee**
MERAS	**Midwifery Employee Representation and Advisory Service**
MFA	**Multi-Factor Authentication**
MIT	**Medical Imaging Technologist** A radiographer who works with technology to produce X-rays, CT scans, MRI scans and other medical images.
MIYA	**MIYA Precision Platform**
MoH	**Ministry of Health**
MOU	**Memorandum of Understanding**
MRES	**Managed Rehabilitation Equipment Service** An ACC contract (Enable NZ)
MRI	**Magnetic Resonance Imaging** A medical imaging technique used in radiology to form pictures of the anatomy using strong magnetic fields and radio waves.
MRSO	**Medical Radiation Officer**
MRT	**Medical Radiation Therapist(s)**
MSD	**Ministry of Social Development**
MWH	**Manawhenua Hauora**
MYFP	**Midwifery First Year of Practice Programme**

NAMD	**Neovascular Age-Related Macular Degeneration**
NARP	**Non-Acute Rehabilitation Programme**
NBSP	**National Bowel Screening Programme**
NCAMP19	**National Collections Annual Maintenance Programme 2019**
NCEA	**National Certificate of Educational Achievement**
NCNZ	**Nursing Council of New Zealand**
NEAC	**National Ethics Advisory Committee**
NEED	**Nursing External Education and Development Committee**
NESP	**Nurse Entry to Specialty Practice Programme (Mental Health)**
NETP	**Nurse Entry to Practice**
NFSA	**National Food Services Agreement**
NGO	**Non Government Organisation**
NHAWG	**National Holidays Act Working Group**
NNU	**Neo Natal Unit**
NOS	**National Oracle Solution**
NP	**Nurse Practitioner**
NPC	**Nurse Practitioner Candidate**
NPTP	**Nurse Practitioner Training Programme**
NZ	**New Zealand**
NZCOM	**New Zealand College of Midwives**
NZCPHCN	**New Zealand College of Primary Health Care Nurses**
NZCRMP	**New Zealand Code of Radiology Management Practice**
NZD	**New Zealand Dollar**
NZHP	**New Zealand Health Partnerships**

NZHRS	**New Zealand Health Research Strategy**
NZNO	**New Zealand Nurses Organisation**
NZPHD Act	**New Zealand Public Health and Disability Act**
O&G	**Obstetrics and Gynaecology**
OAG	**Office of the Auditor-General**
OD	**Organisational Development**
ODP	**Organisational Development Plan**
OE	**Operations Executive** (of a service)
OHS	**Occupational Health and Safety**
OLT	**Organisational Leadership Team** OLT comprises all General Managers, Chief Medical Officer, Executive Directors - Nursing & Midwifery and Allied Health, General Manager of Enable NZ, all Operations Executives and Clinical Executives.
OPAL	**Older People's Acute Assessment and Liaison Unit**
OPERA	**Older People's Rapid Assessment**
OPF	**Operational Policy Framework**
Outsourced	**Contracted to a third-party provider to deliver**
PaaS	**Platform as a Service**
Pae Ora Paiaka Whaiora	**(Base/Platform of health) Healthy Futures (DHB Māori Directorate)**
PACS	**Picture Archiving Communication System**
PANE	**Proactive, Advocacy, Navigation and Education Team**
PAS	**Patient Administration System**
PBE	**Public Sector Benefit Entity**
PCBU	**Person Conducting a Business or Undertaking**
PCCL	**Patient Complexity Clinical Level**

PCT	**Pharmacy Cancer Treatment**
PDRP	**Professional Development and Recognition Programme**
PDSA	**Plan Do Study Act**
PEDAL	**Post Emergency Department Assessment Liaison**
PET	**Positron Emission Tomography**
PHC	**Primary Health Care**
PHO	**Primary Health Organisation (THINK Hauora)**
PHU	**Public Health Unit**
PICC	**Peripherally Inserted Central Catheter**
PICU	**Paediatric Intensive Care Unit**
PIN	**Provisional Improvement Notice** (section 36.2 Health and Safety at Work Act 2015)
PIP	**Performance Improvement Plan** This plan is designed to support the OLT in the prioritisation and optimisation of system wide efforts to achieve our vision. The plan was presented to the MoH as part of MDHB's 2019/20 strategic discussion.
PNCC	**Palmerston North City Council**
POAC	**Primary Options for Acute Care**
POCT	**Point of Care Testing**
PPE	**Personal Protective Equipment**
Powhiri	**Formal Māori Welcome**
PPA	**Promoting Professional Accountability**
PPC	**Public, Primary and Community**
PP&CH	**Public, Primary and Community Health**
PPPR	**Protection of Personal and Property Rights**
PR&RO	**Principal Risk and Resilience Officer**

PSA	**Public Service Association**
PSe	**PS Enterprise**
PSR	**Protective Security Requirements**
PVC	**Poly Vinyl Chloride**
QEAC	**Quality & Excellence Advisory Committee**
QHP	**Qualified Health Plan**
Qlik	**Qlik Sense Data Visualisation Software (Dashboard Analytics)**
Q&SM	**Quality and Safety Markers**
RACMA	**Royal Australasian College of Medical Administrators**
RDHS	**Regional Digital Health Services**
RFP	**Request for Proposal**
RHIP	**Regional Health Infometrics Programme** Provides a centralised platform to improve access to patient data in the central region.
Risk ID	**Risk Identifer**
RM	**Registered Midwife**
RMO	**Resident Medical Officer**
RN	**Registered Nurse(s)**
RP	**Risk Priority**
RSI	**Relative Stay Index**
RSO	**Research Support Officer**
RSP	**Regional Service Plan**
RTL	**Round Trip Logistics** A technology platform.
Rules	**Government Procurement Rules (4th Edition 2019)**
SaaS	**Software as a Service**

SAC	**Severity Assessment Code**
SAN	**Storage Area Network**
SBA	**Smoking Brief Advice (Smoking Cessation)**
SCIG	**Strategic Capital Investment Group**
SFIA	**Skills Framework for the Information Age**
SGOC	**Shared Goals of Care**
SIEM	**Security Information Event Monitoring**
SLA	**Service Level Agreement**
SLMs	**System Level Measures**
SME	**Subject Matter Expert(s)**
SMO	**Senior Medical Officer**
SNE	**Services Not Engaged**
SOI	**Statement of Intent**
SOR	**Standard Operating Responses**
SPE	**Statement of Performance Expectations**
SPIRE	**Surgical Procedural Interventional Recovery Expansion** A project to establish additional procedural, interventional and surgical resources within MDHB.
Spotless	**Spotless Services (NZ) Limited**
SRG	**Shareholder's Review Group**
SSC	**State Services Commission** (from 2020 - Te Kawa Mataaho Public Service Commission)
SSDF	**State Sector Decarbonisation Fund**
SSHW	**Safe Staffing, Healthy Workplaces**
SSIED	**Shorter Stays in Emergency Department**
SSP	**Statement of Service Performance**

SSU	**Sterile Supply Unit**
SUDI	**Sudden Unexpected Death in Infancy**
SUG	**Space Utilisation Group**
STAR	**Services for Treatment, Assessment and Rehabiliation**
TAS	**Technical Advisory Services** (also CTAS)
TCO	**Total Cost of Ownership**
tC02e	**tons of carbon dioxide equivalent**
TCU	**Transitional Care Unit**
THG	**Tararua Health Group Limited**
TKMPSC	**Te Kawa Maataho Public Service Commission** (formerly State Services Commission)
TLP	**Transformational Leadership Programme**
Trendly	A national database capture tool and dashboard that focuses on the measurement of DHBs to the National Māori Health Measures
TTOR	**Te Tihi o Ruahine Whānau Ora Alliance**
UCOL	**Universal College of Learning**
VBS	**Voluntary Bonding Scheme**
VRM	**Variance Response Management**
WDHB	**Whanganui District Health Board**
WebPAS	**Web Based Patient Administration System**
WebPASaas	**Web Based Patient Administration System as a Service**
WHEI	**Whole Hospital Escalation Indicators**
Y	**Yes**
YD	**Yes and delegable**
YOSS	**Youth One Stop Shop**

YTD	Year To Date

Late items

1 March 2022 HDAC

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Late items

Discussion on any late items advised at the start of the meeting

Date of next meeting

1 March 2022 HDAC

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Date of next meeting

Tuesday, 24 May 2022

Exclusion of the public

1 March 2022 HDAC

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Exclusion of public

Resolution:

That the public be excluded from this meeting in accordance with the Official Information Act 1992, section 9 for the items and reasons outlined in the agenda.