MidCentral District Health Board

Te Pae Hauora o Ruahine o Tararua

# Part One HDAC Pack

*14 September HDAC*

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

# Contents

# Agenda and karakia

*14 September HDAC*

*Printed from Stellar by*
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# MidCentral District Health Board

## Health and Disability Advisory Committee Meeting

**Venue:** via Zoom

**When**: Tuesday 14 September 2021, from 9.00am

## PART ONE

### Members

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

### Apology

Brendan Duffy

### In attendance

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

### In attendance (part meeting)

| | |
|---|---|
| Item 3.1 | Lyn Horgan, Operations Executive, Te Uru Arotau and Dr Jeff Brown, Clinical Executive, Te Uru Pā Harakeke |
| Item 4 | Operations and Clinical Executives: Scott Ambridge, Dr Jeff Brown, Debbie Davies, Sarah Fenwick, Dr Claire Hardie, Lyn Horgan, Dr Syed Zaman |
| Item 5.1 | Michelle Riwai, General Manager, Enable New Zealand |
| Item 6.1 | Dr Claire Hardie, Clinical Executive, Te Uru Mātai Matengau |
| Item 6.3 | Sarah Fenwick, Operations Executive and Dr Jeff Brown, Clinical Executive, Te Uru Pā Harakeke |
| Items 6.4 and 6.5 | Kelly Isles, Director of Strategy, Planning and Accountability |
| Item 7.1 | 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 – 13 July 2021, Part One

2.5. Matters arising

**3. STRATEGIC FOCUS** 9.10

3.1 Regional Specialist Services Integration

**4. DIRECTORATE WITH CLUSTER FUNCTIONS REPORTING** 9.35

4.1. Directorate Dashboard

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

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

4.4. Te Uru Arotau – Acute and Elective Specialist Services

4.5. Te Uru Whakamauora – Healthy Ageing and Rehabilitation

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

4.7 Te Uru Rauhī – Mental Health and Addiction Services

**REFRESHMENT BREAK** 10.15

**5. PERFORMANCE REPORTING** 10.25

5.1. Enable New Zealand Report

5.2. Pae Ora Paiaka Whaiora Report

**6. DISCUSSION/DECISION PAPERS** 10.40

6.1. End of Life Choice Act – MidCentral District Health Board's preparation for implementation

6.2. Quality and Safety Dashboard

6.3. Equity Dashboard – Child and Youth Health Indicators

6.4. Regional Services Plan Implementation – Quarter Four

6.5. COVID-19 Delta Resurgence

**7. INFORMATION PAPERS** 11.20

*Information papers for the Board to note*

7.1. Locality Plan Progress Report – Horowhenua

7.2. Committee's Work Programme

**8. GLOSSARY OF TERMS**

**9. LATE ITEMS**

**10. DATE OF NEXT MEETING** – Tuesday 23 November 2021

**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 13 July 2021 meeting held with the public present | |
| Serious Adverse Events (SAC 1) Report | To protect patient privacy | 9(2)(a) |

# Administrative matters

*14 September 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, 17 August 2021**

(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 |
| Dennison, Vaughan | 4.2.20 | Councillor – Palmerston North City Council |
| | 9.2.21 | Member of Palmerston North City Council Infrastructure Committee |
| 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 |
| 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 |
| 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 |

| **Register of Interests: Summary, 17 August 2021**<br>(Full Register of Interests available on Stellar Platform/Board/Board Reference Documents) | | |
|---|---|---|
| | 17.8.21 | Member, Māori Provider Expert Reference Group for Transitional Health Unit |
| Naylor, Karen | 6.12.10<br><br>9.10.16 | Employee – MidCentral DHB<br>Member and Workplace Delegate – NZ Nurses Organisation<br>Councillor – Palmerston North City Council |
| Paewai, Oriana | 1.5.10<br><br>13.6.17<br><br><br><br>30.8.18<br>13.4.21<br>27.7.21 | Member – Te Runanga o Raukawa Governance Group<br>Chair – Manawhenua Hauora<br>Co-ordinating Chair – Te Whiti ki te Uru (Central Region DHB MRBs)<br>Member Nga Manu Taiko, a standing committee of the Council – Manawatu District Council<br>Member – Te Tihi o Ruahine Whānau Ora Alliance<br>Board Member – Cancer Society Manawatu<br>Appointed Member – Massey University Council<br>Trustee – Manawatū/Whanganui Children's Health Charitable Trust Board<br>Member – Governance Board, Mana Whaikaha |
| Waldon, John | 22.11.18<br><br><br><br>9.2.21 | Co-director and co-owner – Churchyard Physiotherapy Ltd<br>Co-director and researcher – 2 Tama Limited<br>Manawatu District President – Cancer Society<br>Executive Committee Central Districts (rep for Manawatu, 1 of 2) – Cancer Society<br>Has a contract with UCOL |
| Warren, Jenny | 6.11.19<br><br><br>12.2.21<br>1.7.21 | Team Leader Bumps to Babies – Barnardos New Zealand<br>Consumer Representatives National Executive Committee – National On Track Network<br>Pregnancy and Parenting Education Contractor – Palmerston North Parents' Centre<br>Member of Locality Advisory Group for both Tararua and Ōtaki/Horowhenua for the Primary Maternity Project<br>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) |
| **Committee Members** | | |
| Allan, Simon (FRAC) | 2.6.20 | Deputy Chair – Manawatu Branch of Cancer Society<br>MDHB Rep – THINK Hauora<br>Palliative Care Advisory Panel (Ministry of Health advisory body)<br>Director of Palliative Care – Arohanui Hospice<br>Chair of Board – Manawatu Badminton Association |

| **Register of Interests: Summary, 17 August 2021**<br>(Full Register of Interests available on Stellar Platform/Board/Board Reference Documents) | | |
|---|---|---|
| Hartevelt, Tony (FRAC) | 14.8.16<br>14.8.16<br>14.8.16<br>7.10.19 | Independent Director – Otaki Family Medicine Ltd<br>Elder son is Director, Global Oncology Policy based at Head Office, USA – Merck Sharpe & Dohme (Merck) (NZ operations for Global Pharmaceutical Company)<br>Younger son is news director for Stuff.co.nz – Fairfax Media<br>Independent Chair, PSAAP's Primary Care Caucus – Primary Health Organisational Service Agreement Amendment Protocol (PSAAP) |
| Munro, Gail<br>(HDAC) | 23.3.21 | Director – Eastern and Central Trust 2020<br>Governance Strategies Ltd 2007 |
| **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)<br>Coordinator for the Indigenous Health Programme – RACMA<br>Member of the Rural Policy Advisory Group – RACMA<br>Fellow of the Australasian College of Health Service Managers (ACHSM) |
| Bradnock, Barb | 26.8.10 | Nil |
| Brogden, Greg | 16.2.16 | Nil |
| Brown, Jeff | | TBA |
| Caldwell, Vanessa | 7.5.18 | Nil |
| Catherwood, Judith | 1.5.18 | Nil |
| Davies, Deborah | 18.5.18 | Member, Alliance Leadership Team – Central PHO<br>Daughter is an employee and works within hospital services – MidCentral DHB |
| Eves, Celina | 14.5.18<br>20.4.20 | Owner personal consulting company, UK – Celina Eves Limited (2020 moved into dormancy)<br>Trustee – Palmerston North Medical Trust |
| Fenwick, Sarah | 13.8.18 | Nil |
| Free, Jennifer | 6.8.20 | Nil |
| Hansen, Chiquita | 9.2.16<br><br>3.3.21 | Employed by MDHB and seconded to Central PHO 8/10ths – MidCentral DHB<br>CEO – Central PHO<br>Employed by THINK Hauora as Chief Executive and seconded to MidCentral DHB as Interim General Manager, Strategy, Planning and Performance 6/10ths<br>Husband is employed by MidCentral DHB<br>Executive member of General Practice New Zealand (GPNZ) |

| **Register of Interests: Summary, 17 August 2021**<br>(Full Register of Interests available on Stellar Platform/Board/Board Reference Documents) | | |
|---|---|---|
| | | Executive member of Health Care Home Collaborative |
| Hardie, Claire | 13.8.18<br>13.8.18<br>13.8.18 | Member – Royal Australian & NZ College of Radiologists<br>Trustee – Palmerston North Hospital Regional Cancer Treatment Trust Inc<br>Member, Medical Advisory Committee – NZ Breast Cancer Foundation |
| Horgan, Lyn | 1.5.17<br>18.5.18 | Sister is Coroner based in Wellington – Coronial Services<br>Member, Alliance Leadership Team – Central PHO |
| Howe, Jonathon | 1.8.19 | Nil |
| Matthews, Rory | 20.8.20 | Managing Partner, FGI (NZ) Ltd trading as Francis Health<br>Trustee/Director Te Hopai Home and Hospital Ltd |
| Miller, Steve | 18.4.17<br>26.2.19<br>6.3.19<br>1.10.19 | Director. Farming business – Puriri Trust and Puriri Farm Partnerships<br>Board Member, Member, Conporto Health Board Patient's First trading arm – Patients First<br>Member, Alliance Leadership Team, Member, Information Governance Group – Central PHO<br>Chair – National DHB Digital Investment Board |
| Ratana, Darryl | 29.5.19 | Nil |
| Russell, Greig | 3.10.16 | Minority shareholder – City Doctors<br>Member, Education Committee – NZ Medical Council |
| Scott, Gabrielle | Dec 19 | 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 | Feb 19 | Nil |
| Williamson, Nicki | Mar 20 | Nil |
| Zaman, Syed | 1.5.18 | Nil |

## Resolution

That the Part One minutes of the 13 July 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 13 July 2021 from 9.00am**

# PART ONE

**Members**

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

**Apologies**

Lew Findlay for the meeting.  Oriana Paewai, Materoa Mar and Karen Naylor for departing early.

**In attendance**

Kathryn Cook, Chief Executive; Kelvin Billinghurst, Chief Medical Officer; Judith Catherwood, General Manager, Quality and Innovation; Celina Eves, Executive Director, Nursing and Midwifery; Chiquita Hansen, Interim General Manager, Strategy, Planning and Performance; Gabrielle Scott, Executive Director, Allied Health; Tracee Te Huia, General Manager, Māori Health; Kerry Hunt, Executive Assistant.

**In attendance (part meeting)**

Scott Ambridge, Operations Executive, Te Uru Rauhī; Keyur Anjaria, General Manager, People and Culture; Dr Jeff Brown, Clinical Executive, Te Uru Pā Harakeke; Dr Vanessa Caldwell, Clinical Executive, Te Uru Rauhī; Mariette Classen, Consumer Experience Manager; Sarah Fenwick, Operations Executive, Te Pā Harakeke; Claire Hardie, Clinical Executive, Te Uru Mātai Matengau; Lyn Horgan, Operations Executive, Te Uru Arotau; Kelly Isles, Director of Strategy; Angela Rainham, Locality and Intersectoral Development Manager; Michalle Riwai, General Manager, Enable New Zealand, Alison Russell, Planning and Integration Lead, Te Uru Kiriora; Dr Syed Zaman, Clinical Executive, Te Uru Whakamauora.

Media – 1; Public – 0

## 1. KARAKIA

The meeting opened with the organisational karakia.

## 2. ADMINISTRATIVE MATTERS

### 2.1. Apologies

An apology from Lew Findlay was received and accepted. An apology was received from Materoa Mar and Karen Naylor who departed the meeting at 11.45am and noon respectively.

### 2.2. Late items

A late item was received for Part Two of the agenda – Provisional Suspected Suicide Statistics MidCentral DHB.

### 2.3. Register of Interests Update

The following updates to the Register of Interests were advised.

Heather Browning

*Add*

- Member, Support and Consultation for End of Life Choice in New Zealand (SCENZ) Group.

Materoa Mar

*Add*

- Member, Te Ahu Whenua Māori Land Trust

### 2.4. Minutes of the 27 April 2021 meeting, Part One

It was resolved that:

> *the Part One minutes of the 27 April 2021 Health and Disability Advisory Committee meeting be approved as a true and correct record.*
>
> *(Moved John Waldon; seconded Materoa Mar)*

### 2.5. Matters arising from previous minutes

No discussion.

## 3. STRATEGIC FOCUS

### 3.1. Disability Service Strategic Direction

The Executive Director Allied Health and the General Manager, Enable New Zealand presented a Disability Sector Overview.

A review of the disability support system is due in September 2021 as the Government has requested further advice on this component of the health and disability system.

Health and Disability Advisory Committee (HDAC) members acknowledged the passing of Maxine Dale, who was pivotal in co-designing and supporting the Enabling Good Lives rollout within the MidCentral DHB region.

In response to a question it was acknowledged that there are still considerable inequities for Māori in the disability sector. It is hoped that this will be addressed by the current health reforms and the formation of the Māori Health Authority.

It was resolved that the Committee:

*note the presentation on the strategic direction for disability services*

*endorse the direction of disability services.*

*(Moved Muriel Hancock; seconded Vaughan Dennison)*

## 4. DIRECTORATE WITH CLUSTER FUNCTIONS REPORTING

### 4.1. Directorate Dashboard

The Operations Executive, Te Uru Arotau presented this report, which was taken as read.

It was resolved that the Committee:

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

*(Moved John Waldon; seconded Karen Naylor)*

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

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

It was confirmed that the risk identified with the Mosaiq move to a cloud-based solution has been mitigated by resource allocation signoff.

The Clinical Executive gave an update on the status of both Taranaki and Hawke's Bay DHB business cases for their capital investment projects.

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

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

Midwifery services are recruiting a permanent Director of Midwifery and implementing the change paper with strengthened midwifery leadership positions.

Tūngia te Ururua project has not yet received sufficient input from Māori and Pasifika, in part because of their necessary focus on COVID-19 vaccination. The timeframe for the project has been extended to ensure engagement and responses are as representative of our population as possible.

In response to a question the Operations Executive confirmed that MDHB has been involved with the Police to strengthen the Family Violence Intervention Programme.

In response to a question about the surcharges for obstetric ultrasound by private providers, the Operations Executive agreed that more would be done to communicate the availability of private providers who do not surcharge for some women such as Community Service Cardholders.

### 4.4. Te Uru Whakamauora – Healthy Ageing and Rehabilitation

The Clinical Executive, Te Uru Whakamauora presented this report, which was taken as read. The departure of the Directorate's Operations Executive, Andrew Nwosu, was noted.

A 12-week pilot for the provision of community stroke rehabilitation services has commenced. This will allow some patients to be able to access rehabilitation services in their own homes. Results of the pilot should be available by the next HDAC meeting.

In response to a question about wait times for SupportLinks assessments, it was confirmed that the increase in wait times was due to staff vacancies. Recruitment is being actively pursued which should lead to a reduction in wait times. The Committee was reassured that pending full assessment, clients are being offered Packages of Temporary Support (PoTS) and access to respite care.

HDAC members acknowledged and congratulated the Te Uru Whakamauora team on the letter of compliment received from the Ombudsman's office on the environmental improvements on the STAR 1 unit since the Ombudsman's inspection in 2020.

### 4.5. Te Uru Rauhī – Mental Health and Addiction Services

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

The Operations Executive confirmed that the paper on the Horowhenua Community step-up service was delayed due to the budgeting process. The paper will be presented to the Board in August for approval.

There was strong support for the Integrated Model of Care proposal, with 62 submissions received from staff and unions.

In response to a question about the escalation in Did not Attends (DNAs) the Operations Executive confirmed that alternative options for appointments via phone or Zoom will be considered as part of the implementation of the Integrated Model of Care as it provides clients with flexibility to be able to keep appointments. Further, under the new Integrated Model of Care the service will be able to offer after hours appointments which will increase service access.

In response to a question there was confirmation that an Acute Mental Health Unit design session will be held with the Board at their 17 August 2021 meeting. The 2021/22 budget provision for extra staff will avoid staff undertaking double shifts in Ward 21.

### 4.6. Te Uru Arotau – Acute and Elective Specialist Services

The Operations Executive, Te Uru Arotau presented this report, which was taken as read.

The acute patient demand is a national issue coupled with the additional respiratory illness which is prevalent in the community. The Operations Executive explained how the Transitory Care Unit is being utilised to cope with the current demands in the hospital.

The Clinical Executive, Te Uru Mātai Matengau gave an update on Telehealth Working Group. Telehealth implementation is progressing and will be introduced across other directorates.

In response to questions on the unmet need/Did Not Waits in the Emergency Department, it was confirmed that the Emergency Department data will have a more detailed focus in future HDAC reporting.

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

The Clinical Executive and the Planning and Integration Lead, Te Uru Kiriora presented this report, which was taken as read.

In response to a question about how the public knows where they can enrol with a General Practitioner (GP) due to a shortage of GPs in the Horowhenua and Foxton areas, the Clinical Executive will take this issue back to discuss with the team. It was noted that the information is regularly updated on the THINK Hauora website. It was suggested that THINK Hauora be invited to a future meeting to have a discussion around GP availability.

In response to a question the Planning and Integration Lead, Te Uru Kiriora confirmed that the ethnicity and locality information of the COVID-19 vaccine rollout in the region could be put up on the website.

## 5. PERFORMANCE REPORTING

### 5.1. Enable New Zealand Report

The General Manager, Enable New Zealand spoke to the paper.

The volume of clients is increasing each month, and a plan to address the pressure on service has been developed.

HDAC Committee members congratulated the General Manager on the great work Enable is doing.

It was resolved that the Committee:

*endorse the Enable New Zealand Report to 31 May 2021.*

*(Moved John Waldon; seconded Materoa Mar)*

### 5.2. Pae Ora Paiaka Whaiora Report

The General Manager, Māori Health presented this report, which was taken as read. The General Manager said she was very proud of the other Directorates efforts toward Māori health evidenced in their reporting.

The Board and Manawhenua Hauora have now approved their shared work plan, and the team are currently developing the workplan related to the internal audit by Technical Advisory Services (TAS) on equity.

There has been high demand for Te Tiriti o Waitangi training with some Directorates funding additional training.

It was resolved that the Committee:

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

*(Moved Vaughan Dennison; seconded Materoa Mar)*

## 6. DISCUSSION/DECISION PAPERS

### 6.1. Clinical Governance and Quality Improvement Framework

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

It was resolved that the Committee:

*note the development and implementation of The Quality Agenda (Clinical Governance Framework) to date*

*note the development of the accompanying frameworks to support quality improvement and innovation*

*note the achievements in improving quality, safety, and clinical governance arrangements*

*endorse the proposal that future reporting on quality and safety programmes and improvement will be provided in the quarterly Quality Accounts, the Quality and Safety Dashboard and Directorate reports.*

*(Moved John Waldon; seconded Oriana Paewai)*

### 6.2. Māori Health Equity Dashboard – Te Ara Angitū Report – Mental Health and Addiction Services Adult Indicators

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

The Operations Executive will advise HDAC members of the number of responses to the online survey.

It was resolved that the Committee:

*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, Mental Health and Addiction Services Adult Indicators.*

*(Moved Materoa Mar; seconded Heather Browning)*

### 6.3. Māori Health Equity Dashboard Report – Workforce Indicators

The General Manager, People and Culture presented this report, which was taken as read. He noted that the target of Māori staff within MDHB has not been met and the appointment of the Senior Māori Workforce Development Officer should see the DHB make positive progress in this area.

There is a focus on increasing the attendance of medical staff in the cultural responsiveness and Te Tiriti o Waitangi training. Recruitment of women and Māori into senior medical roles is another area of focus. Following feedback from the Committee it was noted that the recruitment of 'women' and 'Māori' into senior medical roles should not be linked. There is a recruitment issue developing as numerous organisations wish to expand their Māori workforce.

There was discussion around pay parity and its impact on staffing across the sector. It was noted that DHBs have been asked by the Ministry of Health not to engage in discussion around pay parity as it was being handled nationally.

It was resolved that the Committee:

*note the progress made on workforce indicators identified for the 2020/21 year*

*note the analysis, discussion and proposed next steps to improve the current workforce indicators, and strengthen MidCentral District Health Board's commitment to Te Tiriti o Waitangi*

*endorse the Workforce Indicators report.*

*(Moved Muriel Hancock; seconded Karen Naylor)*

### 6.4. Regional Services Plan Implementation, Quarter 3 – 2020/21

The Director of Strategy, Planning and Performance presented this report, which was taken as read.

It was resolved that the Committee:

*note the final draft of the Regional Services Plan for 2020/21 was submitted to the Ministry of Health in December 2020 and has been formally approved by the Minister of Health*

*note there is no requirement to have a Regional Services Plan presented to the Minister for the 2021/22 year*

*note the progress made on implementing the central region's national and regional priority programmes for the third quarter of 2020/21.*

*(Moved Oriana Paewai; seconded Muriel Hancock)*

## 7. INFORMATION PAPERS

### 7.1. Locality Plan Progress Report – Ōtaki

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

There was discussion about the challenges of retaining migrant GPs due to difficulties in resolving residency issues, and agreement that this issue should be bought to the attention of the Ministry of Health. It was noted that the Ōtaki Health and Wellbeing Advisory Group has raised this issue with government agencies and representatives.

It was resolved that the Committee:

*Endorse that the Board consider writing to the Ministry of Health to highlight issues faced by migrant GPs in gaining residency.*

*(Moved John Waldon; seconded Karen Naylor)*

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

*(Moved Materoa Mar; seconded Muriel Hancock)*

Materoa Mar and Oriana Paewai left the meeting.

### 7.2. 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

A late item will be discussed in Part Two of the agenda – Provisional Suspected Suicide Statistics MidCentral DHB. It was noted that this item cannot be discussed in the Part One agenda due to the paper containing provisional data from the Coroner's Office which cannot be publicly released.

## 10. DATE OF NEXT MEETING

Tuesday, 14 September 2021 – 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 16 February 2021 meeting held with the public present | |
| Health and Disability System Review | To maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and officials | 9(2)(f)(iv) |
| Serious Adverse Events (SAC 1) | To protect patient privacy | 9(2)(a) |
| Consumer Story – Workshop | To protect patient privacy | 9(2)(a) |
| Provisional Suspected Suicide Statistics MidCentral DHB | To maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and officials | 9(2)(f)(iv) |

*(Moved Vaughan Dennison; seconded Lew Findlay)*

Part One of the meeting closed at 11.50am

Confirmed this 14th day of September 2021

……..

Committee Chair

## Health and Disability Advisory Committee – MidCentral DHB

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

| Matter | Raised | Scheduled | Responsibility | Form | Status |
|---|---|---|---|---|---|
| Invite THINK Hauora to future meeting to discuss GP availability | July 21 | Nov 21 | D Davies | Strategic discussion | Scheduled |
| 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 | Scheduled |
| 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 and ongoing | D Davies | Strategic discussion as required | Scheduled |
| **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 |

# Strategic focus

*14 September HDAC*

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


**For:**

| | |
|---|---|
| | Approval |
| | Endorsement |
| **X** | Noting |

**Key questions the Committee should consider in reviewing this paper:**

- Does this report clearly outline the progress made between MDHB and Wairarapa DHB for the Integrated Hub and Spoke Regional Service?
- Is there any additional information the Committee would seek in future updates?

| | |
|---|---|
| **To** | Health and Disability Advisory Committee |
| **Author** | Lyn Horgan, Operations Executive, Te Uru Arotau<br>Jeff Brown, Clinical Executive, Te Uru Pā Harakeke |
| **Endorsed by** | Kathryn Cook, Chief Executive |
| **Date** | 23 August 2021 |
| **Subject** | **Regional Service Integration Update** |

**RECOMMENDATION**

It is recommended that the Committee:

- **note** the progress report for the Regional Service Integration.

**Strategic Alignment**

This report is aligned to the DHB's strategy and regional priorities ahead of the transition to Health New Zealand.

## 1. PURPOSE

To provide the August 2021 update for the MidCentral District Health Board (MDHB) and Wairarapa DHB Service Integration for Specialist Services.

## 2. BACKGROUND

Work has continued between MDHB and Wairarapa DHB to deliver sustainable health services for our respective communities. The focus is to commit to a strong partnership-based sub-regional approach which will link with the MDHB and Whanganui DHB approach. The goals and objectives are to improve clinical and financial sustainability and provide better and closer services to patients in our communities.

## 3. REPORT HEADLINES

The report covers the following:

- The vision
- Concept of Regional Hospitals Network
- Integrated Hub and Spoke Regional Service
- Service Delivery Model
- Principles for service integration
- Specialty updates and next steps
- Risks and issues
- Workstream updates.

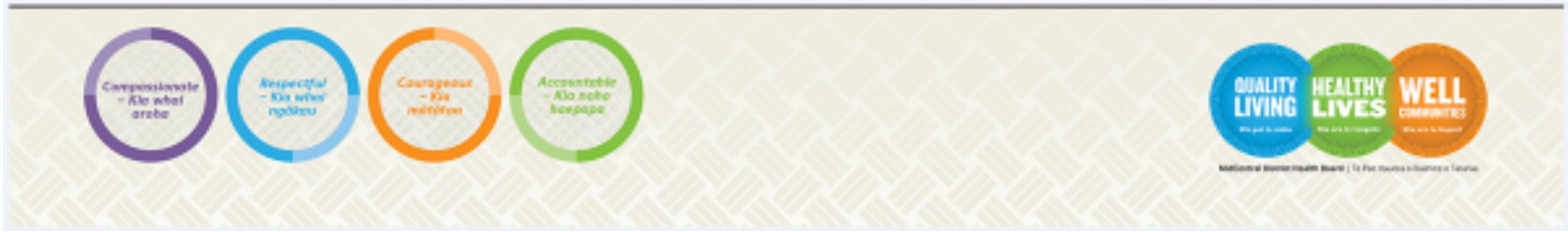
MidCentral DHB

# Service Integration Update

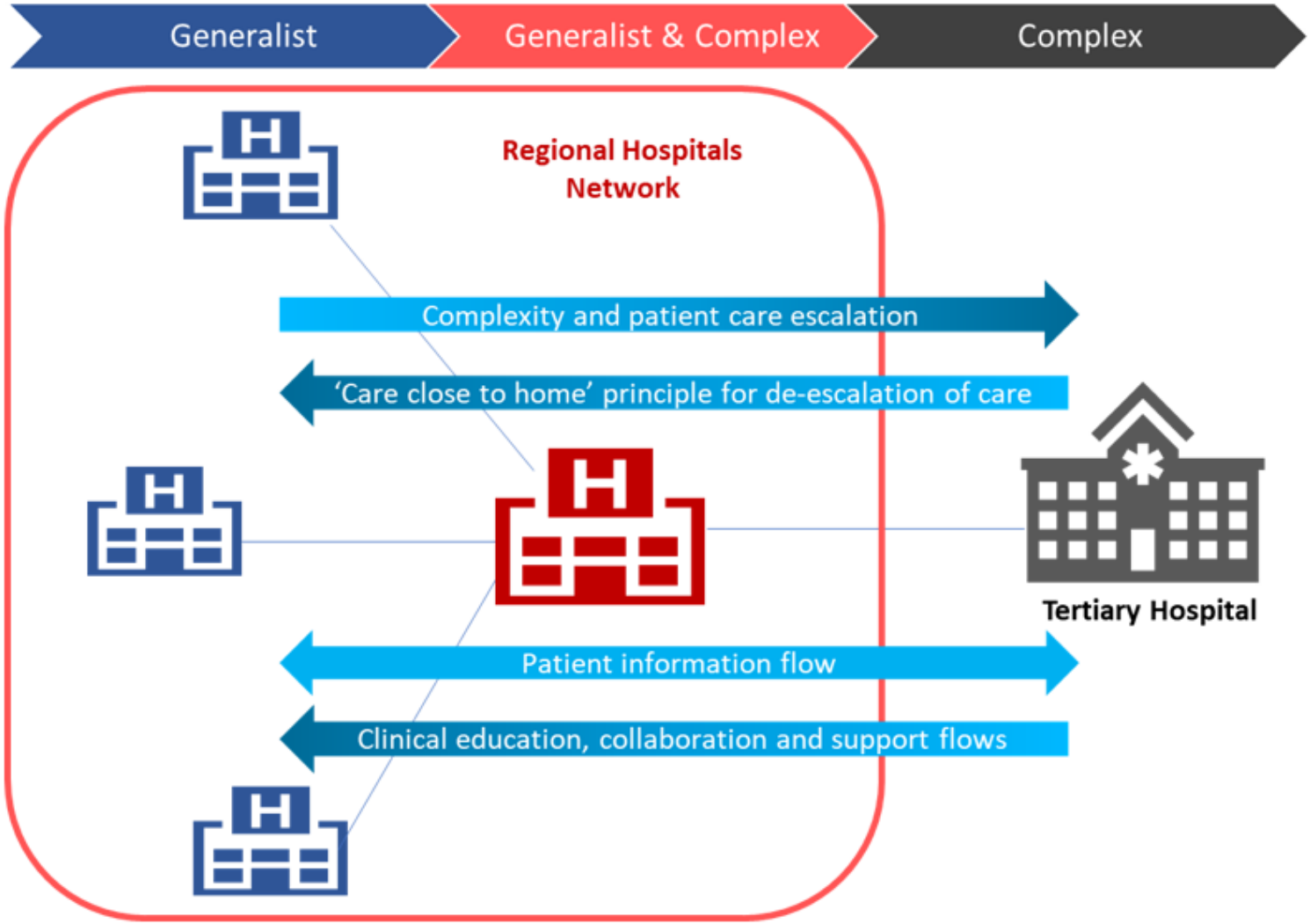
**August 2021**

# The Vision

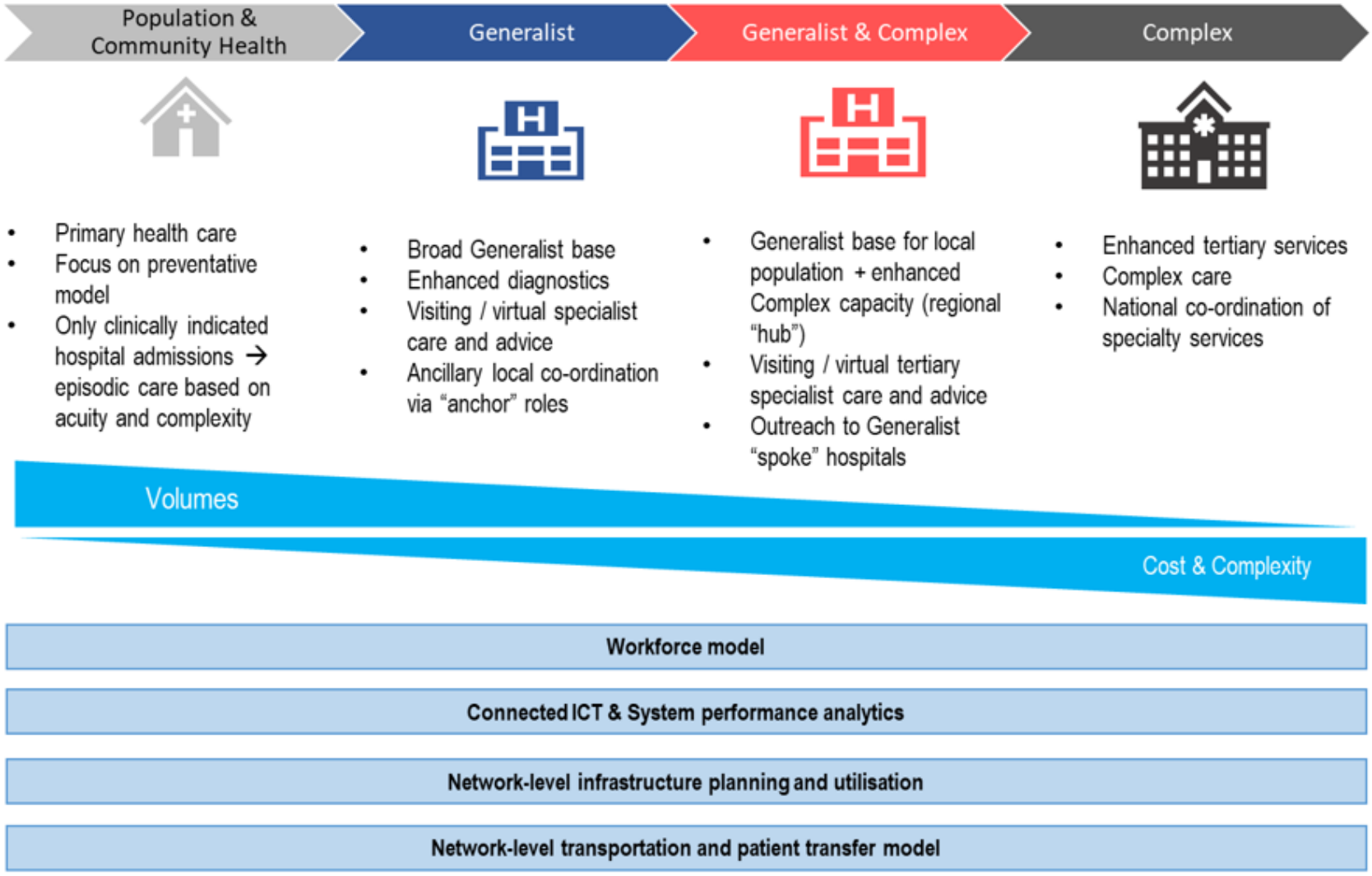
- **Improve equity of care** and **eliminate the 'postcode' lottery** at the level of secondary specialist services
- **Enhance service sustainability** by having a critical mass of population requiring specialist services
- **Improve financial sustainability** by optimising the use of workforce, facilities and resources, and by reducing duplication
- **Capitalise on the uptake of telehealth and digital health** that came out of the response to the Covid-19 pandemic, and drive the use of these delivery modes to support regional and rural service delivery
- **Strengthen specialist expertise, training and research opportunities** in our regions and enhance the relationships between surgeons
- **Balance the use of generalists and specialists** with a range of narrow to broad scopes of practice to provide safe, cost effective and equitable care



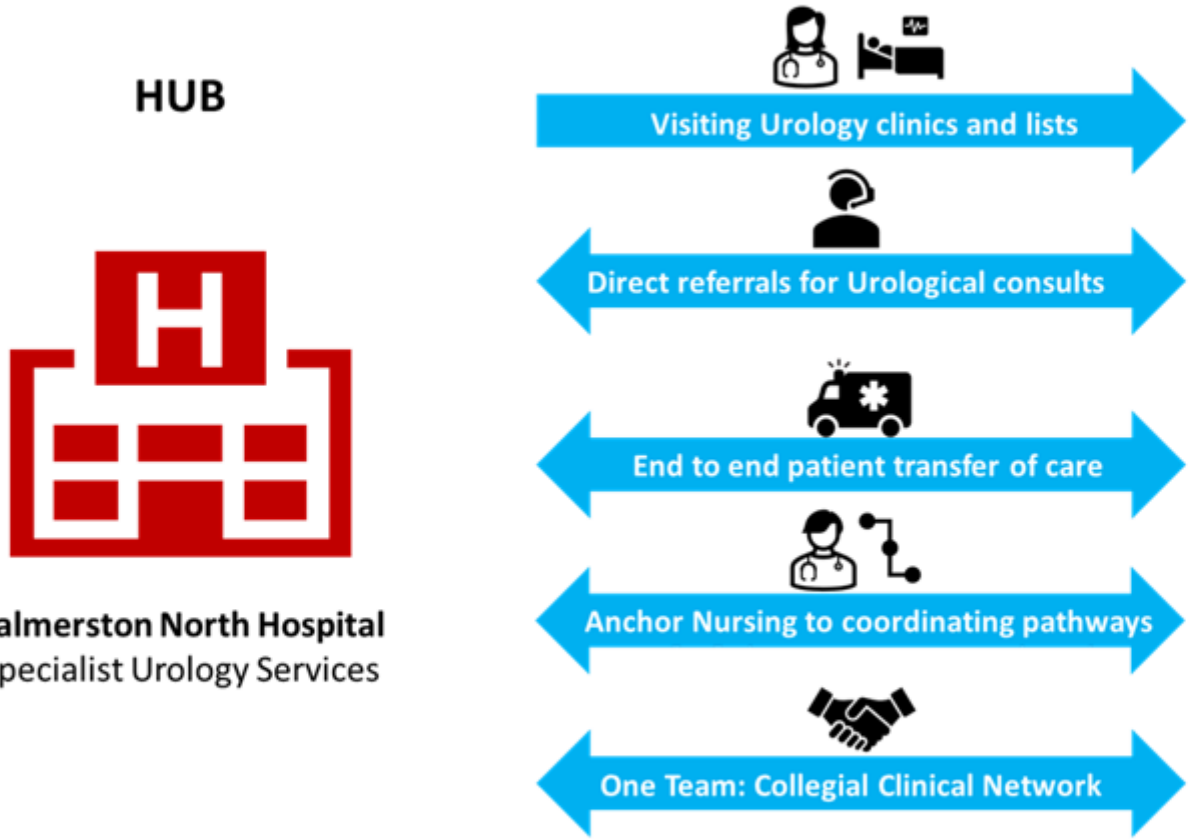
# Utilising generalists and specialists to deliver an integrated specialist service



# Integrated Hub and Spoke Regional Service



# Service Delivery Model

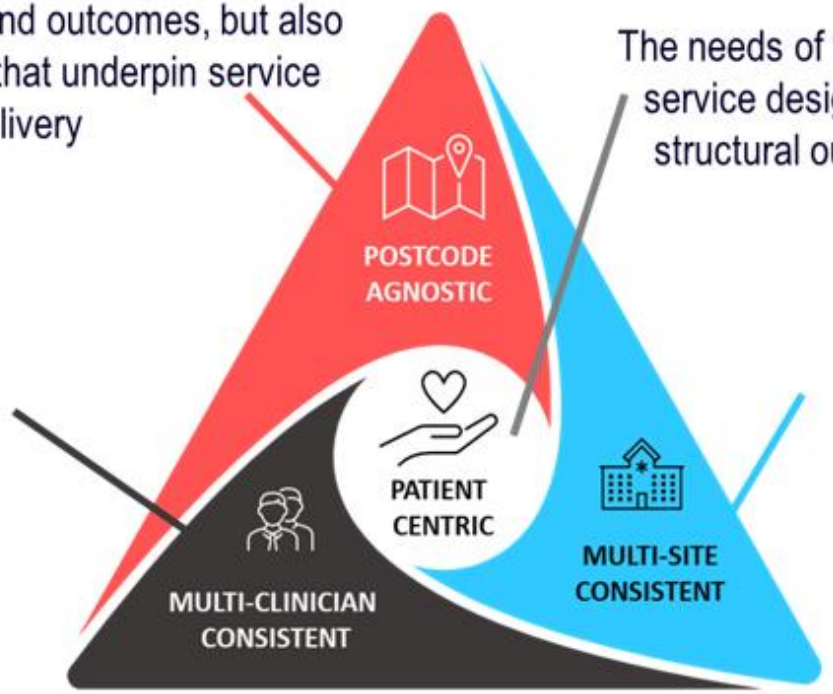



- Clinically driven governance accountable for the collective population
- Care is delivered to locality of patient's residence as the first option
- Consistent patient pathways that enable seamless transition between hub and spoke sites
- Accessible patient information for clinicians and integrated booking and scheduling capabilities

# Principles for service integration

Equitable access and outcomes, but also to the processes that underpin service delivery

The needs of the patients should drive service design, rather than existing structural our funding boundaries.




Clinical staff working within the service should have the same access to information and support systems regardless of where they are located at the point of access.

Across hospital sites, the processes and standards which drive service delivery are consistent.

# Specialty Updates

# Headlines – Urology

- Urology service integration white paper first draft completed and is being reviewed by urology specialists, Wairarapa general surgeons and operational leads
- Awaiting urology team to provide additional input into the whitepaper and endorsement before sharing with the executive team

- **Next steps**: present updated whitepaper with executive team for endorsement on regional model & high-level implementation plan

# Headlines – Orthopaedics

- **Wairarapa will be unable to run its orthopaedics service beyond August given the recent resignations of key SMOs**
- **The two orthopaedic surgeons remaining at Wairarapa hospital require supervision given they do not have vocational registration**
  - There is no immediate source of NZ vocational registered supervisors, but two potential part timers from CCDHB
  - There is one British-trained surgeon available from Australia who would need supervision
- **Wellington, Hutt and MidCentral have assumed on-call management of Wairarapa's orthopaedic acute patients on a weekly rotational basis as an immediate fix**
  - The immediate fix is not sustainable due to limited capacity of neighbouring hospitals and logistical challenges (IT, patient transfer and continuity of care)
  - Unclear how long this interim arrangement will be required, funded and resourced.
  - There is yet to be consensus on a medium term solution (whether regional or sub-regional)
- **Wairarapa has paused recruitment of their 1 FTE of vacant orthopaedic surgeons while the orthopaedic governance group explores interim (2022) and long-term (2023+) options for a regional service**
  - **Governance group consists of CCDHB, HVDHB**, MDHB and WDHB representatives

# Risks and Issues

- **IT integration:**
  - **Service integration relies on a level of IT access and standardisation** to ensure information is retrievable, standardised to appropriate level for clinical safety and does not impede service delivery.
  - Engaged with 3DHB CTO (Bryce O'Kane) and MDHB DCDO (Steve Miller) to develop interim solution to **enable IT access between 3DHB and MDHB – workaround in progress**
  - ***Risk that IT integration will not occur at pace required****; clinical support for integrated service model at risk without appropriate level of IT integration*
- **Recruitment of SMOs:**
  - **It can take a long time (6 – 12+ months)** to recruit new specialist SMOs
  - *Risk to service integration timelines if this is not initiated early*
- **Health reforms:**
  - Context under which the collaboration was initiated has changed, and may impact (positively or negatively) on integration efforts
  - ***Risk of disruption to collaborative programme***
  - *Propose doing a programme refresh at next face-to-face executive update*

# Workstream updates – Snapshot

| Updated 11/8/21 | Surgery<br>Clare French (Wai) & Alberto Ramirez-Rodriguez (MCH) | | | | | | Medicine<br>Niels Dugan (Wai) & Hagay Weinberg (MCH) | | |
|---|---|---|---|---|---|---|---|---|---|
| | **Urology** | **ENT** | **Gynae** | **Ophth** | **Ortho** | **Anaesthetics** | **Gastro** | **Renal** | **Paeds** |
| | MWW | MWW | MWai | MWW | MWW | | MWai | MWW | MWai |
| Primary aim | New integrated service | New integrated service | Expand initial collaboration | New integrated service incl. expanded NLS | Collegial arrangement<br>Regional service model | Alignment to enable surgical models | New integrated service | New integrated service with chairs in Masterton | Mentor – develop thinking of Community child health services |
| Wairarapa Clinical lead | Clare French | Clare French | **TBA** | **TBA** | Ian Stewart | Stephen Pearce | Niels Dugan | Niels Dugan | Andreas Leinfellner |
| MCH Clinical lead | Quinten King / John Crisp | Kumar Thangaraj | Pelle (Per) Kempe | Richard Holmes / John Ah Chan | Gert Starker | Terasa Bulger | James Irwin | Hagay Weinberg | Jeff Brown |
| Whanganui Clinical lead | | | | | | | | | |
| Progress / **Next steps** | - Draft white paper developed; reviewed by urology SMOs, Wairarapa clinicians and operational leads<br>- Feedback provided and draft model endorsed<br><br>**Next Steps:**<br>- **Urology team to endorse whitepaper**<br>- **Schedule Exec presentation once finalised** | - Had second meeting with Kumar. Discussed Urology model. Support in principle for service integration<br><br>**Next steps:**<br>– **Kieran to develop conceptual options for ENT model**<br>– **Send urology white paper and hold follow up meeting** | – No updates<br><br>**Next steps:**<br>– **Send urology white paper and schedule meeting to discuss** | – No updates<br><br>**Next steps:**<br>– **Send urology white paper and schedule meeting to discuss** | – Established regional ortho clinical governance group<br>– Developed options for interim and long term arrangements for WDHB ortho service<br>– **Next Steps: share model options with governance group**<br>– **West Coast DHB COO to share ortho arrangement** | – Anaesthetics model for integration discussed as part of urology model development<br><br>**Next steps:**<br>– **Send urology white paper and schedule meeting to discuss** | - Met with James 12th May<br><br>**Next steps:**<br>- **Kieran to send through gastro model options to James Irwin**<br>- **Send updated urology white paper and schedule meeting to discuss** | – **Pause** for now until other specialities progress | **Next Steps:**<br>– **Andreas and team from Wairarapa to visit MCDHB to look at community child health (24th August)** |

# Directorate with cluster functions reporting

*14 September 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 the dashboard provide insight and an overview of 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** | Sarah Fenwick, Operations Executive, Te Uru Pā Harakeke |
| **Endorsed by** | Kathryn Cook, Chief Executive |
| **Date** | 26 August 2021 |
| **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 the District Health Board's (DHB) strategy and the implementation of its Annual, Operational and Sustainability Plans, Locality and Directorate Health and Wellbeing Plans.

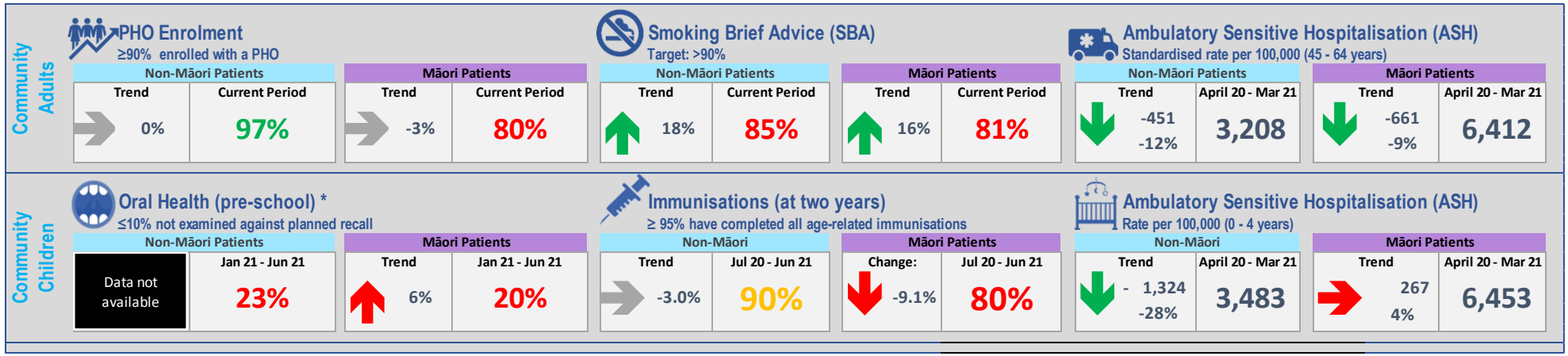
## 1. PURPOSE

To provide an 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 MidCentral DHB (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 the February 2021 Board Key Performance Indicators (KPI) dashboard and cover the period from 1 July 2020 to 31 July 2021 ('Current Period') unless specified differently within a particular metric. The directorate dashboard is in development and shows placeholders for future performance measures that will be included.

### *2.1 Primary and Community*




*Data not available: Oral Health Preschool data for Non–Māori is requested externally; work is underway to ensure that data gaps are addressed.*

MDHB is achieving the target for Primary Health Organisation (PHO) enrolment overall, however, remains behind for Māori enrolment. It is acknowledged that the number of General Practitioners across the rohe is limited and may be influencing the ability for whānau to enrol in a practice of their choice. A collaborative approach with THINK Hauora to ensure new enrolment is underway, with the purpose to make enrolment more streamlined and efficient, with a particular focus on Māori, recognising that the current process of enrolment is a barrier for Māori enrolment.

There has been improvement in the smoking brief advice indicator over this reporting period. Work continues to ensure sustained improvement.

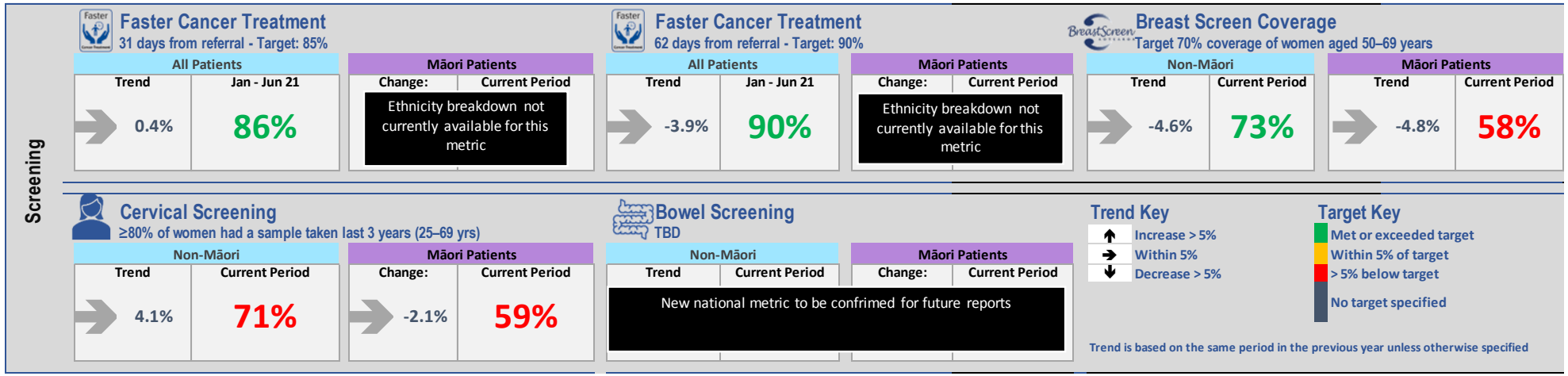
Over this six-month period, the arrears for the Child and Adolescent Oral Health (CAOH) Service have increased by six percent for Māori 0-4 year olds. Some success in reducing inequity has been achieved in keeping these arrears lower that the overall 0-4 year old population (20 percent versus 23 percent). For 2021, the CAOH Service has seen significant issues with sick leave and retirements causing a 20 percent reduction in the therapist workforce that has impacted on further improvement in arrears. Arrears and robust production planning will be a strong focus for the coming months.

On 28 June 2021 MDHB was one of 17 DHBs that received a letter from the Ministry of Health, outlining concerns regarding local childhood immunisation rates. MDHB provided a detailed plan in response, ensuring focus in the following areas:

- Review of data integrity to ensure robust ongoing plan
- Revised invitation and recall processes
- Ensuring sufficient vaccinator resource is focussed on childhood immunisations
- Increasing Outreach Immunisation Resource (OIS) and support
- Diversifying immunisation delivery within communities
- Focussed management of performance at and General Practice level, and
- Public communication and engagement linked to planned national communication, addressing safety and the importance of immunisation.

There has been an increase in the Ambulatory Sensitive Hospitalisation (ASH) rates for Tamariki Māori aged zero to four years, however, admission rates are relatively low, with MDHB overall remaining below the national average overall. Further information is provided in the Te Ara Angitū report.

## 2.2 *Screening*




Ethnicity Breakdown: Ethnocentric data is requested externally and followed up regularly however there is no timeline for when this will be available.
National Metric: The National Metric for bowel screening is yet to be confirmed.

The Tumour Stream Advisory groups are working towards improving the Ministry of Health set, 31-day and 62-day Faster Cancer Treatment (FCT) targets at MDHB. Each Tumour Stream reviews their specialty's FCT report including breaches to identify initiatives to improve their service and to increase the overall uptake of patients on to these pathways. Progress has already been made through the Breast Tumour Stream where an administrative initiative introduced in May 2021 to increase uptake on to the 62-day pathway has seen numbers increase in June and July 2021 compared to previous months. The Head and Neck Tumour Stream has made inroads in to improving FCT pathways by ensuring all head and neck diagnostic Magnetic Resonance Imaging (MRI) scans will be completed within two weeks of referral, where previously this had been within three weeks.

Breast Screen continue to actively invite unenrolled wāhine to attend for breast screening and, in partnership with the screening support services at Whakapai Hauora, offer incentives such as transport and koha to those wāhine who do not attend their first appointment. Monthly Pro-Equity huis have also recently been established to enable more focus on this mahi across the Breast Screening Service.

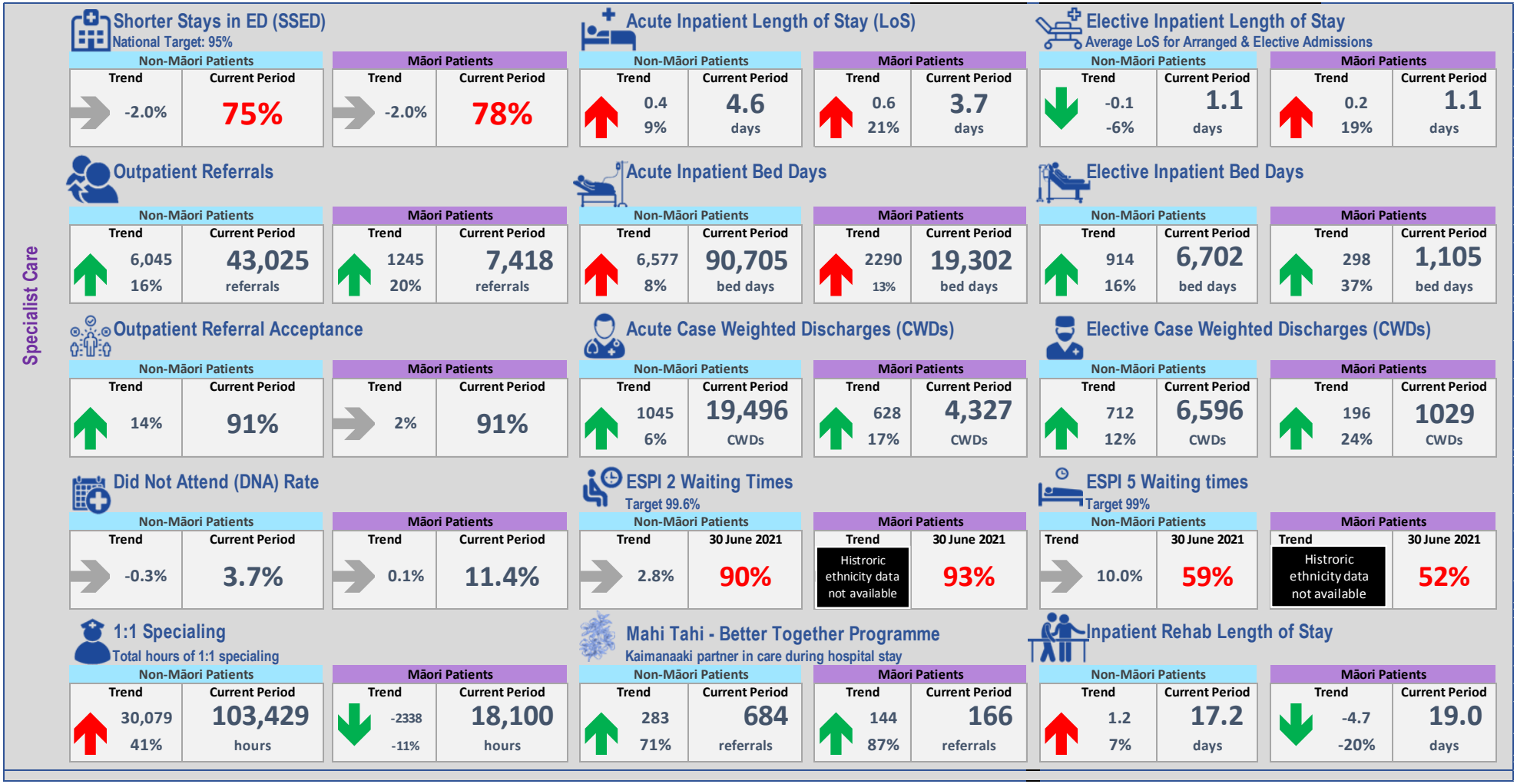
MDHB is performing below the national average for the percentage for Māori wāhine aged 25 to 69 years, who are eligible for cervical screening. The Cervical Screening Action Group (CSAG) 2020/21 plan has three key focus areas:

- Increase cervical screening coverage rates for Māori, Asian and Pacific wāhine to achieve and sustain equity.
- Strengthen relationships, collaboration and integration of services across the screening pathway, improving links with iwi/Māori providers and other groups that are well connected with priority wāhine.
- Sustain culturally responsive cervical screening capability and clinical standards.

To achieve these key focus areas a number of actions are underway, including increasing the number of skilled Māori cervical screeners and support staff; support and guidance for new cervical screeners; increasing the number of screens undertaken; increasing the capacity of skilled cervical screeners; increasing knowledge and awareness for wāhine in the importance of undertaking a colposcopy if required; having standardised processes developed and well communicated, and importantly positive feedback from our wāhine.

The Ka Ao Ka Awatea leadership group, established by THINK Hauora and Te Tihi, has a focus on equitable access to cervical screening for Māori.  Particular areas of focus for this group are the number of Māori smear takers across the district, the provision of cervical screening across the iwi and Māori provider network and removing barriers of access to cervical screening for Māori wāhine.  Training for new cervical screeners and kaimahi was completed March 2021. It is envisaged that it will take up to 12 months to catch up to pre COVID-19 screening rates before improvement can be expected.

## 2.3 *Specialist Care*




*Elective Services Patient Flow Indicators – there has been a system change to enable future data capture.*

Shorter Stays in Emergency Departments (SSIED) remains below target. There were 4357 presentations to the Emergency Department (ED) in June and 4288 in July. These are the two highest months of presentations in the last five years, impacting on performance.

There has been a notable increase with acute presentations for cardiovascular and respiratory disorders for both adult and paediatrics; including respiratory syncytial virus (RSV). ED and Paediatrics worked together to deal with increased children presenting to ED with RSV during June and July. Specifically, utilising the Children's Assessment Unit and at peak times providing Paediatric staffing resource in ED to fast track prioritised assessment and treatment. There was regular utilisation of Transitory Care Unit during June and July. Those services normally provided in this space were temporarily relocated.

Road trauma presentation continues above the monthly average of 33; with 54 in June and 35 in July.

Acute inpatient length of stay increased in this reporting period, impacted by high acuity. Te Uru Whakamauora has piloted a transition lounge initiative in the Older People's Acute Assessment and Liaison Unit (OPAL) Unit for patients cleared for discharge, enabling the bed they were occupying to be released for a new admission. Nine patients met the agreed criteria and benefits realised during the pilot included 15 hours additional bed capacity and increase in admissions to OPAL Unit Monday to Friday. The opportunity for a further six-week trial is being explored to determine if the model can deliver sufficient benefit to patient flow.

The overall elective inpatient length of stay remains stable, however the increase in elective inpatient length of stay for Māori patients is likely due to some complex procedures undertaken during this reporting period.

There is good progress in the Elective Services Performance Indicator (ESPI) 2 at the end of July 2021, with seven of 23 services now fully compliant, with no patients waiting greater than four months. Nineteen services have all patients allocated an appointment. The Directorate is on track to achieve the Ministry's agreed trajectories.

The ESPI 5 indicator remains static, impacted by acute demand in July, resulting in a total of 66 patients having their surgery deferred. Rebooking of these patients is a priority. The clinical teams continue to review all waiting lists to identify any clinical risk.

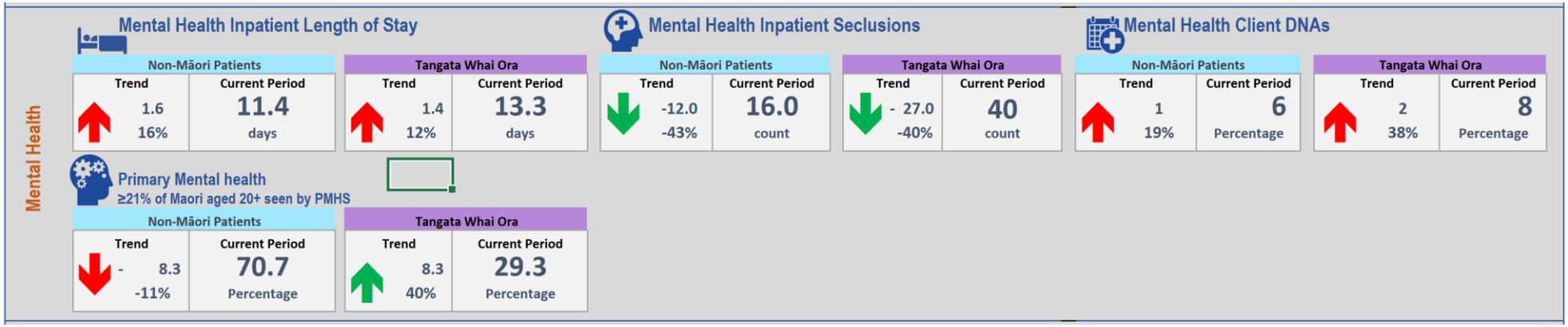
The service not engaged (SNE) rate for whānau Māori continues to be higher at 11.4 percent when compared with non-Māori at 3.7 percent. There are several initiatives in place or underway to support services to better engage with whānau Māori. These include, patient focused bookings, text reminders, utilising non-contact advice for General Practitioners and individuals, and clinics in the community.

A revised suite of referrer and patient letters supporting referral management, booking, and scheduling of outpatient appointments was launched in July 2021. These letters have been developed through a co-design process involving Pae Ora Paiaka Whaiora Hauora Māori, administration, clinicians, consumers, and Write NZ. Write NZ are specialists in creating clear readable documents and communications.

Specialing across Te Uru Whakamauora is above target for June and July. The increase in STAR 2 is due to a cohort of patients with advanced dementia who needed several days to adjust to the new environment, none of whom had family to assist with Mahi Tahi. In the OPAL Unit increased demand was attributable to patients with increased agitation, confusion and aggressive behaviour who required additional input.

Non-Māori inpatient rehabilitation length of stay was impacted by an increase in acuity across all diagnoses with a higher-than-normal number of younger people with dense strokes and other complex diagnoses. Discharge planning is being impacted due to delays with complex housing modifications and accommodation for those who cannot return to their previous place of residence. Ongoing Occupational Therapy vacancies despite efforts to recruit, is a contributing factor.

*2.4 Mental Health*




The Mental Health inpatient length of stay is 11.4 days for non-Māori and 13.3 days for Tangata Whai Ora, against the national key performance indicator (KPI) of between 14 and 21 days. Complex care coordination remains a priority for the service and sub-acute/extended care option is being progressed with urgency with the provider. Of note is that admissions into the ward for the 2020/21 was 521 compared to the 2019/20 year at 716, representing a 37 percent reduction.

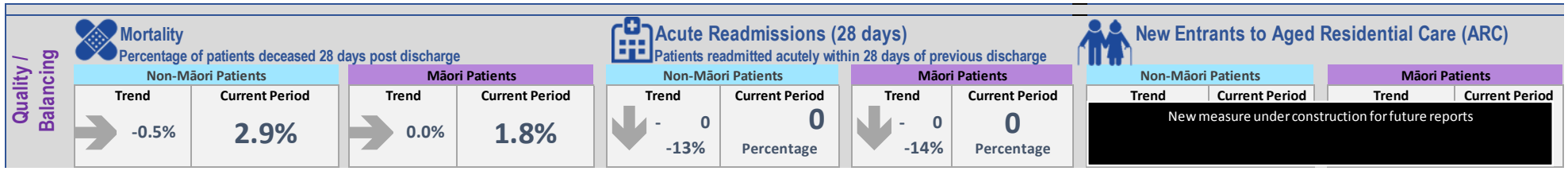
Whilst the overall trend in seclusion reduction remains positive, the disparity between Māori and non-Māori remains. Ward 21 has commenced work to develop individualised de-escalation plans, in partnership with Pae Ora Paiaka Whaiora Hauora Māori within the Te Whare Tapa Whā model, with the aim of reducing seclusion rates for Māori.

The service not engaged KPI is now measured as a percentage. The number of service users not engaged has remained steady across reporting periods, with the current result showing a slight difference between Māori and non- Māori. Those not engaged are proactively followed up by each clinical team, and in most cases, appointments are re-booked. Lack of evening and weekend appointments is cited as the most common barrier to not attending, with the model of care changes being implemented aiming to explore options to address this.

The number of people accessing Primary Mental Health (Te Ara Rau) service who identify as Māori sits above the target of 20 percent. The programme was developed and implemented in partnership with the DHB, THINK Hauora and the WAIORA Roopu.

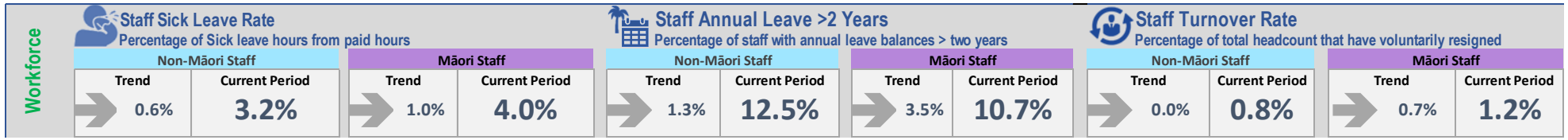
Included are 11 Kaiwhakapuaki Waiora (Health Coaches) roles located within iwi to ensure an overt focus on increasing access for tāngata whaiora and whānau. Conversely, there has been a slight reduction in access for non-Māori.

*2.5 Quality/Balancing*




The readmission rate for Māori year to date (YTD) is 9.6 percent and non-Māori YTD is 9.8 percent, which is a 0.2 percent increase compared with June 2021 data. Readmissions 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 readmission 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. Vacancies and shortages across directorates will impact on their ability to reduce the overall annual leave balance for greater than two years.

## APPENDIX A: SUMMARY OF THE SIX HEALTH AND DISABILITY SERVICE DIRECTORATES

| A SUMMARY OF THE SIX HEALTH AND DISABILITY SERVICE DIRECTORATES | | |
|---|---|---|
| **Te Uru Arotau**<br>**Acute and Elective Specialist Services** | **Te Uru Kiriora**<br>**Primary, Public and Community Health** | **Te Uru Mātai Matengau**<br>**Cancer Screening, Treatment & Support** |
| Te Uru Arotau is responsible for the planning, funding, commissioning and provision of secondary care (hospital level) services:<br>• Medical services and subspecialties<br>• Surgical services and subspecialties<br>• Anaesthetics and Intensive Care Unit<br>• Medical/Surgical inpatient wards<br>• Medical Imaging and Hospital Pharmacy<br>• Emergency services. | Te Uru Kiriora is responsible for the planning, funding, commissioning, and provision of:<br>• Primary and community-based services via a range of contracted partners<br>• Public health services spanning health promotion, protection, regulation, and clinical care delivery<br>• Specialist Sexual Health services<br>• Child and adolescent dental services<br>• 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:<br>• Prevention and early detection (screening) programmes<br>• Cancer diagnostic and treatment services<br>• Cancer support services<br>• Palliative care services<br>• Non-malignant haematology services<br>• Regional services for treatment and screening. |
| **Te Uru Pā Harakeke**<br>**Healthy Women Children and Youth** | **Te Uru Rauhī**<br>**Mental Health and Addictions** | **Te Uru Whakamauora**<br>**Healthy Ageing and Rehabilitation** |
| Te Uru Pā Harakeke is responsible for the planning, funding, commissioning and provision of:<br>• Primary and secondary maternity care<br>• Secondary Obstetrics and Gynaecology services including antenatal day unit, inpatients, outpatient clinics, community midwifery services and lactation services<br>• 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<br>• 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:<br>• General adult mental health in community<br>• Primary Mental Health and Addictions<br>• Mental Health Acute Inpatient services<br>• Eating disorders<br>• Maternal Mental Health<br>• Community Rehabilitation<br>• Child Adolescent and Family<br>• Alcohol and Other Drug Specialist Services<br>• Māori Mental Health<br>• Older Adult Mental Health Services<br>• 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:<br>• ElderHealth<br>• Rehabilitation<br>• Therapy Services<br>• Supportlinks. |

## APPENDIX B: 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 age of 16 years. |
| Ambulatory Sensitive Hospitalisation (ASH) | As per the Ministry of Health's (the Ministry) 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's 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's 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's 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 MoH 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 MoH 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's 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's 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 Pā Harakeke - Healthy Women Children and Youth |
| **FOR PERIOD** | June and July 2021 |
| **PREPARED BY** | Sarah Fenwick, Operations Executive<br>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. Te Uru Pā Harakeke is generally on track, with those actions behind plan 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 | **G** | ↑ |
| 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.

Feedback has been received from the Ministry of Health (the Ministry) through the quarterly reporting process acknowledging the impact that the COVID-19 pandemic has had on community-based health services, including breastfeeding support services. MidCentral DHB (MDHB) breastfeeding rates are expected to improve in the next quarterly reporting period (updated data will be available in October 2021). The MDHB Breastfeeding Steering Group is focusing on key actions that will have maximum impact on closing the breastfeeding equity gap across the region.

Significant efforts have been made to improve the number of babies who live in smoke free households. Although the milestone has not been achieved there has be an improvement from 37.8 percent to 42.1 percent. An interdisciplinary meeting with all parties including smoke quit services, maternity inpatient services, Lead Maternity Carers (LMCs), MDHB Community Midwifery Team, Maternity Quality and Safety Coordinators and others is planned in August 2021. The use of the 'Ara Whanui' database by Well Child Tamariki Ora nurses is a current focus to ensure all are recording the data correctly.

As highlighted in previous papers, the national shortage of midwives, increasing acuity and handover of care are 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 currently 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.

Recruitment to the senior midwifery leadership positions is in progress with good response to the Maternity Manager role, but little interest received in other roles. Further advertising is underway. Recruitment to the Director of Midwifery role has been unsuccessful and the role will be readvertised in September 2021.

### 1.1 Performance Indicators – July 2021

The overall rate for caesarean sections decreased to 26.5 percent in July 2021, a drop of ten percent from the last reporting period. Caesarean section rates for first time nulliparous women remain very low, with repeat elective caesarean sections increasing the rate overall.

Outpatient and colposcopy 'Did Not Attend' (DNA) results were 9.5 percent and 20 percent respectively in July. The increase in the colposcopy rate is being investigated, as progress on decreasing this rate had been successful in previous months and may be due to factors such as school holidays.

## 2. SIGNIFICANT MATTERS

### 2.1 COVID-19

MDHB Palmerston North Hospital is in yellow status on the National Hospital COVID-19 response framework, in response to the COVID-19 national alert Level Four. Business continuity plans have been enacted and all non-urgent care has been deferred or alternative virtual options offered where appropriate.

### 2.2 Maternity/Neonatal Clinical Information System (MCIS/NCIS) Global

As previously reported, the launch of the Maternity and Neonatal Global Clinical Information System took place on 16 June 2021 without incident. Prior to go live, 98 percent of staff were trained, with standard operating guidance and champions available to ensure adequate support for the new system. Digital Services support was outstanding, working closely with the cluster team. The programme has required a number of significant updates since going live and continues to be test intensive.

### 2.3 Tūngia Te Ururua

Community engagement across the communities of Tararua, Ōtaki and Horowhenua regarding service provision across the first 1000 days has now closed, with approximately 220 consumer surveys and 25 provider surveys received to date. Initial analysis of the data indicates that 29 percent of the feedback is from whānau Māori. Independent analysis of the data is now underway, with a full report planned for the next Health and Disability Advisory Committee.

### 2.4 MDHB Child Development Service (CDS) Referral Integration Project

The referral integration project focuses on developing an integrated health and education referral pathway for children with additional needs, development delays or disabilities requiring multi-agency or specialist services across the MDHB region. Phase Two of the project focuses on piloting the integrated model, with a pilot planned to commence in October 2021. This project is now more imperative as primary care referrals to Paediatric Services have increased exponentially over the last 12 months, despite investment in Nurse Practitioners, nurse-led services close to home, and outreach clinics.

## 2.5 Child Development Service (CDS) Psychology

A change paper was released on 24 March 2021 that 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 progress with the proposed model. Work is now underway to progress this decision with staff and union partners.

## 2.6 Strike Action

The New Zealand Nurses Organisation (NZNO) planned strike action took place on 9 June 2021, from 11am to 7pm with full life preserving services (LPS) in place. Minimal disruption to patient care occurred. Strike action planned for 19 August 2021 was revoked due to the increase in national COVID-19 alert levels.

Midwifery Employee Representation and Advisory Service (MERAS) strike action occurred on 11 August 2021, from 11am to 7pm with full LPS in place. Minimal disruption to patient care occurred with elective work postponed. Further strike notice received for 19 August 2021 was revoked due to the national increase to COVID-19 alert levels.

## 2.7 Colposcopy Audit

The DAA Group, on behalf of the National Cervical Screening Programme, commenced their three-yearly audit of colposcopy screening and treatment processes at MDHB on 17 August 2021. The audit was paused at the end of 17 August 2021 due to the increase in COVID-19 alert levels. Further engagement will be arranged following the country's transition back to alert Level One.

## 2.8 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.

| | |
|---|---|
| **SERVICE** | Te Uru Mātai Matengau – Cancer Screening, Treatment and Support |
| **FOR PERIOD** | June and July 2021 |
| **PREPARED BY** | Sarah Fenwick, Operations Executive<br>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 projects for Outreach Radiation Treatment | A | • |
| A | Minimise breaches of the 31- and 62-day Faster Cancer Treatment waiting times | A | • |
| A | Commission outreach chemotherapy at Whanganui Hospital | A | ↓ |

| | | | |
|---|---|---|---|
| A | Refresh Te Korowai O Rongo, the district Palliative Care Strategic Plan | A | • |
| A | Deliver year two 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 is being finalised and focuses on equity, early detection, prevention, including those not engaged in primary care. Pae Ora Paiaka Whaiora Hauora Māori has provided guidance and oversight since commencement of the strategy. Final sign off is expected in the coming months.

The Regional Equity Coordinator continues to engage with the community to improve Māori outcomes across the cancer continuum and is currently collaborating with THINK Hauora's health promotion team regarding the mahi being carried out with whānau in the 4412 post code area, including the Geoff Thompson Wellness Programme. The Regional Equity Coordinator has also initiated discussions with Manawatū prison and Community Corrections regarding health and cancer prevention messages for male prisoners. Interviews have now been completed for the Bowel Screening health promotion role and the successful candidate will work to help improve Māori participation rates in Bowel Screening across the MidCentral DHB region.

Work continues on developing a cancer workforce strategy, with each of the professions contributing to their own section. Succession planning is being developed to maintain sustainability of current services. This includes sharing of knowledge and training to upskill others.

The Capital Investment Committee has provided support for the Hawke's Bay District Health Board (DHB) linear accelerator business case, which has now been progressed for sign off. Taranaki DHB is making good progress with their linear accelerator programme business case.

The Outreach Chemotherapy development at Whanganui Hospital is behind schedule, although a business case is in progress. Te Aho O Te Kahu (Cancer Control Agency) is working with Whanganui District Health Board and MDHB to help progress this development.

Work to refresh Te Korowai O Rongo, the District Palliative Care Strategic Plan has now recommenced. The MDHB Director of Palliative Care is developing a proposal that outlines the strategic directions of palliative care for the district, linking Arohanui Hospice, Palmerston North Hospital and the wider community. The strategic objectives for 2021-2026 will include greater engagement with iwi providers.

## 2. SIGNIFICANT MATTERS

### 2.1. Linear accelerator breakdown

The Regional Cancer Treatment Service (RCTS) business continuity plan was activated following the major failure of one of the linear accelerators on 28 May 2021, with urgent approval gained from the Ministry of Health (the Ministry) to progress with the purchase of a new machine. The new machine was ordered promptly and installed on 7 August 2021. Commissioning of the new machine, along with the building and minor refurbishment work required, is on track. A contingency plan has been established in the event of border closures in response to a COVID-19 outbreak.

The radiation therapy workforce is continuing to work effectively during the replacement programme. There is currently no change required to planned shift work, and to date zero radiation treatment courses have had their start date delayed as a direct result of the replacement programme.

### 2.2. COVID-19

Palmerston North Hospital is in yellow status on the National Hospital COVID-19 response framework, in response to the COVID-19 national alert Level Four. Business continuity plans have been enacted. Cancer care continues to be provided in line with national recommendations.

### 2.3. Medical workforce

The RCTS is experiencing vacancies at Senior Medical Officer (SMO) and Medical Officer of Special Scale (MOSS) level. This is particularly noted in Radiation Oncology who continue to await the arrival of two new Radiation Oncologists from overseas following service sizing earlier in the year. The current SMOs in Radiation Oncology are proactively managing the workload at reduced capacity and this approach continues to mitigate any risk of delay to wait times for patients.

The Medical Oncology SMO workforce will be at reduced capacity towards the end of the year due to the retirement of one of the senior SMOs and another SMO commencing maternity leave in early 2022. In addition, the RCTS MOSS position based at Hastings Hospital is vacant from August 2021 and has a significant Medical Oncology workload. Active recruitment is underway to fill these vacancies, including maternity leave cover, however there is a risk that waiting times for first specialist appointment (FSA) and treatment could increase, with staff being supported to maintain their wellbeing.

### 2.4. BreastScreen Coast to Coast

The Radiology provision for BreastScreen Coast to Coast (BSCC) is currently reduced following the recent retirement of the Clinical Director. A mitigation plan is in place, with outsourced provision supporting the current radiologists. This will be strengthened in September as sabbatical leave comes to an end.

### 2.5. Outpatient clinic amalgamation

The majority of the building work in the outpatient clinic amalgamation has now been completed with all new spaces operational. There is some minor to moderate building remediation work in progress.

### 2.6. Oncology outpatients

Recruitment for the Oncology Ambulatory Care Charge Nurse position continues. The first round of interviews were unsuccessful and the position has been readvertised. The recruitment of this position will help progress the contemporary model of ambulatory oncology care that is being implemented to meet patient's needs and enable clinicians to work at top of scope.

### 2.7. Mosaiq

Business case development continues for Mosaiq to move from the current DHB IT servers to a cloud-based solution. This is to ensure improvements are gained in the resilience, security and performance of the system.

### 2.8. BreastScreen Coast to Coast audit

BreastScreen Coast to Coast has now received the full report from the Designated Auditing Agency (DAA), on behalf of the National Screening Unit. The report was positive, with six low to moderate actions received. An action plan to address these actions is currently being drafted.

In addition, International Accreditation New Zealand (IANZ members) visited the Breast Screen Service on the 9 August 2021 to conduct their annual audit. This audit is to assess the competence and quality of Breast Screen's radiology services. The result was positive, with minor actions to address only.

### 2.9. **Chemotherapy delays due to Ward 23 occupancy**

The Ward 23 contingency plan to enable patients to receive their chemotherapy on schedule has failed recently due to increased occupancy of beds across the hospital and within the regional hospitals. This has resulted in three recent instances where chemotherapy was not delivered on time. Two patients had chemotherapy delayed by one day and one patient could not be transferred from a regional hospital to start chemotherapy for three days, although pre-chemotherapy assessments could be completed at the local hospital. Work is underway to modify inpatient chemotherapy schedules where appropriate to deliver as an outpatient on the day unit.

### 2.10. **Leadership change consultation**

A consultation document to strengthen leadership across Te Uru Mātai Matengau was released on 20 July 2021. The consultation closes on 12 August 2021, with a decision paper expected to be released in September 2021.

| | |
|---|---|
| **SERVICE:** | Te Uru Arotau – Acute and Elective Specialist Services |
| **FOR PERIOD:** | June/July 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 actions behind plan discussed in the section below.

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

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

There continues to be delays with the delivery of the Performance Indicators for Coding Quality (PICQ) audit tool. Despite the delays, progress has been made with technical workshops being held with the vendor. An update with revised timeframes will be provided next meeting. 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)*

Alongside increased presentations, one of the constraints on patient flow is ward bed access that impacts SSIED performance. There are a number of factors contributing to this such as high numbers of acutely unwell and complex patients. Some patients require Enduring Power of Attorney (EPOA) and Protection of Personal and Property Rights (PPPR) orders for personal care welfare to be enacted as they cannot be discharged home. Te Uru Whakamauora is discussing this with the local Ministry of Justice to see how these delays can be improved.

In addition, there have been some intellectually disabled patients where there is no national supportive structure which delays discharge. Each case is individually managed to ensure appropriate care in the community prior to discharge. The Directorate is identifying these patients as early as possible to initiate Multi-Disciplinary Team (MDT) discussions to support discharge and prevent readmission.

Consequently, bed day usage has been consistently over 105 percent in June and July.

The Directorate is progressing work across the system to improve the acute flow of patients from front of house to discharge which includes the following:

- General Medicine is reviewing MDT structures and allocations of patients to specific speciality teams.
- The Chief Medical Officer is working with the Clinical Leads of Medicine and Surgery and the Medical Lead of the Emergency Department (ED) to establish speciality admission allocation. These will include well-defined and agreed clinical lines of responsibility once a diagnosis has been identified in ED.
- All District Health Boards (DHBs), along with MidCentral DHB (MDHB), continue to submit weekly data to the Ministry of Health (the Ministry). This is followed up with a weekly telephone conversation. The Ministry has continued to refine the data requirements and is sharing across DHBs. The Ministry has identified that although acute flow is an issue across the country, contributing factors vary across the DHBs.
- The Needs Assessment and Service Co-ordination (NASC) pilot for digitised referrals has been expanded to other inpatient areas. Allied Health have moved to digital referrals via MIYA (patient journey board). These process improvements are assisting with timeliness and visibility of referrals and progress to support ongoing care co-ordination.
- From 1 June 2021, the ED/COPD (Chronic Obstructive Pulmonary Disease) pathway criteria were extended for patients discharged from the Medical Assessment and Planning Unit (MAPU). Now re-titled to COPD Transition of Care, the aim of the programme is to ensure the smooth transition of care from secondary to primary care providers. The focus is on action planning, long term condition engagement and improved self-management. While numbers have been low in the first few weeks of the programme these are expected to increase.

*Emergency Department – Did Not Waits*

| Month | Total DNW | Total DNW – Māori | Total DNW – Non-Māori |
|---|---|---|---|
| August 2020 | 449 | 143 | 306 |
| September 2020 | 335 | 94 | 241 |
| October 2020 | 410 | 110 | 300 |
| November 2020 | 460 | 110 | 350 |
| December 2020 | 413 | 107 | 306 |
| January 2021 | 263 | 64 | 199 |
| February 2021 | 417 | 117 | 300 |
| March 2021 | 429 | 112 | 317 |
| April 2021 | 318 | 80 | 238 |
| May 2021 | 333 | 83 | 250 |
| June 2021 | 493 | 137 | 356 |
| July 2021 | 574 | 167 | 407 |

The increased did not waits of June and July are a direct consequence of the increased volumes attending ED and the constrained facility in which these operate. ED continues to use Primary Options for Acute Care (POAC) ED-redirection services available in the community. The Post Emergency Department Assessment and Liaison (PEDAL) service continues to initiate early review of the older adult patients. For patients who do not wait, and there is clinical concern for the patient, a nurse from ED will follow up and telephone the patient and potentially ask the patient to return to ED as clinically appropriate.

*Planned Care and ESPIs*

There is good progress in ESPI 2 at the end of July 2021. The Directorate is on track to achieve the Ministry's agreed trajectories.

The ESPI 5 indicator remains static. Acute demand in July saw a total of 66 patients have their surgery deferred. Rebooking of these patients is a priority. The clinical teams continue to review all waiting lists to identify any clinical risk.

While ESPI 5 remains an area of challenge, MDHB continues to work in partnership with Crest Hospital to utilise capacity to provide outsourced and outplaced surgery to deliver surgery to our community.

Five project submissions were submitted in July 2021 to the Ministry as part of Year Two of the Planned Care Improvement Action Plan projects. The Directorate has successfully secured $369,033 additional funding from the Ministry. Two projects were new initiatives with the remaining three to support Year One projects. The projects are listed below.

- Clinical (Registered Nurse) Booking Co-ordinator (new) – the purpose of the role is to provide clinical support to the booking clerks to enable a reduction in cancelled procedures for avoidable reasons, overview of any clinical risk, improve patient and whānau experience and quality of care.
- Waiting List review (new) – the aim of this project is to allocate two temporary administrative roles to undertake administrative reviews of both inpatient and outpatient First Specialist Assessments (FSAs) and follow up waiting lists.
- Community Infusion Service Pilot Nurse Co-ordinator (continuation) – this temporary role will work collaboratively between the hospital and community providers, establishing and strengthening effective professional relationships, providing training and support in the establishment phase and ongoing as required. This role will support patients and their whānau to ensure the transition for patients to a community setting is safe and seamless.
- Theatre flow and clinical audit (continuation) – backfill of staff to support the configuration and implementation of the digital tools.
- Hospital Health Pathways (continuation) – to provide temporary, part time administrative support to the Hospital Health Pathways programme.

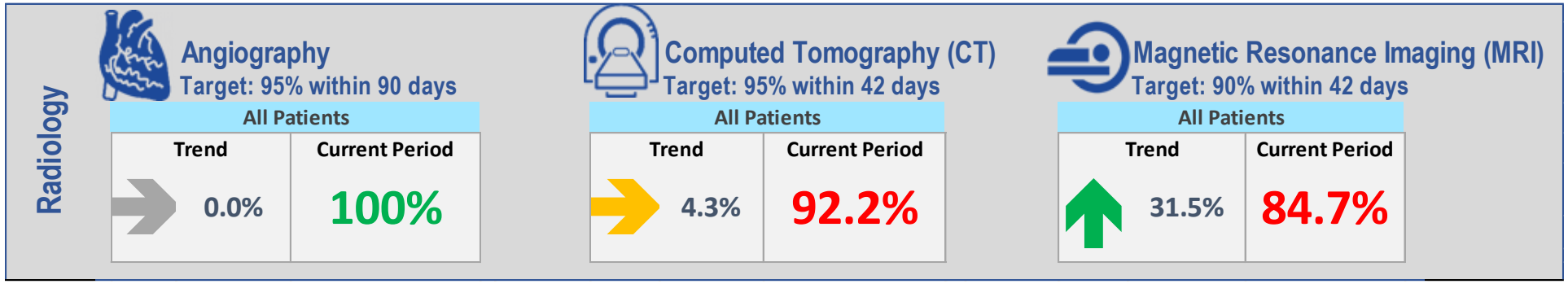
*Services Not Engaged (SNE)*

The Whānau Equity Facilitator (WEF) has commenced working in partnership with diabetes and endocrinology, and maternity services. The initial focus is for early engagement and communication with services and hapū māmā Māori who attend the diabetic antenatal clinic. The WEF has sat with Māori wahine during diabetes in pregnancy clinics and has advocated for culturally safe care as well as being a support person for these wahine. Ethnicity is now identified on the antenatal clinic list, to prioritise Māori hapū māmā. The WEF and Pae Ora Paiaka Whaiora are involved when appropriate. Diabetes involves the Pae Ora team earlier to support engagement with specialist services, compared with previously waiting for a pattern of frequent non-engagement.

In addition to the work with diabetes in pregnancy, the areas of focus for the diabetes service are SNE for youth and Clinical Nurse Specialist clinics at the Youth One Stop Shop.

MDHB has reviewed the national Quarter Four planned care, SNE rates across the 20 DHBs. MDHB is ranked sixth out of 20 (lowest rate to highest rate) for SNE rates for Māori.

## 1.1 Performance Indicators – July 2021




Computed Tomography (CT) performance continues to improve to 92.2 percent in July from 86.5 percent in June. 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 over each 24-hour period.

Currently MDHB works in partnership with Whanganui DHB to provide Computed Tomography Coronary Angiography (CTCA) imaging based at Wanganui Hospital. CT and Cardiology are working together to be able to provide local CTCA imaging at Palmerston North Hospital. Procurement of software and licensing is underway.

Magnetic Resonance Imaging (MRI) performance exceeded target in June at 93.6 percent. This reduced to 84.7 percent in July. The MRI Department continues to operate seven days a week. MRI is currently recruiting for a trainee MRI MIT (Medical Imaging Technologist) and in addition to a current vacancy.

Cardiovascular Magnetic Resonance (CMR) has commenced at MDHB supported by a trial of cardiac software. Prior to this trial patients were travelling to Hutt Valley DHB. The first cardiac MRI scan was completed on 26 July 2021. Procurement of software and licensing is underway. The commencement of CMR imaging will support the interventional cardiology service.

## 2. SIGNIFICANT MATTERS

### 2.1. Major Facility Projects

Progress continues for the Surgical Procedural Intervention Recovery Expansion (SPIRE) facility upgrade. The fit-out and reconfiguration of the former Clinical Records Department was completed in July. This building is now known as the Laurie McCool Learning Centre. Major construction work has been split into two stages, with the first scheduled to begin in October/November. The Detailed Design for Stage 1 has been completed, tenders for a construction firm sought and building consent lodged.

Detailed design work to accommodate the MAPU and Emergency Department Observation Area (EDOA) continues and construction is scheduled to commence later this year.

### 2.2. Incident Management Team – Hospital Response

An Incident Management Team (IMT) has been established and Emergency Operations Centre (EOC) activated, supporting the hospital and the wider DHB COVID-19 response. The hospital is in yellow status on the National Hospital COVID Response Framework in order to operationally respond to National Alert Level 4. All urgent and non-deferrable outpatients, diagnostics and surgeries continue. All non-urgent planned care has been deferred.

### 2.3. Pharmacy Update

The Pharmacy Department will review the Pharmacy on Ruahine (at the main entrance of Palmerston North Hospital) stock holding with a view to increasing the clinical range of products – for example; additional dressings and at home observation equipment (blood pressure machines, thermometers), along with increasing sustainable gifts and products.

Pharmacy has a new third party for the compounding (sterile preparation) for chemotherapy medicines. The new provider is 100 percent New Zealand owned. This is a more financially and environmentally sustainable approach.

| | |
|---|---|
| **SERVICE** | Te Uru Whakamauora – Healthy Ageing and Rehabilitation |
| **FOR PERIOD** | June /July 2021 |
| **PREPARED BY** | Lyn Horgan Operations Executive<br>Syed Zaman, Clinical Executive |

## 1. PERFORMANCE OVERVIEW

All initiatives have been updated accordingly under the Annual and Sustainability Plans. Whilst there are no emerging risks or areas of concern, initiatives rated as 'Behind plan' have remedial action plan in place which are described below.

| | **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. Ombudsman's Report Update

An unannounced visit to STAR 1 was made by the Ombudsman team to assess progress towards achieving recommendations from their report. Although no official communication has since been received, they were happy with progress towards development of a therapeutic environment for this patient cohort and completion of their recommendations from their previous unannounced visit.

## 2.2. Care in the Community

Rehabilitation in the Home programme (Non-Acute Rehabilitation Community Service) commenced late June 2021, partnering with Health Care New Zealand (HCNZ) to support rehabilitation in the community for eligible ACC clients discharged from hospital. Te Uru Whakamauora are also progressing contracts with other Home and Community Support providers to support this initiative.

Riverstone, a new 5- bed residential aged care facility operated by BUPA, has opened in Palmerston North providing hospital, rest home and dementia levels of care.

## 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 guidance, with no wait lists exceeding four months for urgent assessment.

For Occupational Therapy the waitlist has increased to 464 and all areas have wait times greater than 12 months. This is due to increased referrals, staff vacancies and complexity, such as complex wheelchair and seating, equipment and/or housing modifications. Occupational Therapy are interacting with other agencies to manage complex referrals, for example Enable NZ advisors who also have wait times pressures. 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 will include contracting private providers to assist the team with inpatient service provision and prioritising referral criteria for the community. Any referrals declined will be reviewed at regular intervals and appropriate options considered.

The waitlist for Supportlinks has reduced from 415 to 391 during this reporting period. Despite carrying staff vacancies, the waitlist has been maintained at a stable level over the last two months. With new staff now commencing, the service will focus on further waitlist reductions. 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 phone.

## 2.4. Equity

In its commitment to increasing Māori representation in leadership roles, Te Uru Whakamauora has confirmed the permanent appointment for the Associate Charge Nurse position in STAR 4. This role has been filled by an emerging Māori nurse leader. Te Uru Whakamauora is also supporting her to attend Ngā Manukura o Āpōpō which is a marae-based kaupapa Māori leadership development programme to aspiring Māori clinical leaders in nursing.

### 2.5. COVID-19 Vaccination Planning/Aged Care COVID Preparedness

The COVID-19 vaccination uptake in aged residential care facilities by residents is 86.60 percent and staff 70.12 percent with more appointments booked to further increase these levels of vaccination.

A second residential aged care COVID-19 preparedness survey has been completed in line with the process utilised in 2020. Of those that responded, 100 percent of their staff have attended education and training in all aspects of the COVID-19 plan, use of PPE, recognising the deteriorating resident and appropriate management. These facilities also have sufficient PPE supplies.

### 2.6. Consultation Paper Healthy Ageing and Rehabilitation

Following the departure of the Te Uru Whakamauora Operations Executive, a consultation paper regarding a proposal for changes in reporting lines for the directorate was released to all staff and stakeholders on 28 July. Feedback has been received and a final decision will be released late August.

| | |
|---|---|
| **SERVICE** | Te Uru Kiriora – Primary, Public and Community Health |
| **FOR PERIOD** | June and July 2021 |
| **PREPARED BY** | Deborah Davies, Operations Executive<br>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 2020/21 Annual Plan. Te Uru Kiriora's leadership team have continued to respond to Ministry of Health's (the Ministry) direction for COVID-19 community surveillance testing, the ongoing COVID-19 vaccination programme and have again undertaken surge response with the Auckland COVID-19 cluster. COVID-19 will continue 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 | G | • |
| 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)*

The focus on understanding the experiences of Māori and Pasifika whānau in the Horowhenua living with complex LTCs continues. Modelling based on links with specialty teams/services and 'unlocking' access barriers for whānau and providers has been the focus. The scoping of other Non-Governmental Organisations (NGOs) and groups, which will support the model, is underway looking at specific LTC areas, for example respiratory and diabetes.

Community based health care support for people living with Congestive Heart Failure (CHF) continues to increase with the model now underway in the Horowhenua. This shared care pathway is delivered by Clinical Nurse Specialists (CNS) and Nurse Practitioners (NP) in cardiology, in collaboration with Primary Health Care (PHC) Teams, utilising the Primary Options for Acute Care (POAC) programme. This model is now active in five sites across the region.

The trial involving General Medicine, and Medical Assessment and Planning Unit (MAPU) patients to improve the post-inpatient discharge management of people with Chronic Obstructive Pulmonary Disease (COPD) continues in partnership with primary care and POAC. This trial began in June 2021 and focuses on whānau who are discharged home. They are aligned with PHC LTC team members and the extended General Practice Team (GPT) to provide focused post discharge support, including funded and extended consults. Effective care planning and ongoing monitoring is undertaken in partnership with whānau. Home visits by the MidCentral District Health Board (MDHB) physiotherapy team continues to support patients through this transition from hospital to their homes.

## 2. SIGNIFICANT MATTERS

## 2.1 COVID-19 Vaccination Programme

The COVID-19 vaccination programme continues to undergo considerable expansion and improvement nationally and regionally, with the new National Immunisation Booking System (NIBS), (later renamed to Book My Vaccine) being simultaneously developed and implemented. This presents ongoing challenges for the vaccination management team to keep updated on evolving processes while delivering the operational programme.

In the MDHB region, the distributed model has worked well with multiple vaccination providers (General Practice, THINK Hauora, iwi providers, independent vaccinators and pharmacies) ensuring efficient and timely access, including consumer choice. This model appears to be more advanced than other DHBs, ensuring spread across localities for the changing tiers and age bands and providing a range of vaccination opportunities across the district. The Māori Mobile Team arranged their vaccination schedule to ensure iwi have sufficient opportunity to engage for vaccination. The team have also expanded their workforce with more administration support with the NIBS processes being onboarded.

The Palmerston North Central Vaccination Hub at 38 Fitzherbert Avenue is working well and prior to the Level 4 lockdown was building the weekly numbers as the vaccinator workforce came on board. Building the administrative workforce also continues to ensure proactive follow up of appointment making within the community. Working at Level 4 processes has reduced the overall productivity of this site, although the team is actively ensuring they work to the full capacity available in Level 4.

Being able to rapidly establish services at the Arena has supported continued productivity with the Level 4 restrictions. An inside clinic has been established (four days a week) alongside a drive through clinic (two days a week). These clinics will ensure continued provision of vaccinations with the move down the age bands. Currently the Arena site can comfortably provide 700 vaccines per day which will continue to be pushed. On 1 September 2021, an additional one million people were added to the national workload.

Bespoke vaccination events include reaching out to the disabled community and cover many different vaccination environments. A clinic for the deaf community has been undertaken and a low sensory clinic is scheduled for mid-September 2021. People who are in transitional housing or are homeless will also be provided with vaccination opportunities through the MDHB programme, partnering with community organisations to ensure vaccination is available in suitable locations.

MDHB has been consistently delivering above production plan forecast.  Staff recruitment and training remains an important component of the work to meet the predicted numbers for vaccination later in the year. The programme outputs are very actively monitored at a local and national level. A new production plan is in development to take us through to the end of the programme which is late December 2021.

### 2.2 Contact tracing

MDHB Public Health staff have been working as part of the national response to the ongoing COVID-19 outbreak in Auckland and Wellington. All but urgent business as usual has been halted, at the direction of the Ministry. The service was instructed to activate the surge planning, which has required secondment of staff from other parts of the organisation. We are very grateful for the response, with around 14 mainly nursing staff having been trained and are now working with the wider team. We also have a small team in Whanganui who have been supporting our mahi.

The service has contributed to the national response to contact management (first calls and daily follow-up calls) to close contacts. Most of the contacts have been from the wider Auckland area. Assistance is being provided remotely, utilising the NCTS system. This work involves ensuring that any clinical or welfare needs are met, checking symptoms and compliance with testing requirements, and finally releasing the contacts at the end of their quarantine period. Assistance has also been provided with investigating exposure events, relating to locations of interest.

## 2.3 Supported Isolation and Quarantine implementation

MDHB has been provided an additional contract for a 1.0 FTE position to support COVID-19 Community Supported Isolation and Quarantine (SIQ). The concept is around providing wrap-around services to support community cases and close contacts to appropriately self-isolate in their home environment, or to establish local managed isolation/quarantine facilities for cases and close contacts who are unable or unwilling to isolate in their own home. Joann Ransom has been appointed to the role and is responsible for developing and implementing MDHB's Operational Plan.

The current COVID-19 outbreak has added a level of urgency to this work. A commercial facility within the central city has been identified as a potential SIQ site. The premises have been inspected by MDHB Infection Prevention and Control to ensure that the facility meets the minimum requirements to keep those staying there, and the surrounding communities safe. The list of potential issues is being worked through with a view to finalising a contract shortly. Connections have been established with a range of key stakeholders, including with iwi and other welfare providers.

Where capacity allows, local COVID-19 cases would likely be transported to the closest MIQ site in Wellington. The SIQ facility would be used to house close contacts of the case, should they not be able to quarantine at home. Should the MIQ capacity in Wellington be reached, then cases may need to be accommodated within the SIQ facility.

## 2.4 COVID-19 surge testing

On 18 August 2021, Te Uru Kiriora upscaled the Designated Testing Site at 575 Main Street in response to the ongoing surge with the Auckland cluster. Te Uru Kiriora linked with THINK Hauora to ensure increased testing capacity was provided through General Practice Teams across the rohe. A pop-up testing site was undertaken in Ōtaki over the weekend of 21 and 22 August 2021 in anticipation of an increased need with the incidence of Wellington cases. On Saturday, 89 tests were undertaken with 39 on Sunday in Ōtaki. The total number of tests undertaken across the rohe from Monday 16 August 2021 to Sunday 22 August 2021 was 3669, compared with 544 over the previous week.

The drive-through infrastructure on site at 575 Main Street has been reconfigured to provide all-weather protection for both the triaging and testing aspects. A larger off-site all-weather testing location has been scoped and plans are being finalised. This site will enable a significant number of vehicles with occupants waiting for tests to be taken off the main roads.

| | |
|---|---|
| **SERVICE** | Te Uru Rauhī – Mental Health and Addictions Service |
| **FOR PERIOD** | June and July 2021 |
| **PREPARED BY** | Scott Ambridge, Operations Executive<br>Dr Vanessa Caldwell, Clinical 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. | A | • |
| 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. | A | ↓ |

| **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 Board at their August meeting approved this proposed RFP subject to additional information about costs.

**Improve physical health outcomes for service users with mental health and addiction conditions**

Ensuring the physical health needs of service users with mental health and addictions issues is a key feature of the Integrated Model of Care. This will be managed as a partnership between General Practice and a dedicated Specialist Primary Mental Health and Addiction team that will provide specialist consultation, liaison, assessment and treatment options.

**Digital Enhancements**

Since the conclusion of the RFP significant work has been undertaken. Several workshops have been completed between the DHB and the vendor (Whānau Tahi) to confirm technical and operational requirements. The discovery phase of the project will commence in September and is likely to take six weeks.

**Support the Emergency Department for people presenting with mental health needs**

Despite several recruitment rounds we have been unable to recruit to this position. The role will be included as part of the overall management of change process for the Integrated Model of Care as an opportunity for staff to consider.

## 1. SIGNIFICANT MATTERS

### 1.1 Inpatient Bed Occupancy

Whilst the year to date ward occupancy remains high at 120 percent, the service had a strong month for discharges in June that included three patients with a length of stay greater than 50 days. The occupancy for June was 102.7 percent. In July management met with staff and unions to discuss a range of concerns raised that related to the ward occupancy and pressure that this was placing on staff. An action plan has been put in place and a working group has been established to oversee the implementation of the agreed actions.

The service specification and contract for the sub-acute/extended care service based in Palmerston North has been agreed and is currently with sector services for processing. The service will be operational in October 2021.

### 1.2 Child and Adolescent Mental Health and Addictions Services (CAFS)

Over the past six months CAFS have seen a steady increase in referrals. The service has implemented the ALERT program in partnership with the Ministry of Education. The ALERT programme is an evidence-based approach to assist children with self-regulation so that they can better handle life's challenges. It is planned to run for 11 months. The service has also contracted Youthline to work with CAFS to provide brief intervention to young people (teens) who are no longer acutely unwell but require follow up support. A service review to benchmark volumes against resourcing will also be undertaken.

### 1.3 Transition of Care

Due to the ongoing system improvements for post discharge follow up in the community within seven days, KPI 19 increased eight percent in June and by a further eight percent in July to 89 percent, the best performance for at least the last year. This removes Mental Health and Addictions from the Ministry's alert zone for two months in succession and is just one percent below the 90 percent target. Improvements made include:

- provision of training on codes
- making 'out of area' contact with DHB staff to confirm post discharge contact
- routine reminders to clinicians when nearing end of seven-day window for follow up
- daily reporting on discharges in community team huddles
- reminders to enter data on time
- audits to determine reasons for inability to make contact within the required seven days post discharge.

### 1.4 Use of Less Restrictive Care Practices

The MidCentral DHB's Acute Inpatient Unit [Ward 21] continues to see good improvement in the use of less restrictive practices such as seclusion. Statistics from 2017 until 2020 show a reduction in seclusion hours by 68 percent and seclusion events by 47.9 percent. This includes a 50 percent reduction in seclusion on admission between 2018 and 2020.

The Safe Practice and Effective Communication (SPEC) restraint training must be completed by all Ward 21 nursing staff. As at August 2021, 95 percent of all staff have completed this training which also requires a yearly refresher. SPEC training includes least restrictive practices, sensory modulation, de-escalation, trauma informed care and person-centred care. The training has now been extended to include all clinical staff.

### 1.5 Inpatient Facility Rebuild

Mental Health and Addiction Services leadership presented the current draft building design to the Board meeting on 17 August 2021. Based on feedback from a Board member, in partnership with Pae Ora Paiaka, a plan is being developed to ensure that the commitment to Māori models of care is reflected and the kaupapa is well maintained through structural changes. An updated timeline for construction will be provided as soon as it is available, and construction is still anticipated to start in Quarter Three.

### 1.6 Integrated Adult Model of Care

Since the release of the final decision in June 2021, work has progressed on building the foundations to support the change programme. Recruitment to the tier three leadership roles have largely been completed, six of the seven roles have been filled by internal applicants. A change manager has been appointed to support the core elements of the change programme across all services.

DHB management and union representatives from the NZ Nurses Organisation and Public Service Assocaition have agreed the framework for the management of change process and the timeframes for those services impacted by the change. The expressions of interest process will commence on the week commencing 27 August 2021 and will run for three weeks.

A workforce development programme is being progressed to equip staff with the skills to work within the new integrated model. This includes courses to ensure that non-kaupapa services will be supported to access training for culturally responsive care and understanding the practical application of Māori models of care.

A letter has been sent to all service users informing them of the up-and-coming changes. The Service User advisory group remain active participants in the implementation of the model and the Marama Real-time feedback survey is also being relaunched as a key mechanism for feedback.

The baseline monitoring report has been confirmed. This report includes qualitative and quantitative data that will be used to monitor progress as the Integrated Model of Care is implemented.

Maternal Mental Health services will transition to Te Uru Pā Harakeke in September 2021. This move is a realisation of the integrated approach to wellbeing and the ongoing partnership between Te Uru Rauhī and Te Uru Pā Harakeke so women can access the mental health support they need.

In the coming months work will focus on establishing the new locality and specialist primary services, finalising the professional development programme, and completing work in the core operational policies and procedures.

# Performance reporting

*14 September HDAC*

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

# HEALTH AND DISABILITY ADVISORY COMMITTEE


**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** | 26 August 2021 |
| **Subject** | **Enable New Zealand Report** |

**RECOMMENDATION**

It is recommended that the Committee:

- **endorse** the Enable New Zealand Report to 31 July 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. The report also aligns to all three of the strategic goals embedded in Enable New Zealand's Operational Plan.

## 1. PURPOSE

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

## 2. PERFORMANCE OVERVIEW

At year-end, overall performance across Enable New Zealand 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 New Zealand'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. No significant changes have occurred other than expected seasonal variances.

## 3. SIGNIFICANT MATTERS

### 3.1. New contracts

*ACC Contract*

Meeting the pre-condition requirements for the Managed Rehabilitation Equipment Services (MRES) contract with the Accident Compensation Corporation (ACC), Enable New Zealand presented to the ACC evaluation panel. Enable New Zealand has also been successful in pricing the service and the innovation that was included in the presentation. This is a high-value contract which has an expected 10-year tenure (five + three + two years). We hope to hear the outcome early September.

*MOU – Hire, West Coast and Christchurch District Health Boards (DHBs)*

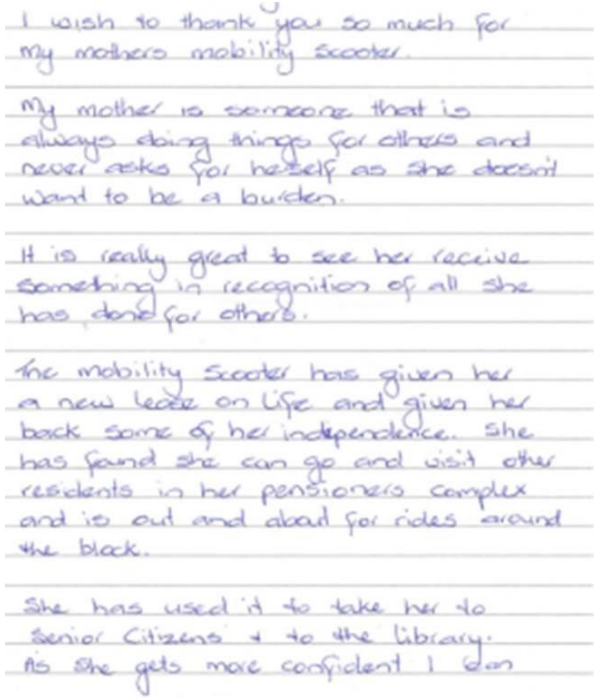
Enable New Zealand was approached by the West Coast DHB to provide a hire service, similar to what is currently provided for the Christchurch DHB. Enable New Zealand has worked with both DHBs to establish a single contract for service and will be providing short-term hire equipment to support those in palliative care, and for bariatric equipment.

## 3.2. **Community update**

The EASIE Living Retail and Demonstration Centre continues to engage with the community through a talk series that is held onsite at the EASIE Living Store. Held monthly whilst being established, the series is focusing on tips and tricks to help the aged and disability communities. In July, Parafed Manawatu spoke about encouraging active participation in sports and other lifestyle activities.

*EASIE Living mobile van service*

The EASIE Living mobile van service continues to frequent the wider community offering free and independent advice. The service is out in the community for an average of three days each week. As a free service when not on the road, the Mobile Outreach Manager works with individuals to apply for lotteries grants for items such as scooters and vehicles. There is a very high success rate in accessing the funds. Two recent recipients provided the following feedback:



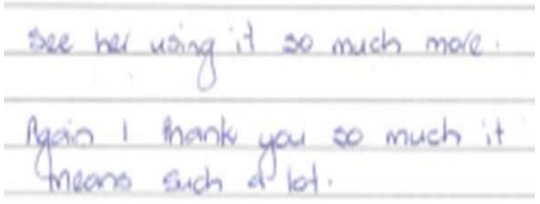
I wish to thank you so much for my mothers mobility scooter.

My mother is someone that is always doing things for others and never asks for herself as she doesn't want to be a burden.

It is really great to see her receive something in recognition of all she has done for others.

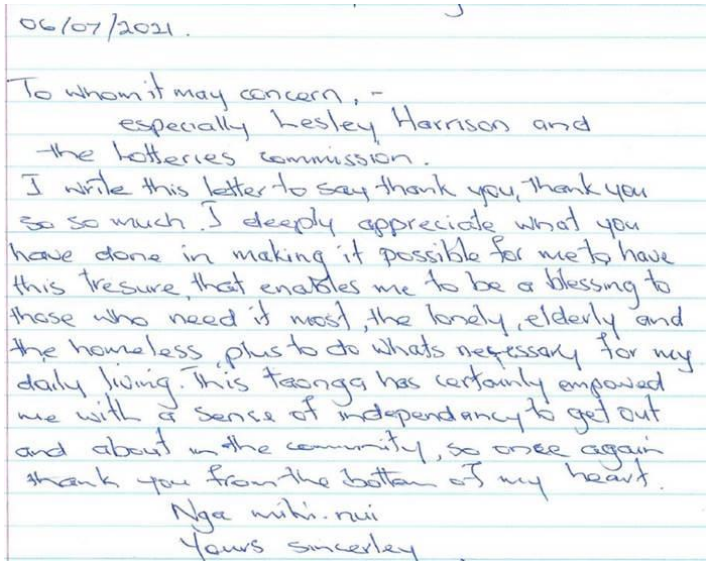
The mobility scooter has given her a new lease on life and given her back some of her independence. She has found she can go and visit other residents in her pensioners complex and is out and about for rides around the block.

She has used it to take her to Senior Citizens & to the library. As she gets more confident I can



see her using it so much more.

Again I thank you so much it means such a lot.



06/07/2021.

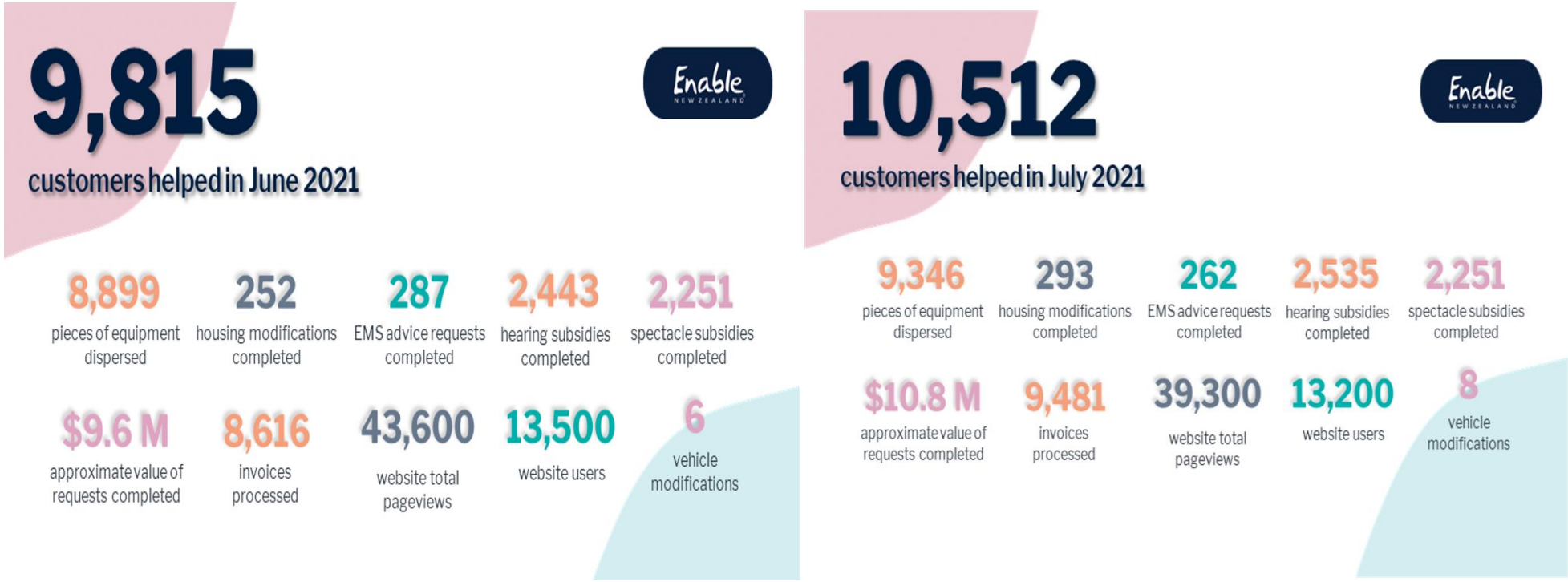
To whom it may concern, -
especially Lesley Harrison and the lotteries commission.
I write this letter to say thank you, thank you so so much. I deeply appreciate what you have done in making it possible for me to have this treasure, that enables me to be a blessing to those who need it most, the lonely, elderly and the homeless, plus to do whats necessary for my daily living. This taonga has certainly empowered me with a sense of independancy to get out and about in the community, so once again thank you from the bottom of my heart.
Nga mihi nui
Yours sincerley

# Appendix One: Performance Indicators

This report relates to the reporting period from 1 June to 31 July 2021

## National volumes

The following chart is a high-level snapshot of the volume of work Enable New Zealand has achieved throughout June and July 2021.




## Regional results

As the 2020/2021 financial year ended, requests across the MDHB region continued to stay consistent over all four service areas. When comparing requests received between 2019/2020, MDHB saw an increase of 16 percent in equipment requests, 27 percent in hearing requests and 21 percent in spectacle requests. These increases are likely due to the decrease in requests seen during April/May 2020 due to COVID-19 and lockdown. Most of these requests would have required face-to-face visits and/or assessment, prior to the requests being sent to Enable New Zealand.

July 2021 has continued well with hearing requests standing out above all other services. This number of requests has not been seen for over two years, with the last memorable one mentioned in December 2019, with 124 requests received during that month.

*Table 1: Volume/demand of customers accessing Enable New Zealand within MDHB region for June 2021 and July 2021*

| Client Volumes by Service | MDHB Region June | MDHB Region July |
|---|---|---|
| Equipment | 322 | 308 |
| Hearing | 118 | 147 |
| Housing | 18 | 13 |
| Spectacles | 119 | 132 |

**Performance indicators against contractual agreements**

Band 1 equipment delivery continues to achieve the five working day Key Performance Indicator (KPI) target. These simple items are readily available in our warehouse or from our suppliers and can be distributed quickly through the network.

The refurbished equipment continues to float between 29 and 31 percent, depending on the demand of equipment currently available in the warehouse. Discussions are being held with the Ministry of Health (the Ministry) to explore their interest in refurbishing more equipment. This would reduce the carbon footprint and landfill volumes, but would result in the costs of repairs increasing.

As per previous months, pressure on installing grabrails within five days continues to be an issue. This relates to the availability of contractors and grabrail stock delays. Several suppliers have experienced significant delays in stock which is imported. These same challenges also exist in terms of the housing sector and delays with our ability to complete housing modifications.

*Table 3: Performance against contractual measures*

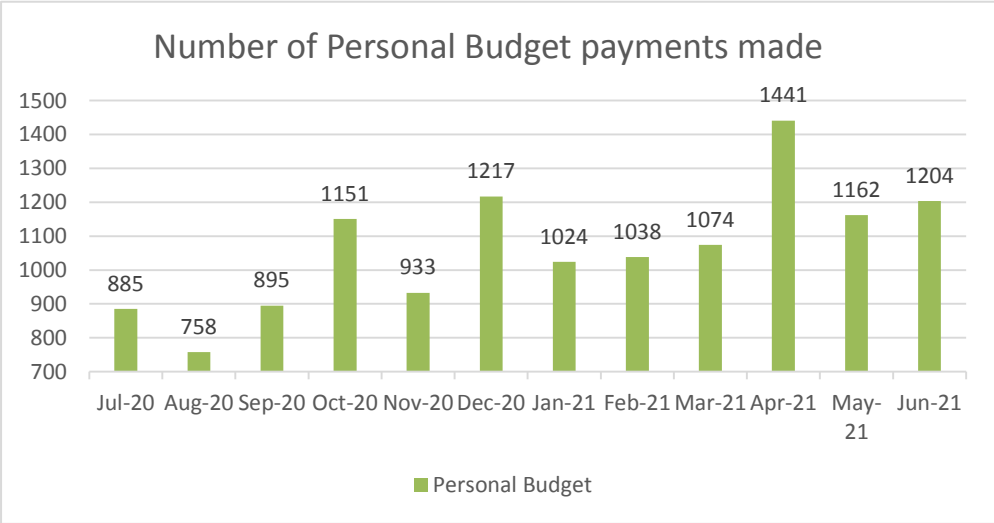
| Key Performance Indicator (KPI)/Measure | Target | Achieved June | Achieved July |
|---|---|---|---|
| Percentage of Band 1 Equipment delivered within five working days | 90% | 97% | 98% |
| Percentage of Complex Housing Modifications completed within 120 working days (Ministry of Health) | 60% | 88% | 64% |
| Percentage of Equipment provided to Service Users supplied from refurbished stock (Ministry of Health) | 35% | 29% | 31% |
| Grabrails Installation Non-Urgent (ACC) installed within five days | 95% | 62% | 73% |

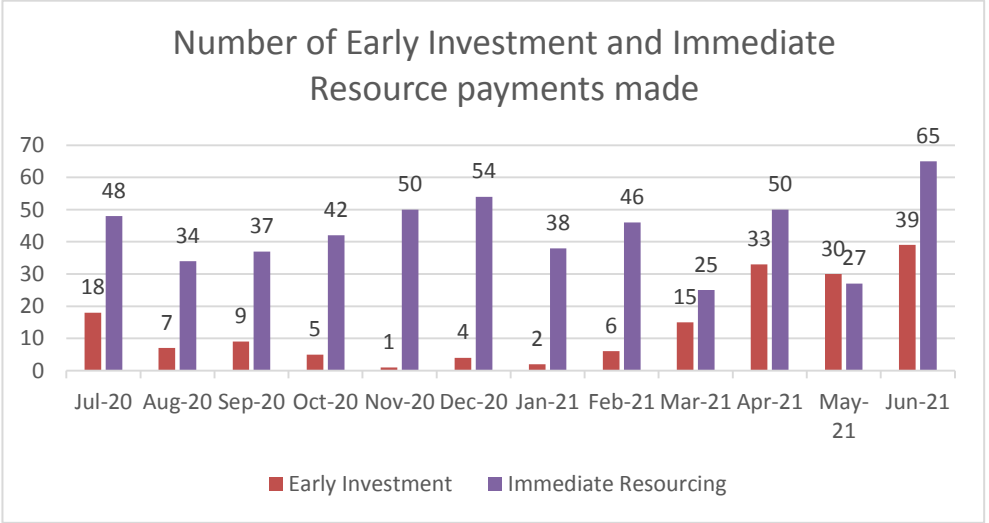
## Mana Whaikaha

All measures across the Mana Whaikaha Prototype have increased. Enable New Zealand continues to support the Ministry to embed its new model of service delivery.

*Table 2: Volume/Demand for Mana Whaikaha Services*

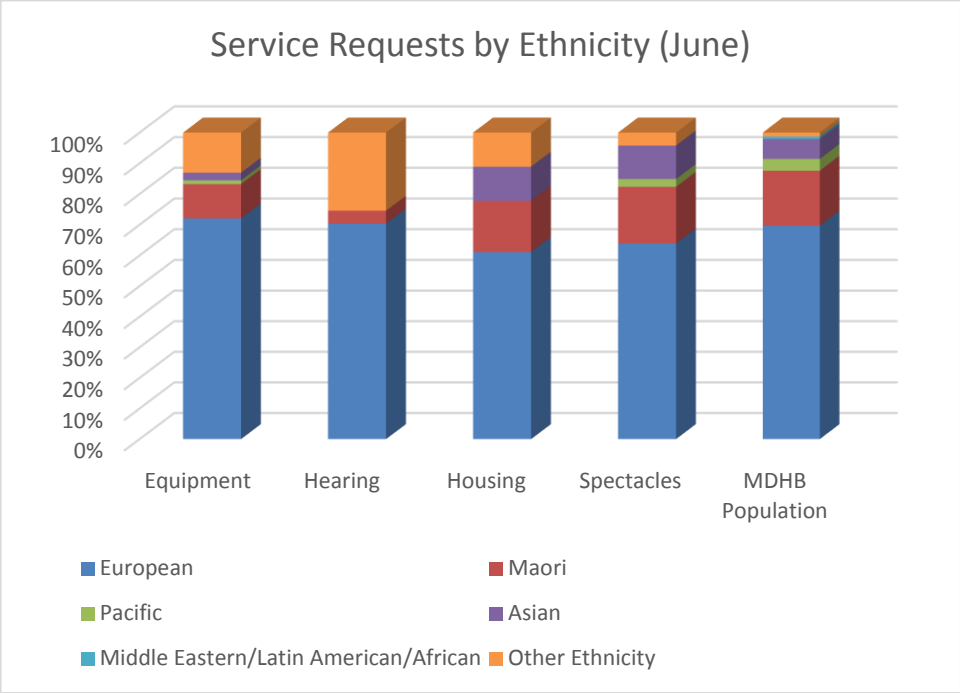
| Mana Whaikaha Regional Results | Launch of Prototype to July 2021 |
|---|---|
| Total disabled people active in the database | 2438 |
| People allocated to a Ministry of Health connector (and are still allocated to a Ministry of Health Connector) | 1281 |
| People allocated to their own/Independent Connector | 167 |
| People in queue (awaiting allocation to a connector) | 295 |
| Total number of individuals under the age of 21 years | 1001 |

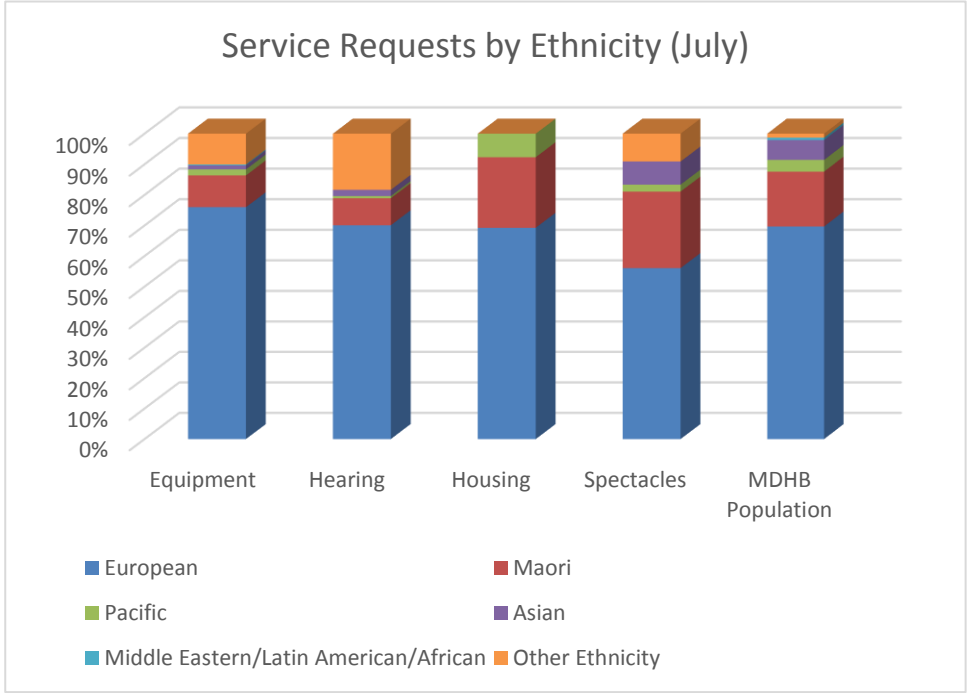


**Ethnicity data**

The following charts represent the ethnicity data for the MDHB region for the months of June and July 2021.



# HEALTH AND DISABILITY ADVISORY COMMITTEE


**For:**

| | |
|---|---|
| | Approval |
| | Endorsement |
| **X** | Noting |

**Key questions HDAC could consider in reviewing this paper:**

- Is the current progress against the annual plan actions satisfactory to HDAC members?
- Are the reports covering specific project updates well?

| | |
|---|---|
| **To** | Health and Disability Advisory Committee |
| **Authors** | Tracee Te Huia, General Manager, Māori Health<br>Lisa Te Paiho, Equity Lead, Te Uru Mātai Matengau |
| **Endorsed** | Kathryn Cook, Chief Executive |
| **Date** | 30 August 2021 |
| **Subject** | **Pae Ora Paiaka Whaiora Report – Māori Health Directorate** |

**RECOMMENDATION**

It is recommended that the Committee:

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

**Strategic Alignment**

This report is aligned to the MidCentral District Health Board's (MDHB's) strategy, the Ka Ao, Ka Awatea Māori Health Strategy 2020-2022 and the DHB's strategic imperatives, particularly Achieving Equity of Outcomes Across Communities.

## 1. OVERVIEW

| | Pae Ora Paiaka Whaiora Hauora Māori Directorate | RATING | |
|---|---|---|---|
| | **Engagement and obligations as a Treaty partner** | | |
| AP | 1. Build and review the training and induction process delivered for the newly constituted MDHB Board, to further their understanding and knowledge of Te Tiriti o Waitangi, WAI 2575 developments, and local Iwi and Māori health aspirations EOA | G | ↑ |
| AP | 2. Provide support to Manawhenua Hauora to identify priorities and aspirations for Māori health across the organisation EOA | G | ↑ |
| AP | 3. Provide Māori specific reporting on progress to achieve health equity to Manawhenua Hauora EOA | G | ↑ |
| | **Māori Health Action Plan – Accelerate the spread and delivery of Kaupapa Māori services** | | |
| AP | 4. Consolidate Kaupapa Māori Service provision within MDHB including the amalgamation of Oranga Hinengaro – Specialist Kaupapa Māori Mental Health Service and Pae Ora Paiaka Whaiora Hauora Māori Directorate EOA | G | ↑ |
| AP | 5. Develop an Outcomes Commissioning Framework that leads to an outcomes approach across the district and ensure it aligns with Kaupapa Māori measures of success and performance. EOA | G | ↑ |
| AP | 6. Prioritise new investment into Kaupapa Māori services across clusters EOA | G | ↑ |
| | **Māori Health Action Plan – Reducing health inequities- the burden of disease for Māori** | | |
| O | 7. Identify the opportunity to establish other Whānau Ora Link Nurses to focus on key high utilisation areas in secondary care for Māori EOA | G | ↑ |
| | **Sustainability Plan Actions** | | |
| AP | 8. Resource and implement the next phase of Kaimahi Ora Whānau Ora – Māori Workforce Development Implementation Plan 2017 – 2022 to advance the pipeline of Māori recruitment EOA | A | ↑ |
| AP | 9. Partner People and Culture to prioritise the recruitment of Māori to key areas of high utilisation by Māori EOA | A | ↑ |
| | **Working with sector partners to support sustainable system improvements** | | |
| AP | 10. Pae Ora will continue to actively contribute and participate in the Kainga Whānau Ora Collective Impact Initiative to support Māori into warmer drier homes EOA | G | ↑ |
| AP | 11. Investigate the establishment of a centralised hub across government agencies to empower families/whānau toward better health and wellbeing EOA | G | • |
| O | 12. Ensure Iwi aspirations are included in planning documentation and investment commissioning at MDHB EOA | G | ↑ |
| | **Delivery of Whānau Ora** | | |
| AP | 13. Align the investment and commissioning framework to Whānau Ora outcomes and intermediary measures to actively support and compliment the successes of Whānau Ora across the district EOA | G | ↑ |
| O | 14. Embed the MDHB Whānau Ora Position Statement and Implementation Framework into the planning and prioritisation material for FY 21/22 | G | ↑ |
| O | 15. Actively support Cluster Areas and Enablers to participate in Te Ara Whānau Ora training as part of the integrated workforce development approach across MDHB | G | • |

| **Rating & Trend Legend** | | | | | | |
|---|---|---|---|---|---|---|
| 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 |

## 2. PURPOSE

To provide the Committee with an update on progress of the work programme for Pae Ora Paiaka Whaiora – Māori Health Directorate from July to August 2021.

## 3. SUMMARY

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

- Māori workforce development implementation
- Combined Board to Board work plan
- Internal Audit – Equity for Māori.

## 4. MĀORI WORKFORCE DEVELOPMENT IMPLEMENTATION

Pae Ora Paiaka Whaiora welcomed Marcy Williams, Senior Māori Workforce Development Manager into the DHB on 2 August. Marcy comes to the DHB with extensive experience in Human Resources and Organisational Development knowledge. MDHB's workforce development strategy Kaimahi Ora Whānau Ora 2017-2022 and its implementation plan is currently being analysed for work completed and work streams yet to be implemented. We are expecting the draft refresh of Kaimahi Ora, Whānau Ora to the Organisational Leadership Team (OLT) and Manawhenua Hauora in September, with an update on this work and consultation on priorities over the coming months. We will seek endorsement for the direction of travel and then look to complete the plan of action from September.

## 5. COMBINED BOARD TO BOARD WORK PLAN

The combined work plan was approved in July by both MDHB and Manawhenua Hauora for implementation. Reports will be provided quarterly on this plan with the first one due in November 2021. A strong emphasis will be placed on the equity deep dive reporting of directorates in the meantime and the implementation of the findings within the Equity Report by Technical Advisory Services (TAS). The equity deep dive report for Child and Youth is included on this agenda. The report was discussed at Manawhenua Hauora at its August meeting with endorsement of the recommendations provided to progress to the Health and Disability Advisory Committee (HDAC). Progress is slow but steady and Manawhenua Hauora supported the continuation of current actions.

## 6. INTERNAL AUDIT – EQUITY FOR MĀORI

Lisa Te Paiho, Pae Ora lead for the internal audit findings on Equity for Māori, has been working with key executive leads on the recommendations and response. Attached is the template for monitoring of the implementation by the Finance, Risk and Audit Committee (FRAC) for your information. This report will be produced for Manawhenua Hauora and FRAC six-monthly. Interim reporting will also be provided through the General Manager, Māori Health to Manawhenua Hauora so that they have oversight inside of the six-monthly timeframe required by FRAC on progress with each recommendation.

Update re Progress on Implementation of Findings – August 2021

| **TITLE**: Māori Health Equity | **AUDIT REFERENCE:** IA01-20-07 Internal Audit report on Māori Health Equity System Review | **AUDIT OWNER:** Tracee Te Huia, General Manager Māori Health |
|---|---|---|
| **DATE OF AUDIT:** August 2020 | **AUDITOR:** TAS | **DATE OF UPDATE:** August 2021 |

**PURPOSE**:
To ensure that MidCentral District Health Board (MDHB) systemically monitors and addresses health inequities from a Māori health perspective. Compliance with the recommendations from this audit will go towards MDHB meeting its Te Tiriti obligations and Ministerial expectations. Under the Health and Disability Act 2000 the Ministry of Health and District Health Boards (DHBs) have a responsibility to ensure that all New Zealanders attain their maximum health potential. As evidenced through the WAI 275 Hauora claim there is much to be done if the goal of Māori Health Equity is to be reached. The following recommendations are from the Māori Health Equity System Review completed in August 2020 which were approved by the Board. Progress against each recommendation is reported directly to the Board at a time determined by them based on the priority of the recommendation.

| No. | Recommendation | Owner | Completion Date | Actions | Status |
|---|---|---|---|---|---|
| 1 | *Build a Māori workforce*<br><br>The Māori health strategy Ka Ao, Ka Awatea was refreshed in 2020. It seeks to guide staff with key simple implementation and monitoring tools. The DHB continues to work at a governance level in partnership with Manawhenua Hauora. A series of trainings and equity Think Pieces were produced by Pae Ora. There has been clear movement in current resourcing towards aligning with the strategic priority for equity. Currently there is limited training and/or support that focuses on Māori health equity and development of associated competency. There are inconsistencies in how important equity is versus how recruitment decisions are made. MDHB needs the right skills to drive health equity with a | GM Māori Health<br><br>GM Māori Health<br><br>GM People and Culture | <br><br>30 September 2021<br><br>Nov 2021 | Implement the strategy Ka Ao, Ka Awatea in tandem with MDHB's 10-year health plan to ensure partnership and alignment across the sector.<br><br>Resource the implementation of the DHB workforce plan Kaimahi Ora, Whānau Ora 2017-2022.<br>• Strategy refresh approved<br>• Action plan out to 30 June completed<br>• Resourcing identified.<br><br>Implement consistent strategies relating to equity within the recruitment processes ie | |

| | | | | | |
|---|---|---|---|---|---|
| | workforce that is fit for purpose**.** More Māori staff (particularly in senior roles), and contemporary Māori health and equity expertise are required across the MidCentral health workforce. This includes advisory groups and committees that influence DHB decisions such as Consumer and Clinical Councils. The role and size of Pae Ora also needs to be strengthened to support the General Manager, Māori Health and to reflect the current priority and expectations relating to equity. This will also enable the team to help build wider organisation capability in Māori health and equity. | GM People and Culture and GM Maori Health<br><br>GM Māori Health<br><br>GM Quality and Innovation | 30 September 2021<br><br>December 2021 then BAU | the importance of equity versus how recruitment decisions are made.<br>• Implement education sessions for hirers<br>• Audit recruitment against ethnicity<br>• Develop HR processes that support increased Māori staff recruitment<br>• Preliminary assessment.<br><br>Set a yearly 10% increase in current Māori staff for each professional grouping.<br>• Review quarterly.<br><br>Prioritise resourcing to strengthen the role and size of Pae Ora and their support to the General Manager, Māori Health.<br><br>Recruit Māori expertise onto advisory groups and committees such as Consumer and Clinical Councils.<br>• Consumer Council<br>• Clinical Council<br>• Clinical governance<br>• CAGs and Cluster Governance. | |
| 2 | *Strengthen Equity Capability*<br><br>Pae Ora has partnered with DHB Directorates to implement equity focused leadership roles. These partnership roles help to give effect to the Articles of Te Tiriti o Waitangi with a shared approach to improve the outcomes for Māori. There is opportunity to increase training and capability of staff and services related to their understanding of Te Tiriti o Waitangi. Current training is receiving high praise, however there is a challenge with the current resourcing. For sustained success in this area MDHB leadership must be champions of pro-equity approaches and take on an organisational leadership role to this effect. They need a learning environment where they can engage external health equity expertise to provide executive team coaching focused on a pro-equity approach. External expertise could also be used for the Board which would better enable them to hold the organisation to account for equity performance | GM Māori Health<br><br>OLT<br><br>GM Māori Health<br><br>GM Māori Health | November 2021<br><br>30 September 2021 | Improve staff capability and understanding of their obligations under Te Tiriti o Waitangi and have the resourcing to make this training compulsory for all staff every three years.<br><br>Determine a budget and prioritise resources for equity expertise for OLT, the Board and staff.<br><br>Commit to a training budget to provide pro-equity, anti-racism and decolonisation training.<br><br>Implement more equity focused leadership roles in partnership with Pae Ora.<br>• Te Uru Mātai Matengau complete<br>• Te Uru Rauhī - complete<br>• Te Uru Pā Harakeke - recruiting<br>• Te Uru Arotau – in discussion phase. | |

| | | | | | |
|---|---|---|---|---|---|
| 3 | *Māori Health Equity reporting and monitoring*<br><br>Ethnicity data is currently captured via the agreed principle of self-identification. There is an opportunity to educate frontline staff and increase the accuracy of this data. The "Equity Dashboard" – Māori Health Indicators report is largely focused on Ministry of Health indicators for monitoring with a couple of local indicators added for Māori workforce. These measures should be reviewed and refined with local focus added and alignment to MDHB equity. | General Manager Finance and Corporate Services | September 2021<br><br>31 August 2021 | Improve the accuracy of ethnicity data and ensure it informs all work and decisions that occur.<br>Educate administration staff on the importance of capturing accurate ethnicity data and implement processes that work.<br><br>Align the current equity dashboard to specific MDHB equity actions.<br><br>Make equity reporting available to all advisory groups and committees such as the Clinical Council, Consumer Council and new enterprise groups (Dec 2021).<br>• Te Ara Angitū to go to councils before HDAC and embed this in the work plan of the group.<br><br>Make available standardised monthly reporting to the GM Māori Health to enable effective monitoring.<br>• Acute and Elective to provide regular reporting like ED did not waits by ethnicity, and DNAs<br>• Non-performance outliers should be reported<br>• All reporting that needs an equity focus should be made available. | |
| 4 | *Demonstrable Action to Achieve Equity*<br><br>Using data to identify clinical areas where inequities exist, setting aims, addressing gaps and implementing strategies to address these gaps is inconsistent. The Ka Ao, Ka Awatea refresh includes an action template which provides an effective means for services to reflect and align with Whānau Ora outcomes and Te Tiriti o Waitangi obligations. Insight needs to be provided into the wider areas where determinants of health impact Māori equity. It is noted that currently the demand for services by Pae Ora exceeds current resourcing. | GM Māori Health | 31 August 2021 | Widen the focus of Te Ara Angitū to include the wider determinants of health so that the DHB can gain insight into issues such as GP access, access to medication and counselling and access to medicine education.<br><br>Evolve local reporting on the performance of the identified equity actions in the annual plan.<br><br>Utilise the Ka Ao, Ka Awatea action plan template. | |

| | | | | | |
|---|---|---|---|---|---|
| | | | 31 August 2021<br><br><br><br>Completed and underway | Resource Pae Ora to enable them to meet the demand to support whānau in and out of the hospital.<br>• Change structure of current roles<br>• New roles to support whānau as inpatients and in the community.<br><br>Include equity activities in quality reporting.<br>• All reporting has ethnicity included in the framework and the method<br>• Complaints have equity defined. | |
| 5 | *Public Health Support for Māori Health.*<br><br>There is a need for a strong public population health response to Māori equity. The review could not identify where support was occurring from the current Public health resources to provide expertise and advice into Māori Health | Operations Executive Uru Kiriora | 30 September 2021 | A strong public population response to Māori equity is required. Ongoing writing of equity think pieces, health needs assessments and health status reviews is required.<br>• Increase equity FTE of Māori advisor<br>• Māori specific equity role required<br>• Māori advisor to have ability to input into pieces of work. | |
| 6 | *The Drivers of Inequity are not well understood*<br><br>The understanding of racism and its connection with health appeared limited. Racism was rarely spoken of in terms of institutional or structural racism. The use of the term racism was seen as taboo by many with a preference to discuss inequity. The review did not identify any activities that looked specifically at the attitudes and behaviours of staff and the role of racism in regard to inequity. | GM Māori Health | 31 December 2021 | Increase the comfort level of staff to discuss racism in terms of structural and institutional racism.<br>Implement activities that encourage staff to look at the role of racism in regard to inequity and to understand the impacts of racism and privilege.<br>• Use equity leads to train clusters<br>• Use Māori staff to support training<br>• Need leadership to support this. | |
| 7 | *Increased use of storytelling*<br><br>There was evidence of storytelling occurring by both staff and patients about how events relating to racism and/or oppression had impacted services and themselves. The DHB is reviewing policies and practices to assess for potential inequitable practice. The effectiveness of these reviews is dependent on the equity capabilities of those involved in the review. | GM Quality and Innovation | 31 December 2021 | Increase storytelling in regard to the impacts of racism on staff and patients. Capture these stories and share them with all staff.<br>• Publish the stories and put in the library<br>• Consider videos as resources<br>• Capture Iwi stories<br>• Patient stories good and not so good told and used<br>• Promote good practice. | |

| | | | | | |
|---|---|---|---|---|---|
| 8 | *Strengthen the authentic partnership with Māori*<br><br>The new equity commissioning framework cantered on Whānau Ora outcomes looks to be promising and to be effective in establishing new innovative services that target Māori equity. Additional methods for monitoring achievement under the framework will be required to align with the change in outcome focus. The DHB is committed to working at a governance level in partnership with Manawhenua Hauora on this.<br><br>The induction to Manawhenua Hauora could be reviewed to ensure members can engage appropriately and contribute to true partnership. Strengthen the consumer voice for Māori equity by strengthening Māori representation on the consumer council. | GM Māori Health<br><br>OLT | Feb/March 2022 | Planning and Integration Leads to use equity commissioning frameworks to establish new innovative services targeting Māori equity.<br>Implement methods for monitoring achievement with an outcome focus.<br><br>Review induction, support and resourcing of Manawhenua Hauora to ensure the ability for members to contribute in true partnership.<br><br>Resource and facilitate meaningful participation in the design of services with Māori whānau, communities and health and social service providers. | |

## 7. COVID-19 PROGRAMME – MĀORI HEALTH

A sterling effort has been made by all teams across the sector including iwi, MDHB, THINK Hauora, Te Tihi, and Māori providers on the rollout of the COVID-19 vaccinations for Māori. A strong monitoring system is in place managed by Te Uru Kiriora in partnership with Pae Ora to ensure any inequity is picked up quickly so that we can implement strategies as required. Te Tihi Alliance has stood up its daily Zoom meetings with iwi and Māori organisations across the district, ensuring all issues are reported and resolved in real time. We commend Te Tihi for its leadership on Māori communications in our rohe and for its coordination of the Māori and iwi voice on COVID-19 related matters. We acknowledge the extensive work iwi and Māori providers have undertaken throughout the rollout of the vaccination campaign. *Ka mau te wehi*.

## 8. BONNIE MATEHAERE, NURSE EDUCATOR MĀORI HEALTH – AWARD FOR OUTSTANDING SERVICE TO NURSING

On 14 August 2021, at a dinner in the Parliament building, Bonnie Matehaere was presented with the Te Runanga o Aotearoa Service Award for her 'Outstanding Services to Nursing'. Last year Pae Ora, in partnership with Nga Manu Teka Practice Development, appointed Bonnie to the position of Nurse Educator Māori Health. Bonnie started her nursing career in Coronary Care at MidCentral DHB before moving to Best Care Whakapai Hauora as a Mobile Primary Health Nurse/Practice Nurse. Bonnie has a broad range of knowledge in Te Ao and Tikanga Māori which coincides with her passion to want to make a difference to the health of Māori populations. She provides leadership and education in cultural and clinical best practice alongside the Pae Ora team. Together they focus on strengthening non-Māori services toward both cultural and clinical competency. In her educator role Bonnie and the team are working to grow the Māori nursing workforce and more particularly the nurse practitioner workforce. This will assist iwi and Māori providers who seek to have nurse practitioners to ensure better access to health care services for whānau.

Bonnie is currently the clinical lead for the Māori health rollout of the COVID-19 vaccination programme across the MidCentral DHB District and in her spare time is studying toward a post graduate diploma in Kaitiakitanga with Te Wananga o Aotearoa. Having been funded by the Nurse Education Research Fund, Bonnie is developing a cultural supervision model that if approved, will be rolled out nationwide.

Bonnie's mantra is 'e hara taku toa i te toa takitahi engari he toa takitini. My strength is not my own, it is the strength of many'. *Tau kē Bonnie*!



# Discussion/Decision papers

*14 September HDAC*

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

# HEALTH AND DISABILITY ADVISORY COMMITTEE


**For:**

| | |
|---|---|
| | Approval |
| | Endorsement |
| **X** | Noting |

**Key questions the Committee should consider in reviewing this paper:**

- Are Committee members sufficiently informed by this paper about the End of Life Choice Act 2019?

| | |
|---|---|
| **To** | Health and Disability Advisory Committee |
| **Author** | Dr Claire Hardie, Clinical Executive, Te Uru Mātai Matengau |
| **Endorsed by** | Kathryn Cook, Chief Executive |
| **Date** | 18 August 2021 |
| **Subject** | **End of Life Choice Act 2019** |

**RECOMMENDATION**

It is recommended that the Committee:

- **note** the current information available regarding implementation of the End of Life Choice Act 2019
- **note** the establishment of a MidCentral District Health Board (MDHB) working group to ensure MDHB meets its obligations under the Act.

**Strategic Alignment**

This report is aligned primarily to MidCentral District Health Board's (MDHB) strategy.

## 1. PURPOSE

To provide the Committee with an update on the implementation of the End of Life Choice Act 2019 within MDHB. It is for the Committee's information. No decision is required.

## 2. SUMMARY

- The End of Life Choice Act 2019 comes into force on 7 November 2021.
- The Act outlines the legal framework that allows a person who has a terminal illness and meets the eligibility criteria the option to request medication to relieve their suffering and end their life.
- Assisted dying is another option for people who have a terminal illness and exists within the context of other health services. It is not a replacement for palliative care or health care services more generally.
- The Ministry of Health (the Ministry) will be responsible for the Act and has developed a work programme to implement it. The Ministry will also hold responsibilities for the ongoing oversight of assisted dying services once they are available.
- MDHB has established a working group to ensure the DHB meets its obligations under the Act.

## 3. BACKGROUND

The End of Life Choice Act 2019 (the Act) outlines the legal framework that allows people who have a terminal illness and meet the eligibility criteria to request medication to relieve their suffering and end their life. An eligible person can choose to self-administer the medication (in the presence of a medical or nurse practitioner), or request that a medical or nurse practitioner administers the medication.

From 7 November 2021, people will be able to request assisted dying. However, they must meet strict and specific criteria to be eligible. Not everyone with a serious illness will be eligible for assisted dying.

To be eligible, a person must meet all of the following criteria:

- be aged 18 years or over
- be a citizen or permanent resident of New Zealand
- suffer from a terminal illness that is likely to end their life within six months

- be in an advanced state of irreversible decline in physical capability
- experience unbearable suffering that cannot be relieved in a manner that the person considers tolerable
- be competent to make an informed decision about assisted dying.

A person cannot receive assisted dying solely because they are suffering from a mental disorder or mental illness, have a disability, or are of advanced age.

Any medical or nurse practitioner who is suitably qualified and willing to do so will be able to provide assisted dying services. This means that assisted dying services may be provided through a variety of different health service providers. It is expected that generally assisted dying services will be provided in home and community settings.

If a practitioner is providing services through private practice, a Non-Government Organisation or a primary care organisation, they will be able to access funding through a fee-for-service model. If a practitioner is providing services as part of their employment within a DHB, DHB funding will cover these costs. Individual practitioners will not receive separate funding in this instance.

Medical and nurse practitioners do not have to be involved with assisted dying if they have a conscientious objection. However, these health practitioners still have obligations under the Act and cannot deny a patient access to legal medical treatment and must ensure a patient still receives continuity of care. If a health practitioner with a conscientious objection is asked by a patient about assisted dying, they must inform the patient of their conscientious objection and tell the patient that they have the right to ask the Support and Consultation for End of Life in New Zealand (SCENZ) Group for the name and contact details of a medical practitioner who is willing to participate in assisted dying.

It is of note that a DHB cannot, as an organisation, be a conscientious objector to assisted dying.

As part of the implementation, the Ministry is providing information, guidance and training about the Act and the assisted dying process to health professionals.

## 4. DELIVERY OF ASSISTED DYING SERVICES AT MDHB

The Ministry of Health will determine the details of how assisted dying services will be provided in practice. This includes developing a service specification, standards of care and clinical guidance for assisted dying services.

DHBs are expected to prepare for situations where people may request information about or access to assisted dying and the Ministry is developing a policy template for DHBs to localise for their own context. It is understood that the Ministry has primary

responsibility for engaging with the community health sector including primary care, primary health organisations and aged residential care facilities. Whilst engagement of DHBs with community providers are welcome, the Ministry has indicated the messaging around roll out and implementation will come from the Ministry.

To meet its obligations under the Act, MDHB has nominated a Clinical Lead for assisted dying implementation, Dr Claire Hardie, Clinical Executive, Te Uru Mātai Matengau (Cancer Screening, Treatment and Support). Dr Hardie is actively seeking to engage with Manawhenua Hauora to present to their Board on the expectations and obligations of DHBs under the Act.

At present, MDHB has established a working group with representation across different clinical disciplines (including medical ethics), spiritual care, Pae Ora Paiaka Whaiora Hauora Māori and a consumer representative to review Ministry information and guidelines as it relates to the Act. The working group will develop the DHB policy on assisted dying once the framework for this policy has been released by the Ministry. A multidisciplinary team will be put in place at MDHB if a patient domiciled within MDHB boundaries requests assisted dying. The aim of this team will be to ensure the patient and the medical/nurse practitioners are supported throughout the process, including their spiritual care and cultural safety.

A communication strategy is being developed with the DHB communications team to ensure all DHB staff are aware of the Act and the resources available that provide information and training on the Act and assisted dying. In addition, members of the working group are meeting with clinical teams across the DHB to raise awareness of the Act and the obligations of health practitioners under the Act.

Whilst it is acknowledged that most assisted dying services will be provided in a person's home, if this is not possible, for whatever reason, an alternative location will need to be provided. Currently, the MDHB working group is considering options for a location either on or close to the Palmerston North Hospital campus.

The working group will continue to meet regularly and action any guidance or directives from the Ministry on the implementation of the Act.

# HEALTH AND DISABILITY ADVISORY COMMITTEE


**For:**

| | |
|---|---|
| | Approval |
| **X** | Endorsement |
| | Noting |

**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 and sufficiently?
- Are there any concerns about quality and safety of patient care measures which require more explanation?

| | |
|---|---|
| **To** | Health and Disability Advisory Committee |
| **Author** | Susan Murphy, Manager Quality Improvement and Assurance<br>Mariette Classen, Manager Consumer Experience |
| **Endorsed by** | Judith Catherwood, General Manager, Quality and Innovation |
| **Date** | 20 August 2021 |
| **Subject** | **Quality and Safety Dashboard** |

**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 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 our clinical teams to have access to the clinical outcome, quality and safety data appropriate to their service or population group.

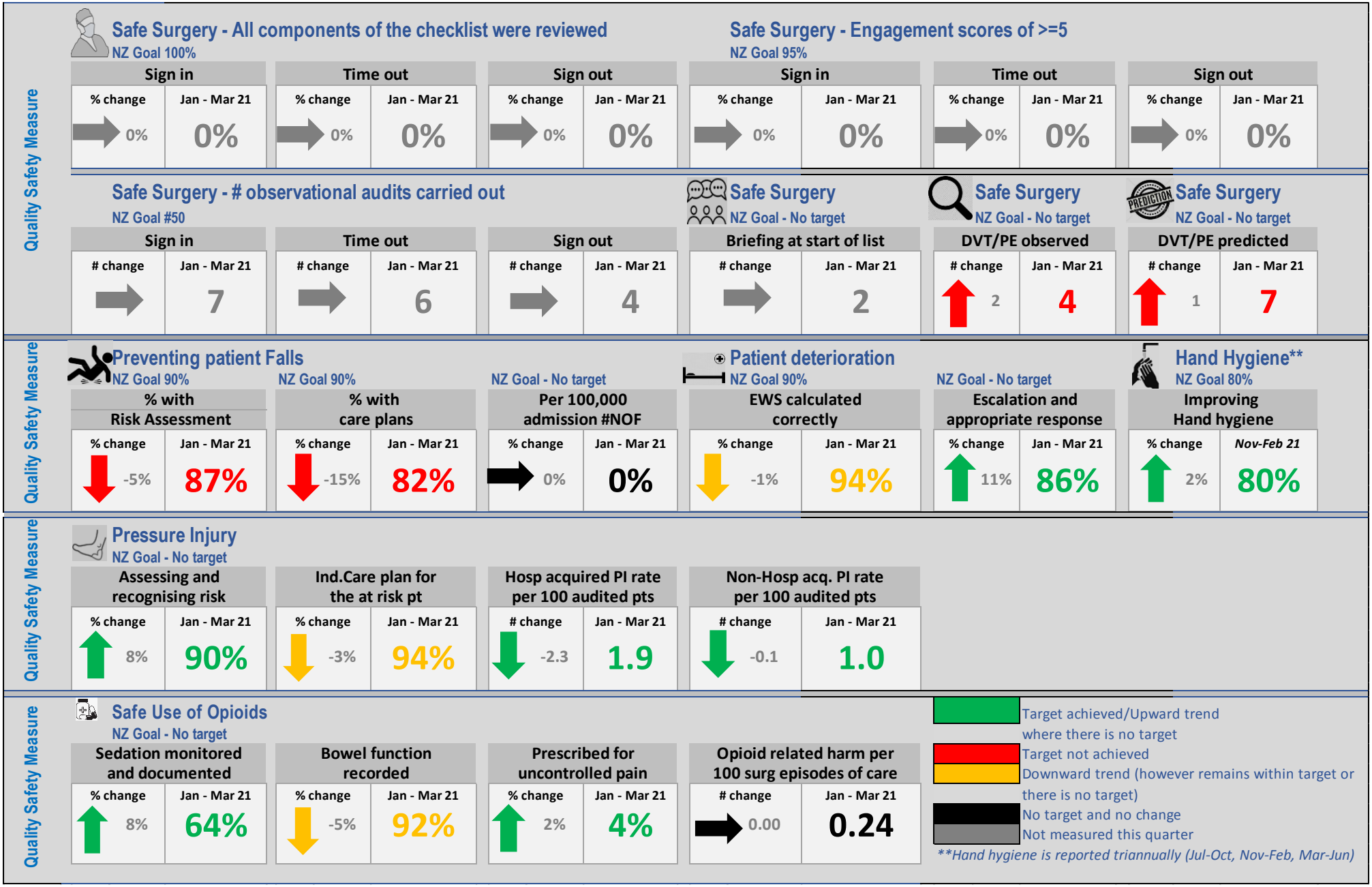
This dashboard provides an 'at a glance' approach and is inclusive of ethnicity breakdown, summary narrative on compliance, achievements and actions being taken for improvement. Further information about the current and historical performance of all DHBs on the QSMs is available on the Health Quality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

As MDHB continues to develop its clinical governance support system, the importance of clinical data and improvement analytics is well articulated and understood. There are plans to recruit an Improvement Analyst to advance this work. Further enhancements to this dashboard will be made as this work is progressed.

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. Appendix One provides trends in the statistical process control (SPC) graphs for several indicators.

## 3. Quality and Safety Marker dashboard (HQSC latest data January 2021 – March 2021)



## 3.1 Quality and Safety Markers Background

Quality and Safety Markers (QSM) 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 has occurred. The following link for further information and data about the QSMs: https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/quality-dashboards/dashboard-of-health-system-quality

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.

The QSMs are designed to embed best practice across the sector. Once improvement is demonstrated in a QSM, it is strong indicator that the sector is engaged and harm is being reduced. Two QSMs have moved into a sustainability phase by the HQSC. This includes the falls and surgical site infection QSMs. DHBs are no longer required to report on these measures. MDHB will continue to collect falls process measurement data and actual surgical site infection rates to inform local improvement.

### 3.1.1 Quality and Safety Marker Performance

Historically when compared to other DHBs, MDHB has performed above average in all QSMs.

The Safe Surgery QSM measures level of teamwork and communication relating to the paperless surgical safety checklist. While surgical teams are doing well in the sign in and sign out process, an action plan is in place to support improved performance in the time out component of the process. The surgical safer surgery audit scores were not reported for this quarter due to a communication error involving data entry. The checklist itself is being used routinely in theatres and the auditing and data entry issues have been resolved for the next quarter.

MDHB performance in prevention of falls demonstrates historical strong performance. MDHB rates of falls with harm are historically low and compare favourably with other DHBs. There has been an overall reduction in falls of 17 percent for the quarter. All patients are assessed for their falls risk when admitted and a falls prevention care plan is used for all patients who are at risk. MDHB will continue to monitor falls risk assessment and care plan process measures and maintain the commitment to the prevention of falls.

The Patient Deterioration QSM measures patients with cardiopulmonary arrests or rapid response escalations. Early Warning Scores (EWS) calculated correctly, shows a one percent change to 94 percent. This is still above the national target of 90 percent and reflective of the sample size difference between each quarter.

The Escalation and Appropriate Response marker measures whether an escalation of care was triggered, and the patient received the appropriate response to that escalation. This marker has shown a continued improvement of 11 percent from the previous quarter to 86 percent; above the national reported figure of 69 percent.

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 continued to meet the target in the last two reporting periods. An action plan is in place to continue to support improvement in the Hand Hygiene QSM. The Infection Prevention Control (IPC) team continues to work with several areas to raise awareness of expected standard of care with regards to hand hygiene. The aim is ongoing improvement in hand hygiene results through maintaining a pool of Gold Auditors who support the undertaking of audit practices. 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 has been a significant improvement in the last quarter relating to assessment rates. A slight decline in the use of individual nursing care plans is observed. Both outcomes are above the New Zealand average. The pressure injury working group continues to provide oversight to nursing leadership on performance and interventions required to continuously improve this QSM.

### 3.1.2 **The Consumer Engagement QSM**

In 2015, the HQSC's consumer engagement programme, Partners in care, commenced work on development of a QSM for consumer engagement. The aim was to understand what effective consumer engagement looks like, how services and consumers know that consumer engagement is happening, and if or how it improves the quality and safety of services. The QSM was successfully developed and introduced to DHBs in July 2020.

MDHB established a Consumer Engagement QSM oversight group with members representing each Directorate as well as Pae Ora Paiaka Whaiora Hauora Māori, Strategy Planning and Performance, Quality and Innovation and the Consumer Council.

The first national reports for the Consumer Engagement QSM were in March 2021. The Consumer Engagement oversight group completed a review of consumer engagement activities for each of the Directorates. Evidence of best practice in supporting consumer engagement was collated, and robust discussions about the measurement criteria and ratings were held. The insight gleaned from this self-assessment rating will support the improvement in consumer engagement (including equity aspects) across MidCentral DHB.

MDHB has reviewed the consumer engagement activities from a Te Tiriti o Waitangi perspective. This has helped gauge the current level of partnership at MDHB. To enable MDHB to fulfil its obligations under Te Tiriti, engaging Māori, co-designing projects with a Māori focus, and embedding Te Tiriti into DHB policy and guidelines should always be supported and facilitated.

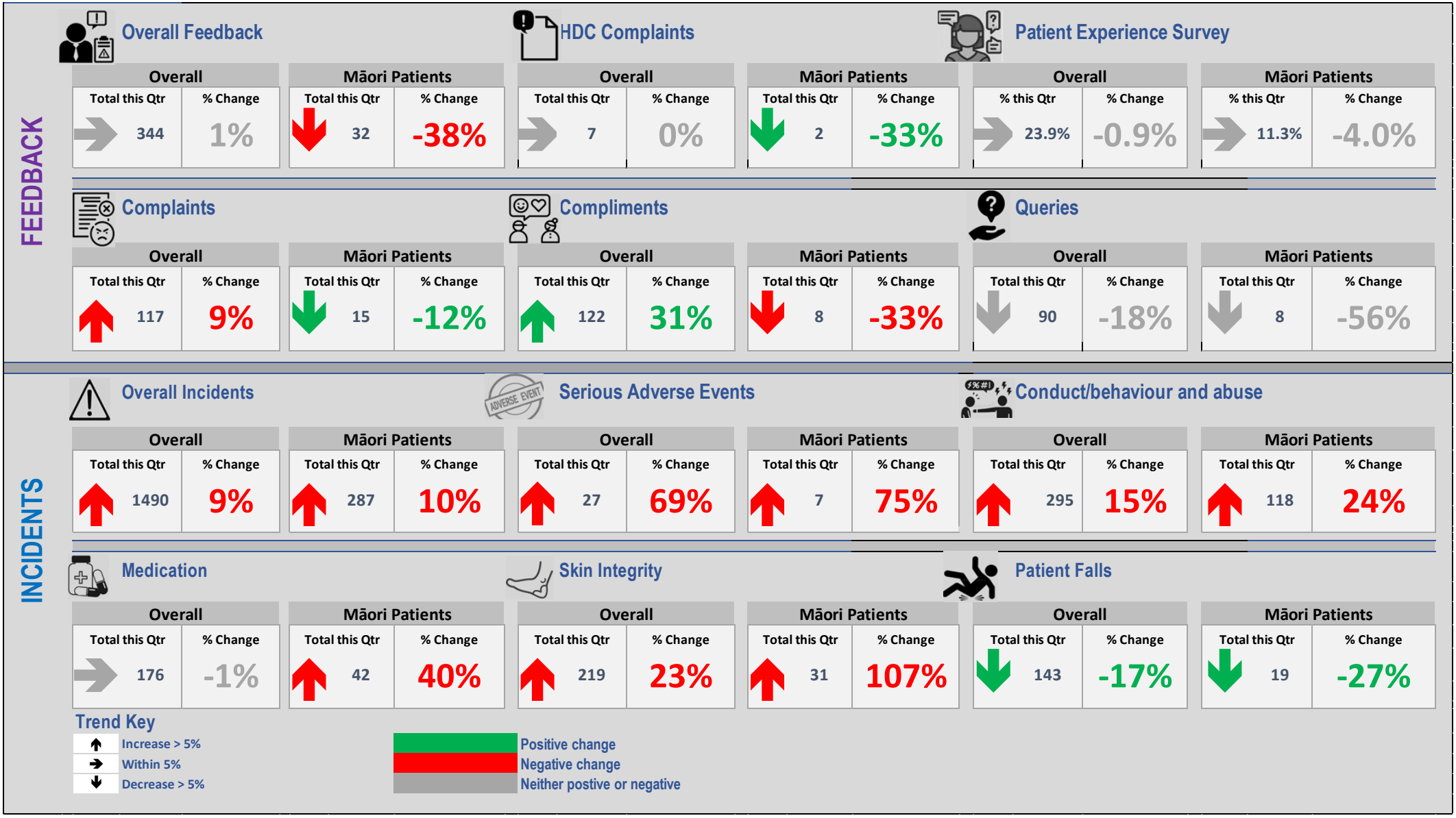
Progress on the implementation of the QSM for consumer engagement will continue with the oversight group guiding this work.

The baseline evidence submitted in the self-assessment, included terms of reference and policy documents demonstrating the infrastructure and intentions to engage with consumers and whānau. The HQSC has provided feedback. The next round of submissions will consider how these have been actioned and/or evaluated. All DHBs will be reporting twice a year on the consumer engagement QSM and MDHB will continue to report on progress.

The baseline data for DHBs was published on the Commission's website on 1 July and can be viewed here: https://public.tableau.com/app/profile/hqi2803/viz/ConsumerengagementQSMJune2021/Home. All ratings and examples across the DHBs, as well as some key questions linked to this QSM are available to view on the Commission's website.

## 4. QUALITY AND SAFETY DASHBOARD

(Quarterly comparison between January 2021 to March 2021 and April 2021 to June 2021)



## 4.1 Feedback

Overall, the number of complaints received remains consistent and within normal variation compared to the previous quarters (Appendix One: Fig 4.1.3.) There has been an increase in the number of compliments received for this reporting period. Overall compliment rates remain slightly lower than expected but within normal variation (Fig 4.1.4). There was an overall decrease of one percent in feedback received this quarter.

Thirty-two percent of complaints received required an extension to the due date for completion. This is an increase from the previous reporting period, however it remains in line with previous trends (Fig 4.1.2). The number of queries received decreased by 18 percent for this reporting period and the rate has returned to 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 (HDC) during this quarter.

### 4.1.1 **Inpatient experience survey**

The HQSC led a national procurement process for a new service provider for the National Patient Experience Surveys in 2020. There was a delay in implementing changes due to COVID-19. The survey was refreshed and supports a more culturally sensitive questionnaire which enables increased participation from under-represented groups (in particular, Māori and Pacific peoples).

The first round of the refreshed survey was completed in November 2020. Due to the change in service providers, no historical data could be transferred, and new baseline data had to be accumulated prior to reports being recommenced. Regular reporting on the MDHB ratings will be provided.

A highlight of the five best and worst performing areas for MDHB in comparison with national results is provided (Appendix Two – Patient Experience Survey May 2021). The results indicate where MDHB is performing well and where there are opportunities for improvement. MDHB results are comparable to other DHBs.

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 lead 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 increased this quarter. Reported rates appear to be showing normalisation back to baseline levels (Appendix One: Fig 4.2.1). The rate of increase remains within the upper and lower control limits and are similar rates 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 (SAE)

There were 27 new SAE (SAC 1 or 2) in this quarter, which includes two staff injuries from falls. Of the 25 patient events, seven are associated with pressure injuries, eight suspected suicides, five falls that resulted in fractures, and one always report and review event. There are three SAC 1 events reported in this quarter that are currently undergoing root cause analysis review.

There has been a significant increase in reported serious adverse events this quarter. This includes increases in reported suspected suicides, falls with harm, and pressure injuries in comparison to previous quarters. A review of trends and implications of this rise is underway. This will be finalised once HQSC release the national reported data at the end of August 2021. MDHB will compare rates with the nationally reported rates, including any actions required to improve safety.

Nineteen SAE reviews were concluded during this quarter (Fig 4.2.2). This is an increase of nine compared to last quarter. The total number of days to complete the reviews remains under the target of 70 working days set by the HQSC. Three case reviews have taken longer due to their complexity and required external input.

Three new action plans have been created this quarter as an outcome of reviews of SAEs. Seven action plans were completed and closed this quarter, as all recommendations have been actioned.

### 4.2.3 Patient falls

The number of patient falls has remained steady since November 2020 with an average rate of 50 falls per month (Fig 4.2.4). This dipped in June to a total of 34 falls. There were six falls resulting in significant harm this quarter which is an increase on the previous quarter. There had previously been no reported falls with harm from September 2020 to February 2021. It has been noted there appears to be an increase in falls over the winter period and may be attributed to the increase hospital occupancy and increased patient acuity. This special cause variation in numbers will be monitored to ensure there is no increasing trend and themes and identified risks from these incidents are being actively reviewed to identify improvement opportunities to maintain safety of patients.

### 4.2.4 **Pressure injuries**

There has been a slight increase in reported skin integrity incidents (stage 1 and 2) (Fig 4.26). These are newly-formed lower severity pressure injuries. Seven significant pressure injuries were reported and classified as SAC 2 events (Stage 3 and 4 skin integrity incidents). The Pressure Injury Working Group is currently identifying if there are any trends with the recent increase in SAC 2 pressure injuries.

### 4.2.5 **Incident rates for Māori**

The increase in skin integrity, conduct behaviour/abuse incidents and medication incidents for Māori this quarter are being reviewed in detail. There has also been a noticeable increase in serious adverse events impacting on Māori in this quarter, increasing from four events last quarter to seven in this reporting period. Four of the seven serious adverse events for Māori are currently undergoing root cause analysis review with a whānau liaison identified for each event. The other three events included unexpected deaths in the Mental Health and Addiction Services Directorate and a fall with fracture for which whānau were present at the time of incident and included in the review process.

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

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

## APPENDIX ONE – TREND DATA FOR FEEDBACK AND INCIDENTS

Figure 4.1.1

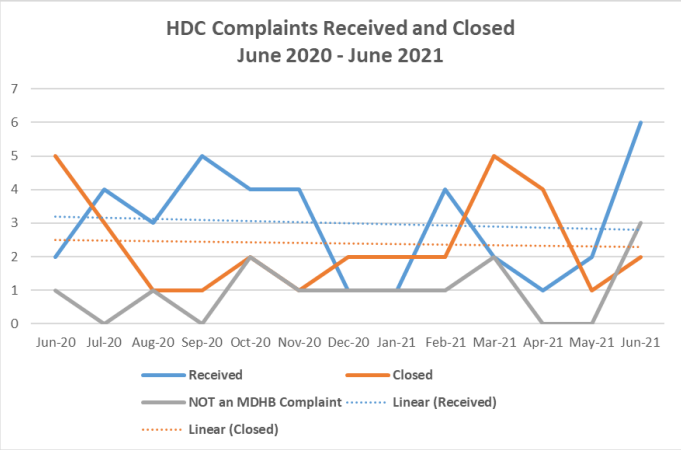



Figure 4.1.2

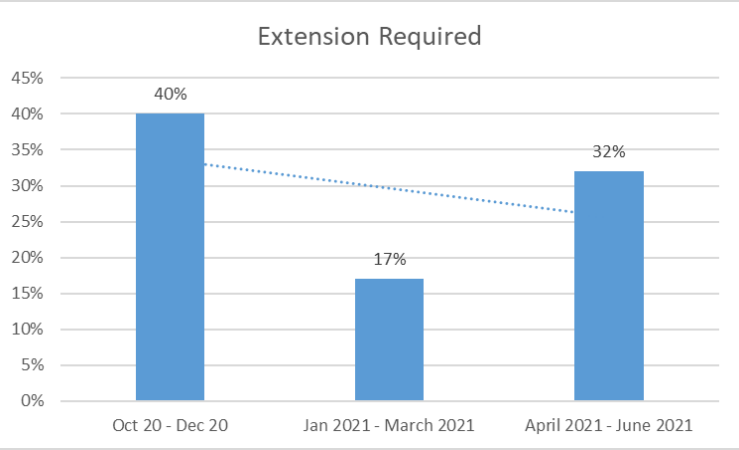



Figure 4.1.3

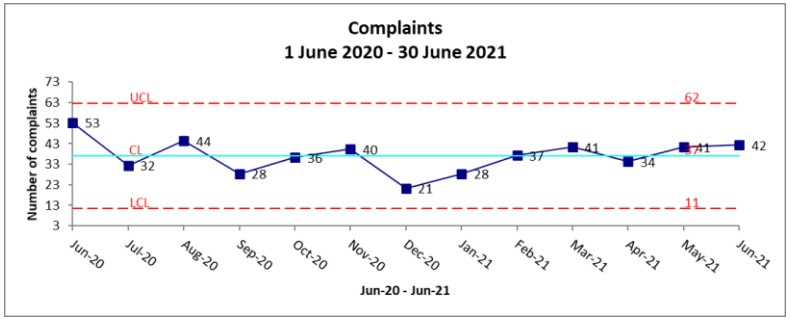



Figure 4.1.4

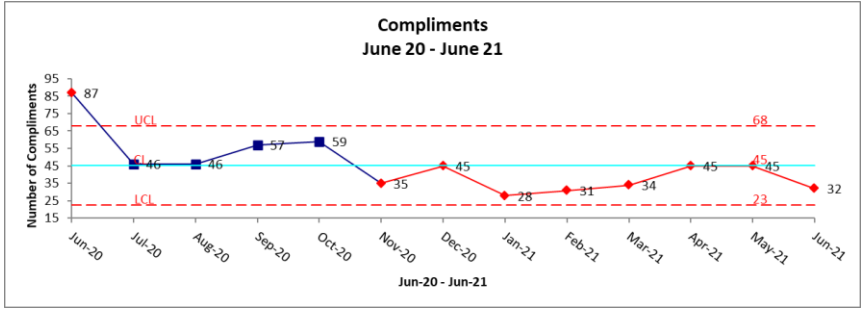



Figure 4.1.5

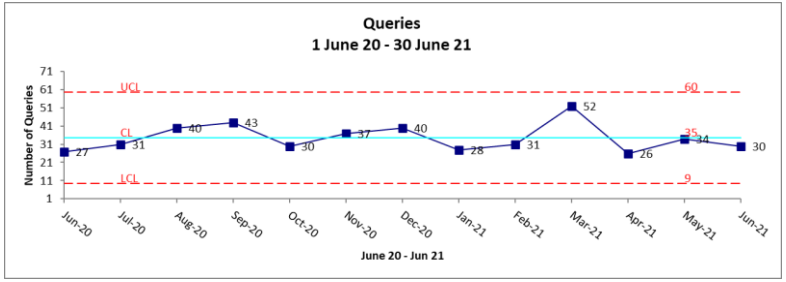



Figure 4.2.1

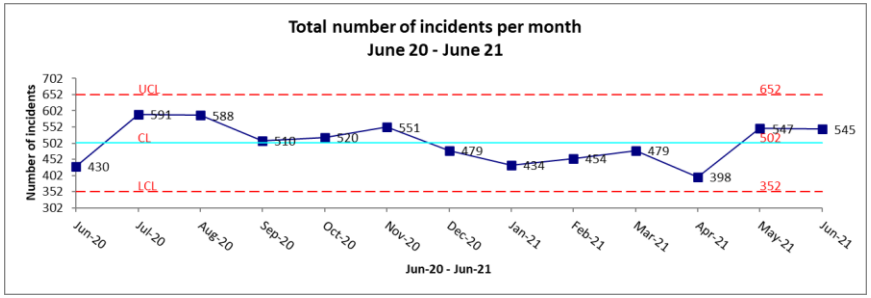


Figure 4.2.2

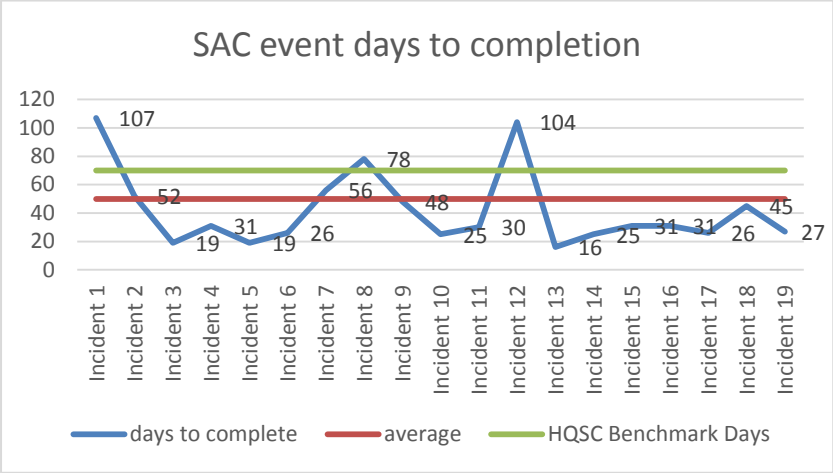



Figure 4.2.3

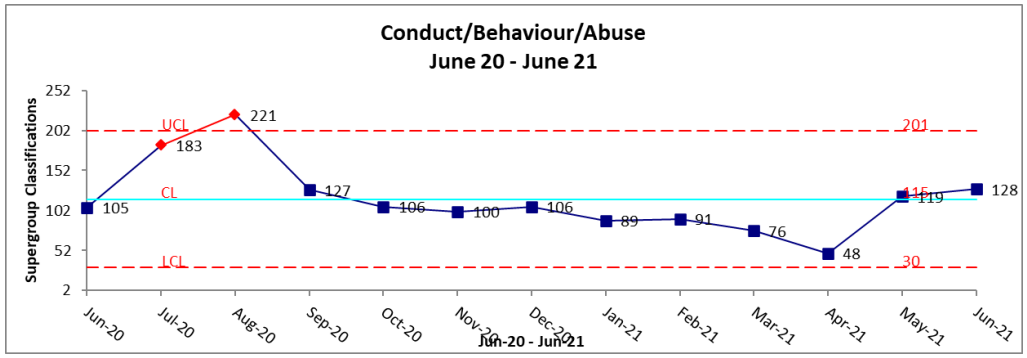



Figure 4.2.4

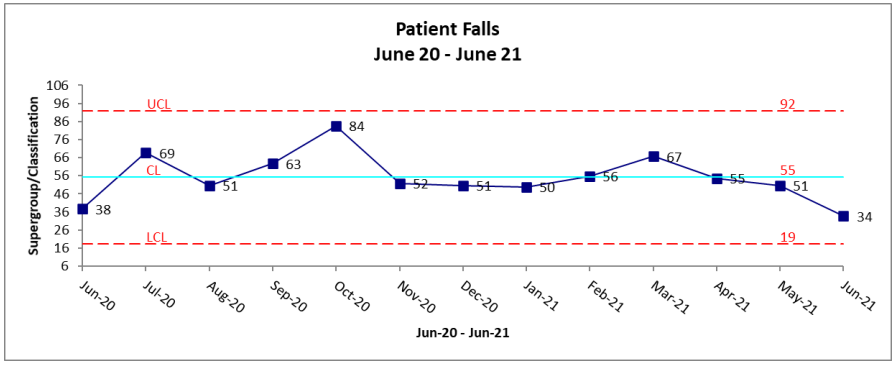



Figure 4.2.5

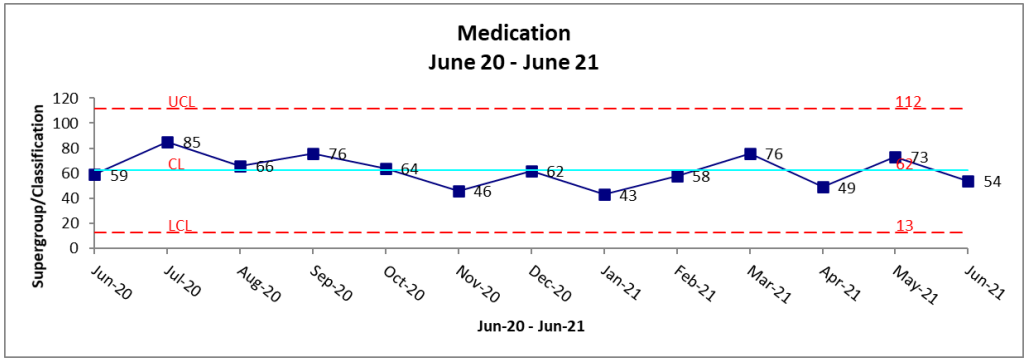
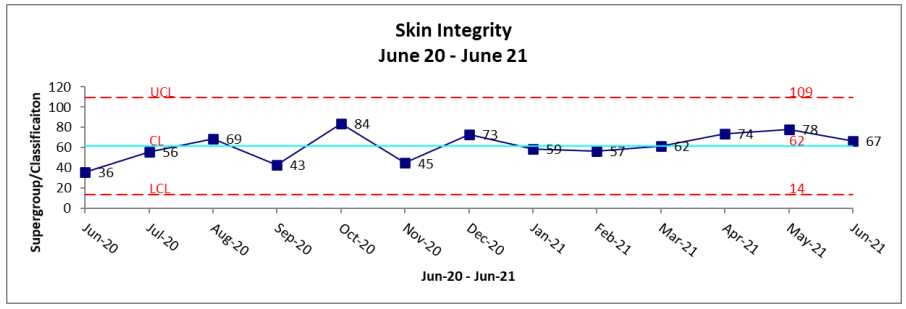
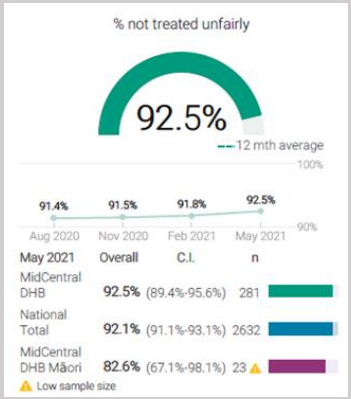
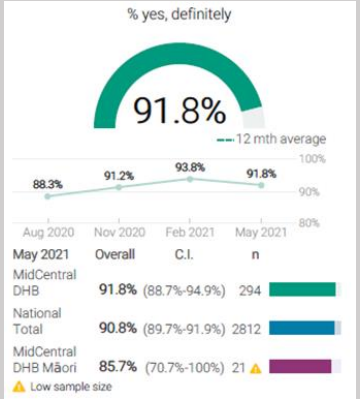
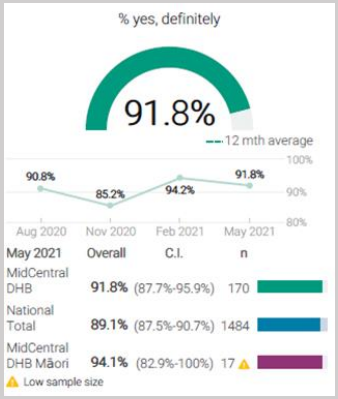
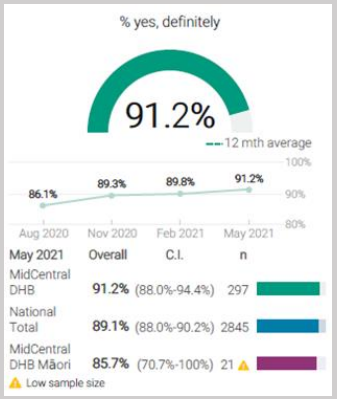
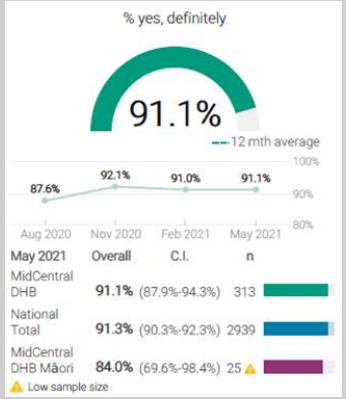



Figure 4.2.6

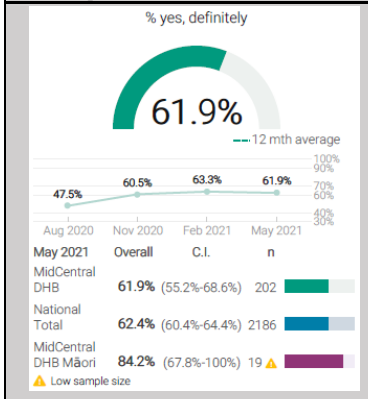
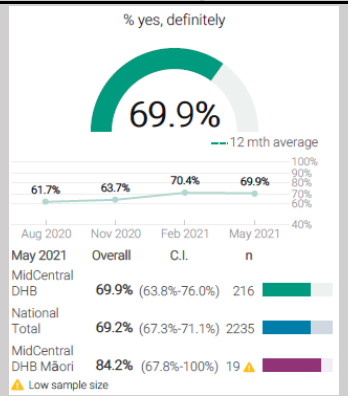
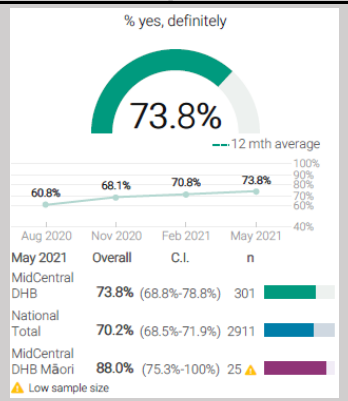
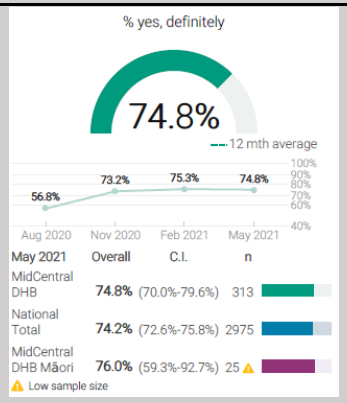
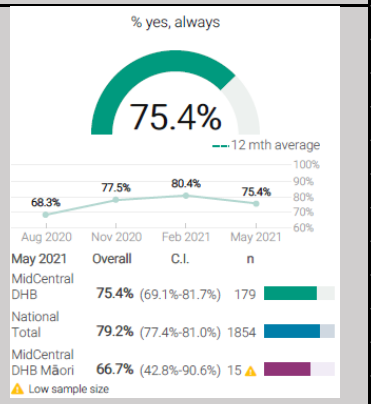


## APPENDIX TWO – PATIENT EXPERIENCE SURVEY (May 2021)

### BEST PERFORMING

| Patient did NOT identify perceived unfair treatment | Patient treated with respect by other members of health care team | Staff helped patient to understand what would happen and what to expect | Patient treated with kindness and understanding | Patient treated with respect by nurses |
|---|---|---|---|---|
|  |  |  |  |  |

### WORST PERFORMING

| Patient was told the possible side effects of the medicine they left the hospital with in a way they could understand | Staff talked with patients about whether they would have the help they needed when they left the hospital | Patient had enough information about how to manage their condidtion or recovery after they left hospital | Patient given enough privacy when talking about treatment or condition | 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 & time out). | |

| Metric | Definition | Exclusions |
|---|---|---|
| **REDUCING SURGICAL SITE INFECTIONS** | | |
| >=2g cefazolin given | Percentage of procedures with the right antibiotic in the right dose – cefazolin 2 g or more or cefuroxime 1.5 g or more | |
| Antibiotic <1hr 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 & 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 & recognition risk | Percentage of audited patients with a documented and current pressure injury risk assessment | |
| Ind. Care plan for @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 & 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 | |

**Quality and Safety Dashboard metric definitions**

| Metric | Definition | Exclusions |
|---|---|---|
| **FEEDBACK** | Views and opinions of service users (ie. Patients and their family or whānau) on the care they have experienced. | |
| Health & 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 a mental 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 response to 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 these figures. |
| 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/Behaviour and 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. | |


**For:**

| | |
|---|---|
| | Approval |
| **X** | Endorsement |
| | Noting |

| | |
|---|---|
| **To** | Health and Disability Advisory Committee |
| **Authors** | Sarah Fenwick, Operations Executive, Te Uru Pā Harakeke<br>Deborah Davies, Operations Executive, Te Uru Kiriora<br>Scott Ambridge, Operations Executive, Te Uru Rauhī<br>Dr Jeff Brown, Clinical Executive, Te Uru Pā Harakeke |
| **Endorsed by** | Manawhenua Hauora<br>Kathryn Cook, Chief Executive |
| **Date** | 19 August 2021 |
| **Subject** | **Māori Health Equity Dashboard Report – Te Ara Angitū for Selected Child and Youth Health Indicators** |

**Key questions the Committee should consider in reviewing this paper:**

- Does the report meet the expectations of the Committee?
- 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 any changes required for future Te Ara Angitū reports?

**RECOMMENDATION**

It is recommended that the Committee:

- **note** the equity position for each of the indicators and the update provided on next steps
- **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 MidCentral District Health Board's Strategic Plan and Ka Ao, Ka Awatea, the Māori Health Strategic Framework.

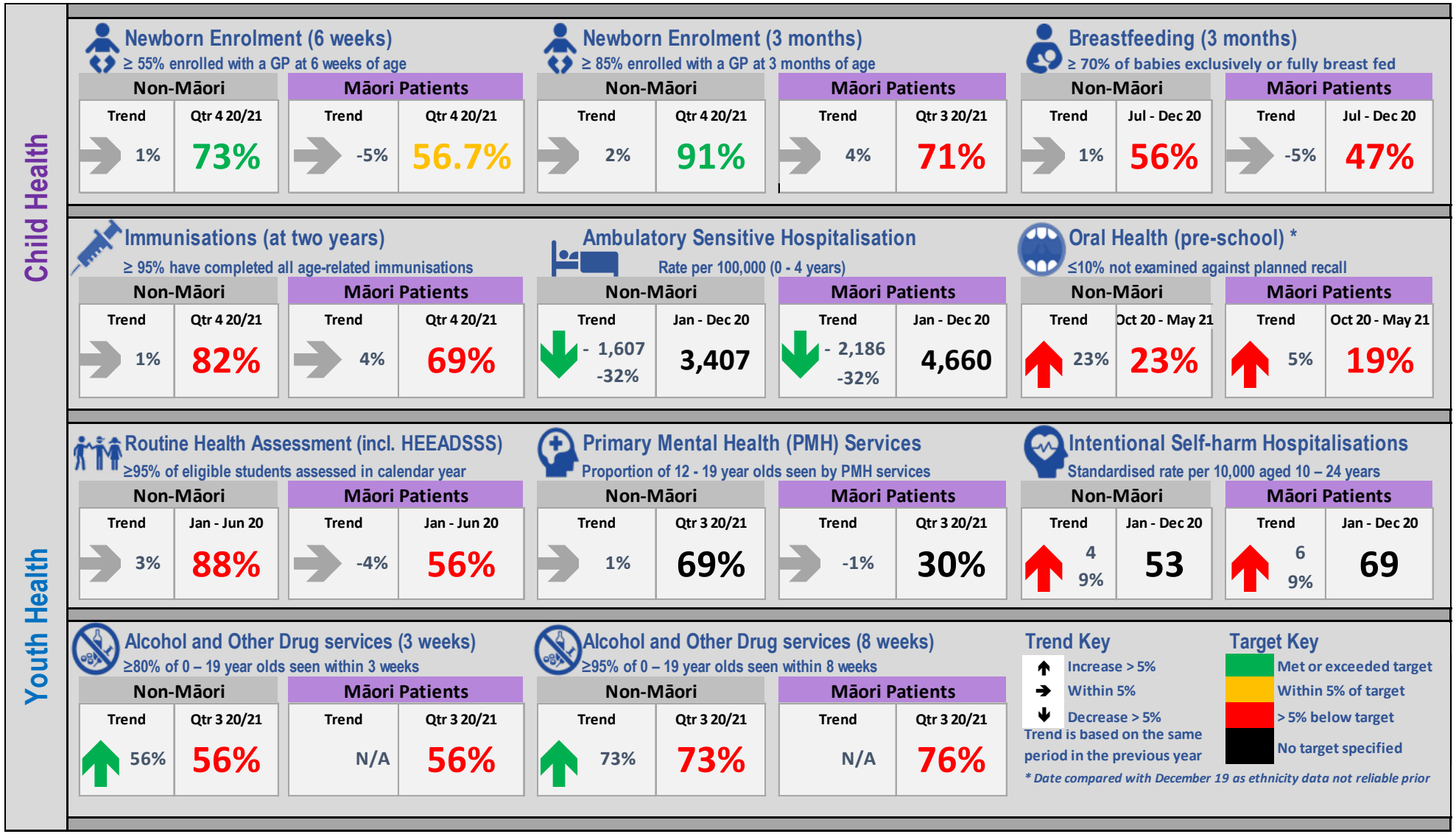
## 1. PURPOSE

To provide the Health and Disability Advisory Committee with an update on progress on the agreed priority child and youth health equity markers first presented to the Committee in November 2020.

The data and information in this report covers different time periods depending on the specific indicator. Data and commentary for each indicator has been provided by the responsible Directorate, with an overarching report collated by Te Uru Pā Harakeke.

Individual reports with description and analysis of each indicator, insights, discussion, strategies to reduce inequities, and updates on next steps are included as Appendix One.

## 2. INDICATOR OVERVIEW



The majority of the child and youth equity indicators for MidCentral District Health Board (MDHB) continue to show an equity gap between Māori and non-Māori. However, progress is being made against next steps commitments made.

No in-depth report is provided on the self-harm indicator as MDHB has remained compliant from the previous reporting period. Data indicate the number of young people admitted to hospital with self-harm who identify as Māori is significantly lower than the national average. Te Uru Rauhī is engaged with four other DHBs on a specific piece of work to examine this data set in more detail to better understand what occurs for young people who present to the Emergency Department (ED) for self-harm.

Work has been undertaken since the previous reporting period to try to ensure improved data quality and availability. This has however been a challenge due to key personnel leaving the organisation.

## 2.1. **Insights**

At life's beginning, MDHB is performing just over the national target of ≥55 percent for enrolment of Māori at six weeks of age at 56.7 percent. At three months of age MDHB is performing under the national target of ≥85 percent with MDHB rates being 71.4 percent. Overall newborn enrolments have decreased slightly over the last year. There remains a clear equity gap between Māori and non-Māori enrolment of up to 23 percent at six weeks of age and up to 27.8 percent at three months of age.

It is acknowledged that the number of General Practitioners across the rohe is limited and may be influencing the ability for whānau to enrol in a practice of their choice. However, despite the slight decrease in enrolment over the reporting period enrolment work has been progressing to ensure progress against the next steps agreed at the previous meeting. A collaborative approach with THINK Hauora to ensure new enrolment is underway, with the purpose to make enrolment more streamlined and efficient, with a particular focus on Māori, recognising that the current process of enrolment is a barrier for Māori enrolment.

The previous report recommended exploring the opportunity for electronic transfer of data through the new Maternity Clinical Information System (MCIS) as a method to improve enrolment. The new system was implemented in June 2021 with clinicians and administrators and data analysts working hard to understand the capability of the new system. Further progress on this step is expected in the next reporting period.

Exclusive breastfeeding rates for Māori fell during this reporting period to 45.9 percent in comparison to 56 percent when comparing all groups. Achieving a higher proportion of exclusively breastfed babies at three months continues to be a challenge across the rohe, however significant progress has been made against the next steps documented in the previous report. Whangai Ora milk bank opened in May 2021 and is now providing pasteurised breastmilk to pēpi across the MDHB region with 25 percent of the pēpi in the Neonatal Unit recipients of pasteurised donor breastmilk.

The Tūngia te Ururua project (primary birthing phase two) focusing on services required across the Tararua, Horowhenua and Ōtaki in the first 1000 days, received a ≥ 29 percent response rate for Māori. The project has taken longer than expected, however it is

essential to ensure feedback that is reflective of communities to ensure services are designed in a way that meets populations needs. The survey has now closed, and the results are being analysed independently. Results from the survey will be shared with local advisory groups, Manawhenua Hauora and HDAC.

Over the Quarter Three reporting period, 141 tamariki of 169 eligible were fully vaccinated by the age of two years, with a slight increase over the quarter. The total rate for two-year-olds fully immunised has not changed this quarter and approximates the national rate. Following the previous report, a capacity review is underway with a view to increasing vaccinator resource within THINK Hauora, Te Wakahuia Outreach Immunisation Team and the Pasifika Team, and diversifying immunisation delivery in line with feedback from whānau and locations, including use of a mobile vehicle in line with the next steps documented.

Māori children aged up to four years continue to be admitted to hospital at a higher rate than non-Māori children so remain a focus for MDHB. Respiratory infections, dental conditions, and skin conditions are the main reasons for admission. While the Emergency Department attendance rate for some is high, the number of admissions is relatively low. An Ambulatory Sensitive Hospitalisation (ASH) audit was conducted in May 2021 and identified that 57 percent of presentations lived in areas described as decile eight to 10, versus only four percent for deciles one to three. As evidence shows the social determinants of health have a significant impact on health outcomes of children, particularly in areas of high deprivation and therefore ensuring a focus on housing and other determinants is an essential part of the assessment process. A full action plan has been developed to improve ASH presentations, with a strong focus on Māori with the Community Child Health team ensuring services provided in areas where ASH admissions are known to be high.

The target for Child and Adolescent Oral Health (CAOH) Service (<18 years) is less than 10 percent outstanding, in arrears or unseen. Data over the reporting period indicates a rise and fall between October 2020 and May 2021, which are normal monthly variations. This is due to locations or individuals not having their assessment completed in the same month each year, there may be a rise in arrears for a particular cohort. There are various reasons for not being seen at the same time every year, such as resourcing, competing demands, staff leave/sickness and the ability of the location to support our visit. There has been a strong focus since the last reporting period on ensuring utilising an equity-based approach when making decisions about prioritisation of schools for service provision.

Statistics for rangatahi for the 2020 school year indicate that 3570 Māori students are attending decile one to five schools in Years 9 to 13, with 710 in Year 9. The previous report detailed that 99 home, education, eating, activities, drugs and alcohol, suicide and depression, sexuality and safety (HEEADSSS) assessments were completed between January and June 2020, with the impact of COVID-19 evident on the numbers. At the end of December 2020 400 HEEADSSS assessments were undertaken representing 56.3 percent which is a significant improvement. In the January to June 2020 period, 547 clinical assessments were undertaken with Māori students, and in the period July to December 2020, 701 assessments were undertaken representing 19.6 percent of the Māori school population.

The national Level Four COVID-19 lockdown affected school closures, and significantly reduced students' and families' ability to access the school-based health service (SBHS) during the 2020 academic year. This created a number of additional challenges for students accessing services, which has eased in the later part of the year.

Thirty-four percent of youth accessing Te Ara Rau primary mental health services were Māori. Given that the programme is still developing, it is difficult to draw any conclusions at this time. A strong focus will be given to ensuring continued focus on ensuring early access to mental health services for Māori.

When requiring access to alcohol and other drug services the percentage of Māori clients seen within three weeks is trending upwards. In Quarter Four 2019/20, 79.2 percent were seen within this timeframe, just below the 80 percent target, and a significant increase from 62.1 percent the same time last year. A similar comparison of the non-Māori clients shows a slight downward trend from 68.2 percent in 2018/2019 to 65.2 percent in 2019/2020. This is a positive result and further focus will be applied in the coming months.

The percentage of Māori clients seen within eight weeks is trending upwards; 95.8 percent in Quarter Four 2019/20, exceeding the 95 percent target. This is an increase from 89.7 percent for the same period last year and represents a 6.1 percent overall reduction in the Māori client wait list.

Overall, this indicates a positive change for Māori clients, suggesting that the introduction of services based where young people are is having a positive impact on reducing wait times and access to services. Additional youth-specific roles are also being funded and will be recruited to from October 2020 and will continue to expand over the next four years. Applying an equity lens on this programme sees the first tranche of roles all located with iwi providers and in the priority needs as determined by iwi.

## 3. THEMATIC ANALYSIS

It is recognised that there has been little progress on many of the indicators, however six months between reporting periods is a very small time period and there is evidence through the more detailed reports that teams are working collaboratively and creatively to try and improve the position and address the next steps they set. Progress against targets has also been poor as there was a decline in many measures as a result of COVID-19 which requires recovery as well as improving the position.

A collaborative approach in the first 1000 days of a child's life is essential to ensure improved outcomes for all equity measures child, youth, adult. Experiences in the first 1000 days have a far-reaching impact on health, social and educational outcomes with the recognition that equity-based investment in the first 1000 days is likely to provide significant return on investment and improve outcomes for tamariki across their whole life. Two significant projects are underway in this area, firstly Tungia Tu Ururua highlighted in the insights section of the report, is likely to have strong recommendations on needs for whānau in the first 1000 days across the districts of Horowhenua, Ōtaki and Tararua. In addition, the General Manager, Hauora Māori and Te Uru Pā

Harakeke have collaborated and been successful in a bid to obtain funds to progress a project to develop a strategy for MDHB across the first 1000 days. MDHB will be working closely with iwi partners to ensure a partnership approach to this project.

In addition, since the previous reporting period Te Uru Pā Harakeke has been concerned about cultural practice observed and heard about in the Maternity Unit. This led to an urgent request to the Chief Executive to recruit an Equity Lead for Te Uru Pā Harakeke. Recruitment has not yet occurred due to lack of suitable candidates, however it remains a significant priority for Te Uru Pā Harakeke.

Whilst child disability is not reported as one of the equity indicators within this report, it is recognised Tamariki Māori have higher levels of disability. A childrens referral integration project pilot, instigated through Ministry of Health (the Ministry) disability funding and centres on a partnership between the DHB and the Ministry, with a strong focus on equity. Engagement with Te Tihi has led to a whānau ora approach to the assessment form, with whānau tahi agreed as the data capture ensuring an outcomes-based data capture method.

Addressing areas such as family violence (with the newly appointed Family Protection Team an example of an initiate to strengthen this focus) drug and alcohol addiction and depression before conception is likely to show long term benefit. During pregnancy and during infancy, providing pregnancy and parenting classes, improving understanding of the impact of family violence, and providing nutritional support is essential. These will improve attachment which is essential to wellbeing and lifetime outcomes in mental and physical health of rangatahi and whānau.

Mainstream ways of delivering services may not meet the needs of Māori and therefore enhanced Māori/iwi providers/services are fundamental to improvement in outcomes, which has been recognised in the family violence change process with additional Full Time Equivalent (FTE) allocated to insource Māori support. The results of the Tūngia Tu Ururua project will assist in identifying the areas of focus for service provision. In addition, the new Family Violence Coordinator will engage with the intersectoral Pā Harakeke project which is essential.

Investment in early intervention models utilising whānau ora and cross sector approach will likely show significant improvement across all indicators over a period of time. The DHB has observed the work of iwi/Māori providers throughout COVID-19 and was impressed with the reach and connectivity made during this time and want to apply the learnings to support effective engagement for Māori when thinking about any early intervention service.

The DHB will continuing to support and promote the Primary Mental Health Access and Choice programme as a key enabler to supporting Māori youth. This service is available for people of all ages, has capacity for walk-ins (no wait times) and can be accessed for any presenting issue of concern. The programme included the appointment of 11 Kaiwhakapuaki Waiora (Health Coaches) roles located within iwi to ensure an overt focus on increasing access for tāngata whaiora and whānau.

Kaiwhakapuaki Waiora are the non-clinical kaimahi within the Te Ara Rau programme. These kaimahi are the rohe connectors, based in iwi and Māori providers, who walk alongside tāngata whaiora and whānau in navigating their own healthcare journey. Kaiwhakapuaki Waiora have lived experience of their own health condition so they are in a prime position to tautoko and awhi others. These kaimahi work alongside Mātanga Whai Ora (clinical staff) and other programme partners and are the rich central cog in connecting our communities for wellbeing.

## 4. NEXT STEPS

Individual reports in the appendix note a range of improvements underway focused on improving Māori health equity. When taking a wider system view, and fulfilling MDHB's Te Tiriti o Waitangi obligations, the following proposed steps are carefully non-didactic so that they can be developed in consultation with relevant Māori stakeholders:

- Work with staff, and the data and analytics team, to improve data recording, quality and digital delivery
- Ensure systems support Māori as priority for care and interventions
- Prioritise investment in iwi and Māori providers
- Progress work with the Māori Alliance Leadership Team to progress an equity based early intervention model that offers enhanced support to whānau in the first 1000 days
- Engage further with Māori/iwi providers to work in partnership to support effective whānau planning, engagement and experience
- Enhance cross service collaboration to provide synergy regarding tamariki and whānau experience, such as the utilisation of pre-schools and schools as 'hubs' for engagement with local iwi
- Work with key Government agencies and intersectoral partners to collectively progress health determinant initiatives
- Work with whānau to understand barriers to accessing health care
- Work with THINK Hauora to ensure accessible General Practice enrolment and care
- Explore diversified options for access and care, for example walk in services and care closer to home.
- Wellness focus for rangatahi through targeted health promotion activities and opportunities in a variety of locations.

| | | |
|---|---|---|
| **INDICATOR TYPE:** | Child Health | **Appendix One** |
| **INDICATOR** | ≥55 percent of Māori New-born babies are enrolled with general practice | |
| **FOR PERIOD:** | July 2020 to June 2021 | |
| **PREPARED BY:** | Sarah Fenwick, Operations Executive, Te Uru Pā Harakeke | |

## 1. PURPOSE

This paper provides an update to HDAC on the Child Health New-Born Enrolment (NBE) indicator.

## 2. INDICATOR AND ANALYSIS

**New-Born Enrolment, by Ethnicity, June 2021**

| New Borns Enrolled by 6 weeks of Age | | | | | |
|---|---|---|---|---|---|
| Ethnicity | Annual Enrolment Rate | | | Quarterly Enrolment Rate | |
| | | June 2021 | Change | June 2021 | Qtrly : Annual |
| **Māori** | 59.3% | 57.9% | -1.4% | 56.7% | 0.98 |
| **Pacific** | 65.7% | 63.4% | -2.3% | 64.8% | 1.02 |
| **Asian** | 75.4% | 76.4% | 0.9% | 76.8% | 1.01 |
| **Other** | 80.9% | 80.7% | -0.2% | 80.1% | 0.99 |
| **Total** | 72.4% | 72.0% | -0.5% | 71.7% | 1.00 |

Notes:
The Annual Enrolment Rate as at June 2021 represents the proportion of babies attaining 6 weeks of age over the period 16 June 2020 to 15 June 2021 who were enrolled with a PHO at that milestone.
The Quarterly Enrolment Rate as at June 2021 represents the proportion of babies attaining 6 weeks of age over the period 16 March 2021 to 15 June 2021 who were enrolled with a PHO at that milestone.
A Quarterly Enrolment rate higher than the Annual Enrolment Rate (Qtrly:Annual greater than 1.00) represents improving performance in enrolment of 6 week olds.
Enrolments are based on the NES. Populations are based on the National Immunisation Register.

| New-Borns Enrolled by 3 months of Age | | | | | |
|---|---|---|---|---|---|
| Ethnicity | Annual Enrolment Rate | | | Quarterly Enrolment Rate | |
| | #REF! | June 2021 | Change | June 2021 | Qtrly : Annual |
| **Māori** | 74.4% | 71.9% | -2.5% | 71.4% | 0.99 |
| **Pacific** | 86.6% | 83.8% | -2.8% | 81.8% | 0.98 |
| **Asian** | 91.9% | 92.2% | 0.3% | 92.6% | 1.00 |
| **Other** | 101.2% | 99.8% | -1.5% | 99.2% | 0.99 |
| **Total** | 90.6% | 89.0% | -1.7% | 88.8% | 1.00 |

Notes:
The Annual Enrolment Rate as at June 2021 represents the proportion of babies attaining 3 months of age over the period 16 June 2020 to 15 June 2021 who were enrolled with a PHO at that milestone.
The Quarterly Enrolment Rate as at June 2021 represents the proportion of babies attaining 3 months of age over the period 16 March 2021 to 15 June 2021 who were enrolled with a PHO at that milestone.
A Quarterly Enrolment rate higher than the Annual Enrolment Rate (Qtrly:Annual greater than 1.00) represents improving performance in enrolment of 6 week olds.
Enrolments are based on the NES. Populations are based on the National Immunisation Register. Differing data sources may lead to enrolment rates in excess of 100%

Data source: National Immunisation Register (populations) and National Enrolment Service (enrolments), Ministry of Health. New-borns Enrolled by six weeks of age and by three months of age. Report date: July 2021.

MDHB is performing just over the national target of ≥55 percent for enrolment of Māori at six weeks of age at 56.7 percent a slight drop of one point two percent. At three months of age MDHB is performing under the national target of ≥85 percent with MDHB rates being 71.4 percent. Overall New-Born Enrolments have decreased slightly over the last year. There is an equity gap between Māori and non-Māori enrolment of up to 23 percent at six weeks of age and up to 27.8 percent at 3 months of age.

The MDHB New-Born Enrolment Programme (NEP) has been in place since 2013 to address a reducing number of GP teams accepting new patients. Whānau complete a manual form that is sent by the New-Born Enrolment (NBE) Coordinator who liaises with parents/caregivers to ensure they are offered the universal services to which they are entitled including:

- General Practice (GP)
- Well Child Tamariki Ora services
- National Immunisation Programme
- Child & Adolescent Oral Health Service.

The NEP arranges provisional enrolment with the GP practice; however, the family is still required to visit the practice and sign up. This appears to be an issue for many whānau who may have access difficulties of their or the practice's making. This manual process was instigated while waiting for a new improved digital solution, but this has yet to happen. A recent quality improvement programme has led to some improvement, but the process remains predominantly manual.

## 3. INSIGHTS

There remains a clear difference between Māori and non-Māori enrolment and therefore an urgent need to prioritise Māori pēpi as a focus for the NEP. Electronic enrolment is likely to assist, and it is hoped that the implementation of Maternity Clinical Information System (MCIS) Global in 2021 may enable this, however this is not likely to be realised until at least 2022.

The number of GPs who are accepting new patients across the rohe is limited, influencing the ability for whānau to enrol and access health services. Data from June 2021 indicates there are no enrolment concerns in Tararua, Feilding is only taking local patients, but Horowhenua has no general practitioner teams taking new patients (although they have agreed to register pēpi if the NBE Coordinator rings). Palmerston North only has two GP practices who accept new patients, significantly impacting whānau in the southwest suburbs.

## 4. DISCUSSION

With new-born enrolment rates still remaining low across MidCentral District MDHB are working through multiple processes to make new-born enrolment with a focus on Māori more streamlined and efficient.

The Planning and Integration Lead (Healthy Women, Children and Youth and New-born Enrolment Coordinator met with General Manager, Clinical Quality THINK Hauora (PHO) in July 2021 to discuss improving the process to ensure all new-borns in MDHB were enrolled with a GP practice. The following have occurred since this meeting:

- Meetings with both practices currently taking on Patients to make plans for more user-friendly enrolment processes and feeding back to the new-born enrolment coordinator when enrolment is completed.
- Think Hauora speaking directly with Primary Care in areas where the practice books are closed to place babies and families with them.
- FTE for an enrolment coordinator employed by Think Hauora -focus will be on Adults but the new-born enrolment coordinator will provide them with a list of Hapū Māmā who are not enrolled with a GP – this will make the enrolment of their new-born babies automatic.

## 5. NEXT STEPS

- Explore electronic transfer of data through the new MCIS Global programme
- Work with new THINK Hauora enrolment coordinator to ensure unenrolled
- New-Born Enrolment (NBE) coordinator to continue to work with GP practices to improve their enrolment procedures
- NBE Coordinator to socialise with LMCs the referral pathway (email and 0800 number) for those Hapū Māmā who don't have a GP
- Regular bi-monthly meetings now scheduled between Planning and Integration Lead Healthy Women Children and Youth, NBE coordinator and GM Clinical Quality THINK Hauora to monitor progress.

| | |
|---|---|
| **INDICATOR TYPE:** | Child Health |
| **INDICATOR** | ≥70 percent of Māori pēpi are exclusively or fully breastfeeding at three months of age |
| **FOR PERIOD:** | July 2020 to December 2020 |
| **PREPARED BY:** | Sarah Fenwick, Operations Executive, Te Uru Pā Harakeke |

## 1. PURPOSE

This paper provides an update to HDAC on the child health breastfeeding indicator.

## 2. INDICATOR AND ANALYSIS

### CW06: Improving breastfeeding rates

Indicator: At least 70% of infants are exclusively or fully breastfeeding at 3 months of age

| Six-month periods | Māori | | Pacific | | High Dep | | Total | |
|---|---|---|---|---|---|---|---|---|
| | MDHB | National | MDHB | National | MDHB | National | MDHB | National |
| 1 January – 30 June 2018 | 43.5%<br>n.123<br>d.283 | 47% | 51.1%<br>n.24<br>d.47 | 50% | 47.6%<br>n.172<br>d.361 | 49% | 53.7%<br>n.519<br>d.967 | 59% |
| 1 July – 31 December 2018 | 49.4%<br>n.134<br>d.271 | 47% | 40.0%<br>n.14<br>d.35 | 49% | 45.6%<br>n.155<br>d.340 | 48% | 55.8%<br>n.542<br>d.972 | 58% |
| 1 January – 30 June 2019 | 46.7%<br>n.120<br>d.257 | 49.1% | 45.5%<br>n.15<br>n.33 | 48.6% | 45.8%<br>n.157<br>d.343 | 49.0% | 54.3%<br>n.496<br>d.914 | 59.4% |
| 1 July – 31 December 2019 | 50.9%<br>n.136<br>d.267 | 48.1% | 58.7%<br>n.27<br>d.46 | 47.7% | 48.8%<br>n.160<br>d.328 | 48.6% | 55.2%<br>n.490<br>d.887 | 58.7% |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1 January – 30 June 2020 | **49.2%**<br>n.127<br>d.258 | 47.3% | **50.0%**<br>n.22<br>d.44 | 47.4% | **49.4%**<br>n.169<br>d.342 | 49.0% | **54.8%**<br>n.499<br>d.910 | 58.6% |
| 1 July – 31 December 2020 | **45.9%**<br>n.124<br>d.270 | 46.8% | **62.9%**<br>n.22<br>d.35 | 46.6% | **42.6%**<br>n.135<br>d.317 | 48.2% | **56.4%**<br>n.496<br>d.880 | 58.1% |

**These figures are sourced from Ministry of Health and are released 6 monthly (Jan-June 21 due for release Oct 21)**

MDHB rates for Māori are 46.9 percent of babies being exclusively or fully breastfed up to three months of age.
There has been a decrease in breastfeeding rates for Māori pēpi over the six-month period to July December 2020.

## 3. INSIGHTS

The Whangai Ora milk bank was opened in May 2021 and is now providing pasteurised breastmilk to some pēpi in the MDHB region. 25 percent of the pēpi in the Neonatal Unit are now recipients of pasteurised donor breastmilk. This is through arrangement between the milk bank and parents with facilitation by MDHB Neonatal staff. Once post pasteurisation testing regime is finalised MDHB will move to formalising the relationship between the milk bank and MDHB including policy.

A five-week peer support breastfeeding course was delivered to the Pasifika team at THINK Hauora and kaimahi Māori at Whakapai Hauora. This will provide basic knowledge and skills to the participants to assist whanau with support and information of services and referral pathways required.

Mokopuna Ora continue to provide a breastfeeding information session during wānanga with the attendance of a Lactation Consultant. Two wānanga were held this quarter with a total of 70 registrations received, 94 participated including whanau support, supporting professionals, weavers and the facilitating team. 19 hapū mama attended (16 or 84.2 percent Māori).

The Tūngia te Ururua (First 1000 days project) has over 220 completed surveys by wāhine and whānau (domiciled in the Tararua & Horowhenua/Otaki areas) who are hāpu or have had a baby in the last 2-5 years. Māori representation in this survey is ≥ 29 percent and representative of the birthing demographic. In addition to the survey, focus groups have been conducted in both localities. Information gathered from the survey includes questions regarding wāhine/whānau experience of breastfeeding education and support and thematic analysis will inform recommendations regarding ongoing resourcing of breastfeeding supports in these localities.

## 4. NEXT STEPS

The MDHB Breastfeeding Steering Group continues to have oversight of the rollout of the MDHB Breastfeeding Strategy. In response to Ministry of Health feedback on quarterly reporting a breastfeeding quality plan has been produced to show the alignment between the National Breastfeeding Strategy, MDHB Breastfeeding Strategy and highlight targeted actions for the next 12 months. These include:

- Establish a peer support programme for Māori & Pasifica by June 2022 and report progress towards this quarterly.
- Engage with Māori and Pasifika kaimahi to plan and support future projects related to breastfeeding by November 2021.
- Develop & socialise a Breastfeeding Community Health Pathway by June 2022 and report progress towards this quarterly.
- Establish a Koawatea learning module for staff that educates specifically on use of donor breastmilk in MDHB facilities, by March 2022.
- Update current informal Donor milk policy to incorporate specific consent for use of Whangai Ora pasteurised Donor breastmilk by July 2021
- Develop a policy for mothers who are separated from their babies to establish and maintain milk supply via expressing and feeding by December 2021.

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| **INDICATOR TYPE:** | Child Health |
| **INDICATOR** | Childhood Immunisations for Period Ending 31 March 2021 |
| **FOR PERIOD:** | July 2020 to March 2021 |
| **PREPARED BY:** | Deborah Davies, Operations Executive, Te Uru Kiriora |

## 1. PURPOSE

This paper provides an update to HDAC on the child health immunisation indicator.

## 2. INDICATOR AND ANALYSIS

Over the Q3 reporting period 141 tamariki of 169 eligible were fully vaccinated by the age of two years, with a slight increase over the quarter. The total rate for two-year-olds fully immunised has not changed this quarter and approximates the national rate.

The trend over the previous quarters continues to show that the immunisation rates for Maori have not improved. An action plan has been activated as directed by the MOH to improve these rates. Further detail regarding the action plan has been included in the attached appendices

## 3. INSIGHTS

Childhood immunisation completion rates continue to show only slight movement, with improvement during the third quarter, particularly for Māori. A number of influences have impacted performance:

- Increasing decline/delayed immunisation rates have been consistent since the original COVID-19 lockdown in 2020. This has been exacerbated by rapid changes in the childhood immunisation schedule, an MMR catch-up campaign, influenza season uncertainties and an increasing focus on the nationwide COVID vaccine programme. All of these factors continue to take resource and focus away from Childhood Immunisations and impact ability to manage the increasing overdue list, contact individual families and support general practices
- Māori tamariki, continue to be more likely to be transient and are referred to Outreach Immunisation Service (OIS).

- Active decline rate for the three months to 31 March 2021 is 5.9 percent for Māori (all ages) and 4.5 precent for overall MDHB population.
- General Practice has focussed on this age group for the 12-month MMR catchup programme evidenced by the increase for both Māori and Pasifika Immunisations resulting in a slight increase in the overall rate. An increase of 0.6 FTE in the THINK Hauora Immunisation team has meant that the team can provide On-Time Immunisation Clinics in areas of highest priority - Levin and Palmerston North.
- Ongoing local shortage of general practice teams enrolling whānau.

## 4. DISCUSSION

MidCentral DHB was one of 17 DHBs that received a letter from the Deborah Woodley the Deputy Director General from the Ministry of Health, detailing her concerns regarding childhood immunisations rates.

MDHB response detailed that several key focus areas are underway as follows:

- Review of data integrity to ensure robust ongoing plan.
- Revised invitation and recall processes.
- Ensuring sufficient vaccinator resource is focussed on childhood immunisations.
- Increasing Outreach Immunisation Resource (OIS) and support.
- Diversifying immunisation delivery within communities.
- Focussed management of performance at the PHO and General Practice level.
- Public communication and engagement linked to planned national communication, addressing safety and the importance of immunisation.

The response outlined what is working well; with the THINK Hauora Immunisation Team commencing On-Time Immunisation Clinics in Quarter 3 to support practice populations that could not or would not present to general practice for their tamariki's childhood immunisations. Clinics in Horowhenua and Palmerston North are experiencing increased numbers of attendance, with feedback from parents saying they are finding it difficult to access general practice. Due to no enrolling practices in Horowhenua, these clinics provide an easily accessible space to have immunisations completed (and opportunity for the THINK Hauora staff to facilitate enrolment elsewhere).

Close working relationships with Horowhenua iwi Raukawa Whānau Ora (co-located for immunisation clinics) have supported this. There is also a specific focus is being developed to ensure engagement with whanau for all immunisations to improve tamariki immunisation rates.

## 5. NEXT STEPS

Immediate actions are underway in the key focus areas and include;

- Data and process review and revision encompassing cleaning up data in practice recall systems, management of current milestone overdue lists, reviewing recalls and access to performance data.
- Capacity review and revision with a view to increasing vaccinator resource within THINK Hauora, Te Wakahuia Outreach Immunisation Team and the Pasifika Team.
- Managing performance of immunisation delivery providers.
- Review the Governance of the Immunisation programme.
- Diversify immunisation delivery in line with feedback from whānau and locations including use of a mobile vehicle.
- Engagement with consistent messaging on multiple platforms ensure focus of Childhood Immunisations not eclipsed by COVID-19 Vaccination campaign.

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| **INDICATOR TYPE:** | Child Health |
| **INDICATOR** | Ambulatory sensitive hospitalisation rate per 100,000 Māori aged zero to four years – specific conditions (dental, skin conditions, respiratory infections, asthma) |
| **FOR PERIOD:** | **December 2019 to December 2020** |
| **PREPARED BY:** | Sarah Fenwick, Operations Executive, Te Uru Pā Harakeke |

## 1. PURPOSE

This paper provides an update to HDAC on the child health ambulatory sensitive hospitalisation (ASH) indicator.

## 2. INDICATOR AND ANALYSIS

Ambulatory sensitive hospitalisations (ASH) are mostly acute admissions that are considered potentially reducible through prophylactic or therapeutic interventions delivered in a primary care setting. In New Zealand children, ASH accounts for approximately 30 percent of all acute and arranged medical and surgical discharges in the 0-4year age group each year. However, determining the reasons for high or low ASH rates is complex, as it is a whole-of-system measure.

It has been suggested that admission rates can serve as proxy markers for primary care access and quality, with high admission rates indicating difficulty in accessing care in a timely fashion, poor care coordination, a lack of continuity of care or resource constraints such as limited supply of primary care workers.

ASH rates are multifactorial, also determined by hospital emergency departments and admission policies, health literacy and socio-economic determinants of health. Decisions to admit, rather than send home from ED, are often influenced by time of day or night, distance to home, transport difficulties, and family factors, rather than the condition itself. Auditing all ED presentations, admitted or not, provides a more comprehensive picture of ASH than limiting to admissions alone. A composite ASH measure is preferred because it incorporates all high-volume conditions and aligns with using measures that operate at a system level rather than ones that focus on a specific condition or service.

ASH highlights the burden of disease in childhood with a strong emphasis on health equity. There is a recognised high variance among priority populations and according to social gradient. Reducing ASH rates requires well integrated, preventive, diagnostic and management systems and a well-skilled and resourced workforce.

The following charts highlight the ASH rates by the specified conditions over the last 12 months to December 2020 and show the differences between MDHB Māori and non-Māori rates and the national total rate.

| Top Ten ASH Conditions: 00 - 04 year old age group | | | | | | | |
|---|---|---|---|---|---|---|---|
| For 12-month period ending December 2020 | Count of ASH events | | | Non standardised rate per 100,000 population | | | |
| | Māori | Other | Total | Māori | Other | Total | National comparison |
| Dental conditions | 63 | 51 | **114** | 1529 | 703 | **1003** | **737** |
| Upper and ENT respiratory infections | 41 | 51 | **92** | 995 | 703 | **809** | **1058** |
| Asthma | 46 | 39 | **85** | 1117 | 538 | **748** | **806** |
| Gastroenteritis/dehydration | 32 | 46 | **78** | 777 | 634 | **686** | **823** |
| Constipation | 5 | 13 | **18** | 121 | 179 | **158** | **143** |
| Lower respiratory infections | 6 | 9 | **15** | 146 | 124 | **132** | **154** |
| Cellulitis | 6 | 9 | **15** | 146 | 124 | **132** | **303** |
| Dermatitis and eczema | 6 | 8 | **14** | 146 | 110 | **123** | **139** |
| Pneumonia | 2 | 6 | **8** | 49 | 83 | **70** | **141** |
| GORD | 1 | 3 | **4** | 24 | 41 | **35** | **85** |

**MidCentral Population**

Combined ambulatory sensitive hospitalisation (ASH) rates for 0–4-year-olds in MidCentral DHB (MDHB) show a steady reduction over the last five years for both Māori and non-Māori children (see graph below). The drop from December 2019 to December 2020 could directly be attributable to COVID-19 and the decline in disease transmission during this period due to lockdowns and closed international borders.

The total rate per 100,000 for both groups combined remained below the national average. The rate per 100,000 Māori children remains higher than the non-Māori rate and slightly above the national average.

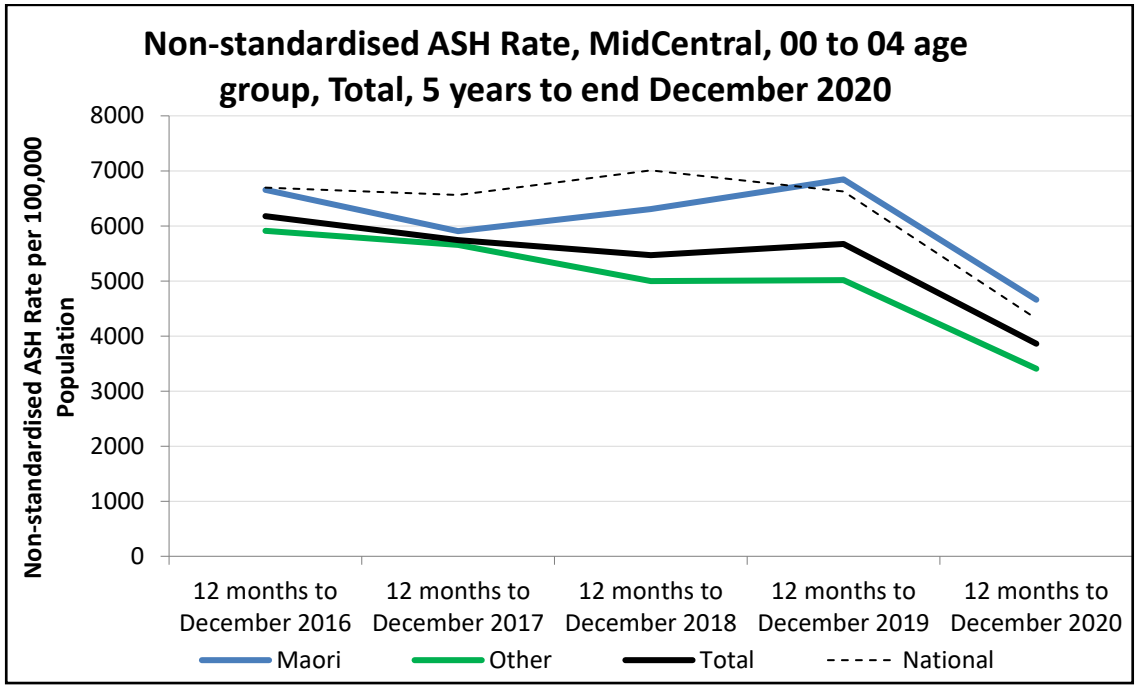


*Figure 1: MidCentral ASH hospitalisations by ethnicity over previous 5 years*

Respiratory conditions (including infections) continue to be the predominant cause for ASH, together with dental caries and some skin conditions (see graph below)

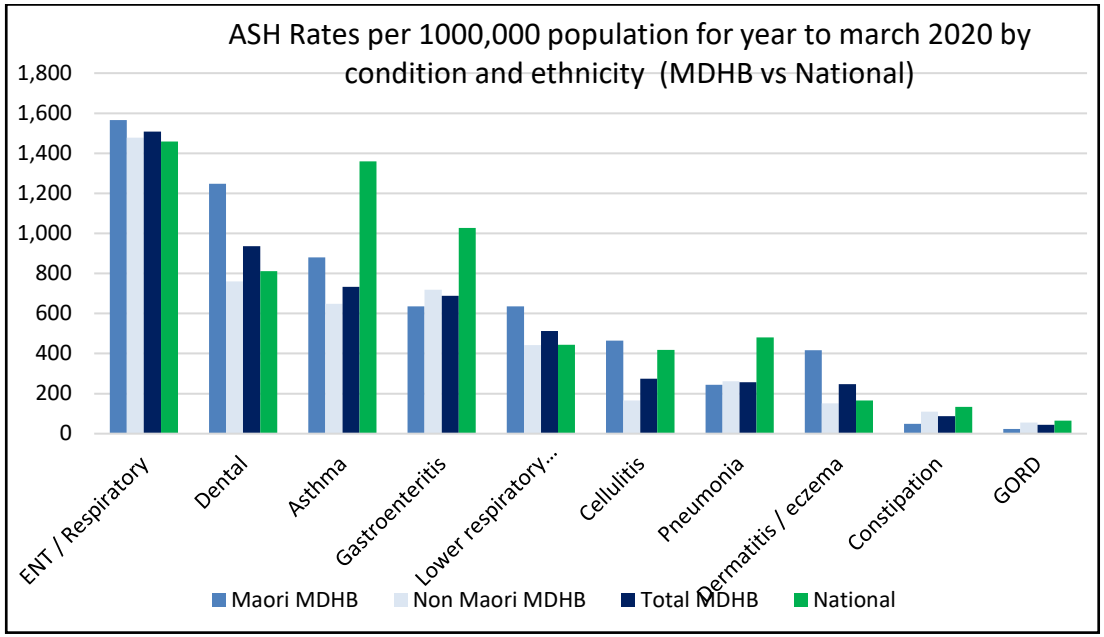


Figure 2: MidCentral vs National 2020 ASH rates by condition and ethnicity

## 3. INSIGHTS

**Project Report: ASH Presentations 0-4 years of age (May 2021)**
This project set out to investigate and audit presentations to Palmerston North Hospital Emergency Department (ED) for children from birth to four years of age with Ambulatory Sensitive Hospitalisations (ASH) between July 2019 and December 2019. The intent was to combine information from primary care, ED, and inpatient records to analyse trends and opportunities for improving whānau and community management with an equity focus on Māori and vulnerable communities.

**Methodology**
A team of senior child health nurses sampled retrospectively the records of children from birth to four years of age who attended Palmerston North ED with ASH conditions between July 2019 to December 2019. The cohort included presentations to ED who were discharged from there, and those admitted as inpatients. Including all presentations allowed the team to evaluate the use of primary care practices for all ASH, not just those admitted to hospital. 309 cases were audited out of the total 641 presentations, based on availability of ED and inpatient notes. The time involved for each case review meant that once more than half the cases had been audited the value of chasing the remainder was deemed too low in terms of themes and information gleaned. Those children with more than one presentation during the designated period had each individual presentation included.

For the purposes of this audit the defined ASH diagnoses include those presenting with one or more of the following:

- Upper Respiratory Tract Infection (URTI) or other Ear, Nose and Throat (ENT) condition
- Gastroenteritis and/or dehydration
- Asthma
- Lower Respiratory Tract Infection (LRTI)
- Cellulitis
- Pneumonia
- Constipation
- Eczema/Dermatitis
- Gastroesophageal Reflux (GORD).

The audit criteria and information gathered were developed by the team based on evidence surrounding preventable childhood hospitalisations. These decisions were moderated by senior members of the Child Health Leadership Team.

309 presentations were audited, this included five children who reside outside our DHB boundary and are enrolled with a General Practice team (GPT) also outside our DHB. 146 (47 percent) presentations occurred after 20:00 hours when there is no after-hours GP service available. Despite GP services being available during the day, 98 (32 percent) still presented to ED. Only 36 (12 percent) of all presentations across the 24-hour period had been referred to ED following a primary assessment by a GPT. Sixty-five (21 percent) presented to ED between 17:00 and 20:00 hours despite a General Practice after-hours services being available. Of the total presentations only 105 (34 percent) were referred on for further inpatient management within the hospital. Of note: 97 percent of cases were enrolled with a GPT.

The 0–1-year age bracket makes up 53 percent (164) of presentations compared to the 1-4-year group at 47 percent. 46 percent (146) of presentations audited are Māori which is disproportionate compared to the number of Māori tamariki in this district.

In collating results all respiratory conditions were grouped together. The distribution for respiratory conditions is similar to national data. Sixty-five percent of participants had either one or two presentations to ED during the audit period. Twenty-seven percent had between three and six presentations with the remaining eight percent being wrongly coded for ASH on final diagnosis. Treatment options vary but there are clear instances when a diagnosis of LRTI or bronchiolitis was made but the child received both steroids and bronchodilators (not indicated for either diagnosis). Deprivation data show 57 percent of presentations lived in areas described as decile 8 to 10. Those in deciles 4 to 7 were 34 percent of the cohort and only four percent lived in deciles 1 to 3. Housing and household data were sporadically available. 54 percent (167) were asked about the number living in each household

and of these 16 percent had six or more living in the one dwelling. In 14 percent of the cohort there are four or more children within the house.

## DISCUSSION

Our ability to follow the true patient journey through primary care into secondary care services proved extremely difficult. We only gained access to two primary practices to review their records. Despite initial indications of support for this audit, we were unable to get permission from PHO or GPTs to access their records. This in itself is significant, demonstrating fragmentation of our health systems.

Respiratory conditions remain the leading cause of ASH presentations in this time period. On analysing the limited data that were available in regard to treatment options in primary care there is some lack of consistency between treatment choices for children that receive steroids, antibiotics, chest x-rays and bronchodilator therapy. How overcrowding and housing type influences these conditions is unknown as we are limited by the data available. However, we do know that more than half our ASH presentations come from the most deprived localities within the DHB. There is a greater emphasis required from all health practitioners to determine if children are living in smoke-free environments as smoke exposure significantly contributes to respiratory conditions in young children.

Our focus on child protection shows only a 30 percent completion of the child wellbeing forms in ED and of these only 38 percent were fully complete. We can see formal child protection alerts on the clinical portal but specific documentation surrounding the alert is only found in the hard copy notes. (The towards excellence for whānau project will allow alert documentation to be directly uploaded to the clinical portal). Despite 18 having child protection alerts it is only obvious in the notes of six children that they have involvement with Oranga Tamariki, data that is limited by our inability to share information across services leading us to work in isolation.

From an equity perspective it is evident that our Māori tamariki make up a higher percentage of ASH presentations to the ED. Interestingly our Asian and Pasifika rates are the same as the population proportion. There is work required to ensure all children are formally enrolled with well child providers. While it is clear that lack of an afterhours GP service creates barriers for families accessing primary care, this does not explain that although 97 percent of participants are registered with a GP, 53 percent of ASH presentations occurred during the hours when a GP service is available. Further discussion with both consumers and GPTs is required to evaluate the barriers to access, even though in hours GPT care is free of charge. For the two practices that we were able to access and audit their practice management systems, family debt was evident which creates a barrier for access.

The evaluation of more comprehensive data is extremely resource intensive and would require collaboration between all relevant parties as the various IT databases do not feed information into one another.

**Limitations**
The fragmentation of IT databases and Practice Management Systems and the lack of ability to access and share vital information decreases our ability to dive deeper into the multifactorial reasons for ASH presentations. Data in relation to family harm screening was limited by what we are asking families when they present.

This audit is based on medical and nursing documentation only and does not include the consumer voice which could provide rich explanations that lead to a better understanding of our primary and secondary interface and the wider reasons why these presentations occur.

## 4. NEXT STEPS

**Recommendations/Actions**
There is considerable work to be done joining up healthcare services and access to databases and Patient Management Systems to improve the overall health and wellbeing of the children in our community. However, there are some actions we can take to share our findings and begin the process of reducing ASH presentations.

1. Equity focus through the appointment of an equity facilitator who can follow up those in the Child Health Service who SNE and those families who are routinely using the ED as their primary source of healthcare.
2. Evaluate the consumer voice through a consumer liaison process to highlight where improvements can be made.
3. Highlight those repeatedly attending ED so that information back to the primary care practice and well child/Tamariki Ora can be flagged for more intensive follow up.
4. Increase our focus on housing screening and assessment at the time of presentation and develop appropriate referral mechanisms to support identified risk.
5. Extend the child wellbeing form so that it can be followed up on in both ED and inpatient services.
6. Increase our focus on child protection through training of all staff and the development of a child protection specific role within the family harm team.
7. Actively progress the review of health pathways for community use to provide consistent management of ASH conditions for children (will require resource to review and support development)
8. Use the collaborative forums already in place to discuss and extend information sharing across services, including the results of this audit.

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|---|---|
| **INDICATOR TYPE:** | Child Health |
| **INDICATOR** | Child (zero to four years old) oral health examinations for period ending June 2020 |
| **FOR PERIOD:** | July 2020 to May 2021 |
| **PREPARED BY:** | Deborah Davies, Operations Executive, Te Uru Kiriora |

## 1. PURPOSE

This paper provides an update to HDAC on the child health pre-school oral health indicator.

## 2. INDICATORS AND ANALYSIS

The target for the entire service (<18 years) is less than 10 percent outstanding, in arrears or unseen. The data over the reporting period indicates a rise and fall between October 2020 and May 2021, which are normal monthly variations.

## 3. INSIGHTS

The Child and Adolescent Oral Health (CAOH) Service provides oral health education, assessment and treatment for children and adolescents under 18 years of age and enrolled with the service. Due to locations or individuals not having their assessment completed in the same month each year, there may be a rise in arrears for a particular cohort. There are various reasons for not being seen at the same time every year, such as resourcing, competing demands, staff leave/sickness and the ability of the location to support our visit.

## 4. DISCUSSION

The COVID-19 lockdown last year saw a sharp rise in arrears due to service closure and a slow return to operating in the new normal. There remains a risk that COVID-19 alert level may change and in turn will impact the routine service. Competing demands exist with children across all age groups and national targets, such as Ministry of Health for five-years-olds and school year eight. There is also pressure for those leaving the service at the end of year eight to be 'fit for discharge', alongside the adolescents to be dentally fit before reaching 18 years of age (last opportunity for free treatment) and having their care transferred to a private

dentist of their choice.  A reduction of Dentists in Feilding has led to an increase in adolescents for our service creating further demand.

CAOH Service is a guest at schools and preschools and any service delivery is subject to their agreement and ability to host the service. Delays occur when these sites cannot host the service. While beyond the service's control, careful rescheduling can help ensure other priority establishments are targeted. As a result of a targeted approach, in December 2020 parity in arrears for 0–4-year-old and Māori non-Māori was reached at 22 percent, since then Māori tamariki have been in less arrears than non-Māori, with the inequity gap reversed. This has been replicated in the total CAOH Service population.

The COVID-19 triage questions remain a requirement before examination and treatment. This takes time and can cause delay when trying to contact parents/care providers. Recovery from the COVID-19 impact is projected to take another 6 months, however this recovery has now been impacted by staff shortages (a national issue). A targeted approach is being undertaken as described below noting that not all schools/facilities, at this time, will be visited every year due to staffing. Of note, there have been further delays in arrears improvement due to staff illness, injury and elective surgery. Completion of production plan (staff verses demand) has highlighted a need for a resource review.

## 5. NEXT STEPS

The CAOHS 2021/2022 annual plan has the goal of equity of outcomes, inter-sectorial partnerships, high performing workforce, maximum productivity and optimal experience of care.

Key approaches and actions that are continuing include:

- Equity driving the decision as to which pre-schools, schools and colleges are prioritised.  Māori are a key priority when scheduling – whilst this has proven successful it will continue to be a focus.
- Actively scheduling pre-schoolers during school holidays and where it is known, and appropriate, siblings will frequently be booked in at the same time to complete the whanau (tamariki only).
- Enduring consent has just been introduced, this gains consent for the whole time the tamariki are registered with our service, it covers routine examination, x-ray and preventative treatment and should improve efficiency. Subsequent treatment for dental caries (i.e., fillings or extractions) require further consent.
- Strong partnerships are a focus to facilitate access, support and attendance of children.
- A team delivery approach aiding a reduction in travel time and increasing available clinical care time.
- Stakeholders and users are being actively encouraged to feedback via 'Tell us what you think' forms, email or phone calls.

- Active engagement of the oral health promoter with this age group to reduce the arrears in a variety of settings – pre-schools, clinics or Plunket rooms, she has also undertaken multiple educational sessions at pre-schools.
- Engagement with Te Awhina Kohanga Reo continues, this will test an approach to delivering care on Kohanga sites – approval to make our drivable clinic independent (on board generator and water) will aid this initiative.

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| **INDICATOR TYPE:** | Youth Health |
| **INDICATOR** | 95 percent of Māori students eligible for a routine assessment (including Home, Education, Eating, Activities, Drugs and Alcohol, Suicide and Depression, Sexuality and Safety (HEEADSSS) assessment) have had an assessment during the calendar year |
| **FOR PERIOD:** | July - December 2020 |
| **PREPARED BY:** | Deborah Davies, Operations Executive, Te Uru Kiriora |

## 1. PURPOSE

This paper provides an update to HDAC on the youth health HEEADSSS assessment indicator.

## 2. INDICATOR AND ANALYSIS

The information presented in the dashboard includes the same time period as reported previously, with a decrease for both Māori and Non-Māori students. This type of result is expected with the schools being at the early portion of Term 2 of any school calendar year.

The Clinical Nurse Manager for the School Based Health Service programme has been able to update the information to the end of December 2020. The updated data for the school year indicated that 3,570 Māori students were attending decile one to five schools in Years Nine to 13, with 710 students in Year Nine.

The previous report detailed that Ninety-nine HEEADSSS assessments had been completed in January to June 2020, with the impact of COVID-19 evident on the numbers. At December Four-hundred HEEADSSS assessments were undertaken representing 56.3 percent.

In the January – June 2020 period, 547 clinical assessments were undertaken with Māori students, and in the period July to December 701 assessments were undertaken representing 19.6 percent of the Māori school population.

## 3. INSIGHTS

The prioritisation for assessments is determined by the individual schools. Over the reporting period, clinical assessments were not prioritised for Māori.

## 4. DISCUSSION

HEADSSS assessments were programmed for catch-up over July to December 2020. It is to be noted that these are optional for the student and require their whānau consent. As highlighted in the previous report achieving a completion rate of 95 percent or greater for Year Nine HEEADSSS assessments would be difficult in 2020. At 31 December 2020 a total of 400 assessments were carried out from a total cohort of 710 students, which equates to 56.3 percent undertaken.

It was determined that a multi-pronged programme would be utilised and some of the key work that was undertaken:

- Weekly internal reporting of completed HEEADSSS assessments, including an ethnicity analysis
- Focus on catching-up on HEEADSSS assessments, which has been impacted by COVID-19 contact tracing work.
- Instigate an enhanced programme with schools to support the planning, prioritisation, access to, and undertaking of health assessments for Māori students. This is a change in focus as to date schools have independently prioritised students based on the school's knowledge of individual student risk. To support success, the Public Health Nursing team is working with schools to provide clear guidance on a strengths-based approach to prioritisation and will also work alongside the school Māori community.

## 5. NEXT STEPS

A number of actions were highlighted from the previous report as next steps:

- Re-engagement with the three Kura not part of the assessment programme, as progress has been stalled due to the focus on the COVID-19 vaccination rollout for Māori.
- Work with Public Health Māori Advisor, Pae Ora Paiaka Whaiora and iwi/Māori Health providers to enhance the SBHS services into the Kura within the MDHB region.
- Commence the programme of working in partnership with schools, and how this kaupapa aligns to developing schools as 'hubs'.

An updated report will be available at completion of the school calendar year in December 2021.

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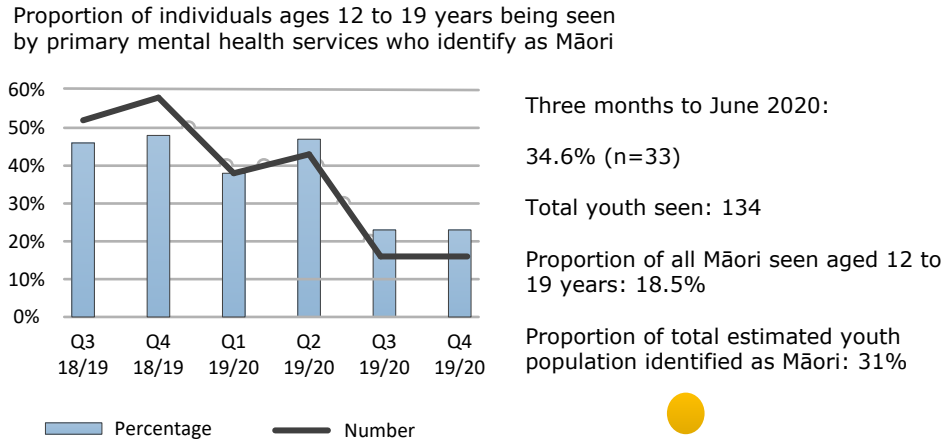
|---|---|
| **INDICATOR TYPE:** | Youth Health |
| **INDICATOR** | Proportion of individuals aged 12-19 years being seen by primary mental health services who identify as Māori |
| **FOR PERIOD:** | January 2018 to July 2020 (6 quarters) |
| **PREPARED BY:** | Scott Ambridge, Operations Executive, Te Uru Rauhī |

## 1. PURPOSE

This paper provides an update to HDAC on the primary mental health youth health indicator.

## 2. INDICATORS AND ANALYSIS




A data extract was taken of the 2019/2020 financial year. THINK Hauora data prior to this period is problematic due to a change in their data collection systems. Until now, this service comprises of referral to counselling and other youth focused therapies including equine therapy. From October 2020 this will also increasingly include Te Ara Rau, Access and Choice programme which is a brief psychological, solutions focused intervention available for all ages.

The gap in data availability and/or reliability for 2018/2019 period creates only a 12-month analysis period.

An interesting note is that for the last half of the year, the volume of males seen dropped substantially. This appears to correspond with a similar reduction in the volume of clients who identify as Māori. The inference then is that the volume of Māori males seen dropped. Any cause to this anomaly is currently unknown.

**Proportion of individuals aged 12-19 years being seen by primary mental health services who identify as Māor**i

| | | | | | PERCENTAGES | | | |
|---|---|---|---|---|---|---|---|---|
| **People seen by service Clients aged 12-19** | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| Number of females seen | 117 | 92 | 89 | 93 | 58.79% | 50.27% | 65.44% | 69.40% |
| Number of males seen | 82 | 91 | 47 | 41 | 41.21% | 49.73% | 34.56% | 30.60% |
| Number of clients seen – unspecified gender | NR | 0 | 0 | 0 | 0% | 0% | 0% | 0% |
| Total number of youth seen | 199 | 183 | 136 | 134 | | | | |
| | | | | | | | | |
| **Ethnic Group** | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| Māori | 74 | 83 | 33 | 33 | 37.19% | 45.36% | 24.26% | 24.63% |
| NZ European | 113 | 84 | 92 | 88 | 56.78% | 45.90% | 67.65% | 65.67% |
| Pacific Island | 8 | 6 | 1 | 4 | 4.02% | 3.28% | 0.74% | 2.99% |
| Asian | NR | 0 | 3 | 2 | | 0% | 2.21% | 1.49% |
| Other | 4 | 10 | 7 | 7 | 2.01% | 5.46% | 5.15% | 5.22% |
| Total Non Māori | 125 | 100 | 103 | 101 | 62.81% | 54.64% | 75.74% | 75.37% |

## 3. INSIGHTS

With the analysis covering only a short time period, and one which included COVID-19 Level 4 restrictions, it is difficult to draw any firm conclusions.

## 4. DISCUSSION

A cause for the apparent drop in Māori males seen between quarter two and quarter three requires further investigation and could relate to the end of the school year during this time.

It would be useful to see a split of localities to better identify any impact/opportunities in service provision.

A split of gender to ethnicity might also provide useful insight.

## 5. NEXT STEPS

Implement Te Ara Rau, Access and Choice programme progressively over the next three to four years as per MoH rollout.

Year One sees current recruitment of seven health practitioner roles and 11 health coaches known as Kaiwhakapuaki Waiora located in iwi providers already underway. These roles will work with all ages and from a whānau perspective.

A robust evaluation of this programme will assist with determining the reach of activity and outcomes in the coming years.

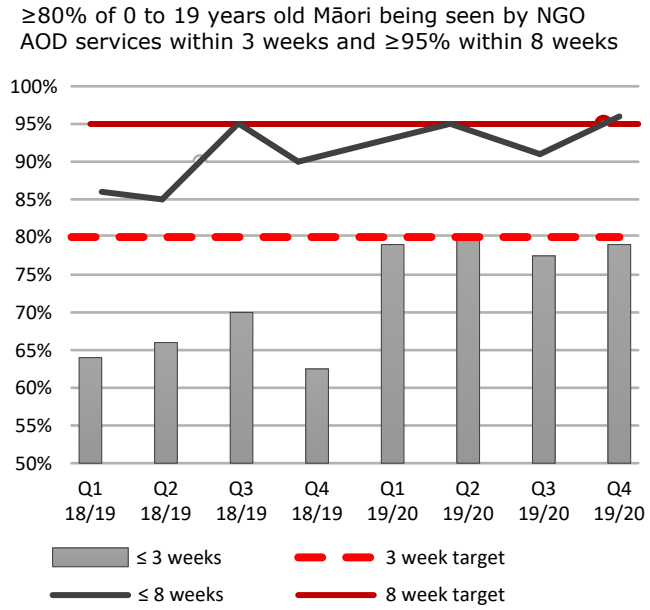
The extension of school-based health services and counsellors in schools is likely to have a positive impact on this indicator as the ability to intervene earlier and at places where young people are is increasingly available.

| | |
|---|---|
| **INDICATOR TYPE:** | Youth Health |
| **INDICATOR** | ≥80 percent of 0-19 years old Māori being seen by Non-Government Organisations (NGO) Alcohol and Other Drug (AOD) services within three weeks and ≥ 95 percent within eight weeks. |
| **FOR PERIOD:** | January 2018 to July 2020 |
| **PREPARED BY:** | Scott Ambridge, Operations Executive, Te Uru Rauhī<br>Vanessa Caldwell, Clinical Executive, Te Uru Rauhī |

## 1. PURPOSE

This paper provides an update to HDAC on the alcohol and other drug waitlist youth health indicator.

## 2. INDICATORS AND ANALYSIS




12 months to March 2020:
79.2% (n.38) within three weeks
95.8% (n.46) within eight weeks

Wait greater than eight weeks: Two

Four NGO providers

Proportion of total seen by providers who identify as Māori: 42.5%

**Data behind the graph:**

Tables below include extracts from the quarterly MoH Non-Financial Monitoring Framework.

**12 months: 01 April 2018 to 31 March 2019 (report run date: 24 June 2019)**

| Alcohol and drug | 0-19 years (12 Months to 31 March 2019) | | | | | | | | | Target | Volume by | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DHB provider and NGOs | Clients seen | | | Percentage (%) | | | Cumulative % | | | | Ethnicity | |
| | Māori | Non Māori | Total | Māori | Non Māori | Total | Māori | Non Māori | Total | | Māori | Non Māori |
| ≤3 weeks | 18 | 30 | 48 | 62.10% | 68.20% | 65.80% | 62.10% | 68.20% | 65.80% | **80%** | 37.50% | 62.50% |
| 3-8 weeks | 8 | 12 | 20 | 27.60% | 27.30% | 27.40% | 89.70% | 95.50% | 93.20% | **95%** | 40% | 60% |
| ›8 weeks | 3 | 2 | 5 | 10.30% | 4.50% | 6.80% | | | | | 60% | 40% |
| **Total** | **29** | **44** | **73** | | | | | | | | 39.73% | 60.27% |

**12 months: 01 April 2019 to 31 March 2020 (report run date: 31 March 2020)**

| Alcohol and drug | 0-19 years (12 Months to 31 March 2020) | | | | | | | | | Target | Volume by | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DHB provider and NGOs | Clients seen | | | Percentage (%) | | | Cumulative % | | | | Ethnicity | |
| | Māori | Non Māori | Total | Māori | Non Māori | Total | Māori | Non Māori | Total | | Māori | Non Māori |
| ≤3 weeks | 38 | 43 | 81 | 79.20% | 65.20% | 71% | 79.20% | 65.20% | 71% | **80%** | 46.91% | 53.09% |
| 3-8 weeks | 8 | 16 | 24 | 16.70% | 24.20% | 21% | 95.80% | 89.40% | 92.10% | **95%** | 33.33% | 66.67% |
| ›8 weeks | 2 | 7 | 9 | 4.20% | 10.60% | 8% | | | | | 22.22% | 77.78% |
| **Total** | **48** | **66** | **114** | | | | | | | | 42.11% | 57.89% |

**Results by quarter: Percentage seen within timeframes 2018/19 – 2019/20**

| 0-19 years old – Alcohol and Drug Services (DHB Provider and NGOs) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Target** | **Ethnicity** | **2018/19** | | | | **2019/20** | | | | **Variance** |
| | | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** | **Q4 to Q4** |
| ≥80% within 3 weeks | Māori | 63.60% | 66.70% | 70% | 62.10% | 78% | 80.90% | 76.60% | 79.20% | 17.10% |
| | Non Māori | 64.30% | 58.70% | 54.30% | 68.20% | 78.10% | 70.60% | 69.70% | 65.20% | -3.00% |
| | **Total** | **64.10%** | **61.20%** | **60%** | **65.80%** | **78.10%** | **74.80%** | **72.60%** | **71%** | **5.20%** |
| ≤95% within 8 weeks | Māori | 86.40% | 85.70% | 95% | 89.70% | 92% | 95.70% | 91.50% | 95.80% | 6.10% |
| | Non Māori | 95.20% | 93.50% | 91.40% | 95.50% | 93.80% | 95.60% | 92.40% | 89.40% | -6.10% |
| | **Total** | **92.20%** | **91%** | **92.70%** | **93.20%** | **93%** | **95.70%** | **92%** | **92.10%** | **-1.10%** |

## 3. INSIGHTS

Data collection is via PRIMHD (the National Mental Health & Addiction data set) which all Mental Health and Addiction (MHA) services contribute to including the four non-government organisations (NGO) providers operating in this category. The methodology is long standing and has remained constant through the reporting period.

The total volume of clients seen increased by 64 percent between the period 2018/19 and 2019/20. This includes a 60 percent increase in Māori and a 66 percent increase in Non-Māori clients.

In the 12 months to March 2020, 42 percent of those seen identify as Māori. This is a slight increase (2.4 percent) from the previous year.

**Percentage of clients 0-19 years seen by NGO AOD services within three weeks:**

The percentage of Māori clients seen within three weeks is trending upwards. 79.2 percent were seen within this timeframe in quarter four 2019/2020, just below the 80 percent target, and a significant increase from 62.1 percent the same time last year.

A similar comparison of the Non-Māori clients shows a slight downward trend from 68.2 percent in 2018/2019 to 65.2 percent in 2019/2020.

**Percentage of clients 0-19 years seen by a NGO and Alcohol and Other Drugs (AOD) services within eight weeks:**

This is a cumulative percentage, including those seen within three weeks.

The percentage of Māori clients seen within eight weeks is trending upwards; 95.8 percent in quarter four 2019/20, exceeding the 95 percent target. This is again an increase from 89.7 percent the same time last year and represents a 6.1 percent overall reduction in the Māori client wait list.

A similar comparison of the Non-Māori clients shows a downward trend from 95.5 percent in 2018/19 to 89.4 percent in 2019/20 and represents a 6.1 percent overall increase in the non-Māori client wait list.

Any impacts of COVID-19 through this period are not visible in the data.

## 4. DISCUSSION

Overall this indicates a positive change for Māori clients, suggesting that the introduction of services based where young people are, is having a positive impact on reducing wait times and access to services.

The change has been supported by the introduction of school based AOD Services in Tararua and more recently Dannevirke High School, and also Counselling and Psychology Services introduced in Ōtaki College through 2019, all of whom report good uptake of these services.

The ability to break down the data set further could provide better insights and help identify impacts and opportunities including by locality, gender or smaller age groupings.

## 5. NEXT STEPS

It is expected that the introduction of the Access and Choice programme (Te Ara Rau) which sees seven additional clinical staff located within Integrated Family Health centres and 11 health coaches located within iwi providers across our rohe this year will also help address previously unmet need. This service is available for people of all ages, has capacity for walk-ins (no wait times) and

can be accessed for any presenting issue of concern.  It is anticipated this service will continue to increase in capacity over the next four years.

Additional youth-specific roles are also being funded and will be recruited to from October 2020.  It is anticipated this roll out will continue to expand over the next four years.  Applying an equity lens on this programme sees the first tranche of roles all located with iwi providers and in the priority needs as determined by iwi.

# HEALTH AND DISABILITY ADVISORY COMMITTEE


**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** | Kelly Isles, Director of Strategy, Planning and Accountability |
| **Endorsed by** | Chiquita Hansen, Interim General Manager, Strategy, Planning and Performance |
| **Date** | 21 August 2021 |
| **Subject** | **Regional Services Plan Implementation, Quarter Four – 2020/21** |

**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 Four of 2020/21.

**Strategic Alignment**

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

## 1. PURPOSE

To provide an update on delivering the Central Region 2020/21 Regional Services Plan (RSP) for Quarter Four (1 April to 30 June 2021). It is for the Committee's information only and no decision is required. Due to the health sector reforms and disestablishment of District Health Boards from 1 July 2022, there is no requirement to present a Regional Service Plan to the Minister of Health for 2021/22. There will still be a Regional Services Plan and the Committee will receive quarterly progress reports.

## 2. OVERVIEW

- The Ministry of Health (the Ministry) has reviewed the region's progress on implementing the deliverables and milestones for Quarter Four based on the report provided by Technical Advisory Services (TAS) and provided an overall assessment rating of 'Achieved'.
- No significant issues or risks to delivering the priority programmes were identified in the report for Quarter Four.
- Highlights for Quarter Four are provided in the tables below. In future, the focus is on aligning areas of work with the Health and Disability System Review.
- As no RSP is required for next year, a plan to focus on DHB priorities is underway and will be presented to the Board.

## 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 District Health Boards (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 three strategic initiatives. These are:

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

These are linked to five agreed priority areas to be progressed in the 2020/21 year:

1. Developing regional single systems of care by prototyping orthopaedics.
2. Planning for sustainable complex care.
3. Developing a plan for regional specialist mental health and addiction services.
4. Implementing the regional cardiology plan.
5. Developing a frailty model of care.

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.

Together with the regional priority programmes for the year, the RSP includes the national regional requirements. These are:

- Healthy ageing – implementation of the New Zealand Framework for Dementia Care.
- Hepatitis C.
- Data and digital – regional ICT investment portfolio.
- Regional workforce.
- Cardiac and stroke services.

A copy of the final draft RSP was provided to the Board in December 2020.

As part of the Non-financial Monitoring Framework and Performance Measures for DHBs, a quarterly progress report on delivering the national regional requirements outlined in the RSP is required to be submitted to the Ministry. TAS prepares and submits these reports on behalf of the six DHBs. The Ministry provides feedback and an assessment of progress in the delivery of each Government priority area and regional performance results each quarter using the following criteria.

**Definitions of ratings of Government priorities**

| | |
|---|---|
| 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 |

The Committee receives updates on progress with implementation of the RSP, together with the performance assessment provided by the Ministry following their review of the report submitted by TAS each quarter.

## 4. DELIVERY OF THE 2020/21 REGIONAL SERVICES PLAN – QUARTER FOUR UPDATE

Implementation of the priority programmes has progressed during Quarter Four. An update on progress of the national regional requirements, regional priority programmes and clinical networks are provided in the following tables.

### 4.1. National Regional Requirements (National Priorities)

Overall, the report on the RSP deliverables for the quarter received an 'Achieved' rating, with all national regional requirements tracking to plan for the most part. It's important to note that TAS prepares and submits these reports on behalf of the six DHBs and the following table summarises the progress of these reports for the quarter. The table also provides the rating for each national regional requirement following the final review by the Ministry.

| National regional requirements | Comment/Summary of progress | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|
| Data and digital | In support of the service optimisation changes that have been recommended, Regional Directorate of Health Services (RDHS) have completed a consultation period and have confirmed their new structure. This new structure brings in vital new resources to deliver services in a modern way. With this change TAS can align their deliverables against the Tenzing report and alignment with the health review.<br>Next steps:<br>• Build new regional capabilities by hiring Chief Information Security Officer (CISO), Shared Decision Making (SDM), Operations Manager and Regional Radiology Information Systems RRIS/PACS Admin – all roles have been advertised.<br>• Review of all governance groups within the region has started<br>Move key decisions back to the DHBs to ensure they are clinically led and provide value. | ● | ● | ● | ● |
| Workforce | GMs HR as the designated leads for workforce in the region are still challenged with a heavy HR work programme. This has not changed but now some additional regional workforce support has been provided to assist GMs.<br>All roles are currently filled. The work in the central region Allied Health Science and Technical (AHST) has continued to make good progress. | ● | ● | ● | ● |

| | | | | | |
|---|---|---|---|---|---|
| Hepatitis C | Positive progress with one-stop shops being implemented and Hepatitis C Point of Care Testing (POCT) tests increasing. | ● | ● | ● | ● |
| Cardiac services | Key progress this quarter has been in relation to:<br>• Key Performance Indicator (KPI) Report – work continues with the revision of the KPI cardiac report to include primary care and All New Zealand ACS Quality Improvement (ANZACS QI) time of referral for door to cath.<br>• Medical imaging – discussions continue to be progressed around a regional medical imaging platform, Synapse.<br>• Sustainable services – as a matter of priority, a select group of Cardiac Network clinicians met on 12 August to discuss sustainable regional cardiology services and the development of cath labs in the region. | ● | ● | ● | ● |
| Stroke services | The regional stroke programme is tracking to plan with a 24/7 regional telestroke service launched on 1 March which is progressing well. 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. | ● | ● | ● | ● |
| Dementia care | The region continues to support the work of the National Dementia Framework Collaborative with the contribution of a geriatrician with a special interest in dementia and a Planning and Improvement Manager (TAS).<br>The regional dementia programme will support the activities of the New Zealand Dementia Foundation and their funded three-year work programme for the Cognitive Impairment Support for Practice and Education Refresh (CASPER).<br>Consultation on the regional dementia work programme is occurring with the Regional Medical Leads and the Health of Older People Network. | ● | ● | ● | ● |

## 4.2. Regional priority programmes

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 |
|---|---|---|---|---|---|
| Regional complex sustainability | Programme is currently on hold. | 🟠 | 🟠 | 🟠 | 🟠 |
| Single system of care | Synergia were commissioned to complete the initial phase and commenced work on 21 February. A final report has been drafted to reflect findings from workshops with orthopaedic stakeholders at all six regional DHBs.<br>A regional clinical network was established to guide this work and co-design a future state. The network has now met four times and has discussed the key findings and opportunities. | 🟠 | 🟢 | 🟢 | 🟢 |
| Frail elderly/Health of Older People | Francis Health has been appointed by the central region Chief Executives to progress the identification of a regional system of integrated care for frail older people ensuring access and equity for Māori as a priority. The proposed model of care is to be supported by best practice approaches, include measurable outcomes and reinforce a whole of system approach.<br>Attendance by Francis Health at regional health of older people meetings is complete and one-on-one interviews are well underway with health professionals, commissioners, community, primary and secondary care service providers. The frailty hui date was set for 5 May 2021 with Dr Ian Sturgess joining by videoconference from the United Kingdom. | 🟢 | 🟢 | 🟢 | 🟢 |
| Mental health and addiction | Francis Health commissioned to complete the initial phase and commenced work in February 2021. The final report which contained over 50 recommendations was accepted as a reference document (June). | 🟠 | 🟢 | 🟢 | 🟢 |

**Clinical networks**

| | | | | | |
|---|---|---|---|---|---|
| Radiology | With the imminent health reforms the project group has decided to engage with other tertiary centres to assess whether the development of Paediatric Radiology clinical pathways should be progressed nationally as opposed to regionally.<br><br>The Regional RMO Training proposal has been endorsed/accepted by Capital and Coast DHB (CCDHB) and progress is being made to implement the first year intake. This includes increasing the CCDHB first year intake from two to three, position starting January 2022 (two replacement positions, one new position).<br><br>The radiology digital strategy is a final draft. A meeting is being scheduled to agree next steps. The RRIS/PACS Working Group now comes under the RRSG umbrella and is being chaired by an RRSG Service Manager. | ● | ● | ● | ● |
| Regional trauma | The review of the trauma system/hospitals in the central region has not been initiated, however this is a key task for the Central Region Major Trauma Strategic Network. The terms of reference are available and a call for nominations for this network closed at the end of June 2021.<br><br>The new Central Region Major Trauma Strategic Network will include representation from GMs Māori and ensure a focus on reporting outcomes for Māori. The regional dashboard enables DHBs to view data for Māori across all data fields reported. | ● | ● | ● | ● |

# HEALTH AND DISABILITY ADVISORY COMMITTEE


**For:**

| | |
|---|---|
| | Approval |
| | Endorsement |
| **X** | Noting |

**Key questions the Committee should consider in reviewing this paper:**

- Does this paper provide an adequate summary of the COVID-19 resurgence response?
- Are there aspects of the response to celebrate or consider as learning points to improve planning for any further resurgence?
- Is the Committee confident in the MDHB's approach to managing the resurgence of COVID-19?

| | |
|---|---|
| **To** | Health and Disability Advisory Committee |
| **Author** | Judith Catherwood, General Manager, Quality and Innovation<br>Kelly Isles, Director of Strategy and Accountability |
| **Endorsed by** | Kathryn Cook, Chief Executive |
| **Date** | 7 September 2021 |
| **Subject** | **COVID-19 Delta Resurgence** |

**RECOMMENDATION**

It is recommended that the Committee:

- **note** the progress in the COVID-19 Delta resurgence response from 17 August to 7 September 2021.

**Strategic Alignment**

This report is aligned to the DHB's strategy and key enablers of people, information, partners, stewardship, and innovation.

## 1. PURPOSE

To provide the Health and Disability Advisory Committee (HDAC) with an update on the COVID-19 response to the recent resurgence, the Level Four lockdown, and the management approach in MidCentral District Health Board (MDHB). It also provides information on the impact this period of resurgence has had on health and wellbeing services within the district.

## 2. SUMMARY

The Prime Minister announced that New Zealand would enter a Level Four lockdown on 17 August 2021. The lockdown was in place for two weeks in the MDHB district. The district moved to Level Three on 1 September and to Delta Level Two on 8 September 2021. The report summarises the COVID-19 resurgence response and other associated activities from the start of lockdown.

- Level Four protocols were established immediately, following national guidance.
- Welfare supports were activated, in partnership with Horizons Regional Council and Red Cross.
- The Incident Management Team (IMT) and Emergency Operations Centre (EOC) was established on 17 August 2021 and remains operational.
- Significant work has been undertaken to support improved access to vaccination across the rohe. The vaccination effort has been led by the Public Primary and Community Health Directorate (PPCH) through partnerships with iwi, local primary and kaupapa Māori health providers. Vaccination rates continue to exceed targets.
- Testing capacity and rates have increased significantly throughout the response period.
- Building on the work delivered in the first COVID-19 response, further work has been completed to prepare the hospital for the requirement to care for any COVID-19 positive patients.

## 3. BACKGROUND

On 17 August 2021 at 6pm, the Prime Minister announced that New Zealand would enter a Level Four lockdown from midnight. This was in response to a single COVID-19 community case which had been detected in Auckland earlier that day. The MDHB district moved to Alert Level Three on 1 September 2021 and to Alert Level Two at midnight on 7 September. The Auckland region remains in Alert Level Four. The Organisational Leadership Team (OLT) acted swiftly and established an IMT on the evening of 17 August. The IMT structure is outlined in Appendix One.

The purpose of the IMT is to provide leadership across the district in the response and management of the lockdown and the period of COVID-19 resurgence in the community. An EOC was established in the Board Room and has been operating seven days per week to support coordination and planning activities. The EOC was stood down at midnight on 7 September after the move to Alert Level Two.

The IMT's focus is to keep the community well informed, support our staff, volunteers, and providers to stay well, and specifically to maintain essential services across the district. The IMT manages and coordinates MDHB's response across all health streams. The IMT is structured using a two-team approach.

Governance for the IMT is provided by Kathryn Cook and Jeff Brown. The Incident Controllers are Celina Eves and Gabrielle Scott. Executives feed into IMT daily and iwi are reported to on any relevant or significant matters through the Te Tihi daily stand up.

The entire district, including all health providers and partner agencies, have responded positively and proactively to the situation.

Existing planning processes and protocols were immediately applied.

At the time of writing, there have been and are no cases of COVID-19 in the district.

## 4. OVERVIEW OF PROGRESS AND CHALLENGES

### 4.1. Community

Iwi and Māori health providers, coordinated by Te Tihi o Ruahine, are working collectively with a focus on ensuring Māori communities are well supported and have good access to vaccinations for COVID-19.

The response by the PPCH Directorate was 'Business as usual' in a surge context. A morning PPCH stand-up meeting of COVID-19 managers and leaders was established.

This initially involved feedback from the public health unit with an update of national and local cases. MDHB has been fortunate to have no local cases.

The public health team has provided additional support to the national contact tracing initiative. There have been over 34,000 contacts emerging from 500 places of interest nationally. MDHB received over 600 of these to case manage. Additional training of staff in contact tracing was undertaken and completed to support this work. This allowed the team to expand to enable remote contact tracing activities.

There has been a surge in COVID-19 testing at both the Palmerston North Main Street testing site and with the primary health organisation (PHO). Testing peaked at 832 on day five of the lockdown, with over 3500 documented for the first week of the Level Four lockdown. Additional testing staff were brought in and improvements were made to the infrastructure and process flow occurring at the Main Street testing site.

Planning commenced for the clinical and welfare management of positive COVID-19 cases in the community. This involves planning for Supervised Isolation and Quarantine (SIQ) facilities, including the identification of facilities, processes and support mechanisms. These will be used when a COVID-19 positive patient cannot isolate in their home environment or have mitigating reasons for not doing so. Plans to connect the clinical and welfare support required for these facilities, with the primary care providers and hospital services is ongoing.

### 4.2. **Hospital**

Significant planning was undertaken across all areas of the hospital in response to the March 2020 lockdown. This has ensured that robust planning is in place to respond to this lockdown and any potential COVID-19 patients. Initially, Emergency Department presentations reduced, however admission rates remained at usual levels. Adult inpatient services occupancy has been at capacity.

All service Business Continuity Plans were enacted. Decisions made regarding essential services follow the National Hospital Response Framework. Staff in services considered non-essential were redeployed to support critical clinical services, taking account of individual competencies and skills. Training and education for staff has been ongoing.

Collaborative work has occurred with local, regional, and national partners to ensure the continuation of national services.

There are some ongoing facilities challenges in some areas of the hospital. These are being managed and mitigated to ensure to safe service delivery.

Plans to address any delays in planned care due to the Level Four and Level Three requirements are in place.

## 5. WORK STREAMS

Eleven work streams have been established under the IMT.

A brief description of the progress to date on each of the work stream leads follows.

## 5.1. Welfare

The response to welfare in the community is coordinated and responded to by Horizons Regional Council through the Civil Defence Emergency Management team. However, the psychosocial response to community is led by District Health Boards. MDHB has been working to ensure all vulnerable groups have a feedback loop and connect back into MDHB. These groups include Māori, Pasifika, Refugee, Disability and elderly. MDHB has set up a system for feedback from staff with the intent to respond within a 24-hour timeframe. This is working very well and some issues of importance to staff have been identified that may not otherwise have been known. A similar feedback process through Facebook has been put in place for the community.

## 5.2. Māori Health

The iwi Māori Leadership Roopu was stood up again by Te Tihi o Ruahine on 18 August for iwi and Māori providers' response in the community. Agencies have also been included in the meetings to ensure consistency, coordination and swift response to need. Key work streams have been stood up and resource has been provided by iwi and Māori providers. MDHB has provided resource to support the kai drop offs and is working through an increase to the Māori Communications Agreement with Te Tihi o Ruahine. There is a huge effort being made by our providers to vaccinate the Māori community with no equity gap between Māori and non-Māori. MDHB want to thank iwi, Māori providers and Te Tihi for the outstanding work you do for our Māori communities. Well done!

## 5.3. Public Information Management (PIM)

Communication has been a key component of MDHB's response to the COVID-19 resurgence in New Zealand.

### *5.3.1. External communications*

Information about changes to alert levels, public health measures, wellness, hospital visitor policies, service provision and more has been sent to media, posted to social media, and shared with MDHB's sectoral and intersectoral partners and providers. MDHB's PIM function has connected with the Manawatu-Whanganui Emergency Management Network, comprised of PIMs from territorial authorities throughout the region, to share COVID-19 messaging and agree on media protocols in the event of the emergence of COVID-19 in the MidCentral DHB rohe. The MDHB COVID-19 microsite has been updated to reflect the appropriate changes.

### *5.3.2. Media*

MDHB's Communication Unit has responded to numerous media requests during the Alert Levels Four and Three. In a proactive capacity, media have been invited to visit the vaccination sites set up in response to the move to Level Four. Various members of the OLT have been interviewed on local radio and on TVNZ's Te Karere show.

### *5.3.3. Internal communications*

Daily staff memos have been sent to all MDHB staff outlining key COVID-19 response updates and messages, including providing the ability for staff to feedback any concerns or issues to either the IMT or to the COVID-19 wellbeing work stream. MDHB lock screens have been utilised for Alert Level information. The MDHB intranet and the Med App is being regularly updated.

## 5.4. **Logistics**

The management of logistics includes ensuring sufficient supplies and resources are available to support the response. The stock and supply of the Personal Protective Equipment (PPE) and other essential medical supplies has been closely monitored. The Ministry of Health (the Ministry) has established stronger and improved links with DHB materials management services after the original COVID-19 response in 2020. PPE is managed directly from the Ministry's supply chains that have been developed. There have been no concerns about PPE stock or supplies over this period. It is important to note that several primary health and iwi providers reported in the initial period of the resurgence response some difficulties in registering and using the Ministry portal set up specifically for their use. The MDHB assisted as appropriate to help resolve this matter.

## 5.5. **Facilities**

The Facilities Team has provided input and ongoing support at all levels to ensure the continuity of services within the hospital while also responding to the resurgence of COVID-19 in the community. The response has been comprehensive. Specific activities of note include:

- All non-essential building work was reviewed at Level Four and ceased to minimise the movement of contractors around our facilities.
- Building systems have been reconfigured in response to changes in clinical pathways.
- Sixty-two patient locations (including nine negative pressure rooms) are available for immediate use for the treatment of any patients with COVID-19.
- The performance of the existing negative pressure rooms has been reviewed and improved.
- The DHB can stand up another 14 patient locations within three days if required for the treatment of COVID-19 patients.
- The DHB has submitted a formal request to the Ministry for access to their bulk supply of air filtration units for a number of specialist locations within the hospital where there is no obvious mitigation method due to either the nature of the building structure or HVAC systems installed at the time of construction. The Ministry has advised that Auckland DHBs and Managed Isolation and Quarantine Facilities (MIQ) will take priority for these units.

## 5.6. Operations Hospital

Business Continuity Plans have been enacted across all services and decisions made regarding essential services in line with the National Hospital Response Framework.
The hospital inpatient pathway plan was enacted. This plan is continually updated, in line with national and international recommendations. An engineering report was urgently commissioned to review ventilation in Block C of Palmerston North Hospital. The report confirmed that this area of the facility had inadequate ventilation to safely manage a COVID-19 positive patient. New pathways have been developed for children and agreed across the business to address this concern. A temporary solution has been put in place to ensure an appropriate place for a birthing mother with COVID-19 if required. A long-term plan is under development.

Horowhenua Health Centre remains operational, with a key member of staff managing the facility to ensure safe service delivery.

Outpatient referrals continue to be received, triaged and accepted across all services. Urgent referrals continue to be seen either in person or via telehealth options. Non-urgent appointments are being deferred or managed through telehealth. Appointments which have been deferred are now being rebooked.

In line with the National Hospital Response Framework, urgent non-deferrable surgeries continue to be undertaken within the facility. The impact of this deferral will be assessed, and a plan is in place to address it. Priority for the rescheduling for the people impacted will take account of urgency of their condition and ensure equity of access for Māori and other priority groups.

## 5.7. Operations Primary

The Public Health Unit recommenced support to the national contact tracing effort on 17 August. The team has been enhanced with the addition of 14 DHB staff and three staff seconded from the Palmerston North City Council. There has been a significantly greater number of contacts being followed up nationally due to the nature of the Delta variant. Over 300 contacts are being followed up by the local Public Health team.

Testing capacity was stood up in accordance with the testing surge plan concurrently, with the Public Health team and THINK Hauora network rapidly mobilising the locality testing sites across the localities. A mobile testing facility was also activated and located in Ōtaki over the first weekend of Level Four due to a reported case in Wellington. Testing remains available seven days per week across the district, available both as drive through (no appointment necessary) and by appointment through general practice. The local primary care network, supported by THINK Hauora, moved rapidly to deliver general practice services virtually where possible from 18 August.

General practice teams continue to provide care, both virtually and in person. As well as providing routine care, general practice teams have focused on key priorities such as the childhood vaccination and are actively delivering COVID-19 vaccinations in all localities.

### 5.8. Intelligence and Planning

The Intelligence team, as part of the Coordinated Incident Management System (CIMS), provided the IMT with:

- a daily overview and wider situational awareness
- an understanding of immediate actions required
- likely outcomes (forecasting) as MDHB transitions through National Alert levels
- identification of emerging risks.

The Planning team developed the Incident Action Plans (IAPs) which guide the actions required over the National Alert Level changes.

### 5.9. Digital Services

Ongoing support has been provided at a variety of levels. Due to the volume of requests, a prioritisation framework has been implemented to ensure vital requests are not missed. Ongoing support has been provided to:

- staff who are working from home
- support various requests from the IMT
- vaccine and testing site establishment and operations
- maintaining critical hospital services
- enabling increased deployment of end user computing and mobile devices, as supply becomes available.

### 5.10. Safety

The ongoing safety patients, staff and wider communities remains the key focus of the IMT. Safety protocols are established throughout the organisation and include (but are not limited to) the following.

- Work from home where possible (non-essential/vulnerable workforce)
- Adherence to National Alert Level Four requirements, including mask wearing and physical distancing
- Increased COVID-19 vaccination availability
- 'Two Teaming' where possible to minimise the risk of transmission and to provide respite
- QR coding and controlled entry/exit
- Management of the 'No Visitors Policy'.

### 5.11. **Workforce**

The key focus areas are staff wellbeing and the DHB's commitment to health and safety of its staff. This includes collating staff vaccination status, vulnerable staff status and fit testing of PPE N95 masks. As at 1 September 2021, 86 percent of staff had reported their vaccination status, with 79 percent being fully vaccinated.

Teams have prepared to move to a 'Two Team' model as required, to ensure ongoing care provision. Triggers for two teams have been agreed and relate to the National Hospital Response Framework and the number of COVID-19 cases in the community. The Integrated Operations Centre and the Human Resources team is coordinating staff redeployment activities. The requests include support for the Metro Auckland DHBs, particularly support for management of MIQ facilities, Pasifika speaking contact tracers and ICU nurses. In addition to daily staff updates being sent to our union partners, a formal weekly update is sent from the Chief Executive's office to all unions about key matters relating to workforce, health and safety, PPE availability and logistics.

## 6. COVID-19 VACCINATION IMPLEMENTATION

As Level Four lockdown commenced, MDHB was in an excellent position to expand the vaccination programme. By being on target with the vaccination production plan, MDHB was able to increase sites, locations and opening hours to increase vaccination numbers. Rapidly enhanced additional vaccination capacity and new delivery models (via drive though delivery) resulted in the delivery of over 18,000 vaccines in week two of the lockdown. This was more than double what was scheduled to be delivered. Over 71% of these were first time vaccinations, further increasing the protective benefit across the district. Significant iwi-led vaccination delivery has supplemented a wide range of opportunity for all whānau to access vaccination. All whānau 12 years of age and over are now eligible for vaccination.

## 7. ENABLE NEW ZEALAND

As Level Four lockdown commenced, Enable New Zealand was able to quickly put in place its business continuity plan. All office-based staff moved to working from home and warehouse staff were moved into a split shift system. Only three staff kept working from the Main Street office. External stakeholders were advised immediately of the new operating requirements for equipment pick-up and delivery. As with the last event, there was a significant increase in applications – probably linked to assessors catching up on paperwork. There was also a significant increase in demand for equipment hire from DHBs wanting to discharge patients from hospitals more quickly. The team were reshuffled to ensure resources were apportioned accordingly to address the extra demand in a timely way. Enable New Zealand has been working closely with the community and providers to ensure the First Port website is relevant and up to date with COVID-19 messaging. This includes easy-read content. Lots of positive feedback has been received.

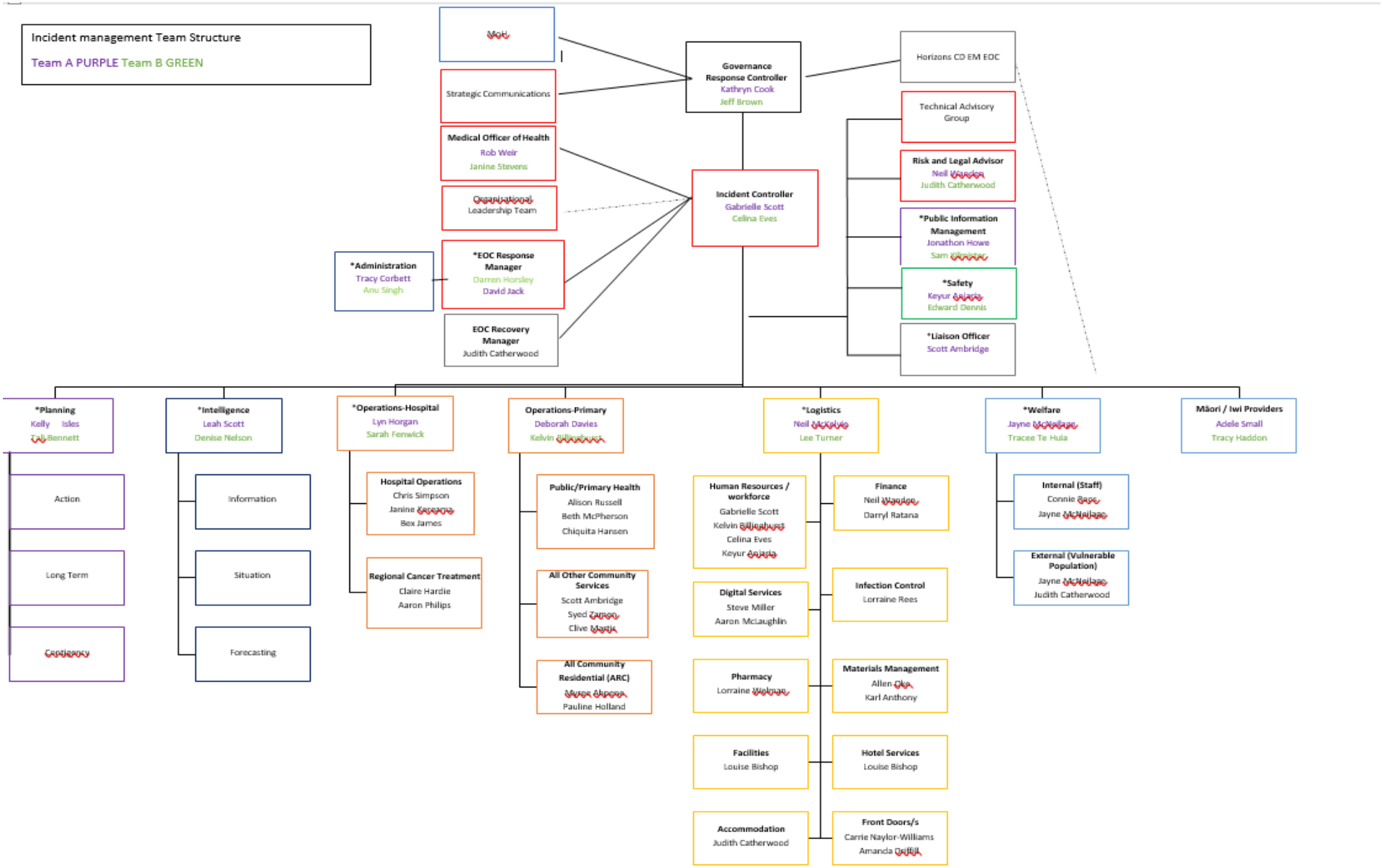
## 8. RECOVERY

Recovery planning has commenced to support the organisation and the wider health and disability provider community. The recovery plan will cover four principal areas:

- **Operations**: the process of progressively moving down the alert levels to enable normal or as near to normal as possible, health care delivery to take place. This includes planning for how the backlog of work associated with the lockdown is managed and how priorities are assessed to ensure MDHB continues to deliver safe and high-quality care to our community.
- **Welfare and wellbeing**: the process of supporting staff to return to work safely, as well as ensuring staff who have worked extremely hard over the period of the response are supported to take breaks and rest or annual leave to support their health and wellbeing. It also includes the ongoing welfare support that needs to be offered to the community as part of MDHB's responsibilities in the regional resurgence plan.
- **Learning and preparedness**: the approach MDHB takes to ensure we learn from the resurgence experience and put in place plans that ensure we are better prepared for any future resurgence of COVID-19 in the community.
- **Innovation and ways of working**: the approach MDHB takes to support rejuvenation, post the immediate recovery exercise, including making new ways of working that serve us to be maintained.

Learnings from this experience are being collated to ensure MDHB is well positioned to manage any future resurgence. In the last lockdown period, MDHB identified new ways of working linked to digital health, collaboration, compassion, team culture, governance and decision making, clinical governance and clinician engagement and leadership. MDHB has observed similar behaviours emerge in this most recent lockdown and it will be important to resist the temptation to revert to previous patterns of working which did not serve us well in the last 12 months.

## Appendix One – Incident Management Team Structure



# Information papers

*14 September HDAC*

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

# HEALTH AND DISABILITY ADVISORY COMMITTEE


**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 Horowhenua?
- 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** | Chiquita Hansen, Interim General Manager, Strategy, Planning and Performance<br>Syed Zaman, Clinical Executive, Te Uru Whakamauora – Healthy Ageing and Rehabilitation |
| **Date** | 26 August 2021 |
| **Subject** | **Locality Plan Progress Report – Horowhenua District** |

**RECOMMENDATION**

It is recommended that the Committee:

- **note** the progress that has been made in relation to Horowhenua 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 Horowhenua District. 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 Horowhenua.

## 3. BACKGROUND

The Horowhenua 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, Manawatū, Tararua 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 | Better Communication and Connections | Healthy Living |
|---|---|---|---|
| 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 | Improving communication | Wider determinants of health |
| Improving people's access to hospital and specialist care | Services working together | Raising awareness of what is available in the Horowhenua District and how to access it | Linking local people to local activities |
| Health working together as one team (improving people's experience) | Reducing Isolation (for older adults and rural communities) | Increasing engagement and visibility | Quality living for older adults |

## 4. PROGRESS IN RELATION TO THE CURRENT PLAN

The current plan has 57 actions in total and the reporting template has had 13 further actions added to it. Sixty-eight of these 70 actions are progressing well or have been completed. Appendix One summarises the action plan progress in each focus area.

### 4.1. An example of progress being made in each of the community priority focus areas

**Access to Healthcare**

A Cardiac Nurse Practitioner has started monthly heart failure clinics at Horowhenua Community Practice. These shared clinics include seeing patients with heart failure and providing advice and support for General Practice Team members. Teaching sessions on specific topics are also being provided to the team. Patients at the clinic are being saved time and travel costs to Palmerston North Hospital by being seen within their own community.

**Mental Health and Addictions**

The new model that has been approved for Adult Secondary Mental Health Services will see a significant increase in the number of staff working in the Horowhenua District (an increase of approximately 15 FTE) as well as the introduction of a local Kaupapa Māori Community Mental Health Service. The new model is designed to make a positive difference in the ability of people in distress to receive joined-up care, delivered locally and to ensure they feel safe and cared for as well as improving equity of access and outcomes for Māori.

**Better Communication and Connections**

The Tūngia te Ururua project's engagement process has recently been completed in the Horowhenua District. This engagement was undertaken to hear the voice of mama and whānau in the Horowhenua district who have birthed and/or cared for pēpi in their first 1000 days in recent years. The engagement process included surveys (paper and online) and focus groups held at local playgroups and playcentres. The engagement undertaken for this project is an example of the action: *When designing health service in the Horowhenua District people, families/whānau will be placed at the centre of planning decisions and design to best meet the needs of their communities.* The information gathered is currently being analysed to understand the needs of pēpi, mama and whānau and then this analysis will be used to inform future service provision.

Other community engagement in the last 12 months has included regular attendance at Horowhenua Community Wellbeing Committee meetings, an Annual Public Forum in Levin, another public forum in Shannon and attendance at a Pacific Leaders Fono. Regular e-newsletters continue to be sent out quarterly to a database of groups, organisations and individuals.

**Healthy Living**

Vaka Ora Pasifika is a health initiative, run by the THINK Hauora Pasifika Health team, supporting Pasifika woman in Horowhenua to improve their wellbeing. The programme focuses particularly on women with a long-term condition (LTCs) and/or those that are at high risk of getting LTCs due to circumstances beyond their control. Women select a 10-minute time that suits them and attend a weekly health check. At the chosen time the women weigh in and complete a health assessment with one of the trusted Pasifika nurses. The appointment includes a check that their screening is up to date. Baseline information is collected and shared so that participants know what areas they need to work on and the health/social services they could access. Sometimes women need more than 10-minutes for the health check and this need is accommodated, as is the need to offer assessment appointments outside of daytime hours.

The initial group has lost more than 100kgs and their lifestyle choices have changed. Participants feedback that a support network has been developed amongst the group, and some members have reported that their mental health has improved as a result of the routine, increase in physical activity, and increase in their social relationships with other Pasifika women in the community.

## 5. CURRENT HEALTH AND WELLBEING ISSUES AND POINTS OF NOTE IN HOROWHENUA

### 5.1. Health and Wellbeing Issues

Recent engagement has highlighted the following challenges affecting the health and wellbeing of people and whānau in Horowhenua.

- There is concern within the community that General Practice Teams are not accepting enrolments in Horowhenua (except for new-borns)
- Education providers are expressing a want for more mental health support for rangatahi and a need for some youth appropriate community housing for 15 to 17 year olds.
- Shannon community representatives highlight poverty and/or transport poverty as key issues affecting resident's ability to access health services.
- Young Pasifika fanau are living in crowded houses.

Other common themes from the past 12 months about issues affecting people's health and wellbeing, include:

- a desire for more services and a bigger health workforce within the district
- a lack of transport is a significant barrier to accessing services for many
- a shortage of affordable housing in the district
- poverty and the growing gap between the wealthy and the poor
- drug use and its effect on whānau is an issue.

### 5.2. Points of note

- The Mayor's Taskforce for Jobs in Horowhenua is seeing success from a programme they are running for young people under 25 years who are not engaged in employment, education or training (NEET). Horowhenua has the second highest NEET rate in the country and this programme is aiming to work with 90 rangatahi per year with the goal of seeing between 50 and 55 enter into jobs or education. Their first course had 15 participants and eight found employment, two are in education and the other five are still being worked with.
- The first two families of Columbian refugees are due to arrive in Levin in November with a second group expected to arrive in January. MDHB will be advertising shortly for a Programme Lead and a Clinical Lead to support the provision of health services for these refugees.
- Planning is underway to set up a youth taskforce in Levin following a recent hui to look at solutions for working with a group of youth whose behaviour has been causing issues in the town.

## 6. COVID-19 VACCINATION ROLLOUT IN HOROWHENUA

COVID-19 vaccinations are well underway within the Horowhenua district, with approximately 17,600 doses having been delivered locally as at 8 August 2021.

The vaccination team are working to plan future clinics in Horowhenua to ensure people who want to be vaccinated locally have the opportunity to do so. Liaison is currently taking place with key community members in Shannon to work out the best way to hold clinics to meet the needs of this community.

Vaccinations are being delivered through various vaccination sites in Levin and Foxton including Muaūpoko Tribal Authority and Raukawa Whānau Ora Services.

Feedback about the delivery of vaccinations in this district has been very positive. For example, during a meeting with the Levin Over 60s group, the members reported that they found the process both easy and stress-free.

## 7. SERVICE PLANNING, HOROWHENUA

MidCentral DHB has two concurrent pieces of work occurring in the Horowhenua district.

### 7.1. Clinical Services Plan

Sapere was recently commissioned to develop a Horowhenua Clinical Services Plan (CSP) to ensure there is an adequate and cohesive provision of specialist services for the current and future population of Horowhenua. The objectives are to:

- Reduce the barriers of time, distance, and travel for Horowhenua communities when accessing specialist health care services
- Increase access to timely, appropriate specialist care for Horowhenua residents
- Address the growing inequity in Horowhenua
- Improve access to services and outcomes for the Māori population
- Increase access to timely care locally
- Improve access to telehealth
- Workforce planning and development.
- The timeframe for the completion of the CSP is December 2021.

### 7.2. Health and Wellbeing Locality Planning

A refreshed Health and Wellbeing Plan is in progress; this plan will primarily focus on primary, community, iwi, cross sector and will have strong links to the Horowhenua Clinical Services Plan (CSP), outlined above. Sapere is supporting the DHB with this refreshed locality plan.

MidCentral DHB, THINK Hauora and the Horowhenua Company Limited (HCL) are scoping a new 'Health and Wellbeing Hub' (placeholder name) facility in Levin. The HCL is currently acquiring land and an MOU is being developed between THINK Hauora and HCL. The Horowhenua Community Practice (owned by THINK Hauora) will move from the Horowhenua Health Centre (HHC) in Liverpool Street and be the anchor tenant in the new development. This will provide space for the increase of specialist services to be available at the HHC, specific details will be determined by the CSP.

Several other general practices and a range of health and social services providers have expressed interest in this new 'Health and Wellbeing Hub' development. A governance group for this development is currently being established. The anticipated membership of this group will comprise the following key stakeholders:

- Horowhenua Company Ltd
- MidCentral DHB
- THINK Hauora
- Horowhenua District Council
- Local iwi – Muaupoko Tribal Authority; Te Rūnanga o Raukawa
- Pasifika Community
- Other potential tenants in the 'Health and Wellbeing Hub'
- Horowhenua Community Wellbeing Committee Chairperson
- Local NGOs (to be determined)

It is envisaged that the development will be completed by 30 June 2023.

## 8. UPCOMING WORK IN NEXT SIX MONTHS

- Continue to work with COVID-19 vaccination team on linking to key community leaders in planning COVID-19 vaccination events in Horowhenua.

- Development and distribution of two further community newsletters (early September and December), including messaging about the local COVID-19 vaccination rollout.
- Continue community engagement and feedback to MDHB executive members. This engagement will include an Annual Public Forum planned for 5pm on Tuesday 9 November (COVID-19 alert levels permitting).
- Refresh the demographic profile information for Horowhenua (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.
- Community engagement to be undertaken to ensure the new model of care for Mental Health and Addiction specialist services, which includes increased resources, are better positioned to be responsive to the needs of Horowhenua residents with significant mental health concerns.

**Appendix One: Progress in each community priority focus area**

| Access to Health Care | Mental Health and Addiction | Better Communication and Connections | Healthy Living |
|---|---|---|---|
| People are able to get help when they need it (improving access to primary care) = nine actions.<br><br>89 percent complete or progressing well, 11 percent yet to start | People are able to get help when they need it = nine actions.<br><br>100 percent complete or progressing well | Improving communication = four actions.<br><br>100 percent progressing well | Wider determinants of health = six actions.<br><br>100 percent complete or progressing well |
| Improving people's access to hospital and specialist care = six actions.<br><br>83 percent complete or progressing well, 17 percent behind/challenges | Services working together = four actions.<br><br>100 percent progressing well | Raising awareness of what is available in the Horowhenua District and how to access it = five actions<br><br>100 percent progressing well | Linking local people to local activities = six actions.<br><br>100 percent complete or progressing well |
| Health working together as one team = seven actions.<br><br>100 percent progressing well | Reducing isolation = three actions.<br><br>100 percent progressing well | Increasing engagement and visibility = six actions.<br><br>100 percent complete or progressing well | Quality living for older adults = five actions.<br><br>100 percent complete or progressing well |

Just two of the 70 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.<br>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.<br>A number of electronic initiatives are underway to streamline the flow of referrals into the organisation. |
| Access to health care – People being able to get help when they need it | Older adults will be able to attend workshops to learn how to use patient portals to get repeat prescriptions, make appointments and receive test results. | THINK Hauora are currently looking at training options that can be put in place. |

# HEALTH AND DISABILITY ADVISORY COMMITTEE


**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** | Judith Catherwood, General Manager, Quality and Innovation |
| **Date** | 26 August 2021 |
| **Subject** | **Committee's Work Programme** |

**RECOMMENDATION**

It is recommended that the Committee:

- **note** the update on the Health and Disability Advisory 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 Advisory Committee's (HDAC) work programme. This is for information only and no decision is required.

## 2. HDAC WORK PROGRAMME

The HDAC work programme was approved by the Committee in November 2020.

Due to the health sector reforms, there is no requirement to present a Regional Services Plan to the Minister of Health for 2021/22. However, there will still be a Regional Services Plan, which will continue to be reported to the Committee on a quarterly basis.

Reporting is occurring in line with the work programme.

| Health and Disability Advisory Committee \| Work Programme | Fqncy | Feb | Apr | Jul | Sep | Nov | Resp |
|---|---|---|---|---|---|---|---|
| **Strategy/Planning** | | | | | | | |
| Health Needs Assessment and Equity Snapshot<br>to consider the health needs assessment of the district and sub-region | Triennial<br>Nov-21 | | | | | X | GMSPP & GMP&P |
| Ka Ao, Ka Awatea – Māori Health Strategic Framework<br>on a three-yearly basis, review/refresh the strategy to ensure it remains relevant and reflects the DHB's Strategy | Triennial<br>Oct-23 | | | | | | GMM |
| Disability Roadmap<br>to determine a disability strategy and roadmap for the district, and thereafter how it has been advanced, changes, and priorities/investments for the future (3-5 years). | Triennial<br>Aug-22 | | | | | | GMENZ<br>EDAH |
| Locality Health and Wellbeing Plans<br>to determine how the locality plans have been advanced, what's changed and priority initiatives/investments for the future (3-5 years), and to receive community feedback | Triennial<br>Apr-21 | | X | | | | OEs & CEs & SPP |
| Cluster Health and Wellbeing Plans<br>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<br>TBC | | | | | | OEs & CEs |
| **Quality Improvement** | | | | | | | |
| Clinical governance and quality improvement framework – progress and trends<br>to monitor the quality and safety of health care services in the district, including trends, performance against dashboard and markers, and confirm the adequacy of the programme planned or established to advance or address issues.<br>to monitor serious and sentinel events, and HDC complaints | 4 / year | X | | X | | | GMQ&I |
| Consumer Stories (workshop)<br>to hear direct from consumers of health and disability services about their experience | 3 / year | | X | X | | X | GMQ&I |
| Quality and Safety Dashboard/Online Quality Report<br>quarterly online quality report which includes information from the quality plans developed by clusters with system wide improvement activities that align with The Quality Agenda | 4 / year | X | X | | X | X | GMQ&I |
| **Performance** | | | | | | | |
| Cluster Reports, including Health and Wellbeing Plans<br>to monitor each Cluster's performance, including the implementation of their Health and Wellbeing Plans, including progress against key targets, initiatives and outcomes. | 5 / year | X | X | X | X | X | OE & CEs |
| Cluster Deep Dive reports (presented under Strategic Focus – rotated between Clusters)<br>to monitor current and emerging matters, including quality and safety, opportunities and challenges, and the adequacy of any mitigations | 5 / year | X | X | X | X | X | OE & CEs |

| | Fqncy | Feb | Apr | July | Sep | Nov | Resp |
|---|---|---|---|---|---|---|---|
| Locality Health and Wellbeing Plans<br>to determine how the locality plans have been advanced, what has changed, and priority initiatives/investments for the future (3-5 years), and to receive community feedback | Annual | Man | PN | Otaki | Horo | Tar | OE & CEs & SPP GMSPP |
| Regional Services Plan (implementation)<br>to monitor the implementation of the Plan and achievement of stated outcomes | 4 / year | **X (Q1)** | **X (Q2)** | **X (Q3)** | **X (Q4)** | | GMSPP |
| **Equity** | | | | | | | |
| Ka Ao, Ka Awatea – Māori Health Strategic Framework<br>to monitor progress being made in achieving the Framework, including the appropriateness of initiatives and investment planned/established. | Annual | | **X** | | | | GM |
| Equity Dashboard – Māori Health Indicators ('Deep Dive' reports)<br>to monitor progress being made in achieving the national Māori health targets, including the appropriateness of initiatives planned/established | Six-monthly each group | | | | | | |
| Child and Youth indicators | | | | | **X** | | OEs and CEs |
| Adult indicators | | | **X** | | | **X** | OEs and CEs |
| Mental Health indicators | | | | **X** | | **X** | OEs and CEs |
| Workforce indicators | | | | **X** | | **X** | OEs and CEs |
| **Disability** | | | | | | | |
| Disability Strategy<br>to monitor progress in implementing the Disability Strategy, including opportunities and challenges, and confirming the priorities and initiatives/investment for years ahead | Annual | | | **X** | | | GMENZ<br>EDAH |
| **Governance** | | | | | | | |
| Policies<br>to determine governance and significant quality and improvement policies | As required | | | | | | |

# Glossary of terms

*14 September HDAC*

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

## Glossary of Terms

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|---|---|
| **AC** | **Assessment Centre** |
| **ACC** | **Accident Compensation Corporation**<br>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** |
| **Anti- VEGF** | **Anti-Vascular Endothelial Growth Factor** |
| **AoG** | **All of Government** |
| **AP** | **Annual Plan**<br>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** |

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| **BAU** | **Business as Usual** |
| **BN** | **Bachelor of Nursing** |
| **BSCC** | **Breast Screen Coast to Coast** |
| **BYOD** | **Bring Your Own Device** |
| **CAG** | **Cluster Alliance Group**<br>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**<br>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** |

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| **CME** | **Continuing Medical Education** |
| **CMO** | **Chief Medical Officer** |
| **CN** | **Charge Nurse(s)** |
| **CNM** | **Clinical Nurse Manager** |
| **CNS** | **Clinical Nurse Specialist** |
| **COI** | **Committee of Inquiry** |
| **ComM** | **Communications Manager** |
| **COPD** | **Chronic Obstructive Pulmonary Disease**<br>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**<br>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**<br>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** |

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| **CWDs** | **Case Weighted Discharges**<br>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**<br>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** |

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| **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**<br>Performance measures that provide information on how well the District Health Board is managing key steps in the electives patient journey. |
| **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** |

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| **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**<br>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** |

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| **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** |
| **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** |

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| **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**<br>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**<br>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**<br>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** |

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| **ITSM** | **Integrated Service Module** |
| **IV** | **Intravenous** |
| **IVP** | **Improving Value Programme** |
| **JDE** | **JD Edwards**<br>Name of software package |
| **Ka Ao Ka Awatea** | **Māori Health Strategy for the MDHB District** |
| **KPI(s)** | **Key Performance Indicator(s)**<br>A measurable value that demonstrates how effectively an objective is being achieved. |
| **LAN** | **Local Area Network** |
| **LDC** | **Local Data Council** |
| **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** |

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| **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**<br>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** |
| **MRI** | **Magnetic Resonance Imaging**<br>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** |

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| **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) |

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| **OHS** | **Occupational Health and Safety** |
| **OLT** | **Organisational Leadership Team**<br>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** |
| **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** |
| **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** |

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| **PIN** | **Provisional Improvement Notice** (section 36.2 Health and Safety at Work Act 2015) |
| **PIP** | **Performance Improvement Plan**<br>This plan is designed to support the OLT in the prioritisation and optimisation of system wide efforts to achieve our vision.<br>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** |
| **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** |

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| **RHIP** | **Regional Health Infometrics Programme**<br>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**<br>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)** |
| **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** |

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| **SOI** | **Statement of Intent** |
| **SOR** | **Standard Operating Responses** |
| **SPE** | **Statement of Performance Expectations** |
| **SPIRE** | **Surgical Procedural Interventional Recovery Expansion**<br>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) |
| **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 |

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| **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

*14 September HDAC*

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# Late items

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

# Date of next meeting

*14 September HDAC*

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# Date of next meeting

Tuesday 23 November 2021

# Exclusion of the public

*14 September 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.