MidCentral District Health Board

Te Pae Hauora o Ruahine o Tararua

Part One HDAC papers

23 November 2021

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

Contents

Agenda and karakia

23 November 2021

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MidCentral District Health Board

Health and Disability Advisory Committee Meeting

Venue: Board Room, Gate 2, Heretaunga Street, Palmerston North

When: Tuesday 23 November 2021, from 9.00am

PART ONE

Members

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

Apologies

Nil

In attendance

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

In attendance (part meeting)

Item 3.1	Chiquita Hansen, Chief Executive and Nicola Russell, General Manager Clinical Quality, THINK Hauora
Item 3.2	Angela Rainham, Locality and Intersectoral Development Manager
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 7.2	Dr Jeff Brown, Clinical Executive, Te Uru Pā Harakeke, Healthy Women, Children and Youth
Item 7.3	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 – 14 September 2021, Part One
2.5. Matters arising

3. STRATEGIC FOCUS 9.10

3.1 Primary Care Access and Affordability Update
3.2 Population Profile Update – with a future focus

4. DIRECTORATE WITH CLUSTER FUNCTIONS REPORTING 9.40

4.1. Directorate Dashboard
4.2. Te Uru Rauhī – Mental Health and Addiction Services
4.3. Te Uru Arotau – Acute and Elective Specialist Services
4.4. Te Uru Whakamauora – Healthy Ageing and Rehabilitation
4.5. Te Uru Pā Harakeke – Healthy Women, Children and Youth
4.6. Te Uru Mātai Matengau – Cancer Treatment, Screening and Support
4.7. Te Uru Kiriora – Primary, Public and Community Health

REFRESHMENT BREAK 10.15

5. PERFORMANCE REPORTING 10.30

5.1. Enable New Zealand Report

5.2. Pae Ora Paiaka Whaiora Report

5.3. Quality and Safety Dashboard

6. DISCUSSION/DECISION PAPERS 11.00

6.1. Quality Account – Quarter One 2021/22

7. INFORMATION PAPERS 11.10

Information papers for the Board to note

7.1. Sale and Supply of Alcohol Act – Position Statement

7.2. Child and Youth Mortality Data 2015-2019

7.3. Locality Plan Progress Report – Tararua

7.4. Committee's Work Programme

8. GLOSSARY OF TERMS

9. LATE ITEMS

10. DATE OF NEXT MEETING – Tuesday 1 March 2022

11. EXCLUSION OF THE PUBLIC

Recommendation

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

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

PART ONE TO FINISH BY 11.30am

Administrative matters

23 November 2021

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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, 15 November 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
	14.9.21	Employee – Homes for People, Kaitiaki, Public Relations
		Director – Social Impact Property, Property and Support Services
		Partner – Dennison Rogers-Dennison, Accommodation Services
		Trustee – Manawatū Whanganui Disaster Relief Fund
		Chair – Camp Rangi Woods Trust
		Board Member – Softball New Zealand
		Patron – Manawatū Softball Association
		Wife is a Partner – Dennison Rogers-Dennison, Accommodation Services
		Wife is an employee – Homes for People, Kaitiaki, Support Worker
		Wife is an employee – Healthcare NZ, Community Support Worker
		Father is Managing Director, Exclusive Cleaning Services
Findlay, Lew	1.11.19	President, Manawatu Branch and Director Central District - Grey Power
		Councillor – Palmerston North City Council
		Member – Abbeyfield
	16.2.21	Vice President Manawatū Branch and Board Member of Grey Power New Zealand
Gray, Norman	10.12.19	Employee – Wairarapa DHB
		Branch Representative – Association of Salaried Medical Specialists

Register of Interests: Summary, 15 November 2021 (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)		
Hancock, Muriel	4.11.19 30.9.20	Sister is casual employee (Registered Nurse, ICU) – MidCentral DHB Volunteer, MidCentral DHB Medical Museum Sister-in-law is employed as a registered nurse at Whakapai Hauora
Mar, Materoa	16.12.19 11.2.20 5.8.20 13.7.21 17.8.21	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 Member of MDHB Cluster Member of local Child and Youth Mortality Review Group (CYMRG) Member of MDHB's Māori Alliance Leadership Team (MALT) Member – Te Ahu Whenua Māori Land Trust Member, Māori Provider Expert Reference Group for Transitional Health Unit
Naylor, Karen	6.12.10 9.10.16	Employee – MidCentral DHB Member and Workplace Delegate – NZ Nurses Organisation Councillor – Palmerston North City Council
Paewai, Oriana	1.5.10 13.6.17 30.8.18 13.4.21 27.7.21 9.11.21	Member – Te Runanga o Raukawa Governance Group Chair – Manawhenua Hauora Co-ordinating Chair – Te Whiti ki te Uru (Central Region DHB MRBs) Member Nga Manu Taiko, a standing committee of the Council – Manawatū District Council Member – Te Tihi o Ruahine Whānau Ora Alliance Board Member – Cancer Society Manawatū Appointed Member – Massey University Council Trustee – Manawatū/Whanganui Children's Health Charitable Trust Board Member – Governance Board, Mana Whaikaha No longer a Board Member – Cancer Society Manawatū No longer a member of Nga Manu Taiko, a standing committee of the Manawatū District Council
Waldon, John	22.11.18 9.2.21	Co-director and co-owner – Churchyard Physiotherapy Ltd Co-director and researcher – 2 Tama Limited Manawatu District President – Cancer Society Executive Committee Central Districts (rep for Manawatu, 1 of 2) – Cancer Society Has a contract with UCOL
Warren, Jenny	6.11.19	Team Leader Bumps to Babies – Barnardos New Zealand Consumer Representatives National Executive Committee – National On Track Network

Register of Interests: Summary, 15 November 2021 (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)		
		Pregnancy and Parenting Education Contractor – Palmerston North Parents' Centre
	12.2.21	Member of Locality Advisory Group for both Tararua and Ōtaki/Horowhenua for the Primary Maternity Project
	1.7.21	Enhancing NZ Clinical Trials – member of Consumer Focus Group (run by the Liggins Institute with funding from the Ministry of Health and Health Research Council)
		No longer Team Leader Bumps to Babies – Barnados New Zealand
	15.10.21	No longer Pregnancy and Parenting Education Contractor – Palmerston North Parents' Centre
	4.11.21	No longer a member of the Locality Advisory Group for Tararua and Ōtaki/Horowhenua for the Primary Maternity Project
	9.11.21	Contract with Horowhenua Life to the Max
Committee Members		
Allan, Simon (FRAC)	2.6.20	Deputy Chair – Manawatu Branch of Cancer Society MDHB Rep – THINK Hauora Palliative Care Advisory Panel (Ministry of Health advisory body) Director of Palliative Care – Arohanui Hospice Chair of Board – Manawatu Badminton Association
Hartevelt, Tony (FRAC)	14.8.16	Independent Director – Otaki Family Medicine Ltd
	14.8.16	Elder son is Director, Global Oncology Policy based at Head Office, USA – Merck Sharpe & Dohme (Merck) (NZ operations for Global Pharmaceutical Company)
	14.8.16	Younger son is news director for Stuff.co.nz – Fairfax Media
	7.10.19	Independent Chair, PSAAP's Primary Care Caucus – Primary Health Organisational Service Agreement Amendment Protocol (PSAAP)
	14.10.21	Resigned as Independent Chair of the Primary Care Caucus for PSAAP negotiations
Munro, Gail (HDAC)	23.3.21	Director – Eastern and Central Trust 2020 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) Coordinator for the Indigenous Health Programme – RACMA Member of the Rural Policy Advisory Group – RACMA Fellow of the Australasian College of Health Service Managers (ACHSM)
Brogden, Greg	16.2.16	Nil
Brown, Jeff		TBA

Register of Interests: Summary, 15 November 2021 (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)		
Catherwood, Judith	1.5.18	Nil
Davies, Deborah	18.5.18	Member, Alliance Leadership Team – Central PHO Daughter is an employee and works within hospital services – MidCentral DHB
Eves, Celina	20.4.20	Trustee – Palmerston North Medical Trust
Fenwick, Sarah	13.8.18	Nil
Free, Jennifer	6.8.20	Nil
Hansen, Chiquita	9.2.16 3.3.21	Employed by MDHB and seconded to Central PHO 8/10ths – MidCentral DHB CEO – Central PHO Employed by THINK Hauora as Chief Executive and seconded to MidCentral DHB as Interim General Manager, Strategy, Planning and Performance 6/10ths Husband is employed by MidCentral DHB Executive member of General Practice New Zealand (GPNZ) Executive member of Health Care Home Collaborative
Hardie, Claire	13.8.18 13.8.18 13.8.18	Member – Royal Australian & NZ College of Radiologists Trustee – Palmerston North Hospital Regional Cancer Treatment Trust Inc Member, Medical Advisory Committee – NZ Breast Cancer Foundation
Horgan, Lyn	1.5.17 18.5.18	Sister is Coroner based in Wellington – Coronial Services Member, Alliance Leadership Team – Central PHO
Horsley, Emma	6.9.21	Husband is employed by MDHB
Miller, Steve	18.4.17 26.2.19 6.3.19 1.10.19	Director. Farming business – Puriri Trust and Puriri Farm Partnerships Board Member, Member, Conporto Health Board Patient's First trading arm – Patients First Member, Alliance Leadership Team, Member, Information Governance Group – Central PHO Chair – National DHB Digital Investment Board
Ratana, Darryl	29.5.19	Nil
Russell, Greig	3.10.16	Minority shareholder – City Doctors Member, Education Committee – NZ Medical Council
Scott, Gabrielle	Dec 2019	Son is a permanent MDHB employee and works within Digital Services
Tanner, Steve	16.2.16	Nil
Te Huia, Tracee	13.7.21	Member of the No Ngā Hau e whā branch of the Māori Women's Welfare League
Wanden, Neil	February 2019	Nil
Williamson, Nicki	March 2020	Nil
Zaman, Syed	1.5.18	Nil

Resolution

That the Part One minutes of the 14 September 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 14 September 2021 from 9.00am

(held via Zoom due to COVID-19 restrictions)

PART ONE

Members

John Waldon (Committee Chair), Brendan Duffy (Board Chair), Heather Browning, Vaughan Dennison, Lew Findlay, Muriel Hancock, Gail Munro, Karen Naylor, Oriana Paewai, Jenny Warren.

Apologies

Norman Gray, Materoa Mar (Deputy Committee Chair).

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)

Scott Ambridge, Operations Executive, Te Uru Rauhī; Dr Jeff Brown, Clinical Executive, Te Uru Pā Harakeke; Sarah Fenwick, Operations Executive, Te Pā Harakeke; Dr Claire Hardie, Clinical Executive, Te Uru Mātai Matengau; Lyn Horgan, Operations Executive, Te Uru Arotau; Emma Horsley, Communications Manager; Kelly Isles, Director of Strategy, Planning and Accountability; Angela Rainham, Locality and Intersectoral Development Manager; Michelle Riwai, General Manager, Enable New Zealand, Dr Syed Zaman, Clinical Executive, Te Uru Whakamauora.

Media – 0; Public – 0

1. KARAKIA

The meeting opened with the organisational karakia.

2. ADMINISTRATIVE MATTERS

2.1. Apologies

Apologies were received and accepted from Norman Gray and Materoa Mar.

2.2. Late items

No late items were advised.

2.3. Register of Interests Update

The following updates to the Register of Interests were advised.

Vaughan Dennison

Add

- Employee, Homes for People, Kaitiaki, Public Relations
- Director, Social Impact Property, Property and Support Services
- Partner, Dennison Rogers-Dennison, Accommodation Services (wife is also a Partner)
- Trustee, Manawatū Whanganui Disaster Relief Fund
- Chair, Camp Rangi Woods Trust
- Board Member, Softball New Zealand
- Patron, Manawatū Softball Association
- Wife is an employee, Homes for People, Kaitiaki, Support Worker
- Wife is an employee, Healthcare NZ, Community Support Worker
- Father is Managing Director, Exclusive Cleaning Services

Item 6.1 – End of Life Choice Act 2019

Heather Browning noted her previously declared interest relating to the Support and Consultation for End of Life Choice in New Zealand (SCENZ) Group. It was agreed that this did not present a conflict of interest.

2.4. Minutes of the 13 July 2021 meeting, Part One

It was resolved that:

the Part One minutes of the 13 July 2021 Health and Disability Advisory Committee meeting be approved as a true and correct record.

(Moved Vaughan Dennison; seconded Karen Naylor)

2.5. Matters arising from previous minutes

No discussion.

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

3. STRATEGIC FOCUS

3.1. Regional Specialist Services Integration

The Operations Executive, Te Uru Arotau, Acute and Elective Specialist Services and the Clinical Executive, Te Uru Pā Harakeke, Healthy Women, Children and Youth presented this report. They noted that the vision and service design was driven by the needs of patients, rather than existing boundaries and funding. Patients would be treated where they would receive the best care, which may not be the closest care.

The Committee complimented staff on the pace of the work already completed. Noting concerns presented by senior medical staff to the Board about workforce challenges and theatre capacity, a question was asked as to how wider communities could also be served. The Clinical Executive, Te Uru Pā Harakeke replied that workforce, IT integration and the health reforms had been identified as risks to the project. An integrated service was aligned with the health reforms. Some regional IT systems were already in place and work-rounds were possible for some systems. The workforce was critical and until there was a commitment to expand the consultant urologist workforce, the regional service could not proceed. Recruitment of specialists was critical to the success of regional services integration. Learnings from previous efforts to develop a regional service with Whanganui District Health Board for women's health and urology had helped to develop this proposal. It was vital that the service was led by clinicians and supported by management. The regional service would not be implemented until clinicians had confirmed that safe patient care could be provided.

It was resolved that the Committee:

note the progress report for the Regional Service Integration.

(Moved Karen Naylor; seconded Lew Findlay)

The Operations and Clinical Executives joined the meeting.

4. DIRECTORATE WITH CLUSTER FUNCTIONS REPORTING

4.1. Directorate Dashboard

The Operations Executive, Te Uru Pā Harakeke, Healthy Women, Children and Youth presented this report, which was taken as read. In response to a question, she noted that the staff turnover rate of 0.8 percent for non-Māori staff shown for the current period was thought to be for the reporting period since the last meeting. This was later confirmed to the be for the month of July 2021.

The Operations Executive, Te Uru Kiriora, Primary, Public and Community Health advised that some Māori nurse vaccinators had been redeployed from the childhood immunisation programme to assist with COVID-19 vaccinations. Discussions with the Ministry of Health (the Ministry) were ongoing following a letter received in June 2021, to ensure childhood vaccination rates were not affected.

4.2. 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. The Operations Executive noted that the Director of Midwifery role had not been recruited to, therefore interviews for the Midwifery Manager would be progressed next week.

A Committee member noted that COVID-19 Alert Level 4 visiting rules where only one parent could stay with a sick child in hospital made it difficult for that parent to have any respite. The Clinical Executive explained that visiting guidelines at MDHB followed national advice. Staff were also affected when having to enforce these visiting rules. Compassionate grounds were able to be considered to allow more than one parent, with strict adherence to PPE (Personal Protection Equipment) and isolation to maintain 'bubbles' in certain circumstances.

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

The Operations Executive and the Clinical Executive, Te Uru Mātai Matengau presented this report, which was taken as read. They noted that the replacement linear accelerator was being commissioned and it was expected to be ready to treat patients by early October. All cancer patients continued to receive treatment through the recent COVID-19 lockdown period.

4.4. Te Uru Arotau – Acute and Elective Specialist Services

The Operations Executive, Te Uru Arotau presented this report, which was taken as read. She noted that high presentations to the Emergency Department (ED) in June and July, as well as the NZ Nurses Organisation industrial action and acute demand had affected planned surgery. COVID-19 restrictions has impacted planned surgery in August, however good progress had been made to improve the ESPI 2 rate, with more than 1500 telephone or virtual consultations carried out.

Committee members asked for the number of people who did not wait to be seen in ED be shown as a percentage of presentations. The Operations Executive noted that some patients told the triage nurse they were not going to wait and were given advice or options for care. Nursing staff reviewed patients who left to check their level of risk, based on the initial Australasian triage system. They would discuss with senior medical staff if necessary and then follow up with the patient and/or their GP. These follow ups would be documented on the patient's notes. The Chief Medical Officer noted that it was not necessary to follow up with every person who did not wait.

In response to questions, the Operations Executive noted that the Transitory Care Unit was used for patients who needed to be admitted to a ward and freed up space in ED. The Medical Assessment and Planning Unit (MAPU) and Emergency Department Observation Area (EDOA) were previously referred to as 'Pods'. As these would be a new build on site, there would be no construction impact on ED. It was hoped the MAPU and EDOA will provide additional capacity when built.

A Committee member advised she had attended the ED several times over recent weeks. On each occasion, she had been impressed by the way staff coped when there were a lot of people in the department and asked that compliments be passed on to the team.

4.5. Te Uru Whakamauora – Healthy Ageing and Rehabilitation

The Operations Executive and the Clinical Executive, Te Uru Whakamauora presented this report, which was taken as read. He noted a correction to the report under section 2.2: Riverstone was a new 56-bed residential aged care facility (not a five-bed facility).

A committee member noted that Radio New Zealand had reported that some aged residential care facilities were struggling to find nursing staff due to immigration issues and were reducing bed numbers as a result. Management advised that around 30 percent of nurses in the MDHB region were internationally qualified, which may impact recruitment in the future. There were no known issues of providers reducing bed numbers in the MDHB region.

The Clinical Executive advised that the Care in the Community Rehabilitation in the Home programme was only available for ACC clients. The Older People's Acute Assessment and Liaison Unit (OPAL) Community Service to provide rehabilitation in the home for people in the community who needed support through illness, rather than an accident will begin implementation in April 2022.

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

The Operations Executive and the Clinical Executive, Te Uru Kiriora presented this report, which was taken as read. The Operations Executive noted that COVID-19 testing had surged to more than 3000 tests per week during the recent resurgence and had now reduced to around 1200 tests per week. MDHB's contact tracing team had been supported by Palmerston North City Council staff. The team were taking the lead on contact tracing of supermarkets that were places of interest in the Auckland region. The Supported Isolation and Quarantine (SIQ) Coordinator had worked closely with the Incident Management Team, Public Health Unit and iwi. An interim SIQ was in place and two 'family bubbles' could be accommodated if required. All providers had increased their vaccination rates, which had peaked at 18,000 in a week. The drive-through vaccination sites had been popular.

Committee members commented on the importance of keeping the community informed about vaccination rates in the MDHB region. The Operations Executive noted that progress was being reported through social media channels and that graphics would be added.

The Clinical Executive had spoken about COVID-19 vaccinations at a meeting of Grey Power members and everyone had been vaccinated after that. He was available to speak to any groups to encourage vaccinations and answer questions from anyone who was 'vaccine hesitant'.

4.7. Te Uru Rauhī – Mental Health and Addiction Services

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

In response to questions, he noted that a Consumer Advisory Group was in place as part of the integrated service model. This group and individuals on it would be asked to support specific pieces of work, such as ward design. The biggest risk to implementation would be difficulties to recruit Māori nurses who had a mental health and addiction background. It was hoped that the new model would encourage the small pool of these nurses to want to work at MDHB.

As part of the construction of the inpatient facility rebuild, demolition and ground works would start in the third quarter of the 2021/22 financial year (between 1 January and 31 March 2022).

It was resolved that the Committee:

note the areas highlighted in the dashboard and associated commentary.

(Moved Karen Naylor; seconded Brendan Duffy)

The Clinical Executive, Te Uru Whakamauora and the Operations Executive, Te Uru Rauhī left the meeting.

The General Manager, Enable New Zealand joined the meeting.

5. PERFORMANCE REPORTING

5.1. Enable New Zealand Report

The General Manager, Enable New Zealand presented this report, which was taken as read. She noted that Enable NZ is meeting all performance KPIs and internal project delivery requirements.

It was resolved that the Committee:

endorse the Enable New Zealand Report to 31 July 2021.

(Moved Muriel Hancock; seconded Lew Findlay)

The General Manager, Enable New Zealand left the meeting.

5.2. Pae Ora Paiaka Whaiora Report

The General Manager, Māori Health presented this report, which was taken as read. She outlined the COVID-19 vaccination mahi that was taking place to get communities to take the lead in their localities. Special mention was made of the iwi and Māori providers who had led the charge on pop-up and drive-through clinics. For the remainder of the programme, a plan would be presented to the September Manawhenua Hauora meeting. A Committee member commended smaller communities such as Foxton and Shannon, who had taken ownership of the programme, with support from THINK Hauora and MDHB.

The Committee acknowledged the work done by Bonnie Mataehaere, Nurse Educator Māori Health, particularly in the Horowhenua area. Her award for outstanding service to nursing was well-deserved and acknowledged by the Committee.

In response to a question, the General Manager, Māori Health advised there was no known confirmed structure that clarified where the Māori consumer voice would sit under the health reforms. It was likely that there would be Consumer Councils at a national level, and it was important to have Māori consumer voices locally.

It was resolved that the Committee:

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

(Moved Karen Naylor; seconded Lew Findlay)

6. DISCUSSION/DECISION PAPERS

6.1. End of Life Choice Act 2019

The Clinical Executive, Te Uru Mātai Matengau presented this report, which was taken as read. She noted that assisted dying was more likely to take place in the community, but it was possible it could be requested in the hospital environment. Specific training would be provided by the Ministry of Health for any medical or nurse practitioner who was willing to provide assisted dying services.

It was resolved 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.

(Moved Muriel Hancock; seconded Heather Browning)

The Clinical Executive, Te Uru Mātai Matengau left the meeting.

The General Manager, Quality and Innovation joined the meeting.

6.2. Quality and Safety Dashboard

The General Manager, Quality and Innovation presented this report, which was taken as read. She noted that once there is more historical data available, the dashboard would show rolling averages on an annualised basis, rather than by quarter. This would reduce the number of 'spikes' based on quarter to quarter variation and provide the Committee with more reliable trend-based reporting.

The timetable for Quality and Safety Walk-rounds was being reviewed. Where it was possible to conduct walk-rounds with social distancing, they would go ahead and virtual Zoom options were being considered for some other walk-rounds.

It was resolved that the Committee:

note the content of the Quality and Safety Dashboard

endorse the improvement activities planned for the next quarter.

(Moved Karen Naylor; seconded Heather Browning)

6.3. Māori Health Equity Dashboard – Te Ara Angitū for Selected Child and Youth Health Indicators

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

Committee members raised questions relating to GP enrolment for newborns and the impact that had on childhood immunisations. The Executives advised that work was ongoing with the primary health organisation to ensure there was adequate access for newborns to enrol in a general practice. Enrolment was currently a manual process and it was hoped this would improve once the Maternity Clinical Information System (MCIS) was in place.

The Clinical Executive spoke about the Ambulatory Sensitive Hospitalisation (ASH) audit. It took hundreds of hours of clinicians' time to gather the required information, as clinical information systems between primary health care providers, the hospital and the Emergency Department were not linked.

It was resolved 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.

(Moved Vaughan Dennison; seconded Oriana Paewai)

The Operations Executives from Te Uru Pā Harakeke and Te Uru Kiriora left the meeting.

The Director of Strategy, Planning and Accountability joined the meeting.

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

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

It was resolved that the Committee:

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 Quarter Four of 2020/21.

(Moved Muriel Hancock; seconded Vaughan Dennison)

6.5. COVID-19 Delta Resurgence

The Director of Strategy, Planning and Accountability and the General Manager, Quality and Innovation presented this report, which was taken as read. They noted that lessons learned from last year's COVID-19 lockdown had helped to develop more robust plans and better collaboration between teams.

The Chief Executive advised that the Ministry of Health (the Ministry) had implemented an Incident Management Team structure to support the current resurgence, which would continue. DHBs had been asked to support the Auckland region by providing staff to work in Intensive Care Units (ICU), Managed Isolation and Quarantine (MIQ) facilities, contact tracing and vaccinations. Staff from MDHB were on standby to work in ICU and eight staff were already helping in Auckland MIQ facilities. Support for contact tracing was being carried out from Palmerston North. A hospital visitor policy had been agreed between the DHB Chief Executives and the Ministry to restrict the spread of COVID-19. This policy had been applied at MDHB.

It was resolved that the Committee:

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

(Moved Brendan Duffy; seconded Vaughan Dennison)

The Director of Strategy, Planning and Accountability and the General Manager, Quality and Improvement left the meeting.

The Locality and Intersectoral Development Manager joined the meeting.

7. INFORMATION PAPERS

7.1. Locality Plan Progress Report – Horowhenua

The Locality and Intersectoral Development Manager presented this report, which was taken as read. She noted that the refugee intake programme had been paused due to the COVID-19 resurgence, so the families expected to arrive in Levin would be delayed. Community COVID-19 vaccination clinics have been held in Shannon. Issues with booking vaccinations in Foxton and Shannon through the BookMyVaccine website were being addressed.

In response to a question, management advised that the Horowhenua Company Limited (HCL) were taking the lead in scoping a new 'Health and Wellbeing Hub' facility in Levin. HCL would establish a governance group to develop the timeline for this to be completed by 30 June 2023.

It was resolved that the Committee:

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

(Moved Heather Browning; seconded Karen Naylor)

The Locality and Intersectoral Development Manager 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 Brendan Duffy; seconded Vaughan Dennison)

8. GLOSSARY OF TERMS

No discussion.

9. LATE ITEMS

No discussion.

10. DATE OF NEXT MEETING

Tuesday, 23 November 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	
Serious Adverse Events (SAC 1)	To protect patient privacy	9(2)(a)

(Moved Brendan Duffy; seconded Vaughan Dennison)

Part One of the meeting closed at 11.50am

Confirmed this 23rd day of November 2021

……..

Committee Chair

Health and Disability Advisory Committee – MidCentral DHB

- Schedule of Matters Arising, 2021/22 as at 15 November 2021

Matter	Raised	Scheduled	Responsibility	Form	Status
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					
Invite THINK Hauora to future meeting to discuss GP availability	July 21	Nov 21	D Davies	Strategic discussion	Completed
Provide details of unmet need/Did Not Waits in the Emergency Department	July 21	Sept 21	L Horgan	Report	Completed
Advise the number of responses to online survey – Mental Health and Addiction Services Adult Indicators, Te Ara Angitū Report	July 21	Sept 21	S Ambridge	Report	Completed
Report on MDHB's preparation for implementation of the End of Life Choice Act	July 21 Board	Sept 21	C Hardie	Report	Completed
Ask Board to consider writing to the Ministry of Health to highlight issues faced by migrant GPs in gaining residency	July 21	August Board meeting	J Waldon	Resolution passed at August Board meeting	Completed
Provide more detail on the increased Mental Health Client DNAs in next HDAC cluster report	Feb 21 – Board mtg	~~April 21~~ July 21	V Caldwell S Ambridge	Report	Completed

Strategic focus

23 November 2021

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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:

- Has this provided the Committee with the necessary information regarding primary care access and affordability?
- Can the Health and Disability Advisory Committee do anything to provide primary care support?

To	Health and Disability Advisory Committee
Author	Chiquita Hansen, Chief Executive, THINK Hauora. Nicola Russell, General Manager Clinical Quality, THINK Hauora
Endorsed by	Deborah Davies, Interim General Manager, Strategy, Planning and Performance
Date	04 November 2021
Subject	**Primary Care Access and Affordability Update**

RECOMMENDATION

It is recommended that the Committee:

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

1. PURPOSE

THINK Hauora is in the third year of its 2019-2025 Strategy. An overview of this year's Annual Work Programme which is in line with the impending health sector reforms, and organised under the acronym of RE-THINK (Research, Equity, Technology, Health, Innovation, Networking and Knowledge) is presented. This paper provides the Committee with an update on access and affordability of primary care across the district.

2. SUMMARY

Primary care access and affordability continues to be an issue across provincial and rural New Zealand, particularly in the MidCentral District. This paper provides an update on access and demand across the MidCentral primary health care rohe. An update of the progress to date on the General Practitioner (GP) sustainability roadmap, as presented to the Health and Disability Advisory Committee (HDAC) at the end of 2020 is also provided under the following themes:

- Developing the Pipeline
- Telehealth/Virtual Health
- Ways of Working.

3. BACKGROUND

At the October 2020 HDAC meeting, the Committee discussed potential access and affordability risks that could disadvantage some people. In November 2020 a paper was presented to HDAC describing national policy around primary care funding, costs, availability, and timeliness of appointments with General Practice Teams (GPTs) and GP workforce recruitment issues.

A progress report was presented to HDAC in July 2021 and this report provides a further update. This update is within the context of the THINK Hauora Annual Work Programme 2021-2022, as depicted below.

THINKHauora
Connecting Communities for Wellbeing

Annual Work Programme | 2021/22

R E - T H I N K

Research & Development	Equity	Technology	Health	Innovation	Networking	Knowledge
International & Academic Relationships	Health Care Home	Interoperability	Population Health	Here Toitū	Community Engagement	System Expertise
Advisory Board	Access	Standards & Architecture	Screening	Whānau Centred	Horowhenua Hub	Backbone Functions
Tamarack Institute	Enrolment	Security	Smoke Free 2025	Dedicated Support Team	Te Waiora Hub	System Leadership
Massey University & UCOL	Long Term Conditions	Information Systems	Immunisation (including COVID Vac)	Locality Hubs	Consumer Voice	Kaimahi Leadership Programme
National Research/ Development	Ka Ao, Ka Awatea	Information Stewardship	Acute Demand	Community Pharmacy Partnership	Engaged Transdisciplinary Teams	Wellbeing & Socioeconomic Determinants
MoH Sensors Research	Developing a tangata Te Tiriti Organisation	Privacy	Review After hours	Minor Conditions	Excellence every day	DOT Loves Data
Poly Pharmacy trigger tool development	Supporting Iwi Strategic Aspirations	Data Sovereignty (+ support Te Tihi with Māori data sovereignty)	Community Referred Radiology	Connecting Primary	Professional Development (IPE & CPD & workforce Dev.)	Quality of Life
Health Reforms	Iwi & Māori Relationships and investment	Information & Data Management	POAC	National Pharmacy Action Plan	Driving Quality - SLMs / Quality improvement plans	Wellbeing Indicators
Commissioning for Outcomes Framework	Ora Konnect Alliance	Digital Literacy	Planned Care	Locality Network Development	Intersectorial Engagement	Te Kete Kōrero
Whānau Ora Outcomes	Active Squad Member Participation	Consumers & Whānau	Community Infusions	Enable Collective Impact for Change	National Agencies	Population Stratification
Quadruple Aim	Strategic Learnings	Healthcare Professionals	Health Pathways	Whānau Ora Strategic Innovation Development Group (WOSIDG)	Local Government	Data Exchanges and Integrations
Contributory Measures	Focused Investment	Communications	DHB - Outpatients Improvement Programme	National locality Planning Frameworks	ACC & MSD	Data Quality & Master Data Management
District Research	Specific Population Networks	Telehealth	Te Ara Rau | Access & Choice	Consumer Friendly Records / Information	GPT Sustainability	Shared Programme Governance
District Research Framework	Refugee, Internally displaced person, Migrant and Asylum Seeker (RIMA)	District Telehealth Services	Outcomes Framework	Hauora in my Pocket	GP Workforce Recruitment & Retention	Clinical Governance
Shared Appointments	Contribute to DHB Cluster Alliance Groups, Clinical & Consumer Council	e-referrals	Workforce Development	Patient Friendly Language	Nursing Career Pathways	Joint Laboratory Clinical Council
Diabetes Improvement	Pasifika Polynations Programme	Patient Portal	Alliance & Locality Approach	Open Notes	Practice Managers & Administrator Development	Primary Care Support Pharmacists

4. ACCESS AND DEMAND

4.1. Sustainable general practice funding

A Capitation Working Group has been established to develop an ethnicity, rurality and frailty adjuster to the capitation funding formula. This work is due to be completed by end of the Quarter Two to inform the primary operating model from 1 July 2022.

4.2. Enrolment and access

The MidCentral District Health Board (MDHB) Primary Health Organisation (PHO) enrolment rate for Māori remains at 79 percent (32,147 total enrolled Māori of 40,670 Total Population Māori. Last quarter this was 31,881 total enrolled Māori of 40,435 Total Population Māori). Source: https://www.health.govt.nz/our-work/primary-health-care/about-primary-health-organisations/enrolment-primary-health-organisation

As reported in the previous report, the data still shows an increasing trend in the number of Māori who have enrolled with GPTs from quarter to quarter. Leveraging off current community access through COVID-19 vaccination clinics, the newly appointed Community Enrolment Connector identified and contacted 64 unenrolled people from the priority population in Quarter One.

 # Enrolled by Month and Ethnicity

Month 2021	Māori	Pasifika	Other	Total
June	30,554	5,242	131,241	167,037
July	30,603	5,247	131,350	167,200
August	30,673	5,256	131,332	167,261
September	30,644	5,233	131,191	167,068

There continues to be no practices enrolling new patients who want to change GPs in Ōtaki or Foxton.

A Nurse Practitioner-led clinic (Kimiora) was commenced during Quarter One. This clinic is an extension of Horowhenua Community Practice (HCP) and is located centrally in Levin. This clinic has been established to provide responsive and culturally appropriate health care services to specifically, but not exclusively, Māori and Pasifika patients and other priority populations who are not enrolled elsewhere. There is a new patient co-payment option available whereby clients can pay a monthly fee via automatic payment and this covers appointments and repeat prescription costs.

The announcement of an additional 300 Managed Isolation and Quarantine (MIQ) positions each month for immigrating health and disability workers has had an immediate positive effect on potential GP recruitment. This is particularly so for the Horowhenua and Ōtaki localities, where a potential five GPs may now be relocating to the region by late January 2022 (pending successful recruitment processes).

Currently there are three Palmerston North practices enrolling patients: The Palms Medical Centre, Kauri HealthCare and The Health Hub Project. Enrolments also remain open in Tararua (Dannevirke and Pahiatua) and Feilding. There is a new general practice opening in Ashhurst in April 2022. This practice will be owned and run by Feilding Health Care.

4.3. **Patients wait-times for appointments: Third Next Available Appointment (TNAA)**

A process to collect data for TNAA as previously committed to, has been designed. General practices will enter information weekly and Te Kete Kōrero will display this on a dashboard (as per image). This will show trends, change on last week, difference to the PHO average, provider benchmarking, and any correlations between a provider's enrolled population and TNAA times.

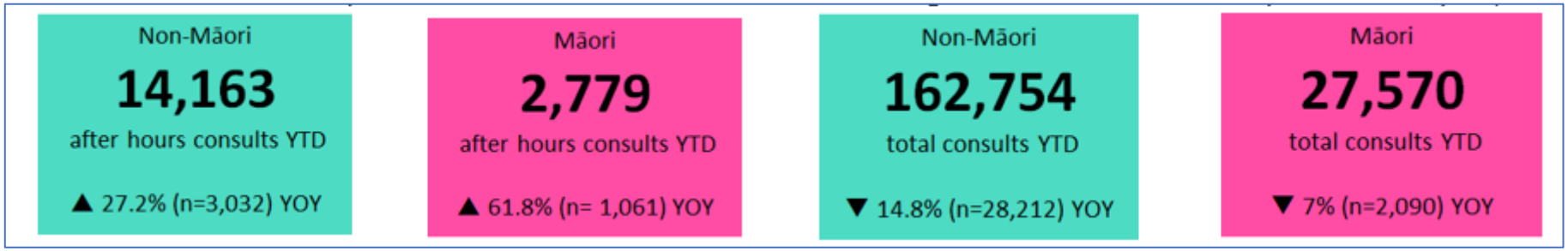
The Health Care Home team will implement and embed the TNAA data collection spreadsheet in general practices, with an initial focus on Integrated Family Health Centres (IFHCs) by the end Quarter Two. With TNAA data available, the Te Kete Kōrero dashboard (as per wireframe image above) will be released.

Patient Experience Survey results for Quarter One 2021 showed that 38 percent of clients needed to wait over a week to get an appointment. Eighty-nine percent felt that the administration/reception staff treated them with respect and 77 percent of all clients were seen within 15 minutes of arriving.

It is pleasing to note that 90 percent of clients felt that their health professional explained things in a way that they could understand, that they were treated with kindness and understanding, were listened to, respected, were able to have family/whānau involvement in discussions about treatment and care, did not identify or perceive unfair treatment and had their names always pronounced properly.

4.4. **Consultation rates**

The below data shows trends for total and after-hours consultations compared to last year, for non-Māori and Māori.



Interpretation of consults data:

- YTD = Year to date (1 July to 30 September 2021)
- YOY = Year on Year (compares to 1 July to 30 September 2020)
- After hours is weekends, public holidays, and weekdays from 6pm to 8am the following day
- July-Sept 2020 includes Level 2 during 12 August 2020 to 21 September 2020
- July-September 2021 includes Level 4 during 18 August 2021 to 31 September 2021; Level 3 during 1 September 2021 to 7 September 2021; Level 2 from 8 September 2021 onwards

NOTE: After hours consults include any invoiced activity at a general practice, for example weekend COVID-19 testing and vaccination delivery.

4.5. After hours service distribution

The PHO Services Agreement requires PHOs to provide all service users with access to Urgent Care Services on a 24-hour a day, 7-day a week basis for 52 weeks a year; that these are provided by a face-to-face consultation and available to 95 percent of its enrolled population: (a) within 30 minutes travel time during regular hours; and (b) within 60 minutes travel time during after hours. As depicted in the table below, the general practice network provides wide distribution of after hours services beyond the minimum expected within the PHO Services Agreement.

After hours utilisation data does show wide variation of access between the localities. Feilding and Tararua had 247 and 160 after hours consults per 1000 enrolled population in Quarter One respectively, which were well above the PHO average of 107. In comparison, Ōtaki and Horowhenua only had 27 and 28 after hours consults respectively. This variation is due to the larger number of after hours COVID-19 vaccination clinics completed in the Feilding and Tararua localities during the quarter.

City Doctors (14 percent) and Horowhenua Community Practice (10 percent) had relatively high percentages of after hours patients not enrolled with THINK Hauora. This suggests that there may be a high cross-boundary flow of patients in Horowhenua and Palmerston North but is also likely influenced by the ongoing enrolment challenges in the Horowhenua locality.

Consult Volumes by Locality

Locality	Enrolled Pop.	Consult Volume	Afterhours Consults per 1,000 Enrolled Pop.
Feilding	19,734	4,873	247
Horowhenua	27,410	754	28
Palmerston North	98,010	9,602	98
Otaki	6,526	173	27
Tararua	15,386	2,465	160
Total	167,068	17,867	107

Volume of calls received by Whakarongarau per month

Calls received by Whakarongarau	Apr21	May21	Jun21	Jul21	Aug21	Sept21
IVR (i.e. voice message explaining practice hours etc)	3389	2981	4202	4671	4024	3246
No Triage	106	104	131	111	85	81
Triage with Handover	50	39	51	59	38	33
Triage with no handover	89	82	149	167	104	89

There were four transfers to St John from Whakarongorau this quarter.

Discussions are planned with Whakarongorau Aotearoa (previously Home Care Medical) in Quarter Two about providing more granular reporting on the level of usage by St John Ambulance services between 8 and 11pm. THINK Hauora will provide a data scope and work with Whakarongorau to ensure this information is received securely.

4.6. **Primary Options for Acute Care (POAC)**

General POAC cases (non-Emergency Department (ED)-Redirect) increased in the last quarter to 204 compared with 178 in Quarter Two and 177 in Quarter Three. There is likely to be a build on this momentum once the sector fully recovers from lockdown and the COVID-19 response (both testing and vaccination). The most utilised pathways are cellulitis, iron infusions and adult rehydration.

The ED Redirection to General Practice programme continues to gain traction with 4186 patients having been redirected since the programme inception on 27 May 2019 up to 30 September 2021. There has been steady growth in the last 12 months with a peak in May 2021 at 266 events and of note, the dramatic effect of lockdown in August with ongoing effects in September. It is expected that the numbers will gradually increase again, COVID-19 permitting.

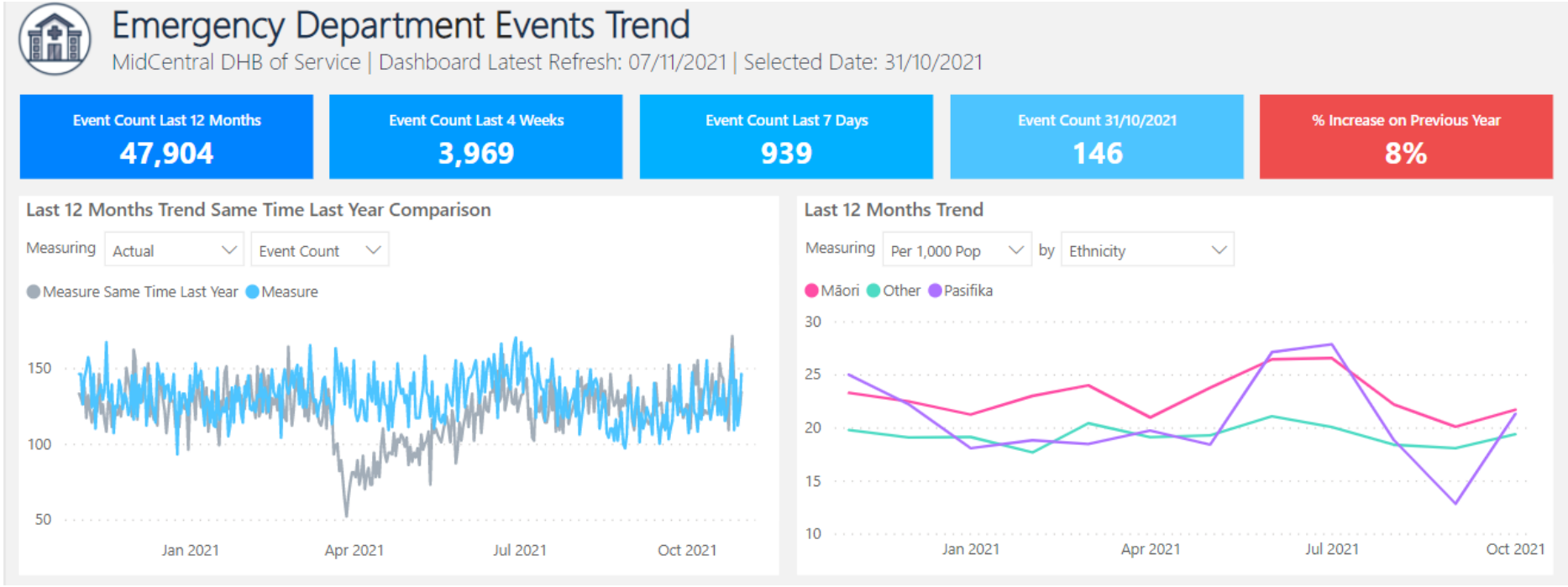
The Palms Urgent Care Clinic began accepting redirected patients earlier this year, and prior to lockdown were making a significant contribution to managing this additional patient load.

The demographics of the redirected population remain consistent with 25 percent Māori and 6 percent Pasifika – both higher than their representation in the overall population. There is a steady increase in numbers from deprivation indices four to nine illustrating the important role ED Redirect serves in providing an acute care service to this group of low acuity patients. The average treatment time for Triage Four and Five patients in ED was between 200 and 250 minutes, compared to a processing time of between 30 and 50 minutes for the patients redirected. This illustrates the role of this programme in helping to relieve some of the congestion in the ED waiting room and other parts of the ED treatment pathway.

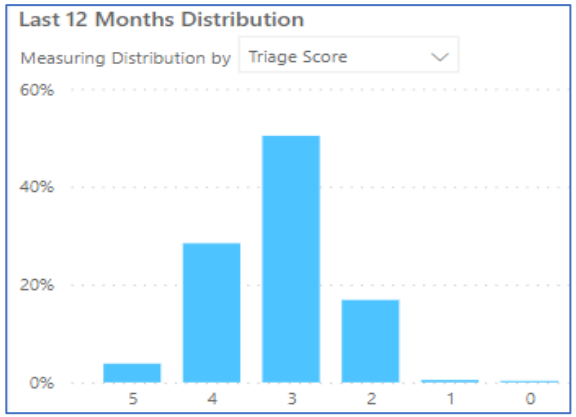
Meetings are planned in Quarter Two with St John to discuss collaboration opportunities with GPTs and to promote POAC services.

4.7. **Emergency Department (ED) presentation rates**

ED presentations remain consistently high, and this is also reflected in the increasing number of ED-Redirect services provided in primary health care (PHC). ED events for Māori, non-Māori and Pasifika people have remained relatively consistent during the year.



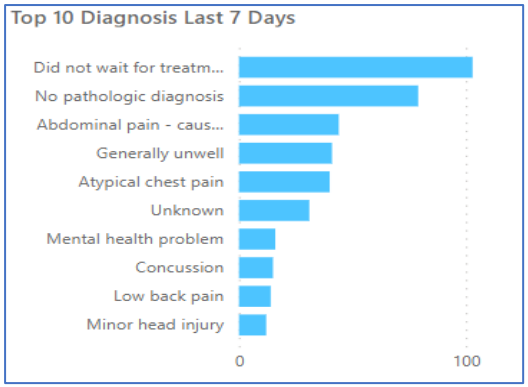
Distribution of presentations by Triage Score:



Triage Scores

5 = routine/administrative
4 = Potentially serious, or potential adverse outcomes from delay > 60 min or significant complexity or severity, or discomfort or distress
3 = Potentially life-threatening, potential adverse outcomes from delay > 30 min or severe discomfort or distress
2 = Imminently life-threatening, or important time-Critical
1 = Immediately life-threatening

The top ten diagnoses for presentation to ED (in past seven days:



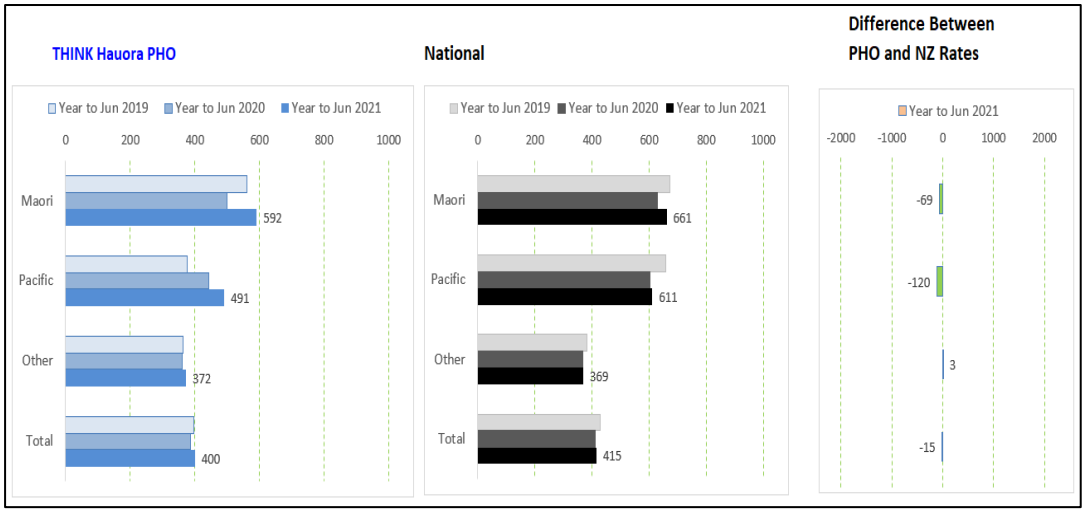
Note: Did not wait for treatment category also includes ED Redirect cases

A process has been established in partnership with MDHB's Chief Medical Officer to explore the numbers and types of ED presentations between 8 and 11pm during Quarter Two.

4.8. **Ambulatory Sensitive Hospitalisations/Acute Bed Days**

Standardised acute bed days per capita rates had trended down over the last few years, with a recent increase in the year ending June 2021. Respiratory infections and inflammations in the district continue to surpass the national average by the largest amount compared to other Diagnosis Related Group (DRG) clusters. Overall MDHB has slightly lower acute hospital bed day rates than the national average, including for its Māori population.

Upper and Ear, Nose and Throat (ENT) respiratory infections are the leading ASH reason for our tamariki, with a significant inequity for Māori, who attend at a rate 30 percent greater than non-Māori. THINK Hauora total rates for these conditions are below the national average for all populations, except for Māori, who have rates similar to the national average. Asthma conditions are the second leading cause of ASH for tamariki, with a significant inequity for Māori, who attend at about twice the rate of non-Māori. THINK Hauora total rates for these conditions are below the national average for all populations, except for Māori, who have rates higher than the national average.



5. GP SUSTAINABILITY ROADMAP UPDATE

5.1. Developing the pipeline

5.1.1. *GP recruitment*

There remains a net shortage of GP/Nurse Practitioners for the population of the district.

THINK Hauora continues to maintain contact with Immigration NZ to discuss the challenges faced by GPTs in supporting overseas GPs and nurses to enter and work in NZ.

A Marketing Agreement has been signed with 'Workin In' to complete a number of eight week international recruitment campaigns. The inaugural campaign commenced in October 2021 and includes targeted marketing to overseas prospective clinicians and provide webinars that include immigration experts and GPT members. THINK Hauora's Principal Medical Advisor is participating in a webinar this month.

The announcement of an additional 300 MIQ positions each month for immigrating health and disability sector workers has had an immediate potential positive effect on GP recruitment. This is particularly so for the Horowhenua and Ōtaki localities, where a potential five GPs may now be relocating to the region by late January 2022 (pending successful recruitment processes).

5.1.2. *GP training*

An improved process to determine training intern Registered Medical Officer (RMO) placement and registrar training has been established. THINK Hauora's Acute Care and System Integration Medical Advisor leads this work in partnership with MDHB.

5.1.3. *Transdisciplinary primary health care team workforce development*

Community pharmacy teams continue to participate in broader health and wellbeing service delivery as part of a transdisciplinary team. Activities this quarter include:

- Funding provided to MidCentral Community Pharmacy Group (MCPG) for the year 2021/22. This funding is for the development, implementation and reporting of a free service for patients presenting at participating community pharmacies with minor skin conditions, and provision of approximately 600 free consultations and approved medicines.

Since the relaunch of the Community Pharmacy Minor Condition Service in May 2021, 130 consultations for the conjunctivitis programme were completed on children aged between two and 14 years. This is a significant increase in consultation rates from the initial commencement of the pilot service in March 2020 (impacted by the first COVID-19 lockdown). A total of 173 consultations have been provided since March 2020.

- 45 percent of the consultations were in the Horowhenua locality
- 27 percent in the Tararua locality
- 27 percent in the 4412 postal area of Palmerston North
- 27 percent of the total consultations were for tamariki Māori and 1.2 percent for Pasifika.

A detailed service plan is in progress with the Community Pharmacy network to continue inclusion of other minor condition work streams.

THINK Hauora is working with MidCentral District Health Board to support the Gateway initiative (work experience placement for Year 12 and 13 students) and support to have joint approaches to schools within the Manawatū to promote primary and secondary health careers.

Discussions with the Central Economic Development Agency (CEDA) regarding joint approaches to promoting the district and health careers continue.

Background research is being carried out on the value of Physician Associates (PAs) as part of GPTs in New Zealand. Interviews with several groups who are currently using Pas within primary care settings in NZ have taken place. Common themes that have emerged include: Strong support for the role, with all managers interviewed stating that they were seeking more Pas; and GPs within the practices strongly support the role.

- PAs are predominantly being used as part of the acute care team, either in the A&M or drop-in clinic setting
- Managers report a significant 'cost benefit' as PAs receive approximately 50 percent remuneration of GPs and are reported to be able to deal with most practice consults with between 70 and 80 percent overall efficiency.
- Supervision requirements of PAs by GPs is a consideration, as the role is currently not formally regulated within NZ. This has been managed in a variety of ways depending on GPT processes and the trust between supervising GPs and PA.
- Practices interviewed were often also considering other innovative workforce solutions, for example two practices were in the process of appointing paramedics.

5.2. Telehealth/Virtual health

5.2.1. *Telehealth*

THINK Hauora has continued to support the development of a telehealth service, which is scheduled to launch in December 2021/January 2022. Initially the service will provide after hours clinical telehealth services, and if successful will consider expanding into in-hours services. Operationally, the service will:

- provide an online secure clinical consultation platform – this can be via phone or video
- be presented as an extension of participating GPTs existing services
- provide access to more clinical resources, as Whakarongorau will be providing GPs for the consultations
- support continuity of care by:
    - enabling clinicians' access to patient's Shared Electronic Health Record (SEHR)
    - ensuring notes from virtual GP consults are sent to the GP the patient is enrolled with
    - be additional to existing after-hours services within the MDHB rohe, meaning that communities will have more options for receiving after hours services
    - be optional for each GPT, meaning that they will only participate if they believe the service will benefit their patients.

A final assessment was considered and approved by the THINK Hauora Finance and Audit Committee and Board-ALT (Alliance Leadership Team) early in November 2021. THINK Hauora is in the process of becoming one of the four Limited Partners in the telehealth service, which will enable THINK Hauora to continue influencing the development of the service to ensure that it best meets the needs of the rohe. The anticipated benefit of this initiative is the ability to add much needed clinical capacity into the district. Over time, it may help reduce acute demand pressures on GPTs, enabling them to spend more time with people who need their attention the most.

5.2.2. *Portal optimisation*

As at the end of December 2020 (the last report from the Ministry), 26 percent of patients enrolled at a GPT in the district, approximately 46,500 people over the age of 16, have registered to use a portal. Since December 2020 a further 2200 people have registered to use a portal with patient portal registrations in mid-June 2021 up to 48,710.

Approximately 7500 people have adopted the portal this year. This increase is largely due to THINK Hauora funding a summer campaign to increase patient portal registrations. A GPT was also funded to prepare material that helps engage with and encourage older people to adopt and use a portal.

Nineteen of 27 GPTs offer patient portal with another practice currently onboarding. Of the remaining seven practices (17,334, or 10 percent of the total enrolled population), two practices (1895) are unable to due to Patient Management Systems (PMS) constraints. The remaining practices are not willing to offer a portal service at present.

Portal registrations continue to increase each quarter. The total population registered as of June 2020 was 18 percent, by the end of December 2020 this increased to 26 percent, and by end of this quarter increased to 31.5 percent. This means that 52,589 of the district's 166,898 enrolled population have actively signed up for patient portal registration.

There remains approximately 14 percent (7280) of patients who are registered but not activated.

One IFHC has completed engagement with consumers and THINK Hauora are developing patient portal promotional material that will be distributed to other GPTs.

Work continues with another general practice to capture patient experiences of using the patient portal. Once patient stories have been collated, this information, along with the IFHC consumer group mahi, will be used to develop a range of support and promotional materials to encourage uptake of the patient portal across the rohe.

5.3. **Ways of working**

5.3.1. *Collaborative clinical pathways*

Steady progress has been made on the Whanganui and MidCentral Community HealthPathways, which went live in August 2019. There are 164 pages live, including 43 clinical pathways.

MidCentral Hospital HealthPathways commenced in August 2021, with the intended launch in February/March 2022.

A number of Community HealthPathways and Hospital HealthPathways meetings have been held, which has strengthened relationships. These meetings are scheduled quarterly.

The established HealthPathways Governance Group has agreed to include representatives from MidCentral and Whanganui Hospitals to ensure a whole of system approach occurs in prioritising pathway development.

5.3.2. *e-Referrals*

MDHB has progressed work, in partnership with THINK Hauora, to realise standard workflows (including use of business rules underpinned by primary and secondary HealthPathways) to support the adoption of two-way e-Referral communication. The primary health care network is engaged in the development of this and are confident that this will create some much-needed capacity.

6. SUMMARY AND NEXT STEPS

This update provides an overview of the mahi that is progressing across the MidCentral primary health care rohe in relation to access and demand and the GP Sustainability Roadmap. Primary care access across the rohe continues to be challenging, particularly in Horowhenua. This will be alleviated if we secure the five GPs who are keen to locate to the Horowhenua and Ōtaki localities by late January 2022, pending successful recruitment processes. The new practice opening in Ashhurst in April 2022 will also provide additional access. There is also discussion underway currently relating to a new general practice within Palmerston North.

THINK Hauora envisages that the new telehealth service to commence in December 2021/January 2022 will create further capacity across the network. This telehealth option was supported by the THINK Hauora Board-ALT as the system is well integrated into the general practice PMS. This will ensure continuity of care and gain people's confidence in utilising the service.

The information and data provided reflects an engaged network who are, despite workforce shortages, providing access in each locality after hours.

Key next steps include:

- Increase GP capacity through immigration and new practice locations – Quarter Three and Four
- Continue to monitor and facilitate enrolment access via locality – Quarter Three and Four
- A review of after hours in each locality – Quarter Three
- Enhance capacity via the endorsed new telehealth service – Quarter Three
- Improve visibility of access via TNAA – Quarter Three
- Collaboration with St John regarding promoting access to POAC across the region – Quarter Three and Four
- Continue to review data and insights as to who is presenting to ED – Quarter Three and Four
- Drive portal registrations and use – Quarter Three and Four.

For:

	Approval
	Endorsement
X	Noting

Key questions the Committee should consider in reviewing this paper:

- Does the report provide a useful update on the current and future population profile for the MidCentral District Health Board rohe?

To	Health and Disability Advisory Committee
Author	Angela Rainham, Locality and Intersectoral Development Manager
Endorsed by	Deborah Davies, Interim General Manager, Strategy, Planning and Performance
Date	29 October 2021
Subject	**Population Profile Update – with a future focus**

RECOMMENDATION

It is recommended that the Committee:

- **Note** the population profile for the district.

Strategic Alignment

This report is aligned to the DHB's strategy and the strategic imperatives within it. It provides information to support 'Achieving equity of outcomes across communities'.

1. INTRODUCTION

Historically this paper has been a triennial Health Needs Assessment and Equity Snapshot report. The last full Health Needs Assessment was a technical document produced in 2017. Since that document was produced, there has been a continued emphasis on addressing equity. An equity lens is now embedded into regular dashboard reporting (the equity and KPI dashboards and the quarterly non-financial reporting update).

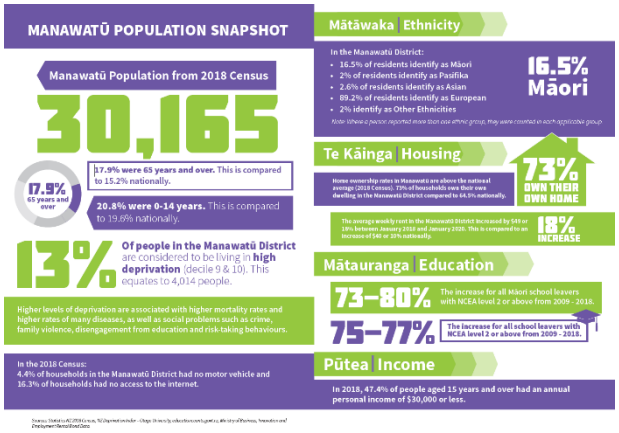
The focus of this paper is to provide the Committee with a summary report of the population demographics and future population profile of the MidCentral District Health Board (MDHB) rohe. The information provides an overview that can be used for future strategic and service planning as we transition to Health New Zealand and the Māori Health Authority. The Committee is invited to discuss and provide feedback on this summary report.

2. BACKGROUND

Statistics New Zealand supplies the Ministry of Health (the Ministry) with population projections for District Health Boards (DHBs) each year, based on certain assumptions. These projections are used to inform population-based funding, policy development and planning. For the 2021/22 year, MDHB has an estimated population of 188,830 people across the five localities that we serve (four Territorial Local Authorities (TLA) and the Ōtaki ward of the Kāpiti Coast District).

The 2018 usually resident population Census data is currently the other key source of statistical information used when seeking insights into the demographic profiles of the different communities served by MDHB. The Statistic New Zealand website has Census place summaries that are useful in providing an overview of information about TLA areas or statistical areas within them. The link to this webpage is: https://www.stats.govt.nz/tools/2018-census-place-summaries/

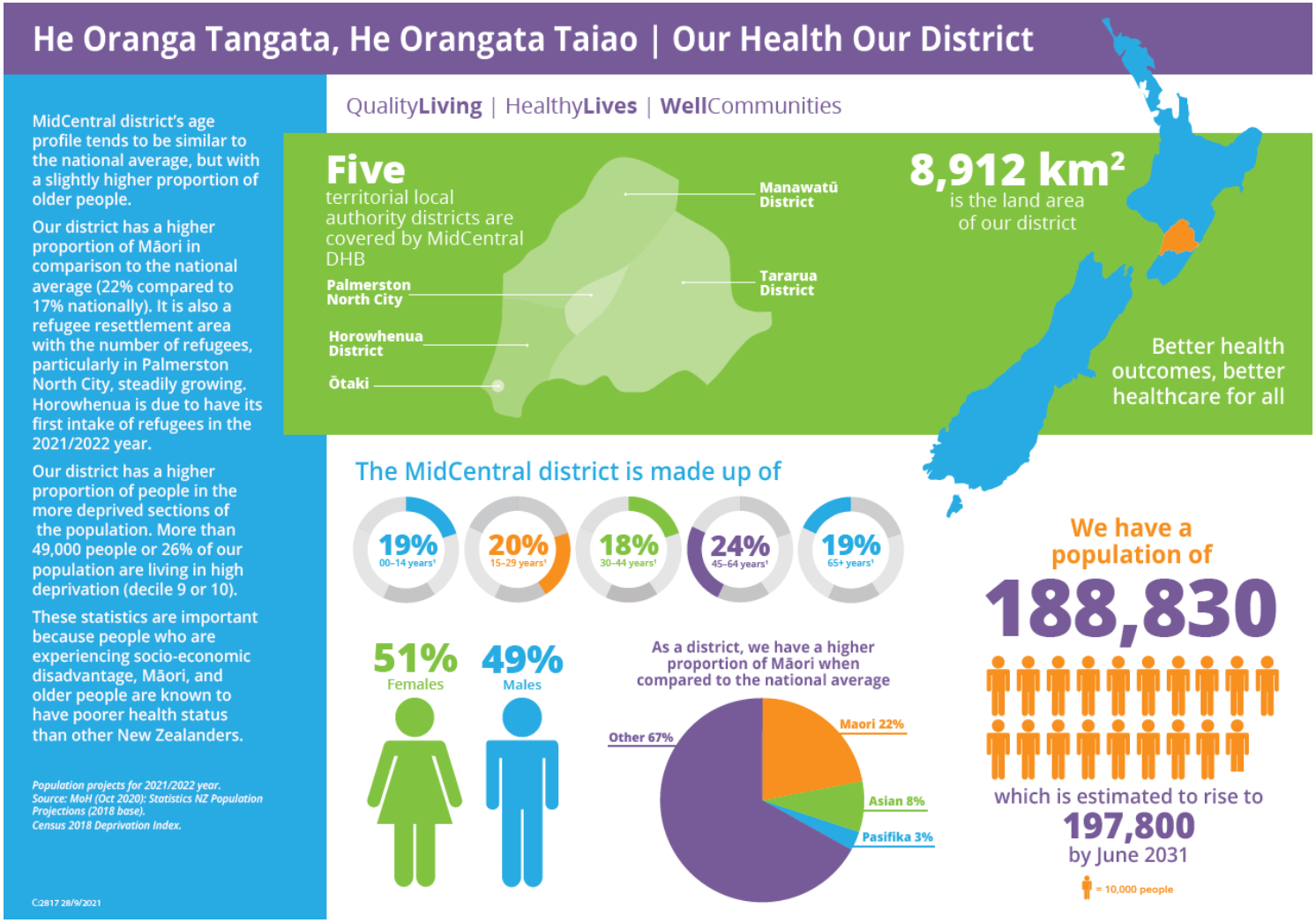
Following the release of the 2018 Census data, a population snapshot was produced for each of MDHB's five localities. These snapshots included information from the 2018 Census, the New Zealand Deprivation Index and from the Ministry of Business, Innovation and Employment (MBIE). Updated versions of the five locality Health and Wellbeing plans were then produced to include these snapshots (the Manawatū District snapshot is shown here).



With the next census not due until 2023, it is very difficult to get up-to-date statistical information about MDHB's localities. Statistics New Zealand has recently published new 2021 population estimates, which provide updated population figures for the main TLA areas and the MDHB population. These are outlined in the following section.

3. CURRENT DEMOGRAPHIC PROFILE

A graphic titled 'He Oranga Tangata, He Orangata Taiao/Our Health Our District' is produced each year to provide an overview of the population profile for the current financial year (using the latest Ministry population projection information). The graphic for the 2021/22 year was produced from the 2020 update, using a Census 2018 base.

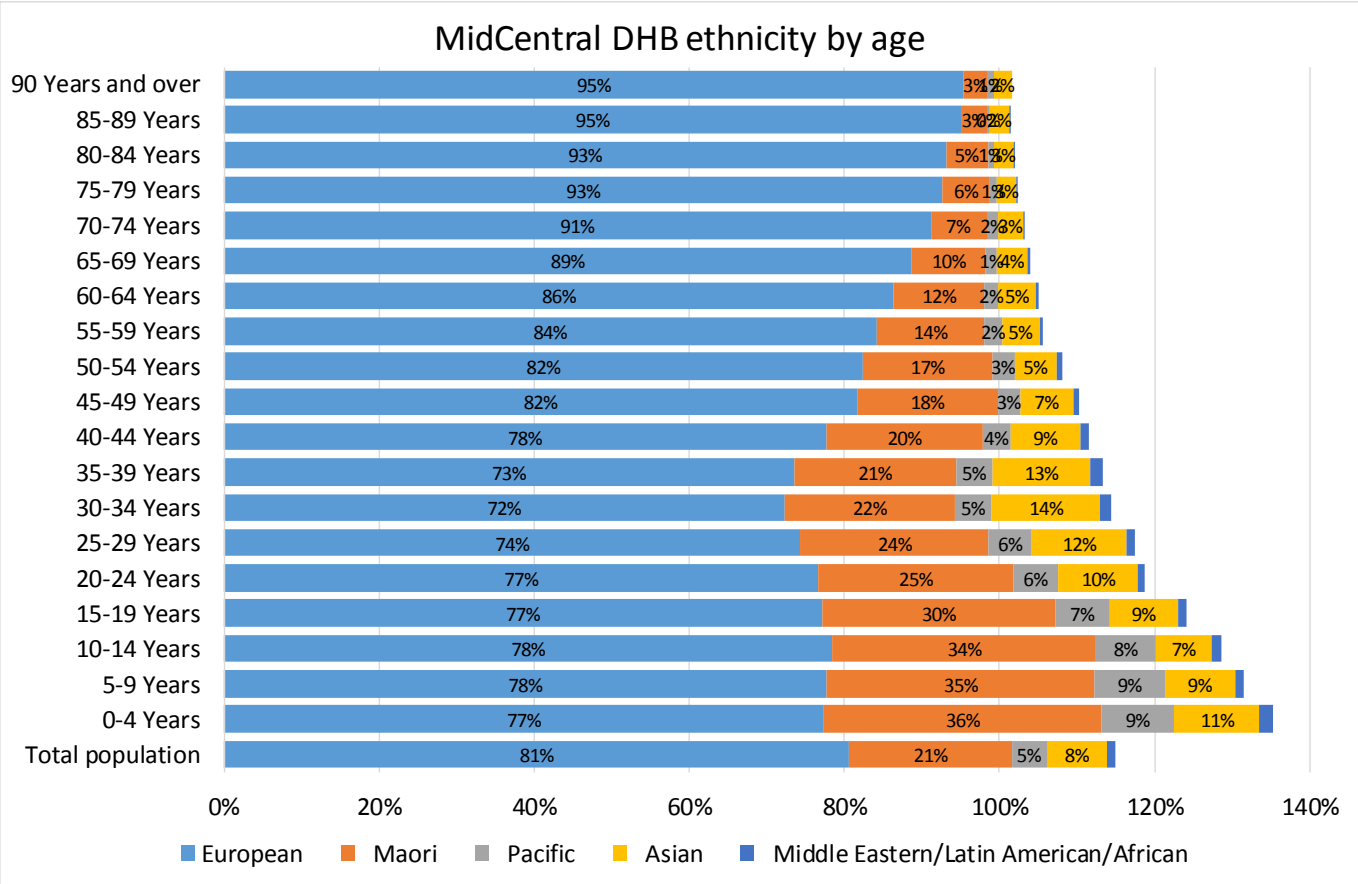


Last month, Statistics New Zealand published new population estimates which list the MDHB **2021 population estimate as 189,100**. This is an increase of 1600 people from 2020 (0.9 percent increase) and it is the first time since the estimates commenced in 1996 that the annual increase for MDHB was higher than the increase for New Zealand (0.6 percent increase).

It is of note that this new 2021 figure of 189,100 is 270 more than the figure given for the 2021/2022 funding year.

3.1. **Ethnicity by age**

The graph below shows the ethnic breakdown of different age groups in the 2018 MidCentral District population. This shows that the proportion of Māori and Pacific peoples are significantly higher in younger age groups. The median ages (years) for Māori and Pacific peoples were 25.4 and 23.4 respectively, compared to 31.3 for Asian and 41.4 for European.



3.2. **Latest figures for TLA areas**

October 2021 population estimates for our five localities are as follows:

Locality	Total population	0-14 Years	Proportion of population	15 – 64 Years	Proportion of population	65+ Years	Proportion of population
Manawatū District	33,000	6,700	20 percent	20,200	61 percent	6,200	19 percent
Palmerston North City	90,500	17,400	19 percent	59,800	66 percent	13,400	15 percent
Tararua District	19,050	3,900	20 percent	11,400	60 percent	3,750	20 percent
Horowhenua District	36,500	6,600	18 percent	20,800	57 percent	9,000	25 percent
Ōtaki Ward	10,260	1,820	18 percent	5,980	58 percent	2,490	24 percent
New Zealand	**5,122,600**	**968,600**	**19 percent**	**3,334,900**	**65 percent**	**819,100**	**16 percent**

These new 2021 estimates suggest actual population growth over the last three years has been 770 people a year higher than Statistics New Zealand had been projecting for the MDHB rohe between 2018 and 2023 (based on the 2020 DHB population projections).

The 2021 population in Manawatū District is already higher than Statistics New Zealand projected for 2023. Palmerston North is the only area lagging. The city had a smaller increase in the year to June 2021 due to the impact of the closed border on international student, former refugee and skilled migrant arrivals. International student tertiary head counts in the city in April 2021 were down by 300 from April 2020.

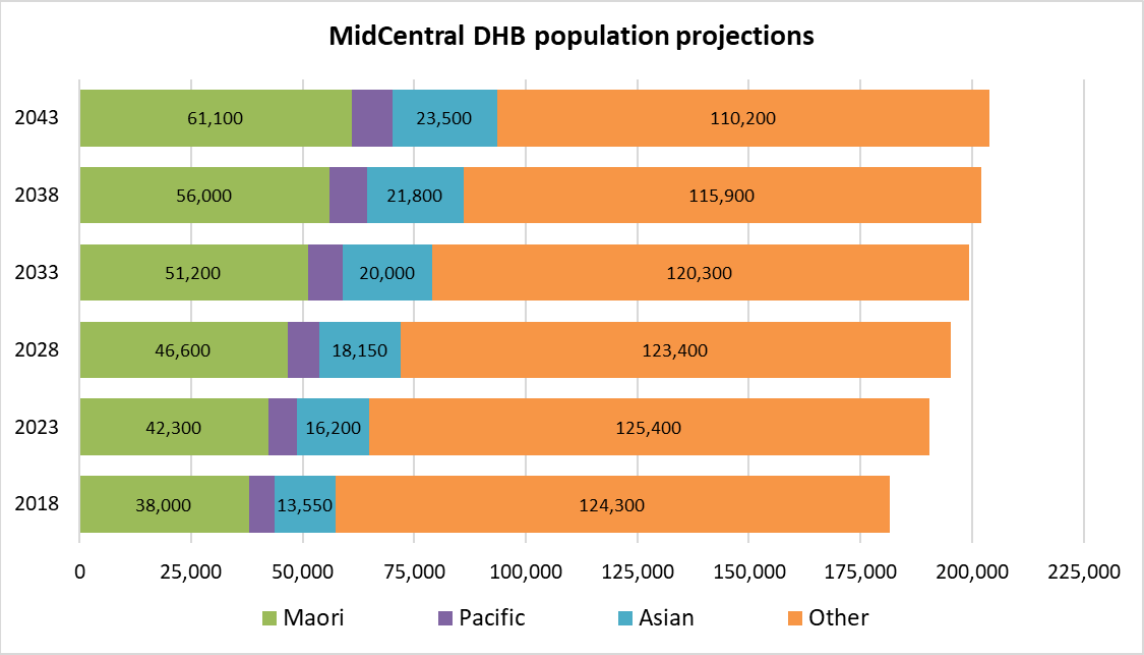
These estimates also highlight that four of MDHB's our five localities have a higher proportion of people aged 65 years or older than the national proportion. A quarter of the population in Horowhenua and 24 percent in Ōtaki are in this older adult age group. This is significant, as older people are likely to have higher health needs.

4. POPULATION PROJECTIONS

In October 2020, Statistics New Zealand published population projection estimates for the MDHB population from 2023 to 2048 (these are medium projections: assuming medium fertility, mortality and migration). These figures are shown in the following table.

Year ending 30 June	Resident total population	Resident Total Population Age Distribution 0-14	Resident Total Population Age Distribution 15-64	Resident Total Population Age Distribution 65+	Median Age (Years)
2023	190,400	18.8	61.8	19.4	39.4
2028	195,300	17.8	60.2	22.1	40.7
2033	199,200	16.9	59.0	24.1	42.2
2038	202,000	16.4	58.0	25.6	43.6
2043	203,800	16.0	57.7	26.3	44.6
2048	204,800	15.7	57.6	26.7	45.1

This table shows that MDHB's population is expected to continue to get older, with the median age and the proportion of people aged over 65 both increasing. As the population grows, the ethnic makeup is also predicted to change. The number of residents identifying as Māori, Pasifika and Asian are predicted to grow, while other ethnicities are projected to decline. This is depicted in the following graph.



The projected numbers for Pacific people do not appear on the graph, they are:

Year	Resident Pacific ethnic group
2018	5,790
2023	6,500
2028	7,140
2033	7,750
2038	8,360
2043	8,990

In March 2021, Statistics New Zealand published updated population projections (2018 base) for TLA areas:

TLA	2023	2028	2033	2038	2043
Manawatū District	32,800	33,600	34,200	34,500	34,800
Palmerston North City	92,300	94,900	97,200	99,100	100,700
Tararua District	19,050	19,350	19,500	19,500	19,450
Horowhenua District	36,800	38,000	38,900	39,500	39,900

As mentioned above in section 3.2, the Manawatū District has already surpassed its projected 2023 population.

The following table has the Infometrics MDHB long term projections that were made in March 2020. There is a substantial difference between Infometrics projected 2048 population of 231,125 and Statistics New Zealand's figure of 204,800.

Infometrics Population projections

	2018	2019	2020	2021	2022	2023	2028	2033	2038	2043	2048
Medium	180,700	183,510	186,356	189,202	192,047	194,893	205,427	212,117	218,697	225,407	231,125

The graph in Appendix One highlights these differences further by showing a comparison between different population projections published by Statistics New Zealand over recent years and the projections made by Infometrics in March 2020.

5. CONCLUSION

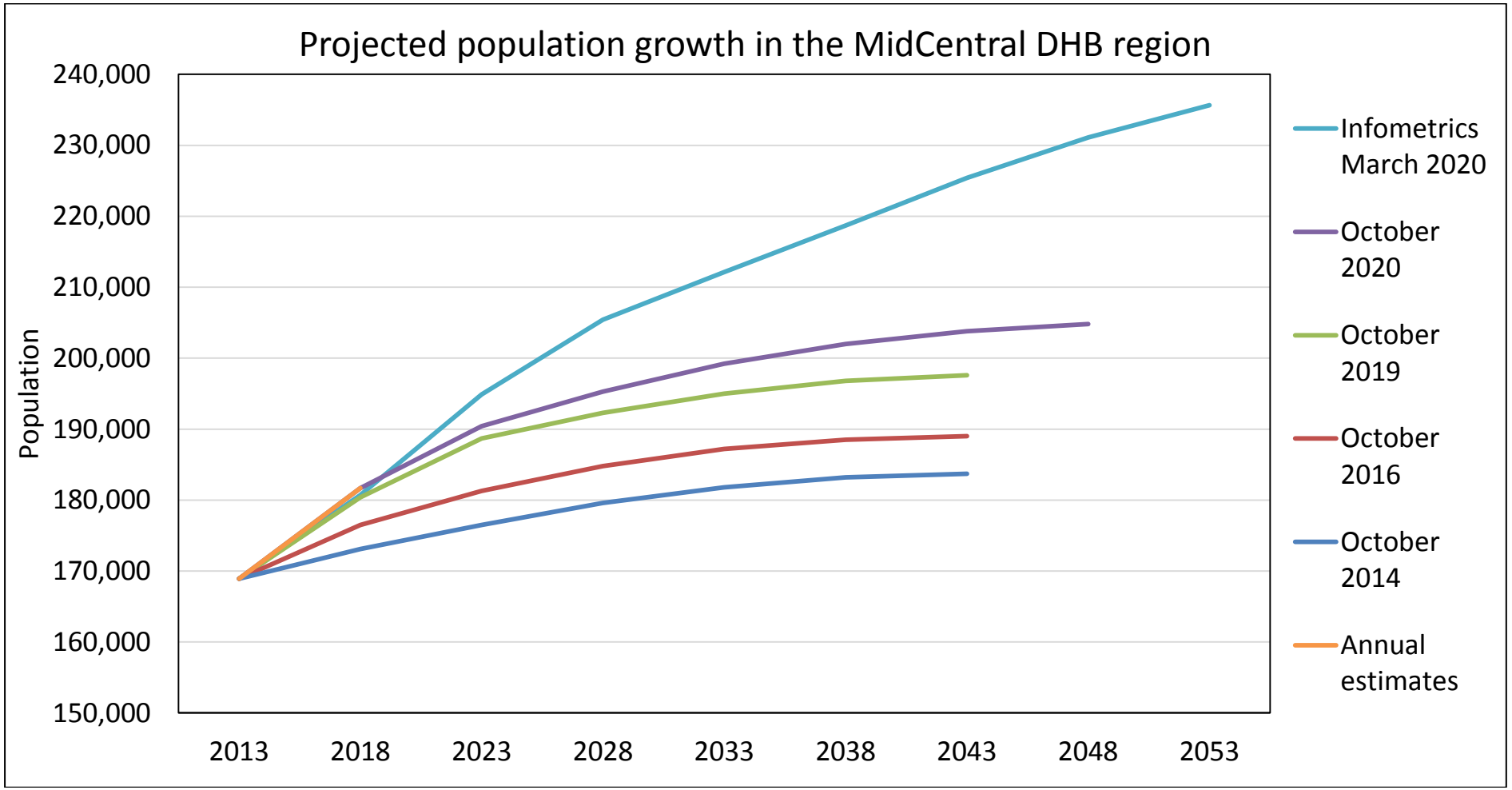
The statistics within this report show that the total MidCentral District population is growing faster than previous projections predicted. The four outer localities are all contributing to this growth as people migrate to rural areas. This puts added strain on the limited resources within the local primary health care system and also has repercussions for the wider determinants of health, such as the ability to find good quality, affordable housing.

The organisation also needs to be aware of the age distribution of the different ethnicities. Māori and Pasifika populations are younger than other ethnicities and make up a significant proportion of the population aged under 40 years old.

In planning future services and infrastructure, it would be prudent to utilise the Infometrics projections, as the Statistics New Zealand projections have historically underestimated our population.

The changing demographic make-up of the district's population also needs to be considered. There is already a significant older population, and the proportion of the population over 65 years of age is going to continue to grow. It is expected that larger proportions of the population will identify as Māori, Pasifika and Asian.

Appendix One



Directorate with cluster functions reporting

23 November 2021

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 the dashboard provide insight and a helicopter view on key areas of Directorate performance for the Committee?
- 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
Endorsed by	Kathryn Cook, Chief Executive
Date	4 November 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 MidCentral District Health Board's (MDHB) strategy and the implementation of its Annual, Operational and Sustainability Plans, Locality and Directorate Health and Wellbeing Plans.

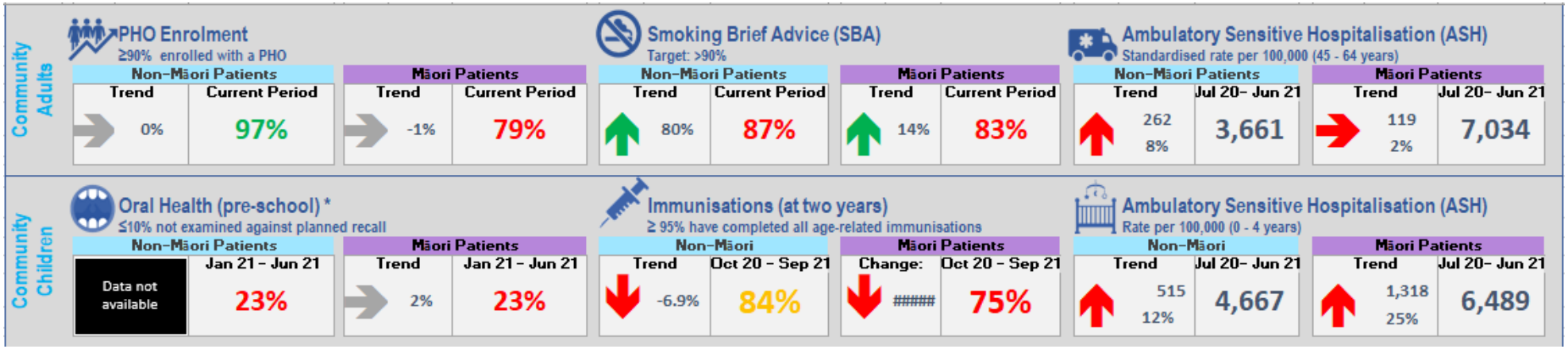
1. PURPOSE

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

2. COMBINED DIRECTORATE VIEW

The metrics follow the same format as outlined in the February 2021 Board Key Performance Indicators (KPI) dashboard and cover the period 1 July 2021 to 30 September 2021 ('Current Period'). They are compared to the same period in the last reporting year, unless specified differently within a particular metric. The directorate dashboard is in development, with placeholders for future performance measures to be included.

2.1. Primary and Community



Data from July to September 2021 shows a slight decline in the Māori patients enrolling with a primary health organisation (PHO). As previously reported, the issue of enrolment pressures continues. With no substantive improvement in the processes to successfully recruit General Practitioners (GPs) from overseas, and significant supply and demand issues for New Zealand based locums, no general practices in the Horowhenua locality were open to enrolments over the quarter. This includes enrolment for newborns and from out of district whānau. Whilst some whānau have the means and ability to enrol and travel to Palmerston North for their vaccinations and primary health care, the most vulnerable populations are impacted most from this situation.

The Smoking Brief Advice (SBA) result for this quarter was 87 percent non-Māori and 83 percent Māori. Whilst the overall target was not met this quarter, there continues to be steady improvement. The Clinical Facilitators have built relationships with the THINK Hauora Pasifika team and iwi/Māori health providers across the district and explore opportunities to partner and assist with this target. Many practices have identified that Māori are less likely to present at the practice, reducing the opportunities to provide SBA and other opportunistic screening activities. The Clinical Facilitator has built relationships with other smoking cessation service providers, including Te Ohu Auahi Mutunga (TOAM) and the MDHB Smokefree Coordinator to identify different approaches to locate 'lost' people and ensure they have access to SBA. Opportunistically providing SBA to clients while they are having their COVID-19 vaccination is a process being explored by the MDHB Smoking Cessation Coordinator. THINK Hauora will be involved in liaising with general practice teams to ensure the results are added to the patient management systems. As previously reported, there are ongoing data issues with up to 30 percent of all contact details of patients in the SBA action list not being valid. Progress towards this target will continue in the next quarter. The Clinical Facilitator will be concentrating efforts on those practices identified as needing the most support.

When examining hospitalisations for potentially avoidable conditions, known as Ambulatory Sensitive Hospitalisations (ASH), the standardised rate for both non-Māori and Māori aged 45 to 64 years has increased over the reporting period. For non-Māori the rate is 3661 per 100,000 and for Māori the rate is 7043 per 100,000. The rate for Māori continues to be almost double that of non-Māori, with a clear equity gap remaining evident.

The last quarter of 2019/20 was the first COVID-19 lockdown. It is well reported that during this quarter the hospital was relatively quiet compared to usual. During the 2020/21 year, there were no lockdown periods, apart from a slight change of level in August 2020 (Level 2) and again in February 2021 (Level 2). A further contributing factor may also be that any care delayed at the end of 2019/20 from the first lockdown, may have resulted in increased ASH at the beginning of the 2020/21 year. On this basis, when comparing these two annual periods it is not unexpected that ASH has increased slightly. Comparing 2020/21 ASH event volumes with 2018/19 (ie pre-COVID-19), then the trend remains relatively flat, perhaps even improving, given that the population has increased over this time.

Arrears (those not examined) for oral health has slowly risen, predominantly due to the catch up required from the previous increase in COVID-19 alert levels, staff vacancies and significant sick leave. On a positive note, the Māori arrears are less than the overall zero-four year age group. Recruitment remains a challenge with national shortages, however arrears and robust production planning are a strong focus for the next academic year.

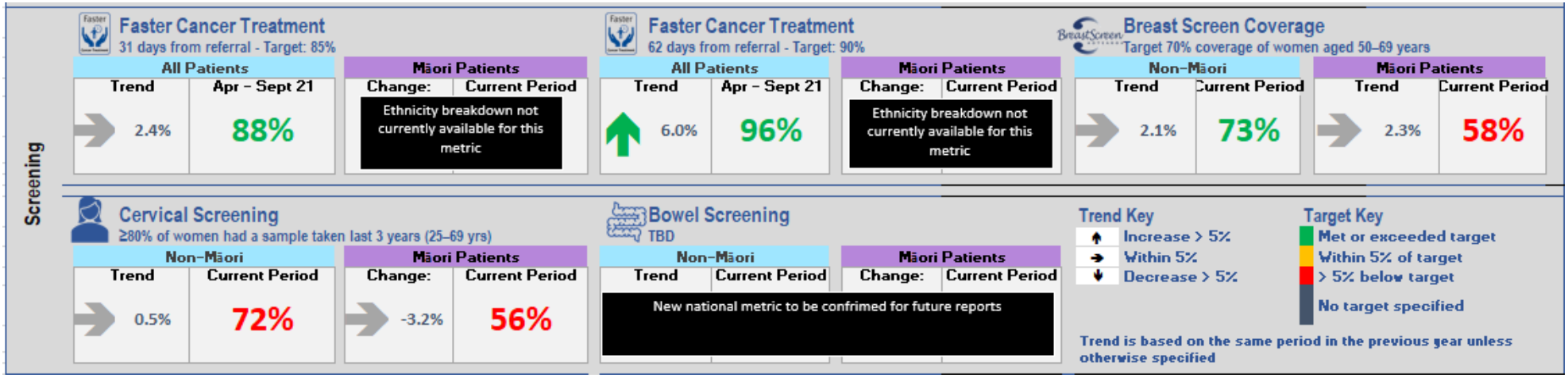
The immunisations rates for Māori and Non-Māori have decreased further despite significant efforts in many of the areas previously reported. Of particular concern, is the growing inequity of completion rates for Māori. Over the first quarter, there has been a significant and sustained effort firstly to assist the General Practice Team (GPT) network with correcting the sizeable number of data errors between the practice Patient Management System (PMS) and National Immunisation Register (NIR) (including a backlog of transfers yet to be added into the NIR); secondly to attempt contacting and have conversations with whānau on overdue lists; and thirdly sending many referrals to the Outreach Immunisation Service (OIS) for follow up. This mahi is not reflected in the NIR data via Qlik.

The COVID-19 Level 4 and 3 restrictions during the second half of this quarter significantly impacted the vaccinating workforce across all service providers. The drive for increased COVID-19 vaccinations continues to put pressure on childhood vaccination efforts. Over this time, the OIS and other non-GPT childhood vaccination services were ceased. The THINK Hauora Immunisation team provided home visits and targeted community vaccination clinics. A total of 25 Horowhenua children were seen and vaccinated in their homes by the Horowhenua-based THINK Hauora Immunisation Facilitator during Level 3.

THINK Hauora continues to work with practices with the highest numbers of overdue pēpi and tamariki to reinforce the need to engage with whānau with conversations rather than 'quick/easy' methods of texting or sending letters.

ASH presentations for zero to 4 years have increased over the reporting period for the standardised rate for both non-Māori and Māori. An increase was expected due to very little winter illnesses being seen in children last year, due to COVID-19 increased alert levels and border closures. An outbreak of Respiratory Syncytial virus (RSV) nationally and locally began to cause significant increased attendances in the Emergency Department (ED) and admissions to the Children's Ward in June 2021.

2.2. **Screening**

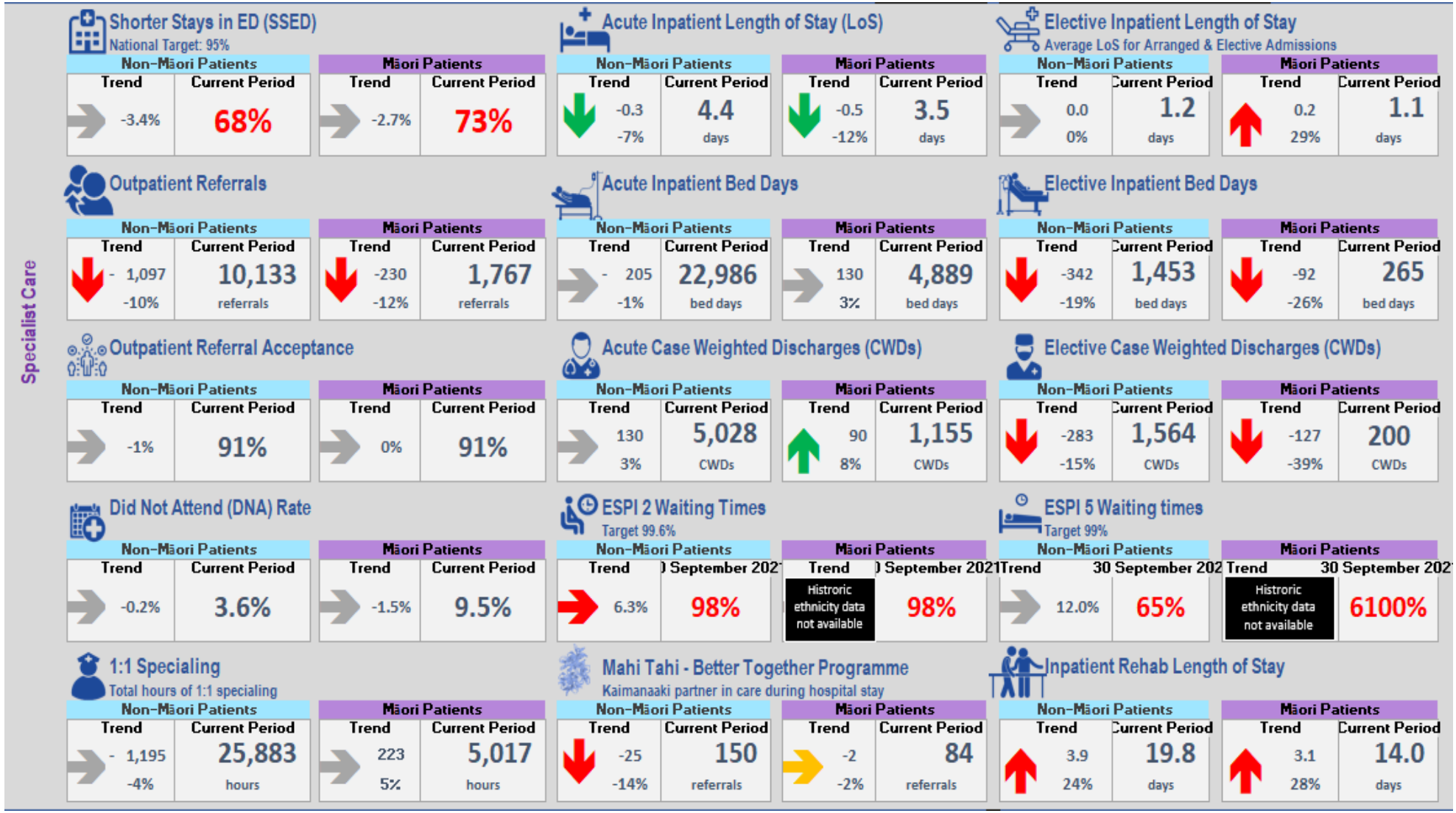


Breast Screen Coast to Coast (BSCC) screening rates are below the required level for Māori, evidencing a clear inequity. BSCC continues to work toward ensuring that all wāhine Māori are offered support to screening services. This offer is included in letters and texts, with verbal offers of support also being encouraged. The koha initiative to encourage wāhine Māori to re-screen is proving successful, with over 75 percent of wāhine who accept the koha attending their screening appointment.

Data to June 2021 shows a decrease in both Māori and non-Māori cervical screening rates. The three-yearly coverage rates have again slightly dropped for all ethnicities, which is likely due to suspended access in Alert Level Four and only urgent access provided in Level Three. Engagement continues from Te Kete Hauora o Rangitāne to provide support to general practice teams to engage priority women in cervical screening. For the Pasifika community, cervical screening is offered as part of the Vaka Ora Pasifika programme and THINK Hauora's Pasifika Team provides health promotion and screening.

The National Cervical Screening Programme (NCSP) July quarterly update confirmed that work is underway finalising the clinical pathway for Human Papillomavirus (HPV) self-testing, which was delayed during 2020 due to COVID-19. This was relaunched in August via social media. A further update is included in the Te Uru Kiriora Directorate report.

2.3. Specialist care



Shorter Stays in Emergency Departments (SSIED) remains below target 72 percent in September. SSIED was 68 percent for Non-Māori and 73 percent for Māori. There were 3770 presentations to the ED in August and 3591 in September, which is similar to the same period last year.

Overall performance in ED continues to be impacted by high occupancy, with adult inpatient wards at 100 percent, which restricts effective patient flow. The acute inpatient length of stay has improved with a seven percent reduction to 4.4 days for Non-Māori, when compared with the same period last year. There was also an improvement to the acute inpatient length of stay for Māori to 3.5 days. This is a reduction of 12 percent compared with the same period last year. Despite challenges with the high acuity and volume of presentations, the acute length of stay result was maintained and improved.

MDHB will participate in a Ministry of Health (the Ministry) sponsored pilot programme aimed to improve patient flow. The pilot will focus on improving weekend discharging of patients and increasing Allied Health availability at weekends. Further information on initiatives to improve SSIED performance is included in the Te Uru Arotau Directorate section of the report.

The Older People's Acute Assessment and Liaison (OPAL) Unit has experienced some periods with increased length of stay, due to patients requiring a Protection of Personal and Property Rights Act 1988 (PPPR) application. The unit is consistently discharging a third of patients with either a one, two or three-day length of stay. The OPAL discharge lounge trial recommenced on 18 October 2021, with support and supervision arrangements in place so older adults ready for discharge can sit in the OPAL lounge to await their transport or discharge papers. This initiative to facilitate earlier release of OPAL beds will be trialled for the next six weeks. In the first two days of the trial, five patients were supported to wait in the OPAL lounge rather than remain in their bed space. This resulted in the beds being available a total of 7.5 hours earlier.

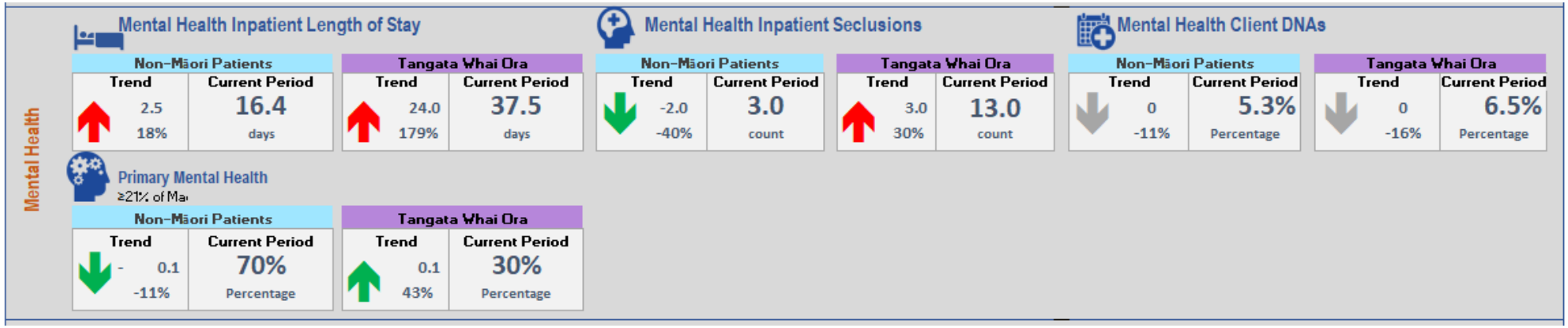
Good progress has been made to achieve the Ministry's agreed Elective Services Performance Indicator (ESPI) trajectories with 19 of 23 services compliant at the end of September. During national Alert Level 3 and 4 there was an increase in the number of telehealth consultations. This included a significantly higher amount of telephone and video outpatient consultations (August 2344 and September 2825) compared with previous year at (August 1588 and September 1718).

ESPI 5 remains an area of challenge, with eight out of nine services non-compliant at the end of September 2021. MDHB continues to work in partnership with Crest Hospital to provide outsourced and outplaced surgical procedures to further improve performance in this area. MDHB is working with clinicians on prioritising Māori and Pasifika in planned care scheduling to ensure there are no unintended consequences. Planned care waiting lists are produced by ethnicity, with regular monitoring to ensure a greater focus on improving Māori timeframes from referral to treatment.

Across the 2020/21 financial year for the Healthy Ageing and Rehabilitation (HAR) wards combined specialing was an average total of 4733 hours per month. In comparison, for the first quarter of this financial year the average total has been 3989 hours per month. The September specialing hours across the HAR wards was the lowest in the last 15 months with a total of 2644.

Length of stay for STAR 2 has increased but remains within normal variation. Occupational Therapist vacancies in July and August have impacted significantly on discharge planning, with complex rehabilitation patients experiencing delays in home visits, kitchen assessments and activities of daily living (ADL) teaching and supervision, leading to prolonged length of stay. This has been mitigated by temporary recruitment of community therapists from other agencies while permanent recruitment options are being progressed. An increase in patients with severe strokes and amputee patients with chronic comorbidities have contributed to the high acuity within the ward and consequently a longer stay. STAR 4 experienced delays in discharge with patients transitioning to Aged Residential Facilities during COVID-19 Level 4 restrictions, but STAR 2 did not experience this issue.

2.4. **Mental health**



Overall mental health contacts for Māori and non-Māori are within the normal variation seen across months.

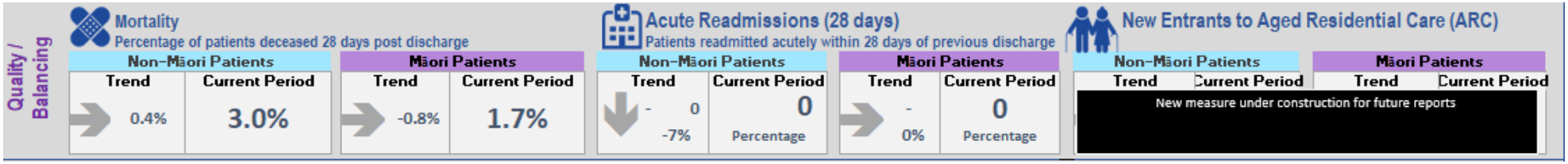
Discharges from inpatient mental health services for Tangata Whai Ora are trending less when compared to the same period last year (19 versus seven), which is proportional to reduced admissions. The complex case review process chaired by the Medical Director is continuing and the process for transition of care from the ward to community has improved greatly. In the last two months follow up by community teams within seven days for Tangata Whai Ora was 100 percent and 93 percent for August and September, as compared to 92 percent for both months for non-Māori.

The average length of stay is calculated as the total number of acute inpatient bed nights occupied for referrals that closed during the reference period (in this case the month). The current result of 37.5 days is being influenced by three discharges of Tangata Whai Ora that occurred last month that each had a length of stay greater than 100 days. Whilst challenges remain with length of stay, the readmission rate for both Māori and non-Māori is 11 percent for the quarter, slightly above the target of 10 percent. The sub-acute/extended care service based in Palmerston North will be operational in October 2021 and following a transition period first admission will occur from 1 November 2021.

In the quarter there were several very complex admissions of Tangata Whai Ora that has resulted in an increase in the number of seclusion events for the quarter. The focus remains on least restrictive practices and de-escalation, including the establishment of a sensory modulation room in the high needs unit.

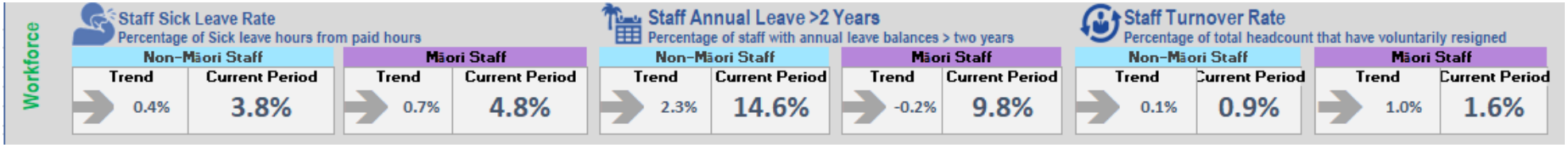
Whilst the Did Not Attends (DNAs) have remained consistent compared to the previous reporting period, over the past 12 months DNAs have reduced by 25 percent for Māori and 40 percent for non-Māori. Adult DNAs have now been included in the project for the Integration of Mental Health Data monthly report as well as breakdown by ethnicity, to enable ongoing monitoring of trends.

2.5. **Quality/Balancing**



The readmission rate for Māori year to date (YTD) remains at 10.7 percent and non-Māori YTD is 9.1 percent, a slight reduction on the previous year. 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 ONE: SUMMARY OF THE SIX HEALTH AND DISABILITY SERVICE DIRECTORATES

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

APPENDIX TWO: DIRECTORATE VIEW METRIC DEFINITIONS

METRIC	DEFINITION	EXCLUSIONS
THINK Hauora Enrolment	Percentage enrolled with THINK Hauora of MDHB population.	
Smoking Brief Advice (SBA)	Percentage of current smokers (or recent ex-smokers) who have received brief advice to quit smoking or an offer of cessation support in the last 15 months.	Patients not enrolled with THINK Hauora; non-coded smoking status and SBA; smokers under age of 16 years.
Ambulatory Sensitive Hospitalisation (ASH)	As per the MoH 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 MoH 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 MoH 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)	MoH 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 MoH 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 MoH 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 Rauhī – Mental Health and Addiction Services (MHAS)
FOR PERIOD	August and September 2021
PREPARED BY	Scott Ambridge, Operations Executive

PERFORMANCE OVERVIEW

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

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

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

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

The RFP for the Horowhenua Service was released on 2 November 2021.

Support the Emergency Department for people presenting with mental health needs

The role remains unfilled despite numerous recruitment attempts. Other options (such as job sharing) will need to be considered given current approaches has been unsuccessful.

1. SIGNIFICANT MATTERS

1.1 Inpatient bed occupancy

From July through to September the average number of patients on the ward has been 26 (total including those on leave is 28). Whilst the current budget provides safe staffing levels up to 28 beds, recruitment to vacant positions remains a challenge. The Charge Nurse resigned in October and pending a permanent replacement being found, an internal expression of interest will be completed to secure an acting Charge Nurse.

Management, staff, and unions continue to meet regularly to oversee a range of agreed actions relating to staff welfare, recruitment, facility improvements, clinical and cultural practice. The Operations Lead and Medical Director remain actively involved in clinical oversight and in particular the complex care coordination. The Patient and Bed Flow Manager position has been appointed to support the transition of clients from the ward into the community.

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

KPI #	Description	Target	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	vs. Last Month
KPI 2	28 day acute inpatient readmission rate	0-10%	17%	16%	7%	18%	16%	20%	11%	14%	9%	11%	13%		↑
KPI 8	Average length of acute inpatient stay (days)	14-21 days	16.9	12.9	16.5	14.8	31.0	10.8	15.4	20.4	12.0	31.1	19.4	14.2	↓

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

Over the past six months CAFS has 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. CAFS is working through a procurement process to contract Youthline to provide brief interventions to young people (teens) who are no longer acutely unwell but require follow up support. A service review has been undertaken and a business case is being developed to ensure the CAFS service continues to meet current and future demands.

1.3 Transition of care

The extensive work carried out by a project team appointed to improve the quality of post discharge follow up in the community (KPI 19) initiated in March 2021 has started to pay off. For the first time in several years MHAS met the Ministry of Health's (the Ministry) 90 percent target for seven-day follow ups, achieving 96 percent in August and 92 percent in September. Follow up performance has been slightly higher for Māori clients over the two months (100 percent and 93 percent) versus non-Māori (92 percent and 92 percent).

KPI #	Description	Target	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	vs. Last Month
KPI 19	Post-discharge community care (Seen in 7 days following ward discharge)	90-100%	69%	76%	57%	74%	75%	78%	80%	73%	81%	89%	96%	92%	↓

This is the result of a review of best practices in place across District Health Boards and resultant system strengthening initiatives currently being embedded across MHAS including:

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

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

1.4 Inpatient facility rebuild

The preliminary design has been agreed in principle. The one remaining area still under discussion is the entranceway, ensuring it is culturally appropriate but clinically safe. A meeting involving the clinical team and iwi has been organised for early November to agree a way forward.

The team received positive feedback from the Ministry on the model of care for the acute mental health facility which was deemed an "exemplar" for what others should be aiming for across the Mental Health Infrastructure Programme.

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

Throughout September and October, the management of change process was undertaken for impacted staff. The process was somewhat 'revolutionary' in its approach as it included an interview as part of the selection process. Overall, the process was highly valued both for the panel and the staff member and it was pleasing to see many staff express optimism about Te Mātāpuna o te Ora. It was a great opportunity to connect with individuals to acknowledge the work they do within their roles as well as alleviate some uncertainty that is part of any change process. All staff have been offered positions, although for a small number not in their current service. What was particularly pleasing is that the process identified five Māori MHAS nurses who have been offered roles within kaupapa services. Should the staff member decline the offer, other redeployment options which are outlined in the relevant MECA will be considered.

Work continues getting staff ready to transition from the 'old to the new'. Currently work is focused on equipping staff with the skills and tools to be successful to begin to develop practices for the new model of care that includes:

- creating a shared strength-based language approach for Te Mātāpuna o te Ora. Proactively develop our people in the new ways of working that is underpinned by the values of Realising WAIORA
- holding training sessions covering professional development, practice changes and cultural responsiveness
- familiarising staff and partner agencies with the new integrated service policies and procedures, using a rapid prototype and continuous improvement approach
- developing the core technology tools – connected care record (Whānau Tahi), contact centre and rollout of hardware (laptops, telephony system)
- progressing the development of the Horowhenua facility
- updating the Tararua facility
- configuring the locality-based services, specialist primary, mental health liaison, crisis resolution and kaupapa into teams and locality
- continuing to engage with service users, whānau, NGO and community providers to socialise the model
- ensuring leaders are skilled in supporting service users through these changes and responding to their feedback
- not deploying the Integrated Model of Care until there has been sufficient time for everyone to become familiar with the new work practices and care pathways.

As services transition and various components of the model are adopted, service users and whānau will start seeing changes to the way in which services interact and support them. Proactive engagement and ongoing consultation with service users and whānau throughout this period will be critical. As well as leveraging off existing networks such as locality groups, the service will be establishing regular locality-based forums to keep service users and whānau updated on the changes and what will look different for them.

Services will progressively transition from November 2021 with the aim to have all services fully deployed in their teams and facilities by April 2022. The only exception to this will be the Horowhenua kaupapa service which is unlikely to be fully deployed until December 2022.

The Te Mātāpuna o te Ora Governance Group is scheduled to meet for the first time in November. The meeting is co-chaired by the Operations Director, Pae Ora Paiaka Whaiora Whakahaere Hauora Māori and includes representation from the Clinical and Consumer Councils. The objective of the Governance Group is to provide independent advice and critique of progress towards Te Mātāpuna o te Ora, including staying authentic to our responsibilities as a Treaty partner as defined by the partnership agreement between Pae Ora Paiaka Whaiora Māori Health Directorate and Te Uru Rauhī.

Digital enhancements

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

A demonstration for a new 'soft' telephony system was held and a pilot of the new system is currently being planned.

Facilities

Given the pressure on the DHB facility team and market pressures, little progress has been made on the development of the new facility in Horowhenua. It is now unlikely that the facility will be ready as initially planned by February. The service is working on developing a contingency plan to identify other short-term options.

1.6 **Community facilities update**

Emerge Aotearoa

While completing landlord repairs and maintenance in preparation for the new service, Emerge has identified an internal leak which requires some roof repairs. This has resulted in a delay to service commencement which is now likely to be early December.

Discussions are underway to explore a reduced volume start at the house or opportunities for short-term use of alternative premises.

Horowhenua Acute Alternative Service

Procurement plans, including revised budgets and implementation funding are now complete and endorsed. The RFP documents have been released to the market.

Salvation Army – Social Detox

The Ministry has previously indicated a planned relocation of the Salvation Army social detox service from Palmerston North to Wellington. Recent discussions confirm that this is still likely to happen early 2022. However, the Ministry is looking to provide the DHB with funding to support development and integration of local social detox services with Te Mātāpuna O Te Ora. Formal advice from the Ministry is expected shortly.

Youthline

Formal arrangements are being finalised to implement a new community-based youth support service. The service will look to:

- support young people who have accessed CAFS and are on the road to wellbeing and would greatly benefit from ongoing skills building in a community setting (step down from CAFS)
- provide brief intervention to young people who have accessed CAFS during a crisis situation (suicidal gesture or low risk attempt) and after assessment, in partnership with the young person and their family, recommendation is made for community based brief intervention and support.

This service will greatly increase the continuation of care and opportunity for recovery.

Living Well Counselling Centre

Service specification/development is underway to provide funding support to an existing counselling service based in Horowhenua, which will help to support financial security and provide the opportunity for a reduction in waiting lists, staff retention and increased volumes.

This will allow the Living Well Counselling Centre to strengthen its community with early intervention, compassionate, safe and mana enhancing care that increases the wellbeing, hopes and potential of those who turn to them for help.

SERVICE:	Te Uru Arotau – Acute and Elective Specialist Services
FOR PERIOD:	August and September 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	G	↑
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 have not already been covered under the Directorate Dashboard commentary.

The contract has been signed with the vendor for the delivery of the Performance Indicators for Coding Quality (PICQ) audit tool. The tool is expected to be implemented by December 2021. 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)

SSIED remains below target at 72 percent in September. SSIED was 68 percent for Non-Māori and 73 percent for Māori. There were 3,770 presentations to the Emergency Department (ED) in August and 3,591 in September. This is similar to the same period last year.

Road trauma presentations have decreased below the average of 33; with 24 in both August and September. This is likely to be due to the National COVID-19 Level 4 lockdown.

Overall performance in ED continues to be impacted by high occupancy with adult inpatient wards at 100 percent. This restricts effective patient flow. The acute inpatient length of stay has improved with a seven percent reduction to 4.4 days for non-Māori when compared with the period last year. There was also an improvement to the acute inpatient length of stay for Māori to 3.5 days. This is a reduction of 12 percent compared with the same period last year. Despite challenges with the high acuity and volume of presentations, the acute length of stay result improved.

An action plan to improve SSIED performance has been developed which includes, short, medium and long-term initiatives. This has been shared with the Ministry of Health (the Ministry) to provide a more in-depth view of initiatives.

Initiatives undertaken to improve SSIED and patient flow:

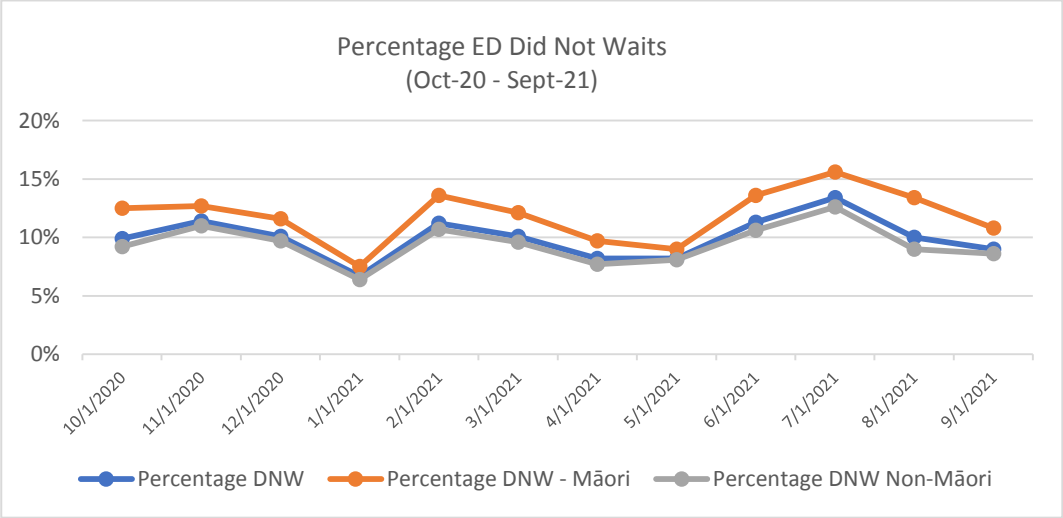
- A surge plan is being developed by the senior medical staff from ED for the rapid decant of patients in a significant time of over capacity.
- As part of the Care Capacity Demand Programme (CCDM) the Variance Response Management (VRM) system is being reviewed.
- The ED TrendCare working group has been established to plan for the implementation of TrendCare in ED.
- The Chief Medical Officer (CMO) is working with Senior Medical Officers (SMOs) to review the service allocations. The CMO has had initial discussions with services for the establishment of service allocations with patient groups in ED.
- There has been increased communications to clinical teams to raise awareness for the ability to utilise the bariatric advisory team. Engaging with the bariatric advisory team can support a timely and safe stay and discharge for this cohort of patients.
- Full employment to agreed CCDM staffing is an enabler for patient flow from ED to wards and subsequent discharge. For example, when the inpatient surgical wards have a full complement of staff, one Registered Nurse is allocated the defined role of admission and discharge nurse.

All District Health Boards (DHBs), along with MidCentral DHB (MDHB), continue to submit weekly data to 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.

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

Month	Total Presentations	Total DNW	Percentage DNW	Māori Presentations	Total DNW Māori	Percentage DNW – Māori	Non-Maori Presentations	Total DNW Non-Māori	Percentage DNW Non-Māori
October 2020	4,124	410	9.9%	878	110	12.5%	3,246	300	9.2%
November 2020	4,043	460	11.4%	867	110	12.7%	3,176	350	11%
December 2020	4,074	413	10.1%	919	107	11.6%	3,155	306	9.7%
January 2021	3,945	263	6.7%	851	64	7.5%	3,094	199	6.4%
February 2021	3,730	417	11.2%	863	117	13.6%	2,805	300	10.7%
March 2021	4,218	429	10.1%	925	112	12.1%	3,293	317	9.6%
April 2021	3,895	318	8.2%	822	80	9.7%	3,073	238	7.7%
May 2021	4,020	333	8.2%	927	83	9%	3,093	250	8.1%
June 2021	4,354	493	11.3%	1,006	137	13.6%	3,348	356	10.6%
July 2021	4,293	574	13.4%	1,071	167	15.6%	3,222	407	12.6%
August 2021	3,762	376	10%	856	115	13.4%	2,906	261	9%
September 2021	3,606	327	9%	777	84	10.8%	2,829	243	8.6%

Emergency Department Percentage – Did Not Waits Trend Graph



There is a clear correlation between the percentage of ED DNWs with the number of ED presentations. Māori and Pasifika ethnicities are considered priority flags as part of the ED triage process.

Planned Care and ESPIs

ESPI 2

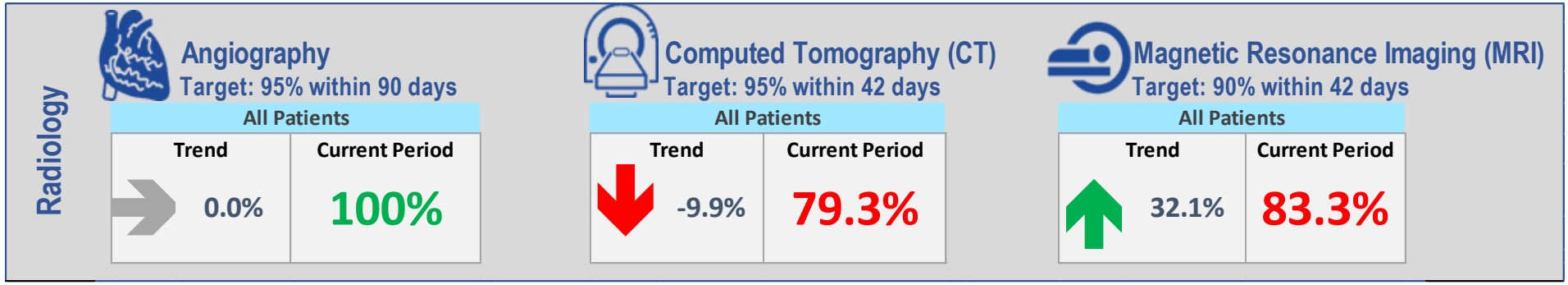
Good progress has been made to achieve the Ministry's agreed trajectories with 19 of 23 services compliant at the end of September 2021. During the National Level 3 and Level 4 lockdowns there was an increase in the number of telehealth consultations. There was significantly higher amount of telephone and video outpatient consultations (August 2344 and September 2825) compared with previous year at (August 1588 and September 1718).

ESPI 5

ESPI 5 remains an area of challenge. MDHB has been working in partnership with Crest Hospital to provide outsourced and outplaced surgical procedures to further improve performance in this area. MDHB is working with clinicians on prioritising Māori and Pasifika in Planned Care scheduling to ensure there are no unintended consequences. Planned Care waiting lists are produced by ethnicity with regular monitoring to ensure a greater focus on improving Māori timeframes from referral to treatment. There are eight out of nine services non-compliant at the end of September 2021.

Planned Care Improvement projects with funding from the Ministry are progressing as planned and further information is provided in the Sustainability Plan reporting to the Finance, Risk and Audit Committee (FRAC).

1.1 Performance Indicators – September 2021



Computed Tomography (CT) performance exceeded target in August at 91.7. This reduced to 79.3 percent September due to the National COVID-19 Level 3 and Level 4 lockdowns. The Medical Imaging department is currently recruiting for an additional two Medical Imaging Technologists.

Magnetic Resonance Imaging (MRI) performance improved by 32 percent to 83.3 percent in September compared with the same period last year. The Medical Imaging department continues to recruit to the trainee MRI role.

Outsourcing as part of planned care trajectories for both CT and MRI continues to improve performance.

2. SIGNIFICANT MATTERS

2.1 Major Facility Projects

Construction of stage one of SPIRE (Surgical, Procedural, Interventional, Recovery, Expansion) is underway with the appointment of Maycroft Construction to lead the work. Maycroft Construction commenced on site on Tuesday 26 October 2021, to start refurbishment of the area previously occupied by Renal Services, the Clinical Library and Lecture Theatre into Day of Surgery Admissions, Gastroenterology and second stage Recovery Unit.

The contract for the construction of the Medical Assessment and Planning Unit (MAPU) and the Emergency Department Observation Area (EDOA) has been endorsed by FRAC and approved by the Board at its November meeting. The first stage will be the floor slab and the in-ground services required, such as water. There will be some disruption from both projects to car parking and hospital entrances.

There is a significant upgrade to oxygen supply planned for Ward 24. This is the designated COVID-19 ward and will enable the provision of improved high flow oxygen. This is due to commence on 29 November 2021 and is expected to take three weeks. There is a plan for managing the disruption to the ward for this period to minimise impact on inpatient beds.

The fluoroscopy replacement project is on schedule and is expected to be commissioned early 2022.

2.2 Medical Imaging Clinical Services Plan

MDHB has been successful in securing sustainability funding (Round 2) from the Ministry to support the completion of a Medical Imaging Clinical Services Plan. The scope of this initiative is two-fold: to ensure medical imaging diagnostic services are meeting community and clinician needs and are delivered in the right place at the right time; and maximum value from the available resource is realised for Māori and vulnerable populations. The desired outcome of the project is to have a road map that will consider the short, medium and long term future environment. MDHB has gone out to market for an external contractor to support this mahi.

2.3 Emergency Department Child Friendly Environment Upgrade

ED and Pae Ora Paiaka Whaiora Hauora Māori have been working in partnership to upgrade the environment for tamariki and whānau. Palmerston North Rotary has agreed to fund the upgrade of the tamariki and whānau room along with paintings in the waiting room and entrances. Part of this upgrade would see an improved waiting room play space.

This will improve the experience and provide a more child friendly environment for our tamariki and their whānau. Below are some images of proposed designs for the waiting room play space. It is anticipated that this work will commence in 2022.

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

1. PERFORMANCE OVERVIEW

The following table provides a summary of the progress to date against the equity outcome, sustainability and other actions in the 2021/22 Annual Plan. Te Uru Whakamauora is generally on track, with those actions behind plan discussed in the section below. There are no emerging risks or areas of concern.

	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. Care in the community

Modelling is underway to review the ongoing capacity to deliver the Rehabilitation in the Home programme (Non-Acute Rehabilitation Community Service) to Palmerston North and Manawatū and extend service provision to Tararua and Horowhenua. Te Uru Whakamauora has finalised contracts with Home and Community Support Services (HCSS) providers to support service provision.

A 12-week post-acute community stroke rehabilitation pilot was completed end of August 2021 and is being evaluated to inform future service delivery. Clients with mild to moderate stroke were seen in their home and supported with a rehabilitation plan. The team supporting the client included a physiotherapist, occupational therapist and speech language therapist. Initial data review and feedback indicates positive outcomes for those clients involved in the programme.

2.2. Community capacity

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

The waitlist for Occupational Therapy non-urgent referrals has reduced from 464 to 433 and all areas have wait times greater than 12 months. This is due to continued high numbers of referrals, staff vacancies and complexity, such as complex wheelchair and seating, equipment and/or housing modifications. Occupational Therapy is 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 has included contracting private providers to assist the team with inpatient service provision and prioritising referral criteria for the community. A triage tool in the form of a risk matrix will be applied to all new referrals by a triage team, and the current waitlist reviewed to determine the level of ongoing need for Occupational Therapy services. Recruitment remains a challenge with reduced numbers of applicants for positions advertised.

Hand Therapy service provision has been impacted in September and October due to unplanned staff leave. Priority ACC and Ministry patients have been contracted out to the private providers. There is a balance of 60 patients on the waitlist, which is being reviewed to look at further options such as referring onto Arthritis Society for education sessions on equipment and community exercise classes.

The waitlist for Supportlinks has reduced from 391 to 352 during this reporting period. Supportlinks has successfully recruited to all vacancies with orientation and interRAI training still being completed. 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.

The health and disability sector is experiencing significant service coverage challenges due to an inability to recruit to existing vacancies for both registered nurses (RN) and community support workers. Locally, MidCentral District Health Board (MDHB) aged residential care (ARC) providers have reported issues with recruitment and covering rosters in times of sickness or vacancies. Mitigation plans that have been implemented in ARC include RNs working longer shifts, clinical managers working on the floor for up to two or three times a week and using senior care givers with an RN on call.

MDHB has received verbal notification from an aged care provider that they are in a consultation process with a proposal to close a residential care facility in the MDHB area. The consultation process and decision date is 29 November 2021. There will be a three-month notice period.

The Ministry has been working with the Ministry of Business, Innovation and Employment (MBIE) and Immigration New Zealand to support the continued flow of critical health workers into New Zealand and reduce pressure on our health and disability workforce. A number of Managed Isolation and Quarantine (MIQ) spaces are now allocated on a monthly basis.

Nationally, mandatory vaccination for frontline staff has seen home and community providers report a surge in resignations. It is estimated that the sector nationally could lose between three and four percent of its workforce. Technical Advisory Services (TAS) is working with providers to develop a nationally consistent approach to manage and mitigate the downstream consequences of the implementation of the mandatory Vaccination Order for the health workforce.

2.4. Equity

The Dietetics Service is negotiating clinic space in conjunction with iwi providers (through Pae Ora Paiaka Whaiora) to ensure improved access to Adult and Paediatric Dietetic services in Ōtaki, Horowhenua, Foxton.

2.5 Orthogeriatric Service

The Golden Hip Award is an annual award presented in both New Zealand and Australia by the Australia and New Zealand Hip Fracture Registry to the hospital with the best overall performance measured against the Hip Fracture Care Clinical Care Standard.

Successful hospitals are those that perform well across all the Clinical Indicators and excellently in a few areas. To achieve this requires all specialties involved in hip fracture care to be working well together as a team. This award was presented for the first time on 22 September 2021 and the top five performing hospitals in New Zealand were recognised, with Palmerston North Hospital

in third place. This is an excellent achievement, supporting the implementation of the orthogeriatric model of care and recognising the collaboration between Elder Health, Orthopaedics and the Emergency Department.

SERVICE	Te Uru Pā Harakeke – f ealthy Women Children and Youth
FOR PERIOD	August, September and October 2021
PREPARED BY	Sarah Fenwick, Operations Executive Dr Jeff Brown, Clinical Executive

1. PERFORMANCE OVERVIEW

The following table provides a summary of the progress to date against the equity outcome, sustainability, and other actions in the 2021/22 Annual Plan. 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	Reduce the number Ambulatory Sensitive Hospitalisation (ASH) events for Māori children	**A**	↓
A-E	Support whānau who do not engage with services	**G**	•
A-E	Complete Tūngia Te Ururua community engagement	**A**	•
A-E	Develop a regional first 1000 days strategy	**G**	•
A-E	Develop equity leadership across Te Uru Pā Harakeke	**G**	•
A	Support a sustainable midwifery workforce	**R**	•
A	All families are provided Sudden Unexpected death of Infant (SUDI) prevention information at a WCTO contact before 50 days of age.	**G**	•
A	Complete Ambulatory Sensitive Hospitalisation (ASH) project correlating data across primary and secondary care	**G**	•
A	Deliver district wide breast-feeding strategic plan	**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 measures that are not covered under the dashboard commentary.

The user of donor milk through the Whāngai Ora milk bank has significantly contributed to improving the exclusively breastfed rate on discharge from hospital, with 83 percent achievement in August 2021. However, the exclusively or fully breastfeeding rate at three months remains lower than the national average at 56 percent for the region, 49 percent for Māori and 38 percent for Pasifika. 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. The MDHB Breastfeeding Steering group is focusing on agreeing key actions that can have maximum impact on closing the breastfeeding equity gap.

Significant efforts have been made to improve the number of babies who live in smokefree households, with an interdisciplinary meeting held in August 2021 with all parties, including smoke quit services, maternity inpatient services, Lead Maternity Carers (LMCs), MDHB Community Midwifery Team, Maternity Quality and Safety Coordinators. Whilst the milestone has not been achieved, there has been significant improvement from 42.1 percent to 58.2 percent smokefree.

Approximately 220 consumer surveys and 25 provider surveys have been received as part of the Tūngia te Ururua, first 1000 days Tararua, Ōtaki and Horowhenua community engagement. An independent analysis of the data is underway, with some delay due to the analyst's COVID-19 duties. The full report will be shared with the Committee when available and will be fed back to the communities.

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 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.

Local recruitment continues with job offers for three new graduate applicants in process. Two external recruitment companies are engaged to recruit midwives internationally, however this has not been successful to date. MDHB participated in a national coordinated online final year midwifery student job expo on 20 September 2021. There is some interest in MDHB's return to practice midwifery programme and a return to practice open day was held on 6 November 2021.

Recruitment to the senior midwifery leadership positions is in progress, with an appointment made to the Secondary Care Midwifery Manager role. There has been little interest for the other roles to date and further advertising is underway. The Clinical Midwifery Coach has been appointed and will start in mid-January 2022, in time for the new graduates commencing.

As part of our commitment to Te Tiriti and equity of outcomes for Māori, recruitment has commenced for a Kaiaraara Tu Ora – Primary Midwife Specialist. This multidisciplinary role will work closely with Pae Ora Paiaka Whaiora Hauora Māori to enhance the experience and outcomes for wāhine and whānau Māori across the rohe.

Performance indicators

The overall rate for caesarean sections increased to 26.5 percent in September 2021. (Note clinical coding is not complete and will affect the overall result.) 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 4.9 percent and 6.3 percent respectively in September.

2. SIGNIFICANT MATTERS

2.1 MDHB Child Development Service (CDS) Referral Integration Project

The CDS referral integration project focuses on developing an integrated health and education referral pathway for children with additional needs, development delays or disabilities requiring multi-agency or specialist services across the MDHB region. Phase one of the project was completed in February 2021, with phase two now piloting the integrated model. The project is progressing well, with good engagement from education, child health and Child, Adolescent and Family Services (CAFS), along with other agencies including general practice. The software to facilitate the process of fast and efficient referral, data gathering and whānau ora outcomes approach is now under development. The working group will scenario test the software then pilot it in the New Year.

2.2 Child Development Service (CDS) Psychology

A change paper released in March 2021 proposed moving to a fully outsourced arrangement for neuropsychological assessments, currently performed by psychologists in the CDS. A decision document was released on 28 June 2021 confirming the decision to proceed with the model proposed. Work continues to progress this decision with staff and union partners.

2.3 Colposcopy Audit

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

2.4 First 1000 Days Strategy

MDHB has been successful in securing sustainability funds to develop a strategy for the first 1000 days for MidCentral 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. This project is expected to commence in January 2022.

2.5 Recruitment

A new Paediatrician commenced in September 2021 meaning the team is now fully staffed. The obstetric and gynaecology team has three full time equivalent Senior Medical Officer vacancies, with one new SMO commencing in November 2021. This risk is being mitigated as much as possible through locum cover.

2.6 Antenatal Clinic

The antenatal clinic is temporarily relocating to Te Papaioea Birthing Centre on 26 November 2021 to enable essential work as part of COVID-19 resilience preparation across the organisation. Work is continuing to confirm a permanent location for the clinic.

2.7 Ultrasound

The introduction of surcharges for obstetric ultrasound by local private providers is impacting on women accessing scans and causing significant pressure on the Medical Imaging Department and a risk for the Obstetric Service. A DHB and private provider meeting is planned for 12 November to agree a local plan that ensures best outcomes for wāhine and pēpi across the rohe.

2.8 **Francis Health**

Following a Request for Proposal (RFP) process, Francis Health was commissioned to support a programme of work to improve culture across the maternity service. The team leading this work have extensive experience working in culture, leadership and organisational development.

After individual interviews with a wide breadth of the team, a whole of service representative steering group was established, with Pae Ora Paiaka Whaiora Hauora Māori supporting Te Uru Pā Harakeke. Two workshops were held exploring how the service can thrive and staff can work cohesively, consistently and help others do the same across the service. A maternity culture survey was conducted in July 2021, with 41 percent of the team completing the survey. Face to face feedback sessions and culture workshops, planned for August 2021, were postponed and revised, due to COVID-19 Delta national alert level four, and held via Zoom in September 2021. The outcomes of these sessions were sent to staff in October 2021. A wide leadership group Zoom to identify how to progress this work further was held on 21 October 2021 with ongoing weekly huddles of the wider leadership team now occurring.

SERVICE	Te Uru Mātai Matengau – Cancer Screening, Treatment and Support
FOR PERIOD	August and September 2021
PREPARED BY	Sarah Fenwick, Operations Executive 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 measures that are not covered under the Directorate Dashboard commentary.

The Māori Cancer Research Strategy has now been aligned with Te Tiriti o Waitangi and the Wai 275 principles. It continues to have a focus on equity, early detection, prevention, and engaging with those who are not connected with primary care. Final review, feedback and sign off are expected before the end of the year.

The Bowel Screening Team is continuing their health promotion activities during the various COVID-19 Delta alert levels. All kanohi ki te kanohi events have been cancelled, and instead the emphasis has switched to social media, billboards, and posters. The Foxton (identified as a population with low participation numbers) focus campaign, using digital and print media has been able to successfully continue. The new Māori Bowel Screening Promoter is now in post and has strong connections within the Highbury/ Awapuni area and has several avenues for promotion planned.

Breast Screen Coast to Coast (BSCC) continues to work towards ensuring that all wāhine Māori are offered support to screening services. This offer is included in letters, texts, and verbal offers of support are also being encouraged. The koha initiative to encourage wāhine Māori to rescreen is proving successful with over 75 percent of wāhine who accept the koha attending their screening appointment.

Each profession within Te Uru Mātai Matengau continues to contribute to the development of a Cancer Workforce Strategy. This piece of work will be further strengthened with the new and refreshed senior leadership roles that have been adopted from the recent leadership change proposal.

As the Regional Radiation Treatment Outreach project progresses, Te Aho O Te Kahu (Cancer Control Agency) has now been assigned leadership of this work by the Ministry of Health (the Ministry). MidCentral DHB (MDHB) will continue to contribute to the project as subject matter experts and as the service provider.

The Tumour Stream Advisory Groups continue to review all Faster Cancer Treatment pathway breaches to identify barriers to timely access to care and treatment. To date there has been no over-representation of Māori in the breaches, however the tumour streams continue to closely monitor.

The outreach chemotherapy development at Whanganui Hospital is behind schedule. Te Aho O Te Kahu (Cancer Control Agency) is providing programme management support and a meeting will be scheduled between MDHB and Whanganui DHB soon.

Work to refresh Te Korowai O Rongo, the District Palliative Care Strategic Plan has been put on hold due to the recent escalating COVID-19 Delta alert levels and subsequent work on the COVID-19 Resilience Plan. It is hoped that this refresh will be restarted in the coming months.

2. SIGNIFICANT MATTERS

2.1. New Linear Accelerator

The replacement of the third linear accelerator is now complete. A blessing ceremony for the new linear accelerator took place on 21 September 2021, with the first patient treated the same afternoon. Radiation therapy staff have now returned to normal working hours, with shift work ceasing on 24 September 2021. There were no delays to radiation treatment courses through this replacement programme. The Radiation Therapy tTeam were recently presented with the MDHB Allied Health Award, Te Ngākau Tapatahi, Award for Outstanding Team due to their hard work through this time, which coincided with the COVID-19 Delta Alert Level 4 lockdown. A formal opening will occur when COVID-19 levels permit.

2.2. Medical Workforce

The Regional Cancer Treatment Service (RCTS) continues to experience vacancies at Senior Medical Officer (SMO) and Medical Officer of Specialist Scale (MOSS) level. One new Radiation Oncologist has commenced in post however a further Radiation Oncologist appointment has proved unsuccessful due to visa difficulties. The current SMOs in Radiation Oncology continue to proactively manage the workload at reduced capacity and this approach continues to mitigate any risk of delay to patients' wait times while active recruitment continues.

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, an existing SMO vacancy and another SMO commencing maternity leave in early 2022. A MOSS is now in place at

Taranaki DHB and interviews have recently been completed for a new Medical Oncology SMO in Hawke's Bay, however they have a MOSS vacancy that is proving difficult to recruit to. There is still concern regarding maternity leave cover. Active recruitment continues to fill these positions.

2.3. BreastScreen Coast to Coast (BSCC)

Radiologist support has been strengthened with the end of sabbatical leave in August however the mitigation plan in place to support current radiologists continues with outsourced provision. A permanent outsourcing solution to ensure the stability of BSCC is under negotiation.

2.4. Oncology Outpatients

The permanent position of Oncology Ambulatory Care Charge Nurse has not yet been successfully recruited to. However a secondment to this position for six months has been successful, with the role filled from 1 November 2021. This secondment will help progress the contemporary model of ambulatory oncology care that is being implemented to meet patients' needs and enable clinicians to work at top of scope. The permanent position will be readvertised early next year.

2.5. Mosaiq as a Service

The Mosaiq as a Service business case to move Mosaiq from the current MDHB Information Technology servers to a cloud-based solution is on track to be presented to the Finance, Risk and Audit Committee on 30 November 2021 and the Board on 14 December 2021. Once approved, implementation is expected to take approximately four months for the installation to the cloud, with the estimated completion of this work scheduled for April 2022.

2.6. BreastScreen Coast to Coast Audit

The action plan to address the six low to moderate actions received from the previous month's visit by the Designated Auditing Agency, on behalf of the National Screening Unit has now been completed. Two of the six actions have now been implemented and the remaining four are all in progress.

2.7. Ward 23 Stem Cell Transplants from Auckland

Due to the significant waiting times for stem cell transplants in the Auckland region, Te Aho o Te Kahu (Cancer Control Agency) is facilitating Auckland region patients to be treated at other cancer centres in New Zealand. MDHB is one of the cancer centres accepting these patients. A clear framework for patient transfer and treatment is in place with associated COVID-19 screening and testing processes. It is not expected to cause any increase in waiting times for MDHB patients requiring stem cell transplants.

2.8. **Leadership Change Consultation**

A change proposal to strengthen leadership across Te Uru Mātai Matengau was released in July 2021. Significant feedback was received, that clarified that further consultation was required, with the final decision paper released on 1 October 2021. Recruitment is now in process for the Operations Lead and Associate Director of Nursing roles.

SERVICE	Te Uru Kiriora – Primary, Public and Community Health
FOR PERIOD	1 July to 30 September 2021
PREPARED BY	Deborah Davies, Operations Executive Kelvin Billinghurst, Clinical Executive

1. PERFORMANCE OVERVIEW

The following table provides a summary of the progress to date against the equity outcome, sustainability and other actions in the 2021/22 Annual Plan. Te Uru Kiriora's leadership team have continued to respond to Ministry of Health's (the Ministry) direction for COVID-19 community surveillance testing, the ongoing COVID-19 vaccination programme and continue to undertake 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	A	•
A-E-S	Improve management of Long-Term Conditions (Chronic Pain, Diabetes and Respiratory Care) with a focus on improved outcomes for Māori	A	•
A	Drive effective integrated Locality based care delivery through locality team prototype development and workforce planning	G	↑
A	Strengthen community based Acute and Urgent Demand model of care and delivery	G	•
A	Improve patient health care outcomes and experience in primary care and community settings through scaling of Health Care Home	G	•

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

Plan Legend	A	Annual Plan	S	Sustainability Plan	E	Equity Indicator

1.1. Key progress commentary

1.1.1 Improve management of long term conditions (LTCs)

Further workforce issues have impacted THINK Hauora's and MidCentral District Health Board's (MDHB) ability to progress the integrated locality-based service model development work in the Horowhenua locality during this quarter. The focus has been on supporting the general practices who had a short period of reduced General Practitioner (GP) cover (due to unexpected sickness) with transdisciplinary team members and remote assistance provided by several Palmerston North based GPs. Discussions are underway with the Alcohol and Other Drug (AOD) service to assist in some key areas. Part of the ongoing modelling has included identifying key support service providers in each locality to target the unenrolled population and leveraging off opportunities from vaccination campaigns to offer LTC screening.

Despite workforce pressures during the quarter, THINK Hauora continued to explore innovative LTC service delivery, and has several pilots planned for implementation late Quarter Two/early Quarter Three. These include a shared appointment self-management pilot for patients newly diagnosed with Type 2 diabetes with integrated follow up support group, and assisting a practice with developing an identification and intervention programme for patients identified as having pre-diabetes.

Concurrent to this is work commissioned by the DHB regarding the Horowhenua Clinical Services Plan currently being undertaken by Sapere. This is behind timeframes and will extend into early 2022. Additionally, the LTC service specifications are currently being reviewed to align with the commissioning for outcomes framework.

Community based integrated care for whānau with heart failure continues in five sites across the region. The Nurse Practitioner Cardiology aligned with the newest area Horowhenua, is undertaking shared collaborative clinics, and providing education, support and mentorship to the Primary Health Care (PHC) teams. Over the recent lockdown periods, this support continued virtually.

The transition of care programme for post-discharge management of people with Chronic Obstructive Pulmonary Disease (COPD) continues from both the Emergency Department (ED) and inpatient settings. Volumes through this pathway remain low. A Respiratory Syncytial Virus (RSV) epidemic followed by a winter with comparatively little 'influenza-like illness' and then lockdown periods during August and September 2021 has combined to substantially reduce the numbers of COPD patients presenting to ED.

2. SIGNIFICANT MATTERS

2.1 COVID-19 vaccination programme

The COVID-19 vaccination programme is adapting in the final quarter of delivery, in response to both reducing public demand, and in ensuring efforts are focussed on areas that have lower coverage. The operational programme has developed a broader reach

into communities and has transitioned from primarily venue-based delivery to neighbourhood delivery. The distributed model with multiple vaccination providers – General Practice Teams (GPTs), THINK Hauora, iwi providers, independent vaccinators and pharmacies – has made this possible in terms of reaching across the rohe. The programme is using detailed locality and ethnicity based data and Māori insights provided by Te Tihi o Ruahine to inform the targeted delivery. This provides a working model of care for future delivery of healthcare. At time of writing, the vaccination rates for first dose are total population at 87 percent, Māori at 73 percent and Pasifika at 85 percent. For second doses they are at 74 percent total, Māori at 54 percent and Pasifika at 67 percent, with small variations in locality coverage.

An additional push to this model is providing the opportunity for one-to-one discussion with clinicians about vaccine concerns. An example of this is a pop-up clinic that has been established in the Plaza Palmerston North. This is proving successful in reaching populations that are younger and a higher percentage of Māori and Pasifika, which is great to see. Negotiations are underway to have the team in the Plaza through to Christmas. The team is also responding to requests to have kanohi to kanohi korero with whānau. In the past month, the Clinical and Operations Executives have engaged with groups such as the Rotary Club in Palmerston North, and with whānau in the Manawatū and Tararua. Queries regarding multiple COVID-19 related issues are being received and responded to across the broader team(s).

The Super Saturday event on 16 October 2021 provided an ideal opportunity to further engage whānau and increase coverage, particularly for first doses. With a significant collaborative effort, the collective teams provided 29 different vaccination locations and opportunities spanning from Ōtaki beach to Dannevirke. There are usually around six vaccination sites open on a Saturday. The team set the weekly target of 15,000 and surpassed this with over 16,000 delivered – with over 5000 on Saturday alone. The teams were supported by a range of community volunteers and initiatives providing entertainment, kai and spot prizes. There was a definite 'festival' atmosphere at the localities. This proved well timed to reinforce the campaign and drive up vaccination rates. This has allowed for inter-sectoral working relationships to deepen with significant further connections made that will provide an ongoing network to support for the programme. The Māori Mobile Team provided a responsive vaccination schedule that ensured iwi had sufficient opportunity to engage for vaccination.

Discussions have begun with the Ministry and local stakeholders regarding the transition of the programme. It has been indicated the programme will continue in a different form in 2022 and is likely to include boosters and the vaccination of 5 to 12-year-olds. The Ministry is also driving a broader strategic discussion regarding an integrated national immunisation programme. The current primary care-based providers have the opportunity to grow their current contribution to the programme (general practice, community pharmacy, iwi and Māori providers).

2.2 COVID-19 case investigation and contact management

With increasing numbers of daily COVID-19 cases, MDHB Public Health staff have continued to work as part of the virtual team of Public Health Units (PHUs) supporting colleagues at the Auckland Regional Public Health Service. For several weeks MDHB's PHU was the single point of contact for all supermarket exposure events. This has now shifted to a focus on case investigation work.

The service was instructed to stop all but essential business as usual in mid-October and focus on the COVID-19 response. The teams are operating under the Auckland protocols which are constantly changing to manage their evolving suppression approach. Should cases occur in other locales, including MDHB rohe, the focus will still be looking to eliminate COVID-19.

The PHU has been gradually growing capacity to handle multiple cases. Many of the cases are highly complex, time consuming, hard to track down and with a lower level of compliance. While the service is utilising most of the PHU staff, activity progresses to support an ongoing broader DHB staff response. This will allow an increase in capacity of the case numbers that can be allocated.

New response models centred around manaaki are being developed by the Pae Ora team in Auckland in order to facilitate cooperation amongst some hard to reach communities. MDHB will almost certainly experience similar requirements once the outbreak spreads to this region. Local planning is underway to ensure that the DHB is ready for this eventuality.

2.3 Supported isolation and quarantine implementation

The COVID-19 Community Supported Isolation and Quarantine (SIQ) programme is being developed to provide wrap-around services to support community cases and close contacts to appropriately self-isolate. Isolation may be in their home environment, or in alternative facilities for cases and close contacts who are unable or unwilling to isolate in their own home.

MDHB's SIQ Coordinator has been working on MDHB's Operational Plan, which is nearing completion. This is a rapidly changing environment, with key policy changes taking place. Strong networks have been forged with local iwi and the welfare sector.

Five facilities have been secured to accommodate five whānau bubbles and a number of further facilities have been identified as potential accommodation sites. 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.

In early October 2021 the DHB was notified of an Auckland truck driver who tested positive to COVID-19 and was in Palmerston North at the time that he was notified. He was accommodated in one of the hospital flats, admitted to hospital as his symptoms worsened and then discharged back to the flat. He has now been released from isolation and has returned home.

Where capacity allows, local COVID-19 cases would likely be transported to the closest Managed Isolation and Quarantine (MIQ) site in Wellington. Should the MIQ capacity in Wellington be reached, then cases may need to be accommodated within one of the local SIQ facilities.

2.4 COVID-19 surge testing

Demand for symptomatic testing has remained higher for longer following the last surge. It is thought there are several contributing factors to this. There appears to be a higher level of anxiety in the community as COVID-19 moves down the country. An increasing number of businesses are requesting tests from employees despite not meeting current criteria. Lastly there are increased volumes of mobile workers who require tests for their general business activities.

Te Uru Kiriora linked with THINK Hauora to ensure increased testing capacity was provided through GPTs across the rohe during the surge and this capacity remains in place.

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

Work is underway with the Ministry to implement electronic ordering of laboratory tests. This will reduce the potential gaps in the ordering pathway and will also reduce the administrative load of test ordering.

2.5 COVID care in the community

Detailed planning is well underway to identify the care in the community. The Ministry has released the Operational Guidelines that will inform and support this process. Generally, this involves the following:

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

Key primary care roles will encompass being the first point of contact for clinical management, leading initial assessments, supporting the identification of social and welfare services, ongoing clinical management, and the core provision of telehealth services. A primary and community care commissioning model is progressing at pace and is expected to include equity loading and adherence to the agreed clinical model of care as foundational. This is undergoing final peer review process nationally.

2.6 Update on Human Papillomavirus (HPV) Self Testing

On 9 May 2021 the Government announced that it will be developing and rolling out a new HPV self-testing kit. HPV is the cause of 99 percent of cervical cancer. In October 2021 an update from the National Cervical Screening Programme (NCSP) detailed that the programme is moving to primary HPV screening from July 2023 – with the option to self-test with the person either taking the swab themselves at the clinic, or having it taken by a clinician. The change to HPV primary screening is an exciting prospect for all wāhine. The NCSP has sought feedback on many aspects of the new programme before implementation, in order to achieve best possible results in terms of equity and quality.

A safe transition to the new screening test requires changes across the programme, which will take time. As well as developing a fit-for-purpose IT system (NCSP Register); clinical guidelines, workforce training/education and referral pathways will be impacted.

Initial funding is being used to develop key requirements for the design of the NCSP ICT system and programme changes, and for a comprehensive communications strategy. Work is underway on timelines and the approach, and more detail will be provided in the next sector update. The current cervical screening programme approach is clinically safe and will continue to be so as the programme transitions. Work on encouraging all eligible participants to continue to have cervical screening through the current programme is paramount as cervical changes can occur quickly.

The NCSP recently completed a public consultation on the revised HPV primary screening clinical pathway to introduce self-testing. The consultation closed on 8 June 2021 and the feedback received will inform the implementation approach and clinical pathway. A document outlining the findings will be released by the NCSP in October on the NCSP website.

2.7 Update on MidCentral DHB Alcohol Position Statement

To support the implementation of the MDHB Nutrition Policy, an Alcohol Position Statement is submitted as a separate paper for the Committee's endorsement. This has been tabled with Manawhenua Hauora who supported the Statement.

There remain significant ongoing challenges with accessibility to alcohol across the rohe. There has been strong conversation regarding public health's role in advocacy and work is being undertaken to determine the current position with this.

Performance reporting

23 November 2021

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

For:

	Approval
X	Endorsement
	Noting

Key questions the Committee should consider in reviewing this paper:

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

To	Health and Disability Advisory Committee
Author	Michelle Riwai, General Manager, Enable New Zealand
Endorsed by	Kathryn Cook, Chief Executive
Date	23 November 2021
Subject	**Enable New Zealand Report**

RECOMMENDATION

It is recommended that the Committee:

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

Strategic Alignment

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

1. PURPOSE

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

2. PERFORMANCE OVERVIEW

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

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

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

2.1. Performance indicators

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

3. SIGNIFICANT MATTERS

3.1. New contracts

ACC Contract

Enable was notified in September that we were successful in securing the Managed Rehabilitation Equipment Services (MRES) contract with the Accident Compensation Corporation (ACC). This high-value contract has a 10-year tenure (five + three + two years). Enable and ACC have been working in partnership over the past eight weeks to ensure the transition of this service, from the incumbent to Enable, is as streamlined as possible.

Feedback already received from ACC staff has been very positive with comments such as *"processes are simple and straight forward"* and *"staff should have no trouble picking it up*, *it should save staff time".* Overall, the feedback has been well received by the project team who have put in an extraordinary effort to stand up the full service, including a bespoke technology solution, in a very short time. The service will go live on 15 November 2021.

Short-Term Loan Services

Enable has service contracts commencing with Taranaki District Health Board (from 1 December 2021) and Whanganui District Health Board (from 1 February 2022) to provide access to Enable's short-term equipment loan service and the inventory control software service (ZOHO app) that allows District Health Boards to manage, track and recall their short-term loan equipment. This allows patients to be discharged from hospital in a timely manner and ensures efficient use of their equipment pools.

3.2. **Community update**

EASIE Living Retail and Demonstration Centre

The EASIE Living Retail and Demonstration Centre operated for much of this reporting period within COVID-19 restrictions. As such, the Sensory Room and all workshops have been postponed until restrictions ease.

Through Alert Levels 3 and 4, the EASIE Living team were available instore as an essential service, to process any urgent equipment or disability supports that enable people, many of whom are vulnerable, to continue to live independently and safely in their own home.

The EASIE Living team also proactively called customers who were regular visitors to the store for necessary products, to inform them of how the service would operate through lockdown and to process urgent orders. Courier fees were waived through this period to ensure that cost was not a barrier to accessing the products that customers needed.

The Enable Mobile Outreach Manager submitted 11 Lottery applications for scooters that will increase recipients' access to their communities. In this reporting period, seven applications have been successful, with the remainder being reviewed in late December.

Once Alert Levels allow, workshops planned to resume in the EASIE Living Retail and Demonstration Centre are:

- Home safety and falls presentation
- Lynn Kirkland – writing your memoirs
- Alzheimer's Society
- Community Law – Power of Attorney and Welfare Guardianship
- Carer Support
- Continence Workshop
- St John's (service information, alarm monitoring).

Firstport

COVID-19 vaccination campaign

Enable was contracted and funded, by the Ministry of Health (the Ministry) to run a social media campaign that sought to encourage disabled New Zealanders to get their COVID-19 vaccination. The campaign consisted of a series of five videos, primarily featuring people from Aotearoa's disabled community sharing their reasons for getting vaccinated and ran through Firstport's Facebook page from 29 September to 1 November. The main aim of the campaign was to reach as many people in the disabled community as possible.

Across the five videos 861,292 people were reached; 1,339,385 impressions were generated; and 774,300 video views were received. In addition, during the campaign the Firstport website received 3559 unique visits to its page about the COVID-19 vaccine.

Market research

During this reporting period, Enable engaged the market research agency, Perceptive, to complete market research on Enable's Firstport website. Perceptive set out to find out how well known Firstport was to the disabled community and to find out what information and support they would like to receive through it. Overall, the research has found, while specific information needs may vary, interest and need was consistent across people with disabilities and caregivers of both children and adults with disabilities. The Firstport website is currently in an excellent position in terms of addressing these needs and the 'gaps' in the current Firstport offer are relatively few.

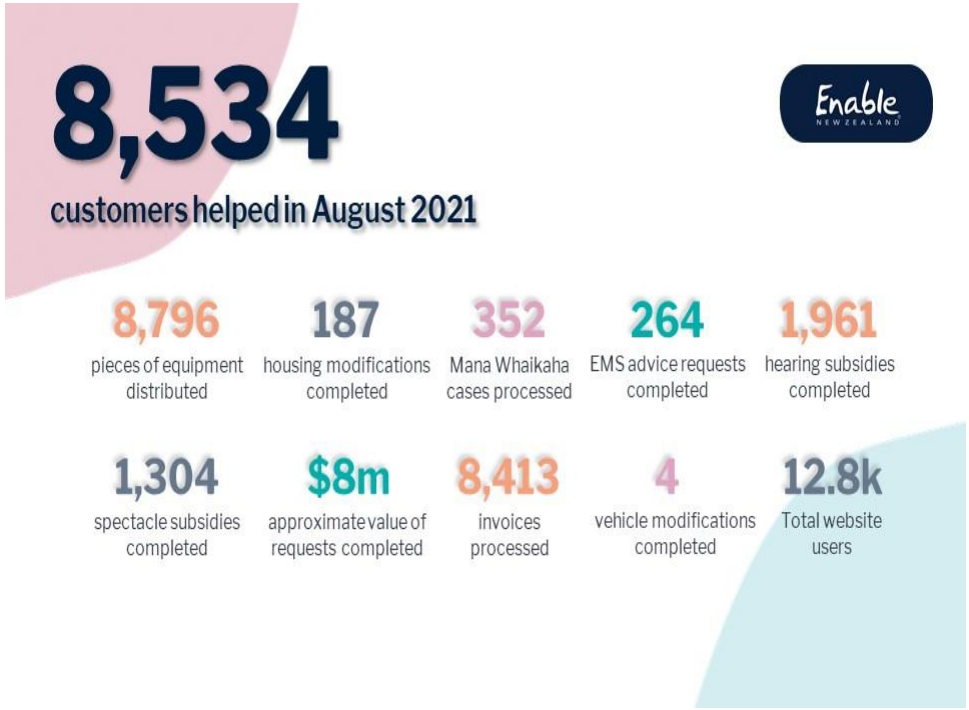
Following the final research report, Enable will look to develop a plan to further grow Firstport and fill some of the gaps identified. A comprehensive marketing and communication plan will also be developed to raise awareness of Firstport in Aotearoa's disabled community.

Appendix One: Performance Indicators

This report relates to the reporting period from 1 August to 30 September 2021. Please note that data for October 2021 was unavailable at the time of writing this report and will be included in the next reporting period.

National volumes

The following chart is a high-level snapshot of the volume of work Enable has achieved throughout August and September 2021.



Regional results

August saw a high volume of equipment requests, reflecting a nationwide trend of increased volumes in the supply of simple and complex equipment. The significant reduction in September is due to COVID-19 restrictions affecting assessors being able to do assessments, resulting in high waitlist backlogs that now require actioning.

The increase between August and September in clients requiring spectacles is likely due to COVID-19 restrictions easing towards the end of this period. There is a significant increase in high-level spectacle requests from clients which is impacting on service cost. With support from the Ministry, Enable is carrying out further investigation into what is causing this increase.

Other lines in the table below reflect similar volumes to previous months.

Table 1: Volume/demand of customers accessing Enable New Zealand within MDHB region for August and September 2021

Client Volumes by Service	MDHB Region August	MDHB Region September
Equipment	428	280
Hearing	129	117
Housing	11	16
Spectacles	76	130

Performance indicators against contractual agreements

The Key Performance Indicator (KPI) targets continue to track above for Band 1 equipment and Complex Housing Modifications, although due to COVID-19 restrictions and supply chain delays, service numbers were slightly down compared to previous months.

With COVID-19 restrictions having eased, Enable is working closely with contractors to prioritise urgent work and keeping clients updated with changes to work schedules.

Availability of contractors and supply chain issues present challenges within the construction and logistics industries and will continue to impact on the completion of housing modifications and equipment refurbishments. For September, refurbishments have fallen below 30 percent for the first time in several months, due to delays in the flow of collections and returns and subsequent impact on reissuing timelines. Building material shortages have contributed to the decrease in the number of grabrail installations.

Enable is in regular contact with ACC and the Ministry, who understand the challenges in the current environment and the potential impact on KPI service outcomes, that are out of the control of Enable.

Table 2: Performance against contractual measures

Key Performance Indicator (KPI)/Measure	Target	Achieved August	Achieved September
Percentage of Band 1 equipment delivered within five working days	90%	96.1%	96.1%
Percentage of Complex Housing Modifications completed within 120 working days (Ministry of Health)	60%	85.3%	79.8%
Percentage of Equipment provided to Service Users supplied from refurbished stock (Ministry of Health)	35%	30.9%	27.4%
Grabrails Installation Non-Urgent (ACC) installed within five days	95%	93%	65%

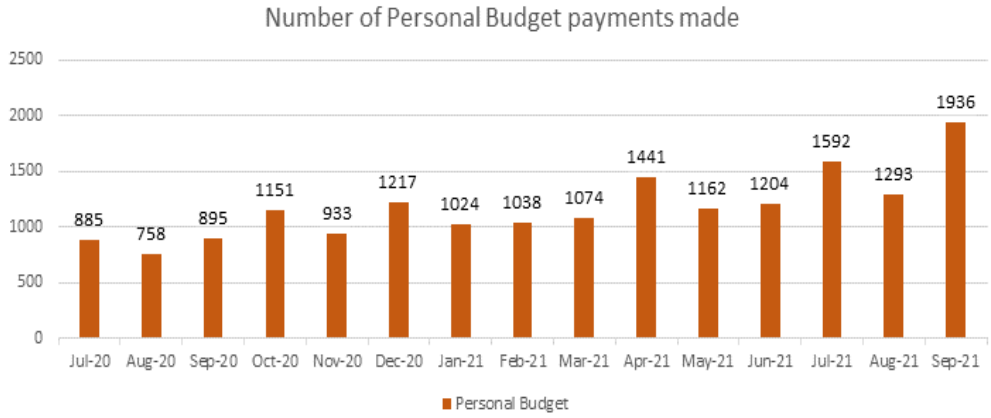
Mana Whaikaha

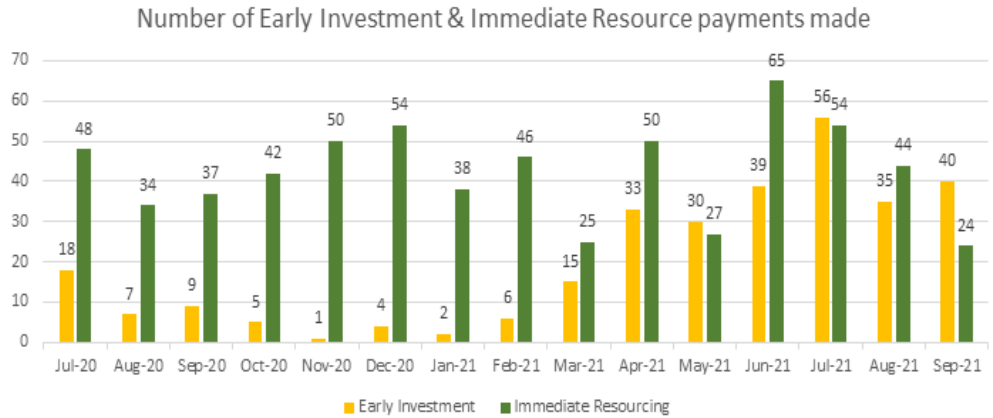
All but one of the measures across the Mana Whaikaha Prototype have increased. The total number of individuals under the age of 21 years has decreased from 1001 to 917, because of a system recalculation update of ages.

Enable continues to support the Ministry to embed its new model of service delivery.

Table 3: Volume/demand for Mana Whaikaha services

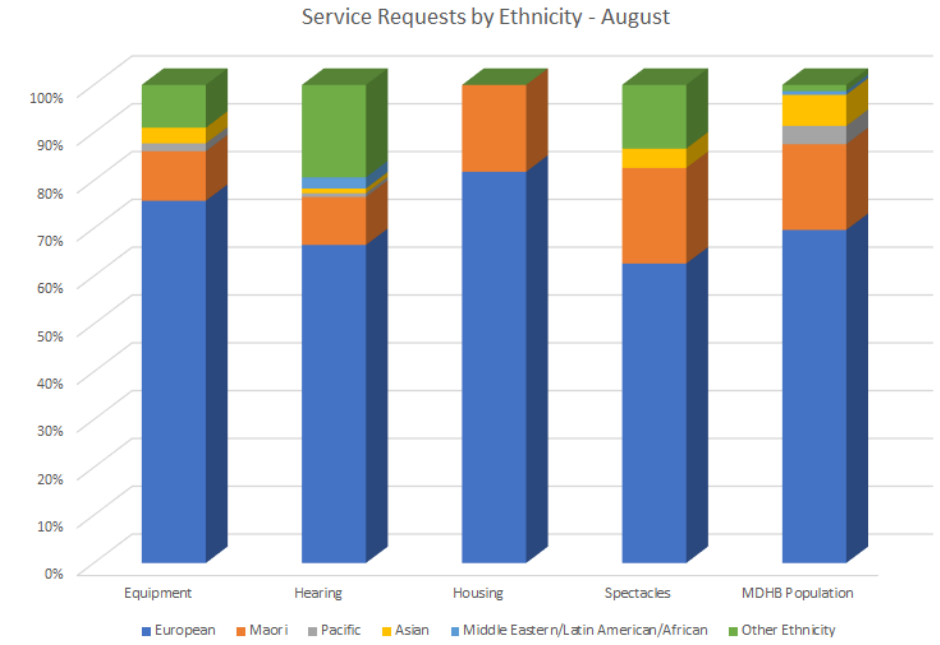
Mana Whaikaha Regional Results	Launch of Prototype to September 2021
Total disabled people active in the database	2449
People allocated to a Ministry of Health Connector (and are still allocated to a Ministry of Health Connector)	1370
People allocated to their own/Independent Connector	184
People in queue (awaiting allocation to a connector)	265
Total number of individuals under the age of 21 years	917

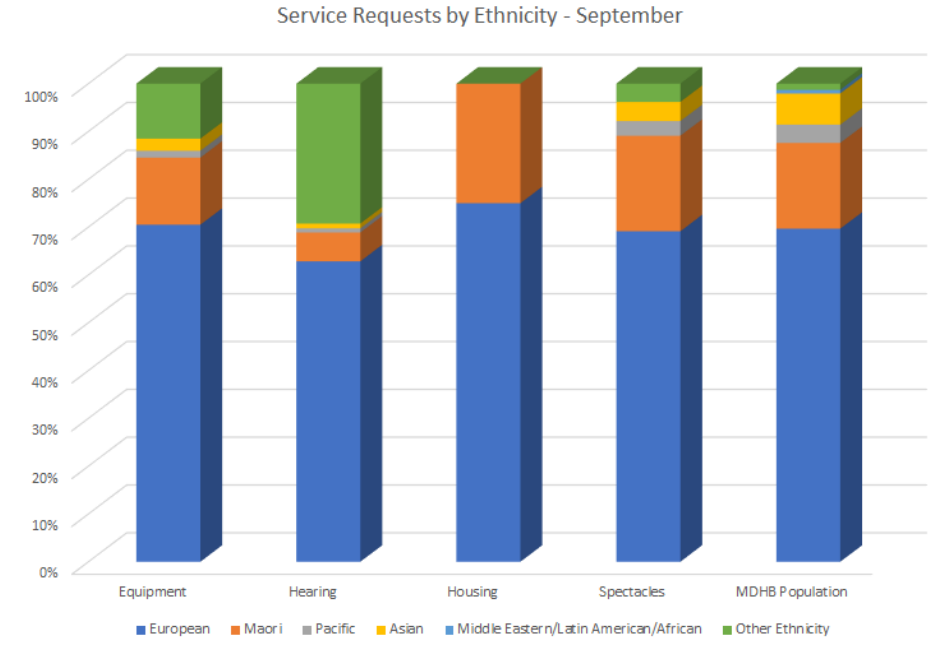




Ethnicity data

The following charts represent the ethnicity data for the MDHB region for the months of August and September 2021.





For:

	Approval
	Endorsement
X	Noting

Key questions the Committee should consider in reviewing this paper:

- Is the current work focus for Pae Ora meeting the expectations of HDAC?
- Are the Annual Plan actions in the dashboard performing to the Committee's expectations?

To	Health and Disability Advisory Committee
Authors	Marcy Williams, Senior Māori Workforce Development Manager Tracee Te Huia, General Manager, Māori Health
Endorsed by	Kathryn Cook, Chief Executive
Date	4 November 2021
Subject	**Pae Ora Paiaka Whaiora Māori Health Directorate report**

RECOMMENDATION

It is recommended that the Committee:

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

Strategic Alignment

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

1. OVERVIEW

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

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

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

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

2. PURPOSE

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

3. SUMMARY

In particular, this report provides the Committee with an update on the following:

- Te Ara Angitū equity dashboard reporting
- Equity funding for iwi and Maori providers
- Te Puni Kokiri funding for the COVID-19 Māori response
- Combined Board work programme
- Kaimahi Ora Whānau Ora implementation
- Regional Interagency Network
- First 1000 days project.

4. DRIVING THE HEALTH SYSTEM TO REDUCE MĀORI EQUITY

Te Ara Angitū reporting is consistent and progressing well, with most indicator population sets now reporting against their action plans. The partnerships between Directorates and Pae Ora on the planning and implementation is a successful model for improving equity. One pleasing example is that prevalence of smoking by Māori women has reduced to 20 percent from 36.5 percent compared to the previous quarter three. This can be attributed to two specific programmes of work being delivered by TOAM (Te Ohu Auahi Mutunga, smoking cessation service): the 'Hapū Mama Stop Smoking' initiative as well as the six week 'Wahine Māori Programme' targeted at Māori hapū women aged between 18 and 30 years old, developed using a co-design approach. Reporting on the identified indicators will continue through to 30 June 2022, where some good traction on performance for Māori is expected.

The equity investment into iwi and Māori providers is now in place and recruitment for new positions commenced on 1 October. Providers have reported their appreciation for the additional resource into high need areas such as community nursing and population health services. More capacity during the COVID-19 vaccination rollout is ensuring greater coverage and longer hours for delivery.

The Ministry of Health (the Ministry) has been allocated $36 million from Te Puni Kōkiri to bolster the Māori COVID-19 response. The majority of the funding will be allocated to iwi and Māori health providers using a streamlined contestable process. The purpose of the funding is to ensure equitable health outcomes for Māori in relation to COVID-19, and equitable uptake of the vaccination amongst Māori. Demonstration of clear partnerships between iwi Māori providers, the DHB and PHO are required to attain any funding. The priority groups for this funding include:

- rangatahi
- whānau without permanent housing
- tangata Whaikaha
- whānau in remote and rural locations
- whānau not well connected to health services

5. ENABLING IWI AND MĀORI TO REACH PAE ORA

A comprehensive six-month update on the combined Board work programme was submitted to the Board for its November meeting. It demonstrates good traction on the agreed focus areas with strong intention by both parties to ensure the Māori population for this district are well serviced by contracted providers and hospital. Funding has been provided to four rongoa services for the district with one provider discussing the opportunity for these services being delivered into Ward 21 for those patients. This is a breakthrough for traditional healing services largely operating unfunded and has been welcomed particularly by Rangitāne o Manawatū and He Puna Hauora.

6. GROWING THE MĀORI WORKFORCE ACROSS THE SECTOR

The Senior Māori Workforce Development Manager was appointed in August. She has reviewed the Kaimahi Ora Whānau Ora 2017-2022 strategy and refreshed the implementation plan. The review encompassed a preliminary quantitative and qualitative assessment, alongside a refresh and co-designed approach. The implementation plan approved by the Organisational Leadership Team (OLT) and Manawhenua Hauora is managed using project methodology and will be monitored by the governance group currently being established. Progress to date includes the following:

- Fourteen of the 16 Māori nurses who applied through the Nurse Entry to Practice (NETP) process gained permanent roles into MDHB, with the remaining two followed up on why they did not get positions.
- Following the NETP process and observations undertaken by the Māori Workforce Manager, a recruitment review was written for People and Culture and the hiring managers. Recommendations have been provided to improve the process and ensure recruitment processes into the organisation are more culturally responsive.
- Seven of the 21 PGY1 doctors who have been registered for next year's DHBs PGY1 programme are Māori, with three of these having local iwi whakapapa. We are seeking other medical placements with one elective placement in medical administration identified for Quarter Two. This placement will be managed by our Chief Medical Officer Dr Kelvin Billinghurst.
- Collection of Māori staff data has been extracted to assist being able to contact them directly on workforce development opportunities. Any engagement will be through hiring managers to ensure buy in and support for growth pathways identified.
- Ten Treaty training courses have been confirmed with Jen Margaret for up to 55 attendees for the next year. More sessions will support the teams who have not been able to attend to date.
- Māori staff working in the COVID-19 programme whose contracts end in December 2021, are being supported to identify job opportunities. Assistance will be provided for them to apply for other jobs that may suit their skill sets. The intention is to retain every Māori staff member who is on a fixed term contract within the COVID-19 programme.
- MDHB has been working alongside iwi and Māori providers to establish COVID-19 Vaccinator Working Under Supervision (CVWUS) positions to increase vaccinator capacity across the DHB region. The Māori Nurse Educator based in Te Uru Kiriora (Primary Health) has led this process, working alongside the Immunisation Advisory Centre (IMAC). Approximately 25 CVWUS have been trained to date, operating within iwi and Māori providers in Horowhenua, Palmerston North and Dannevirke. The support provided through this work includes supporting entrance into this career pathway, upskilling the workforce in mandatory training, and liaising and advocating for iwi with the Ministry and IMAC. The focus is on reducing the barriers for Māori kaimahi considering entering the clinical health space. This work will continue with the development of a pilot programme to support the recruitment/transition and retention of the non-regulated vaccinator workforce across localities. This work has recently been showcased by University of Otago NRV workforce research. The Māori Nurse Educator has been invited to participate in the COVID-19 Vaccinator Working Under Supervision Working Group to further develop the non-regulated vaccinator pathway.

7. TACKLING DETERMINANT FACTORS THAT IMPACT ON MĀORI COMMUNITIES

The Regional Interagency Network is well underway with its planning against the priorities of Youth/Rangatahi, Mental health and Addictions and Housing. In addition, the terms of reference for the RIN has recently been refreshed at the request of the group to better align with its priorities and with the Regional Public Service Leaders group. Ordinarily the Regional Commissioner for MSD for each region chairs the RPSL. Following Katie Bresnahan's resignation as RC for MSD we are awaiting another appointment by the Minister.

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

To	Health and Disability Advisory Committee
Authors	Susan Murphy, Manager Quality Assurance Mariette Classen, Manager Consumer Experience
Endorsed by	Judith Catherwood, General Manager, Quality and Innovation
Date	2 November 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 the MidCentral District Health Board's (MDHB) strategic imperative of committing to quality and excellence in everything we do.

1. PURPOSE

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

2. BACKGROUND

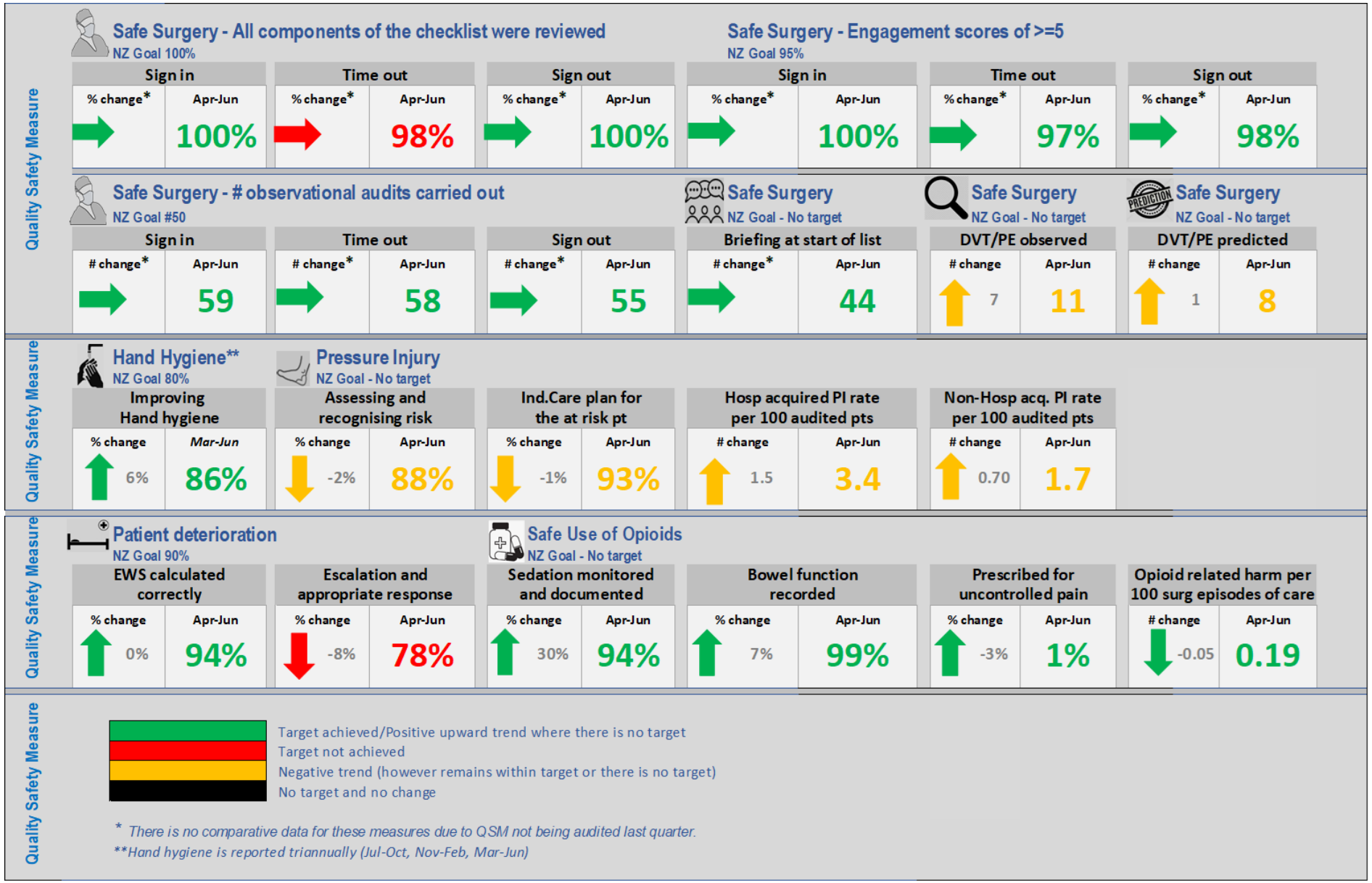
MidCentral District Health Board (MDHB) developed its Clinical Governance Framework (The Quality Agenda) in 2018. This sets the framework through which quality, safety and clinical risk is managed, embracing a shared governance model. A strong clinical governance system requires a robust quality and safety measurement system with trend-based analysis. It also requires 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. The revised MDHB clinical governance structure has been implemented. An Improvement Analyst is being recruited to advance the reporting of clinical data and improvement analytics.

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

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

3. QUALITY AND SAFETY MARKERS DASHBOARD (HQSC LATEST DATA APRIL 2021 TO JUNE 2021)



3.1. Quality and Safety Markers Background

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

3.1.1. Quality and Safety Marker Performance

MDHB has and continues to perform well in all QSMs.

The Safe Surgery QSM measures the level of teamwork and communication relating to the paperless surgical safety checklist. The surgical teams continue to achieve the target with the sign in and sign out processes. The time out component of the process is showing consistent improved performance, with all markers above 97 percent. Although below the national target of 100 percent, they are the same as the national average.

The Patient Deterioration QSM measures patients with cardiopulmonary arrests or rapid response escalations. Early Warning Scores (EWS) calculated correctly, shows no change. This QSM remains at 94 percent, which is above the national average of 90 percent.

The escalation and appropriate response marker measures whether an escalation of care was triggered, and the patient received the appropriate response to that escalation. Performance in this latest quarter has deteriorated to 78 percent. This is a decline from the previous quarter of 86 percent, but still above the national average of 74 percent. The percentage difference equates to two patients who were responded to outside of the timeframes required in MDHB guidelines due to hospital capacity at the time. No further harm eventuated due to this delay in response. The Deteriorating Patient Governance Group is currently scoping a Patient at Risk service that could address early deterioration identified in patients and alleviate the number of escalated response calls and Medical Emergency Team (MET) calls.

The Hand Hygiene QSM measures the five moments of hand hygiene (before touching a patient, before clean/aseptic procedures, after body fluid exposure/risk, after touching a patient and after touching patient surroundings). MDHB has consistently achieved

the target over the last year through improvement activities undertaken. To sustain this achievement, the goal of maintaining a pool of Gold Auditors who support the undertaking of audit practices is progressing. 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 slight decline in rates of both assessment and use of care plans in the last quarter. To improve this marker, the Pressure Injury Working Group has participated in the development of the revised nursing care plan, with a focus on documentation compliance. Both outcomes are near or above the New Zealand average. The 'Assessment' QSM is 88 percent in MDHB and 89 percent in New Zealand. The 'Plan' QSM is 93 percent in MDHB and 85 percent in New Zealand.

The number of reported hospital and non-hospital acquired pressure injuries has increased over the last two quarters. More information about the improvement initiatives to address this is provided in section 4.2.4.

3.1.2. The Consumer Engagement QSM

The second round of national self-rating submissions for this QSM was submitted in September 2021. The Consumer Engagement QSM Oversight Group has agreed to keep the organisational self-rating the same as for the previous rating period. The group agreed that undertaking this work should provide meaningful change and not be tokenistic. The focus in the last six months has been to progress from an initial organisation-wide stocktake and/or self-rating to the development of a work plan that aims to lift the rating across the district.

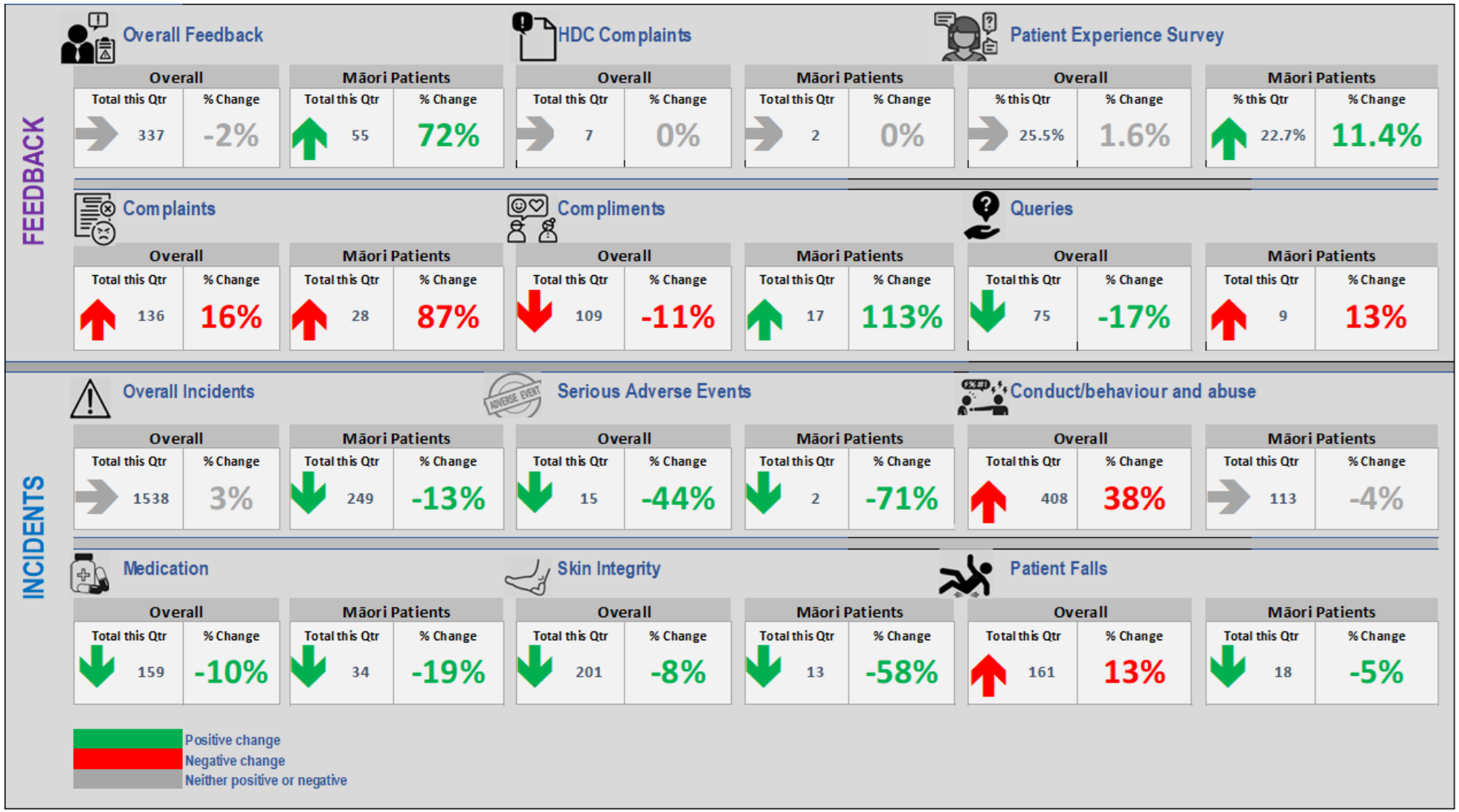
The following focus areas for improvement have been identified and will be progressed within the next six months.

MEASURE	ACTION ONE	ACTION TWO	ACTION THREE
Engagement	Strengthening of Consumer Council work by including goals and aspirations captured in consumer specific forums in strategic direction of Council	Improving health literacy of patients and staff	Support increased health equity by increasing education opportunities for staff and strengthening awareness of, and focus on tangata whenua perspective
Responsiveness	Improving systems by identifying multiple platforms/methods for consumers and whānau to be part of service and programme design and continuous improvement	Strengthening community voices by supporting the Quality Account with more examples of when consumer engagement is being used to provide better patient outcomes	Improving staff skills by sharing and utilising consumer engagement methods across our community
Experience	Facilitating improved metrics by ensuring that Health Disability Services Standard requirements regarding ethnicity are fully embedded	Strengthening project system to ensure reporting is robust and all evaluation and feedback is documented	Strengthen the resources tools and templates to encourage the capture of more consumer and whānau stories

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

4. QUALITY AND SAFETY DASHBOARD

(Quarterly comparison between April to June 2021 and July to September 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 a slight decrease 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 two percent in feedback received.

There has been a noticeable increase in feedback from Māori consumers. MDHB received 87 percent more complaints from Māori consumers during this reporting period. This is offset by the substantial increase of 113 percent in compliments received from Māori. This trend is being closely monitored and can in part be attributed to the improved attentiveness of frontline staff to record the ethnicity of patients, which enables more robust and accurate reporting. The rate of feedback from Māori is currently 16 percent, which is an increase of seven percent from the previous reporting period. Māori population for MDHB is 21 percent of the overall population. Current feedback numbers are not yet fully representative of the Māori population but are increasing.

Twenty-three percent of complaints required an extension. This is a decrease from the previous reporting period and remains in line with previous trends (Fig 4.1.2). This decrease was achieved despite the recent COVID-19 Alert Level 4 lockdown, which reduced the capacity of staff to investigate and respond to complaints as they were redeployed to other areas. The number of queries received decreased by 17 percent and the rate is within normal variation (Fig 4.1.5).

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

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

4.1.1. Inpatient experience survey

A highlight of the five best and worst performing areas for MDHB in comparison with national results is provided in Appendix Two – Patient Experience Survey August 2021. The results indicate where MDHB is performing well and where there are opportunities for improvement. MDHB results remain comparable to other DHBs. The highest response rate since the commencement of the new survey was recorded during this survey period, with a sharp increase of 11.3 percent in response rates for Māori patients. This upward trend is encouraging and will be monitored to ensure it is maintained.

Survey results show that 97.4 percent of Māori patients and 93.2 percent of all patients surveyed did not perceive any unfair treatment and 90.2 percent of patients felt their cultural needs were met. However, during this survey period, there was a decline in the number of patients who felt that their rooms or wards were always kept clean. MDHB's rating of 71.69 percent is significantly lower than the national score. Actions to implement improvement initiatives will be progressed in collaboration with the service provider if this decline remains consistent.

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

4.2. **Incidents and adverse events**

4.2.1. Incidents

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

4.2.2. Serious Adverse Events

There were 15 new Serious Adverse Events (SAC 1 and 2) in this quarter, which is a significant decrease from the peak reported in the last quarter. All were SAC 2 events and included 12 pressure injuries, two suspected suicides and one clinical process event, which was an unexpected death.

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

During this quarter, 18 SAE reviews were concluded (Fig 4.2.2). This is a decrease of one compared to the last quarter. The total average number of days to complete the reviews remains under the target set by the HQSC of 70 working days. Seven case reviews have taken longer due to their complexity and the lack of staff availability. Further training to increase the number of SAC 1 and SAC 2 event reviewers is planned in the new year.

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

4.2.3. Patient falls

The number of patient falls has remained stable 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 no falls resulting in significant harm this quarter. The last fall with significant harm occurred in May 2021.

4.2.4. Pressure injuries

There has been a slight increase in reported skin integrity incidents (stage 1 and 2) (Fig 4.2.6). These are newly-formed lower severity pressure injuries. Twelve significant pressure injuries were reported and classified as SAC 2 events (Stage 3 and 4 skin integrity incidents) for the July to September period.

The Pressure Injury Working Group identified a trend of increasing SAC 2 pressure injuries. Detailed reviews indicate multifactorial issues including patient comorbidity and acuity. Following their findings and discussions, the group's members included a new initiative of increasing the number of ward nurses with specialised wound care knowledge. This action is now in progress.

4.2.5. Incident rates for Māori

The incident rates for Māori this quarter have significantly reduced compared to the previous quarter. Of the SAE reported this quarter, two of the 15 reported as Māori. This is also a reduction of five from the last quarter. The number of conduct or behaviour abuse events remained stable for Māori and this is due to multiple incidents being recorded against the same patient. There has been no trends or themes found from these reviews that relate to Māori. Training of staff in the review of incidents will incorporate cultural responsiveness. This includes timely reviews and the opportunity to have meetings with patients, family and whānau to identify what is needed to better support Māori patients. Training is scheduled to be provided from January 2022.

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

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

APPENDIX ONE – TREND DATA FOR FEEDBACK AND INCIDENTS

Figure 4.1.1

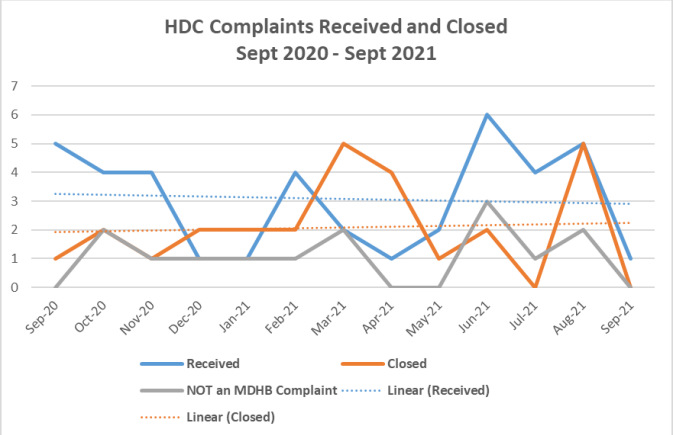


Figure 4.1.2

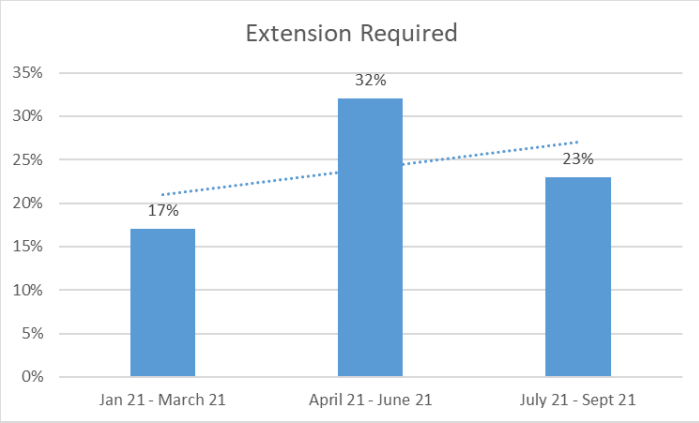


Figure 4.1.3

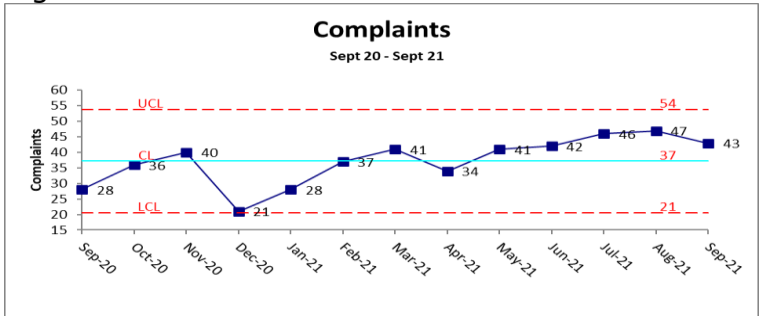
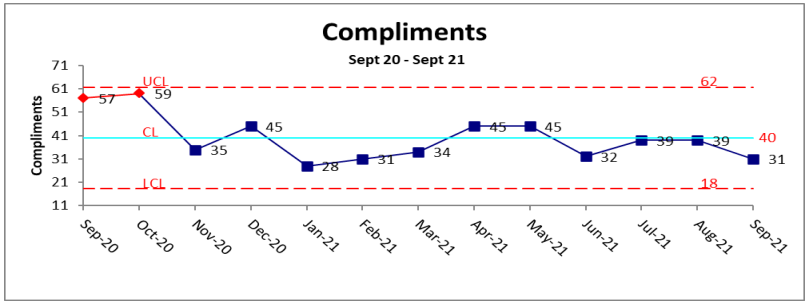


Figure 4.1.4



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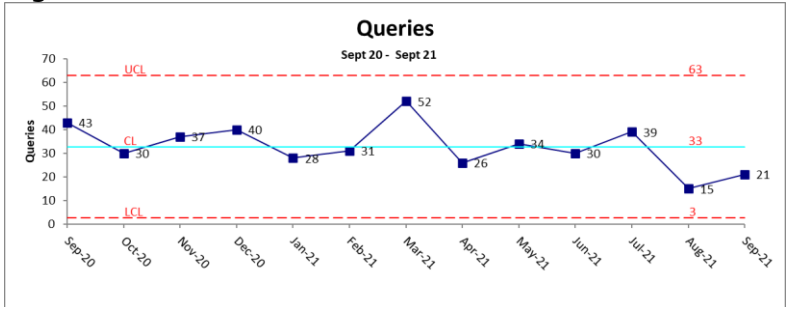


Figure 4.2.1

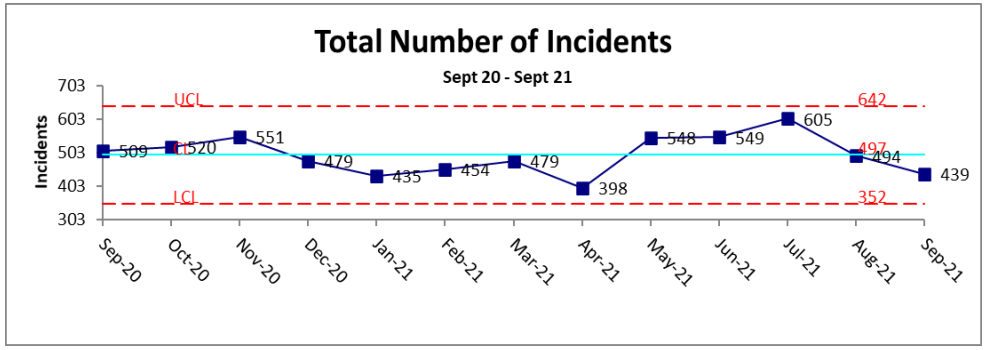


Figure 4.2.2

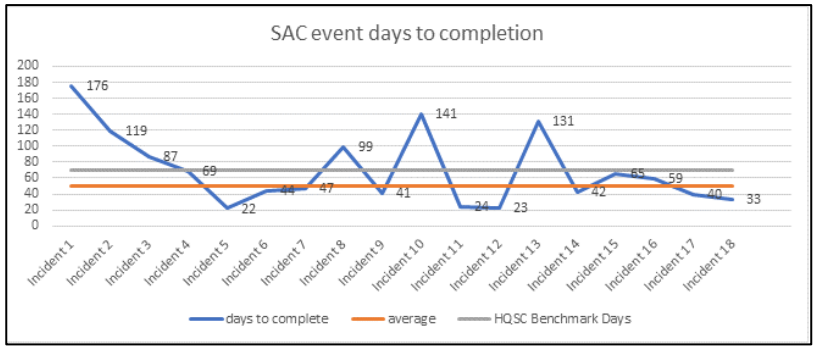


Figure 4.2.3

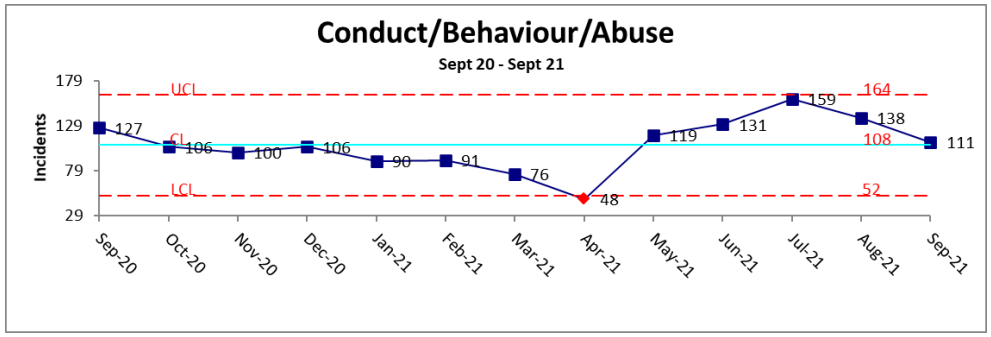


Figure 4.2.4

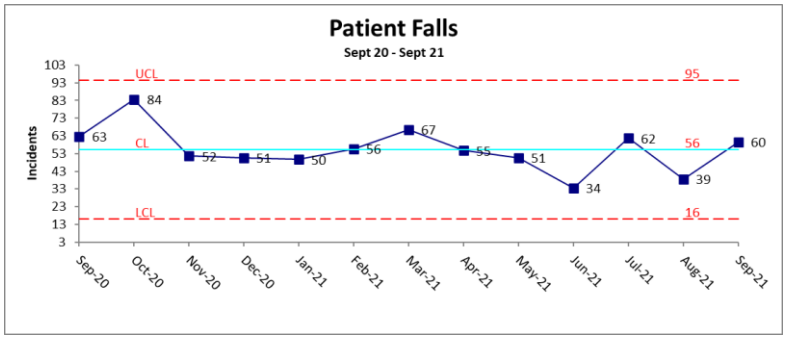


Figure 4.2.5

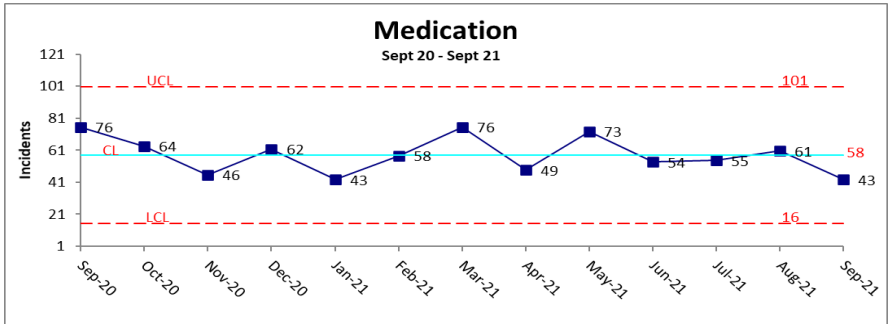
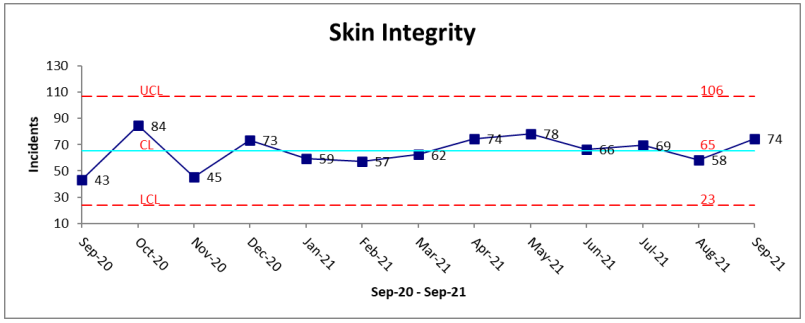


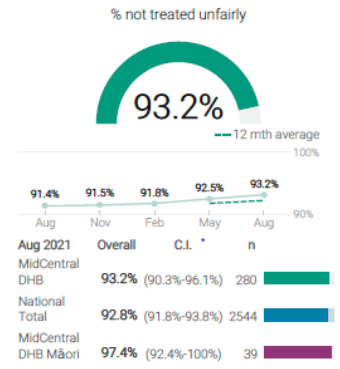
Figure 4.2.6



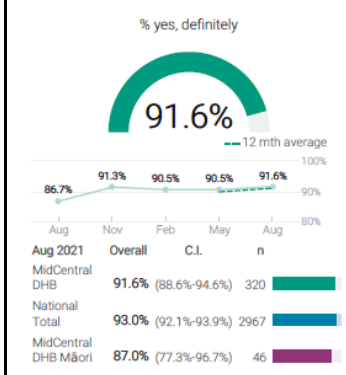
APPENDIX TWO – PATIENT EXPERIENCE SURVEY RESULTS (August 2021)

BEST PERFORMING

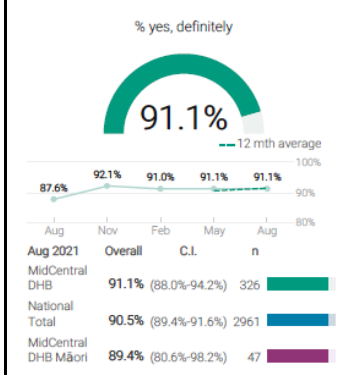
Patient did NOT identify perceived unfair treatment



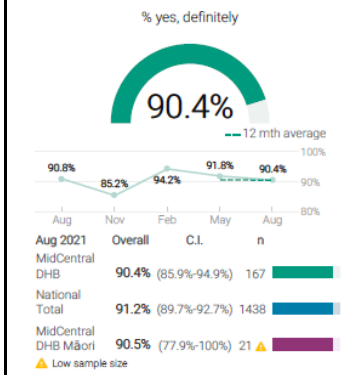
Patient was treated with respect by doctors



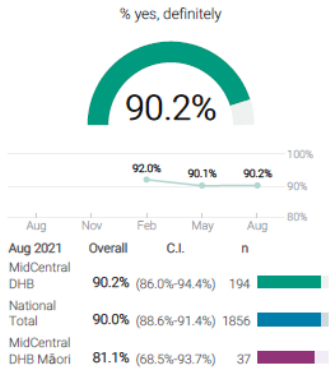
Patient treated with respect by nurses



Before the operation, staff helped patient to understand what would happen and what to expect

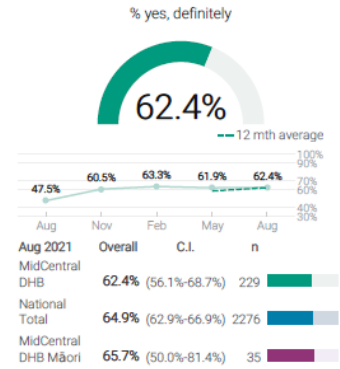


Patient felt that their cultural need was met

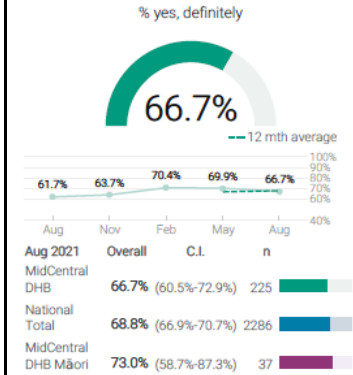


WORST PERFORMING

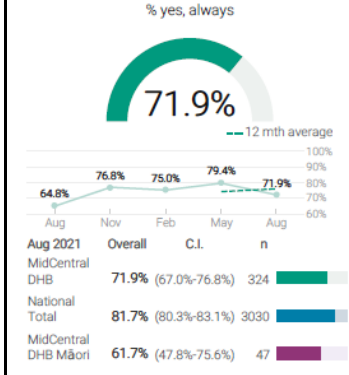
Patient was told the possible side effects of the medicine they left the hospital with in a way they could understand



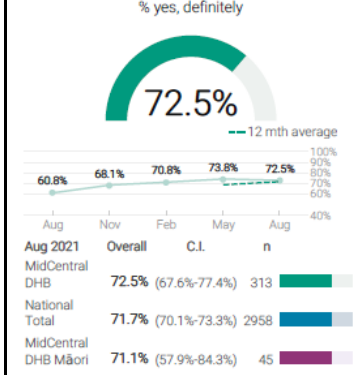
Staff talked with patients about whether they would have the help they needed when they left the hospital



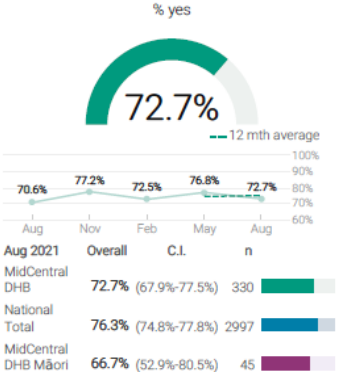
Hospital rooms or wards were always kept clean



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



Patient was not given conflicting information by different doctors or staff involved in their care



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 & recognitionrisk	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 rateper 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	

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

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

Discussion/Decision papers

23 November 2021

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:

- Is the Committee satisfied with the content of the first quarterly online Quality Account?
- Does the Committee have any suggestions about the future content?

To	Health and Disability Advisory Committee
Author	Harminder Gill, Quality Improvement Advisor
Endorsed by	Judith Catherwood, General Manager, Quality and Innovation
Date	3 November 2021
Subject	**Quality Account – Quarter One 2021/22**

RECOMMENDATION

It is recommended that the Committee:

- **note** the Quarter One 2021/22 Quality Account.

Strategic Alignment

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

1. PURPOSE

The Health and Disability Advisory Committee endorsed the plan to move to a quarterly online version of the Quality Account in July 2021. The Committee is asked to note this report for Quarter One 2021/2022.

2. BACKGROUND

The Health Quality and Safety Commission (HQSC) has historically recommended that all DHBs publish an annual Quality Account. The Ministry of Health (the Ministry) included this requirement in the DHB Operational Framework. The Quality Account is a report primarily aimed at the general public. It promotes quality improvement initiatives within the DHB, including a focus on specific areas such as the Quality and Safety Markers (QSMs) and Serious Adverse Event reviews and learning, to promote a continuous improvement culture.

The Ministry's Operational Framework was updated in 2020. The requirement to produce an annual Quality Account was removed from the framework. MDHB last published an annual Quality Account in December 2020. In July 2021, HDAC endorsed a proposal to move from an annual Quality Account to an online quarterly version of this report. This would be a short and easy read publication which would promote initiatives and deliver improvement activities across our district. MDHB will continue to work with THINK Hauora and other partners in developing and publishing these quarterly reports.

The aim of the quarterly publication is to share more frequently the real time improvement stories delivered by MDHB staff to the communities we serve. The Quality Account will be shared widely through online media releases, and social media and will be placed on the MDHB website.

The publication will be aligned to the HQSC QSM and adverse event publication schedule. This will provide time to MDHB teams to collate improvement stories and for the publications to contain the most current QSM data.

Appendix One: Quality Account – Quarter One publication for the 2021/22 financial year

QUALITY LIVING Kia pai te noho
HEALTHY LIVES Kia ora te tangata
WELL COMMUNITIES Kia ora te hapori

MidCentral District Health Board | Te Pae Hauora o Ruahine o Tararua

MidCentral District Health Board

Quality Account

Quarter One 2021/2022

Introduction

The MidCentral District Health Board (MDHB) Quality Account is an important document. This is because it shows MDHB's commitment to continuously improving the quality of service provided in their rohe. The stories in this document are evidence of the commitment MDHB staff bring to the community they serve.

There are a number of examples of quality improvement activities showcased in this publication. It also includes a summary of published results for Quality Safety Markers (QSM) that MDHB reports on to the Health Quality and Safety Commission (HQSC), and a summary of the serious adverse events within our DHB.

Previously MDHB published the Quality Account as an annual document. MDHB are now moving to a quarterly publication and this is the first publication for Quarter One 2021/2022.

From next year, MDHB will have the Quality Account publications available via the Quality portal page on our website, reducing MDHB's carbon foot print.

Financial Year 2021/2022:

Quarter One:
July to September

Quarter Two:
October to December

Quarter Three:
January to March

Quarter four:
April to June

Importance of shared common purpose

Acute care for older people with frailty (OPF) is better when it is delivered by a multi-disciplinary team (MDT) with expertise in geriatrics on a dedicated unit. The Older People's Acute Assessment & Liaison (OPAL) unit opened in November 2019.

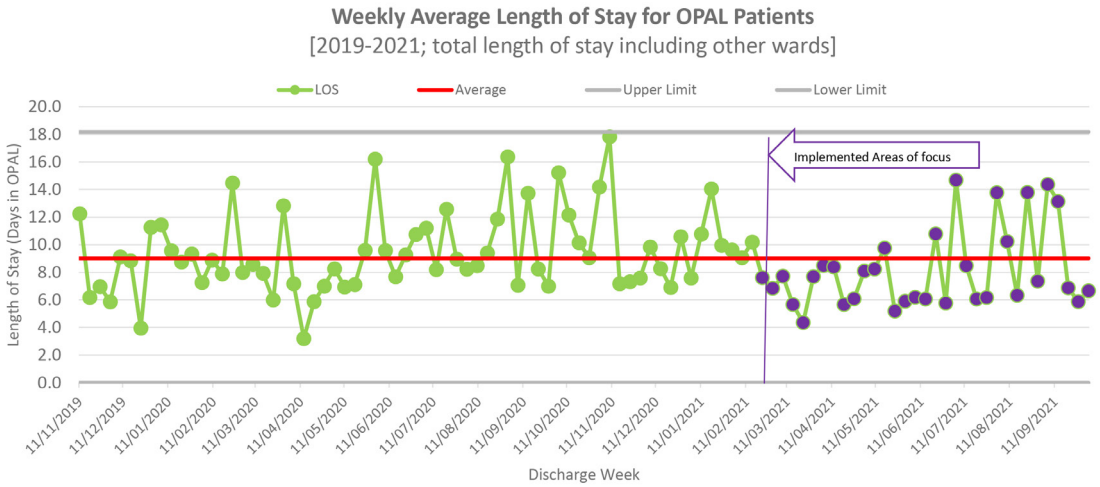
The benefits of the unit were realised quickly with more OPF discharged to their usual residence, with fewer readmissions compared to usual care. Despite the higher proportion of OPF with delirium on the unit, average length of stay (ALOS) and readmissions for this group of patients were lower compared to usual care.

However, these benefits were achieved at the expense of an overall increase in ALOS to nine days (compared to ALOS on general medicine of 6.5 days).

The OPAL unit MDT developed a plan to address this as follows: Areas of Focus

Interface Geriatrics (IG)	Ward Discharge Planning	Ambulatory/Short Stay Patients	Stranded Patients
• Clarify arrangements with ED – OPAL interface (screening, referral to IG, transfer to OPAL) • IG proactively pulling patients from ED • Comprehensive Geriatrics Assessment • IG shift times (8–4, 10–6), 12–8)	• Identifying discharges the day before: – Nurse prep discharges night before – Reg prep discharge paperwork • Early morning discharge • Optimise R2G (management plan, clinical criteria for discharge, EDD) • Changing the mindset: Red2Green is a measure for improvement not judgment • Discharge lounge with chairs	• Protecting assessments bays for ambulatory OPAL patients • Simplifying discharge paperwork for short stay patients	• Clinical peer review with MDT – Review of patients LOS 7 days + – Identify common barriers to discharge (waiting for what)

As a result this focus – OPAL ALOS has improved from 9 days to 6.7 days



All discharges from OPAL – includes time spent in other wards prior

P2A transition service

All young people with a chronic condition or disability that are treated in our children's service will eventually need to be transferred to an adult healthcare service and/or a General Practice Team.

The manner in which the young person is transitioned to the adult healthcare system is crucial to their continued wellbeing and willingness to engage. Poorly managed transition can lead to preventable co-morbidities, reduced life expectancy, reduced productivity and additional costs to health care services.

Child health recognised the importance of an effective transition process and has set up a new Paediatric to Adult transition service (P2A) which commenced in January 2019. The team consists of two registered nurses with social worker support.

There are several aims of transition:

- To maximise capabilities to live well and achieve goals regardless of condition/disability
- To improve sense of control and independence in regards to healthcare
- To help develop skills in communication, decision-making and self-care
- To provide support and guidance for the young person's parents/carers.

One of the key activities for a successful transition to adult health services is to set some realistic goals that young people can achieve throughout the process.

Progress Evaluation of P2A

Data was taken from the initial assessment done on youth entering the P2A service for the first time in January–June 2019 and then from their final assessment done in July–December 2020. The same questions were used in both the initial and final assessments to assess if progress had occurred. The overall results were very positive.

The youth were engaging in the service and taking on responsibility towards their own health and social needs. They become empowered to achieve their set goals, make decisions, and self manage in the adult health setting.

There was dramatic improvement in the youth knowing about:

- Their medications
- Making appointments
- Where to get help
- How to get support with education/employment
- Awareness for support with drugs and alcohol.

Overall we have found the P2A service is meeting our objectives and we are excited with how it is meeting the needs of the youth.

Development of Ka Aroha Ngā Kōrero

The Clinical Nurse Specialist (CNS) Breast Care, identified a long standing issue that has concerned many staff within the Ambulatory Care setting. Patients received their cancer diagnosis in clinic rooms that are small and cramped with little space for a support person, and frequently had no space for additional whānau to be present. The rooms are adjacent to clinical offices and conversations can be heard taking away patient privacy.

The CNS Breast Care discussed this concern with staff and identified a larger, more suitable clinic room. However, the environment was still very sterile and not supportive to the delivery of a cancer diagnosis or sensitive and difficult discussions.

Once the appropriate clinic room was found and agreement to change the use of the room, the CNS Breast Care set about designing what this room could look like to provide maximum comfort to patients and their whānau, whilst still retaining the clinical function required when seeing and assessing a patient.

A funding application to the Regional Cancer Treatment Trust was successful, and the room has been transformed to have a more pleasant atmosphere for patients and their whānau when meeting with clinicians for these difficult discussions.

This room is available to any service within MDHB that delivers a cancer diagnosis. Bookings can be made via the diary in Reception A.

A blessing for the room is expected to take place shortly.

Pae Ora have gifted the room a name appropriate to the purpose:

Ka Aroha Ngā Kōrero | Compassionate News Room

Early intervention in psychosis

"I know I will get a letter in case I forget what we talk about",

and *"not complicated, in my language".*

This is the confidence that young people are having in the Early Intervention in Psychosis service (eIMPACT) after this quality initiative.

The practice historically, is for psychiatrist clinic notes to be sent to the GP only, and the service user is left trying to remember what was said at the appointment. This has all changed for young people and their whānau at the eIMPACT youth team, with a simple but fundamental change in practice.

For the past two years, all doctor summaries usually sent to the GP are crafted as letters direct to the young person and their whānau accessing the service, with the GP receiving a cc copy.

"The letter becomes therapeutic in nature, and it really helps young people and their whānau successfully journey with the team towards shared recovery goals" says Clinical Manager, Brent Cooper. A whānau member who the team has worked with, states "I find it reflective, I can see exactly where my loved one is after reading them".

Dr. Andy Aston led this change in his practice, and began noticing that people were reading their letter and coming to the next session more informed. In Mental Health & Addictions, there is always the practice of using the language of the person journeying with the service. However this takes it further with Dr. Aston noticing that "suddenly we have a shared language to discuss a difficult concept or delicate situations. It all helps the young person invest in their own journey towards well-being – we have had fantastic feedback".

Dr. Aston retires at the end of November after 34 years as a Psychiatrist in our region. The eIMPACT team is appreciative of his investment and his contemporary approach to youth and best practice. This change in note practice being the cherry on the top of an innovative and successful career.

Improving patient safety through correct ID and procedure matching

At MDHB, we are committed to continuously improving how we deliver safe patient care, and this is reflected in the Patient Identification and Procedure Matching campaign.

Patient identification involves correctly matching a patient to any intended intervention they might undergo and communicating information about the patient's identity accurately, and reliably throughout their healthcare journey.

MDHB has taken a proactive approach through the Patient Identification and Procedure Matching campaign which was launched on 24 November 2020 to reduce the incidence of near misses and serious harm, which can result from patient misidentification.

MDHB sees patients and their whānau as integral partners in reducing incidents of patient misidentification, as most, if not all, patient misidentification errors are preventable.

Patients or their whānau, are asked to remind our staff to check ID wristbands, or ask for identification, before transporting patients, giving medications, administering IV fluids, before blood transfusions or blood samples, and before any procedures.

We have developed posters, a billboard, video and social media to encourage the public to prompt our staff to ask for ID if they haven't done so.

You can view the video here: https://youtu.be/OgmJU6t6ciM.

Know Your IV Lines

In December 2019, MDHB participated in the Accident Compensation Corporation (ACC) sponsored Know Your IV Lines improvement programme to examine the impact of complications from short term peripheral intravenous catheter (PIVC) insertion and care.

Know Your IV Lines is a programme designed to reduce complications from peripheral intravenous cannula (PIVC). Peripheral intravenous catheters are the most commonly used intravenous devices in hospitals, but carry risk of bloodstream and PIVC infections which can result in serious injury. The programme focused on a bundle on interventions which targets the three stages of PIVC use:

- Ready (insertion using aseptic technique and appropriate antiseptic)
- Review (phlebitis monitoring) and
- Remove (remove when no longer indicated).

The programme also included the IV to Oral Antibiotics Switch to strengthen the quality and safety of patient care provided in the acute adult medical and surgical areas. The IV to Oral Antibiotics Switch programme aims to improve appropriate antibiotic prescribing, and supports antimicrobial stewardship by reducing the risk of induced multi-drug resistant organisms. Ultimately this is about 'choosing wisely' to improve patient outcomes.

A phased approach to the improvement programme commenced with a pilot in Ward 26. This enabled quick rapid 'Plan Do Study Act' cycles with lessons learned prior to rolling this out to other wards. Some of the process improvements included updating policies, a broad education campaign including a video of a MDHB patient story on PIVC related bloodstream infections, changes to products and equipment and a relaunch of the campaign with a quiz competition following COVID interruptions. The final point prevalence audit concluded in June 2021. The KYIVL program has demonstrated improved understanding of PIVC management and has highlighted further opportunities for improvement. Understanding gaps in PIVC complication rates must continue to be a phenomenon of interest for future quality improvement initiatives.

Staff engagement has been positive with the changes right from the testing phase (a big thank you to the leadership and staff of Ward 26). Ongoing clinical education and engagement with a staff quiz competition was held on during the week of 4 March 2021. Our quiz winners were Ward 27 (shout out to Sally and her team).

Ward 26

Ward 27

Consumer experience

In 2015, the Health Quality Safety Commission's consumer engagement programme, Partners in Care, commenced work on the development of a Quality Safety Marker (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 District Health Boards in July 2020.

Consumer engagement quality safety marker:

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.

National reporting for the Consumer Engagement QSM took place in March and September 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 support the improvement in consumer engagement (including equity aspects) across our rohe.

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 will be supported and facilitated.

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

Measuring the experience of our inpatients:

Patient experience surveys are used to understand patients' views of the care they receive, and to make health care more responsive to their needs. The information gathered at local, regional and national levels through these measures can be used to benchmark patient experience across the country and to improve services locally. Feedback about the care received in public hospitals is a valuable indicator of how well health services are working for patients and their whānau.

During 2020 a culturally sensitive questionnaire that enables increased participation from under-represented groups (in particular Māori and Pacific peoples) was implemented on a national level.

MDHB's results are comparable to other DHB's. Our patients generally feel that that are treated with respect and fairness. They also feel that their cultural needs are generally met. Communication is indicated to be an area that could be improved, and patients would like to receive more information on medication and how to manage their condition when they leave the hospital.

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.

Where to next?

On 21 April 2021, the Government confirmed the details of the health system reforms in response to the Health and Disability System Review.

The new health system will be a single health service aiming to provide consistent, high-quality health services for all people.

The Ministry of Health will be focused on policy, strategy and regulation while a new body, Health New Zealand, will take over the planning and commissioning of services and the functions of the existing 20 District Health Boards to remove duplication and support national planning.

These changes will change the governance structure for health services but will not reduce the importance of continually striving for improved quality of care. The Quality and Innovation Team will continue to work within Clinical Teams and other health service providers in our district to deliver high quality, safe and equitable care for our community. Our focus is to commit to a strong partnership-based district and regional approach which will support health and care delivery across the center of the North Island.

The goals and objectives are to improve health outcomes and clinical care through the delivery of sustainable health services for our respective communities, while focusing on closer to home to patients in our communities.

Our next quarterly quality account will showcase a range of new initiatives demonstrating this commitment and goal.

Quality & Safety Markers

Quality and Safety Markers (QSM) are national measures set by the Health Quality and Safety Commission for all DHBs to ensure DHBs are acting to reduce harm or potential harm to patients. Each QSM is a targeted set of process and outcome measures designed to track the uptake of interventions supporting the Commission's improvement programmes. MDHB is performing well against the QSMs, with ongoing improvement initiatives such as further refining the audits collected via the i:Auditor tool.

The following link is for further information and data about the QSMs: www.hqsc.govt.nz/our- programmes/health-quality-evaluation/projects/quality-dashboards/dashboard-of-health-system-quality

The falls and safe surgery New Zealand (SSNZ) QSM have moved to a sustainability phase on 31 March 2021 (falls) and 1 July 2021 (SSNZ) respectively. This means the MDHB does not continue to report process measure data however we continue to collect process measurement data to inform our own improvement as is the case with the falls data now captured as part of the Safe Mobility agenda.

Marker Definition	NZ Goal	Jul-Sept 2020	Oct-Dec 2020	Jan-Mar 2021	Apr-Jun 2021	On Target
Safe Surgery: % of audits where all components of the checklist were reviewed. Data is not presented where fewer than 50 audits. • Sign in • Time out • Sign out	100%	 100% 98% 98%	 100% 100% 94%	 - - -	 100% 100% 98%	 ✓ ✓ X
Safe Surgery: % of audits with engagement scores of 5 or higher (on a scale of 1–7). Data is not presented where fewer than 50 audits. • Sign in • Time out • Sign out	100%	 98% 98% 98%	 100 96 93	 - - -	 100% 98% 97%	 ✓ X X
Safe Surgery: Number of observational audits carried out • Sign in • Time out • Sign out	50	 56 54 60	 64 57 81	 7 4 6	 59 55 58	 ✓ ✓ ✓
Safe Surgery: Briefings – the number of times a briefing, including all three clinical teams, was done at the start of the list	*No Target*	20	26	2	44	✓
Safe Surgery: DVT/PE observed	*No Target*	5	4	7	11	✓
Safe Surgery: DVT/PE (Deep Vein Thrombosis/Pulmonary Embolism) predicted	*No Target*	8	8	8	8	✓
Patient Deterioration: % EWS (Early Warning Score) calculated correctly	*No Target*	97%	91%	93%	94%	✓
Patient Deterioration: % of patients that triggered an escalation of care and received appropriate response	*No Target*	67%	66%	86%	78%	✓
Improving Hand Hygiene: % of opportunities for hand hygiene for health professionals	80%	78%	79%	80%	86%	✓
Pressure Injury: % patients with a documented and current PI Risk assessment	*No Target*	86%	91%	91%	88%	✓
Pressure Injury: % Patients with a documented & current Ind. care plan	*No Target*	90%	96%	94%	93%	✓
Pressure Injury: % patients with Hospital-acquired PI	*No Target*	5.4%	2.4%	1.9%	3.4%	✓
Pressure Injury: % patients with a non-hospital acquired PI	*No Target*	1.6%	1.8%	1.0%	1.7%	✓
Safe Use of Opioids % of patient whose sedation levels are monitored & documented following local guidelines	*No Target*	95%	56%	64%	95%	✓
Safe Use of Opioids % of patient with bowel function activity recorded	*No Target*	95%	97%	92%	99%	✓
Safe Use of Opioids – Balancing Measure: % of patient prescribed opioid for uncontrolled pain	*No Target*	4%	4%	4%	1%	✓
Safe Use of Opioids – DHB NMDS Data: % of surgical admission episodes with opioid related harm	*No Target*	0.11%	0.44%	0.21%	0.19%	✓

Serious Adverse Events

A Serious Adverse Event (SAE) is one that causes or has the potential to result in a lasting disability or death of a patient, and is not related to the natural course of the patient's illness or underlying health condition.

During Jul/Aug/Sep 2021, there have been:

SAEs reported to hospital and health services

These are related to the following:

Clinical process*

Pressure injury

Suspected suicide

**assessment, diagnosis, treatment and general care*

The pressure injury group has noted the high number of pressure injuries this period. This is a high priority for nurse educators and nursing leadership. There has been an increase in the number of patients with higher acuity and chronic co-morbid conditions. These patients are more at risk of developing pressure injuries. Continual education on pressure injury assessment is ongoing and necessary with turnover of new staff in wards.

Always report and review events:

The Always Report and Review list is a subset of SAEs that should be reported and reviewed in the same way irrespective of whether or not there was harm to the patient. Always Report and Review events are events that can result in serious harm or death but are preventable with strong clinical and organisational systems. Reporting Always Report and Review events can highlight weaknesses in how an organisation manages fundamental safety processes.

During Jul/Aug/Sep 2021, there were no Always Report and Review events reported by MDHB.

Review process:

Every SAE which occurs within our services is thoroughly reviewed to reduce the chance of a similar incident happening again. We report all SAEs and our subsequent actions to the Health Quality and Safety Commission.

Here are some of the actions we have taken to counteract potential Serious Adverse Events:

- To improve pressure injuries, the Pressure Injury working group have participated in the development of the revised nursing care plan with the focus on documentation compliance.
- Pressure injury group members also included a new initiative of increasing the number of ward nurses with specialised wound care knowledge. This action is now in progress.

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Information papers

23 November 2021

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For:

	Approval
X	Endorsement
	Noting

Key questions the Committee should consider in reviewing this paper:

- Does the alcohol position statement reflect the vision and values of MidCentral District Health Board?

To	Health and Disability Advisory Committee
Author	Kelvin Billinghurst, Clinical Executive, Te Uru Kiriora, Primary, Public and Community Health Deborah Davies, Operations Executive, Te Uru Kiriora
Endorsed by	Kathryn Cook, Chief Executive
Date	3 November 2021
Subject	**Midcentral District Health Board (MDHB) Position Statement on Alcohol**

RECOMMENDATION

It is recommended that the Committee:

- **endorse** the Position Statement for submission to the Board.

Strategic Alignment

This Position Statement aligns to the DHB's Strategy and Strategic Imperatives, in particular partnering with people and whānau to support health and wellbeing, with a focus on equity as a priority.

1. PURPOSE

To provide an update to the Committee on MidCentral District Health Board's (MDHB) Position Statement on Alcohol.

2. BACKGROUND

Alcohol was identified as one of two key priorities for National Public Health Advocacy in 2020 with the District Health Board (DHB) National Chief Executives endorsing the approach of the National Public Health Advocacy Team in its support and co-ordination with DHBs on alcohol-related harm to:

- advocate for a review of the Sale and Supply of Alcohol Act 2012 and to identify key opportunities and influencers to achieve this
- support DHBs to adopt Position Statements on Alcohol and Harm Minimisation Action Plans
- support DHBs to adopt and ensure consistent measurement and implementation of key alcohol programmes including the Alcohol ABC Approach.

Alcohol is not an ordinary commodity[1] but an intoxicant, toxin and an addictive psychotropic drug. While seen by many as a normal, harmless part of New Zealand life, it causes more harm than any other recreational drug.[2] The way alcohol is viewed, sold, supplied and marketed in New Zealand influences how much and the way in which people drink. Hazardous alcohol use has impacts across many sectors of society and contributes to sizeable problems in New Zealand in respect of physical and mental ill health; and social and economic burdens.[3]

Alcohol use can affect peoples' relationships and ability to work or study. Harm from alcohol extends beyond the individual and can result in harm to children (including those exposed to alcohol during pregnancy), whānau, friends, and the wider community.[4]

The harm is not limited to those with alcohol addiction and dependence, or to those drinking excessively, but affects even those who drink low to moderate amounts.[5,6,7,8] These harms are not distributed evenly across our communities, with some population groups more affected than others.[9]

In December 2012, the Government introduced the Sale and Supply of Alcohol Act 2012.[10] This Act has significant changes from the previous Sale of Liquor Act 1989. Particularly pertinent to health services are a broader definition of alcohol related harm; an increased role of the Medical Officer of Health; and the ability of Councils to adopt Local Alcohol Policies restricting hours, density and location for alcohol purchase or access. However, over the last decade the Government has only made limited progress towards

reducing alcohol-related harm by introducing this new Act, lowering blood alcohol limits, increasing alcohol screening and brief interventions in primary health care, and increasing funding for alcohol and drug addiction services. Despite this, rates of hazardous drinking have not improved.

The MDHB's position on alcohol in our communities has been developed in the context of the principles of Te Tiriti o Waitangi, which necessitate comprehensive strategies that address longstanding inequities in alcohol-related harm between Māori and non-Māori.

The appended Position Statement has been developed by the Public Health Unit (PHU) in partnership with key stakeholders. This details the key commitments, the adoption of evidence-based strategies to reduce harm, the alignment of aligned Government policies and the internal and external activities that the PHU is committed to progressing. A broad summary of available evidence is provided for further reference. This complements the Nutrition and Physical Activity Policy endorsed late 2020 which is under implementation.

Note: The footnotes in this report relate to the appended Position Statement.

MIDCENTRAL DISTRICT HEALTH BOARD

Te Pae Hauora o Ruahine o Tararua

MIDCENTRAL DISTRICT HEALTH BOARD

POSITION STATEMENT ON ALCOHOL

BACKGROUND

Alcohol is not an ordinary commodity[1] but an intoxicant, toxin, and an addictive psychotropic drug. While seen by many as a normal, harmless part of New Zealand life, it causes more harm than any other recreational drug.[2] The way alcohol is viewed, sold, supplied and marketed in New Zealand influences how much, and the way in which, people drink. Hazardous alcohol use has impacts across many sectors of society and contributes to sizeable problems in New Zealand in respect of physical and mental ill health; and social and economic burdens.[3]

Alcohol use can affect peoples' relationships, and ability to work or study. Harm from alcohol extends beyond the individual and can result in harm to children (including those exposed to alcohol during pregnancy), whānau, friends, and the wider community.[4]

The harm is not limited to those with alcohol addiction and dependence, or to those drinking excessively, but affects even those who drink low to moderate amounts.[5,6,7,8] These harms are not distributed evenly across our communities, with some population groups more affected than others.[9]

POLICY AND LEGISLATIVE ENVIRONMENT

MidCentral District Health Board's (MDHB) position on alcohol in our communities has been developed in the context of the principles of Te Tiriti o Waitangi, which necessitate comprehensive strategies that address longstanding inequities in alcohol-related harm between Māori and non-Māori.

In December 2012, the Government introduced the Sale and Supply of Alcohol Act 2012.[10] This act has significant changes from the previous Sale of Liquor Act 1989. Particularly pertinent to health services are a broader definition of alcohol related harm; an increased role of the Medical Officer of Health, and the ability of Councils to adopt Local Alcohol Policies restricting hours, density and location for alcohol purchase or access.

MIDCENTRAL DHB'S POSITION

MDHB desires to see a reduction of alcohol-related harm. This requires the following commitments.

1. The District Health Board will lead by example by:

    a. ensuring that alcohol will not be sold or provided on District Health Board sites or premises or at DHB events
    b. regulating and actively monitoring compassionate or extraordinary exemptions as described below
    c. not advertising or promoting alcohol, or alcohol-related events
    d. not accepting sponsorship from alcohol-related entities
    e. ensuring no Vote Health funds are spent on alcohol
    f. promoting its position among partners and into the community.

2. The adoption of effective population-based strategies to reduce harmful use of alcohol including. This includes:

    a. reducing the availability of alcohol
    b. increasing the purchase age
    c. supporting adequate roadside enforcement testing
    d. increasing the price via ethanol-level-based excise tax and/or minimum unit prices
    e. reducing alcohol advertising and marketing.

3. Supporting all Government policies that:
    a. reduce excessive drinking by adults, young people and pregnant women
    b. reduce the harm caused by alcohol use including crime, disorder, public nuisance and negative public health outcomes
    c. support the safe and responsible sale, supply and consumption of alcohol
    d. improve community input into local alcohol licensing decisions
    e. improve the operation of the alcohol licensing system.

4. Actively working towards reducing alcohol harm inequalities in identified high-risk populations.

This requires internal and external activities such as:

5. an ongoing updated MDHB Alcohol Harm Reduction Strategy and Action Plan
6. promoting harm reduction strategies regarding alcohol through the provision of information to
    a. health care professionals
    b. all staff
    c. the public
7. increasing opportunities for screening and brief interventions in DHB and partner settings (emergency departments, primary care and midwifery settings).
8. supporting public health and clinical staff in their work to; plan for, promote, support and deliver alcohol harm reduction and treatment strategies appropriate for our region'' communities.
9. public health nurses supporting alcohol statements in schools.
10. increasing access to treatment options for alcohol across the region, particularly for high-risk populations

11. actively working to increase our capacity to assess the impact of interventions
12. actively working to increase our capacity to monitor the impact of alcohol and drug-related harm on health services especially with an equity focus
13. engaging with local government and our community partners to identify alcohol issues and support the implementation of local solutions
14. supporting and assisting Territorial Local Authorities (TLAs) to develop local alcohol plans that seek to reduce alcohol-related harm and working collaboratively with Police and TLAs on licensing issues and monitoring compliance.

Exemptions

Alcohol consumption may be permitted on compassionate grounds as part of palliative or end of life care.

Alcohol may also be supplied to residents in aged care facilities, as they are considered (in the context of this policy) to be living in their own home. These exemptions may only be granted by a consulting physician, charge nurse or duty manager. Exemption approval would need to include consideration of:

- managing the quantity of alcohol brought in to the setting
- storage and access
- health and safety for a patient who consumes alcohol, for example, falls risk
- other patients for whom the concession is not granted.

APPENDIX: SUMMARY OF EVIDENCE

Alcohol related harm

Alcohol use is a major risk factor for numerous health conditions, injuries and social problems. It causes approximately five percent of deaths worldwide[11] and 5.4% of all deaths in New Zealand under 80 years old.[12] Acute harm resulting from intoxication includes: road traffic injuries and fatalities, burns, falls, drownings, poisonings, foetal alcohol spectrum disorder, assault, self-inflicted injury, family harm, suicide and homicide.

Biological effects of alcohol

Alcohol affects the brain. It alters the mood and impairs memory and psychomotor function. People who consume alcohol are less inhibited and therefore more likely to take risks and behave aggressively, leading to motor vehicle accidents and other injuries.[13] Alcohol use is linked to a wide range of major diseases, including: heart disease, cancer (e.g. breast, mouth, throat larynx, esophagus, liver, large bowel and rectum)[14], psychiatric and neurological conditions, gastrointestinal disease, and birth defects including foetal alcohol syndrome.[6] It also contributes to diabetes, sleep disorders, and infectious diseases such as pneumonia and tuberculosis.[15]

Unborn children and adolescents are particularly vulnerable to the effects of alcohol. Unborn children exposed to alcohol are at higher risk of problems with memory, language, attention, learning, visuo-spatial ability, fine and gross motor skills, and social and adaptive functioning.[16,17] Adolescent brains are still developing and therefore vulnerable to alcohol toxicity, addictive problems, under-achievement and psychiatric disorders.[18,19,20,21]

Social and economic alcohol-related harm

Alcohol contributes to crime in New Zealand. Research shows that nearly half of all homicides in New Zealand involved alcohol. Around 40% of interpersonal offences are known to involve alcohol, with either the offender, the victim, or both, drinking at the time. Additionally, around a third of all offenders are estimated to have consumed alcohol.[12,22] Drink driving causes substantial harm - alcohol is known to have been a factor in 1 in 5 fatal crashes between 2017 and 2018. It is also a factor in 12 percent of serious injury crashes and 11 percent of minor injury crashes.[23]

Social harm results from alcohol: Almost half of adults experienced harmful effects on friendships, social life, home life, work/study/employment opportunities, financial position, and legal problems or difficulty learning from their own or others drinking in the past year. [24]

The economic cost of alcohol-related harm in New Zealand is significant. Depending on the methodology, estimates have ranged from $1.2 billion to $7.85 billion annually.[25] Recent studies show $1.65 billion in lost productivity alone, suggesting the total economic cost of diverted resources is considerably more and well in excess of the $1.4 billion excise tax take from alcohol.[26,27]

Alcohol-related harm and population groups

Alcohol-related harm is experienced variably throughout the population. Men have a higher rate of alcohol-related mortality than women and Māori have a higher rate than non-Māori.[9,12,28] Evidence clearly demonstrates that Māori suffer disproportionately from a wide range of alcohol-related harms compared to non-Māori.[9] New Zealanders with lower socioeconomic status also bear a disproportionate burden of alcohol-related harm.[29, 30] Children are particularly vulnerable to alcohol-related harm caused by the drinking of other people and can suffer from increased susceptibility to child abuse, neglect and witnessing family violence if caregivers have an alcohol problem.[9,31]

Cost of alcohol-related harm to the health sector
Alcohol-related harm in New Zealand costs the health sector significant money, time and resources.[25] Intoxicated patients may also impact negatively on staff and other patients.[32] An estimated 35% of injury-based national emergency department presentations are alcohol-related [22,33,34] and studies at MDHB have put this figure between 20 and 35 percent, with this figure rising to 61 percent between hours of 10.00pm and 6.00am.[35]

NZ DRINKING PATTERN

Alcohol is widely available in NZ
Alcohol is easily accessible from a wide variety of outlets and to anyone over the age of 18. In the MDHB region it can be purchased in-person, 16 hours of the day, 7 days a week and on most days of the year. It can also increasingly be purchased online with short delivery times.

Alcohol can be consumed either on the premises (on-licences) in bars, restaurants, cafes, hotels, pubs and clubs or at special functions; or off the premises (off-licences) when purchased from liquor stores, supermarkets, or local grocery stores.

Alcohol is more widely available now than in the past. The number of licences of all types in the MDHB region (excluding Special Licences) is over 600, with around 200 in the Palmerston North area alone.

Alcohol is relatively inexpensive: a brief search of bottle store and supermarket websites on 3/5/21 found:

- 2 litres of cask wine that could be purchased for $17 (77c per Std Drink)
- 1 litre of 13.9% vodka costing $9.99 (91c per Std Drink) and
- A 500ml 12% beer costing $4.50 ($1.13 per Std Drink).

Drinking patterns in NZ
According to recent surveys, most New Zealanders (81.5 percent) have drunk alcohol in the last year and over half in the previous week.[9] While 82 percent of those surveyed drank at or below the recommended daily limit, 18% of drinkers got drunk some or most/all of the time and 26% of past year drinkers are "hazardous drinkers". (AUDIT score $\geq$ 8.)[24] While figures are often cited indicating reductions in New Zealanders drinking (and hazardous drinking), the reduction seems to have occurred between 2006/7 and 2011/12, with no further significant reductions since then. Hazardous drinking has increased since then in some groups, particularly in Māori women and older age groups.[36] More Māori and Pacific are non-drinkers than other groups, but hazardous drinking is more common amongst those who do drink. (Māori 46 percent, Pacific 38 percent vs 26 percent total population) Māori also have a death rate from alcohol twice that of non- Māori.[9,12]

How the current law impacts upon these drinking patterns
The Sale of Liquor Act (1989) liberalised the sale of alcohol, allowing it to be sold widely, including from supermarkets and over a 24-hour period. In 1999 the purchase age was dropped to 18 (from 20 years), beer became available in supermarkets and alcohol could be purchased on Sundays. Having found that the liberalisation did not lead to the projected "café style" drinking, the Law Commission produced a 2009 report "Alcohol in Our Lives – Curbing the harm" which contained 153 recommendations and led to the Sale and Supply of Alcohol Act 2012.[13]

This was intended to put more controls around the sale and supply of alcohol but did not include some measures public health advocates felt were more likely to be effective against excessive consumption and alcohol related harm. The Sale and Supply of Alcohol Act 2012 was intended to place more power in the hands of local communities but subsequent developments (driven by

extensive legal action by the alcohol industry) have been described as undermining the worthy intentions of the review. It is felt by many that this has led to measures intended to address problems like exposure in supermarkets and relative lack of community influence on the granting of local licences, not delivering their potential benefits. The provisions for Local Alcohol Policies, (intended to enhance local control of the licensing parameters), have also not delivered on their promise.) [37]

EVIDENCE BASED STRATEGIES TO REDUCE HARM

Raise prices

Evidence shows that when alcohol prices go up, consumption goes down. One of the best ways to influence the consumption of alcohol is through pricing.[1] Alcohol prices are subject to excise tax, which in New Zealand is set at a particular rate depending on which band of alcohol strength the product falls into (e.g. alcoholic beverages between 9-14 percent alcohol are taxed at 10 percent).

Currently excise tax rates are lower than those of other countries and they are also not adjusted for inflation.[22] In New Zealand there is often a price differential between on and off-licences, which encourages “pre-loading" (loading up on cheap alcohol before frequenting on-licences) and more drinking in uncontrolled private locations. In other jurisdictions, minimum unit prices for alcohol have been shown to increase the price of the cheapest alcohol that is predominantly consumed by hazardous drinkers.[38]

Raise the purchase age

Research shows that the legal purchase age affects how much youth drink. A lower purchase age has been associated with increased harm (including traffic crashes).[39] In order for a higher purchase age to be effective, it needs to be combined with adequate enforcement.[40] A higher purchase age acknowledges that the effect of alcohol and its harms is much greater on the adolescent brain as it is still developing.

Reduce alcohol accessibility

It is practically and economically effective to restrict the physical availability of alcohol in order to reduce harm. Limiting the physical availability of alcohol can be achieved through limiting the hours and days of sale, controlling outlet density and tightening the law around the granting of licences. Currently alcohol is easily purchased and high densities of alcohol outlets have been shown to be associated with increased harm, including traffic crashes.[1,10]

Reduce marketing and advertising

Advertising of alcohol has increased in many countries including Aotearoa/New Zealand over recent decades. Prior to the 1980s there was very little alcohol advertising in New Zealand due to legislation. Now alcohol advertising is left to the self-regulation of the industry. Since 1992, advertising of alcohol has been allowed on both television and radio – albeit at restricted times (8.30pm-6am) for television. Since 1987 alcohol companies have been allowed to sponsor sports and advertise corporately.[41] Alcohol advertisements often sell the image that drinking is attractive, glamorous and fun; and these messages are particularly appealing to young people. [42,43] Alcohol advertising not only leads to greater consumption of alcohol, but also colours people’s perceptions of the drinking habits of others. [1,10, 44]

Support drink-driving counter-measures

The risk of motor vehicle accident increases exponentially with increasing alcohol consumption.[1,45] In New Zealand, it is estimated that over a quarter of road traffic injuries across all road user groups involve alcohol. [46] A recent Health Promotion Agency survey showed 23 percent of drinkers drove after drinking and 13 percent of all respondents had been in a vehicle after the driver had been

drinking.[24] It is important that strategies to address the 100 plus impaired driving fatalities include adequate and well-publicised enforcement testing as well as media strategies.[47]

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For:

	Approval
	Endorsement
X	Noting

Key questions the Committee should consider in reviewing this paper:

- Does this paper sufficiently inform you about the role and function of the local Child and Youth Mortality Review Group?
- Does this paper sufficiently outline the national and local disparities in deaths of pēpi, tamariki and rangatahi?

To	Health and Disability Advisory Committee
Author	Dr Jeff Brown, Clinical Executive, Te Uru Pā Harakeke Perryne Brasko, CYMRG Co-ordinator for MidCentral and Whanganui DHBs
Endorsed by	Kathryn Cook, Chief Executive
Date	3 November 2021
Subject	**The 15th National Child and Youth Mortality Data Report 2015-2019**

RECOMMENDATION

It is recommended that the Committee:

- **note** this report on the deaths of pēpi, tamariki and rangatahi aged from 28 days to 24 years in Aotearoa
- **note** that this brief review of data provides a link to part of the roadmap to reducing the number of deaths and disproportionate outcomes across ethnicities, age groups, sexes and deprivation levels.

Strategic Alignment

This paper is aligned to MidCentral District Health Board's (MDHB) strategy in committing to quality and excellence in everything we do and ensuring equity of outcome for our population.

1. PURPOSE

To provide the Committee with an update on the 15th National Child and Youth Mortality Data Report 2015-2019. Although a report of national data, it has the real purpose of representing the lives of many pēpi, tamariki and rangatahi who have died too young and their whānau, who experience the enduring grief of loss.

The report covers the five year period from 1 January 2015 to 31 December 2019. The lag in the data exists due to the finalisation of cases by various officials.

Attempting to provide a comprehensive paper in a few pages, risks missing rich information. This paper is consistent with the cause of death groupings, brief information on ethnicity, sex and deprivation, identified trends and conclusions, and provides a background on the establishment of our local Child and Youth Mortality Review Group (CYMRG). The full national report can be accessed online at CYMRC 15th data report (hqsc.govt.nz).

2. SUMMARY

Over this five year reporting period, 2,666 pēpi, tamariki and rangatahi have died in Aotearoa. The reported categories are medical, injury, suicide and Sudden Unexpected Death in Infancy (SUDI). The most common individual causes of these deaths were suicide, transport incidents, cancers and SUDI**.** Many of these deaths were preventable.

Some information is demonstrated by number, some as the rate per population represented (eg SUDI rates are per 1000 live births) and some as a percentage.

3. STATISTICS

National data overview

Of the total 2666 lives lost, cause of death is listed in broad categories. Suicide was previously reported with assaults under intentional deaths; assaults are now included in the injury category and suicides reported as a category.

Cause of Mortality	Number	Percentage
Medical	981	36.8
Injury (including transportation)	817	30.6
Suicide	655	24.6
SUDI	198	7.4
Missing data	15	0.6
Total	**2666**	100

Medical conditions were the most common cause of death in children aged younger than 15 years; suicide was the most common category in those aged 15–19 years. The youth suicide rate in 2017 in Aotearoa was the worst among 41 OECD countries surveyed. The Māori confirmed suicide death rate was 2.5 times that of non-Māori, non-Pasifika. The MidCentral Māori confirmed suicide mortality number for 12 months (2020-2021) is small in the 10-24 years age group and reporting the number would likely make the deceased identifiable.

Ethnicity

Of the 2666 national total deaths, 1012 of those tamariki and rangatahi were Māori. Large inequities remain in mortality rates for pēpi, tamariki and rangatahi Māori, compared with non-Māori, non-Pasifika children and young people.

Deprivation also had a disproportionate impact on pēpi, tamariki and rangatahi Māori.

Disproportionate national mortality rate by ethnicity

Ethnicity	**Mortality Rate per 100,000**	**MidCentral *Number* July 2020 – June 2021**
Māori	51.6	6
Pasifika	39	3
Asian	18.4	2
MELAA	29	0
European and other	28	7
		18

Disproportionate national mortality by ethnicity and by cause of mortality

Cause of Mortality	**Number**	**Rate Māori (per 100,000)**	**Rate non-Māori, non-Pasifika (per 100,000)**
Medical	318	16.2	10 (rate ratio 1.6)
Injury (including transportation)	295	15	8.7 (rate ratio 1.7)
Suicide	332	25.4	10.2 (rate ratio 2.5)
SUDI	39	1.3 (per 1000 live births)	0.21 (rate ratio 6.2) (per 1,000 live births)
Missing data	4	0.2	0.1 (rate ratio 1.8)
	1012	**52**	**26 (rate ratio 2)**

Disproportionate SUDI rates for Māori

Following the release of this data, New Zealand national media report that multiple health and social service agencies in New Zealand acknowledge the unacceptable rates where Māori pēpi are six times more likely to die from SUDI than non-Māori and for Pasifika pēpi that ratio is eight times.

Mortality by DHB of domicile – MidCentral

The five year total mortality 2015-2019 in this age group was 127 which is 41.9 per 100,000.

MidCentral SUDI

In the five year reporting period, MidCentral DHB reported seven SUDI, four of those were pēpi Māori. Overall, the rate of 0.64 per 1000 live births places MidCentral just below the national mean rate. The rate of SUDI for Māori was 0.94 per 1000, well below the mean national rate mean of 1.31. The MidCentral region reported two SUDI in the 12 months 2020-2021. Regarding one case; a letter was sent to the Coroner by the CYMRG chair, asking the Coroner to consider commissioning an evaluation of the substandard state of the dwelling in which a two month old pēpi Māori was found dead from an unexplained cause.

Disproportionate mortality by deprivation index for Māori

Mortality rates are also highest in areas of high socio-economic deprivation, with Decile 10 (with the highest deprivation) three times more likely to die than Decile 1 (the least deprivation). Deciles 8, 9 and 10 all show Māori to have almost twice the mortality rate of non-Māori, non-Pasifika. Māori are more likely to be living in areas of high deprivation and socio-economic hardship; 40 percent of pēpi, tamariki and rangatahi Māori compared to 15 percent of non-Māori, non-Pasifika. Nearly half of all deaths occurred in those aged 10 to 24 years living in deprivation Deciles 8-10.

Mortality percentage by sex and by category

	Percentage of Category Male	Percentage of Category Female
Medical	57	43
Injury	73	27
Suicide	67	33
SUDI	59	41

Males are over-represented in all categories with significant disproportion in injury by almost three times and suicide just over two times.

Mortality numbers and percentage by age group and by category

Cause of Mortality	<1 year	1-4 years	5-9 years	10-14 years	15-19 years	20-24 years	Total by Category
Medical	215	166	105	94	161	240	**981**
Injury	26	86	49	60	233	363	**817**
Suicide	-	-	-	43	263	349	**655**
SUDI	198	-	-	-	-	-	**198**
Missing data	3	-	<3	-	5	6	**15**
Total by age	**442**	**252**	**155**	**197**	**662**	**958**	**2,666**

Leading causes of deaths change with age. The leading medical causes under one year are congenital abnormalities and perinatal conditions and after age five cancers. Injury deaths occur in two peaks; the first in under five years and then again in adolescence. The leading cause of injury deaths is transportation. Assault deaths also occur in the same two peaks, under five and then in adolescence.

4. BACKGROUND TO THE CYMRC

The establishment of a national Child and Youth Mortality Review Committee (CYMRC) was a key recommendation of the Child Health Strategy (February 2005), reinforced by the Child Health Service Review (September 2005). Responsibility for mortality review under the New Zealand Public Health and Disability Act rests with the Minister of Health.

The Local CYMRG (Child and Youth Mortality Review Group) was established in 2006. This was informed by a very prescriptive model developed by the CYMRC linked to the experience of the two main pilot projects in Auckland/Waitematā (jointly) and Tairāwhiti DHBs. The need for and development of a mortality review process was prompted in part by a number of high profile cases such as the deaths of James Whakaruru and Lillybing. Of the over 500 deaths per annum in New Zealand of children and youth aged between 28 days to 24 years, overseas data suggested that in 60 percent there are preventable factors. A number of these are related to processes within systems, between agencies and providers.

DHBs are regarded as being well placed to provide a crucial leadership role in their respective regions, having both expertise and existing systems to manage the process through the roles of chair and co-ordinator. The word 'local' is used to denote the area covered by DHB boundaries, which may cross the regional boundaries of other key agencies, eg Police and education districts.

Local CYMRGs have a Co-ordinator and local Chair and members from agencies including the District Health Board, primary health, mental health, well-child, welfare, child protection, education, regional Technical Advisory Services, CVorrections, ambulance, suicide prevention/postvention, SUDI prevention and others. These members are expected to have the authority to effect change

within their agencies. The Chair and Co-ordinator of the CYMRG are agents of the CYMRC. They are selected and endorsed by the CYMRC, in consultation with the DHB, being individuals with credibility and relevant expertise within the local community. Other members are also agents, bound by confidentiality agreements and data is securely stored centrally.

The CYMRG reviews the collated case with local information via group members. The information provides a detailed overview of local and national trends which would otherwise not be identified. Each review informs systems issues that can be modified by recommendations and local and national actions to reduce the likelihood of future deaths.

The function of the local CYMRG continues to be to:

- review the lives of children and young people who die in the community aged between 28 days to 24 years in the MidCentral District Health Board region, with a view to reducing the numbers of preventable deaths that occur each year.
- act as advocates for the improvement of services for children and youth, their whānau and communities, where the review process has identified actions/interventions that have a direct bearing on reduced child and youth deaths.
- collate local case data for incorporation into the national CYMRC database.

Local MidCentral DHB review meetings are held two-monthly with the aim to review all deaths, independent of Coronial or other reviews. A number of other districts have reduced their target to 80 percent and now 60 percent of all deaths. The current Chair has been incumbent since the CYMRG started. Many of the reviews identify information unknown to the separate agencies and reach recommendations that would not otherwise have concluded, which inform national and local actions for individuals and agencies.

5. CONCLUSION

The information in this report raises the urgency and importance of doing more within social determinants of health to reduce child and youth mortality. While strong progress was previously made in reducing mortality rates of all pēpi, tamariki and rangatahi in the past, that improvement momentum has stagnated over the five year reporting period. Intersectoral investment in the first 1000 days and equity based approaches are essential to ensuring progress into the future.

Recognition of the challenges of improving health is explained in the Aotearoa health restructure. The CYMRGs believe the current health and disability reforms and the establishment of the new Māori Health Authority present real opportunities to address the structural changes that are needed, not only within the health system but in our society more generally. This data is a vital evidence-based part of the roadmap for improving the health outcomes and addressing equity for the pēpi, tamariki and rangatahi of this country.

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 Tararua?
- Is the Committee satisfied with current progress?
- Are there any additional matters that should be included in future locality updates?

To	Health and Disability Advisory Committee
Author	Angela Rainham, Locality and Intersectoral Development Manager
Endorsed by	Deborah Davies, Interim General Manager, Strategy, Planning and Performance Sarah Fenwick, Operations Executive, Te Uru Pā Harakeke – Healthy Women, Children and Youth
Date	26 October 2021
Subject	**Locality Plan Progress Report – Tararua District**

RECOMMENDATION

It is recommended that the Committee:

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

3. BACKGROUND

The Tararua Locality Plan was completed in 2018 and was one of five plans created for the different localities (Territorial Local Authority areas) across the MidCentral District Health Board (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, Horowhenua and Palmerston North) can be found at: http://www.midcentraldhb.govt.nz/Planning/localPlan/Pages/LocalityPlanning.aspx.

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

Access to Health Care	Mental Health and Addiction	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	Play a role in tackling wider determinants of health
Improving people's access to hospital and specialist care	Locally designed and operated services	Raising awareness of what is available in the Tararua District and how to access it	Provide local initiatives that help people make good lifestyle choices
Health working together as one team (improving people's experience)	Supporting youth and rural communities	Increasing engagement and visibility	Quality living for older adults

4. PROGRESS IN RELATION TO THE CURRENT PLAN

The current plan has 51 actions in total and the reporting template has had 10 further actions added to it. Sixty of these 61 actions are progressing well or have been completed. Appendix One summarises the action plan progress in each focus area.

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

Access to health care

The provision of iwi-led health and wellbeing services in the Tararua District is expanding, with new roles being established with Ngāti Kahungunu ki Tāmaki nui-a-Rua and the provision of existing services with Rangitāne o Tāmaki Nui A Rua being increased. These additional services will improve access to health and wellbeing services provided by Māori, for Māori within their local community.

The Acute and Elective Services directorate is investigating how telehealth can be better utilised in the Tararua District to save people trips to Palmerston North Hospital where possible. This includes the provision of services at Dannevirke Community Hospital (and other potential venues such as Eketahuna Health Centre) for people who may not be digitally enabled in their own homes.

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 Tararua District (an increase of 7.4 FTE to 17.4 FTE across a range of clinical and non-clinical roles). 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 was undertaken this year in the Tararua District. The purpose of this engagement was to hear the voice of mama and whānau in the Tararua 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 in Dannevirke, Woodville, Mangamaire, Eketahuna and Ti Tree Point. Phone calls were also made to Māori mama to ensure that Māori were adequately represented in the responses.

The engagement undertaken for this project is an example of the action: *When designing health service in the Tararua District, residents will be engaged in the process.* An analysis of the information gathered has now been undertaken and findings about the needs of pēpi, mama and whānau from this analysis will soon be shared back with the community as well as being used to inform future service provision.

A by-product of this engagement process has been a new initiative in Woodville to connect mama and their young tamariki with older people in their community. MDHB is supporting the local Woodville member of the Tararua Health and Wellbeing Group to get the initiative started, as similar initiatives have shown beneficial effects for both older people and the tamariki involved.

The initial start date has been delayed due to COVID-19 Alert Levels, but feedback from the local Playcentre attendees, a Young at Heart Group and the local Women's Institute indicates that they are all very keen to be involved. Our organiser reported "Many of the institute women are very excited, as their children and grandchildren are living in other parts of the country so they don't see them often and they also have lots of skills to share."

Healthy living

Ngāti Kahungunu ki Tāmaki nui-a-Rua, in conjunction with Te Puni Kōkiri, and with additional funding from MDHB, is facilitating a Housing Repairs Programme for the residents of Tararua. The programme supports whānau who own their homes to access critical

housing repairs to enable warm, dry, healthy homes. Whānau are identified and referred to the Housing Repairs Programme through their access to health services via Tararua Health Group or MDHB. Whānau with respiratory conditions are prioritised for access to the programme.

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

5.1. Health and wellbeing issues

Recent engagement with social service organisations has highlighted the following list as key challenges affecting the health and wellbeing of people and whānau in Tararua:

- A shortage of housing
- Mental health issues
- Whānau experiencing financial stress/hardship
- Isolation of older and/or anxious people who are fearful of COVID-19.

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

Access to health care

- Cost and difficulty of accessing services and programmes that are only provided in Palmerston North
- Waiting times for health services
- Lack of transport to access services.

Mental health and addictions

- Waiting times for various services
- Drug addictions and lack of rehab facilities
- Stress in rural sector.

Healthy living

- Affordability of housing (along with the shortage)
- Isolation of older people and of low-income families who have moved to rural areas for cheaper housing
- Increasing family harm incidents.

5.2. Other points of note

- Work is currently underway with Eketahuna Health Centre to support the board in ensuring the centre's future sustainability and also in ensuring that the provision of health services is meeting the health needs of the local community.
- A second pharmacy has gained approval to operate in Dannevirke and is planning to open in May 2022. The pharmacy will be next to the Barraud Street Health Centre, providing easy access for people who have just received prescriptions from the general practice team.
- A Housing Forum organised by the Tararua Health and Wellbeing group in November 2020 was very successful, highlighting the impacts that a lack of housing in the district is having on local whānau. This brought together local key stakeholders and representatives from Government organisations who work in the provision of housing. This forum led to Tararua District Council committing to develop a Housing Strategy for the district. This process involved engagement with the key stakeholders from the forum as part of a Housing Needs Assessment and that information was used to develop the strategy which is currently in draft form.
- Tararua District Council has introduced two Community Development Advisor roles as it focuses on lifting the wellbeing of local communities and enabling those communities to flourish. They will be helping communities with a range of advice, from how to navigate regulations to get things moving faster, to securing funding.

6. COVID-19 VACCINATION ROLLOUT IN TARARUA

The COVID-19 vaccination programme within the Tararua district has resulted in 83 percent of the population having had at least one dose (as at 2 November 2021). Vaccinations are being delivered through various vaccination sites in Dannevirke, Woodville and Pahiatua, including Ngāti Kahungunu ki Tāmaki nui-a-Rua and Rangitāne o Tāmaki Nui A Rua. There have also been a number of 'pop-up' sites in locations throughout the district, including Eketahuna and Pongaroa.

The vaccination team is working to plan future clinics/mobile operations in Tararua to reach the 2280 unvaccinated people within the eligible population.

7. UPCOMING WORK IN NEXT SIX MONTHS

- Continuing to work with the COVID-19 vaccination team on linking to community leaders in planning COVID-19 vaccination events in Tararua.
- Developing and distributing of the December 2021 community newsletter.

- Continuing community engagement and feedback to MDHB executive members.
- Refreshing the demographic profile information for Tararua (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.
- Undertaking community engagement to ensure the new model of care for Mental Health and Addiction Specialist Services, which includes increased resources, is better positioned to be responsive to the needs of Tararua 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. 100 percent progressing well	People are able to get help when they need it = five actions. 100 percent complete or progressing well	Improving communication = four actions. 100 percent complete or progressing well	Wider determinants of health = five actions. 100 percent complete or progressing well
Improving people's access to hospital and specialist care = seven actions. 86 percent complete or progressing well, 14 percent behind/challenges	Locally designed and operated services = one action. 100 percent progressing well	Raising awareness of what is available in the Tararua District and how to access it = five actions 100 percent progressing well	Local initiatives to help people make good lifestyle choices = five actions. 100 percent complete or progressing well
Health working together as one team = five actions. 100 percent complete or progressing well	Supporting youth and rural communities = five actions. 100 percent completed or progressing well	Increasing engagement and visibility = five actions. 100 percent complete or progressing well	Quality living for older adults = five actions. 100 percent complete or progressing well

Just one of the 61 actions are classed as 'Behind/challenges':

Focus area	Action	Comment
Access to health care - Improving people's access to hospital and specialist care	People's circumstances (such as locality and family/ whānau responsibilities) will be taken into consideration by more flexible hospital booking systems.	This project has been deferred. The focus remains on seeing patients at a facility closer to home where possible. The use of telehealth is being encouraged, where appropriate, making it easier for patients to access a secondary care assessment. A number of electronic initiatives are underway to streamline the flow of referrals into the organisation.

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	12 November 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.

The Strategy, Planning and Performance and Pae Ora Paiaka Whaiora Directorates are working on aligning reporting with the transition to the new health system indicators.

The six-monthly reporting on the Te Ara Angitū (Māori Health Equity Dashboard) reporting is critical to this alignment. However, the reduced number of HDAC meetings has impacted the timeliness of data.

The analysis of data for the adult indicator report was scheduled to be presented to this meeting. This analysis was carried out some months ago and is not being presented as it is no longer up to date. The Committee is asked to note that the Quarter One indicators were presented to the November 2021 Board meeting. Most indicators reported Māori data.

The mental health indicators and workforce indicators were due to be reported in July but were deferred until September 2021. As these reports are provided six-monthly, the next reports on these two indicators will be provided at the March 2022 meeting.

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

HEALTH AND DISABILITY ADVISORY COMMITTEE

Health and Disability Advisory Committee | Work Programme	Fqncy	Mar 2022	May 2022	July 2021	Sep 2021	Nov 2021	Resp
Strategy/Planning							
Health Needs Assessment and Equity Snapshot to consider the health needs assessment of the district and sub-region	Triennial Nov-21					X	GMSPP & GMP&P
Ka Ao, Ka Awatea – Māori Health Strategic Framework on a three-yearly basis, review/refresh the strategy to ensure it remains relevant and reflects the DHB's Strategy	Triennial Oct-23						GMM
Disability Roadmap to determine a disability strategy and roadmap for the district, and thereafter how it has been advanced, changes, and priorities/investments for the future (3-5 years).	Triennial Aug-22						GMENZ EDAH
Locality Health and Wellbeing Plans to determine how the locality plans have been advanced, what's changed and priority initiatives/investments for the future (3-5 years), and to receive community feedback	Triennial Apr-21		X				OEs & CEs & SPP
Cluster Health and Wellbeing Plans to determine each cluster's planned outcomes, priorities and targets for the next three years, and the roadmap for achieving these, including required investment and resources	Triennial TBC						OEs & CEs
Quality Improvement							
Clinical governance and quality improvement framework – progress and trends 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. to monitor serious and sentinel events, and HDC complaints	4 / year	X		X			GMQ&I
Consumer Stories (workshop) 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 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 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) 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	Mar 2022	May 2022	July 2021	Sep 2021	Nov 2021	Resp
Locality Health and Wellbeing Plans 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) 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 to monitor progress being made in achieving the Framework, including the appropriateness of initiatives and investment planned/established.	Annual		**X**				GM
Te Ara Angitū – Equity Dashboard – Māori Health Indicators ('Deep Dive' reports) to monitor progress being made in achieving the national Māori health targets, including the appropriateness of initiatives planned/established	Six-monthly each group						
Child and Youth indicators		**X**			**X**		OEs and CEs
Adult indicators			**X**				OEs and CEs
Mental Health indicators		**X**				**X**	OEs and CEs
Workforce indicators		**X**				**X**	OEs and CEs
Disability							
Disability Strategy to monitor progress in implementing the Disability Strategy, including opportunities and challenges, and confirming the priorities and initiatives/investment for years ahead	Annual			**X**			GMENZ EDAH
Governance							
Policies to determine governance and significant quality and improvement policies	As required						

Glossary of terms

23 November 2021

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Glossary of Terms

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

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

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

CWDs	**Case Weighted Discharges** Case weights measure the relative complexity of the treatment given to each patient. For example, a cataract operation will receive a case weight of approximately 0.5, while a hip replacement will receive 4 case weights. This difference reflects the resources needed for each operation, in terms of theatre time, number of days in hospital, etc.
DCFO	**Deputy Chief Financial Officer**
DDIGG	**Digital and Data Informatics Governance Group**
DHB	**District Health Board**
DIVA	**Difficult Intravenous Access**
DNA	**Did Not Attend**
DNW	**Did Not Wait**
DoN	**Director of Nursing**
DS	**Digital Services**
DSA	**Detailed Seismic Assessment**
DSA	**Digital Subtraction Angiography**
DWP	**Digital Workplace Programme**
DX	**Data Exchange** A data exchange software mechanism developed with the Social Investment Agency (SIA) to support encrypted data sharing between public services.
EAP	**Employee Assistance Programme**
EBITA	**Earnings Before Interest, Taxes and Amortisation**
ECM	**Enterprise Content Management**
ED	**Emergency Department**
EDAH	**Executive Director Allied Health**
EDG-VPSR	**Electrocadiograph – Visual Positioning System Rhythm**
EDN&M	**Executive Director, Nursing & Midwifery**

EDOA	**Emergency Department Observation Area**
EDON	**Executive Director of Nursing**
EECA	**Energy and Efficiency Conservation Authority**
ELT	**Executive Leadership Team**
EMERGO	**Emergo Train System**
EMR	**Electronic Medical Record**
EN	**Enrolled Nurse**
ENT	**Ear Nose and Throat**
ENZ	**Enable New Zealand**
EOC	**Emergency Operations Centre**
EP	**Efficiency Priority**
EPA	**Electronic Prescribing and Administration**
EPMO	**Enterprise Project Management Office**
ERCP	**Endoscopic Retrograde Cholangio Pancreatography**
ERM	**Enterprise Risk Management**
ESPI	**Elective Services Patient Flow Indicator** Performance measures that provide information on how well the District Health Board is managing key steps in the electives patient journey.
EV	**Electric Vehicle**
EWS	**Early Warning System**
EY	**Ernst & Young**
FACT	**Flexible Assertive Community Assessment Team**
FHC	**Feilding Health Care**
FHIR	**Fast Healthcare Interoperability Resources**
FIT	**Faecal Immunochemical Test**

FM	**Facilities Management**
FM Services	**Facilities maintenance and hotel services required by the DHBs**
FPIM	**Finance and Procurement Information Management System**
FPM	**Financial Planning Manager**
FRAC	**Finance, Risk and Audit Committee**
FSA	**First Specialist Appointment**
FSL	**Fire Service Levies**
FTE	**Full Time Equivalent** The hours worked by one employee on a full-time basis.
FU	**Follow Up**
Gap	**Analysis used to examine current performance with desired, expected performance**
GETS	**Government Electronic Tenders Service**
GHG	**Greenhouse Gases**
GM	**General Manager**
GMFCS	**General Manager, Finance and Corporate Services**
GMM	**General Manager, Māori Health**
GMPC	**General Manager, People and Culture**
GMQI	**General Manager, Quality and Innovation**
GMSPP	**General Manager, Strategy, Planning and Performance**
GP	**General Practitioner**
GST	**Goods and Services Tax**
H&S	**Health and Safety**
HaaG	**Hospital at a Glance**
HAI	**Healthcare Associated Infection**
HAR	**Te Uru Whakamauora, Healthy Ageing and Rehabilitation**

HBDHB	**Hawke's Bay District Health Board**
HCA(s)	**Health Care Assistant(s)**
HCSS	**Home and Community Support Services**
HDAC	**Health and Disability Advisory Committee**
HDU	**High Dependency Unit**
HEAT	**Health Equity Assessment Tool**
HEEADSSS	**Home, education/employment, eating, activities, drugs, sexuality, suicide and depression, safety (wellness assessment)**
HIP	**Health Infrastructure Programme**
Hira	**National Health Information Platform**
HISO	**Heath Information Security Framework**
HQSC	**Health, Quality and Safety Commission**
HR	**Human Resources**
HRC	**Health Research Council**
HRIS	**Human Resources Information System**
HROD	**Human Resources and Organisational Development**
HSWA	**Health and Safety at Work Act**
Hui	**Formal meeting**
HV	**High Voltage**
HVAC	**Heating, Ventilation and Air Conditioning**
HVDHB	**Hutt Valley District Health Board**
HWIP	**Health Workforce Information Programme**
HWNZ	**Health Workforce New Zealand**
IA	**Internal Audit**
IAAS	**Infrastructure as a Service**

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

IT	**Information Technology/Digital Services**
ITSM	**Integrated Service Module**
IV	**Intravenous**
IVP	**Improving Value Programme**
JDE	**JD Edwards** Name of software package
Ka Ao Ka Awatea	**Māori Health Strategy for the MDHB District**
KPI(s)	**Key Performance Indicator(s)** A measurable value that demonstrates how effectively an objective is being achieved.
LAN	**Local Area Network**
LDC	**Local Data Council**
LEO	**Leading an Empowered Organisation**
LMC	**Lead Maternity Carer**
LOS	**Length of Stay**
LSP	**Leadership Success Profile**
LTC	**Long Term Condition(s)**
LV	**Low Voltage**
MALT	**Māori Alliance Leadership Team**
MAPU	**Medical Assessment and Planning Unit**
MBIE	**Ministry of Business, Innovation and Employment**
MCH	**MidCentral Health**
MCIS	**Maternity Clinical Information Service**
MDBI	**Material Damage and Business Interruption**
MDHB	**MidCentral District Health Board**
MDM	**Master Data Management**

MDT	**Multi-disciplinary Team**
MECAs	**Multi Employer Collective Agreements**
MEED	**Midwifery External Education and Development Committee**
MERAS	**Midwifery Employee Representation and Advisory Service**
MFA	**Multi-Factor Authentication**
MIT	**Medical Imaging Technologist** A radiographer who works with technology to produce X-rays, CT scans, MRI scans and other medical images.
MIYA	**MIYA Precision Platform**
MoH	**Ministry of Health**
MOU	**Memorandum of Understanding**
MRI	**Magnetic Resonance Imaging** A medical imaging technique used in radiology to form pictures of the anatomy using strong magnetic fields and radio waves.
MRSO	**Medical Radiation Officer**
MRT	**Medical Radiation Therapist(s)**
MSD	**Ministry of Social Development**
MWH	**Manawhenua Hauora**
MYFP	**Midwifery First Year of Practice Programme**
NAMD	**Neovascular Age-Related Macular Degeneration**
NARP	**Non-Acute Rehabilitation Programme**
NBSP	**National Bowel Screening Programme**
NCAMP19	**National Collections Annual Maintenance Programme 2019**
NCEA	**National Certificate of Educational Achievement**
NCNZ	**Nursing Council of New Zealand**
NEAC	**National Ethics Advisory Committee**

NEED	**Nursing External Education and Development Committee**
NESP	**Nurse Entry to Specialty Practice Programme (Mental Health)**
NETP	**Nurse Entry to Practice**
NFSA	**National Food Services Agreement**
NGO	**Non Government Organisation**
NHAWG	**National Holidays Act Working Group**
NNU	**Neo Natal Unit**
NOS	**National Oracle Solution**
NP	**Nurse Practitioner**
NPC	**Nurse Practitioner Candidate**
NPTP	**Nurse Practitioner Training Programme**
NZ	**New Zealand**
NZCOM	**New Zealand College of Midwives**
NZCPHCN	**New Zealand College of Primary Health Care Nurses**
NZCRMP	**New Zealand Code of Radiology Management Practice**
NZD	**New Zealand Dollar**
NZHP	**New Zealand Health Partnerships**
NZHRS	**New Zealand Health Research Strategy**
NZNO	**New Zealand Nurses Organisation**
NZPHD Act	**New Zealand Public Health and Disability Act**
O&G	**Obstetrics and Gynaecology**
OAG	**Office of the Auditor-General**
OD	**Organisational Development**
ODP	**Organisational Development Plan**

OE	**Operations Executive** (of a service)
OHS	**Occupational Health and Safety**
OLT	**Organisational Leadership Team** OLT comprises all General Managers, Chief Medical Officer, Executive Directors - Nursing & Midwifery and Allied Health, General Manager of Enable NZ, all Operations Executives and Clinical Executives.
OPAL	**Older People's Acute Assessment and Liaison Unit**
OPERA	**Older People's Rapid Assessment**
OPF	**Operational Policy Framework**
Outsourced	**Contracted to a third-party provider to deliver**
PaaS	**Platform as a Service**
Pae Ora Paiaka Whaiora	**(Base/Platform of health) Healthy Futures (DHB Māori Directorate)**
PACS	**Picture Archiving Communication System**
PANE	**Proactive, Advocacy, Navigation and Education Team**
PAS	**Patient Administration System**
PBE	**Public Sector Benefit Entity**
PCBU	**Person Conducting a Business or Undertaking**
PCCL	**Patient Complexity Clinical Level**
PCT	**Pharmacy Cancer Treatment**
PDRP	**Professional Development and Recognition Programme**
PDSA	**Plan Do Study Act**
PEDAL	**Post Emergency Department Assessment Liaison**
PET	**Positron Emission Tomography**
PHC	**Primary Health Care**
PHO	**Primary Health Organisation (THINK Hauora)**

PHU	**Public Health Unit**
PICC	**Peripherally Inserted Central Catheter**
PICU	**Paediatric Intensive Care Unit**
PIN	**Provisional Improvement Notice** (section 36.2 Health and Safety at Work Act 2015)
PIP	**Performance Improvement Plan** This plan is designed to support the OLT in the prioritisation and optimisation of system wide efforts to achieve our vision. The plan was presented to the MoH as part of MDHB's 2019/20 strategic discussion.
PNCC	**Palmerston North City Council**
POAC	**Primary Options for Acute Care**
POCT	**Point of Care Testing**
PPE	**Personal Protective Equipment**
Powhiri	**Formal Māori Welcome**
PPA	**Promoting Professional Accountability**
PPC	**Public, Primary and Community**
PP&CH	**Public, Primary and Community Health**
PPPR	**Protection of Personal and Property Rights**
PR&RO	**Principal Risk and Resilience Officer**
PSA	**Public Service Association**
PSe	**PS Enterprise**
PSR	**Protective Security Requirements**
PVC	**Poly Vinyl Chloride**
QEAC	**Quality & Excellence Advisory Committee**
QHP	**Qualified Health Plan**
Qlik	**Qlik Sense Data Visualisation Software (Dashboard Analytics)**

Q&SM	**Quality and Safety Markers**
RACMA	**Royal Australasian College of Medical Administrators**
RDHS	**Regional Digital Health Services**
RFP	**Request for Proposal**
RHIP	**Regional Health Infometrics Programme** Provides a centralised platform to improve access to patient data in the central region.
Risk ID	**Risk Identifer**
RM	**Registered Midwife**
RMO	**Resident Medical Officer**
RN	**Registered Nurse(s)**
RP	**Risk Priority**
RSI	**Relative Stay Index**
RSO	**Research Support Officer**
RSP	**Regional Service Plan**
RTL	**Round Trip Logistics** A technology platform.
Rules	**Government Procurement Rules (4th Edition 2019)**
SaaS	**Software as a Service**
SAC	**Severity Assessment Code**
SAN	**Storage Area Network**
SBA	**Smoking Brief Advice (Smoking Cessation)**
SCIG	**Strategic Capital Investment Group**
SFIA	**Skills Framework for the Information Age**
SGOC	**Shared Goals of Care**
SIEM	**Security Information Event Monitoring**

SLA	**Service Level Agreement**
SLMs	**System Level Measures**
SME	**Subject Matter Expert(s)**
SMO	**Senior Medical Officer**
SNE	**Services Not Engaged**
SOI	**Statement of Intent**
SOR	**Standard Operating Responses**
SPE	**Statement of Performance Expectations**
SPIRE	**Surgical Procedural Interventional Recovery Expansion** A project to establish additional procedural, interventional and surgical resources within MDHB.
Spotless	**Spotless Services (NZ) Limited**
SRG	**Shareholder's Review Group**
SSC	**State Services Commission** (from 2020 - Te Kawa Mataaho Public Service Commission)
SSHW	**Safe Staffing, Healthy Workplaces**
SSIED	**Shorter Stays in Emergency Department**
SSP	**Statement of Service Performance**
SSU	**Sterile Supply Unit**
SUDI	**Sudden Unexpected Death in Infancy**
SUG	**Space Utilisation Group**
STAR	**Services for Treatment, Assessment and Rehabiliation**
TAS	**Technical Advisory Services** (also CTAS)
TCO	**Total Cost of Ownership**
tC02e	**tons of carbon dioxide equivalent**
TCU	**Transitional Care Unit**

THG	**Tararua Health Group Limited**
TKMPSC	**Te Kawa Maataho Public Service Commission** (formerly State Services Commission)
TLP	**Transformational Leadership Programme**
Trendly	A national database capture tool and dashboard that focuses on the measurement of DHBs to the National Māori Health Measures
TTOR	**Te Tihi o Ruahine Whānau Ora Alliance**
UCOL	**Universal College of Learning**
VBS	**Voluntary Bonding Scheme**
VRM	**Variance Response Management**
WDHB	**Whanganui District Health Board**
WebPAS	**Web Based Patient Administration System**
WebPASaas	**Web Based Patient Administration System as a Service**
WHEI	**Whole Hospital Escalation Indicators**
Y	**Yes**
YD	**Yes and delegable**
YOSS	**Youth One Stop Shop**
YTD	**Year To Date**

Late items

23 November 2021

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Late items

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

Date of next meeting

23 November 2021

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Date of next meeting

Tuesday, 1 March 2022

Exclusion of the public

23 November 2021

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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.