MidCentral District Health Board

Te Pae Hauora o Ruahine o Tararua

# Part One HDAC papers

**28 June 2022**

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

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# Agenda and karakia

*28 June 2022*

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

# MidCentral District Health Board

# Health and Disability Advisory Committee Meeting

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

**When**: Tuesday 28 June 2022, from 10.00am

## 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, Jenny Warren.

### Apologies

Stephen Paewai

### In attendance

Kathryn Cook, Chief Executive; Jeff Brown, Incoming Interim District Lead; Kelvin Billinghurst, Chief Medical Officer; Debbie Davies, Interim General Manager, Strategy, Planning and Performance; Celina Eves, Executive Director, Nursing and Midwifery; Gabrielle Scott, Executive Director, Allied Health and Interim General Manager, Quality and Innovation; Tracee Te Huia, General Manager, Māori Health; Shivarn Stewart, Communications Team Leader; Margaret Bell, Board Secretary.

### In attendance (part meeting)

Item 3 Lyn Horgan, Operations Executive, Te Uru Arotau, Acute and Elective Specialist Services
Item 4.1 Michelle Riwai, General Manager, Enable New Zealand
Item 5.2 Sarah Fenwick, Operations Executive, Te Uru Pā Harakeke, Healthy Women, Children and Youth

*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** 10.00

| 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** 10.05

2.1. Apologies

2.2. Late items

2.3. Register of Interests Update

2.4. Minutes of Health and Disability Advisory Committee meeting – 1 March 2022, Part One

2.5. Matters arising

**3. DIRECTORATE WITH CLUSTER FUNCTIONS REPORTING** 10.10

3.1. Directorate Dashboard

3.2. Te Uru Arotau – Acute and Elective Specialist Services

3.3. Te Uru Whakamauora – Healthy Ageing and Rehabilitation

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

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

3.6. Te Uru Rauhī – Mental Health and Addiction Services

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

**4. PERFORMANCE REPORTING** 10.20

4.1. Enable New Zealand Report

4.2. Pae Ora Paiaka Whaiora Report

4.3. Quality and Safety Dashboard

**REFRESHMENT BREAK – AND FORMAL FAREWELL** 10.30

**5. DISCUSSION/DECISION PAPERS**

5.1. No items

**6. INFORMATION PAPERS** 11.15

*Information papers for the Board to note*

6.1. Tūngia Te Ururua – Primary Birthing Project

**7. GLOSSARY OF TERMS**

**8. LATE ITEMS**

**9. EXCLUSION OF THE PUBLIC**

*Recommendation*

That the public be **excluded** from this meeting in accordance with the Official Information Act 1982, 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 1 March 2022 meeting held with the public present | |
| Serious Adverse Events (SAC 1) Report | To protect patient privacy | 9(2)(a) |

# Administrative matters

*28 June 2022*

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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, 26 April 2022** (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents) | | |
|---|---|---|
| **Board Members** | | |
| **Name** | **Date** | **Nature of Interest / Company/Organisation** |
| Browning, Heather | 4.11.19 | Director – HB Partners Limited |
| | | Member – MidCentral Governance Group Mana Whaikaha |
| | | Board Member and Chair, HR Committee – Workbridge |
| | 26.7.20 | Director and Shareholder – Mana Whaikaha Ltd |
| | 23.10.20 | Member – Te Aho o Te Kahu (Cancer Control Agency) Consumer Reference Group |
| | 9.2.21 | Project Manager to lead Mana Whaikaha out of the Ministry of Health; stood down from appointed role of Deputy Chair of the MidCentral Governance Group for the MidCentral prototype |
| | | Resigned as Director of Mana Whaikaha Ltd – effective from December 2020 |
| | 12.7.21 | Appointed to the Support and Consultation for End of Life Choice in New Zealand (SCENZ) Group – a statutory part-time role within the Ministry of Health. |
| | 27.3.22 | Project manager role with the Ministry of Health ended late 2021. |
| | | Resumed role as Director of Mana Whaikaha Ltd in August 2021 (temporary). |
| Duffy, Brendan | 3.8.17 | Chair and Commissioner – Local Government Commission |
| | | Member – Representation Commission |
| | | Chairperson – Business Kapiti Horowhenua Inc (BKH) |
| | 17.8.21 | Trustee – Eastern and Central Community Trust |
| | 16.12.21 | Chairperson – Horowhenua Health and Wellbeing Hub Stakeholder Advisory Group |
| Dennison, Vaughan | 4.2.20 | Councillor – Palmerston North City Council |
| | 9.2.21 | Member of Palmerston North City Council Infrastructure Committee |
| | 14.9.21 | Employee – Homes for People, Kaitiaki, Public Relations |
| | | Director – Social Impact Property, Property and Support Services |
| | | Partner – Dennison Rogers-Dennison, Accommodation Services |
| | | Trustee – Manawatū Whanganui Disaster Relief Fund |
| | | Chair – Camp Rangi Woods Trust |
| | | Board Member – Softball New Zealand |
| | | Patron – Manawatū Softball Association |
| | | Wife is a Partner – Dennison Rogers-Dennison, Accommodation Services |
| | | Wife is an employee – Homes for People, Kaitiaki, Support Worker |
| | | Wife is an employee – HealthCare NZ, Community Support Worker |
| | | Father is Managing Director, Exclusive Cleaning Services |
| | 26.4.22 | Wife ceased employment with HealthCare NZ in January 2022 |
| 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 |

| **Register of Interests: Summary, 26 April 2022** (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents) | | |
|---|---|---|
| Gray, Norman | 10.12.19 | Employee – Wairarapa DHB |
| | | Branch Representative – Association of Salaried Medical Specialists |
| Hancock, Muriel | 4.11.19 | Sister is casual employee (Registered Nurse, ICU) – MidCentral DHB |
| | | Volunteer, MidCentral DHB Medical Museum |
| | 30.9.20 | Sister-in-law is employed as a registered nurse at Whakapai Hauora |
| | 19.11.21 | Sister-in-law works as a COVID-19 vaccinator for MidCentral DHB |
| | 1.2.22 | Sister-in-law no longer works for Whakapai Hauora |
| Mar, Materoa | 16.12.19 | Upoko Whakarae Te Tihi O Ruahine Whānau Ora Alliance |
| | | Chair – EMERGE Aotearoa |
| | | Matanga Mauri Ora Ministry of Health Mental Health and Addiction |
| | | Chair, 'A Better Start – E Tipu Rea', National Science Challenge, Liggins Institute, University of Auckland |
| | 11.2.20 | Member of MDHB Cluster |
| | | Member of local Child and Youth Mortality Review Group (CYMRG) |
| | 5.8.20 | Member of MDHB's Māori Alliance Leadership Team (MALT) |
| | 13.7.21 | Member – Te Ahu Whenua Māori Land Trust |
| | 17.8.21 | Member, Māori Provider Expert Reference Group for Transitional Health Unit |
| Naylor, Karen | 6.12.10 | Employee – MidCentral DHB |
| | | Member and Workplace Delegate – NZ Nurses Organisation |
| | 9.10.16 | Councillor – Palmerston North City Council |
| Paewai, Oriana | 1.5.10 | Member – Te Runanga o Raukawa Governance Group |
| | | Chair – Manawhenua Hauora |
| | 13.6.17 | Co-ordinating Chair – Te Whiti ki te Uru (Central Region DHB MRBs) |
| | | Member Nga Manu Taiko, a standing committee of the Council – Manawatū District Council |
| | | Member – Te Tihi o Ruahine Whānau Ora Alliance |
| | | Board Member – Cancer Society Manawatū |
| | 30.8.18 | Appointed Member – Massey University Council |
| | 13.4.21 | Trustee – Manawatū/Whanganui Children's Health Charitable Trust Board |
| | 27.7.21 | Member – Governance Board, Mana Whaikaha |
| | 9.11.21 | No longer a Board Member – Cancer Society Manawatū |
| | | No longer a member of Nga Manu Taiko, a standing committee of the Manawatū District Council |
| | 9.2.22 | Co-Chair, Regional Skills Leadership Group, Manawatū-Whanganui |
| Waldon, John | 22.11.18 | Co-director and co-owner – Churchyard Physiotherapy Ltd |
| | | Co-director and researcher – 2 Tama Limited |
| | | Manawatu District President – Cancer Society |
| | | Executive Committee Central Districts (rep for Manawatu, 1 of 2) – Cancer Society |
| | 9.2.21 | Has a contract with UCOL |
| | 14.12.21 | No longer contracted to UCOL |

| **Register of Interests: Summary, 26 April 2022** (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents) | | |
|---|---|---|
| | | Appointed as Research Advisor Māori to Massey University (commencing 17 January 2022) |
| Warren, Jenny | 6.11.19 | Team Leader Bumps to Babies – Barnardos New Zealand |
| | | Consumer Representatives National Executive Committee – National On Track Network |
| | | Pregnancy and Parenting Education Contractor – Palmerston North Parents' Centre |
| | 12.2.21 | Member of Locality Advisory Group for both Tararua and Ōtaki/Horowhenua for the Primary Maternity Project |
| | | 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) |
| | 1.7.21 | No longer Team Leader Bumps to Babies – Barnados New Zealand |
| | 15.10.21 | No longer Pregnancy and Parenting Education Contractor – Palmerston North Parents' Centre |
| | 4.11.21 | No longer a member of the Locality Advisory Group for Tararua and Ōtaki/Horowhenua for the Primary Maternity Project |
| | 9.11.21 | Contract with Horowhenua Life to the Max |
| | 19.11.21 | Contract with The Horowhenua Company |
| **Committee Members** | | |
| Allan, Simon (FRAC) | 2.6.20 | Deputy Chair – Manawatu Branch of Cancer Society |
| | | MDHB Rep – THINK Hauora |
| | | Palliative Care Advisory Panel (Ministry of Health advisory body) |
| | | Director of Palliative Care – Arohanui Hospice |
| | | Chair of Board – Manawatu Badminton Association |
| Hartevelt, Tony (FRAC) | 14.8.16 | Independent Director – Otaki Family Medicine Ltd |
| | 14.8.16 | Elder son is Director, Global Oncology Policy based at Head Office, USA – Merck Sharpe & Dohme (Merck) (NZ operations for Global Pharmaceutical Company) |
| | 14.8.16 | Younger son is news director for Stuff.co.nz – Fairfax Media |
| | 7.10.19 | Independent Chair, PSAAP's Primary Care Caucus – Primary Health Organisational Service Agreement Amendment Protocol |
| | 14.10.21 | Resigned as Independent Chair of the Primary Care Caucus for PSAAP negotiations |
| Paewai, Stephen (HDAC) | 24.11.21 | Trustee – THINK Hauora |
| | | Member of MDHB's Consumer Council (Interim Chair from November 2021) |
| | | Member of THINK Hauora's Clinical and Digital Governance Committee |
| | | Beneficiary of Rangitane o Tamaka nui a Rua Inc Society |
| | | Trustee – Te Tahua Trust |
| | | Trustee – Te Ohu Tiaki o Rangitane Te Ika a Maui Trust |
| | | Director – Rangitane o Te Ika a Maui |
| | | Board member – Tararua REAP |
| | | Member – Lottery Community Manawatū/Whanganui |
| | | Wife is an employee of MCI and Associates, accounting practice |
| | | Brother-in-law is a senior manager, ACC |

| **Register of Interests: Summary, 26 April 2022** (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents) | | |
|---|---|---|
| **Management** | | |
| Cook, Kathryn | 13.4.21 | Nil |
| Ambridge, Scott | 20.8.10 | Nil |
| Amoore, Anne | 23.8.04 | Nil |
| Anjaria, Keyur | 17.7.17 | Wife is a user of the Needs Assessment and Service Co-ordination Service – MDHB |
| Bell, Margaret | 28.7.20 | Nil |
| Billinghurst, Kelvin | 6.8.20 | Fellow of the Royal College of Medical Administration (RACMA)<br>Coordinator for the Indigenous Health Programme – RACMA<br>Member of the Rural Policy Advisory Group – RACMA<br>Fellow of the Australasian College of Health Service Managers (ACHSM) |
| Brogden, Greg | 16.2.16 | Nil |
| Brown, Jeff | 1.3.22 | Nil |
| Davies, Deborah | 18.5.18 | Member, Alliance Leadership Team – Central PHO<br>Daughter is an employee and works within hospital services – MidCentral DHB |
| Eves, Celina | 20.4.20 | Trustee – Palmerston North Medical Trust |
| Fenwick, Sarah | 13.8.18 | Nil |
| Hansen, Chiquita | 9.2.16<br><br>3.3.21 | Employed by MDHB and seconded to Central PHO 8/10ths – MidCentral DHB<br>CEO – Central PHO<br>Employed by THINK Hauora as Chief Executive and seconded to MidCentral DHB as Interim General Manager, Strategy, Planning and Performance 6/10ths *(until 30 September 2021)*<br>Husband is employed by MidCentral DHB<br>Executive member of General Practice New Zealand (GPNZ)<br>Executive member of Health Care Home Collaborative |
| Hardie, Claire | 13.8.18<br>13.8.18<br>13.8.18 | Member – Royal Australian & NZ College of Radiologists<br>Trustee – Palmerston North Hospital Regional Cancer Treatment Trust Inc<br>Member, Medical Advisory Committee – NZ Breast Cancer Foundation |
| Horgan, Lyn | 1.5.17<br>18.5.18 | Sister is Coroner based in Wellington – Coronial Services<br>Member, Alliance Leadership Team – Central PHO |
| Miller, Steve | 18.4.17<br>26.2.19<br>6.3.19<br>1.10.19 | Director. Farming business – Puriri Trust and Puriri Farm Partnerships<br>Board Member, Member, Conporto Health Board Patient's First trading arm – Patients First<br>Member, Alliance Leadership Team, Member, Information Governance Group – Central PHO<br>Chair – National DHB Digital Investment Board |
| Ratana, Darryl | 29.5.19 | Nil |
| Russell, Greig | 3.10.16 | Minority shareholder – City Doctors<br>Member, Education Committee – NZ Medical Council |

| **Register of Interests: Summary, 26 April 2022** (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents) | | |
|---|---|---|
| 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 1 March 2022 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 1 March 2022 from 9.00am**

**via Zoom due to COVID-19 restrictions**

## PART ONE

**Members**

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

**Apologies**

Brendan Duffy (Board Chair).

**In attendance**

Kathryn Cook, Chief Executive; Dr Kelvin Billinghurst, Chief Medical Officer (and Clinical Executive, Te Uru Kiriora); Gabrielle Scott, Executive Director, Allied Health (and Acting General Manager, Quality and Innovation); Emma Horsley, Communications Manager; Tracee Te Huia, General Manager, Māori Health; Margaret Bell, Board Secretary.

**In attendance (part meeting)**

Scott Ambridge, Operations Executive, Te Uru Rauhī; Dr Jeff Brown, Clinical Executive, Te Uru Pā Harakeke; Sarah Fenwick, Operations Executive, Te Pā Harakeke and Te Uru Mātai Matengau; Lyn Horgan, Operations Executive, Te Uru Arotau and Te Uru Whakamauora; Dr David Peel, Radiation Oncologist; Angela Rainham, Locality and Intersectoral Development Manager; Michelle Riwai, General Manager, Enable New Zealand; Dr Syed Zaman, Clinical Executive, Te Uru Whakamauora.

Media – 1 Public – 0

*Unconfirmed*

## 1. KARAKIA AND HE WHAKATAU

The meeting opened with the organisational karakia.

**He Whakatau – Greetings from the Chair**

"This is the second to last meeting for the Health and Disability Advisory Committee (HDAC) and I wish to take this opportunity to thank Kathryn Cook, Chief Executive, and her management team who have supported and responded to HDAC. We are a sub-committee of MidCentral District Health Board (MDHB), a sub-committee of the Board who are part of the necessary governance for the oversight of healthcare. An important and necessary part are the people who rely on the DHB's services and hold us accountable in our commitment to provide better healthcare for the community. This includes members of the press and I especially acknowledge Owen and Carey Hume, whose daughter Erica died here in Palmerston North in May 2014. Owen and Carey have attended many of our meetings since. I would also acknowledge those who served on HDAC and its predecessors, the dedicated health workers, professional staff and senior management who supported this committee with their service and goodwill; not forgetting previous members of the Quality and Excellence Advisory Committee chaired by Barbara Robson, the Community and Public Health Advisory Committee chaired by Diane Anderson, with Barbara Cameron serving as her deputy."

## 2. ADMINISTRATIVE MATTERS

### 2.1. Apologies

The apology from Brendan Duffy, Board Chair was accepted.

### 2.2. Late items

No late items were advised.

### 2.3. Register of Interests Update

No updates to the Register of Interests were advised.

Materoa Mar noted the following interests in relation to agenda items for this meeting that had previously been declared:

Item 3.4 – Chair of Emerge Aotearoa

Item 6.1 – Upoko Whakarae Te Tihi O Ruahine Whānau Ora Alliance

### 2.4. Minutes of the 23 November 2021 meeting, Part One

It was resolved that:

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

*(Moved John Waldon; seconded Karen Naylor)*

### 2.5. Matters arising from previous minutes

No discussion.

The Clinical and Operations Executives joined the meeting.

*The meeting agreed to reorder some agenda items. The original agenda item numbers are used in these minutes.*

## 3. DIRECTORATE WITH CLUSTER FUNCTIONS REPORTING

### 3.1. Directorate Dashboard

The Operations Executive, Te Uru Rauhī, Mental Health and Addiction Services presented this report, which was taken as read. Executives provided the following responses to questions raised by Committee members.

Most District Health Boards (DHBs) had been unable to provide regular childhood immunisations at the same time as COVID-19 vaccinations due to resourcing issues. The childhood immunisation rate had been affected by the 'Anti vax' and 'No vax' movement. The best way to get people to change their mind about vaccinations is for someone who is trusted by the whānau to talk with them.

There are 3731 people on the ESPI 2 (First Specialist Assessment) waiting list – 354 have waited more than four months; 245 of those people have an appointment which is just outside of the four-month target wait time. There are 2006 patients on the ESPI 5 waiting list – 1026 have waited more than four months; 92 of these people have a date for surgery booked. Staff shortages are expected to increase as staff become unwell with Omicron. This is a challenge for the whole country and the Chief Operating Officers in the central region are working together to try and reduce surgical waiting lists.

The COVID-19 testing site on Main Street, Palmerston North has been busy and caused traffic congestion in surrounding streets. A further testing site has been set up at the Central Energy Arena Trust for people to collect Rapid Antigen Tests, with PCR testing carried out at the Main Street site.

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

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

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

The Operations and Clinical Executives, Te Uru Pā Harakeke presented this report, which was taken as read. They noted that the results of the Tūngia te Ururua community engagement would be available soon. Analysis would include ethnicity and locality.

In response to a question, the Operations Executive advised that before being able to practice in New Zealand, midwifery staff from overseas were required to complete a cultural module as part of their midwifery registration. They would also be supported by the MidCentral District Health Board's (MDHB) Māori Clinical Coach and complete cultural competency training as soon as possible after commencement.

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

The Operations Executive, Te Uru Rauhī presented this report, which was taken as read. He offered to provide the Committee with analysis of the access to Child and Adolescent Mental Health and Addiction Services (CAFS) by locality and ethnicity. Support was available to staff who were working under increased pressure. All referrals were managed through a multi-disciplinary team process to manage any clinical risk.

### 3.5. 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 the all-day additional Saturday acute theatre list was full. Staff were able to 'volunteer' to work on Saturdays and were being paid overtime rates, using funding from the Ministry of Health. The detailed design phase of Stage Two of the SPIRE (Surgical Procedural Interventional Recovery Expansion) project had been completed and costings had yet to be received. Stage Two would start on 1 July 2022.

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

The Operations and Clinical Executives, Te Uru Whakamauora presented this report, which was taken as read. The Gardenview Dementia Unit in Levin closed on 25 February 2022, with all residents transitioned to other providers.

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

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

A Committee member noted the importance of connectivity between Smokefree 2025 work being done by public health and iwi Māori providers. She also noted that a kohanga reo had contacted her about the lack of progress made regarding the provision of dental services. It was agreed that the Operations and Clinical Executives from Te Uru Pā Harakeke would follow up.

It was resolved that the Committee:

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

*(Moved Oriana Paewai; seconded Jenny Warren)*

## 6 DISCUSSION/DECISION PAPERS

### 6.1 **Māori Health Equity Dashboard – Te Ara Angitū Report – Mental Health Indicators**

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

It was resolved that the Committee:

*note the equity position for each of the indicators*

*note the analysis, discussion and proposed next steps to improve Māori health equity and further strengthen MidCentral District Health Board's commitment to Te Tiriti o Waitangi*

*endorse the Te Ara Angitū report.*

*(Moved Muriel Hancock; seconded Stephen Paewai)*

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

The Radiation Oncologist joined the meeting.

## 4. STRATEGIC FOCUS

### 4.1. **Regional Cancer Services and Te Aho o te Kahu**

The Radiation Oncologist presented this report and advised he was willing to talk to any GP practice to discuss how the programme worked.

Committee members congratulated everyone involved in developing this successful project, which was now considered to be 'business as usual'.

It was resolved that the Committee:

*note the update regarding the Advisory Oncology Service.*

*(Moved Heather Browning; seconded Stephen Paewai)*

The Operations Executive, Te Uru Pā Harakeke and Te Uru Mātai Matengau; the Operations Executive, Te Uru Arotau; the Chief Medical Officer and the Executive Director, Nursing and Midwifery left the meeting.

## 5. PERFORMANCE REPORTING

### 5.2 Pae Ora Paiaka Whaiora Report

The General Manager, Māori Health presented this report, which was taken as read. She noted that 55 FTE Māori staff had joined the DHB over the last quarter (not over the last 12 months as noted in the report). Of these, 23 people were clinical. The Chair acknowledged the support for the Māori Education Trust and its predecessor, the Māori Education Foundation (both led by Sir John Bennett) and this Board's support of Kia Ora Hauora and its predecessor, Whakatutukui Moemoea, chaired by Shane Ruwhiu.

In response to questions, it was noted that $40k per annum was available for the scholarship programme, taken from the equity funding for the Māori workforce.

It was resolved that the Committee:

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

*(Moved Heather Browning; seconded Stephen Paewai)*

The General Manager, Enable New Zealand joined the meeting.

### 5.1 Enable New Zealand Report

The General Manager, Enable New Zealand presented this report, which was taken as read. The volume of equipment issued had increased significantly since taking on the ACC Managed Rehabilitation Equipment Service (MRES) contract. It had been estimated that 35 staff would be needed to work on this contract, but only 20 had been recruited so far. A meeting had been held with the new Chief Executive of ACC which had reinforced a strong partnership approach to the delivery of the service.

It was resolved that the Committee:

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

*(Moved Heather Browning; seconded Materoa Mar)*

The General Manager, Enable New Zealand left the meeting.

### 5.3 Quality and Safety Dashboard

The Acting General Manager, Quality and Innovation presented this report, which was taken as read. In response to a question, she advised that the majority of complaints were from people having to wait for long periods to be seen in the Emergency Department, although the feedback was good once they were seen.

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 Jenny Warren; seconded Muriel Hancock)*

## 6. DISCUSSION/DECISION PAPERS *(continued)*

The General Manager, People and Culture joined the meeting.

### 6.2 **Māori Health Equity Dashboard – Workforce Indicators**

The General Manager, People and Culture presented this report, which was taken as read.

It was resolved that the Committee:

*note the progress made on workforce indicators identified for the 2021/22 year*

*note the analysis, discussion and proposed next steps to improve the current workforce indicators.*

*(Moved Stephen Paewai; seconded Lew Findlay)*

The General Manager, People and Culture left the meeting.

The Locality and Intersectoral Development Manager joined the meeting.

## 7. INFORMATION PAPERS

### 7.1 **Regional Services Plan – Quarter One and Quarter Two**

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

A Committee member noted that Joanne Hayes had been appointed as the Manawhenua Hauora representative on the Technical Advisory Services Board.

It was resolved that the Committee:

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

*note the progress made on implementing the central region's national and regional priority programmes for Quarter One and Quarter Two of 2021/22.*

*(Moved Muriel Hancock; seconded Karen Naylor)*

### 7.2 Locality Plan Progress Report – Manawatū

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

It was resolved that the Committee:

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

*(Moved Vaughan Dennison; seconded Jenny Warren)*

The Locality and Intersectoral Development Manager left the meeting.

### 7.3 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 Jenny Warren; seconded Muriel Hancock)*

## 8. GLOSSARY OF TERMS

No discussion.

## 9. LATE ITEMS

No discussion.

## 10. DATE OF NEXT MEETING

Tuesday, 24 May 2022 – Board Room, MidCentral District Health Board, Gate 2 Heretaunga Street, Palmerston North.

## 11. EXCLUSION OF PUBLIC

It was resolved:

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

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

*(Moved Muriel Hancock; seconded Jenny Warren)*

Part One of the meeting closed at 11.28am

Confirmed this 24th day of May 2022

…………………………………………………..

Committee Chair

**Health and Disability Advisory Committee – MidCentral DHB**

- Schedule of Matters Arising, 2021/22 as at 2 May 2022

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

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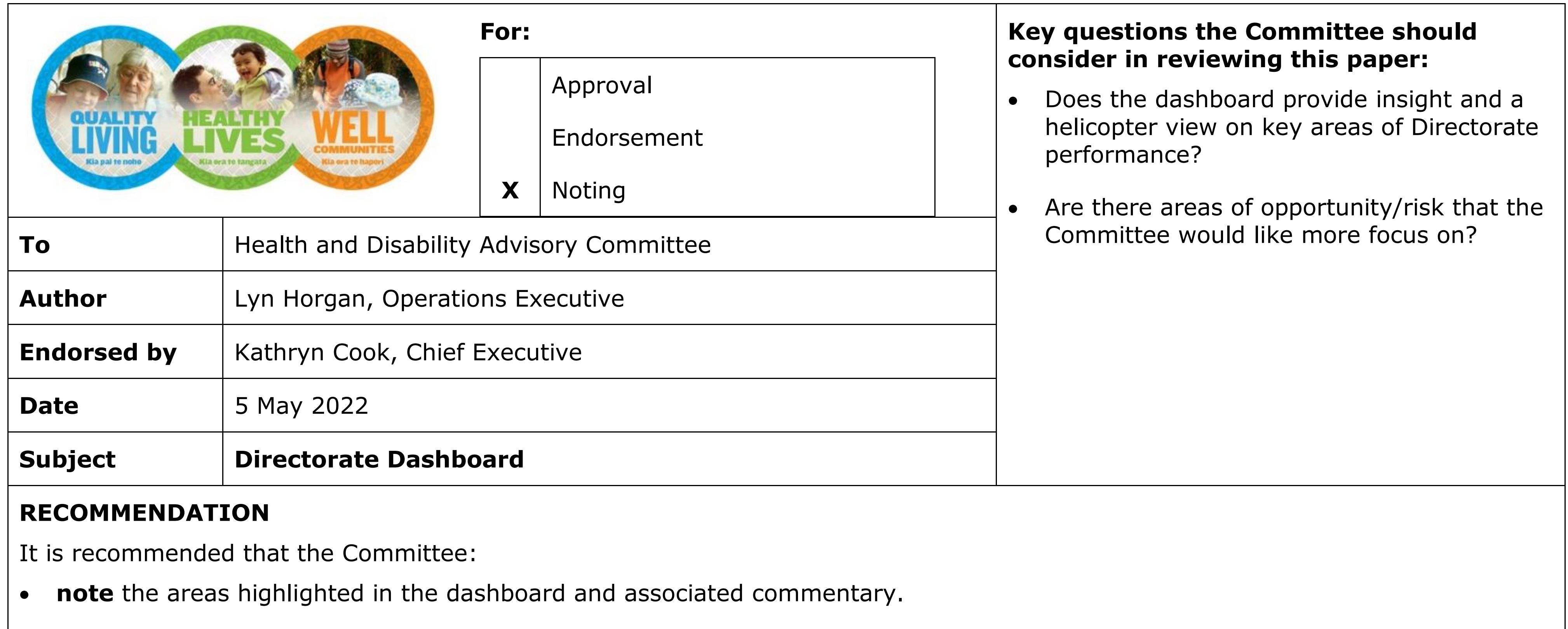
# Directorate with cluster functions reporting

*28 June 2022*

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




**For:**

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

| | |
|---|---|
| **To** | Health and Disability Advisory Committee |
| **Author** | Lyn Horgan, Operations Executive |
| **Endorsed by** | Kathryn Cook, Chief Executive |
| **Date** | 5 May 2022 |
| **Subject** | **Directorate Dashboard** |

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

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

**RECOMMENDATION**

It is recommended that the Committee:

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

**Strategic Alignment**

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

## 1. PURPOSE

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

## 2. COMBINED DIRECTORATE VIEW

The metrics follow the same format as outlined in previous reports and cover the period 1 January to 31 March 2022. They are compared to the same period in the last reporting year, unless specified differently within a particular metric.

### 2.1. Primary and Community

**Community Adults**

| PHO Enrolment ≥90% enrolled with a PHO | | | |
|---|---|---|---|
| Non-Māori Patients | | Māori Patients | |
| Trend | Current Period | Trend | Current Period |
| -0.1% | 97% | -2% | 79% |

| Smoking Brief Advice (SBA) Target: >90% | | | |
|---|---|---|---|
| Total Patients | | Māori Patients | |
| Trend | Jan 2022 - Mar 2022 | Trend | Jan 2022 - Mar 2022 |
| -17% | 68% | -13% | 67% |

| Ambulatory Sensitive Hospitalisation (ASH) Standardised rate per 100,000 (45 - 64 years) | | | |
|---|---|---|---|
| Non-Māori Patients | | Māori Patients | |
| Trend | 12 months to Sep 2021 | Trend | 12 months to Sep 2021 |
| 373<br>12% | 3599<br>Rate | 19<br>0% | 6574<br>Rate |

**Community Children**

| Oral Health (pre-school) * ≤10% not examined against planned recall | | | |
|---|---|---|---|
| Non-Māori Patients | | Māori Patients | |
| Trend | Current Period | Trend | Current Period |
| 0% | 26% | 35% | 26% |

| Immunisations (at two years) ≥ 95% have completed all age-related immunisations | | | |
|---|---|---|---|
| Non-Māori | | Māori Patients | |
| Trend | Oct 2021 - Dec 2021 | Change: | Oct 2021 - Dec 2021 |
| -2.9% | 87% | -11.6% | 71% |

| Ambulatory Sensitive Hospitalisation (ASH) Rate per 100,000 (0 - 4 years) | | | |
|---|---|---|---|
| Non-Māori | | Māori Patients | |
| Trend | 12 months to Sep 2021 | Trend | 12 months to Sep 2021 |
| 2,119<br>69% | 5208<br>Rate | 2,733<br>65% | 6952<br>Rate |

Data from the reporting period shows a similar trend for Māori patients enrolling with a primary health organisation. The issue of enrolment pressures continues as previously reported due to General Practitioner (GP) workforce shortages. The most vulnerable populations continue to be impacted from this situation, which includes enrolment for newborns. The opening of Managed Isolation and Quarantine (MIQ) places for essential workers has seen a new GP starting in Levin in January. THINK Hauora will be undertaking a data match of all unenrolled people notified to the Central Coordination Hub, to review their enrolment status post COVID-19. This is expected to increase enrolments across the district.

Data for Smoking Brief Advice (SBA) over the reporting period showed a significant decrease in the trend for both Māori and non-Māori from the previous year (January 2021 to March 2021). The trend reflects the focus on the COVID-19 response utilising general practice and THINK Hauora staff who would usually undertake SBA. It is envisioned that a focused effort will commence in May, as the current COVID-19 Care in the Community requirements reduce.

Ambulatory Sensitive Hospitalisations (ASH) for 45-64 years reflect the standardised rate for both non-Māori and Māori for hospitalisations for potentially avoidable conditions. The rate of 6574 per 100,000 for Māori has decreased from the previous report (7033), with the rate for non-Māori of 3599 per 100,000 remaining similar to the previous report (3661). A clear equity gap is evident with the rate for Māori continuing to be almost double that of non-Māori.

The arrears for oral health examinations have been significantly impacted by COVID-19, sick leave and vacancies. Stabilisation is expected as normal business resumes. Pleasingly, the driveable mobile clinic is now independent and does not require power or water to operate, allowing for greater flexibility of service to kohanga reo and other locations with Māori prioritised across all elements of service provision.

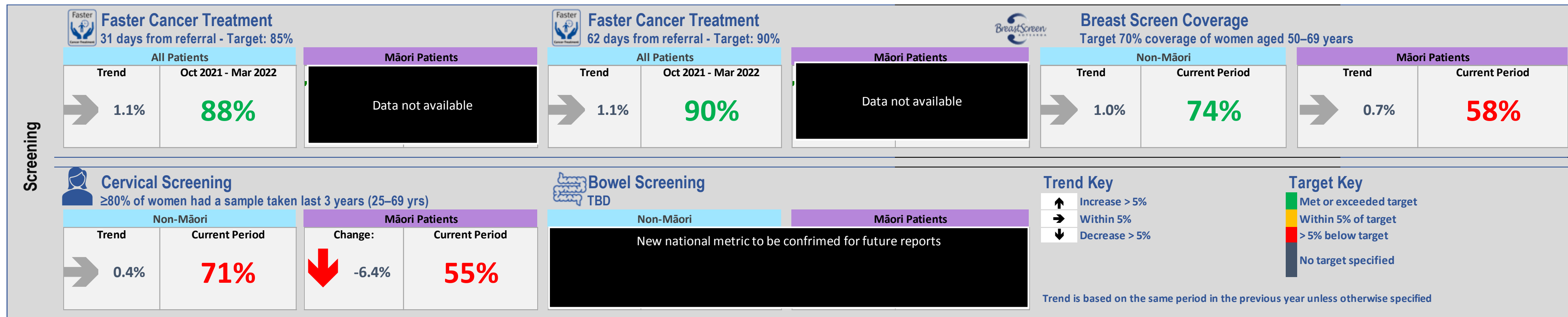
The reporting of immunisation rates for Māori and non-Māori continue to show percentages below the target of 95 percent, with Māori 24 percent below the target. This data compares the current year to date (YTD) with the previous YTD (October 2020 to December 2021) and shows a decrease of 11.6 percent. This decline reflects the commentary presented with the previous report, that the ongoing threat of community spread of COVID-19 is likely to continue to impact vaccination declines and vaccine hesitancy (delayed acceptance).

The data does not reflect the hard mahi that is being undertaken by providers to engage with whānau by providing additional clinics, undertaking home visits and going directly to locations and events where these communities live, work and play.

The drive for increased COVID-19 vaccinations remains, which places pressure on childhood vaccination efforts. Specific areas of focus include the provision of whānau vaccination opportunities that are already underway, alongside usage of Mobile Vehicles (MV) that iwi and Māori providers have been resourced with. Iwi and Māori providers are mobilising the MVs across the district to take vaccination delivery closer to whānau to increase uptake and to support any transport issues. The Vaccination Coordinators based in iwi and Māori providers are connected with their communities and this connection alongside of the data analysis is informing where MVs mobilise. With the legislation supporting the broadening of the scope of the COVID-19 Vaccinator Working Under Supervision (CVWUS) workforce being gazetted with the legislation change expected to come into effect by mid-May 2022, this will support increased vaccinator capacity within iwi and Māori providers.

ASH presentations for 0-4 years for the period July 2020 to June 2021 have now been confirmed by the Ministry of Health (the Ministry) and are unchanged. The apparent change compared with the previous report is due to the 2019/20 numbers being adjusted down. This quarter shows a decrease in non-Māori and no change in Māori to the standardised ASH rate for 2020/21 which was to be expected. This is due to very few winter illnesses in 2019/20 due to border closures and increased COVID-19 alert levels, then an outbreak of Respiratory Syncytial Virus (RSV) and winter illnesses in 2021 with borders opened and reduced COVID-19 restrictions in place.

## 2.2. Screening




BreastScreen Coast to Coast (BSCC) has seen prioritisation of wāhine Māori continue at 58.6 percent (58 percent in the previous quarter), with steady participation rates during the recent COVID-19 Omicron outbreak. The support to screening providers from Whakapai Hauora is prioritising the mobile visit to Ōtaki with texts, e-mails and kanohi ki te kanohi (face to face) visits, along with Pae Ora Paiaka Whaiora Hauora Māori representation to encourage participation. The administration team at BSCC continue to follow the new Māori engagement flowchart with increased referrals to support to screening and increased use of texts. This has resulted in Māori rescreens at 22 months with others at 23 months.

The data presented shows a similar result for both Māori and non-Māori with low cervical screening rates evident. The screening rates for Māori remained at 55 percent and the rates for non-Māori decreased from 72 percent to 71 percent. The ongoing low screening rates reflect the ongoing COVID-19 pandemic with the impact on both available workforce and the ongoing reluctance from many women to attend cervical screening appointments.

Planning is underway to recommence the work across the screening pathway once Public Health staff are able to cease secondments for COVID-19 activities. This will see Te Whare Tapa Wha Hauora Days continuing with Health Promotion staff supporting the process of engagement which is paramount in building rapport and trust with Māori wāhine.

## 2.3. Specialist Care

Specialist Care

| Measure | Non-Māori Patients – Trend | Non-Māori Patients – Current Period | Māori Patients – Trend | Māori Patients – Current Period |
|---|---|---|---|---|
| Shorter Stays in ED (SSED) – National Target: 95% | -14.9% | 64% | -11.1% | 70% |
| Acute Inpatient Length of Stay (LoS) | -0.1 / -3% | 4.5 days | 0.3 / 8% | 4.0 days |
| Elective Inpatient Length of Stay – Average LoS for Arranged & Elective Admissions | 0.0 / -4.2% | 1.12 days | 0.2 / 24% | 1.12 days |
| Outpatient Referrals | - 2,859 / -9% | 29378 referrals | -387 / -7% | 5228 referrals |
| Acute Inpatient Bed Days | - 1,280 / -1.9% | 67381 bed days | 957 / 7% | 15266 bed days |
| Elective Inpatient Bed Days | -739 / -15% | 4344 bed days | -70 / -8% | 819 bed days |
| Outpatient Referral Acceptance | -1% | 90% | -1% | 90% |
| Acute Case Weighted Discharges (CWDs) | -150 / -1% | 14,594 CWDs | 658 / 21% | 3,849 CWDs |
| Elective Case Weighted Discharges (CWDs) | -713 / -14% | 4,360 CWDs | -140 / -17% | 689 CWDs |
| Did Not Attend (DNA) Rate | -0.4% | 3.7% | -13.1% | 9.8% |
| ESPI 2 Waiting Times – Target 99.6% | 1.3% | 31 March 2022: 85% | 3.8% | 31 March 2022: 86% |
| ESPI 5 Waiting times – Target 99% | -19.0% | 31 March 2022: 47% | -12.00% | 31 March 2022: 0% |
| 1:1 Specialing – Total hours of 1:1 specialing | - 3,419 / -4% | 75093 hours | 1723 / 12% | 16312 hours |
| Mahi Tahi - Better Together Programme – Kaimanaaki partner in care during hospital stay | 71 / 14% | 566 referrals | 23 / 10% | 225 referrals |
| Inpatient Rehab Length of Stay | 1.2 / 7% | 18 days | -2.5 / -13% | 16 days |

Shorter Stays in Emergency Departments (SSIED) remain below target at 67 percent in March. SSIED was 64.9 percent for non-Māori and 72.3 percent for Māori. There were 3877 presentations to the Emergency Department in January, 3393 in February and 3625 in December. This is similar to the same period last year.

During January to March 2022 of the patients in ED who were not admitted, 24 percent waited over six hours. Of the patients in ED who were admitted, 68 percent waited over six hours.

Road trauma presentations has increased above the baseline of 33; with 62 in January, 65 in February (the highest in the last 18 months) and 45 in March.

Overall performance in SSIED continues as an area of challenge. High acuity and the COVID-19 Omicron outbreak resulted in patients requiring specialist assessment or admission. Our wait times are impacted by these factors but also by our ability to move patients into acute beds.

This was significantly limited with one ward being dedicated for COVID-19 patients and their isolation needs. Acute inpatient length of stay and acute inpatient bed days remained steady for both non-Māori and Māori patients when compared with the period last year.

*Elective Services Patient Flow Indicators (ESPI) 2*

MDHB continues to work towards the achievement of ESPI 2. In January, nine of the 21 services were compliant. February saw this reduce to eight services compliant. At the end of the quarter (March 2022) this increased to 11 of the 21 services. At the end of March 2022, there were five services with less than five patients exceeding the four-month target. The recent decline in compliant services can be attributed to the impact of previous COVID-19 lockdowns and the rescheduling of a significant number of COVID-19 positive patients during the last quarter.

*ESPI 5*

ESPI 5 remains an area of challenge. MDHB continues to work in partnership with Crest Hospital to provide outsourced and outplaced surgical procedures to further improve performance in this area. MDHB is working with clinicians on prioritising Māori and Pasifika in Planned Care scheduling to ensure there are no unintended consequences. Planned Care waiting lists are produced by ethnicity with regular monitoring to ensure a greater focus on improving Māori timeframes from referral to treatment. All nine services were non-compliant at the end of March 2022. All surgery waiting list numbers have deteriorated in the last quarter due to the COVID-19 Omicron outbreak, the number of COVID-19 positive patients and pressure on the hospital due to workforce constraints, acute surgeries and bed availability.

*Acute Inpatient Length of Stay*

The Older People's Acute Assessment and Liaison Unit (OPAL) cumulative average length of stay (ALOS) for both geriatrician and medical teams was 8.83 at the start of this quarter and decreased to 8.61 by March 2022. Patients managed by geriatrician teams have a lower ALOS at 6.65 days. All teams' ability to discharge patients to Aged Residential Care (ARC) facilities from March onwards has been greatly impacted by COVID-19 within ARC facilities. Availability of ambulance patient transportation services this quarter continues to regularly be problematic and is impacting on both length of stay and rate of discharges/transfers before noon.

*Specialling*

The level of combined specialling hours required per month across the Healthy Ageing and Rehabilitation (HAR) wards has increased this quarter (total hours this quarter was 12,191 compared with total hours of 9875 last quarter) but is lower than the same three month period in 2021 (total combined specialing hours January to March 2021 was 15,049 hours). Cohorting patients together to enable a more cost-efficient model of specialling wherever possible continues to be promoted and, as a result, cohort specialling hours have increased this last quarter.

*Inpatient Rehabilitation Length of Stay*

Cumulative ALOS continues to improve in STAR 2 and STAR 4 and continues to reduce back towards the previous two years cumulative ALOS (current cumulative ALOS for STAR 2 20.5 days, previous year 19.5 days, current cumulative ALOS for STAR 4 15.65 days, previous year 15 days).

*Mahi Tahi – Better Together Programme*

In March a significantly higher number of patients across the hospital had Mahi Tahi indicated as part of their care on the MIYA board compared to the number in January and February this year (226 patients in March had Mahi Tahi recorded on the MIYA board, in contrast to 83 patients in January and 68 patients in February). The increase in recording Mahi Tahi was primarily in medical and HAR wards and is likely to be due to visitor restrictions during March requiring more specific clarification and documentation of whānau support arrangements permitted in wards.

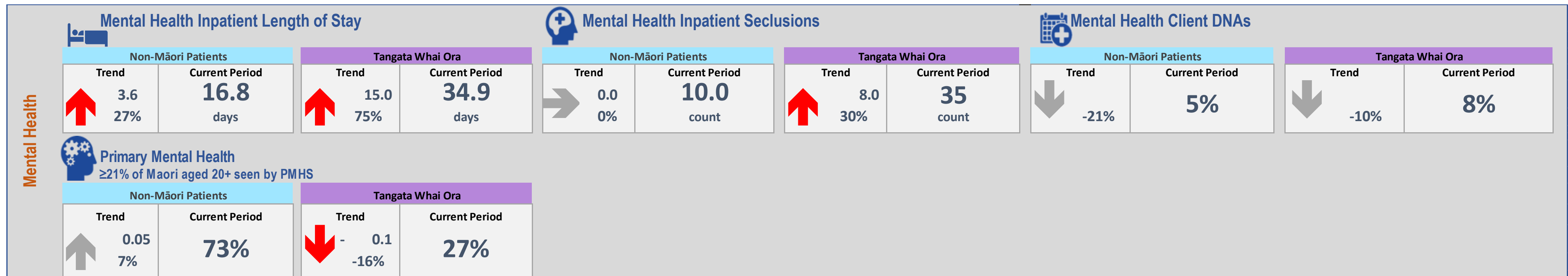
*OPAL Discharge Lounge*

The OPAL patient flow nurse is in post and health care assistants/kaiāwhina are being orientated. The lounge will be operational by the end of May 2022.

*Discharge to Short Term Care Initiative*

Over this quarter SupportLinks has received 20 referrals for the ‘Discharge to short term care service’ initiative which focuses on supporting people wherever possible to return to their prior home from their inpatient stay. Of the referrals received, four people were able to return home.

## 2.4. Mental Health




The ALOS is calculated as the total number of acute inpatient bed nights occupied for referrals that closed during the reference period (in this case the month). The current result of 34.9 days is being influenced by two discharges of tangata whaiora that occurred in March, with a length of stay of 204 and 73 days respectively. It should be noted that whilst the LOS remains stubbornly high, the average 28-day readmission rate for the December to February period of six percent was zero in February. This is a result of improved collaboration between inpatient and community teams, both during the inpatient stay and through supported discharge, a greater emphasis of person and whānau involvement and proactive follow up post discharge.

The first discharge from Te Uruuru Tangata (extended care rehabilitation service) took place in December. During the stay, the client has worked toward greater independence and self-management, has reconnected with whānau and gained casual employment. (NB: This person had multiple acute admissions over the past 12 months and the last length of stay was 100 days.)

In March, inpatient services saw an increase in very complex and challenging drug induced presentations of tangata whaiora that required seclusion on or shortly after admission. The team worked diligently to put in place mitigations and throughout April saw a 20-day period of zero seclusions and for the whole month there was only one seclusion episode.

The last three months has seen a decline in Did Not Attends (DNAs) for Māori and non-Māori. How we engage with Māori is a key feature of Te Mātāpuna o te Ora, with a particular emphasis on improving access and providing options and choices to tangata whaiora.

The Integrated Primary Mental Health and Addiction Programme (IPMHA) continues to promote engagement and enhance strengths through services being delivered in accordance with whānau whaiora preference of either face to face, telephone or through virtual mediums. Quarter Three's data breakdown of ethnicity is Māori 27 percent, Pasifika 5 percent, Asian 2 percent and Other 66 percent of referrals. Two thousand and twenty-nine (2029) whānau whaiora accessed the service in Q3, which is a slight decrease on the previous quarter.

Positively there has been an increase in Māori whānau whaiora under the age of 29 accessing support via the IPMHA programme this past quarter. Ongoing collaboration between Mātanga Whai Ora (Health Improvement Practitioners) and Kaiwhakapuaki Waiora (Health Coaches) has led to 25 percent of whānau whaiora seen under the IPMHA Programme being actively engaged with Kaiwhakapuaki Waiora.

## 2.5. Quality/Balancing

| Quality / Balancing | Non-Māori Patients Trend | Non-Māori Patients Current Period | Māori Patients Trend | Māori Patients Current Period |
|---|---|---|---|---|
| Mortality – Percentage of patients deceased 28 days post discharge | 10.6% | 3.1% | -9.26% | 1.6% |
| Acute Readmissions (28 days) – Patients readmitted acutely within 28 days of previous discharge | -6% | 9% | 11% | 11% |
| New Entrants to Aged Residential Care (ARC) | New measure under construction for future reports | | | |

The re-admission rate for Māori (YTD) remains stable at 11 percent and non-Māori YTD is nine 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

| Workforce | Non-Māori Staff Trend | Non-Māori Staff Current Period | Māori Staff Trend | Māori Staff Current Period |
|---|---|---|---|---|
| Staff Sick Leave Rate – Percentage of Sick leave hours from paid hours | 1.3% | 3.1% | -10.7% | 3.5% |
| Staff Annual Leave >2 Years – Percentage of staff with annual leave balances > two years | 0.0% | 14.7% | -6.7% | 9.9% |
| Staff Turnover Rate – Percentage of total headcount that have voluntarily resigned | 31.3% | 1.1% | -9.0% | 1.6% |

Sick leave rates remain stable. The District Health Board (DHB) experienced a significant increase in unplanned absences across all staff groups. This increase was as a result of either the staff member getting COVID-19 or caring for children and/or dependents who got COVID-19. In accordance with national guidelines on this, this leave of absence was recorded as special leave and therefore has not been included as sick leave. MDHB continues to emphasise that staff must not come to work if they have any cold or flu symptoms, even if mild.

Annual Leave (A/L) balances greater than two years continue to increase. While individual leave plans are managed, travel restrictions, coupled with the recent resurgence of COVID-19 in New Zealand, continues to prevent staff taking A/L for overseas travel. The current percentage of staff with A/L balances over two years is over 14 percent. A more detailed analysis, comparisons across other DHBs and commentary has been provided in the workforce report to the Board.

Employee turnover for the period ended 31 December increased from 10.7 percent (annualised) to 12.6 percent (annualised). More analysis and commentary about workforce turnover has been provided in the workforce report to the Board.

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

| A SUMMARY OF THE SIX HEALTH AND DISABILITY SERVICE DIRECTORATES | | |
|---|---|---|
| **Te Uru Arotau**<br>**Acute and Elective Specialist Services** | **Te Uru Kiriora**<br>**Primary, Public and Community Health** | **Te Uru Mātai Matengau**<br>**Cancer Screening, Treatment & Support** |
| Te Uru Arotau is responsible for the planning, funding, commissioning and provision of secondary care (hospital level) services:<br>• Medical services and subspecialties<br>• Surgical services and subspecialties<br>• Anaesthetics and Intensive Care Unit<br>• Medical/Surgical inpatient wards<br>• Medical Imaging and Hospital Pharmacy<br>• Emergency services<br>• Integrated Operations Centre<br>• Specialist Sexual Health services. | Te Uru Kiriora is responsible for the planning, funding, commissioning, and provision of:<br>• Primary and community-based services via a range of contracted partners<br>• Public health services spanning health promotion, protection, regulation and clinical care delivery<br>• Community based nursing services including District and Primary Health Care nursing. | Te Uru Mātai Matengau is responsible for the planning, funding, commissioning, and provision of:<br>• Prevention and early detection (screening) programmes<br>• Cancer diagnostic and treatment services<br>• Cancer support services<br>• Palliative care services<br>• Non-malignant haematology services<br>• Regional services for treatment and screening. |
| **Te Uru Pā Harakeke**<br>**Healthy Women Children and Youth** | **Te Uru Rauhī**<br>**Mental Health and Addictions** | **Te Uru Whakamauora**<br>**Healthy Ageing and Rehabilitation** |
| Te Uru Pā Harakeke is responsible for the planning, funding, commissioning and provision of:<br>• Primary and secondary maternity care<br>• Secondary Obstetrics and Gynaecology services including antenatal day unit, inpatients, outpatient clinics, community midwifery services and lactation services<br>• Family centred inpatient, outpatient and community care for neonates (including neonatal intensive care), children (including high dependency care) and young people – up to their 16th birthday as inpatients and until end of school for ongoing ambulatory care<br>• Child and Adolescent Oral Health Service<br>• The commissioning of appropriate services to help improve the local population's health needs with a particular focus on the first 1000 days and youth-oriented care. | Te Uru Rauhī is responsible for the planning, funding, commissioning and provision of:<br>• General adult mental health in community<br>• Primary Mental Health and Addictions<br>• Mental Health Acute Inpatient services<br>• Eating disorders<br>• Maternal Mental Health<br>• Community Rehabilitation<br>• Child Adolescent and Family<br>• Alcohol and Other Drug Specialist Services<br>• Māori Mental Health<br>• Older Adult Mental Health Services<br>• 24-hour Mental Health Acute Care Team. | Te Uru Whakamauora is responsible for the planning, funding, commissioning and provision of specialist services for people over the age of 65 years (55 years for Māori) and those between the ages of 16 and 64 with a physical disability, with a focus on assessment, treatment and rehabilitation. Services are structured into:<br>• ElderHealth<br>• Rehabilitation<br>• Therapy Services<br>• Supportlinks. |

**APPENDIX TWO: DIRECTORATE VIEW METRIC DEFINITIONS**

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

| | | |
|---|---|---|
| Acute Inpatient Length of Stay (ALOS) | The ALOS for acutely admitted patients discharged during the reporting period with an admission type of (AC). | Excluding Mental Health |
| Elective Inpatient Length of Stay | The ALOS for elective admitted patients discharged during the reporting period with an admission type of (WN). | |
| Outpatient Referrals | Number of outpatient referrals received. | Excluding where Ministry reported = Not required/null/blank |
| Acute Inpatient Bed Days | Total number of acute inpatient bed days. | |
| Elective Inpatient Bed Days | Total number of elective inpatient bed days. | |
| Outpatient Referral Acceptance Rate | Number of outpatient referrals received that were accepted. | Excluding where Ministry reported = Not required/null/blank |
| Acute Case Weighted Discharges (CWDs) | The case weight derived from eligible coded planned care acute inpatient discharges. | |
| Elective Case Weighted Discharges (CWDs) | The case weight derived from eligible coded planned care elective inpatient discharges. | |
| Did Not Attend (DNA) Rate | Patients who did not attend their booked outpatient appointment. | Last YTD under the non-Māori column is actually all patients as ethnicity was not pulled back with snapshots at that point |
| ESPI 2 Waiting Times | As per the Ministry definition used in the non-financial metrics. | Last YTD under the non-Māori column is actually all patients as ethnicity was not pulled back with snapshots at that point |
| ESPI 5 Waiting Times | As per the Ministry 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 Arotau – Acute and Elective Specialist Services |
|---|---|
| **FOR PERIOD:** | January/February/March 2022 |
| **PREPARED BY:** | Lyn Horgan, Operations Executive |

## 1. PERFORMANCE OVERVIEW

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

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

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

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

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

*Unplanned Care – Shorter Stays in Emergency Department (SSIED)*

Acute flow continues to be a challenge for the organisation and this is reflected in the SSIED results. This is also reflected across the country with increasing acute demand for hospital services, in particular the complexity of presentations and the inability to flex capacity to meet this demand.

MidCentral District Health Board (MDHB) is represented on the National Acute Care Advisory Group where the focus is on a national acute hospital flow plan with actions over the short, medium and long term. These are focused around the following:

- Data and analytics for insights
- Appropriate resourcing for acute health services
- Operational improvements through consistent standards of care
- Interprofessional behaviours
- Seasonal and surge planning
- System improvements for frail older adults and mental health and addiction patients.

MDHB continues to experience high acuity and the COVID-19 Omicron outbreak resulted in patients requiring specialist assessment or admission. Our wait times are impacted by these factors but also by high occupancy which impacts our ability to move patients into acute beds. This was significantly limited with one ward being dedicated for covid patients and their isolation needs.

The COVID-19 ward was stood up on 2 March to cohort care for the number of inpatients with COVID-19. As at the end of April MDHB has implemented a step-down solution to the COVID-19 ward. This permits rooms within the ward to operate as an independent COVID-19 unit with the remainder of the ward being available for post-COVID-19 recovery and normal operations.

The Clinical and Operational teams are meeting with the Ministry of Health (the Ministry) Acute Demand Performance and Support team in early May to discuss support, innovations and learnings.

Improving performance is a priority focus for MDHB. The directorate continues to progress work across the system to improve the flow of patients from presentation to the Emergency Department (ED) to discharge.

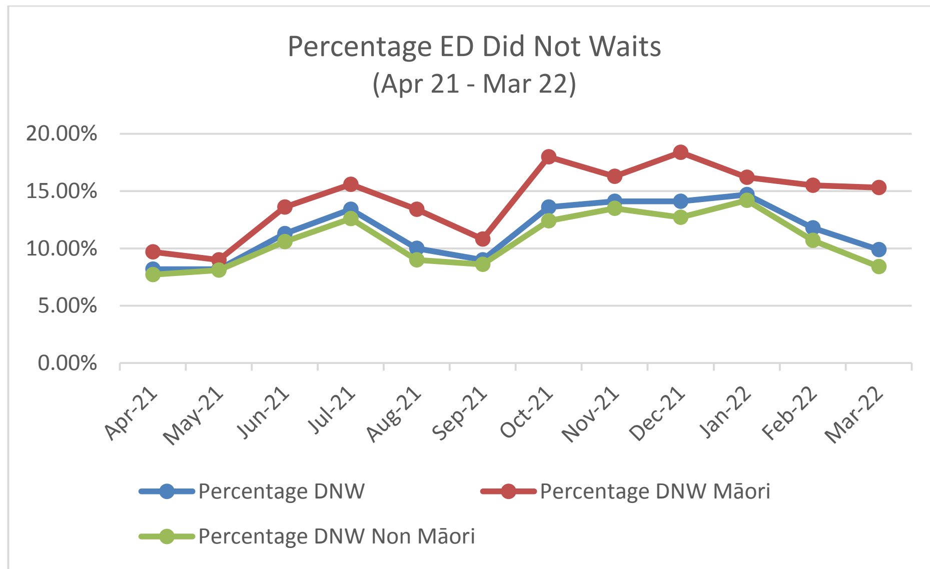
In response to the increasing wait times through the ED, several additional initiatives are underway to improve whole of system patient flow, as listed below.

- MDHB is participating in a Ministry sponsored pilot focussed on weekend discharging of patients. Three areas have been identified with the Ministry which are being scoped include a Package of Treatment Support (PoTS) service as an extension of the Post Emergency Department Assessment Liaison (PEDAL) service, weekend and extended hours for Allied Health Therapies and a Patient at Risk (PAR) nurse role.
- Establishment of a dedicated Patient Flow Nurse to focus on system flow of patients from decision to admit in ED through to the wards. This role commenced on 28 March 2022.
- Establishment of a dedicated Complex Nurse Coordinator role to support the discharge of patients with complex needs. This role will commence in May 2022.
- An additional all day Saturday acute theatre list to improve the flow of acute surgical patients and reduce deferred planned care surgeries on Mondays.
- Te Uru Arotau is working in partnership with Pae Ora Paiaka Whaiora Hauora Māori to progress the establishment of an Equity Coordinator to be based in the ED. This role will commence in May 2022.
- The ED-POAC (Primary Options for Acute Care) redirection continues and there is good uptake of this ongoing initiative.

*Emergency Department – Did Not Waits (DNW) 12 months ending March 2022*

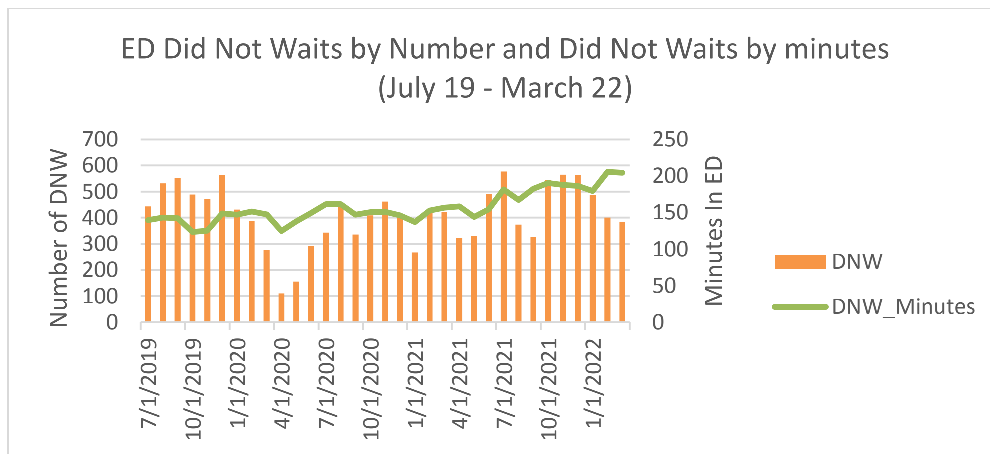
| Month | Total Presentations | Total DNW | Percentage DNW | Māori Presentations | Total DNW Māori | Percentage DNW – Māori | Non-Māori Presentations | Total DNW Non-Māori | Percentage DNW Non-Māori |
|---|---|---|---|---|---|---|---|---|---|
| April 2021 | 3,895 | 318 | 8.2% | 822 | 80 | 9.7% | 3,073 | 238 | 7.7% |
| May 2021 | 4,020 | 333 | 8.2% | 927 | 83 | 9% | 3,093 | 250 | 8.1% |
| June 2021 | 4,354 | 493 | 11.3% | 1,006 | 137 | 13.6% | 3,348 | 356 | 10.6% |
| July 2021 | 4,293 | 574 | 13.4% | 1,071 | 167 | 15.6% | 3,222 | 407 | 12.6% |
| August 2021 | 3,762 | 376 | 10% | 856 | 115 | 13.4% | 2,906 | 261 | 9% |
| September 2021 | 3,606 | 327 | 9% | 777 | 84 | 10.8% | 2,829 | 243 | 8.6% |
| October 2021 | 3,958 | 540 | 13.6% | 877 | 158 | 18.0% | 3,081 | 382 | 12.4% |
| November 2021 | 4,021 | 568 | 14.1% | 906 | 148 | 16.3% | 3,115 | 420 | 13.5% |
| December 2021 | 3,994 | 562 | 14.1% | 927 | 171 | 18.4% | 3,067 | 391 | 12.7% |
| January 2022 | 3,325 | 489 | 14.7% | 844 | 137 | 16.2% | 2,481 | 352 | 14.2% |
| February 2022 | 3,393 | 401 | 11.8% | 776 | 120 | 15.5% | 2,617 | 281 | 10.7% |
| March 2022 | 3,877 | 384 | 9.9% | 805 | 125 | 15.3% | 3,072 | 259 | 8.4% |

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




The percentage of DNW is decreasing. This is likely due a decrease in the number of presentations to ED between January and March 2022. Māori and Pasifika ethnicities are considered priority flags as part of the ED triage process.

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




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

*Planned Care and ESPIs*

MDHB is progressing well towards the achievement of ESPI 2. The use of Telehealth during the Omicron surge has increased and enabled continued access to specialist care.

ESPI 5 remains an area of challenge. During this period, COVID-19 Omicron surged with significant increases to community cases and increased presentations to ED and subsequent admissions. The COVID-19 ward was activated on 2 March 2022, to cohort care for the number of inpatients with COVID-19. Consequently, there was a reduction in Planned Care surgeries undertaken due to the reduced inpatient beds, workforce and MDHB's COVID-19 operating theatre being stood up. MDHB continues to work in partnership with Crest Hospital to provide outsourced and outplaced surgical procedures to further improve performance in this area. Senior Medical Officers continue to be involved with planning surgery based on those with greatest clinical urgency and long waiting times.

The stand alone COVID-19 theatre has also been stood down and positive COVID-19 patients will be managed through usual theatres with COVID-19 processes in place. Planned Care surgery has recommenced from the end of April.

Table 1: **Referrals received, accepted and declined as below threshold/capacity from 1 June 2021 to 31 May 2022**

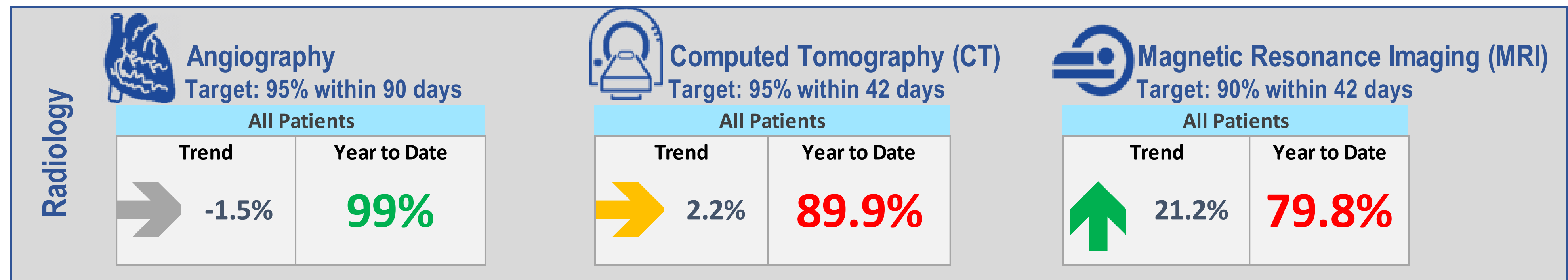
| Specialty | Total received (12 months) | Accepted (12 months) | Declined below threshold/capacity (12 months) | Percentage declined (12 months) |
|---|---|---|---|---|
| Cardiology | 2634 | 2188 | 1 | 0 |
| Dental | 2298 | 1903 | 0 | 0 |
| Diabetes | 273 | 179 | 5 | 1.8 |
| Ear Nose Throat | 3503 | 2899 | 5 | 0.1 |
| Endocrinology | 615 | 369 | 0 | 0 |
| Gastroenterology | 2422 | 2398 | 0 | 0 |
| General Medicine | 1271 | 1178 | 1 | 0.1 |
| General Surgery | 5862 | 5093 | 595 | 10.2 |
| Gynaecology | 2539 | 2374 | 5 | 0.2 |
| Maxillo-Facial | 121 | 120 | 0 | 0 |
| Dermatology | 817 | 689 | 2 | 0.2 |
| Infectious Diseases | 187 | 181 | 0 | 0 |
| Neurology | 1393 | 1000 | 49 | 3.5 |
| Opthalmology | 3021 | 2765 | 0 | 0 |
| Orthopaedics | 5709 | 5650 | 16 | 0.3 |
| Paediatric Medicine | 1627 | 1625 | 0 | 0 |
| Respiratory | 1362 | 1302 | 0 | 0 |
| Urology | 3192 | 2751 | 362 | 11.3 |
| Rheumatology | 422 | 380 | 1 | 0.2 |
| Renal Medicine | 296 | 296 | 0 | 0 |
| **Total** | **39564** | **35340** | **1042** | **2.6** |

**Note:** The process to review and triage referrals is a continuous one across rolling months, for example a referral may be received at the end of one month and processed early in the following month.

*Community Infusion Service*

The Community Infusion Service (CIS) pilot has been completed with three General Practice (GP) sites. Following the successful pilot, the CIS will continue to be delivered. Plans include increasing the number of GP sites and the types of infusions that can be delivered at a GP site.

### 1.1 Performance Indicators – Year to Date to March 2022




The Angiography performance target has been met.

Computed Tomography (CT) performance remains steady when compared to the same period last year. Demands for service continue to increase and acute demand impacts on planned CTs.

The Board approved at the March 2022 meeting to replace the main CT machine. The replacement of the existing CT scanner will offer improved features over the old one, enabling better diagnostic results, especially for clinical support and management of stroke cases. Approval has been given for a second CT machine. The current CT scanner has a throughput of up to 95 cases per day via extended hours and shift work. A normal case load would be 45 cases per day and the current volumes are not sustainable for staff, patient scheduling or the equipment uptime. This additional scanner will assist to meet the needs of the MDHB population.

Magnetic Resonance Imaging (MRI) performance has improved when compared with the same period last year. The April result was 98 percent.

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

## 2. SIGNIFICANT MATTERS

### 2.1 Major Facility Projects

*2.1.1 SPIRE (Surgical Procedural Interventional Recovery Expansion)*

Stage 1 construction is underway and involves the establishment of a new Day of Surgery Admission and Recovery area and the expansion of the Endoscopy Unit on the first floor of Block A. This stage also included the upgrade of the Theatre Staff Change Area within the theatre suite and this work was completed in February. Feedback from clinical staff has been very positive.

As advised previously, some issues are being encountered as the walls and ceilings are opened up. These are impacting on the project cost and timeline. The detailed design for Stage 2 is currently being costed and the construction timeframe reviewed. This project, and the MAPU/EDOA (Medical Assessment and Planning Unit/Emergency Department Observation Area) project, are experiencing cost pressure from supply chain disruption and scarcity of market capacity in most trades. The scope is being maintained but our ability to restrain costs against market forces is limited.

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

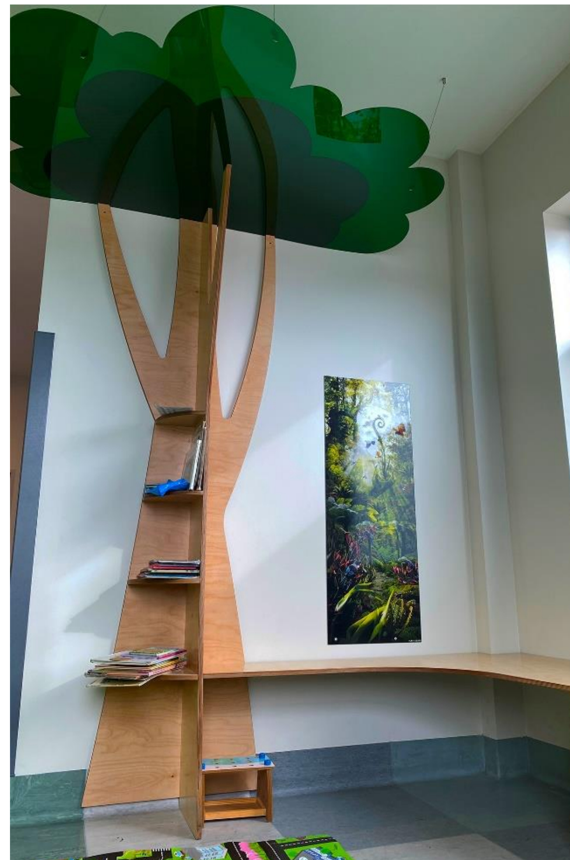
Work on creating the foundations for this $750m^2$ building is well underway. New accessibility parks in front of the hospital's main entrance opened on 7 March. These replace those displaced by the construction works in Car Park C.

### 2.2 Omicron

The COVID-19 ward was activated on 2 March 2022 to cohort care for the number of inpatients with COVID-19. On 8 April 2022 representatives from the Heartlands Lion Club, Palmerston North, met with Charge Nurse Jo, Associate Charge Nurse Febe and Nurse Educator Ann for the dedicated COVID-19 ward. Heartlands Lion Club donated a number of gift bags to thank and acknowledge the hard work of the staff on the ward.

## 2.3 Emergency Department Child Friendly Environment Upgrade

Palmerston North Rotary, the Emergency Department and Pae Ora Paiaka Whaiora Hauora Māori have worked in partnership for an upgrade to the environment for tamariki and whānau. Feedback received from whānau is positive for this child friendly space.



## 2.4 Medical Imaging Update

### *2.4.1 Accreditation for Clinical Radiology Training*

Palmerston North Hospital has successfully obtained provisional accreditation for Clinical Radiology Training by The Royal Australian and New Zealand College of Radiologists. Palmerston North Hospital will be linked as a training site to Wellington Hospital to provide Clinical Radiology Training on a rotational basis. The training rotation will be offered as an option for Year Two Clinical Radiology Training Registrars.

*2.4.2 Ultrasonographer Training*

Recruitment for a trainee Ultrasonographer is underway. This will be the first training position in several years. Training had been paused while there were Ultrasonographer vacancies.

*2.4.3 Hospital Health Pathways*

The Hospital Health Pathways will go live on 4 May 2022. The new system will provide a whole of system approach to the delivery of healthcare, making better use of resources and standardising information making it easier to process.

The information available is locally agreed information to support GP teams, clinicians, community and hospital-based staff to support making the right decision with their patients. The standardisation of the information supports consistent service delivery for MDHB and partner organisations and complements the Community Health Pathways site which aims to improve quality and consistency of care in hospital and facilitate early discharge planning and post-discharge coordination with GPs.

| | |
|---|---|
| **SERVICE** | Te Uru Whakamauora – Healthy Ageing and Rehabilitation |
| **FOR PERIOD** | January/February/March 2022 |
| **PREPARED BY** | Lyn Horgan, Operations Executive<br>Syed Zaman, Clinical Executive |

## 1. PERFORMANCE OVERVIEW

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

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

**Rating & Trend Legend**

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

**Plan Legend**

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

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

## 2. SIGNIFICANT MATTERS

### 2.1. Omicron Management

Through the COVID-19 Omicron surge the Directorate worked closely with Aged Residential Care (ARC) and Home and Community Support Services (HCSS) providers to identify vulnerable service users when workforce issues impacted on service delivery. Regular meetings were held between Directorate representatives and ARC/HCSS providers to provide ongoing support and reassurance. ARC provider workforce mitigation plans included extended shifts, use of volunteers and whānau and prioritising essential services. The Older People's Rapid Assessment (OPERA) team provided specialist ElderHealth support to ARC providers with a hospital prevention focus and on call after hours geriatrician/clinical support. HCSS provider mitigation plans included prioritising complex clients that require a higher level of support and reducing or suspending non-urgent services, for example home management.

ElderHealth nursing team, SupportLinks and allied health therapy staff provided support across various shifts in the inpatient wards and at designated testing sites in addition to their normal duties and hours of work.

### 2.2. Care in the Community

The Post-Acute Community Rehabilitation business case has been approved by the Board. Implementation planning is under way and this service will align with the Older People's Acute Liaison (OPAL) Community Service and existing community services to deliver multidisciplinary, targeted rehabilitation programmes to our population across the MidCentral DHB rohe.

The OPAL Community Service model of care working group continues to refine the model of care. In tandem with the model of care design, the project team has been meeting with primary care, NGOs (Non-Government Organisations) and community networks in Horowhenua/Ōtaki to raise awareness about the OPAL Community Service and adjust the model of care based on feedback. Recruitment is underway for allied health staff to resource teams across Horowhenua/Ōtaki, Palmerston North and Manawatū. Recruitment for Tararua will be scheduled to align with implementation of the team in 2023.

### 2.3. Community Capacity

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

A focus on community Occupational Therapy non-urgent referrals has reduced the number of clients waiting for service from 433 at the end of December 2021 to 364 at the end of March 2022.

This has been achieved through a combination of increased staffing, that is, the addition of a rotational therapist to the community team, consistent application of eligibility criteria and a targeted waitlist review and prioritisation. Three hundred and forty-one (341) referrals were received and a total of 128 new cases were allocated to the team in addition to current caseloads.

Urgent referrals where clients are at immediate risk of deterioration, admission to hospital or transfer from other DHBs are actioned within two days. The level of urgent cases in addition to current caseloads has limited the team's ability to pick up cases who are waiting, contributing to the high waitlist numbers and wait times.

Mitigation includes contracting a private provider to assist the community team to further reduce the waitlist, prioritising those who have been waiting in excess of 12 months. In April a new therapist joined the team and will specialise in the provision of wheelchairs and seating (0.5 FTE) to focus on complex wheelchair and seating needs. A number of vacancies still exist for experienced Occupational Therapists, despite active recruitment. A new initiative establishing the role of a clinical coach to support the new graduate transition to the workplace and provide mentoring and ongoing education has been highly successful, resulting in less experienced staff members developing confidence and competence.

The Hand Therapy Service waitlist has reduced to 10 patients from 50 patients in the last quarter and is within the Ministry's guidance.

Most patients referred to the Clinical Dietitian Service have been seen as per Ministry guidance except for urgent Gastroenterology referrals (inflammatory bowel diseases). We do not have a Clinical Dietitian dedicated to the specialty area of Gastroenterology and our capacity to respond to urgent Consultant referrals is very limited – these patients are a high priority and need to be seen within a two-week timeframe. Currently we prioritise these referrals for any last-minute cancellations within the limited number of general outpatient clinics currently available onsite. To date there has been no compromise to the care of patients referred by the Gastroenterology team; the Clinical Dietitian Service has responded by offering appointments outside of usual clinic days and by assigning more senior Dietitians to action these referrals rather than less experienced staff members. However, this model of care is not sustainable and is likely to be impacting on other acute clinical work and masking the actual demand for dedicated Clinical Dietitian expertise and time in Gastroenterology. Currently the dietetic professional lead is working with the Gastroenterology Department to establish the required dietetic FTEs based on data collected from informatics as well as benchmarking against national and Australasian best practice quality standards.

The waitlist for SupportLinks has increased from 222 to 383. Demand on the service is constant and continues to impact on staff, particularly during periods of leave, sickness and recruitment. Mitigation of client risk continues with Packages of Temporary Care (POTS), providing respite and carer relief packages prior to assessment if required, applying a proactive assessment approach based on risk and urgency for vulnerable client groups and assessment by telephone. In response to COVID-19 in the community responding to referrals in a timely way the use of contact assessment by telephone has been maximised. Active recruitment continues for vacant positions.

BUPA Gardenview, a 41-bed dementia facility in Levin, closed on 6 March 2022. The 21 residents were relocated to existing beds within the MidCentral District Health Board (MDHB) area and two moved out of the area. Ranfurly Residential Care centre had four additional dementia beds certified to support the relocation. Millvale House Psychogeriatric ARC facility in Levin is now certified for 26 residents after opening a closed wing on 28 March 2022; this is an increase from 18. Wimbledon Villa, a 38-bed ARC facility in Feilding, has been sold and new owners took over on 9 March 2022.

The health and disability sector continues to experience significant service coverage challenges due to an inability to recruit to existing vacancies for both Registered Nurses (RNs) and community support workers. Locally, MDHB ARC providers have reported issues with RN recruitment and covering rosters in times of sickness and vacancies. This has been further exacerbated by the COVID-19 outbreak.

Mitigation plans that have been implemented in ARC include RNs working longer shifts, clinical managers and facility managers working on the floor and using senior caregivers with an RN on call. HCSS providers are experiencing recruitment issues across all localities especially for weekend supports. There has been an impact on timely discharges for all levels of care for new residents into ARC and for complex support packages in the community.

Scenario-based training sessions have been completed involving ARCs to improve preparedness for a pandemic outbreak and COVID-19 resurgence (aligned to the New Zealand Aotearoa Pandemic response policy for Aged Residential Care).

MDHB had regular Zoom meetings with ARC and HCSS providers before and during the Omicron outbreak to provide support and early notification of risks that may affect delivery of supports. MDHB supplied ARC facilities with personal protective equipment (PPE) requests as the central supply chain and courier drivers became overwhelmed. Access to PPE N-95 masks and rapid antigen testing kits for HCSS providers through the Ministry central supply chain was not resolved until many weeks into the outbreak.

The Fracture Liaison Service (FLS) has recently transitioned back to Te Uru Whakamauora following exiting of the contract with THINK Hauora. The previous coordinator of the FLS resigned in January 2022 prior to the transition of the service. Te Uru Whakamauora is currently working through the recruitment process to recruit a coordinator, part-time clinician and administrator to support service provision. Clinical resource has been secured for a short period of time to progress clients who had been accepted by THINK Hauora and had not completed their plan of care at the time of transition. The service continues to engage with the funder (Accident Compensation Corporation) regarding the transition of the service and the impact on service delivery. They are satisfied with the current status and progress to date.

### 2.4. Equity

Recruitment for a Kaihāpai Kaumātua Ora Clinical Nurse Specialist role in Horowhenua is underway. This will assist with the development and implementation of OPAL Community Service, with a particular focus on clinical and cultural best practice across the care that Kaumātua receive within the Horowhenua Elder Health and OPAL community service. The role has a focus on prevention, identification and management of frailty for priority populations, access and equity outcomes for Māori.

### 2.5 STAR 4 Hospital Friends

A volunteer information evening was recently held at Horowhenua Health Centre with 10 people attending. Attendees included two librarians from Te Takere Levin Library who were scoping the possibilities for offering library services at STAR 4. This will be followed up with a Memorandum of Understanding. Once implemented in STAR 4, consideration will be given to implementing a similar initiative in the STAR Ward in Palmerston North and the OPAL Unit.

| **SERVICE** | Te Uru Mātai Matengau – Cancer Screening, Treatment and Support |
|---|---|
| **FOR PERIOD** | January, February, March 2022 |
| **PREPARED BY** | Sarah Fenwick, Operations Executive<br>Dr Claire Hardie, Clinical Executive |

## 1. PERFORMANCE OVERVIEW

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

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

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

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

| **Plan Legend** | A | Annual Plan | S | Sustainability Plan | E | Equity Indicator |
|---|---|---|---|---|---|---|

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

The Māori Cancer Research Strategy, aligned with Te Tiriti o Waitangi and the Wai 2575 principles was signed off in February 2022.

Bowel Screening reporting occurs six months in arrears, with the recognition that participants have six months to return the bowel screen kit sent to them. Current data for this reporting period is therefore low, however is expected to improve over the coming months, in line with previous years. Final data from August 2021, confirmed in February 2022, shows that the service met the minimum 60 percent target for Māori, however a significant inequity for Māori remains. In response to this, there has been continued Māori focused promotional activity occurring with a 'back of the bus' image of a local Highbury whānau, kōrero with Tararua residents which has resulted in a tāne Māori focus partnering with the Māori Cancer Coordinators to follow up Māori who have not completed their kits.

BreastScreen Coast to Coast (BSCC) has seen prioritisation of wāhine Māori continue at 58.6 percent (58 percent in the previous quarter), with steady participation rates during the recent COVID-19 Omicron outbreak. The support to screening provider from Best Care Whakapai Hauora is prioritising the mobile visit to Ōtaki with texts, emails and kanohi ki te kanohi (face to face) visits, along with Pae Ora Paiaka Whaiora Hauora Māori representation to encourage participation. The administration team at BSCC continue to follow the new Māori engagement flowchart with increased referrals to support to screening and increased use of texts. This has resulted in Māori rescreens at 22 months with others at 23 months.

Te Uru Mātai Matengau Senior Leadership Team continues a strong focus on the cancer nursing workforce strategy including enabling nurses to work at top of scope and succession planning for future service delivery. This is a priority to ensure a safe and sustainable oncology nursing workforce. Once this strategy has been implemented, similar working models can be rolled out across the Regional Cancer Treatment Service (RCTS).

Taranaki District Health Board is progressing well with their Radiation Therapy and Systemic Therapy Unit installation and are now in the final design stages, on track to have an operational linear accelerator (LINAC) by 2024. Hawke's Bay District Health Board's project is delayed due to the need to re-work their business case, secondary to the requirement to change the location of the proposed Radiation Treatment unit at the Hasting's Hospital campus and incorporate a Systemic Therapy Unit. The project timelines are currently being worked through and are not available at the time of this report. MidCentral DHB (MDHB) continues to contribute to both projects as subject matter experts, and as the service provider.

The outreach chemotherapy solution at Whanganui Hospital remains behind schedule. Whanganui District Health Board continues to pursue alternative solutions for service provision via an integrated day stay unit. Te Aho o Te Kahu is providing programme management for this project with MDHB contributing as subject matter experts as the service provider.

Work to refresh Te Korowai O Rongo, the District Palliative Care Strategic Plan, remains on hold due to the resignation of the Project Lead late last year and the recent COVID-19 Omicron outbreak in the community with subsequent service resources impacted by this outbreak. This work will be revisited following the transition to Health New Zealand on 1 July 2022.

## 2. SIGNIFICANT MATTERS

### 2.1. **Medical Workforce**

The RCTS continues to experience vacancies at Senior Medical Officer (SMO) and Medical Officer of Specialist Scale (MOSS) level. Active recruitment continues in Radiation Oncology for two SMO vacancies. A business case for a fourth Registrar has recently been submitted for approval, in line with training recommendations. Risk mitigations are in place, however, increasing referrals are impacting these. Regular liaison is in place with Te Aho o Te Kahu on Radiation Oncology First Specialist Assessment (FSA) and radiation treatment waiting times to determine if support from other centres should be activated. To date this has not been required.

The Medical Oncology workforce remains at reduced capacity, however positively a new Medical Oncologist in Hawke's Bay commenced in March 2022 and a six-month locum position to cover maternity leave in Hawke's Bay has been recruited to and will commence in April 2022. These positions will allow MDHB to reduce visiting Medical Oncology clinics to Hawke's Bay. Waiting times to FSA are being monitored and any delays due to these staff shortages will be communicated to multidisciplinary tumour groups.

The Clinical Haematology workforce is currently impacted by increasing referrals, reduced registrar numbers, SMO parental leave and no MOSS position in Hawke's Bay. The team have reallocated and prioritised clinics and waiting times to FSA and follow up appointments are being actively monitored.

### 2.2. BreastScreen Coast to Coast

The Clinical Director for the BSCC and the Breast Imaging Service has now been confirmed. Active recruitment for a Breast Radiologist continues, with outsourced radiology services in place to mitigate the workforce risk.

### 2.3. Oncology Outpatients

Recruitment to the permanent position of Charge Nurse, RCTS Ambulatory Care has been unsuccessful. Therefore, following discussion expressions of interest for an Associate Charge Nurse, RCTS Ambulatory Care for an initial 12-month period are being sought. In the interim, this position continues to be filled by the Associate Director of Nursing Te Uru Mātai Matengau.

### 2.4. Mosaiq as a Service

The upgrade and migration to the cloud is on track and expected to be completed and operational by August 2022.

### 2.5. COVID-19 Omicron

The Te Uru Mātai Matengau Business Continuity Plan was implemented in response to the current COVID-19 Omicron community outbreak, allowing FSAs and cancer treatment to continue in a timely manner for patients.

| **SERVICE** | Te Uru Pā Harakeke – Healthy Women Children and Youth |
|---|---|
| **FOR PERIOD** | April and May 2022 |
| **PREPARED BY** | Sarah Fenwick, Operations Executive<br>Dr Jeff Brown, Clinical Executive |

## 1. PERFORMANCE OVERVIEW

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

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

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

| Plan Legend | A | Annual Plan | S | Sustainability Plan | E | Equity Indicator |
|---|---|---|---|---|---|---|

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

Data for reducing the equity gap between Māori and non-Māori babies who are exclusively or fully breastfeeding at three months is taken from a Ministry of Health (the Ministry) local data set. The most recent data from September 2021 shows the three months breastfeeding rate to be 45.9 percent for Māori babies and 56 percent for non-Māori babies, indicating no real change for Māori and a two percent increase for non-Māori babies. The use of donor milk through the Whāngai Ora milk bank has continued to significantly improve the exclusively breastfed rate on discharge from hospital, with 89 percent achievement in February 2022. It is therefore hoped that the three-month breastfeeding rate will improve over coming months.

Data for babies who live in smokefree households is provided six monthly, with the latest data published in February 2022 for the period ending September 2021. This data show the MidCentral District Health Board (MDHB) result was 41 percent for Māori babies and 55 percent for non-Māori, compared with a national average of 56 percent. This is a decrease of one percent for Māori and three percent for non-Māori from the previous six-month reporting period. The interdisciplinary team is working hard to make improvements, with a focus on the recording of data.

The final Tūngia te Ururua report has now been received and feedback from Locality Advisory Groups incorporated. An overarching report has been provided to the Committee for their information, with the full report available for Committee members on Stellar (MDHB/HDAC/HDAC Reports and Documents/Tungia Te Ururua final report). The information from this report will be used to inform the First 1000 Days Strategy.

As highlighted in previous papers, the national shortage of midwives, increasing acuity and handover of care are all factors impacting on the ability to recruit and retain midwives at MDHB. A robust workforce action plan and staffing escalation plan are in place to mitigate the workforce risk.

Local recruitment efforts continue with three new graduate midwives now fully orientated. Two further midwives have been recruited with start dates in early May. In addition, four additional midwives totalling 2.8 full time equivalent have now been recruited for Te Papaioea Birthing Centre, enabling the Centre to increase staffed provision every week from 7am Mondays to 5.30pm Fridays, as from Monday 9 May 2022.

Two external recruitment companies are engaged to recruit midwives internationally, with one candidate from the United Kingdom successfully recruited, however arrival has been delayed due to Midwifery Council processes.  A further international midwife has been interviewed with an offer pending.

Recruitment to an Associate Director of Midwifery role has been paused following three unsuccessful attempts.  As part of Te Uru Pā Harakeke’s commitment to Te Tiriti and equity of outcomes for Māori, the Kaiaraara Tu Ora role – Primary Midwife Specialist is in place.  This multidisciplinary role is working with Pae Ora Paiaka Whaiora Hauora Māori to enhance the experience and outcomes for wāhine and whānau Māori across the rohe.  Recruitment to the Equity Lead role has been confirmed with the successful candidate commencing on 7 June 2022.

## 2. SIGNIFICANT MATTERS

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

This project focuses on removing barriers to accessing health and education support for children requiring multi-agency services to meet additional needs arising from developmental delays or disability.  MDHB is working in collaboration with other agencies to develop an integrated, whānau centred referral and care model.  The pilot model incorporates the application of Enabling Good Lives (EGL) and Te Whare Tapa Whā principles into an intersectoral integrated service model supporting tamariki aged 0 to 8 years with additional needs, disabilities and/or developmental delays.  Key partners from Te Whakahuia Whānau Ora support our intention to develop a service that is culturally appropriate and meets the needs of tamariki.

Successes at Phase Two of the project include:

- Establishment of Kia Kotahi te Tamaiti (Child Hub Collaborative) digital platform and online referral portal
- An operating multi-agency referral review team
- Refinement of whānau centred support planning format
- First live referrals and service provision, including success stories of barriers to accessing services being removed.

The project team presented the outcomes of Phase Two to the Ministry on 9 May 2022

### 2.2 Child Development Service (CDS) Psychology

The Child Development Service change paper released in March 2021 proposed moving to a fully outsourced arrangement for neuropsychological assessments.  The decision document, released on 28 June 2021 confirmed the decision to proceed with the outsourced model. Work continued to progress this decision with staff and union partners with the process finalised in February 2022. The request for proposals closed on Friday 13 May 2022.

### 2.3 Colposcopy Audit

The National Cervical Screening Programme run by the Ministry undertook the mandatory three-yearly audit of colposcopy screening and treatment processes at MDHB on 17 August 2021. The audit report has been received with three corrective actions. These have all been actioned and evidence submitted to the Ministry. Final sign off is awaited.

### 2.4 First 1000 Days Strategy

Evidence confirms that experiences during the period from conception until a child’s second birthday, known as the first 1000 days, have a far-reaching impact on health, education, social outcomes, and on health equity. Research shows that many challenges in adult society have their roots in the early years of life, including major public health problems such as obesity, heart disease, and mental health problems, as well as societal challenges such as unemployment, poverty, imprisonment and early death.

MDHB has been successful in securing sustainability funds to develop a strategy for the first 1000 days for the MidCentral DHB region, with Francis Health and Synergia partnering with MDHB to complete this work. The objective is to ensure that every child born across the district is supported to thrive, by developing a strategy that engages with Māori, communities and sector stakeholders ensuring the best start of life for future generations.

Learnings from Tūngia te Ururua will help inform the project, which will involve community engagement commencing in May 2022.

### 2.5 Recruitment

The Obstetrics and Gynaecology team has recruited a Senior Medical Officer (SMO) who commenced in November 2021, reducing their vacancy to two full-time equivalent (FTE) SMO vacancies. A further SMO has been recruited initially with a March start date but is now likely to be late May 2022 due to Medical Council requirements. A locum has been secured for a six-month period who commenced in April 2022 to bring the team to full staffing. Ongoing recruitment will continue until a final permanent SMO is secured.

The Paediatric team is currently fully staffed with SMOs but with a resignation to take effect in July 2022. The RMO FTE has improved from previous months with no vacancies as of April 2022.

### 2.6 Antenatal Clinic

Antenatal clinic will permanently relocate to premises beneath Te Papaioea Birthing Centre, known as the ‘The Salt Rooms’ following the recent signing of a lease. Building work has been delayed and the clinic will now not be operational until August 2022. The Antenatal Clinic will remain at Te Papaioea Birthing Centre until this work is complete.

### 2.7 **COVID-19**

The Te Uru Pā Harakeke Business Continuity Plan was implemented in response to the current COVID-19 Omicron community outbreak to ensure care and staffing was prioritised based on need. Teams returned to the 'new normal' business in May 2022.

| **SERVICE** | Te Uru Rauhī – Mental Health and Addiction Services (MHAS) |
|---|---|
| **FOR PERIOD** | January, February, March 2022 |
| **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 – Horowhenua community based acute alternative service**

Following evaluation of the Request for Proposal (RFP), the consortium made up of Muaūpoko Tribal Authority, Raukawa Whānau Ora Services, Mana o te Tangata Trust, Whaioro with Emerge Aotearoa have been engaged to undertake a collaborative co-design process for the service. Raukawa Whānau Ora is appointed as the lead. The co-design will inform next steps in service development and implementation.

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

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

## SIGNIFICANT MATTERS

### 1.1 Acute Services

The average length of stay (ALOS) averaged 21.4 days for the quarter. The ALOS for Māori was 34.9 days which was influenced by two discharges of whānau whaiora that occurred in March, with a length of stay of 204 and 73 days respectively. It should be noted that whilst the LOS remains stubbornly high, the average 28-day readmission rate for the December to February period of six percent and was zero in February. This is a result of improved collaboration between inpatient and community teams, both during the inpatient stay and through supported discharge, a greater emphasis of person and whanau involvement and proactive follow up post discharge.

| KPI # | Description | Target | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | vs. Last Month |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| KPI 2 | 28 day acute inpatient readmission rate | 0-10% | 11% | 14% | 9% | 11% | 13% | 16% | 13% | 19% | 9% | 8% | 0% | | ↓ |
| KPI 8 | Average length of acute inpatient stay (days) | 14-21 days | 15.4 | 20.4 | 12.0 | 31.1 | 19.4 | 14.2 | 27.5 | 21.9 | 9.7 | 22.4 | 20.5 | 21.2 | ↑ |

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

The first discharge from Te Uruuru Tangata (extended care rehabilitation service) took place in December. During her stay, she has worked toward greater independence and self-management, has reconnected with whānau, and gained causal employment (NB: this person had multiple acute admissions over the past 12 month and her last length of stay was 100 days).

To support work already underway with the new Inpatient development and the implementation of Te Mātāpuna o te Ora, Te Uru Rauhī is currently developing a peer-led Crisis Resolution Service Model of Care. It will describe the future Crisis Service Model of Care that is based on best practice currently implemented locally, nationally, and internationally and informed where applicable by evidence-based practices.

### 1.2 Child and Adolescent Family (CAFS) Service access

At the last Board meeting a question was raised about access for Māori to Child and Adolescent Family Service within MDHB. For the July 2021 to March 2022 period, 31 percent of people who accessed services were Māori. The split by locality was 20 percent Horowhenua, 7 percent Tararua and 70 percent Manawatū. These numbers are generally in line with the population.

### 1.3 Workforce – recruitment and retention

Workforce recruitment and retention remains particularly challenging. Of note is our Senior Medical Officer workforce where we have 8.0 permanent SMO against a current planned resource of 18.0 and use an average of 10 locums for the year. We continue to actively recruit but there is simply not the pipeline of trained psychiatrists either locally or nationally to draw from. We have completed an interim service sizing to address the recruitment and retention challenges that the service currently faces.

Kaupapa Māori Mental Health and Addiction Services continue to proactively recruit for Māori kaimahi, however due to the demand for Mental Health and Addiction Services, this remains a very challenging space. Until we can fully resource and employ Māori kaimahi in these services we will need to implement a staged approach to ensure the front door is returned to Oranga Hinengaro.

### 1.4 Inpatient facility rebuild

The developed design for our new mental health ward is complete, which is an exciting and significant milestone. This has included, for example, the redesign of the entranceway, led by iwi in partnership with the clinical team, to ensure this is a welcoming and culturally responsive space for all.  Following the completion of developed design, the project will move into detailed design. This phase will focus on planning out specific landscape, furnishings, fixtures and equipment. This piece of work initially will be led by iwi and the project team to ensure that our Te Waonui a Tāne and Te Whare Tapa Whā approach is visible throughout.

We anticipate being able to engage contractors and commence siteworks by spring. At that point we will be able to create a construction programme to give a more definitive date for the ward's opening.

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

Te Mātāpuna o te Ora outlined a five-year programme to transform Mental Health and Addiction Services towards locality based contemporary model of care. The first year of implementation has concluded and a service review was presented to the May Board meeting.

The review identified that whilst the complexity and scale of the change has been challenging, it enabled Te Uru Rauhī and Pae Ora Paiaka Whaiora Hauora Māori Health to reorient and repivot resources towards the priorities outlined in the business case. Overall, it has been a successful first year with the foundational structures and systems established that will enable the aspirations of whānau whaiora to be realised. In the first year there was a strong focus on supporting our kaimahi through several change management initiatives that were focused on providing our staff with the confidence to operate in the new model. As a result we are seeing the early signs of bicultural practice emerging.

We had several challenges, the most significant being progress towards establishing community hubs that was delayed due to the COVID-19 pandemic. The next 12 months will bring a focus on bedding down the changes, continuing to build capability and capacity and focusing on the implementation of critical digital and infrastructure enablers.

*Commitment to devolve kaupapa services to iwi*

Te Uru Rauhī in partnership with Pae Ora Paiaka Whaiora Hauora Māori Health remain committed to realising the aspirations of iwi to progress the devolution of kaupapa Māori Mental Health and Addiction services. This is very important kaupapa with Pae Oranga Ruahine Tararua (the newly formed Iwi Māori Partnership Board) and we will continue to work alongside Te Roopu WAIORA to progress this work over the coming 12 months.

### 1.6 **Commissioning**

*Medication Support*

The Medication Support service provided by MASH Trust reached capacity in February, resulting in any new referalls being halted. An update to internal processes resulted in a review of existing service users to ensure the appropriateness of the individual care plans and mechanisms for ongoing reviews within agreed timeframes. The service recommenced accepting referrals in early March and is now actively monitored to ensure operation within capacity limitations.

*Integrated Primary Mental Health and Addiction (IPMHA)*

The service provided by THINK Hauora continues to face recruitment challenges with 2.25 FTE vacant Matanga Whaiora (HIP) positions and one FTE vacant Kaiwhakapuaki Waiora (Health Coach) position. Retention is also facing a current challenge with 3.15 FTE HIP resignations pending. THINK Hauora continues to explore recruitment opportunities including working with iwi/Māori providers with a view to subcontracting 2.8 FTE in Horowhenua.

| **SERVICE** | Te Uru Kiriora – Primary, Public and Community Health |
|---|---|
| **FOR PERIOD** | January, February, March 2022 |
| **PREPARED BY** | Deborah Davies, Operations Executive<br>Kelvin Billinghurst, Clinical Executive |

## 1. PERFORMANCE OVERVIEW

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

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

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

| **Plan Legend** | A | Annual Plan | S | Sustainability Plan | E | Equity Indicator |
|---|---|---|---|---|---|---|

## 1.1. Key progress commentary

### *1.1.1 Improve Management of Long Term Conditions (LTCs)*

THINK Hauora and MidCentral District Health Board's (MDHB) progress in the integrated Horowhenua locality-based service model development continues. This is at a slower rate than anticipated due to the impacts of the COVID-19 Community Care response.

All practices in Horowhenua (aside from Te Waiora and Tararua Medical Centre) have now managed to recruit to General Practitioner (GP) vacancies. As the impact of COVID-19 in the community settles to more manageable levels, practices will be able to review their enrolment policies and ensure continued prioritisation of unenrolled Māori.

Key LTC service delivery innovations in the Horowhenua locality that commenced at the end of Quarter Two (shared appointment pilot for patients newly diagnosed with Type 2 diabetes and a support group in partnership with the Manawatū Diabetes Trust) was suspended through most of Quarter Three as staff were deployed into the local COVID-19 response. This work is expected to restart early Quarter Four.

Community based integrated care for whānau with heart failure continues in five sites across the region. Support with shared collaborative clinics, education, support and mentorship to the Primary Health Care (PHC) teams continued virtually because of COVID-19.

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. This month the pathway was presented and promoted as part of the Respiratory IPE virtual session which was open to providers across hospital and primary care settings. It is anticipated that a relaunch and refresh of this pathway will be undertaken over the next quarter once the impact of COVID-19 diminishes and 'business as usual' returns.

### *1.1.2 New Long Term Conditions Service Specification*

MDHB worked with THINK Hauora to formulate a new LTC service specification in line with the Commissioning for Outcomes Framework developed by Strategy, Planning and Performance. The Commissioning for Outcomes Framework guides those involved in commissioning services to achieve the best outcomes in the most efficient, effective and sustainable way, by utilising and achieving 11 high-level outcomes, the quadruple aims and the whānau ora outcomes.

Commissioning continuously develops services and commits resources to achieve the best health outcomes for individuals and the population, ensuring equity and enhanced experiences within resources available.

The new LTC service specification uses a Transdisciplinary Long Term Conditions (TLTC) team approach as individual needs require different levels of intervention and support. Key aspects of the new LTC service specification are:

a) the use of approved rurality and equity methodology to align the locality based TLTC services based on the identified aspirations and needs of each community

b) the ability to provide patient level dashboards for TLTC and General Practice Teams (GPTs) to identify and focus on individuals with LTCs who are assessed as moderate to high risk

c) to reinforce that recognition of cultural values and beliefs is imperative as they profoundly influence the effectiveness of services for Māori people living with, or at the risk of LTCs and must consult and include Māori in service design and delivery

d) to emphasise that equity is a central focus of LTC improvement, and that Māori and Pacific people have a higher prevalence of LTCs and a substantially reduced life expectancy

e) to reinforce to health providers that service planning will take full account of relevant documents including the 2019 Wai 2575 Health Service and Outcomes Kaupapa Inquiry and subsequent updates and He Korowai Oranga. Services will be co-designed and culturally appropriate to improve care delivery in line with Whakamaua, the Māori Health Action Plan and Ola Manuia, the Pacific Health and Wellbeing Action Plans 2020–2025.

## 2. SIGNIFICANT MATTERS

### 2.1 Smokefree 2025

MDHB is committed to He whakapai ake i te hauora, hei oranga mō te katoa: Better health outcomes, better health care for all and recognises that tobacco use results in significant morbidity, mortality and extensive harm experienced by people within the MDHB region.

The burden of this harm is carried disproportionately by Māori, with smoking making a significant contribution to health inequities. According to the 2018 Census 15 percent of people in the MDHB region identified as regular smokers (20,931) down from 16.9 percent in 2013. While the proportion of those who have never smoked regularly increased to 85,557 (61 percent) in 2018 from 70,023 (54 percent) in 2013, the prevalence of Māori people who smoke declined from 42 percent in 2006 to 28 percent in 2018; and for Pacific people from 33 percent in 2006 to 22 percent in 2018.

MDHB is committed to achieving the Government’s Smokefree Aotearoa 2025 goal and beyond through our current Smokefree Policy and the development of a MDHB Tobacco Control Plan.

On 1 July 2022, subject to the enactment of the Pae Ora Bill, Health New Zealand and the Māori Health Authority will be established as the new entities to lead and operate our future health system. Taking into cognisance of this historical health change, it will be fitting and appropriate that the development of a Smokefree Position Statement be strategically better placed as a priority within the pending transition. This will be an opportunity to consider a regional position statement focusing on the combined effects of smoking, alcohol and obesity and the cause-specific morbidity susceptibility in our rohe. With the locality approach as a cornerstone of embedding and underpinning population health through mauri ora, taking advantage of prioritisation of a Smokefree Position Statement in the rohe health reforms will be a worthwhile and fit for purpose strategy.

### 2.2 Immunisation Programmes

The Ministry is moving to utilise the COVID-19 vaccination infrastructure and resource to provide support to primary care for childhood and other vaccinations. The first step on this pathway has been the introduction of the influenza vaccine through many COVID-19 vaccination sites. At all sites, providers are required to work within the eligibility criteria for this vaccine.

Discussions are taking place on how best to incorporate other vaccinations into this activity, with Measles, Mumps and Rubella (MMR) being activity targeted. The funding and contracting mechanisms are also being examined as the funding for the individual vaccines differ.

The flow of data is being examined to ensure GPTs are informed of any vaccines given in the community. This will avoid any duplication of effort in contacting individuals and whānau, ensuring an effective and efficient workflow.

School-based immunisation events are restarting with HPV and DTap, as Public Health Nurses transition from COVID-19 work to 'business as usual'. Planning is underway to catch up any missed doses from the previous year in association with COVID-19 vaccination for adolescents.

### 2.3 COVID-19 Vaccination Programme

The COVID-19 vaccination programme has focused on the provision of adult boosters (including 16 and 17-year-olds) and the commencement of the 5 to 11-year-old vaccination programme. Public uptake for the child vaccinations has been slower than the adult doses. To motivate parents, an extensive campaign was rolled out over the school holiday period, which resulted in a pleasing uplift in the number of child vaccinations administered.

Public demand has waned over the last month for the adult booster. A promotional campaign from the Ministry, supported by MDHB communications, has seen a continued uptake. There are also a large number of people who will become eligible for the booster in June 2022, due to reaching the three-month milestone after having a COVID-19 infection.

The distributed model continues to ensure there is good access across the rohe and despite reduced demand, all providers are continuing to offer the vaccine. All providers are delivering the boosters although due to space constraints and other factors, some community providers will not be delivering the child vaccinations. Most providers are offering the influenza vaccination.

Planning is well underway to utilise schools as vaccination sites. There has been some hesitancy due to the political heat in the vaccination discussion currently. Clinics run at schools will be open to the public to provide another opportunity for adult vaccination in the community.

At the time of writing this report, the vaccination rates for total eligible population are 88 percent, Māori at 77 percent and Pasifika at 85 percent. This percentage includes the child doses therefore total population percentage is lower than adult percentage. The boostered rates are 72 percent, Māori at 56 percent and Pasifika at 60 percent. Vaccination rates for 5 to 11-year-olds partially vaccinated are 29 percent, Māori at 25 percent and Pasifika at 32 percent. Fully vaccinated rates for 5 to 11-year-olds are 22 percent, Māori at 12 percent and Pasifika at 15 percent.

Community outreach for the COVID-19 programme continues with good responses seen, particularly when the influenza vaccination is also available.

### 2.4 COVID-19 Case Investigation and Contact Management

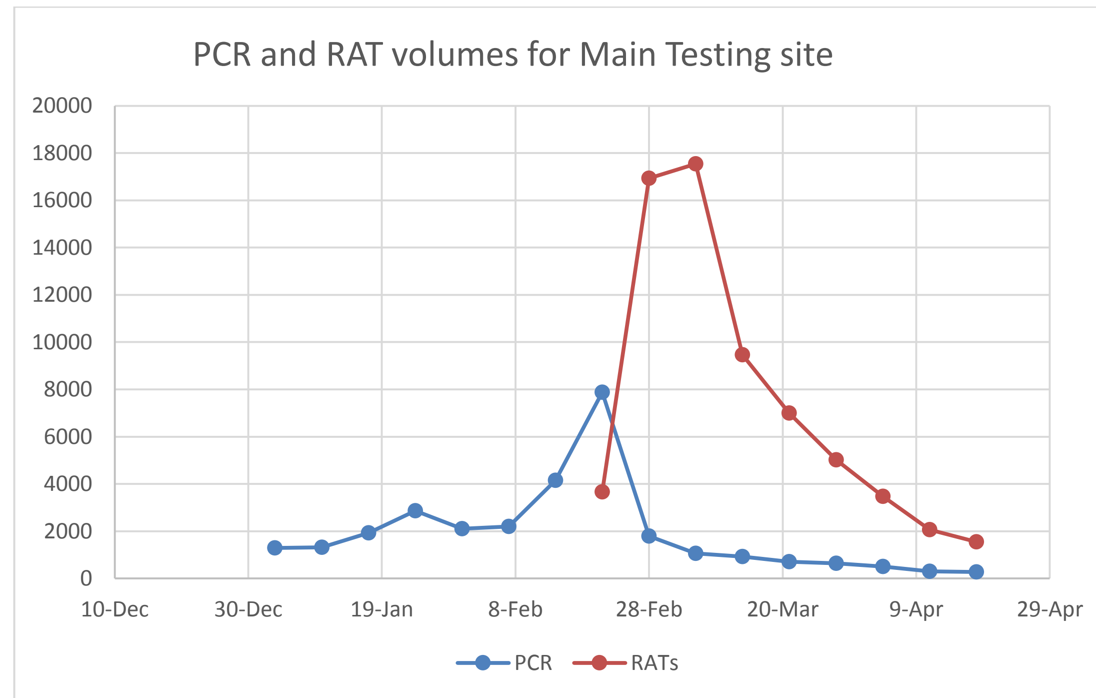
Due to the substantial increase in case numbers and to prioritise resources, the Ministry's strategy shifted Public Health Units (PHU) pandemic response to focus on settings that are of highest priority. Workplaces and schools are predominantly self-managing in accordance with the Omicron strategy, where settings that are able to self-manage are encouraged to do so.

In our rohe, Public Health Services have been focusing on identification of prioritised exposure events mainly in Aged Residential Care (ARC), social gathering events, faith based events/places of worship, marae and tangihanga, residential housing including transitional housing, youth justice and Corrections facilities and the disability sector. The PHU is and has been supporting with advice, guidance on COVID-19 transmission reduction in these high risk areas. ARC facilities continue to be experiencing pressure due to both residents and staff affected by COVID-19. The PHU is keeping a surveillance and monitoring approach and hold meetings to provide support as required.

### 2.5 COVID-19 Testing

The introduction of Rapid Antigen Testing (RATs) in February 2022 has provided greater accessibility to testing for the public. MDHB was quick to adopt this method of testing and a network of community providers has supported good access across the rohe. Following very high demand it is thought most households now have a good supply of the tests and public demand has dropped away.

The introduction of RATs was predicted to reduce the demand for PCR testing. The graph below shows this is very much the case in the MDHB district.




The main testing site at 575 Main Street, Palmerston North was relocated on 6 May 2022 to the Central Energy Trust Arena (the Arena). The move was required due to the landlord needing 575 Main Street to be vacant. The Arena is another central site that has been active in both the vaccination and testing programme. A communications plan has ensured the public know where testing is available.

## 2.6 COVID-19 Care in the Community

Key to the smooth running of the CiTC programme was the early identification of 'pillar' and 'enabler' leads, and associated teams to support the smooth alignment and transition of care for whānau impacted by COVID-19 in our rohe. The MDHB COVID-19 Central Coordination Hub (CCH) officially stood up on 21 January 2022 following a period of engagement, planning and co-design resulting in a central hub and spoke operating model.

Daily operations were supported by a range of clinical and non-clinical services/providers which included public Health, primary care, iwi/Māori, welfare, hospital services and community care. Enabler representatives for Workforce, Communications, Data/Digital, Logistics and Infrastructure were key to providing support for the workstream processes. Integral to this model were the community partnerships and tireless mahi that was undertaken (and continues to be) by the five locality teams across the rohe in Palmerston North, Manawatū, Tararua, Horowhenua and Ōtaki.

Key learnings:

- Deliberate partnering, ongoing engagement and regular communications via the CCH platform were really important from the beginning through to the current state, and continue to be as challenges arise and the approach pivots.
- The relationships, whether existing or new, and the ongoing commitment of teams to be in the mahi on a daily basis proved pivotal for the coordination of timely responses to whānau.

# Performance reporting

*28 June 2022*

*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** | 4 May 2022 |
| **Subject** | **Enable New Zealand Report** |

**RECOMMENDATION**

It is recommended that the Committee:

- **endorse** the Enable New Zealand Report to 31 March 2022.

**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

Overall performance across Enable continues to track well for the first quarter of 2022 with performance measures being met. Considerable effort in planning for and resourcing of projects, while maintaining momentum in operations, is an ongoing 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 | A |

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

### 2.1. **Performance indicators**

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

## 3. SIGNIFICANT MATTERS

### 3.1. **New contracts**

*Short Term Loan – District Health Boards (DHBs)*

The short-term loan contract with South Canterbury DHB will commence, under the wider Southern DHB agreement, on 5 May. Conversations and initial scoping meetings with Waikato DHB to evaluate whether they would like to adopt this system have been paused due to COVID-19.

This short-term loan service results in DHB patients receiving equipment upon release from hospital that is in good condition, which is delivered, tracked, collected and maintained by Enable for reissue or disposal.

### 3.2. **Community update**

*EASIE Living Retail and Demonstration Centre*

The EASIE Living Talk Series/Workshops recommenced with excellent results. The purpose of these talks is to offer a service as a part of our wider Disability Information and Advisory Service (DIAS) and to promote the EASIE Living Centre to a broader audience. The talks are free to attend, and the aim is to have one or two per month. In this reporting period, workshops have included:

- Will information and advice – Manawatu Community Law
- How to use your personal budget – Lisa Totoro/Leigh Rowe, Mana Whaikaha

- What is Enduring Power of Attorney – Manawatu Community Law
- Heart health awareness – Heart Foundation
- Stroke awareness – Stroke Central.

The Sensory Room has reopened and has been actively promoted for the school holidays. Bookings are starting to increase as the community gathers confidence to be out and about again. The Sensory Room is free to book, with families having exclusive use of the space for one hour. March also saw additional schools reach out to come and view the sensory space and to learn how to create one for themselves.

EASIE Living was approached to support mobility scooters at the Lido Aquatic Centre for Palmerston North residents to enjoy along the river walkways. This was a long-term project instigated by a Palmerston North resident, who approached EASIE Living and Palmerston North City Council (PNCC) for support. Enable has provided a scooter, free, to PNCC on a long-term lease arrangement, and Olive Tree Rest Homes has sponsored a second scooter. PNCC will service and maintain the scooters as a part of the agreement, with the Lido Aquatic Centre managing these on behalf of PNCC. Enable also already provides PNCC with a scooter for use from its i-Site Visitor Centre based in Te Marae o Hine, the Square.

### 3.3 General

*Warehouse and Logistics Review*

With considerable growth in activity and increased pressure being experienced in Enable's warehouses recently, a review of the warehouse and logistics function was commissioned. Phase One of the review concluded in March, with findings and several recommendations for improvements being made. The results of the review have been rolled out to the wider warehouse teams with an action plan to address some of the immediate challenges and realise quick wins. The next phase of the review is to consider the longer-term options and models for delivery of the function. A detailed options paper is currently being drafted and will be completed by late May. Following this, a detailed business case will be developed, if required.

*Enterprise Resource Planning (ERP) update*

The 'develop and implementation' phase of the new financial system, replacing the currently used JD Edwards (JDE) financial system, is now underway. This phase is occurring as five iterative sprints, allowing for early visibility of progress and allowing for the business to have input during development so changes can be captured early, avoiding later need for rework. The current phase is progressing to plan, with the next phase of end-to-end testing occurring from July. The Product Information Catalogue, to support the ERP, is planned to be released into production in early June.

*ACC (Accident Compensation Corporation)*

The co-design stage of the ACC Managed Rehabilitation Equipment Service (MRES) contract has commenced with several items being worked on by both parties. The first sprint includes additional visibility of the MRES app for ACC recovery partners, changes to ACC forms for additional usability in their systems and reporting. Future sprints, commencing in June, will include pre-approval impact and beyond economic repair reviews, as well as the development of a framework to move to a provider-led model.

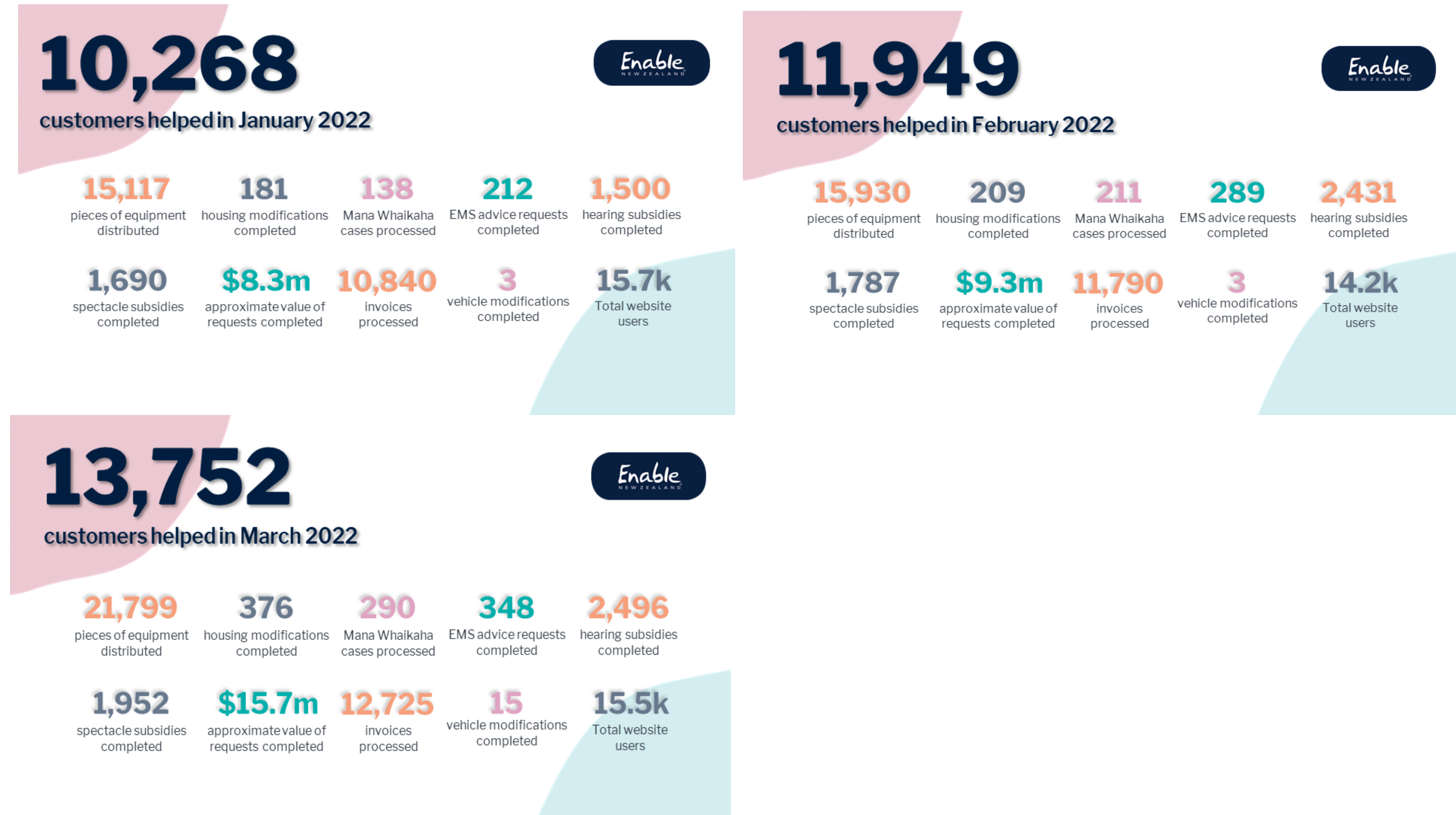
Enable provided ACC with a COVID-19 contingency plan which proposed a range of initiatives to reduce administration and approval burdens. The reduction of these burdens would ensure customers continue to receive equipment in a timely manner, should either organisation experience a workforce shortage. Consequently, ACC have since approved a three-month trial where new delegations have been given to Enable to internally approve specific items including the purchase of simple, standard and complex equipment on behalf of ACC, as well as the approval of hire requests and repairs on equipment. It is anticipated that by providing Enable with these delegations, it will reduce processing timeframes and streamline activity. If the trial is successful, the delegations will be put in place permanently.

**Appendix One: Performance Indicators**

This report relates to the reporting period from 1 January to 31 March 2022, unless otherwise stated.

**National volumes**

The following chart is a high-level snapshot of the volume of work Enable has achieved during this reporting period.



## Regional results

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

*Table 1: Volume/demand of customers accessing Enable New Zealand within MDHB region for January to March 2022*

| Client Volumes by Service | MDHB Region January | MDHB Region February | MDHB Region March |
|---|---|---|---|
| Equipment | 200 | 252 | 331 |
| Hearing | 73 | 132 | 115 |
| Housing | 4 | 6 | 15 |
| Spectacles | 94 | 98 | 152 |

## Performance indicators against contractual agreements

The Key Performance Indicator (KPI) results for this period remain on track within the current environment challenges outside our control.  Enable continues to ensure contractors are supported and that any delays with completion timeframes are managed accordingly and communicated to our clients.

The refurbishment ratio is showing some consistency and is continuing to maintain an average in the 28 percent range.

*Table 2: Performance against contractual measures*

| Key Performance Indicator (KPI)/Measure | Target | Achieved January | Achieved February | Achieved March |
|---|---|---|---|---|
| Percentage of Band 1 equipment delivered within five working days | 90% | 94.2% | 91.9% | 94.5% |
| Percentage of Complex Housing Modifications completed within 120 working days (Ministry of Health) | 60% | 77.8% | 86.8% | 85.0% |
| Percentage of Equipment provided to Service Users supplied from refurbished stock (Ministry of Health) | 35% | 28.3% | 29.9% | 27.4% |
| Grabrails Installation Non-Urgent (ACC) installed within five days | 95% | 86.0% | 73% | 88.0% |

**Mana Whaikaha**

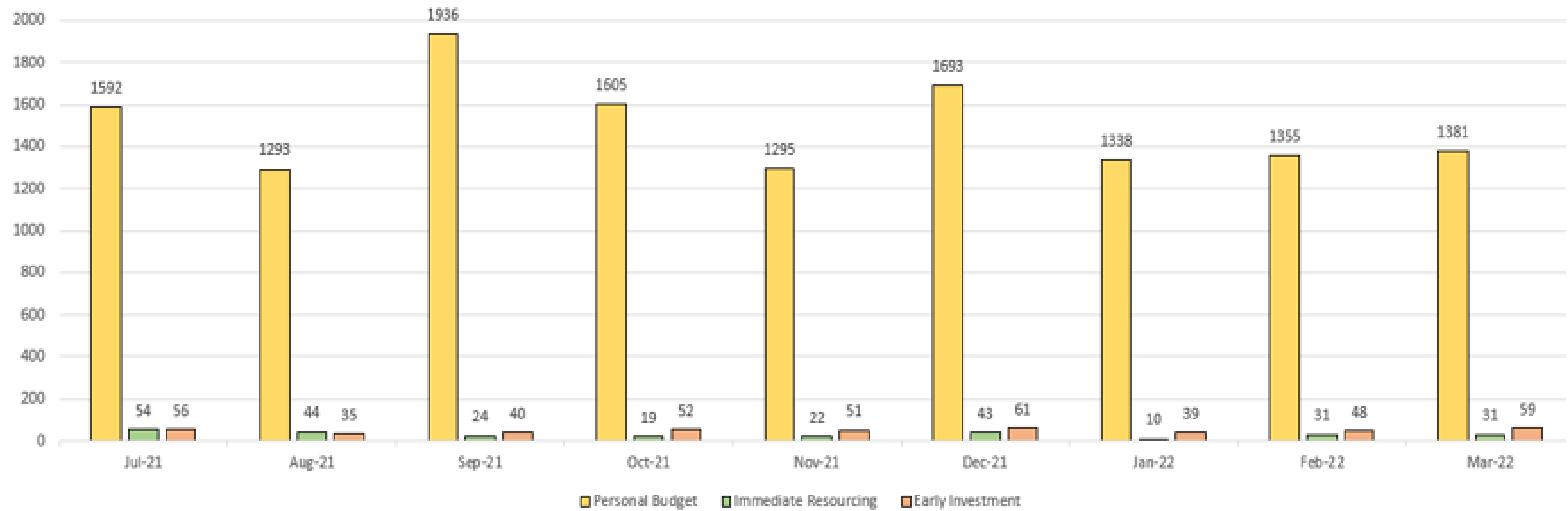
Mana Whaikaha has seen a continued increase in engagement from the disabled community. To address the additional support requests, a recruitment drive has recently been undertaken. Several Connectors and support staff have been recruited in the past few months, with some vacancies yet to be filled. It is anticipated that as new staff are trained, the number of disabled people awaiting assignment to a Connector will reduce. It is encouraging that more people are electing to self-connect with the support of Mana Whaikaha staff. This will continue to be an option to allow disabled people to have greater choice and control in developing what a good life means for them.

Enable continues to support the Ministry of Health to embed its new model of service delivery. In addition, discussions with the Ministry of Social Development (MSD) as the hosts to the new Ministry for Disabled People have also been initiated. Information technology and property teams have begun transitional work to link Mana Whaikaha staff into their systems.

*Table 3: Volume/demand for Mana Whaikaha services*

| Mana Whaikaha Regional Results | Launch of Prototype to March 2022 |
|---|---|
| Total disabled people active in the database | 2554 |
| People allocated to a Ministry of Health Connector (and are still allocated to a Ministry of Health Connector) | 1470 |
| People allocated to their own/Independent Connector | 189 |
| People in queue (awaiting allocation to a connector) | 306 |
| Total number of individuals under the age of 21 years | 1078 |

*Graphic 1: Number of weekly payments made from July 2021 to March 2022*



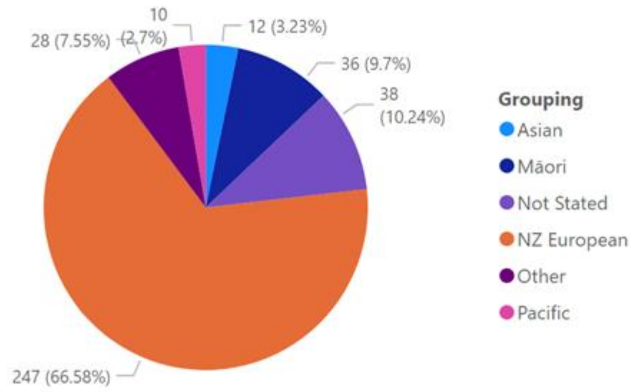

*NB: The increase in personal budget payments in September is due to the Ministry of Health increase in payments.*

## Ethnicity data

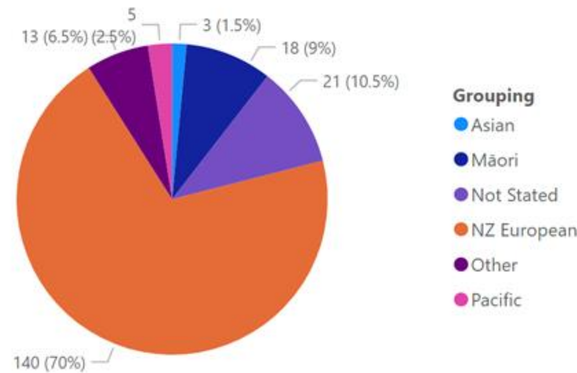
The following graphs represent the ethnicity data for the MDHB region for the months January to March 2022.

*January 2022*

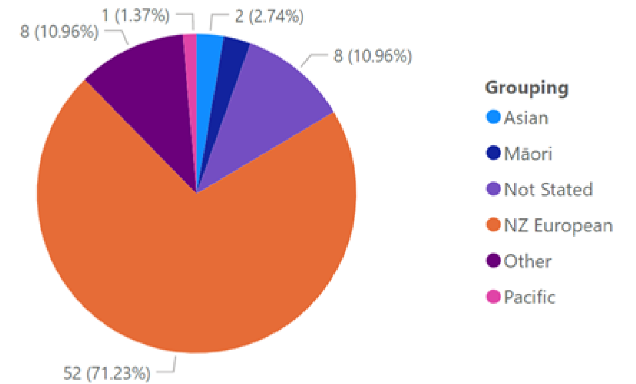
*Overall*



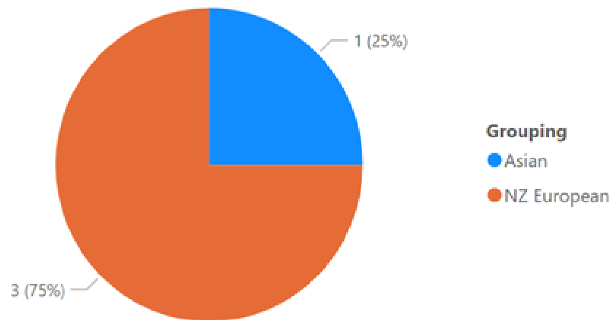

*Equipment*



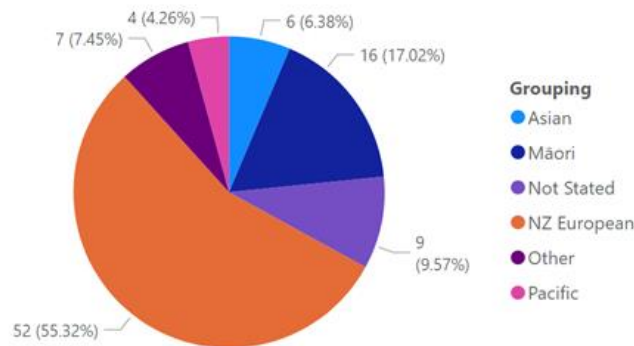

*Hearing*




*Housing*

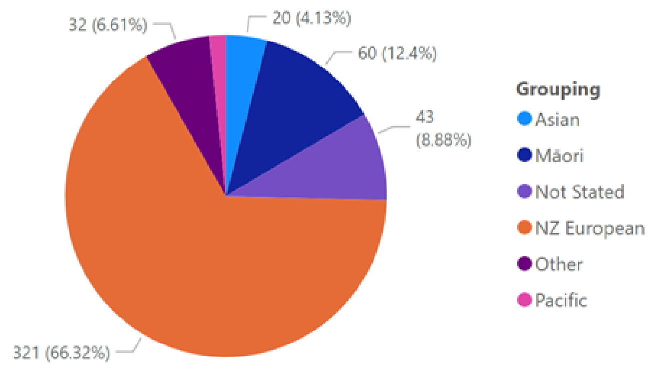



*Spectacles*

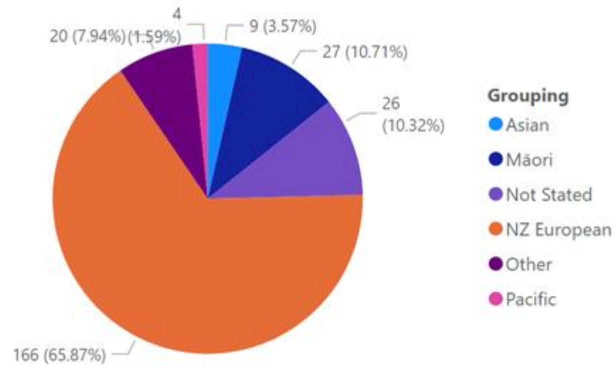


## February

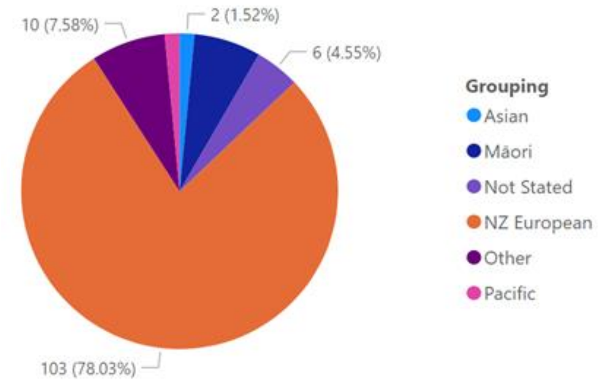
### Overall



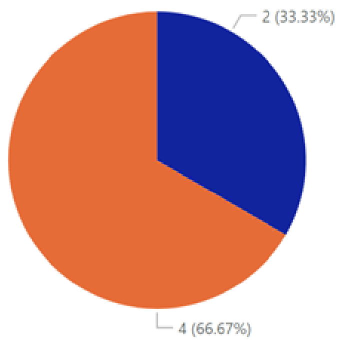

### Equipment



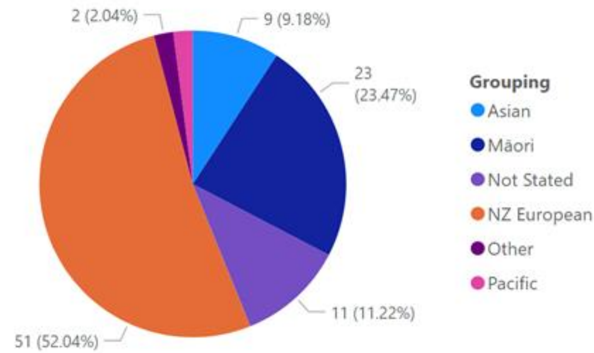

### Hearing




### Housing

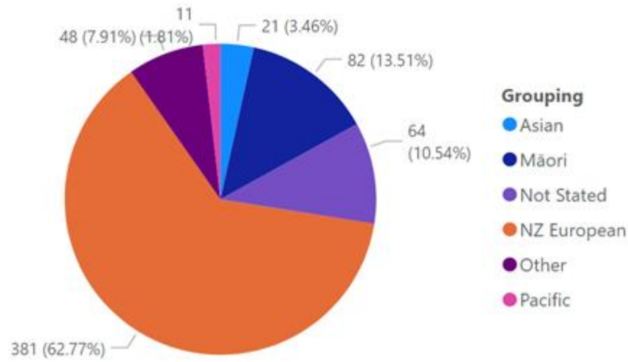



### Spectacles

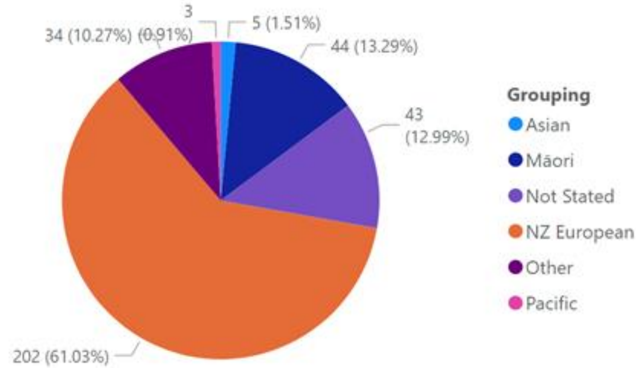


*March 2022*

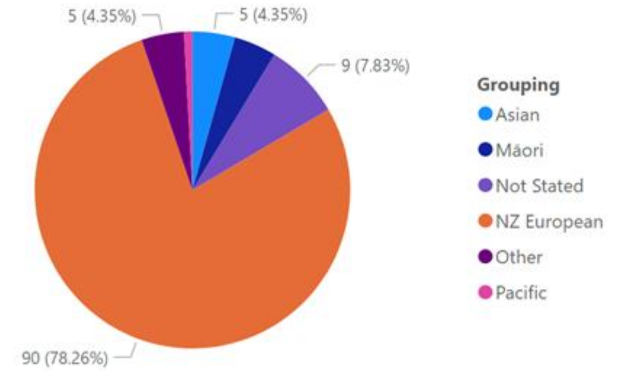
*Overall*



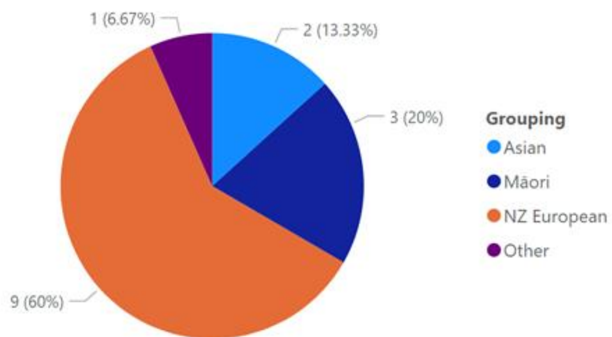

*Equipment*



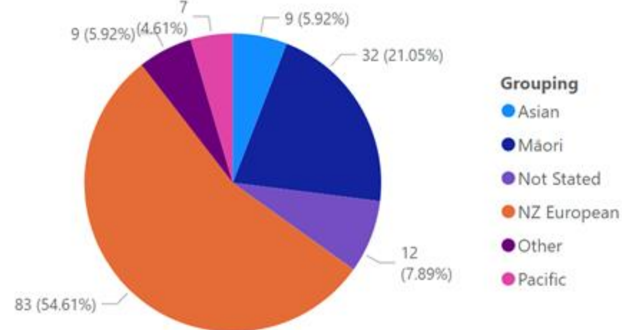

*Hearing*

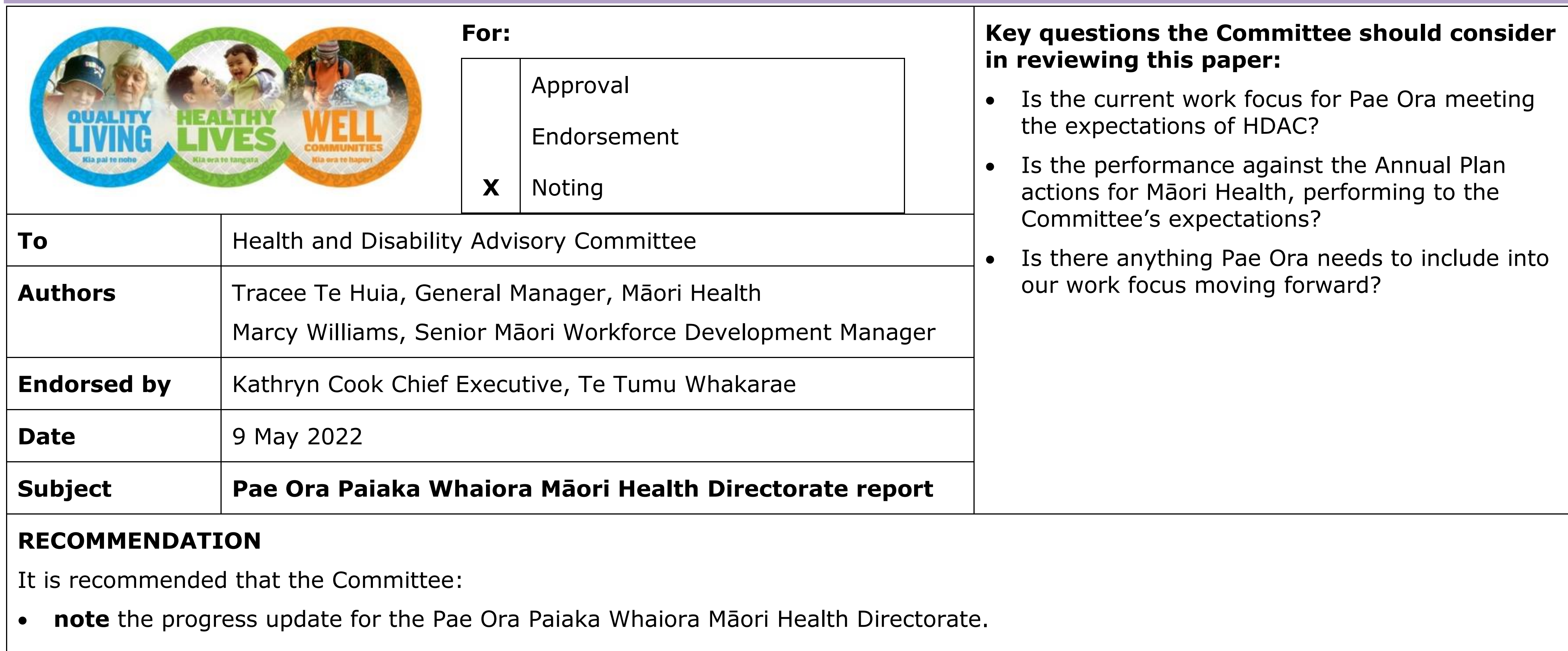



*Housing*




*Spectacles*





| | For: | |
|---|---|---|
| | | Approval |
| | | Endorsement |
| | X | Noting |

| | |
|---|---|
| **To** | Health and Disability Advisory Committee |
| **Authors** | Tracee Te Huia, General Manager, Māori Health<br>Marcy Williams, Senior Māori Workforce Development Manager |
| **Endorsed by** | Kathryn Cook Chief Executive, Te Tumu Whakarae |
| **Date** | 9 May 2022 |
| **Subject** | **Pae Ora Paiaka Whaiora Māori Health Directorate report** |

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

- Is the current work focus for Pae Ora meeting the expectations of HDAC?
- Is the performance against the Annual Plan actions for Māori Health, performing to the Committee's expectations?
- Is there anything Pae Ora needs to include into our work focus moving forward?

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

## 1. OVERVIEW

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

## 3. SUMMARY

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

- He Toa Manawarahi - Living Our Values Awards 2022
- Gout Improvement Programme for Tāne
- New Staff to Pae Ora
- Enabling Iwi and Māori to reach Pae Ora
- Kaimahi Ora Whānau Ora Māori Workforce Development
- Growing the Māori Workforce across the Sector
- Project Puawaitanga.

### 3.1. He Toa Manawarahi – Living Our Values Awards 2022

Thirteen nominations were received for the awards this year. The Pae Ora Whānau Care Team were the successful recipients of the 'He Toa Manawarahi – Living our Values Team Award'. This is a true reflection of their effort and commitment to whānau when they were working at capacity with limited staff over the past year due to COVID-19 and staff leaving. This is the second time since the establishment of the awards that Pae Ora has been nominated. The awards were originally due to be held in December 2021 but were shifted due to COVID-19 restrictions. This is a truly deserving team who stand by staff and the community to ensure they get the services needed. We are very proud of our whānau care team. *Kei whea mai koutou!*

### 3.2. Gout Improvement Programme for Tāne

Gout is an inflammatory condition that affects the joints. This is both debilitating and can impact on people being able to work. Compared to other regions and nationally, the MidCentral District Health Board (MDHB) region has a significantly higher prevalence than that of the national average. In 2019 within the MDHB region there were over 7300 people affected by gout. Those affected were predominantly Māori. Māori were prescribed twice the amount of Non-Steroidal Anti-Inflammatory medications (NDAIDs) than any other population group. NSAIDs dispensed were to help relieve symptoms. Those who were provided NSAIDs were more likely to end up in hospital. The long-term effects of NSAIDs affect kidney health and the cardiovascular system. A flow-on effect is an increase in other medication for additional diagnosis.

In response to the issue of gout, Pae Ora has been working with subject matter experts to explore opportunities based on current research and evaluation of the Gout Out and Gout Stop programme in New Zealand. A feasibility study will be developed with the intention to focus on male Māori across localities. The feasibility study will consider mismanagement of gout and related socio-economic issues that affect male Māori. Partnership with the Māori Alliance Leadership Team and THINK Hauora will be sought.

### 3.3. New Staff into Pae Ora

Tracey Simpson-Smith has been appointed as the Executive Assistant (EA) to the General Manager, Māori Health. Tracey is of Ngai Tahu descent where she is currently working. Tracey has worked in EA roles in New Zealand Pharmaceuticals, UCOL and Te Tihi o Ruahine Whānau Ora Alliance. Tracey is currently studying toward a Bachelor of Health Science, majoring in Psychology. We will welcome Tracey on 23 May at the new staff powhiri.

Romaine Rahui from Te Roroa, Ngāti Whātua, Ngāpuhi, Taranaki, is our new Māori Workforce Development Advisor supporting Marcy Williams. With a Human Resources background, Romaine has a wealth of experience in workforce development. Using a business partnering approach, the workforce team will work across the services to provide advice and support that enables Māori staff to flourish. Romaine's key focus areas are Enabler Directorates, Clinical Services and People and Culture. Romaine is a great asset to the team and we are very fortunate to have her support us to implement Kaimahi Ora Whānau Ora.

Pae Ora and Te Uru Pā Harakeke have established a partnership role appointing Leandra Wetere Ngāti Porou, into the role as Tumu Kaitōkeke ai me te Tikanga Rua te Uru Pā Harakeke. Leandra was employed by Plunket Services as the Kaiārahi Māori Capability Adviser. Leandra is very experienced in the role of equity, having also completed a Bachelor of Māori and Indigenous Planning and Development. This role focuses on reducing inequities across tamariki, rangatahi and wāhine services. Leandra will be welcomed at the new staff powhiri on 23 May with her official start date being 30 May.

Aunty Lovey Hodgkinson of Ngāpuhi, Te Roroa descent has rejoined Pae Ora. We welcome her back after a long break from the whare where she will be providing support three days a week. Her mahi includes:

- Tautoko and awhi to kaumātua in hospital
- Cultural support to staff and whānau when required
- Kaitiakitanga and manaakitanga to whānau within the hospital as requested
- Advocating for whānau.

### 3.4. Enabling Iwi and Māori to reach Pae Ora

In preparation for the transition to the new entities under the health reform, all iwi and Māori provider service specifications have now been updated to align with the agreed MDHB template. All provider contracts have been issued new contract numbers, with the majority of providers now having one contract with all specifications featuring on the same contract. All contracts have been processed through DHB Sector Services in preparation for elevation to the Transition Unit and dissemination to the new entities.

COVID-19 vaccination uptake remains low across the region; however, this is impacted by COVID-19 infection rates and the stand down period for receiving a vaccine post infection. Iwi and Māori providers are working collaborating with vaccination approaches to provide a focused effort that is specific to their respective communities. This is resulting in whole of whānau vaccination approaches being promoted, with influenza being offered alongside the Pfizer vaccine at all iwi and Māori clinics, and childhood immunisations from the 0-5 year-olds immunisation schedule being offered at iwi and Māori-led clinics where this vaccination capability exists. Legislation supporting the broadening of the scope of the COVID-19 Vaccinator Working Under Supervision (CVWUS) workforce was recently gazetted with the legislation change expected to come into effect by mid-May 2022. Whilst further training of this workforce is still required to ensure the kaimahi can administer the additional vaccines, once completed it will support increased vaccinator capacity within iwi and Māori providers.

As a further COVID-19 outbreak is expected, as well as potential outbreaks with RSV (Respiratory Synctial Virus) and influenza, the inclusion of iwi providers in Care in the Community (CitC) hubs is ensuring appropriate care is provided across communities. With the introduction of antiviral medicine, iwi nurses are working collaboratively with General Practice Teams (GPTs) to support equitable prescribing. The DHB is working to source data for antiviral dispensing and this information will be monitored alongside COVID-19 infection and hospitalisation data.

The extensive efforts of iwi and Māori providers in the response to COVID-19 has increased the understanding of the breadth of work these providers undertake, thus strengthening the existing relationships between providers and businesses in their respective communities. Providers report businesses requesting provider vaccination teams to administer other vaccines to their employees, such as the seasonal flu vaccine. The DHB is providing support to iwi and Māori providers to establish the infrastructure required to ensure continuation of the increased service provision beyond the COVID-19 response. The increased primary health care options across localities through the increased provision of services being provided by iwi and Māori providers will further support access to essential health care services for communities, therefore supporting equity of health outcomes across communities.

MDHB acknowledges the response to COVID-19 will be prolonged and as such there are ongoing demands on providers despite declining COVID-19 infection rates. Due to the ongoing work required reporting requirements for the majority of iwi and Māori provider services for the quarter ending 31 March 2022 (Quarter Three) and the quarter ending 30 June 2022 (Quarter Four) have been relaxed.

### 3.5. **Growing the Māori Workforce across the Sector**

MDHB continues to see an increase trend in Māori staff this month; sitting at 10.63 percent; previously lifted from 10.27 percent as of May 2022. We continue to track higher than the national average for other similar sized DHBs. MDHB is hopeful that further work in this space to encompass equitable recruitment practices will continue to see us tracking well. In relation to departures, our departure for the month of April has increased slightly.

There has been a slight drop in the uptake of the MDHB cultural responsiveness training given the requirement for keeping staff safe during COVID-19. We anticipate that the attendees will increase in numbers as we begin to with the new COVID-19 guidelines recently released.

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

- Visibility of all Māori applicants across MDHB is being reviewed monthly.
- Pae Ora Paiaka Whaiora Hauora – Māori Health Directorate and Māori Education Trust equity scholarship programme has been completed, and as an organisation we have supported 24 recipients with scholarships.
- Partnership formalised with Pūhoro STEMM Academy has been confirmed, and was celebrated on 5 May 2022.
- Tuakana Tēina Programmes are being established across various services and networks starting with the PGY1 doctors which is being developed by the Tikanga Team and supported by our new Māori Workforce Development Advisor, Romaine Rahui.

| **TITLE**: Kaimahi Ora, Whānau Ora Implementation report | **REPORT PREPARED BY:** Marcy Williams |
|---|---|
| **DATE OF REPORT:** 3 May 2022 | |

**PURPOSE**:

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

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

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

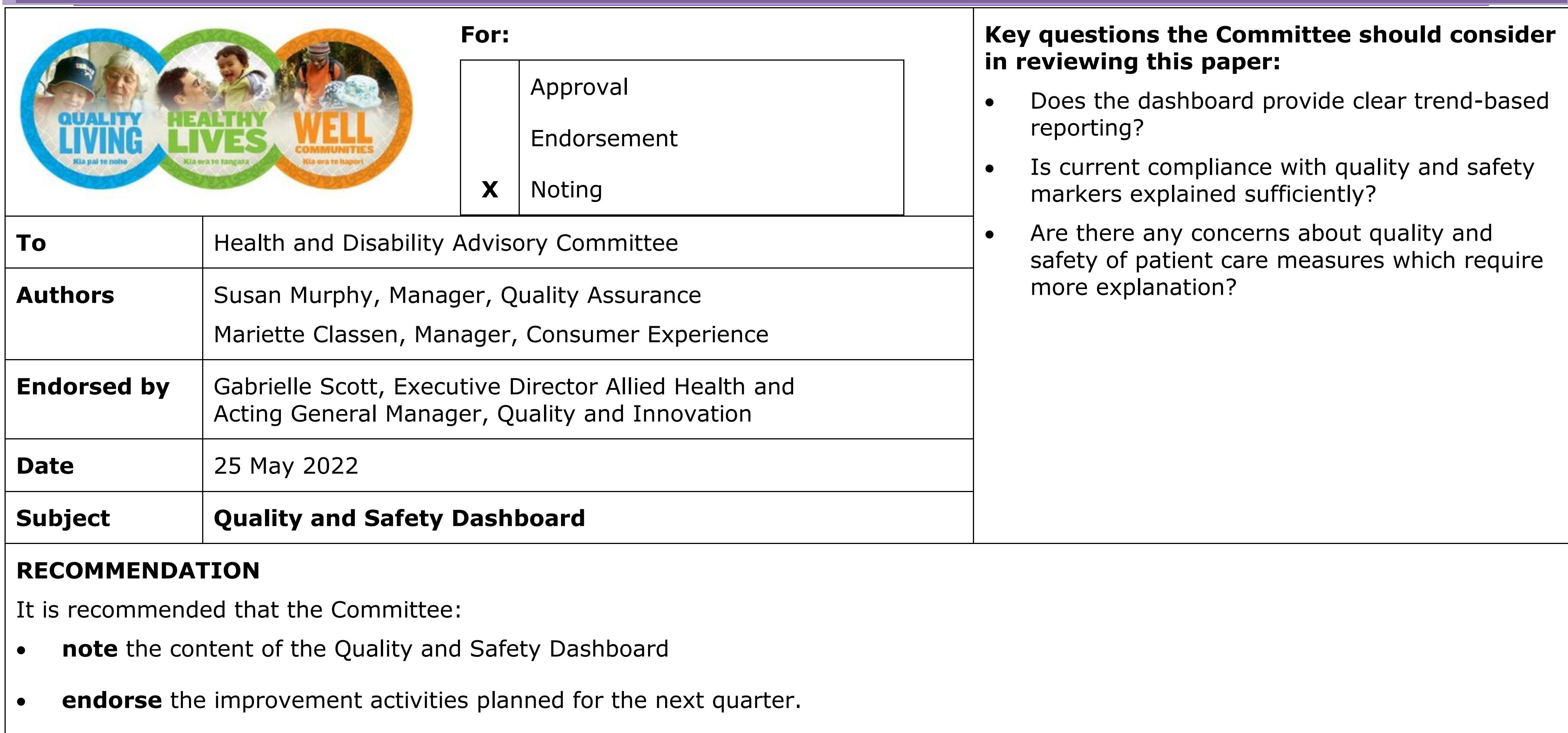
| **Rating & Trend Legend** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **G** | On track, progressing as planned. | **A** | Behind plan – remedial action plan in place. | **R** | Behind plan – major risks and exception report required. | **D** | Not completed as planned |
| ↑ | Improved from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

### 3.6. Project Puawaitanga (to blossom, flourish, breakthrough)

With the reforms fast approaching, it is necessary to look at ways in which we can build a stronger Māori workforce, support the growth in capability and capacity of hauora Māori healthcare providers, and encourage more innovation in services that contribute to improved Māori health outcomes. The recent model used for the COVID-19 rollout of vaccinations has seen a strengthening of the partnership between the DHB and iwi providers with tino rangatiratanga for Māori over hauora prioritised and tikanga and mātauranga Māori upheld. This approach is central to te Tiriti o Waitangi and has ensured Māori have better access, support, and education with vaccinations. This model included support to upskill registered nurses working within iwi health providers, which extended into their non-clinical workforces.

Registered nurses are constantly needing to upskill, train and educate to improve our ability to care for Māori. The model utilised for COVID-19 has presented an opportunity for iwi nurses to extend their services within their organisation through further training and development opportunities. This proposal identifies a model of support for Māori nurses to clinically upskill, offered through the DHB. The intention is to identify those who wish to upskill clinically and provide a training package that will expose them to experiences and education that allows them to build their capability. The training package will also include access to study days to support the care of whānau with renal issues, diabetes, respiratory diseases, phlebotomy, pharmacology and pain management. This approach considers the opportunity for nurses to experience ward-based care, allowing nurses to spend time on specific wards to care for whānau in an acute setting. A tuakana/tēina model will be adopted for the nurses being partnered with a DHB nurse (preferably a Māori nurse) to help navigate the new environment of learning and support to extend their clinical learning and skills.

The aim of this approach is to increase the skillset of Māori nurses working within iwi and Māori health providers. This would support them to extend the services they provide to whānau in their communities. The nurses will be supported by a Nurse Educator Māori. This opportunity can also provide a pathway into the Community Nurse Prescriber Programme which can support equity of access to medicines for rural communities. Furthering post graduate study can also support nurses into the pathway of Nurse Practitioner. Discussions continue in senior nursing and this proposal will bes tabled with Manawhenua Hauora for endorsement at their hui on 16 May. It is envisioned this will become a two-way upskilling programme where hospital nurses could be given the opportunity to work in iwi and Māori provider environments.



## HEALTH AND DISABILITY ADVISORY COMMITTEE



**For:**

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

| | |
|---|---|
| **To** | Health and Disability Advisory Committee |
| **Authors** | Susan Murphy, Manager, Quality Assurance<br>Mariette Classen, Manager, Consumer Experience |
| **Endorsed by** | Gabrielle Scott, Executive Director Allied Health and Acting General Manager, Quality and Innovation |
| **Date** | 25 May 2022 |
| **Subject** | **Quality and Safety Dashboard** |

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

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

**RECOMMENDATION**

It is recommended that the Committee:

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

**Strategic Alignment**

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

## 1. PURPOSE

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

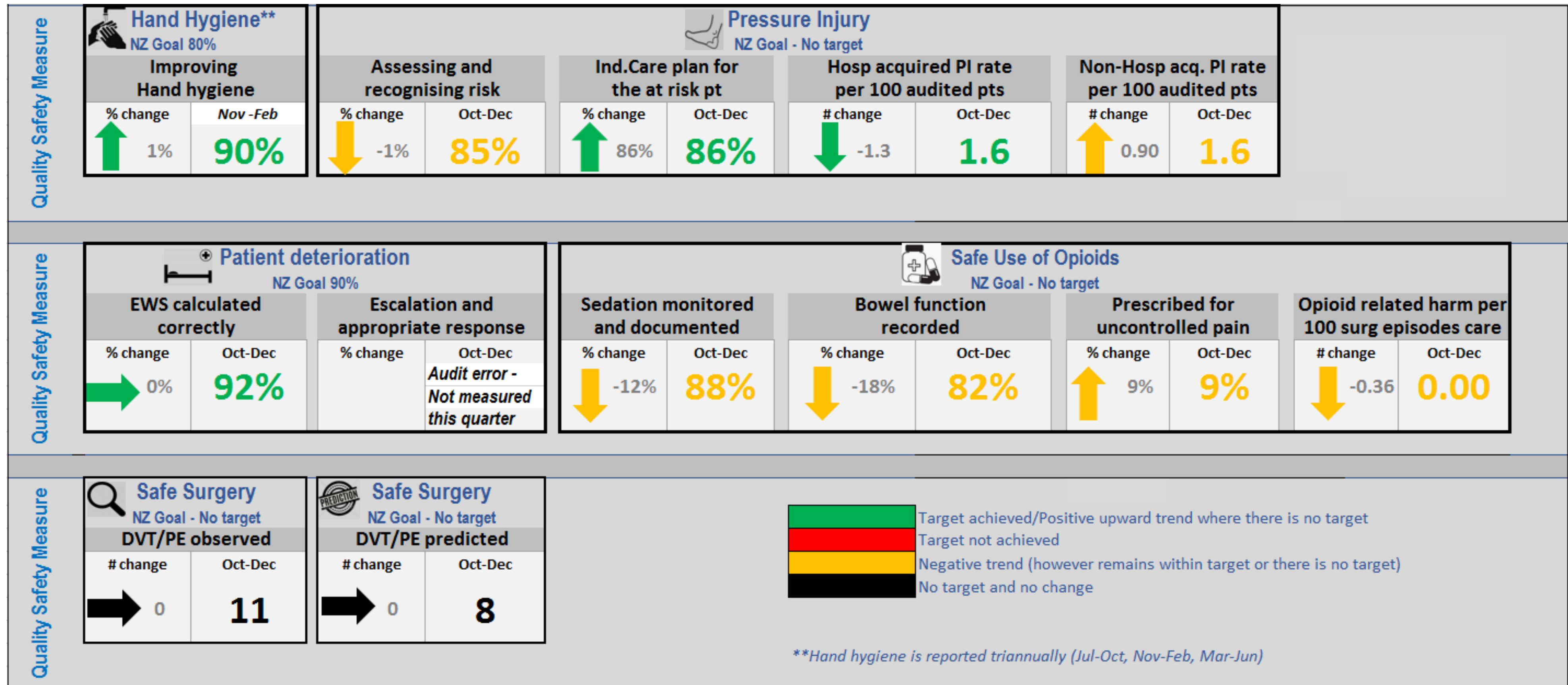
## 2. BACKGROUND

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

This dashboard provides an 'at a glance' approach and is inclusive of ethnicity breakdown, summary narrative on compliance, achievements and actions being taken for improvement. Further information about the current and historical performance of all DHBs on the QSMs is available on the Health Quality and Safety Commission (HQSC) website. The 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 OCTOBER 2021 TO DECEMBER 2021)




### 3.1. Quality and Safety Markers Background

Quality and Safety Markers (QSMs) were designed by the HQSC in partnership with DHBs, to evaluate the success of its quality improvement programmes and determine whether the desired changes in practice and reductions in harm and cost have occurred. The following link is for further information and data about the QSMs: https://www.hqsc.govt.nz/our-data/quality-and-safety-markers/qsms-october-december-2021/

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

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

### *3.1.1 Quality and Safety Marker Performance*

The QSMs for October to December of 2021 have been released by the Health Quality and Safety Commission New Zealand. The following QSMs are required by the HQSC to report on.

MDHB has seen an increase in patient falls from zero to 13.5 per 100,000 admissions in this quarter. The New Zealand median is sitting at 9.55 per 100,000 admissions.

Hand Hygiene has increased one percent to 90 percent in this quarter. MDHB continues to stay above the national average of 88 percent for this QSM.

Patient deterioration remains at 92 percent for the NZ Early Warning Score (NZEWS) data in the quarter. MDHB continues to stay above the national average of 90 percent for this QSM. Cardiopulmonary arrests have increased to 1.6 per 1000 admissions in this quarter, compared to the previous quarter.  Rapid response escalations (medical emergency calls) has not changed in this quarter and remains at 42 per 1000 admissions.

There has been no change this quarter for Pressure Injuries reported. Improvement initiatives continue to be progressed, namely education provided on the early prevention of pressure injuries.

Regarding Safe Surgery, MDHB had predicted eight cases of Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) this quarter, however 11 cases were reported. This is one less case than was reported in the previous quarter.

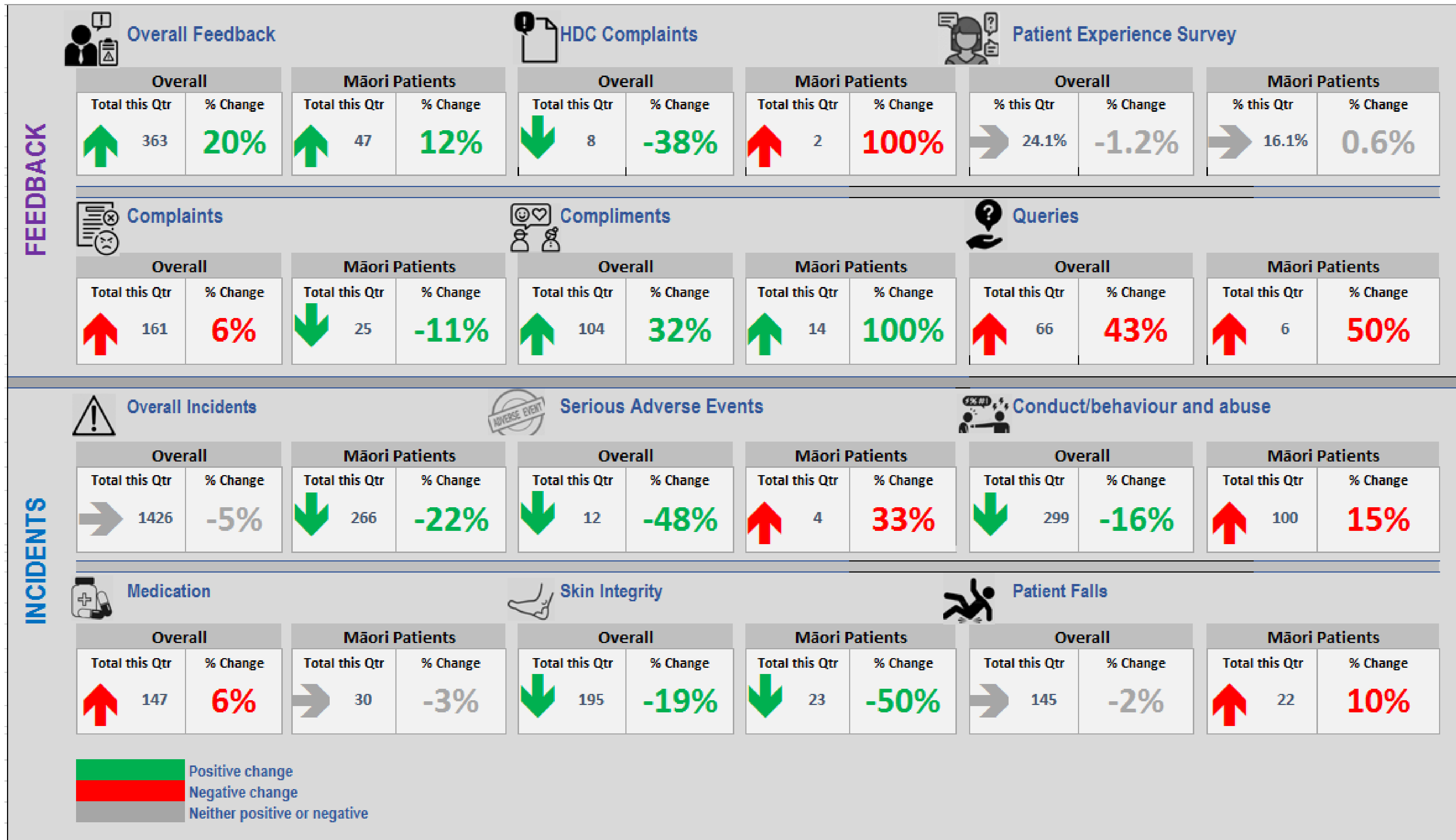
MDHB remains well above the national DHB benchmark of 60 percent, with 74 percent of patients having their sedation scores monitored and documented for the Safe Use of Opioids QSM. However, there is a negative trend this quarter across all these indicators. The education delivered through Nurse Educators has recommenced, after it was postponed due to COVID-19, to support improvement in this area.

### *3.1.2 The Consumer Engagement QSM*

The third round of the national self-rating submissions for this QSM was postponed to the end of May 2022.  The Oversight Group's workplan actions to improve identified focus areas are progressing however, several pieces of work have been paused due to redeployment of key Quality and Innovation staff to support the COVID-19 response. The data for all DHBs will published on the HQSC's website with all ratings, examples, and key questions linked to this QSM will be available for DHBs to view.

## 4 QUALITY AND SAFETY DASHBOARD

(Quarterly comparison between October to December 2021 and January to March 2022)



## 4.1 Feedback

Overall, the number of complaints received remains within normal variation compared to the previous quarters (Appendix One, Fig 4.1.3). However, there was an increase in complaint numbers for January and February 2022 that normalised again in March 2022. This upward trend is expected and in line with historical data for the first quarter of the year. There was an increase in the number of compliments as well as queries received for this reporting period. Overall compliment rates have returned to within normal variation (Fig 4.1.4).

An overview of organisational feedback is periodically provided to the executive leadership team of MDHB. The Acute and Elective Specialist Service (AESS) has the largest number of in-hospital patients, and it is therefore anticipated that the highest number of feedback would be generated from this directorate. Furthermore, within AESS, the Emergency Department (ED) has the highest patient turnover and subsequently received the highest number of both positive as well as negative feedback within the service. Feedback mostly relates to the level of care provided and communication with patients and their whānau. Perceived longer waiting times and concerns regarding the limitation on the number of support persons for patients in ED were the main themes for concerns raised during this reporting period. Conversely, patients and their whānau provided positive feedback about the care provided in ED and high praise was given to staff for the work they do.

Complaints from the Health and Disability Commissioner (HDC) have decreased. MDHB received 39 percent less complaints from the HDC compared to the previous reporting period. Thirty-two percent of complaints received required an extension (Fig 4.1.2). This is a decrease from the previous reporting period. The number of queries received increased by 44 percent however remains within normal variation and slightly below average (Fig 4.1.5).

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

### *4.1.1 Inpatient experience survey*

A snapshot of the five highest and lowest performing areas for MDHB in comparison with national results is provided in Appendix Two – Patient Experience Survey February 2022. The results indicate where MDHB is performing well and where there are opportunities for improvement. MDHB’s results remain comparable to other DHBs.

Survey results show that 93.5 percent of Māori patients and 91.7 percent of all patients surveyed did not perceive any unfair treatment and 90.4 percent of patients felt that they were definitely treated with respect by nurses. During this survey period, there was a decline in the number of patients who felt that they were kept informed as much as they wanted about what would happen and what to expect before they could leave the hospital. It is however positive to note that 82.9 percent of Māori patients definitely felt that they were given enough privacy when talking about treatment or condition.

## 4.2 Incidents and adverse events

### *4.2.1 Incidents*

Overall, reported incidents have seen a decline 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 2021. 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 13 new Serious Adverse Events (SAC 1 and 2) from January to March 2022 which is a decrease from the last quarter. Two events were SAC 1 (two intrauterine deaths) and the remaining were SAC 2 events which included four pressure injuries, one suspected suicide, four clinical process events and two unexpected deaths. During this quarter, nine SAE (Serious Adverse Events) reviews were concluded (Fig 4.2.2). This is a decrease of six compared to the last quarter. The total average number of days to complete the reviews has gone above the target set by the HQSC of 70 working days to 80 working days. This is due to engaging with family/whānau in reviews and allowing for adequate time for family/whānau to feedback and for the analysts in each review to consider this feedback. One case took considerably longer due to its complexity and the need for family/whānau meetings.

Further training to increase the number of SAC 1 event reviewers which was due to occur in March 2022, has been delayed due to COVID-19. Training of 15 staff is booked in to occur in May. SAC 2 event reviewer training has been added to the education calendar for 2022 and will be available every month for staff to attend.

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

### *4.2.3 Patient falls*

The number of patient falls has fluctuated, with an average rate of 48 falls per month (Fig 4.2.4). However, there was a noticeable increase in January with 65 falls recorded which was attributed to the patient’s clinical presentations during that month. The falls group continue to work with staff on preventative measures for falls whilst maximising patient independence to mobilise. No falls resulted in significant harm this quarter.

#### *4.2.4 Pressure injuries*

There has been a decrease in reported skin integrity incidents (Stage 1 and 2) (Fig 4.2.6) in the month of March. Four significant pressure injuries were reported and classified as SAC 2 events (Stage 3 and 4 skin integrity incidents) for the January to March period.

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

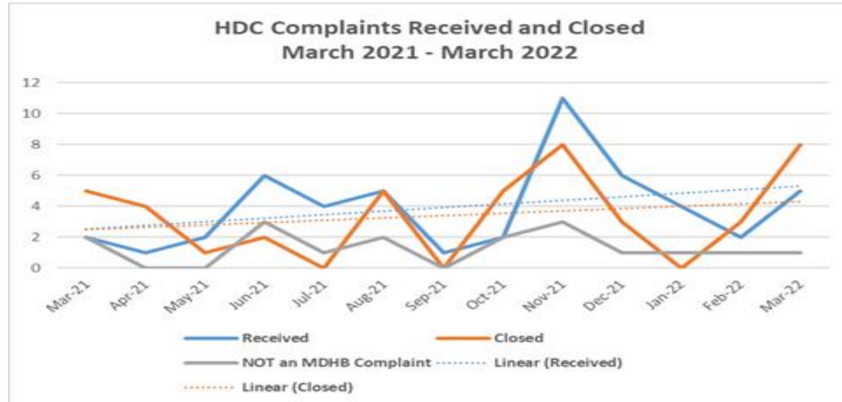
#### *4.2.5 Incident rates for Māori*

The incident rates for Māori this quarter have decreased compared to the previous quarter. Of the 13 SAE reported this quarter, four were reported as Māori. Rates for Māori increased for conduct/behaviour/abuse and slightly decreased for medication incidents. There has been no trends or themes found from these reviews that relate to Māori. Training of staff in the review of incidents will incorporate cultural responsiveness. This includes timely reviews and the opportunity to have meetings with patients, family and whānau to identify what is needed to better support Māori patients. Training has been provided since January 2022 with a good uptake of staff registering for this training. Engagement with Pae Ora Paiaka Whaiora to further support this work, will occur, as the respective teams are now better staffed.

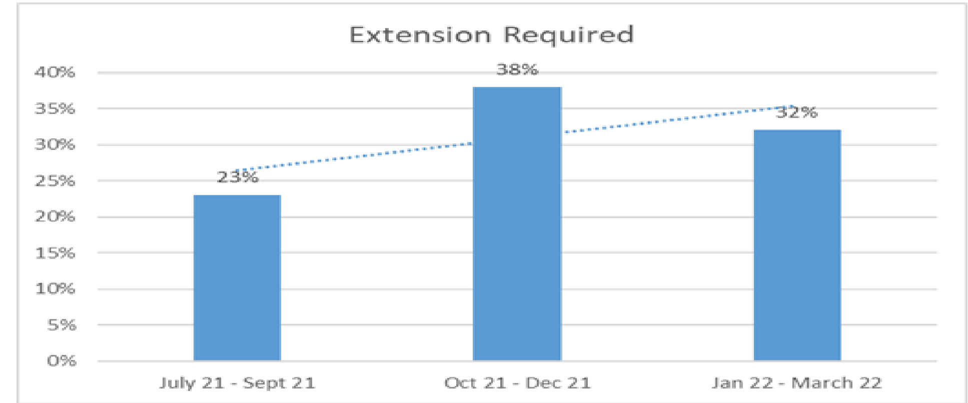
Incident metric definitions and/or exclusions are provided in Appendix Three.

## APPENDIX ONE – TREND DATA FOR FEEDBACK AND INCIDENTS

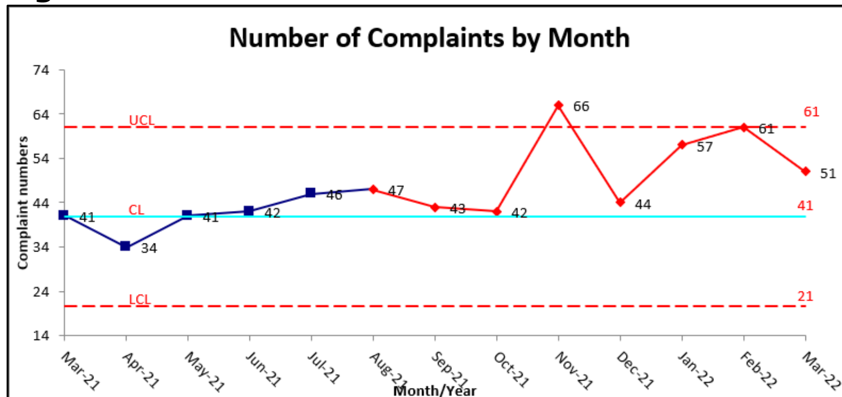
### Figure 4.1.1




### Figure 4.1.2




### Figure 4.1.3




### Figure 4.1.4

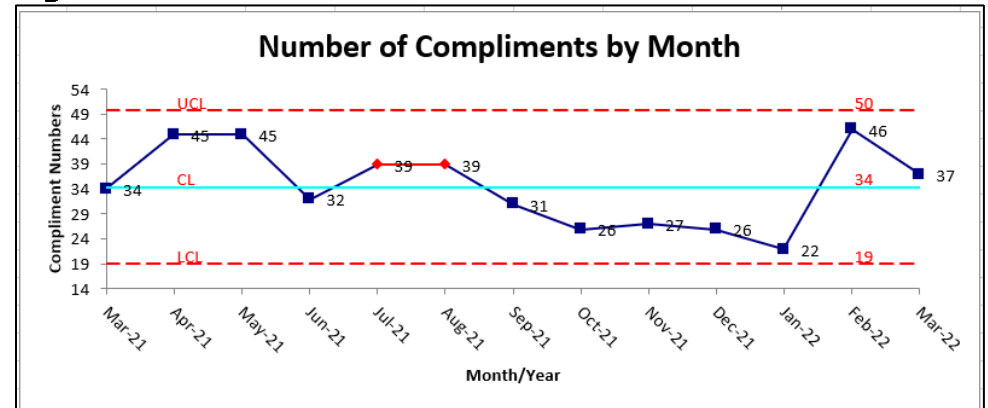


**Figure 4.1.5**

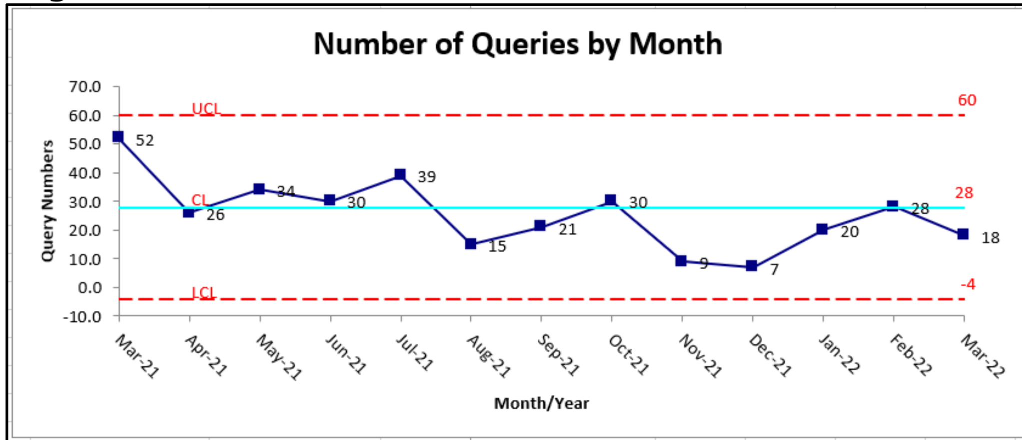



**Figure 4.2.1**

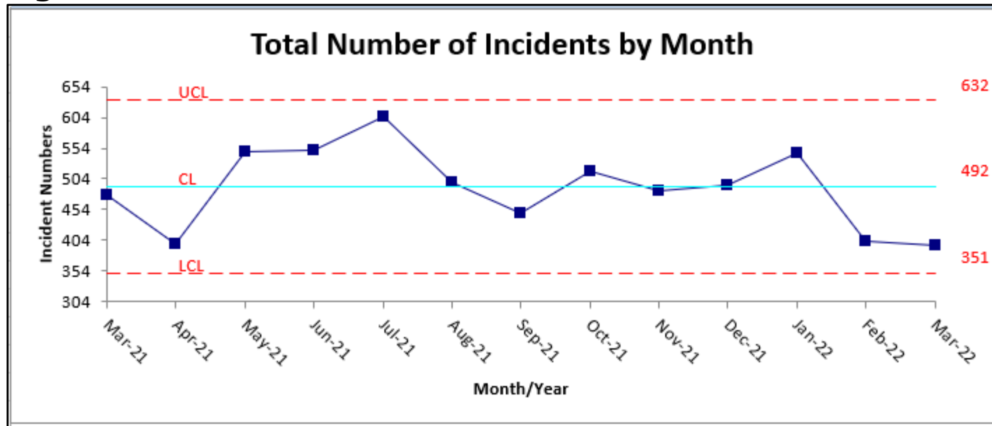



**Figure 4.2.2**

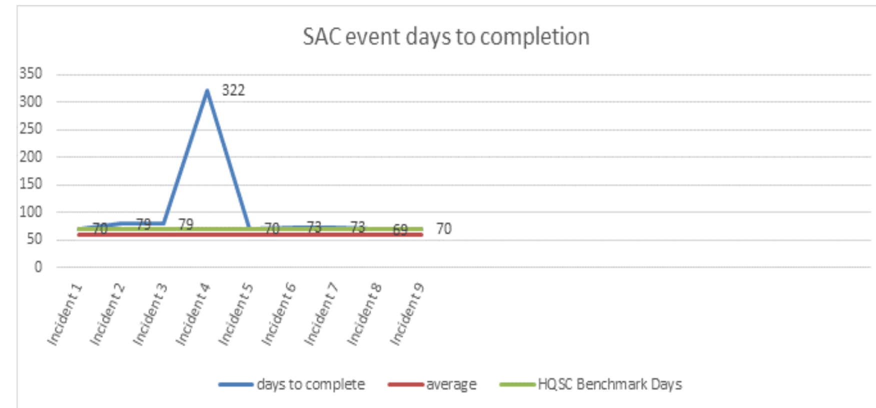


**Figure 4.2.3**

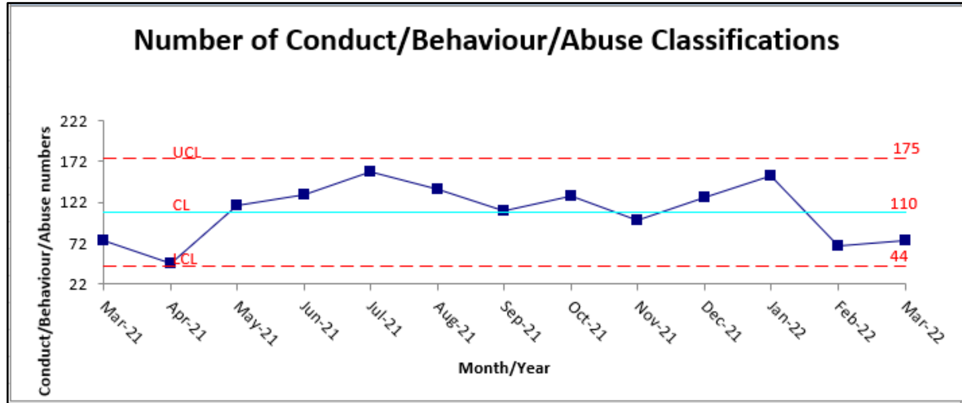



**Figure 4.2.4**

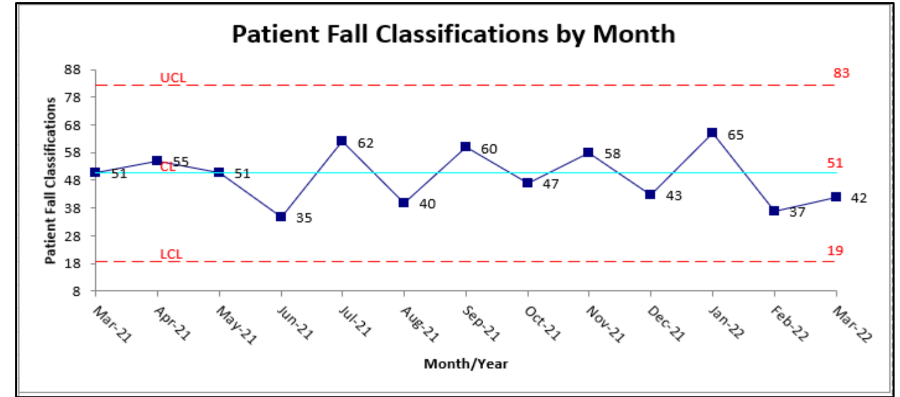



**Figure 4.2.5**

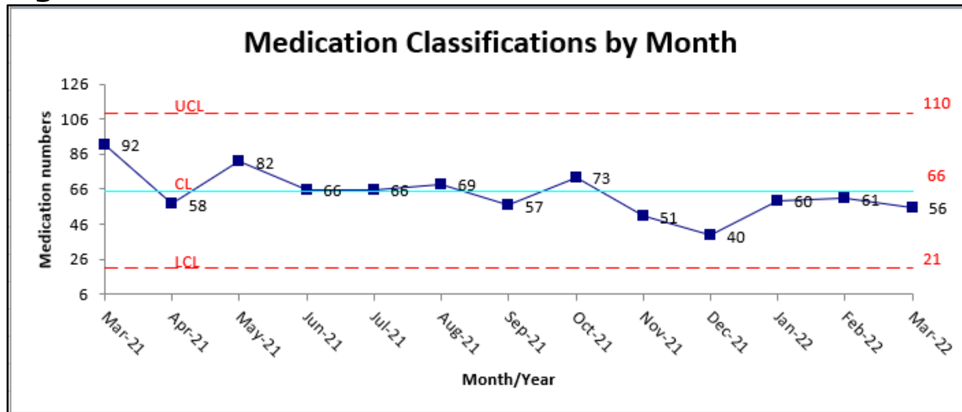
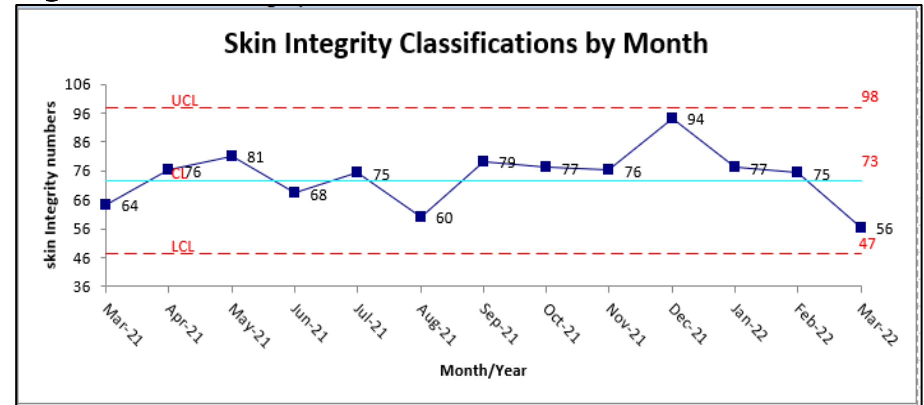
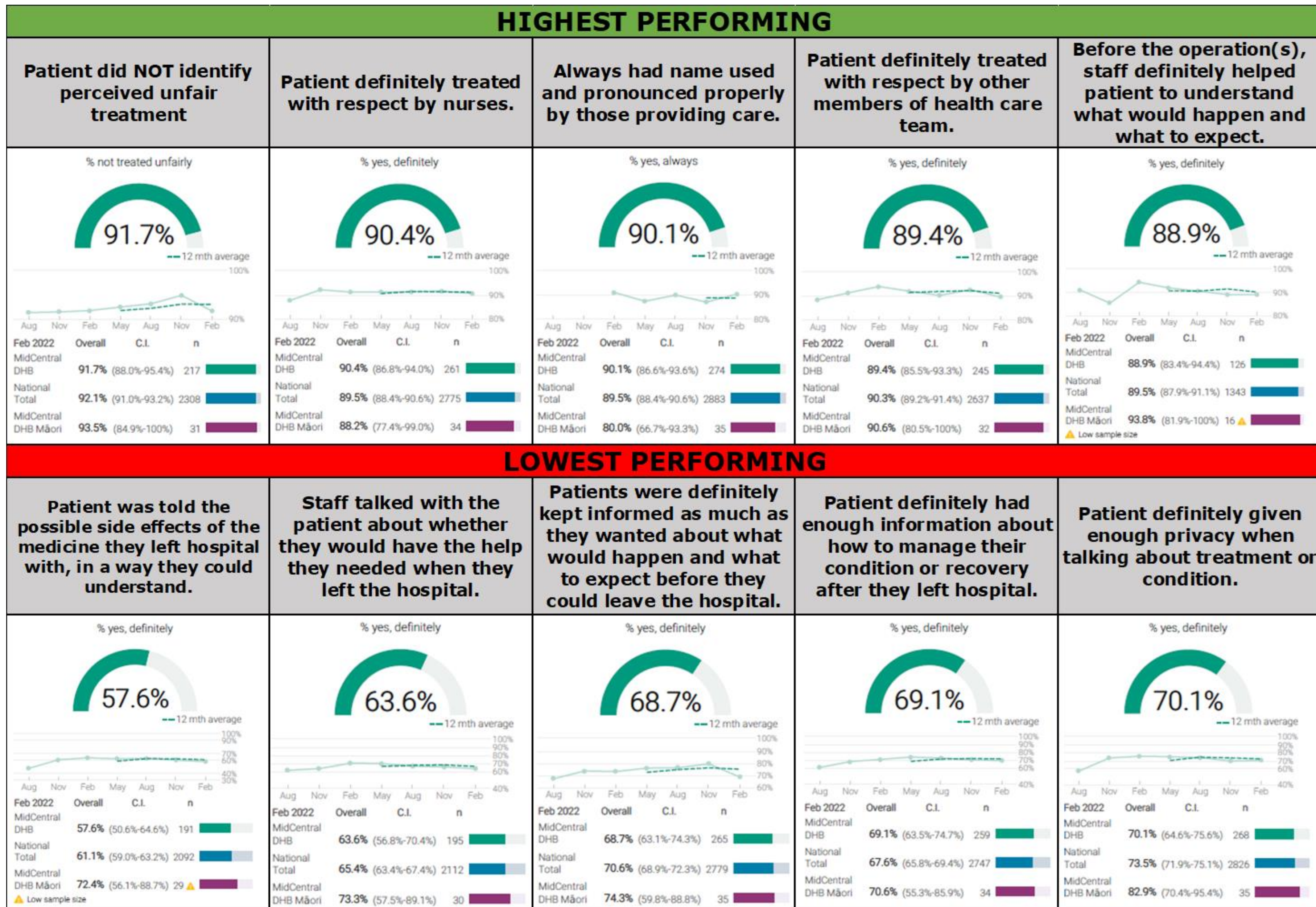



**Figure 4.2.6**



**APPENDIX TWO – PATIENT EXPERIENCE SURVEY RESULTS (February 2022)**



**APPENDIX THREE – METRIC DEFINITIONS**

**Quality Safety Markers metric definitions**

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

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

*28 June 2022*

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

# Discussion/Decision Papers

No items

# Information papers

*28 June 2022*

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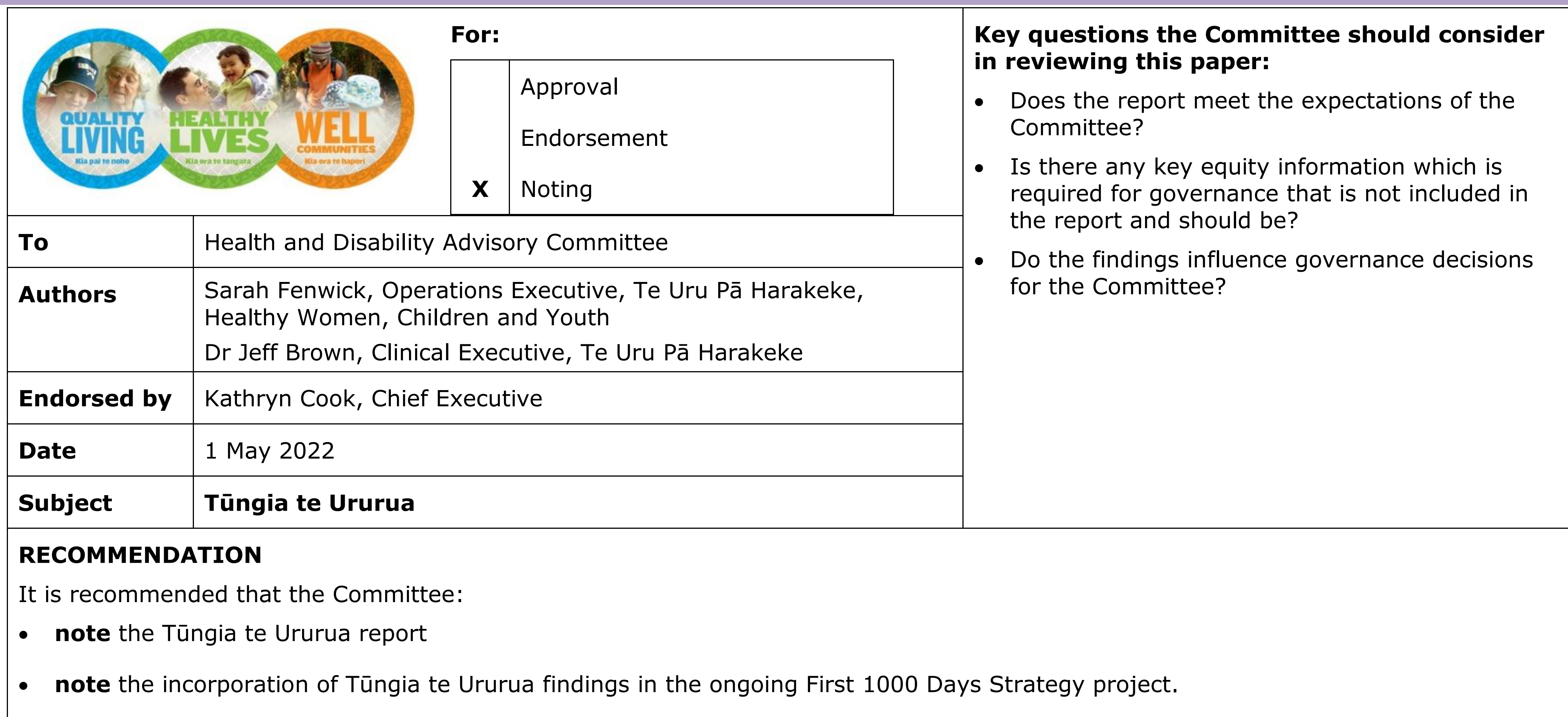



**For:**

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

| | |
|---|---|
| **To** | Health and Disability Advisory Committee |
| **Authors** | Sarah Fenwick, Operations Executive, Te Uru Pā Harakeke, Healthy Women, Children and Youth<br>Dr Jeff Brown, Clinical Executive, Te Uru Pā Harakeke |
| **Endorsed by** | Kathryn Cook, Chief Executive |
| **Date** | 1 May 2022 |
| **Subject** | **Tūngia te Ururua** |

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

- Does the report meet the expectations of the Committee?
- Is there any key equity information which is required for governance that is not included in the report and should be?
- Do the findings influence governance decisions for the Committee?

**RECOMMENDATION**

It is recommended that the Committee:

- **note** the Tūngia te Ururua report
- **note** the incorporation of Tūngia te Ururua findings in the ongoing First 1000 Days Strategy project.

**Strategic Alignment**

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

## 1. PURPOSE

To provide the Committee with an overview of the outcomes of the Tūngia te Ururua, First 1000 Days project. The full report is available for Committee members on the Stellar platform *(MidCentral District Health Board/HDAC/HDAC Reports and Documents/ Tūngia te Ururua – final report).*

## 2. BACKGROUND

Phase One of the Primary Birthing Review in 2019 looked at the provision of maternity services in Palmerston North. The increasing complexity of women, difficulties in recruitment and retention of midwives, increasing costs, increasing birth rate and an inequitable model of care were all drivers that culminated in the transfer of Te Papaioea to MidCentral District Health Board (MDHB) management in April 2020. In July 2020, the Board approved Te Uru Pā Harakeke to progress with Phase Two of the review. The focus of Phase Two was maximising potential and outcomes for wāhine, pēpi and whānau in the first 1000 days, for the communities of Tararua, Horowhenua and Ōtaki, aligning to the Te Uru Pā Harakeke Health and Wellbeing Plan Goal Three: 'Maximising lifelong health and wellbeing by targeting the first 1000 days'. It was agreed that full community engagement was required for this phase of the project.

Following engagement with Manawhenua Hauora, the project launched on 27 October 2020, engaging sector leaders and iwi across all three localities. An Engagement Manager, with extensive experience engaging with local and national iwi and Māori communities, was appointed to develop engagement plans for each area and to lead the engagement process. Building strong relationships with iwi and Māori providers was pivotal to connecting with Māori communities and key to understanding their aspirations, challenges and solutions to addressing inequities in line with MDHB's commitment to equitable outcomes for Māori. In consideration of this, the planning and delivery of this project was respectful of indigenous social norms and processes guided by the voice of mana whenua and Māori leadership.

MDHB's Pae Ora Paiaka Whaiora Hauora Māori gifted Te Uru Pā Harakeke the project name 'Tūngia te Ururua'. This gifted name is the first line of a whakataukī related to the phase of planting a new pā harakeke, where the land is cleared by burning away overgrowth to prepare space for new planting and the potential of new beginnings.

Local Advisory Groups in Tararua, Horowhenua and Ōtaki were established on advice of mana whenua and the Locality Health and Wellbeing Group Chairs in each region. Representatives were reflective of skills, experience and community connection, working within the scope of this project and ensuring that the community was well represented. Successful gathering of data across all three localities required guidance from kaupapa Māori principles for all members working together with respect, upholding the mana of each committee member and whānau Māori in each community. Locality Advisory Groups agreed that surveying consumer and

provider organisations would provide the greatest level of feedback, along with some face to face sessions in communities, with the groups agreeing survey questions.

The project was originally due to be completed in March 2021, however was extended due to COVID-19, with support from the MDHB Health and Disability Advisory Committee, to ensure adequate consultation across all localities and communities giving respect to those being asked to participate while they were intensely working to support their communities through COVID-19.

## 3. ENGAGEMENT AND RESPONSE

Following initial engagement and in partnership with the Locality Advisory Groups, online engagement surveys were created for both providers and consumers. It was identified that some members of the community may not identify with an online survey and therefore face to face hui were planned in pre-school settings, and with Māori and Pasifika whānau.

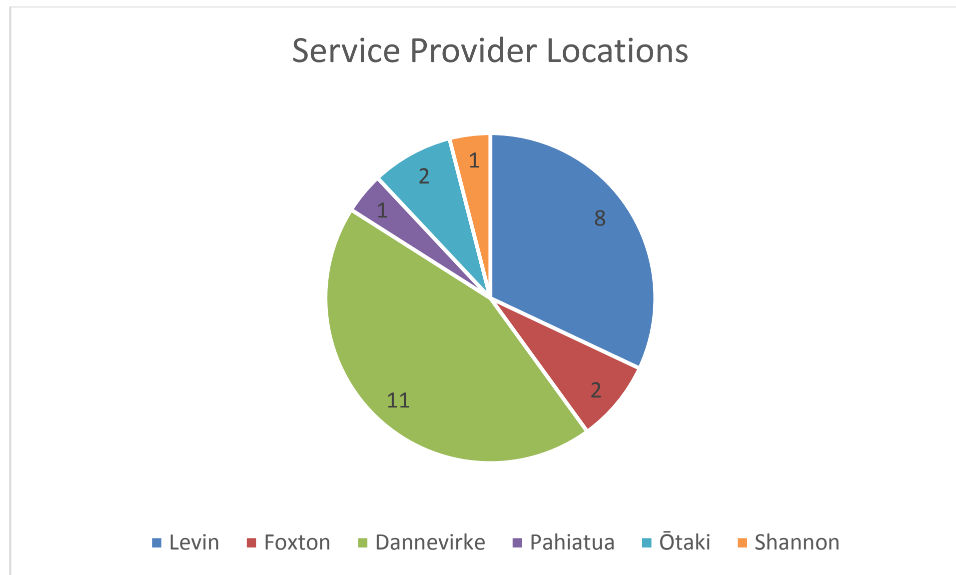
### 3.1. Provider survey

The provider survey targeted all birthing/pregnancy/well-child/Non-Government Organisation (NGO) services that operate across the Horowhenua, Ōtaki and Tararua. The survey asked four qualitative questions, designed to assess what works well in current services, what gaps may exist in current services and recommendations for improvements.

The questions asked were:

- As a service provider, what do you think works well in the provision of services for hapū/pregnant wāhine and their whānau in your local area?
- Do you have any suggestions about how services could be provided differently to better meet the needs of local wāhine and whānau through pregnancy and birthing?
- As a service provider, what do you think works well in the provision of services for whānau caring for pēpi up to two years of age?
- Do you have any suggestions about how services could better meet the needs of local whānau in caring for their pēpi?

Ninety-five questionnaires were distributed to community providers across the three localities – 49 to Horowhenua and 46 to Tararua. A total of 25 service providers across all three localities (26 percent) completed and returned the survey questions. Of the 49 surveys distributed to Horowhenua and Ōtaki, 13 were returned (26.5 percent) and in the Tararua locality, of the 46 surveys sent to providers 12 responded (26 percent).




Analysis of the responses received from providers confirmed the following key themes for each question:

- Centralised, well connected, close to home services serve communities best, allowing whānau to connect with services without having to travel long distances
- The current services are working well but could do with additional support in the form of knowledge and gap filling
- Services need to be tailored to individual needs by listening to client's needs, allowing the client to lead the process.

There were no stand-out features that were considered completely missing or not functioning well. As such, recommendations for improvements focused on location-specific additions/alterations to the existing structure. This was due to the strengths of the existing services and the areas for improvement being basically the same.

### 3.2. **Consumer workshops**

Face to face hui were planned by the Engagement Manager with Māori and Pasifika whānau, however these did not progress due to the alert level and traffic light requirements as part of COVID-19. In addition, providers were required to undertake work related to COVID-19 so were not able to support these sessions.

Ten consumer workshops were held at pre-school institutions across targeted locations. The local workshops focused on group workshop activities with six questions. The public attending the workshops worked collaboratively with paper and post-it notes to answer and had all experienced birthing/pregnancy services over a two-year period. The questions asked were:

- First 1000 days – what went well?
- First 1000 days – where are the gaps?
- First 1000 days – what could have been better?
- What works well?
- What didn't work well?
- What would you like to see more support in?

There was a total of 98 participants across all areas, in the following locations.

| Pre-school | Numbers |
|---|---|
| **Horowhenua** | |
| Waitarere Beach Play Group | 10 (average) |
| Levin Plunket Playgroup | 12 |
| Creative Mind Playgroup Levin | 16 |
| **Ōtaki** | |
| Little Giggles Ōtaki | 15 |
| Ōtaki Mainly Music | 20 |
| **Tararua** | |
| Eketāhuna Play Centre (south) | 4 |
| Ti tree Point Play Group (rural north) | 5 |
| Tots and Toddlers Dannevirke (north) | 5 |
| Mangamarie Playgroup (south) | 6 |
| Woodville Play Centre (south) | 5 |

Ethnicity and age were not recorded for these workshops, which will affect assessing representation over the whole project.

The key themes were:

- Māmā generally had a positive birthing experience.
- Māmā enjoyed local playgroups and received an appropriate level of information and training.
- Some māmā stated that there could be more and better connected specialist services, such as dental check-ups, chiropractors, tongue-tie specialists, counselling for māmā and in particular – lactation help and specialists.
- Some māmā were also concerned that they did not have a single midwife for the duration of their experience and that there was not enough support for midwives.

### 3.3. **Consumer survey**

A total of 947 hard copy surveys, with an additional online link, were sent out to targeted māmā who birthed between December 2018 and December 2020, with postal codes in either Tararua, Horowhenua or Ōtaki. Over this two year period there was a total of 1082 births for wāhine residing in these three localities, as shown below.

| | **Horowhenua** | **Ōtaki** | **Tararua** | **Total** |
|---|---|---|---|---|
| **2019** | 372 | 45 | 178 | **595** |
| **2020** | 323 | 27 | 137 | **487** |

In addition, any consumer who had birthed in the previous five years was encouraged to participate in the consumer survey, with advertising and an online survey link sent using social media channels, newspaper articles, local engagement events and distribution through local networks.

Anyone living in Palmerston North was excluded from the study as this locality was addressed as part of the first phase of the project.

The public surveys comprised 42 questions, broken into the following periods:

- pregnancy
- birthing
- services provided post-birth through to two years of age.

The full list of questions can be viewed by Committee members in Stellar incorporated as an appendix to the full report.

A total of 223 participants participated in the survey from the following localities.

| Locality | Number | Percentage |
|---|---|---|
| Tararua | 116 | 52 |
| Horowhenua | 75 | 34 |
| Ōtaki | 32 | 14 |
| **TOTAL** | **223** | **100%** |

Ethnicity data was recorded as shown below.

| Ethnicity | Number | Percentage |
|---|---|---|
| European | 141 | 64 |
| Māori | 72 | 32 |
| Pasifika | 3 | 1 |
| Other | 6 | 3 |
| **TOTAL** | **223** | **100%** |

Given that a key priority for MDHB is achieving equity for Māori, achieving a high level of engagement with Māori in an area which has often been historically under-represented in rural birthing statistics, is positive. The report provides a significant opportunity to better understand the experiences and differences of this portion of the birthing population in a rural setting. However, Pasifika engagement was low.

When combined with the number of recipients who attended face to face workshops with online surveys, participation is thought to be adequate to be reflective of communities.

| Locality | Online survey Number | Face to face engagement session | Total | Percentage |
|---|---|---|---|---|
| Tararua | 116 | 25 | 141 | 44 |
| Horowhenua | 75 | 38 | 113 | 35 |
| Ōtaki | 32 | 35 | 67 | 21 |
| **TOTAL** | **223** | **98** | **321** | **100%** |

## 4. ANALYSIS

It must be acknowledged that COVID-19 had a significant impact on service provision from March 2020 until the completion of the survey in 2021. Providers were required to change the way services were delivered to ensure compliance with Government requirements. It is highly likely to have created a very altered service provision for some whānau and therefore may have impacted on the answers provided for those whānau who birthed in 2020.

Despite COVID-19 limitations and the changes required to service provision throughout 2020 and 2021, project participants positively articulated that locality midwifery services, Whānau Āwhina Plunket Services and Hospital/Birthing Units were of high quality and staff were considered professional and caring. This is pleasing giving local midwifery workforce difficulties. However, whilst these services were incredibly popular, many wāhine surveyed indicated that the care of a single midwife would be preferable to seeing multiple midwives.

Feedback suggested that a single midwife could be difficult to find and retain for the duration of the pregnancy and postnatal period especially in Tararua, where wāhine indicated that they were significantly more likely to have issues with multiple midwives/midwife availability, etc. Whilst this was the feedback it should be acknowledged that the majority of Lead Maternity Carer (LMC) practices now operate using a team based approach which is more sustainable for midwives, allowing adequate rest time and also ensures adequate support for māmā at all times.

Survey analysis found that Māori wāhine were more likely to have difficulty finding a midwife, especially in Horowhenua. This was expected due to the lack of LMCs in this locality, which is of concern given the growing community. In addition, Māori wāhine were less likely to receive antenatal care, with 67 percent of Māori hapū māmā not attending antenatal classes – 20 percent less likely than pregnant NZ European wāhine. Horowhenua survey participants were less likely to receive any antenatal care, particularly Māori māmā from both Horowhenua and Ōtaki. The main reason given for not attending antenatal classes was experience (meaning they had already given birth). Whilst this discrepancy may be due to higher birth rates for Māori māmā in this locality it may also be because current provision does not meet the needs of Māori whānau. This must be considered in re-contracting of antenatal and postnatal education in future.

Twenty percent of wāhine who completed the survey confirmed they had experienced mental wellbeing concerns during pregnancy. Of that 20 percent, Māori hapū māmā were more likely than NZ European hapū māmā to have mental wellbeing concerns during pregnancy. Māori māmā were also less likely to feel comfortable speaking about these concerns. Whilst 35 percent were able to confirm that they shared their concerns and got the help they required, 17 percent shared their concerns but identified they did not get the support required. In addition, 20 percent shared that they didn't feel comfortable talking about their concerns and 11 percent were not able to find anyone who understood their cultural values/beliefs. Mental wellbeing concerns during the postnatal period were significantly higher than during pregnancy, particularly within the first six weeks after having given birth. This mainly appears to relate to first-time māmā and may be related to the new transition to motherhood and stress and pressure associated with this. Further detailed information regarding mental health is available in the full report.

Seventy percent of all māmā surveyed chose breastfeeding for their pēpi. Of the 30 percent who did not breastfeed, 85 percent were due to complications with breastfeeding. The opening of the Whāngai Ora Milk Bank on 19 May 2021 has seen a sharp rise in those māmā choosing to breastfeed following birth to between 85 and 90 percent, but this has not translated to 12-week or six-month data, especially for those in localities further away from Palmerston North. A district-wide contract is in place for community breastfeeding support post discharge from hospital. However Tararua survey results show a higher proportion of respondents using private lactation consultants, and the difficulty – particularly for first time māmā – in providing milk to pēpi is a strong and passionate theme. This feedback requires consideration and discussion with the contracted service provider to ensure adequate time and resource is allocated to the Tararua district.

Service providers stated that full and comprehensive wrap-around birthing services that are locally available (in the form of a hub) or well-connected are required for whānau to avoid travel and stress during the first 1000 days. In addition, 'one stop shops' that were local and provided care close to home were favoured, providing support in areas such as lactation and mental health support. It is pleasing to note that some areas do have multiple wrap-around services on site in the same location. These could be enhanced to avoid multiple visits for whānau.

Consumers identified that further wrap-around support services in the first 1000 days would be beneficial, for example practical support such as meal preparation, provision of nappies, someone to look after pēpi while they shopped or slept, more ongoing postnatal midwife support, help with nutrition etc. It is acknowledged that the midwifery scope is legislated until pēpi is six weeks old. Therefore, whilst care beyond six weeks is not part of the midwifery role, feedback from māmā is valid and needs to be considered when planning for services across the first 1000 days, with the recognition that any support offered in the first 1000 days that develops competence and confidence in parenting is likely to have a positive impact for pēpi.

NZ European māmā tended to support the more traditional models of care – such as midwives and Whānau Āwhina Plunket, while Māori māmā were more likely to support and provide positive feedback regarding the Whānau Ora and iwi-led services. NZ European māmā who did use the Whānau Ora styled services also had high levels of satisfaction with these services.

All locality data indicated that Māori mothers were far more likely to experience a miscarriage or pregnancy loss of some sort and were more likely to have mental health concerns that went unmet. Horowhenua māmā were less likely to attend any antenatal classes or receive antenatal care – particularly Māori mothers. While finding a midwife could be difficult across regions, Horowhenua mothers tended to find this more difficult and cited availability as the main reason.

## 5. LIMITATIONS OF THE ENGAGEMENT

Thirty-two percent of survey respondents were from whānau Māori, despite a number of face to face workshops not proceeding due to COVID-19 restrictions and provider work requirements. Support and work from iwi and Māori providers across all three localities, committed to ensuring that the voice of their communities was heard, produced this good representation. The project team are incredibly appreciative of this engagement and commitment to the project. Despite significant engagement work to ensure the voice of the Pasifika communities in all three localities, response levels were very low and face to face sessions planned with the Pasifika in Horowhenua were impacted by COVID-19 changes in alert levels. Therefore, results cannot be assumed to be representative of Pasifika communities.

It is acknowledged that limited distinction has been made between northern and southern Tararua in much of the report. It may have been beneficial to consider this distinction as part of the overall consumer online survey, to examine the community of southern Tararua and the rural elements of northern Tararua, in more detail. Southern Tararua, including Woodville, does not have a maternity facility or a team of LMC midwives. There is no public transport available across the whole locality, so those without cars can be very isolated. Those in southern Tararua often use services in Palmerston North or Masterton, which were not surveyed. The more rural isolated communities of Horowhenua are not visible in the report. For example, Shannon does not have the services that are provided in Levin and public transport is limited.

Results from Ōtaki may not provide an accurate representation of the entirety of birthing and midwifery, as many women in Ōtaki may choose a primary birthing unit in the Kāpiti district or alternatively in the secondary care unit at Capital and Coast District Health Board. Whilst analysis identifies the number who birthed in an alternative area, it does not link with the other questions.

Birthing population data was used as the basis for communicating directly with wāhine. Whilst this is appropriate for birthing questions, it is likely to have excluded many wāhine who experienced a miscarriage, which is a deficit of the engagement.

## 6. NEXT STEPS

This report will be shared with communities in the localities through their Health and Wellbeing Groups, to check that we have listened well and that the themes can properly inform future service provision.

Sustainability funding has been received to progress the development of a First 1000 Days Strategy for the MidCentral district. The learnings from Tūngia te Ururua are being shared and used as part of engagement for this strategy to inform workshops and hui to determine best investment to ensure pēpi and whānau thrive and flourish into the future.

# Glossary of terms

*28 June 2022*

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

## Glossary of Terms

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

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

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

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

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| **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**<br>Performance measures that provide information on how well the District Health Board is managing key steps in the electives patient journey. |
| **ETA** | **Energy Transition Accelerator** |
| **EV** | **Electric Vehicle** |
| **EWS** | **Early Warning System** |
| **EY** | **Ernst & Young** |

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| **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**<br>The hours worked by one employee on a full-time basis. |
| **FU** | **Follow Up** |
| **Gap** | **Analysis used to examine current performance with desired, expected performance** |
| **GETS** | **Government Electronic Tenders Service** |
| **GHG** | **Greenhouse Gases** |
| **GM** | **General Manager** |
| **GMFCS** | **General Manager, Finance and Corporate Services** |
| **GMM** | **General Manager, Māori Health** |
| **GMPC** | **General Manager, People and Culture** |
| **GMQI** | **General Manager, Quality and Innovation** |
| **GMSPP** | **General Manager, Strategy, Planning and Performance** |
| **GP** | **General Practitioner** |
| **GST** | **Goods and Services Tax** |

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| **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** |

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| **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**<br>The default way that funding follows a patient around the health system irrespective of where the are treated. |
| **IEA** | **Individual Employment Agreement** |
| **IFHC** | **Integrated Family Health Centre**<br>General practice teams with the patient at the centre, providing quality health care when, where and how patients need it. |
| **IFM / IFM20** | **Integrated Facilities Management** |
| **IL** | **Importance Level**<br>Seismic assessment rating |
| **IMAC** | **Immunisation Advisory Centre** |
| **IMT** | **Incident Management Team** |
| **Insourced** | **Delivered directly by the DHBs via its staff** |
| **IOC** | **Integrated Operations Centre** |
| **IOL** | **Intraocular Lens** |
| **IOT** | **Internet of Things** |

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| **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**<br>Name of software package |
| **Ka Ao Ka Awatea** | **Māori Health Strategy for the MDHB District** |
| **KPI(s)** | **Key Performance Indicator(s)**<br>A measurable value that demonstrates how effectively an objective is being achieved. |
| **LAN** | **Local Area Network** |
| **LDC** | **Local Data Council** |
| **LED** | **Light Emitting Diode** |
| **LEO** | **Leading an Empowered Organisation** |
| **LMC** | **Lead Maternity Carer** |
| **LOS** | **Length of Stay** |
| **LSP** | **Leadership Success Profile** |
| **LTC** | **Long Term Condition(s)** |
| **LV** | **Low Voltage** |
| **MALT** | **Māori Alliance Leadership Team** |
| **MAPU** | **Medical Assessment and Planning Unit** |
| **MBIE** | **Ministry of Business, Innovation and Employment** |

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| **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**<br>A radiographer who works with technology to produce X-rays, CT scans, MRI scans and other medical images. |
| **MIYA** | **MIYA Precision Platform** |
| **MoH** | **Ministry of Health** |
| **MOU** | **Memorandum of Understanding** |
| **MRES** | **Managed Rehabilitation Equipment Service**<br>An ACC contract (Enable NZ) |
| **MRI** | **Magnetic Resonance Imaging**<br>A medical imaging technique used in radiology to form pictures of the anatomy using strong magnetic fields and radio waves. |
| **MRSO** | **Medical Radiation Officer** |
| **MRT** | **Medical Radiation Therapist(s)** |
| **MSD** | **Ministry of Social Development** |
| **MWH** | **Manawhenua Hauora** |
| **MYFP** | **Midwifery First Year of Practice Programme** |

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| **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** |

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| **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**<br>OLT comprises all General Managers, Chief Medical Officer, Executive Directors - Nursing & Midwifery and Allied Health, General Manager of Enable NZ, all Operations Executives and Clinical Executives. |
| **OPAL** | **Older People's Acute Assessment and Liaison Unit** |
| **OPERA** | **Older People's Rapid Assessment** |
| **OPF** | **Operational Policy Framework** |
| **Outsourced** | **Contracted to a third-party provider to deliver** |
| **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** |

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| **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**<br>This plan is designed to support the OLT in the prioritisation and optimisation of system wide efforts to achieve our vision.<br>The plan was presented to the MoH as part of MDHB's 2019/20 strategic discussion. |
| **PNCC** | **Palmerston North City Council** |
| **POAC** | **Primary Options for Acute Care** |
| **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** |

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| **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**<br>Provides a centralised platform to improve access to patient data in the central region. |
| **Risk ID** | **Risk Identifer** |
| **RM** | **Registered Midwife** |
| **RMO** | **Resident Medical Officer** |
| **RN** | **Registered Nurse(s)** |
| **RP** | **Risk Priority** |
| **RSI** | **Relative Stay Index** |
| **RSO** | **Research Support Officer** |
| **RSP** | **Regional Service Plan** |
| **RTL** | **Round Trip Logistics**<br>A technology platform. |
| **Rules** | **Government Procurement Rules (4th Edition 2019)** |
| **SaaS** | **Software as a Service** |

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| **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**<br>A project to establish additional procedural, interventional and surgical resources within MDHB. |
| **Spotless** | **Spotless Services (NZ) Limited** |
| **SRG** | **Shareholder's Review Group** |
| **SSC** | **State Services Commission** (from 2020 - Te Kawa Mataaho Public Service Commission) |
| **SSDF** | **State Sector Decarbonisation Fund** |
| **SSHW** | **Safe Staffing, Healthy Workplaces** |
| **SSIED** | **Shorter Stays in Emergency Department** |
| **SSP** | **Statement of Service Performance** |

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| **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** |
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# Late items

*28 June 2022*

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# Late items

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

# Exclusion of the public

*28 June 2022*

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# Exclusion of public

*Resolution:*

That the public be excluded from this meeting in accordance with the Official Information Act 1982, section 9 for the items and reasons outlined in the agenda.