CSAC 25 March 2022 - Public

25 March 2022 09:30 AM - 10:30 AM

Interest Register

Name	Date	Interest
Annette Main *Chair CSAC*	21 August 2020 27 August 2021	▪ Appointed to the Whanganui Community Foundation ▪ A member of the Whanganui District Council District Licensing Committee.
Adams Graham	16 December 2016	▪ A member of the executive of Grey Power Wanganui Inc. ▪ A trustee of Akoranga Education Trust, which has associations with UCOL.
Anderson Charlie	16 December 2016 3 November 2017	An elected councillor on Whanganui District Council. A board member of Summerville Disability Support Services.
Baker-Hogan Philippa	10 March 2006 8 June 2007 24 April 2008 29 November 2013 3 March 2017	An elected councillor on Whanganui District Council. A partner in Hogan Osteo Plus Partnership. Her husband is an osteopath who works with some of the hospital surgeons, on a non paid basis, on occasions hospital patients can attend the private practice, Hogan Osteo Plus, which she is a Partner at. Chair of the Future Champions Trust, supporting promising young athletes. A Trustee of Four Regions Trust.
Bellamy Maraea	 4 May 2018 1 February 2019	▪ Te Runanga O Ngai Te Ohuake (TRONTO) Iwi Delegate for Nga Iwi O Mokai Patea Services Trust. ▪ A trustee of Mokai Patea Waitangi Claims Trust ▪ Hauora a Iwi – iwi delegate for Nga O Mokai Patea Services Trust Director of Taihape Health Limited Trustee of Mokai patea Waitangi Claims Trust
Bristol Frank	8 June 2017 27 August 2021	▪ A member of the WDHB Mental Health and Addiction (MH&A) Strategic Planning Group co-leading the adult workstream. ▪ Management role with the NGO Balance Aotearoa which holds Whanganui DHB contracts for Mental health & addiction peer support, advocacy and consumer consultancy service provision. ▪ The MH&A consumer advisor to the Whanganui DHB through Balance Aotearoa as holder of a consumer consultancy service provision contract. ▪ A member of Sponsors and Reference groups of National MH KPI project. ▪ A Member of Health Quality and Safety Commission's MH Quality Improvement Stakeholders Group. ▪ Various roles in Whanganui DHB MHA WD, Quality Improvement programmes and Strategic planning ▪ A member of Whanganui DHB CCDM Council ▪ A steering group partner via Balance Aotearoa with Ministry of Health on Disability Action Plan Action 9d).This is legal and improvement work associated with MH Act, Bill of Rights and UN Convention on Rights of disabled people. ▪ A member of the Balance Aotearoa DPO Collective doing work with the Disability Action Plan representing the mental health consumers. ▪ Life member of CCS Disability Action ▪ Advisor Consumer Engagement working party ▪ Appointed as Co Chair of Te Pūkāea (The WDHB Consumer Council) ▪ Work with the WDHB doing Consumer Engagement via contract under Balance Aotearoa
Chandulal-Mackay Josh	10 December 2020 21 February 2020	An elected councillor on Whanganui District Council A member of Aged Concern Deputy Chair for Whanganui Youth Services Trust
Gifford Heather	20 November 2018	▪ Ngāti Hauiti representative on the Hauora a Iwi Board; ▪ A senior advisor and founding member of Whakauae Research for Māori Health and Development (currently engaged in research with WDHB);

Name	Date	Interest
		▪ Advisor to WALT project 'Whanganui primary Health Research Collaborative"
McDonnell Te Aroha	6 March 2020	Pouherenga – Chairperson – Te Orangqanui Trust : Delivery of contractual services with Whanganui DHB
Peke-Mason Soraya	21 February 2020	▪ Director, Ruapehu Health Limited ▪ Trustee, Whanganui Community Foundation ▪ Iwi Rep, Rangitikei District Council Standing Committee ▪ Whanganui Health Network Board Member
Smith Debra		Nil
Teki Christie	12 March 2020	Employee, AccessAbility Whanganui
Whelan Ken	13 December 2019	Crown monitor for Waikato DHB Crown monitor for Counties DHB Board member RDNZ (NZ) Chair Eastern Bay of Plenty PHO Contractor General Electric Healthcare Australasia

Conflicts and register of interests up to and including 26 November 2021

WHANGANUI DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

Minutes
Public session

Meeting of the Combined Statutory Advisory Committee

held (virtually) in the Board Room, Fourth Floor, Ward/Administration Building
Whanganui Hospital, 100 Heads Road, Whanganui
on Friday 26 November 2021, commencing at 9.30am

Committee members
Annette Main, Chair
Philippa Baker-Hogan
Deb Smith
T McDonnell
F Bristol
M Bellamy
C Teki
C Anderson
G Adams
J Chandulah-Mackay

Management
G Dyer, Acting chief executive
N Mackintosh, Executive officer
A Kemp, Chief professional officer allied health
I Murphy, Chief medical officer
R Kui, GM Maori Health and equity
L Adams, Director of nursing/COO

Guests
R Davies

1. PROCEDURAL

1.1 Welcome
The meeting was opened by A Kemp

1.2 Apologies
The committee accepted the apologies from H Gifford and S Peke-Mason

1.3 Interest Register
Frank Bristol will provide interest register updates to the secretariat

1.4 Minutes of the meeting
Minutes of the meeting were accepted as a true and accurate record

Moved P Baker-Hogan **Seconded** J Chandulah-Mackay **CARRIED**

2. PRESENTATIONS

2.1 Growing Collective Wellbeing Suicide Prevention Strategy

The presenter acknowledged the unique approach undertaken by WDHB for a true community led, whole of strategy.

Protective factors normally resides at the crisis end of the model and does not reside at the community level of care.

The Insights reports have allowed community groups to select which initiatives best meet the needs of the members involved.

This session is to provide members of the committee with a progress update

Insight gather process highly indicated toxic stress, and most attempted suicides were related childhood trauma.

- Unemployment
- Domestic violence
- Poverty
- Physical abuse
- Alcohol abuse
- Drug abuse

Working with the co-leads of education of learning to address the impacts of toxic trauma, we are working with the DHB on hapu-mama.

Action: R Davies would like to have a strategy on the first 1000 days.

Farmer suicides have a tendency to isolate. Work has been undertaken in the Taihape region with identification of their wellbeing response during Covid, which involved key contacts list for check-in on each other and provide assistance were possible.

RWT – Workshops have been undertaken on with community to define what an ideal model of care would look like for this community.

Maori Tane engagement commenced in September, has created a growing and formal movement to address and support the toxic stress without shame. One of the members shared a story on facebook and received 14,000 regional views.

Staff and those people working across the sector and with family do not always recognise the factors. There will be seminars over the next two weeks and for those that are unable to attend, communications will be released. (Upskilling, training and development needs to occur year on year.)

Next year we are looking at the support hub, with train the trainers.

The committee members discussion covered:

- Seminars
- Health reform funding implications, noting that the transition unit have shown interest in this work in relation to the Mental Health framework.
- Committed suicide is no longer a terminology used as commit is associated with a crime

Action: The chair recommended that contact is made with both the Chamber of Commerce and Whanganui & Partners as they have high uptake on seminars.

The Combined Statutory Advisory Committee resolved to:

a. **Receive** the paper
b. **Note** the publication of the three papers
c. **Note** the next steps for implementation of the strategy and how this inform changes in the clinical changes

Moved F Bristol **Seconded** C Anderson **CARRIED**

2.2 Covid Resurgence

Our Covid response is focused on how we can support people to be well in their communities and when isolating we ensure that the household have all requirements to ensure there is no need to leave the house. We are localising the national shamrock model which covers public health, welfare, primary and hospital.

Workforce has been impacted nationally and plans are being developed to address the gaps as a central region response across the health sector.

The public health response is well established and the medical officer of health can order public to remain in their house and the police can invoke this order.

We have developed four community hubs

- Public Health and Regional Leads will collectively undertake contact tracing
- Information packs (Information on isolation, pulse oximeter, medications)
- Hygiene packs
- Welfare packs (food, wifi, phone)

Management confirmed that we have a good level of preparedness, and we have a collective community approach

- Low socio economic areas
- Low vaccinations

The resilience side is to build in mitigation strategies to limit the impact of the spread of covid. IMT have been developing safe clinical pathways, PPE and community welfare.

Primary care response is a remote monitoring function with regular telehealth check-ups.

If we need a ward the medical ward will become the covid ward. WDHB does not have a ICU but a CCU with three ventilators.

3. DISCUSSION

3.1 Provider arm report

The paper was taken as read with management advice that a majority of time is spent on Covid planning and planned care procedures.

A verbal update on midwifery services in Waimarino was received and it was encouraging to note that discussions with a replacement midwife have commenced.

The Combined Statutory Advisory Committee resolved to:

a. **Receive** the paper
b. **Note** the comments around operational performance for hospital and clinical, maternity, child and youth services, primary and community services.

Moved A Main **Seconded** M Bellamy **CARRIED**

3.2 Quarterly report

The paper was taken as read with verbal advice on improvements to the targets since we published the papers.

The Combined Statutory Advisory Committee resolved to:

a. **Receive** the paper titled Preliminary Q1 Reporting; Non-financial performance measures

b. **Note** that Quarter 1 results are preliminary

Moved A Main **Seconded** P Baker-Hogan **CARRIED**

3.3 Immunisation

The paper was taken as read with the acting chief executive briefing the committee on our plans to co-commit immunisations and vaccinations. Whilst we are facing the vaccine hesitant population for Covid, which require a tailored approach we are not yet able to co-commit the Covid vaccination and immunisations.

There was a discussion on the possibility of linking immunisation, vaccination, hearing, eyesight and dental.

Our key messaging for the Covid vaccine is wellness in the communities. Management were informed to consider that the vaccinations to 5-12 year olds might negatively impact the decisions of the undecided population.

The Combined Statutory Committee resolved:

a. **Receive** the paper titled Scoping Report - Strategies to increase uptake of childhood immunisations 0 – 5 years

b. **Note** the findings of a scoping report in progress

- declining coverage and ethnic disparities particularly for Maori families in the region
- the potential impact of Covid-19 on vaccine hesitant parents

- the need for collaborative action with Maori Health providers and Iwi in the design and dissemination of childhood immunisation resources.

c. **Note** the Scoping Report was commissioned prior to the COVID vaccination programme which has since changed the environment.
d. **Note** an update will be provided to the Committee at the next meeting.

Moved A Main **Seconded** D Smith **CARRIED**

4. INFORMATION

4.1 Te Pukaea Committee

The paper was taken as read noting the change in direction for the consumer council in particular approach to co-design care aspects. This supports providing the community with a greater voice.

E O'Leary was to be thanked for a well written paper.

The Combined Statutory Advisory Committee:

a. **Received** the paper titled: Update on Whanganui DHB Consumer Engagement Council – Te Pukaea.
b. **Noted** the next steps are:
    i. Complete orientation
    ii. Identify and establish relationships with key teams such as the WDHB Project Management Team and the Design and Engagement Team to ensure quality consumer engagement in future project work and communications.

Moved F Bristol **Seconded** C Teki **CARRIED**

4.2 Vaccination paper

At the time of writing the paper we 4,398 has been reduced to 2,360. Conversations that were taking up three minutes are now requiring conversations of over 30 minutes.

4.3 Clinical Board

The paper was taken as read.

The Combined Statutory Advisory Committee:

a. **Received** the paper titled Clinical Governance Update
b. **Noted** that the current position of the WDHB in respect of clinical governance
c. **Noted** that the current issues arising from the Clinical Board
d. **Note** the next steps proposed prior to the next committee reporting

Moved A Main **Seconded** C Anderson **CARRIED**

4.4 Disability update

The paper was taken as read with advice that they represent a significant percentage of the population across our communities that this will be lead in partnership with MSD. This segment

The Combined Statutory Advisory Committee:

a. **Receive** the paper entitled Disability Update

b. **Note** the appointment of several key roles in Disability

c. **Note** several key changes in disability including the establishment of the Ministry for Disabled People, the Accessibility for New Zealanders Bill, and WAI2575 Disability Claims

d. **Note** the work that has progressed in the space of COVID-19 response for disability

e. **Note** the need to identify resource to progress the DHB Disability Strategy

Moved A Main **Seconded** J Chandulah-Mackay **CARRIED**

4.5 Annual Plan

The acting chief executive reported that it was pleasing to received sign-off on our annual plan early in the process.

The Combined Statutory Advisory Committee:

a. **Receive** the paper titled 'Whanganui DHB's 2021/22 Annual Plan'

b. **Note** that the DHB have received approval for the Whanganui DHB's 2021/22 Annual Plan

PUBLIC EXCLUDED

PROCEDURAL

Mental Health

There are seasonal peaks with a noticeable higher acuity in the community. The committee were pleased to see management addressing the staffing gaps. Management advised the committee that there have been no indications that the occurrence of suicide has no significance to our high mental health service rates.

Management provided an explanation on the terminology a youth contagion, the youth are known to one another. The social media platform's have vulnerabilities and of concern to management is Tik tok, as the search enhancement encourages promotion of similar content, which can be dark. We need to start in a proactive space, but are currently in a reactive response.

A Main	Josh	CARRIED

5.2 Regional Service Plan

This is prepared by TAS on behalf of the six central region district health board. This report signals where the central region is heading.

F Bristol	P Baker-Hogan	CARRIED

GENERAL

The committee sought clarification on one of the many Covid rumours, management will investigate and report back to the committee chair.

Limitation's on carparking and potential DNA's or appointment delays.

CLOSE

The

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WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Discussion Paper**
	25 March 2022
Author	Kilian O'Gorman, Business Support Manager, Strategy, Commissioning and Population Health
Endorsed by	Ron Dunham, General Manager Strategy, Commissioning and Population Health
Subject	Finalised Q2 Reporting: non-financial performance measures
Equity Considerations	Equity considerations are integral to the performance framework

Recommendations

Management recommend that the Combined Statutory Advisory Committee:

a. **Receive** the paper titled Preliminary Q2 Reporting; Non-financial performance measures

b. **Note** that Quarter 2 results are now finalised.

1. Purpose

This paper provides an update on Final Quarter 2 Non-Financial Performance Framework results

2. Index

1) Final Ratings Quarter Two Non-Financial performance framework measures

2) Detailed quarterly reports to the Ministry of Health for Quarter 2

3) Updates to the 2021-22 Annual Plan

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1) Preliminary Ratings Quarter Two Non-Financial performance framework measures

Measure	Q-1	Q-2	Q-3	Q-4
Ratings confirmed?	✓	✓		
Key Achieved / Partial / Not achieved / Not req'd / Update due				28/02/22
Child-wellbeing				
CW01: Children caries-free at five years of age				
CW02: Oral Health- Mean DMFT score at school Year 8				
CW03: Improving the number of children enrolled in and accessing the Community Oral Health Service.				
CW04: Utilisation of DHB-funded dental services by adolescents from School Year 9 up to and including age 17 years				
CW05: Immunisation coverage 8 month				
CW05: Immunisation coverage 5 year				
CW05: Immunisation coverage HPV				
CW05: Immunisation coverage influenza				
CW06: Improving breast- feeding rates				
CW07: Improving newborn enrolment in Gen. Practice				
CW08: Increased Immunisation 2 years				
CW09 Better help for smokers to quit (Maternity)				
CW10: Raising healthy kids				
CW12: Youth mental health				

Mental wellbeing				
MH01: Improving the health status of people with severe mental illness through improved access				
MH02: Improving mental health services using wellness and transition (discharge) planning				
MH03: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds				
MH04: Mental Health and Addiction Service Development PRIMARY				
MH04: Mental Health and Addiction Service Development SUICIDE PREVENTION				
MH04: Mental Health and Addiction Service Development CRISIS RESPONSE				
MH04: Mental Health and Addiction Service Development OUTCOMES FOR CHILDREN				
MH04: Mental Health and Addiction Service Development EMPLOYMENT & PHYSICAL NEEDS				
MH05: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders				
MH06: Output delivery against plan				
MH07: Improving mental health services by improving inpatient post discharge follow-up rates				

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Measure	Q-1	Q-2	Q-3	Q-4
Primary health care				
PH01: Improving System Integration & SLMs				
PH02: Improving the quality of data collection in PHO and NHI registers				
PH03: Improving Maori enrolment in PHOs to meet the national average of 90%				
PH04 :Better help for smokers to quit (primary care)				
Improving wellbeing through prevention				
PV01: Improving breast screening coverage and equity for priority women.				
PV02: Improving cervical screening coverage and equity for priority women.	*Measure Removed (MoH)*			
Strong and equitable public health and disability system				
SS01: Faster cancer treatment (31 days)				
SS02: Delivery of Regional Service Plans	*Measure Removed (MoH)*			
SS03: Ensuring delivery of service coverage				
SS04: Implementing the Healthy Ageing Strategy				
SS05: Ambulatory sensitive hospitalisations (ASH adult)				
SS06: Better help for smokers to quit in public hospitals	Reporting by WDHB no longer required due to progress made 2020			
SS07: Planned Care Measures				
SS09: Improving the quality of identity data NHI				
SS09: Improving the quality of identity data NATIONAL COLLECTIONS				
SS09: Improving the quality of identity data PRIMHD				
SS10: Shorter stays in Emergency Departments				
SS11: Faster cancer treatment (62 days)				
SS12: Engagement and obligations as a Treaty partner				
SS13: FA1 Long Term Conditions				
SS13: FA2 Diabetes services				
SS13: FA3 Cardiovascular health				
SS13: FA4 Acute heart services				
SS13: FA5 Stroke services				
SS15: Improving waiting times for colonoscopies				
SS17: Delivery of Whānau Ora				

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2) Detailed reports to the Ministry of Health for Quarter TWO

CHILD WELLBEING

CW03: Improving the number of children enrolled in and accessing the Community Oral Health Service

	ALL ETHNICITIES					MĀORI ONLY				
	Number of Children Overdue	Total Number Enrolled	Percentage Overdue	Longest waiting time Duration (in months)	Longest waiting time Number Affected	Number of Children Overdue	Total Number Enrolled	Percentage Overdue	Longest waiting time Duration (in months)	Longest waiting time Number Affected
Pre-School Children (age 0 -4)	480	4,431	11%	10	2	193	1,773	11%	10	1
Primary School Children (age 5 - Year 8)	575	8,106	7%	11	1	251	3,242	8%	9	2
TOTAL	1,055	12,537	8%	11	1	444	5,015	9%	10	1

	PACIFIC ONLY					OTHER				
	Number of Children Overdue	Total Number Enrolled	Percentage Overdue	Longest waiting time Duration (in months)	Longest waiting time Number Affected	Number of Children Overdue	Total Number Enrolled	Percentage Overdue	Longest waiting time Duration (in months)	Longest waiting time Number Affected
Pre-School Children (age 0 -4)	20	177	11%	5	1	267	2,481	11%	10	1
Primary School Children (age 5 - Year 8)	23	324	7%	3	1	301	4,540	7%	11	1
TOTAL	43	501	9%	5	1	568	7,021	8%	11	1

Summary of results: Number of enrolled pre-school and primary school children overdue for their scheduled examinations *Please provide a summary of the DHB's performance in the Progress Report section below. Please add additional rows as required*
Progress report Consistant coverage at 5 fixed sites. All 51 mobile sites visited and treatment provided at least once this year. High risk schools visited twice. High risk schools are our focus. All visited twice and teatment provided on site at mobiles during 2021. We planned to reduce the arrears to 6% but were unable to achieve this. We have however covered all bases. While some schools have waited longer for a visit than we would like, we have been/covered all schools. Our GA list waiting time is 4 months. We maintain compliance here. Those children who are referred for GA who are urgent are brought forward to a 6-8 week wait.
Actions to address issues/barriers impacting on performance *Please provide a brief summary of any issues arising in the quarter that affected ability to meet the arrears target and how these are being addressed*
Larger arrears than usual as a result of the lockdown. Children absent from school in reasonably large numbers. Loss of a dental therapist to the vaccine mandate. General sickness amongst staff. Sick leave for surgery amongst aging workforce.

Hosted five AUT 3rd year students, hoping that one would want to come to Whanganui. But no luck here.
New initiatives and successes
Mobile sites at all Whanganui city secondary schools. All rural secondary schools covered by fixed sites in Ohakune, Taihape and Marton. 1368 teenagers enrolled with 5 % arrears. 43% of the enrolments are Maori .

CW05: Immunisation coverage 8 month

Indicator 1: Immunisation coverage at 8 months (B CW05, FA1) 21/22
Contact (role and name):
Target definition Percentage of eligible children fully immunised at eight months of age for total DHB population, Māori and Pacific. Achievement requires that the target is met for the total population and the equity gap between Māori and non-Māori is no more than two percent. Note: Immunisation coverage of less than 90 percent for any one of the priority groups, or an equity gap between Māori and non-Māori populations of five percent or more will be rated as Not Achieved regardless of any other results.

Summary of results: Coverage at age 8 months
Please complete the table (optional) and provide a brief summary of the DHB's performance in the Progress Report section.

Target: 95%	**Total**	**Māori**	**Pacific**	**Dep 9-10**	**Change: total**	**Change: Māori**
Q1 2021/22	**82.1%**	**76%**	**88.9%**	**82.1%**	**+0.2%**	**+6.9%**
Q2 2021/22	**84.0%**	**78.9%**	**88.9%**	**84.0%**	**+2.1%**	**+3.6%**
Q3 2021/22						
Q4 2021/22						

Progress report

Not immunised on time
There were 15 children not immunised on time.

- One has completed but after turning eight months.
- Five children have not started any immunisations,1 has social/housing issues,1 is sick,1 is delaying starting til 6mths,1 has moved but we don't have their new address and the final child we have been unable to contact.
- Four have had their 6weeks but not completed 3/5mth. Two have social/housing issues,1 we have not been able to local and the last 1 has declined outreach services
- Five are needing their 5mth immunisations only are engaged with outreach.

10 of the 15 children who have not completed on time were Maori These children came from both rural and urban GP's but 5 were from rural areas and 1 had no GP

Decliners: This quarter saw 18 children decline 13 of whom were Maori

New initiatives and successes this quarter

- 7-week project continues to highlight 4-6 children most weeks who have not completed their 6week event. Working with both the NIR, GP practice and the new-born enrolment lead at WRHN to decrease the number not starting on time.
- Started linking with hotels/motels who provide emergency housing so we can follow up earlier for families who are without GP or due/overdue immunisations

Issues/barriers impacting on performance and actions taken
Please provide a brief summary of any issues arising in the quarter that affected ability to meet the immunisation target and how these are being addressed

- Impact of COVID-19 immunisation on resources

CW05: Immunisation coverage 5 year

Indicator 3: Immunisation coverage at 5 years (B CW05, FA2) 21/22

Contact (role and name):

Target definition
Percentage of eligible children fully immunised at 5 years of age for total DHB population, Māori and Pacific. Achievement requires that the target is met for the total population and the equity gap between Māori and non-Māori is no more than two percent.

Note: Immunisation coverage of less than 90 percent for any one of the priority groups, or an equity gap between Māori and non-Māori populations of five percent or more will be rated as Not Achieved regardless of any other results.

Summary of results: Coverage at age 5 years
Please complete the table (optional) and provide a brief summary of the DHB's performance in the Progress Report section.

Target: 95%	**Total**	**Māori**	**Pacific**	**Dep 9-10**	**Change: total**	**Change: Māori**
Q1 2021/22	**82.3%**	**75.2%**	**85.7%**	**77.7%**	**-4.9%**	**-7.5%**
Q2 2021/22	**82.5%**	**71.7%**	**100%**	**75.0%**	**-0.3%**	**-4.7%**

Q3 2021/22						
Q4 2021/22						

Progress report

Not immunised on- time:

- There were 24 children not immunised on time
- 18 of these were Māori.
- Twelve were only missing their 4yr immunisation
- Three of the 24 have completed their B4 School check
- Six children we had not been able to locate
- 2 were on catch up from overseas

Decliners: This quarter saw 12 decliners

- Ten were Maori,
- Mixture of both rural and urban GP's

New initiatives and successes this quarter

- Started linking with hotels/motels who provide emergency housing so we can follow up earlier for families who are without GP or due/overdue immunisations

Issues/barriers impacting on performance and actions taken
Please provide a brief summary of any issues arising in the quarter that affected ability to meet the immunisation target and how these are being addressed

Impact of COVID-19 immunisation on resources

CW05 Immunisation coverage - FA4: Influenza immunisation at age 65 years and over 21/22
No report required this quarter

CW06 Improving breastfeeding rates
No report required this quarter

CW07 Improving new-born enrolment in General Practice

QUARTER 2 2021-2022

Period: 16 September to 15 December 2021

Measure 1
Number of newborns enrolled with a general practice by 6 weeks of age

% Enrolled by 6 weeks of age
70.4% Total
58.8% Māori

15.4% above target of 55% for total population.

Measure 2

Whanganui District Health Board

% Enrolled by 3 months of age
90.6% Total 77.1% Māori

5.6% above target of 85% for total population

(n=19 Māori not enrolled)

The WDHB is leading an integration working group across LMC, general practice and WCTO with a focus on improved collaboration and sharing of information and referral pathways. One workstream is focused on the implementation of the best start tool in general practice and improving new born enrolment rates.

The 2 PHOs are actively working together to look at improving these rates, and to identify earlier those that are not enrolled so that outreach can begin to locate them before 6 weeks. We have made progress in terms of improving our 3 month enrolment target of 4.4% for the total population and a 3% increase for Māori.

CW08 Immunisation coverage at 2 years 21/22

Indicator 2: Immunisation coverage at 2 years (B CW08) 21/22
Contact (role and name):
Target definition Percentage of eligible children fully immunised at 2 years of age for total DHB population, Māori and Pacific. Achievement requires that the target is met for the total population and the equity gap between Māori and non-Māori is no more than two percent. Note: Immunisation coverage of less than 90 percent for any one of the priority groups, or an equity gap between Māori and non-Māori populations of five percent or more will be rated as Not Achieved regardless of any other results.

Summary of results: Coverage at age 2 years (24 months)
Please complete the table (optional) and provide a brief summary of the DHB's performance in the Progress Report section.

Target: 95%	**Total**	**Māori**	**Pacific**	**Dep 9-10**	**Change: total**	**Change: Māori**
Q1 2021/22	**81.8%**	**72.6%**	**100%**	**77.1%**	**+4.7%**	**+8.6%**
Q2 2021/22	**83.1%**	**73.7%**	**88.9%**	**80.3%**	**+1.6%**	**+1.9%**
Q3 2021/22						
Q4 2021/22						

Progress report

Not immunised on- time:
There were 17 children not immunised on time

- Two have been completed after the child turned 2yrs
- Eight need to complete their 2nd MMR to be up to date.
- Five need to complete both 12mth and 15mth events to be up to date.
- Two have gone with no follow up address.

Decliners: This quarter saw 26 decliners

- 13 were Maori,
- 13 declined all immunisations.

New initiatives and successes this quarter

- Started linking with hotels/motels who provide emergency housing so we can follow up earlier for families who are without GP or due/overdue immunisations

Issues/barriers impacting on performance and actions taken
Please provide a brief summary of any issues arising in the quarter that affected ability to meet the immunisation target and how these are being addressed

Impact of COVID-19 immunisation on resources

CW09 Better help smokers to quit (maternity) 21/22

Whole of DHB

	Number of events (a)	Number of Smokers	Brief advice given	Offered cessation support	Referred to cessation support	Smokers' gestation (weeks) (b)	% offered brief advice	% offered advice and support to quit	% accepted cessation support	Smoking prevalence (c)
ALL	7	1	1	1	1	11	100	100	100	14.3
MAORI	1	1	1	1	1	11	100	100	100	100

2020/21 *Better help for smokers to quit* quarterly reporting template - Maternity

DHB:	WDHB	*please select from the drop down box*
Reporting Quarter:	Q2	*please select from the drop down box*
Name and contact details of person completing the report	Rosie McMenamin Rosie.mcmenamin@wdhb.org.nz	

Please answer ALL of the questions below

Whanganui District Health Board

What planning has occurred in your DHB to support the maternity health target, specifically for Māori and Pacific women? Please include information on how your DHB is supporting LMCs and/or DHB-employed midwives to increase the number of pregnant women being offered brief advice and support to quit smoking.	We are in discussion with a beautiful new Maori run company who provide breathing necklaces to help with stress and anxiety. I'm hoping to secure funding and run a project on how to breathe properly to reduce stress and help in labour. New training resources have been developed and LMC's will be handed out special vaping in pregnancy guidebooks based on a UK resource to help offer advice. Regular College of Midwife meetings are attended by our Tobacco co-ordinator where long term relationships have been fostered.	*Target:* 90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.
What actions and/or projects is your DHB undertaking that reduces smoking in pregnancy, specifically for Māori and Pacific women?	We have now got our regional vaping position statement signed off and are looking forward to setting up some projects to provide vapes to our Hapū clients as an alternative to smoking from our quit service. Working with our rural populations is key to this success.	
Is there anything else you would like to tell the Ministry?	We plan to aid those with Covid who smoke and send out Vape kits and smoking in pregnancy info with welfare packs to prevent further spread in the community and encourage the use of a less harmful nicotine delivery system. After comparing last years Q2 prevalence rates there has been a drop of 6% in our rohe!	

CW10 Raising Healthy Kids

CW10 Raising healthy kids Q2 2021/22

Name of DHB: Whanganui	**Quarter reported on: Q2**
Target performance to date and rate of progress based on data provided.	
DHB Comments:	Result for Quarter **MOH data: Total 81% By ethnicity: Other 64% Māori 89%**
Your activity to support the achievement of the target and initiatives to realise a reduction in childhood obesity, as reflected in your commitments in your Annual Plan, including: • progress with getting referrals acknowledged from the B4 School Check (B4SC) • progress with the development of referrals pathways from the B4SC for assessment and family based nutrition, activity and lifestyle interventions • activity to ensure DHBs, PHOs and other primary care and community partners work together to ensure families experience seamless transition and support post referral from the B4SC • activity to support primary care and community partners having the conversation with families.	
DHB Comments:	Business as usual.
Barriers to achieving the target and mitigation strategies over the next quarter by DHB and the PHOs.	

Whanganui District Health Board

DHB Comments:	Issues with parents not accepting that their child is obese and therefore not willing to be reviewed.
Collective action and link to broader approach to reducing childhood obesity across government agencies, the private sector, communities, schools, families and whānau.	
DHB Comments:	WDHB continues to engage with Sport Whanganui to develop a collaborative approach to deliver healthy eating and physical activity in schools, kura, kohanga reo and early learning services to create supportive environments priority populations and settings.
What the DHB is doing to build in evaluation, measure effectiveness, and monitor outcomes over time.	
DHB Comments:	Area for development.

Completed	Obese and Over	Obese and Over & Referral Acknowledged	Obese and Over & Referral Sent but not Acknowledged	Obese and Over & Not Referred	Obese and Over & Under Care	Obese and Over & Referral Declined	Obese and Over Health Target Rate
378	**11%**	**60%**	**0%**	**20%**	**13%**	**8%**	**80%**

CW12: Youth Health Initiatives 2021/22

Improving Child Wellbeing CW12: Youth Health Initiatives 2021/22

By delivering youth health initiatives district health boards (DHBs) will support Government's priority to make New Zealand the best place in the world to be a child and our health system outcome priority that we have equity for Māori and other groups.

This measure reports on three youth health focus areas.

- Focus Area 1: Improve the responsiveness of primary care to youth.
- Focus Area 2: School Based Health Services (SBHS) in secondary schools, teen parent units and alternative education facilities.
- Focus Area 3: Youth Primary Mental Health services (reported under MH04).

Focus area 1: Improve the responsiveness of primary care to youth

Reporting requirement
Describe actions undertaken in this quarter to ensure the high performance of the youth SLAT (or equivalent) in your local alliancing arrangements.
Actions

Unfortunately, we were unsuccessful in our tender for the youth primary mental health RFP. Despite huge efforts in partnership with our Iwi and NGO colleagues, we were not considered.

The Maternal child and youth service level alliance has met regularly over this past year with good community engagement. Each session has had a particular focus and opportunity to workshop identified areas of concern. The last session of the year focused on developing a single point of entry for DHB child and youth services and toxic stress in schools. It is anticipated that the first hui of the year will have a specific youth focus, led by youth themselves.

Part of the plan for youth mental health was to enhance the counselling/wellbeing services offered via our youth one stop shop; however, as mentioned above, this was not possible as we were not successful with the RFP. We will consider now if there are other ways of addressing the high volume of youth wanting to access their counselling service. We have begun some discussions with the DHB community mental health services to explore if there could be more integration between the YOSS and the CMH, discussions are on-going.

Reporting requirement	
Name and describe progress on your actions to improve the health of the DHB's youth population. • *Name actions, measures, and milestones with dates.* • *Describe progress on milestones. If off track, please provide mitigation strategies to get on track.* • *Add table rows as required.*	
Action	Progress
New service provider for youth planned and crisis respite is Mash Trust is Palmerston North. Youth have been accessing this service since July. Initial feedback from clinicians and youth has been positive. This service can manage youth with a higher level of acuity, has day programmes and can see children as young as 5 years.	On Track, Off Track (manageable), Off Track (risk)
Additional funding has been allocated to Youth Services Trust (YOSS) to cope with increased numbers of youth wanting to access their mental health and counselling service. They have been able to improve their triaging by using a registered social worker who can also see any urgent or more	The DHB provided additional funding in the first instance, unsuccessful tender for youth primary mental health RFP>
He Puna Ora, a new service for hapu mama with AOD issues and not connected to services is getting up and running and will be delivered by our Maori health providers using a kaupapa Maori approach	On track, service review complete after one year. The service is slowly developing its unique approach based on mātauranga Māori and whanau ora approach. Looking at how this can be further integrated within other Iwi health services.
Transgender pathway development A single point of entry has been formed for the under 25-year-old transgender population within the community. All referrals will be received by the Public health/Sexual health clinic and triaged. For those clients over the age of 25 years, information, support and resources will be provided and possible recommendations to the general practitioner around treatment, maintenance and screening as per the Guidelines for Gender Affirming Healthcare. For the under 25 years, we have worked collaboratively with YST. The referral will be received, a confirmation letter will be sent to the client which will outline the initial appointment and what to expect. During the assessment their goals will be assessed and if puberty blockers or	On track and completed

hormone therapy is wanted recommendations will be sent to the general practitioner for treatment. The DHB will continue to support the client as and if needed	
Single point of entry for children and youth project to enhance access to hospital services	Funding approved for project manager to lead the project, recruitment in progress.

Focus area 2: School Based Health Services (SBHS)

SBHS Narrative Report: Quarter Two, October – December 2021

Service

The attached reporting links both qualitative and quantitative information from October to December 2021. The Following identifies what is working well, areas of improvements, barriers, emerging themes and trends.

The PHN team continues to deliver the School Based Health Services in the school environment decile 1-5 within the WDHB catchment. Clinic contacts made through Quarter Two a total number of 80 contacts, with total year contacts of 835 students visits in school clinics for 2021.

Priority continues to identify and engage with high-risk students identified by the schools and Maori, Pacifica students. The PHNs have seen and completed HEEADSSS on 81 percent of the identified high-risk group. The high priority group that PHNs have not engaged with have either not returned to school or justified reason for not being at school.

PHNs have continued to have the opportunity to refer any complex student needs to a Nurse Practitioner (NP) which is available 4 hours a week, giving advice, treatment, referrals to other agencies as needed.

Area of improvement

SBHS has had difficulties obtaining space in the schools to complete HEEADSS assessments and clinics. We have discussed and placed a contingency plan to utilise the newly wrapped Waka Hauora, the Health Bus, we have the opportunity to book and to be able to offer a private, safe space for students to be seen. Unfortunately, this hasn't come to fruition as it has been deployed for the Covid vaccine drive which is well needed at this stage. Potential for availability next year in 2022, if available.

Promoting and providing resource and management for Transgender pathway which PHNs can refer to Sexual health Clinic to support, until SBHS pathway is completed.

Barriers

PHNs business as usual requested on the 11/10/21, this has meant that a contingency plan was implemented, where PHN was available to cover for urgent referrals. This has meant that the SBHS and Clinics have not been operating since 11/10/21, accessed for the service has mainly been contraceptive prescribing repeat students. Most students around Term 4 are currently studying or in exams and tend to make an opportune visit to clinics as and when they are available on days present in the school. Because this service is not operating, we haven't had the same number attending, high risk students would not have been seen.

Uncertain times with SBHS due to all PHNs working in Covid contact tracing role for 2022. Currently this has been at the detriment of students and schools, uncertainty as to 2022 for SBHS when will business as usual commence

or plans to be put in place to cover. Ongoing conversations with WDHB for future planning will be required in the very near future to manage.

Awaiting further resources support for students vaping aimed at youth required. Following the ARFNZ/SPANZ Vaping in NZ Youth Survey 2021– which many of the schools in the WDHB catchment weren't aware of survey to be able to participate. Results from school responses; a small cohort sampled of the low decile and Maori, not a true picture of trends. We have also seen increasing use of vaping products in year 7-8 students has been reported by the PHNs.

Whanganui regional services are under pressure many have long waiting lists or have closed their bookings until further notice, adding to the pressure of who the PHNs can refer to. PHNs continue to encourage students to use any external services, agencies and networks as part of the SBHS contract.

Themes

We have received reports from teachers and students regarding low attendance in school. Students have stated they are unwell with Covid like symptoms, and not been tested then informed not to come to school, until all symptoms are resolved. Conversations have been instigated to address anxiety and concerns by PHNs. Also reports that families and students themselves worried about going to school due to the anxiety, fear of catching Covid, this has greatly impacted on their learning and attendance records. Referrals to agencies include, Dietitian, Active Families, Audiology, Dental, GP, MICAMHAS, SUPP, Nurse Practitioner, Youth Services Trust, Family Planning, Oranga Tamariki – Reports of Concern, numerous conversations with Child Protection and Oranga Tamariki Liaison for the WDHB.

SBHS has utilised services; Family Planning (who now have waiting times to be seen) and Youth Services Trust directing students to access their services due to the unavailability of the PHNs due to Covid response, decreased clinics in schools. Increased anxiety, anger, vaping with nicotine – when students have never smoked a cigarette before. Contraception advice, treatment for students as requiring to cover over the school holiday break has increased, fortunately we have had a SBHS PHN cover as and when needed.

Intended Outcome	Measure	Measure Numerator Description	DHB Numerator	Disaggregation
Availability of primary health care services in secondary schools	M1: Percentage of all facilities with SBHS *(providing a service as per the tier three service specification)*	N1: Number of facilities with SBHS *(secondary and composite schools of all deciles, teen parent units (TPU) and alternative education facilities (AE))*	14	
	M2: Percentage of eligible facilities with mandatory SBHS	N2: Number of facilities with SBHS *(secondary schools, composite schools, TPU and AE)*	14	
Youth access to appropriate primary health care services	M3: Percentage of eligible students who have access to SBHS	N3: Number of secondary school aged students attending facilities with SBHS *(secondary schools, composite schools) TPU and AE)*	1,757	European / Pakeha
			1,361	Maori
			107	Pasifika
			115	Asian
			131	Other
			3,471	Total

	M4: Percentage of students eligible for a routine health assessment *(including HEEADSSS assessment)* who have had an assessment this calendar year to date *(all year 9 students and all students in TPU and AE)*	N4: Number of students attending facilities eligible for a routine health assessment who have had an assessment this calendar year	244	European / Pakeha
			273	Maori
			15	Pasifika
			14	Asian
			2	Other
			548	Total
	M5: Percentage of students who visited SBHS nurse this calendar year to date *(including advice or treatment, and excluding routine health assessments)*	N5: Number of students attending eligible facilities who have visited the SBHS nurse this calendar year to date	73	European / Pakeha
			90	Maori
			3	Pasifika
			3	Asian
			0	Other
			169	Total
	M6: Student visit rate *(including advice or treatment, and excluding routine health assessments)*	N6: Number of student visits to SBHS nurse this calendar year for students attending relevant facilities	144	European / Pakeha
			161	Maori
			3	Pasifika
			5	Asian
			0	Other
			313	Total
Number of interventions	M7: Percentage of SBHS interventions that were for mental health concerns	N7: Number of interventions for mental health *(including advice, treatment and referrals resulting from any visit or health assessment)*	26	Total
	M8: Percentage of SBHS interventions that were for sexual health	N8: Number of interventions for sexual health *(including advice, treatment and referrals resulting from any visit or health assessment)*	122	Total
Youth health population outcomes	M9: Percentage of students who had a health assessment who are within healthy BMI range	N9: Number of students attending facilities assessed who are within healthy BMI range	151	European / Pakeha
			123	Maori
			6	Pasifika
			11	Asian
			2	Other
			293	Total
Improved quality of SBHS	M10: Percentage of students who report that their last visit with a SBHS health care professional was private and confidential	N10: Number of students attending facilities who report that their last visit with a SBHS health care professional was private and confidential	104	*Note: survey and reporting required annually, due January.*
	M11: Percentage of facilities (or groups of facilitites) with SBHS who have submitted a satisfactory written continuous quality	N11: Number of secondary and composite schools, TPU and AE with SBHS which have an active continuous quality improvement programme *(as*	0	

	improvement programme *(based on the "Youth Health Care in Secondary Schools: A framework for continuous quality improvement")*	*an individual school or as a group of schools)*		
Best value for public health system resources	M12: Ratio of Registered Nurse (RN) FTE to number of students attending school with SBHS	N12: Total number of RN FTE for SBHS to secondary schools, TPU and AE	0.19	TPU / AE
			1.83	All decile schools
	M13: Total cost of SBHS per student	N13: Total cost of SBHS to secondary schools, TPU and AE *(paid by DHB, PHO and school for SBHS, including optional additions) Note: if you can't split out the costs, just select "No" under cell F3 and enter the whole amount in cell D40*		All facilities
	M14: Number of completed health assessments and student visits to RN per RN FTE	N14: Number of completed routine health assessments, plus number of student visits to SBHS nurse to date this calendar year for facilities *(as per N4 and N6)*	22	TPU / AE
			347	All decile schools

Intended Outcome	Measure Denominator Description	DHB Denominator	Disaggregation	Goal	DHB Result *(Calendar Year to Date)*
Availability of primary health care services in secondary schools	D1: Total number of secondary schools, TPU and AE in the DHB area *(all deciles, including composite schools with secondary school aged students)*	16			87.5%
	D2: Total number of eligible facilities in the DHB area *(secondary schools, composite schools, TPU and AE)*	14		90%	100.0%
Youth access to appropriate primary health care services	D3: Total number of secondary school aged students attending eligible facilities in the DHB area *(secondary schools, composite schools) TPU and AE)*	1,757	European / Pakeha	95%	100.0%
		1,361	Maori	95%	100.0%
		107	Pasifika	95%	100.0%
		115	Asian	95%	100.0%
		131	Other	95%	100.0%
		3,471	Total	95%	100.0%
	D4: Total number of students attending facilities eligible for a routine health assessment	413	European / Pakeha	95%	59.1%
		345	Maori	95%	79.1%
		22	Pasifika	95%	68.2%
		22	Asian	95%	63.6%
		6	Other	95%	33.3%

		808	Total	95%	67.8%
	D5: Number of secondary school aged students attending eligible facilities with SBHS	1,757	European / Pakeha		4.2%
		1,361	Maori		6.6%
		107	Pasifika		2.8%
		115	Asian		2.6%
		131	Other		0.0%
		3,471	Total		4.9%
	D6: Number of students attending facilities who have visited the SBHS nurse this calendar year to date	73	European / Pakeha		1.97 visits
		90	Maori		1.79 visits
		3	Pasifika		1.00 visits
		3	Asian		1.67 visits
		0	Other		
		169	Total		1.85 visits
Number of interventions	D7: Total number of interventions *(including sexual health, mental health, ACC, general health and other)*	394	Total		6.6%
	D8: Total number of interventions (including sexual health, mental health, ACC, general health and other)	394	Total		31.0%
Youth health population outcomes	D9: Number of students eligible for a routine health assessment who attend facilities and have had an assessment this calendar year *(excluding students declined or were not applicable for this measure)*	215	European / Pakeha		70.2%
		235	Maori		52.3%
		11	Pasifika		54.5%
		13	Asian		84.6%
		2	Other		0.0%
		476	Total		61.6%
Improved quality of SBHS	D10: Total number of students attending facilities surveyed who had visited a SBHS health care professional in the last year	114	*Note: survey and reporting required annually, due January.*	100%	91.2%
	D11: Number of facilities with SBHS *(secondary schools, composite schools, TPU and AE)*	14		100%	0.0%
Best value for public health system resources	D12: Number of secondary school aged students attending facilities with SBHS *(as per N3)*	30	TPU / AE	1:200	1:158
		1,231	All decile schools	1:750	1:672
	D13: Number of secondary school aged students attending facilities with SBHS				
		1,261	All facilities		$0

		0.19	TPU / AE		115.8
	D14: Total number of RN FTE for SBHS to secondary schools, TPU and AE	1.83	All decile schools		189.5

Focus area 3: Youth Primary Mental Health services
The reporting for this focus area is in MH04.

This quarter we experienced an increase in referrals from the previous year

There has been the usual busy period before the closure of schools, the expected quietening just prior to the Christmas break did not occur and we found contact continued right up till Christmas.

Covid/Delta has continued to affect how SUPP operate within schools with more protocols about who can visit and how visits are conducted. SUPP have worked at relationships with schools so are considered a vital service and most of the schools continue to welcome their input.

Vaping continues to be an issue with young people who have never smoked but are taking up vaping and with the highest levels of nicotine. Young people new to nicotine are reporting using 60mg where chronic smokers are using 18-20 mgs. This is encouraged by the companies who make vape products by having pop flavours. It is the view of the team that this marketing towards young people should be closely monitored and in fact pop flavours should be banned. This is fostering a new level of addiction for young people. The use of high-level nicotine vapes, and energy drinks is leading to anxiety, poor concentration, poor sleep and the resulting impact on mental health.

March 2022 Public

MENTAL WELLBEING

MH01: Improving the health status of people with severe mental illness through improved access

		2020/21 Performance against target			2021/22Q2 Performance against target		
Age Group	**Ethnicity**	**2020/21**	**Target**	**Variance**	**2021/22 Q2**	**Target**	**Variance**
0-19	**Māori**	5.01%	5.50%	- 0.49% ▼	5.04%	5.50%	- 0.46% ▼
	Other	6.20%	5.50%	0.70% ▲	5.98%	5.50%	0.48% ▲
	Total	5.69%	5.50%	0.19% ▲	5.57%	5.50%	0.07% ▲
20-64	**Māori**	10.41%	7.00%	3.41% ▲	10.14%	7.00%	3.14% ▲
	Other	6.71%	7.00%	- 0.29% ▼	6.48%	7.00%	- 0.52% ▼
	Total	7.74%	7.00%	0.74% ▲	7.50%	7.00%	0.50% ▲
65+	**Total**	2.81%	3.00%	- 0.19% ▼	2.90%	3.00%	- 0.10% ▼

MH02: Improving mental health services using wellness and transition (discharge) planning.

Quarter 2 Reporting -12 Month Period to 30 September 2021.
Reporting 20 January 2022 – (data produced 1 quarter in arrears)

All clients will have at least one form of Wellness/Transition Plan on file

Audit of Wellness /Transition Plans in place - data to cover the 3 months to 30 September 2021.

Wellness (Relapse) Plans - data information (for those current clients who have been in the service more than 12 months) was extracted from JCC036 Mental Health Ethnicity Report which shows start and close dates for all referrals.

All clients have Wellness (Relapse) plans in at least one of the following forms – Letters to GP, Risk Assessments, CP Notes

Transition (Discharge) Plans - data information (for those clients who have been discharged from the service in the 12 months and had at least 3 face to face = minimal contact monthly been in service at least 3 months) was extracted from WDHB MHS JCC036 Ethnicity Report which shows start and close dates for all referrals.

All clients have Transition (Discharge) plans in at least one of the following forms –Transition Plans, Risk Assessments, CP Notes

Inpatient data information extracted from WDHB MHS JCC032 Admission-Discharge with LOS report . Plans found in Transition/Discharge CP Notes. Risk Assessments.

Note

Whanganui District Health Board

- CMH Transition / Wellness Form still under review.
- Inpatient now have identified transition / discharge form being completed by RMOs usually found in CP notes not a CP form. Current Connecting Care Project reviewing forms using co design lens.

MH02 Quarter 2 – 12 months to 30 September 2021

Percentage of MH&A clients discharged from MH&A community services with a transition (discharge) plan		
Numerator	Denominator	Percentage
Number of MH&A clients discharged from the community with a transition (discharge) plan (Data Source: DHB)	Number of MH&A clients discharged from the community MH&A services (DHB data source DHB)	Percentage of MH&A clients discharged from the community with a transition (discharge) plan
100	101	99%
Number of files audited with a transition (discharge) plan of acceptable standard (Data Source: DHB)	Number of files audited (Data Source: DHB)	Percentage with a transition plan of acceptable standard
20	21	95%

Percentage of MH&A clients open to services for greater than 12 months with a wellness plan		
Numerator	Denominator	Percentage
Number of MH&A clients open to services for greater than 12 months with a wellness plan (Data Source: DHB)	Number of MH&A clients open to services for greater than 12 months (DHB data source DHB)	Percentage of MH&A clients open to services for greater than 12 months with a wellness plan
112	115	97%
Number of files audited with a wellness plan of acceptable standard (Data Source: DHB)	Number of files audited (Data Source: DHB)	Percentage with a wellness plan of acceptable standard
112	115	97%

Percentage of MH&A clients discharged from MH&A adult inpatient services with a transition(discharge) plan		
Numerator	Denominator	Percentage
Number of clients discharged from MH&A inpatient services with a transition (discharge) plan (Data Source: DHB)	Number of clients discharged from MH&A inpatient services (DHB data source DHB)	Percentage of clients discharged from MH&A inpatient services with a transition (discharge) plan
288	291	98%
Number of files audited with a transition (discharge) plan of acceptable standard (Data Source: DHB)	Number of files audited (Data Source: DHB)	Percentage with a transition (discharge) plan of acceptable standard

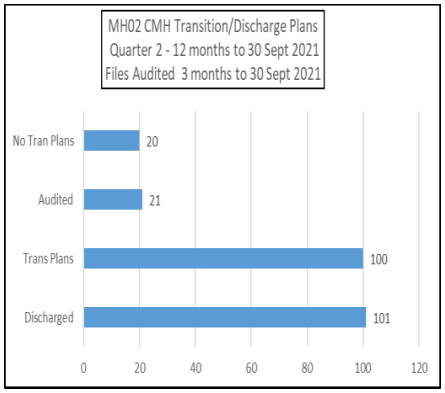
77	79	97%

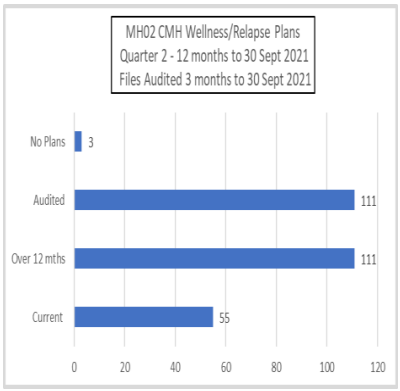
MH03: Shorter waits for mental health services for under 25-year olds.

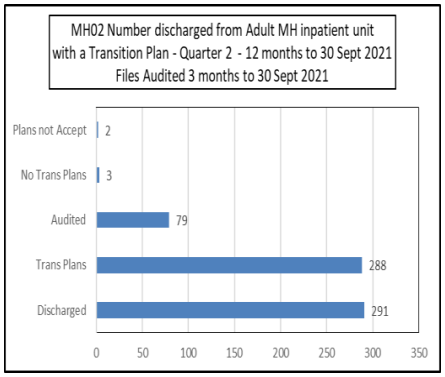
Age/ethnicity	Number of new clients aged under 25 seen within three weeks this quarter reporting.	Total new clients aged under 25 this quarter reporting	Percentage seen within 3 weeks for this quarter reporting period.
Under 25-year olds Total	85	101	84%
Under 25-year olds Māori	22	26	85%
Under 25-year olds Pacific	1	1	100%
Under 25-year olds Other	62	74	84%

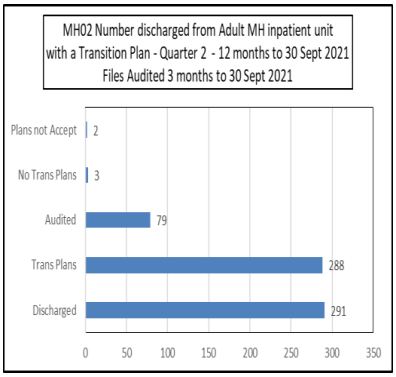
Balancing measure	
Balancing measure e.g. waiting time to the 3rd face to face contact from the C&Y KPI programme	**Measure this quarter e.g., Waiting time to the third face to face contact this quarter.**
Balancing measure – waiting time from 1st face to face 2nd face to face	80% seen within 3 weeks for this quarter reporting period 98% seen within 8 weeks for this quarter reporting period

Narrative	
What actions are being undertaken to reduce waiting times for young people?	Previous actions taken such as the introduction of CAPA as a service model have improved wait times so annually targets are met
How is the DHB working across service boundaries (Adult and Child and Youth) to improve waiting times?	Clear communication and good working relationships between services
How are the DHB adult services prioritising the needs of 18-24-year olds?	There is an action in the WDHB Annual Plan for this which has not been progressed as there are too many vacancies within the service to be able to consider this at this stage.









MH04 Focus Area 1 Primary Mental Health and Addiction

Whanganui District Health Board

March 2022 Public

MH04 Focus Area 1

Quarterly Primary Mental Health and Addiction reporting template

DHB Whanganui Year

		The number of people where the service is begun or delivered in the quarter			
1	**Client Information**				
	People seen by service	Q1	Q2	Q3	Q4
	Clients aged 12-19				
1.1	Number of females seen	39	58		
1.2	Number of males seen	15	36		
1.3	Number of clients seen - unspecified gender	0	0		
1.4	Total number of youth seen	54	94	0	0
1.5	People re-presenting to service	Number of people who re-present and are seen by PMHI service within 6 months of concluding a course of treatment (note that this period is recorded across reporting years)			
	Clients aged 20+				
1.11	Number of females seen	286	317		
1.12	Number of males seen	140	132		
1.13	Number of clients seen - unspecified gender	0	1		
1.14	Total number of adults seen	426	450	0	0
1.15	People re-presenting to service	Number of people who re-present and are seen by PMHI service within 6 months of concluding a course of treatment (note that this period is recorded across reporting years)			
	Number of referrals				
1.21	Number of referrals (12-19)	8	11		
1.22	Number of referrals (20+)	166	163		
	Ethnic group				
	Clients aged 12-19				
1.23	NZ European	32	42		
1.24	Maori	22	48		
1.25	Pacific Island	0	0		
1.26	Asian	0	0		
1.27	Other	0	0		
	Clients aged 20+				
1.33	NZ European	297	308		
1.34	Maori	106	122		
1.35	Pacific Island	8	8		
1.36	Asian	5	5		
1.37	Other	10	7		

Whanganui District Health Board

	Kessler 10 Score	The average score at the start of care and at discharge for all clients discharged per quarter	Q2 at start	At exit
1.43	K10 average score (12-19)			
1.44	K10 average score (20+)		31	23

	PHQ-9 Score	Q2 at start	At exit
1.45	PHQ-9 average score (12-19)		
1.46	PHQ-9 average score (20+)		

	Other outcome measure	Q2 at start	At exit
1.47	Average score (12-19)		
1.48	Average score (20+)		

1.49 What is the outcome measure?

1.50 Please explain this measure

Note, K10 scores only for POC clients that have a score correctly recorded. It is average for scores recorded in the quarter rather than pre-post for clients discharged in the quarter. N=28 at start and n=21 at exit.

	Number of Referrals to	Q1	Q2	Q3	Q4
1.51	Psychologist/psychotherapist (youth 0-19)	2	4		
1.52	Specialist CAMHS or Adult Mental Health Service (youth 12-19)	3	2		
1.53	Psychologist/psychotherapist (youth 0-19) (PH/AV)				
1.54	Specialist CAMHS or Adult Mental Health Service (youth 12-19) (PH/AV)				
1.55	Psychologist/psychotherapist (adults 20+)	18	23		
1.56	Specialist CAMHS or Adult Mental Health Service (adults 20+)	30	24		

2 Extended Consultations

Definition: The usual consultation period is extended to allow additional time for assessment and/or interventions. Delivered by a GP or Practice Nurse.

The number of consults delivered to those clients during reporting quarter:

		Q1	Q2	Q3	Q4
2.1	Youth (aged 12-19) who received an extended consult	49	40		

2.2	Adults (aged 20+) who received an extended consult	277	299		
2.3	Total	326	339		
2.7	General Practitioner - number of consults	254	211		
2.8	Practice Nurse - number of consults	64	123		
2.9	Total	326	339		

3 Brief Intervention Counselling (BIC)

Definition: Includes assessments, reviews and problem solving support or counselling provided by primary mental health clinicians or counsellors. Usually 1-2 sessions and can be planned or unplanned.

The number of BIC commenced and delivered to those in reporting quarter

		Q1	Q2	Q3	Q4
3.1	Number of BIC sessions for youth aged 12-19	4	4		
3.2	Youth (12-19) average wait time from referral to first seen	NG	NG		
3.3	Youth (12-19) DNA Rate (%)	NG	NG		
3.7	Number of BIC sessions for Adults aged 20+	NA			
3.8	Adult (20+) average wait time from referral to first seen	NA			
3.9	Adult (20+) DNA Rate (%)	NA			
3.13	Total Number of BIC sessions	4			
3.14	Total average wait time from referral to first seen	NG	Date referral received by the provider (e.g. GP) to the time of the first appointment. (Time of the first appointment may be influenced by the client choice as well as availability).		
3.15	Total number of clients that missed any session or DNA	NG			
3.16	Total number of clients attending any session	NG			
3.17	Total number enrolled (if different to total attending sessions)	NG			
3.18	Total DNA Rate (%)	NG	Client did not turn up to a scheduled/agreed appointment, and/or did not postpone or cancel the appointment within 24 hours		

4 Alcohol Brief Intervention (ABI)

Definition: Structured assessment and screening, advice, ABC style brief intervention and/or referral to appropriate counselling or specialist AOD service, this may involve extended consultation. **Note:** ABC is a three step approach. **A**sk about the person's alcohol consumption; **B**rief advice is offered if there are concerns; **C**ounselling referral if needed.

The number of BIC commenced and delivered in reporting quarter

		Q1	Q2	Q3	Q4
4.1	Number of ABI sessions for youth aged 12-19	3	2		
4.2	Number of ABI sessions for adults aged 20+	113	93		
4.3	Number of ABI sessions for youth aged 12-19 (PH/AV)				

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4.4	Number of ABI sessions for adults aged 20+ (PH/AV)				

4.5 Please describe the specific services being offered for the ABI service (youth)

Alcohol SBI in general practice. Primary care staff can implement Alcohol screening brief intervention (SBI). This can be guided by Mohio

4.6 Please describe the specific services being offered for the ABI service (adults)

5 Group Therapy

Number of group therapy sessions begun and delivered during reporting quarter

		Q1	Q2	Q3	Q4
5.1	Number of group therapy sessions for youth aged 12-19	55	22		
5.2	Youth (12-19) average number of group sessions per client	3	7		
5.3	Youth (12-19) average wait time from referral to first seen	0	0		
5.4	Youth (12-19) DNA Rate (%)	5%	0%		
5.9	Number of group therapy sessions for adults aged 20+	NA			
5.10	Adults (20+) average number of group sessions per client	NA			
5.11	Adults (20+) average wait time from referral to first seen	NA			
5.12	Adults (20+) DNA Rate (%)	NA			
5.17	Total number of group therapy sessions	55			
5.18	Total number of clients that missed any session or DNA	NG			
5.19	Total number of clients attending any session	NG			
5.20	Total number enrolled (if different to total attending sessions)	NG			
5.21	Total average number of group sessions per client	NG			
5.22	Total average wait time from referral to first seen	NG	Date referral received by the provider (e.g. GP) to the time of the first appointment. (Time of the first appointment may be influenced by the client choice as well as availability).		
5.23	Total DNA Rate (%)	5%	Client did not turn up to a scheduled/agreed		

			appointment, and/or did not postpone or cancel the appointment within 24 hours		

6 Packages of Care (POC)

Definition: Involves development of a care plan (i.e. an assessment is done to identify needs and a plan is developed, with the client/patient, that includes a timeframe for review and completion of the plan). Plan involves a series of interventions such as CBT, medication reviews, counselling and other psychosocial interventions (those that are not captured 2-6 above).

Number of POC begun and delivered in period

		Q1	Q2	Q3	Q4
6.1	Number of POC for youth aged 12-19	31	44		
6.2	Youth (12-19) average number of sessions per POC	3	9		
6.3	Youth (12-19) average wait time from referral to first seen	14	22		
6.4	Youth (12-19) DNA Rate (%)	25%	20%		
6.9	Number of POC for adults aged 20+	237	241		
6.10	Adults (20+) average number of sessions per POC	2	3		
6.11	Adults (20+) average wait time from referral to first seen	30	26		
6.12	Adults (20+) DNA Rate (%)	6%	12%		
6.17	Total number of POC	268	285		
6.18	Total number of clients that missed any session or DNA	NG	NG		
6.19	Total number of clients attending any sessions	NG	NG		
6.20	Total number enrolled (if different to total attending sessions)	NG	NG		
6.21	Total average number of sessions per POC	NG	NG		
6.22	Total average wait time from referral to first seen	NG	NG		
6.23	Total DNA Rate (%)	8%	Client did not turn up to a scheduled/agreed appointment, and/or did not postpone or cancel the appointment within 24 hours		

7 Youth PMH Narrative Report

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7.1 Overall Assessment of services delivered (including actions taken to enable early identification of mental health and/or addiction issues, better access to timely and appropriate treatment and follow up and equitable access for Maori, Pacific and low decile youth populations).

Overall youth PMH services appear adequate for the general practice setting. There were fewer extended consults but an increase in POC. Wait times for POC have reduced following the impact COVID alert levels had on wait times in Q1. Ethnicity of 12-19 year olds seen (28% Māori) indicates inequal access for Q2 by the enrolled youth population (38% Māori). IPMHA practices also improve timely access to early brief intervention through HIPs and HCs (these contacts are not reported here). The contact numbers over the three months was reduced from the last quarter due to Covid-19 restrictions imposed by the schools for group work and the end of year/ December breaks. There continues to be the use of the three contracts Mental Health and Addiction services have involving tamariki/rangatahi across three kaimahi offering the wider range of clinical, mentoring skills and gender mix. Referrals for specific work come from the range of places including self, whanau alternative education and Youth to Work (WINZ). Two of the kaimahi attend MICAMHS MDT meetings weekly where the relationship continues to be much improved. Issue themes include a lot of conflict with whanau changes (i.e. parents splitting, shifting, custody) and anxiety about school involving social phobia rather than worry around academic problems.

7.2 Any major achievements/successes

Wait times reduced following impct of COVID alert levels
A collaboration group provided by Te Oranganui Primary Mental Health Nurse and Mental Health and Wellbeing Support at Whanganui High School for Year 9 students has gone very well and will continue in 2022. It is aimed at resilience and wellness for all the group participants who may or may not have issue with mental health. The involvement in the whanau group at WHS for maori students and the ongoing work at Tupoho Kura who continue to be accepting of having the service involved.

7.3 Major issues that have affected the achievement of contracted services.

As per the last report Covid-19 affected the face to face group at Alert Level 3 and Whanganui High School, Y Alt Education and Tupoho were stopped and continued for Alert Level 2 and traffic light Red.

7.4 Whether the service has been externally evaluated/reviewed/audited and the status of recommendations made.

8 Adult PMH Narrative Report

8.1 Overall Assessment of services delivered.

Overall services appear good. Services have addressed the needs of an increase in volume of patients and increase in levels of distress for this quarter. Ethnicity of 20+ year olds seen (27% Maori) indicates service supporting equitable access for enrolled 20+ year old population (22% Māori). IPMHA practices also improve timely access to early brief intervention through HIPs and HCs (these contacts are not reported here).

8.2 Any major achievements/successes

Wait times reduced following impact of COVID alert levels

8.3 Major issues that have affected the achievement of contracted services.

Increase in volume of patients and severity of need. Demonstrated in K10 scores for the quarter and anecdotally. More has been provided in practice and average sessions for a POC has increased. Impacting financial sustainability of service.

8.4 Whether the service has been externally evaluated/reviewed/audited and the status of recommendations made.

MH04 Focus Area 2 District Suicide Prevention and Postvention

Q2 October – December 2021

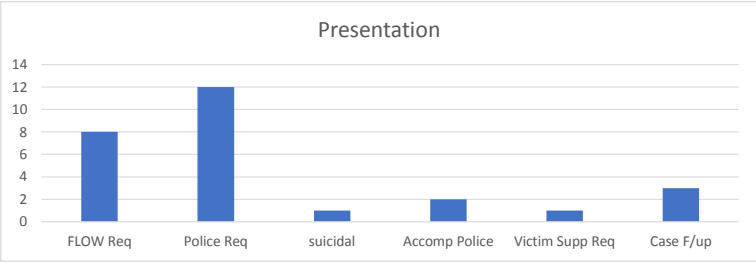
Organising suicide prevention training which falls under both categories of training/education and community initiatives. This will be held in May 2022 and be facilitated by Dr Annette Beautrais.

Three attended suicide prevention trainings by Barry Taylor. One workshop was titled Grey not Blue which dealt with suicide prevention of older adults.

MH04: FA3 Mental Health and Addiction Service Development CRISIS RESPONSE

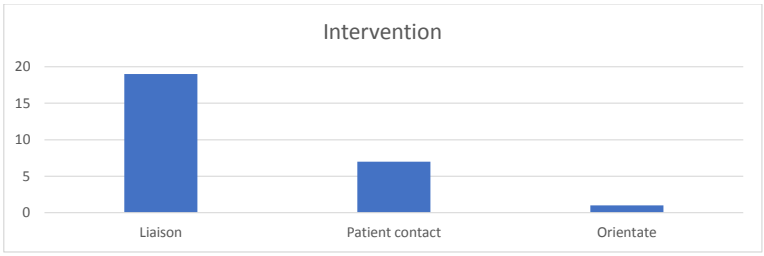
Reducing the demand on police for crisis support of known clients is an important interagency goal. There is a significant range in the rate of known clients referred by police crisis services. Please provide actions that have been undertaken to reduce the rate of known clients being referred by police to crisis teams and what difference have the above actions made to police referrals.

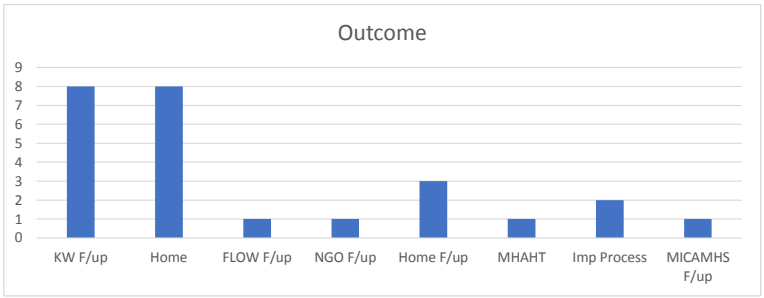
The police liaison role has made improvements to the working relationship between the police and the Whanganui crisis assessment team. A spreadsheet compiled by the police liaison health professional lists types of contacts and highlights various interventions that have reduced the need for police to contact crisis. The role provides early intervention, and promotes people staying safely in their own homes.



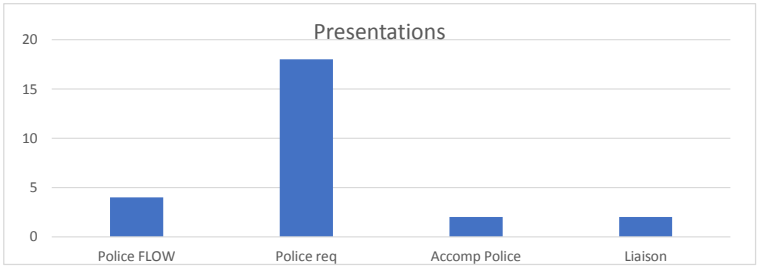
March 2022

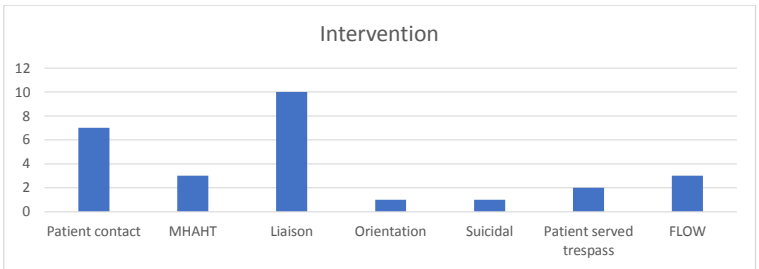
Public





December 2021





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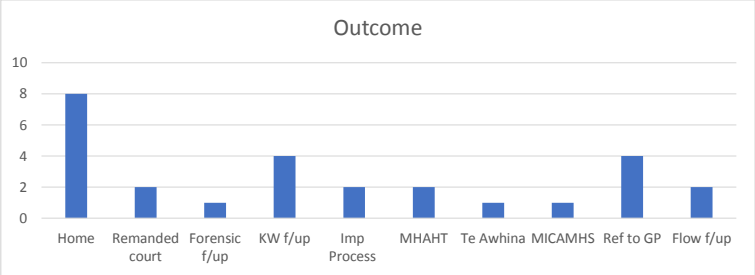

There are gains for families who are referred to police for family harm incidents (FLOW) where the crisis management support becomes part of the safer community response service.

The Whakarongorau (Home Care Medical) crisis triage line ended its contract with WDHB December 2021 primarily due to the delays in emergency services who had to wait in a queue before their calls were answered. The MHAHT team have recommenced a 24/7 urgent mental health service that is more responsive directly by using their own answering service.

Focus area 5 improving employment and physical health needs of people with low prevalence conditions:

The four General Practice medical centres are continuing to strengthen working relationships with CMHAS psychiatrists who regularly meet with each practice to discuss patients jointly.

There is a weekly Relpreev Depot administration clinic held in the community where service users are provided a healthy morning snack. Physical monitoring performed and recorded when permission is provided by each service user.

The Clinical Portal Anthropometric Data records metabolic measurements so that physical health can be monitored.

The smoke cessation health professional representative maintains a stock of resources for people wanting to utilise nicotine replacement and quit smoking. Each psychiatrist outpatient appointment smoke cessation is promoted and referrals generated to the hospital quit coach as required.

MH04 Focus Area 4 – Improving Outcomes for Children Q1 2021/2022

WDHB Supporting Parents Healthy Children (COPMIA) MOH Quarterly Report 01/10/2021-31/12/2021

Requests for parenting support of parents experiencing mental illness and/or addiction have continued at a steady rate. Face-to face Triple P parenting program and Circle of Security continue to be offered. Unfortunately, free access to the online Triple P parenting program is no longer available to our region as Auckland and Hamilton have been prioritised to receive this free access.

Due to Covid19 face-to-face trainings for clinicians continued to be interrupted however did take place with the adult Mental Health and Addictions teams and nursing students (separately) at WDHB. Alternative methods (other than face-to-face) training are being explored for some of the SPHC related programs offered. The use of the following case studies in this training proved successful in encouraging clinicians who are working with families/whānau with parental mental illness/addictions;

Family A scenario one

- 'A' has severe depression and anxiety. Supportive husband and two primary school age children 11 years and 6 years. Planned admission to MH inpatient unit. Referral for SPHC input by Psychiatrist.
- Meeting one – with 'A' discussion about 5 most common worries of children and young people living with MI. Parent concerns. MI impact on parenting. COPMIA resources given.
- Meeting two – with 'A' and husband. Request by parents to plan discussion with children about 'A' MI and pending admission. Discussed simple descriptions to use at age appropriate language.
- Meeting three – 'A', husband, close family member (also carer) and children present. 'A' led the meeting and informed children she was going to be away for a period of time in hospital. Oldest child burst into tears and asked if she had cancer. 'A' and husband able to reassure children and explain about depression and anxiety. Oldest child identified things he noticed when 'A' unwell such as sleeping a lot, not being able to do the cooking and not liking loud noise. Youngest child asked about the hospital and could they visit. Different strategies for keeping in touch explored. Youngest child also asked who was going to look after them - family member and husband able to answer these questions. Written SPHC COPMIA resources given to family member with contact details for primary community organisation and other services should it be needed.

Family B scenario two

- 'B' has depression and Borderline Personality Disorder. Was an inpatient at the time of contact. No current partner however supportive maternal grandmother who was caring for the four children aged 17 years, 15 years, 9 years and 7 years. Contact was made by the grandmother at the recommendation of the Psychiatrist. Parent too unwell to participate at the time.
- Meeting one- with grandmother. Discussion about 5 most common worries of children and young people living in the presence of MI, MI impact on parenting and carers. SPHC COPMIA resources given. Decision made to meet with the children in two groups due to differences in development ages and stages.
- Meeting two – with grandmother and two younger children. Children asked questions about how long their mother was going to stay in hospital (unknown), what was she doing to get better (explained about therapy, nurses, doctors, health care team and medication, sleeping, eating well, resting etc), explanations of what is mental illness in the broader sense given.
- Meeting three – with grandmother, 17-year-old and his girlfriend (also 17 years). 15-year-old (who was accessing MICAMHAS services at the time declined to participate). Discussion included what is depression and BPD. Teens asked about transmission of both these illnesses and support for when 'B' comes out of hospital. Short resource videos shown about both MIs. SPHC COPMIA resources and service information given to both teenagers.

<u>POINTS TO REMEMBER for Clinicians</u>

- All meetings can be a part of usual scheduled contacts
- All clinicians able to do basic information and give resources
- Single Session Family Consultation can provide a structured approach
- Preferable to have a meeting with adults only first to ascertain what they do/do not want talked about
- Can be short meetings (up to 30 minutes)

- Lots of resources available for clinicians to use including short videos made by teens for teens
- Document that the SPHC COPMIA discussions happened

MH05: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders

Improving Employment

- Eight Paid employment outcomes for the quarter- one each for 40,30,28,21.5,20, 16,15 and 12 hours
- 43 people have been referred into service since 1 July 2021
- From these referrals we have seen 30 people enter the service this quarter
- Exit figures have seen 22 people leave the service for this quarter – 17 opting off because they did not require service anymore and 5 settled in employment
- 24 people are currently active within the service at the 17 December 2021, with a further four pending referrals
- We have continued service through raised Covid alert levels by reactivating our emergency response plans. We continued to work and support people, including new referrals for people requiring employment support.
- Workwise Whanganui Employment Consultant Helena Allen has been inducted.
- Connections within the community this quarter include: Work and Income case managers to have transition to work discussions; supported living case managers to have discussions on how we can help find employment for people on their caseloads; Connect Employment Liaison Advisor; Gonville Health; Te Oranganui; Whanganui Port Employment Precinct; Resource recovery (Recycle Centre); Education institutions, business breakfast event and

  Health network meeting attended.
- We have continued service through raised Covid alert levels by reactivating our emergency response plans. We continued to work and support people, including new referrals for people requiring employment support.

Improving physical health

The four General Practice medical centres are continuing to strengthen working relationships with CMHAS psychiatrists who regularly meet with each practice to discuss patients jointly.

There is a weekly Relpreev Depot administration clinic held in the community where service users are provided a healthy morning snack. Physical monitoring performed and recorded when permission is provided by each service user.

The Clinical Portal Anthropometric Data records metabolic measurements so that physical health can be monitored.

The smoke cessation health professional representative maintains a stock of resources for people wanting to utilise nicotine replacement and quit smoking. Each psychiatrist outpatient appointment smoke cessation is promoted, and referrals generated to the hospital quit coach as required.

March 2022 Public

MH06 MH PRICE VOLUME SCHEDULE

PU Code	Description	2021/22 Vol	2021/22 Prices	2021/22 Total $	Unit of Measure	Contract Delivery FTE's or Available bed days 2021/22			
						Qtr 1Vo	Qtr 2 Vo	Qtr 3 Vo	Qtr 4 Vol
MHA01	Acute 24 Hour Clinical Intervention (inpatient)	2,190.0	860	1,884,079	Available bed d	547.00	547.0	547.00	547.00
MHA02	Intensive Care	2,190.0	995	2,179,160	Available bed d	547.00	547.0	547.00	547.00
MHA04C	Crisis Intervention Service - Nursing and/or allied health staff	8.5	125,294	1,064,996	FTE	8.50	8.5		
MHA06	Acute Package of Care	1.5	49,485	74,228	Occupied bed d	2.00	1.5		
MHA09A	Community Clinical Mental Health Service - Senior medical staff	3.5	314,664	1,101,324	FTE	3.50	3.5		
MHA09C	Community Clinical Mental Health Service - Nursing and/or allied health staff	13.0	125,294	1,628,818	FTE	13.00	13.5		
MHA11C	Mobile Intensive Treatment Service - Nursing and/or allied health	2.0	125,294	250,587	FTE	1.80	1.9		
MHA18C	Needs Assessment and Service Coordination - Nursing and/or allied health staff	0.6	125,294	75,176	FTE	1.00	0.9		
MHAD14C	Co-existing disorders (mental health & addiction) - Nursing and/or allied health staff	3.1	125,294	388,410	FTE	3.20	3.2		
MHD69	Alcohol & Other Drugs Service - Opioid Substitution Treatment – Primary Care Support Places	45.0	2,767	124,495	Client	50.00	48.0		
MHD70	Alcohol & Other Drugs Service – Opioid Substitution Treatment – Specialist Service	90.0	3,663	329,629	Client	110.00	112.0		
MHD71C	Alcohol and other drug consultation liaison service – Nursing and allied health staff	0.2	160,692	27,318	FTE	0.20	0.2		
MHD74A	Community based alcohol and other drug specialist services – Senior medical staff	1.0	314,664	314,664	FTE	1.20	1.1		
MHD74C	Community based alcohol and other drug specialist services – Nursing and allied staff	6.4	125,294	801,880	FTE	6.30	6.6		
MHDI48C	Child, adolescent and youth alcohol and drug community services - Nursing and/or allied health staff	1.0	125,294	125,294	FTE	1.10	1.2		
MHE30C	Community service for eating disorders - Nursing and/or allied health staff	1.2	155,943	187,132	FTE	1.20	1.2		
MHF81	Forensic Mental Health – Extended Secure Service	5,285.6	1,069	5,649,725	Available bed d	1,321.00	1,321.0	1,321.00	1,321.00
MHI44A	Infant, child, adolescent & youth community mental health services - Senior medical staff	2.0	314,664	629,328	FTE	2.10	2.1		
MHI44C	Infant, child, adolescent & youth community mental health services - Nursing/allied health staff	12.0	125,294	1,503,524	FTE	12.20	12.10		
MHM90C	Specialist Community Team – Perinatal Mental Health – Nurses & allied health	1.5	136,494	204,741	FTE	1.80	1.80		
MHO101C	Mental Health Older People Dementia Behavioural Support – Nurses & allied health	0.5	125,294	62,647	FTE	0.50	0.50		
MHO99A	Mental Health of Older People – Specialist Community Service – Senior medical staff	0.5	314,664	157,332	FTE	0.50	0.50		
MHO99C	Mental Health of Older People - Specialist Community Service – Nurses & allied health	2.0	125,294	250,587	FTE	2.10	2.20		
MHW68D	Family whanau support education, information and advocacy service – Non-clinical staff	4.7	101,851	478,701	FTE	5.00	5.00		

MH07: Improving mental health services by improving inpatient post discharge follow-up rates

Inpatient 7-day follow-up post discharge measure.

The data comprise all eligible acute inpatient referrals discharged between Oct 1,2020 and Sep 30, 2021

Whanganui District Health Board

Percentage of MH&A Total clients discharged from MH&A adult inpatient services that are followed up within 7 days.		
178	**233**	**76.4%**
Numerator defined as above. (Data Source: PRIMHD/KPI)	Count of acute inpatient discharges (Data Source: PRIMHD/KPI)	Percentage of clients follow up within 7days

Percentage of MH&A Maori clients discharged from MH&A adult inpatient services that are followed up within 7 days.		
73	**95**	**76.8%**
Numerator defined as above. (Data Source: PRIMHD/KPI)	Count of acute inpatient discharges (Data Source: PRIMHD/KPI)	Percentage of clients follow up within 7days

Percentage of MH&A Pacific discharged from MH&A adult inpatient services that are followed up within 7 days.		
2	**2**	**100%**
Numerator defined as above. (Data Source: PRIMHD/KPI) (Data Source: PRIMHD/KPI)	Count of acute inpatient discharges (Data Source: PRIMHD/KPI)	Percentage of clients follow up within 7days

Narrative quarterly reporting

Data capture process improvements are slower to take hold than initially expected. The frequent turnover of RMO's who now have scheduled inpatient follow-up booked appointments within the 7 days and are often first to see discharged MH inpatients within that timeframe. By the time RMO's are up to speed with some of our quite complicated and time-consuming electronic requirements to record activities, they have gone on to another non mental health rotation and the new RMO's take a while to understand the processes. We have dedicated technical resources to this especially during alert level 3 restrictions and expect to see continued improvements in the next quarter.

The Community Mental Health and AOD services continue to have linkages with MH inpatient services discharging inpatients. However, since early in the year the bed utilisation rates in our single 12 bed inpatient unit has been over capacity, at times double the bed capacity and no additional corresponding staffing capacity. We think this may impact the ability to plan discharge as well as could be if the unit had 12 inpatients at most.

The MH quality coordinator for HQSC project Connecting Care continues to work on identifying those not recorded as seen and understanding why inpatients discharged are not being recorded as seen within the 7 days and he has found that they have either been seen and a note written but the activity has not been recorded in the completely separate system, they have been seen but within 8-10 days or they have been discharged to different DHB or they are new to MH, or, they have been discharged off the MHA, do not want to engage with community services and have then DNA'd their RMO appointment within the 7 days and decline or ignore further contact.

Although only a small improvement is noted, the rate of Māori followed up within 7 days has improved. This is optimistically attributable to increased haumoana interaction with inpatients and their whānau, staff and MDT. Whanganui DHB quality coordinator continues to monitor and audit the 7 day follow up monthly and look for any trends or patterns which can be addressed and improved upon.

March 2022 Public

Whanganui DHB MH&AS are committed to engaging with whānau to improve engagement with community services post discharge and are dedicated to continuous work to improving inpatient post discharge follow-up rates by utilising a wide range of ways from technical input, team learning, service integration and interaction and consumer/whānau engagement principles.

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PRIMARY CARE

PH01 SYSTEM LEVEL MEASURES IMPROVEMENT PLAN REPORTING TEMPLATE FOR QUARTERS ONE, TWO AND THREE

Name of District Alliance: WALT

Name of DHB reporting: Whanganui

This report has been agreed by our District Alliance	No

SYSTEM LEVEL MEASURE	ON TRACK WITH THE IMPLEMENTION OF THE PLAN	OFF TRACK WITH THE IMPLEMENTION OF THE PLAN	IF OFF TRACK, MITIGATIONS TO GET ON TRACK WITH THE IMPLEMENTATION OF THE PLAN TO ACHIEVE THE AGREED IMPROVEMENT MILESTONE
ASH 0- 4 year olds	Y		
Acute hospital bed days	Y		
Amenable mortality	Y		
Patient Experience of care	Y		
Youth access to and utilisation of youth appropriate health services	Y		
Babies living in smokefree homes	Y		

PH03- Maori enrolment in a PHO

Result 17276 Maori enrolled in PHO from Population of 18700 = 92.4%

ACHIEVED

Whanganui District Health Board

March 2022 Public

MINISTRY OF HEALTH
MANATŪ HAUORA

PHO Enrolment Demographics as at January 2022

Lead DHB	(All)
DHB of Domicile	Whanganui DHB
PHO ID	(All)
PHO Name	(All)
Funding Formula Type	(All)
Funding Age Band	(All)
Reporting Age Band	(All)
Gender	(All)
Deprivation Quintile	(All)
HUHC Status	(All)
CSC Status	(All)
Maori/Pacific	(All)
Highly Deprived	(All)
High Needs	(All)

Row Labels	Sum of ENROLCOUNT
Asian	2,314
European	43,801
Maori	17,276
Non Stated	109
Other	436
Pacific	1,650
Grand Total	65,586

2019 Stats NZ Pop Projections: Summary Pivot

Note: 2019 Update uses Census 2013 as the base year for projections.
Financial Years use 31 December Projections produced by Statistics NZ for the first time in 2015
'Ethnicity 2' merges 'Other' and 'Asian' ethnicity groupings when used as part of the PBFF model
Projections produced by Statistics New Zealand according to assumptions specified by the Ministry of Health. Please refer to the technical notes for Methodology and Assumptions

Sex	(All)
Age_Group	(All)
DHB_name	Whanganui

Row Labels	Sum of pop2020_2021
Asian	2,620
Maori	18,700
Other	45,160
Pacific	1,915
Grand Total	68,395

PH04- Better Help for Smokers to Quit Health Target – Primary Care

	Better Help for Smokers to Quit Health Target – Primary Care *90% of enrolled patients who smoke and are seen by a health practitioner in primary care will be offered advice and help to quit*
Name of DHB	**Whanganui**

Whanganui District Health Board

DHB contact person for this report	**Name: Candace Sixtus** **Job title: Portfolio Manager** **Email: Candace.sixtus@wdhb.org.nz** **DDI: 06 3473400 / 027 2069500**
Quarter reported on	**Q2**
Which PHOs does this report cover?	Whanganui Regional Health Network
Do you think you have met the overall target (as noted above) this quarter? If not, what issues are preventing the target from being met and sustained? What actions are being put in place to improve performance and how will these actions be monitored?	Overall target has not been met and the percentage of patients who are current smokers who have been given brief advice and provided/referred for cessation is lower than expected. This quarter continues to be challenged by the impacts of COVID-19 including lockdown catch up of deferred health needs, the diversion of resource into the COVID-19 vaccination programme including on boarding of general practice. Clinicians are expected to opportunistically address multiple different issues when patients are being seen. The demand for appointments outstrips the availability and pressure is on clinicians to manage this time succinctly to ensure that their enrolled population have their needs met. What is being done? - Increased phone outreach/support with a focus on the practices with low utilisation is being provided - Leadership continues to support connection and advancement of the SSPs involved in delivery of smoking cessation mahi. - Clinical lead continues to work in the regional and national smoking cessation advisory groups and feedback key messages each way - Training has continued with education of clinical staff followed by practical experience sitting in with quit coach to gain experience of smoking cessation conversations - Increased ABC support activity in early pregnancy prior to midwife referral - Pregnant wahine screened and smoking status updated using the Best Stat Tool - Enhanced outreach support provided
Do you think you have met the target for Māori and Pacific (as noted above) this quarter? If not, what issues are preventing the target from being met and sustained? What actions are being put in place to improve performance and how will these actions be monitored?	Help for our enrolled Māori who are registered as smokers has been better from an equity perspective, with a greater percentage of Māori than non-Māori being provided with advice and referrals. We will continue to highlight the inequities in health outcomes and support increasing the volume of Maori who are being offered this advice & support to meet the MOH target. Enhanced Outreach support received eleven referrals for safe sleep spaces including three mama smoking and the remaining were whanau. Referrals were received from, self, lead maternity carer, DHB special care baby unit and Pregnancy and parenting classes. All were supported with tikanga antenatal advice and support along with safe sleep korero as well as offered quit smoking support and referred as agreed.

Is there any further support you require from the Ministry to achieve the target? If so, what support is required?	
Is there anything else you would like to tell the Ministry?	

March 2022 Public

Strong and equitable public health and disability system

SS01: Faster cancer treatment (31 days)

31-day indicator (policy priority)

DHB	Expected monthly cancer registrations	Number of records submitted *Patients within the 31-day FCT health target cohort, by month of first treatment*							Number of records within 31 days							Achievement
		Jul	Aug	Sep	Oct	Nov	Dec	Total	Jul	Aug	Sep	Oct	Nov	Dec	Total	Jul - Dec 2021 Tracking
Auckland	*161*	111	122	128	84	94	100	639	107	114	115	77	84	97	594	93.0%
Bay of Plenty	*115*	97	99	105	86	85	83	555	80	84	90	70	76	70	470	84.7%
Canterbury	*246*	142	177	154	118	162	106	859	128	165	140	110	145	97	785	91.4%
Capital and Coast	*107*	79	104	122	83	120	73	581	66	86	103	72	111	70	508	87.4%
Counties Manukau	*177*	153	133	140	131	159	130	846	127	113	124	106	135	118	723	85.5%
Hawkes Bay	*76*	66	81	41	0	0	0	188	60	70	36	0	0	0	166	88.3%
Hutt Valley	*60*	66	56	62	41	51	31	307	57	53	55	35	47	26	273	88.9%
Lakes	*47*	36	41	25	26	27	33	188	32	38	23	25	26	30	174	92.6%
MidCentral	*81*	87	72	81	66	78	71	455	81	63	72	64	68	66	414	91.0%
Nelson Marlborough	*74*	86	80	85	62	82	57	452	72	71	75	50	74	51	393	86.9%
Northland	*84*	95	79	79	56	81	59	449	71	71	71	53	73	49	388	86.4%
South Canterbury	*34*	27	20	31	16	34	19	147	22	18	30	16	29	16	131	89.1%
Southern	*136*	120	137	127	118	129	130	761	96	114	103	97	106	115	631	82.9%
Tairawhiti	*20*	19	11	18	15	21	11	95	18	11	14	14	19	9	85	89.5%
Taranaki	*57*	56	55	76	53	57	43	340	47	49	69	45	53	38	301	88.5%
Waikato	*161*	122	139	139	139	124	103	766	108	122	124	122	107	94	677	88.4%
Wairarapa	*22*	17	23	20	19	30	15	124	17	22	17	17	25	14	112	90.3%
Waitemata	*222*	192	191	183	122	157	152	997	174	160	164	109	145	146	898	90.1%
West Coast	*17*	18	15	20	17	17	13	100	16	13	14	16	10	11	80	80.0%
Whanganui	*34*	34	47	48	32	38	36	235	30	44	41	31	35	31	212	90.2%
National total	***1929***	**1623**	**1682**	**1684**	**1284**	**1546**	**1265**	**9084**	**1409**	**1481**	**1480**	**1129**	**1368**	**1148**	**8015**	**88.2%**

SS03: Ensuring delivery of service coverage
DHBs are asked to provide reports on the following areas as part of quarter two reports:
Reporting requirements

1. Confirm that your DHB is collecting data on urogynaecological procedures involving surgical mesh as per the minimum data set

RESPONSE: we confirm this is the case

2. For the period 1 July 2020 – 31December 2020 please identify:
i.the number of surgeons that performed urogynaecological procedures involving surgical mesh
ii. RESPONSE: 1 July 2021 – 31 December 2021 here - 0

ii.the number of urogynaecological procedures involving surgical mesh performed by each of the surgeons identified in (i) above
REPSONSE: 1 July 2021 – 31 December 2021 – 0
SS04: Implementing the Healthy Ageing Strategy

Whanganui District Health Board

Component	Classification	Number of people (Quarter)	Number of people (YTD)	Narrative from DHB
Report the number of older people (65 and over, or younger if identified as a falls risk) that have received **in-home strength and balance retraining services:**	Number of people that received in-home strength and balance retraining **(65-74, people under 65 if identified as a falls risk):**	10	20	Youngest participant age 59yrs. There were another 38 people in both age groups who had home visits or phone contact and who either declined to participate in the in home S&B OEP, were referred directly to an exercise group or were already participating in group exercise classes but required inhome assessment and advice on personal/home environmental safety requirements.
Report the number of older people (65 and over, or younger if identified as a falls risk) that have received **in-home strength and balance retraining services:**	Number of people that received in-home strength and balance retraining **(75+):**	24	44	Oldest participant 100yrs. The number of referrals over 75's continues to increase particularly for those over 85 years. Referrals for the Falls Prevention Service in home assessment and interventions remains strong.
Report the number of older people (65 and over, or younger if identified as a falls risk) that have received **community / group strength and balance retraining services:**	Number of people that received community / group strength and balance retraining **(65+, people under 65 if identified as a falls risk):**	Attendence numbers not available due to the holiday period. Many classes not restarting until the beginning of the school year as participants are looking after children whilst parents return to work. SAYGo coordinator reports '10 groups were "on hold" during the quarter and places within 2 groups were reduced as distancing requirements reduced the available space'. Participants are referred to online exercise programmes if their class is unable to run.		
Report the number of older people (65 and over, or younger if identified as a falls risk) that have been seen by the **Fracture Liaison Service or similar fracture prevention service:**	Number of people that have been seen by the Fracture Liaison Service or similar fracture prevention service **(65-74, people under 65 if identified as a falls risk):**	52	71	
Report the number of older people (65 and over, or younger if identified as a falls risk) that have been seen by the **Fracture Liaison Service or similar fracture prevention service:**	Number of people that have been seen by the Fracture Liaison Service or similar fracture prevention service **(75-84):**	19	36	

Report the number of older people (65 and over, or younger if identified as a falls risk) that have been seen by the **Fracture Liaison Service or similar fracture prevention service:**	Number of people that have been seen by the Fracture Liaison Service or similar fracture prevention service **(85+):**	27	43	
Report the number of people (50 years or over) who have received a **DEXA scan following identification of a fragility fracture**	Number of people aged **50 – 74 year**s who received a DEXA scan following identification of a fragility fracture	13	19	33 DEXA ordered by FLN and 1 ordered by GP
Report the number of people (50 years or over) who have received a **DEXA scan following identification of a fragility fracture**	Number of people **75 years or over** who received a DEXA scan following identification of a fragility	4	8	
Report the number of people (50 years or over) who received an infusion of **IV Zoledronic acid following identification of a fragility fracture**	Number of people aged **50 – 74 years** who received an infusion of IV Zoledronic acid following identification of a fragility fracture	7	9	
Report the number of people (50 years or over) who received an infusion of **IV Zoledronic acid following identification of a fragility fracture**	Number of people **75 years or over** who received an infusion of IV Zoledronic acid following identification of a fragility	2	2	

Q1	Q2
1.a COVID-19	

Whanganui District Health Board

The national roll out of the COVID-19 Vaccination Programme has been the key focus with the initially targeting people in our community who are disabled, complex, high risk, high need, receiving residential disability support or with underlying health conditions. Coordination and service delivery considerations ensures provision of safe, inclusive and accessible vaccination options for disabled people and their communities. This includes identifying with organisations the most appropriate approach which suits the people they support including mobile teams to familiar sites, home visits and low sensory options. *COVID vaccination disability coordinator roles have been established that will assist to break down any system barriers which make it difficult for people to access vaccinations. They will also reach out to networks and whanau to help design different models/clinics*		*Booster doses for WDHBs ARC providers have been completed. A nurse pracitoner for health of older people employed by the PHO has been working across the sector to ensure thatolder people who contract COVID are well supported. Clinical pathways in community for COVID positive patients have been developed. The DHBs HOP portfolio manager has participated in the pathway development and has incuded a focus on ARC and HBS populations and how providers will be supported. Note that there are challenges due to existing workforce pressures. Work has also been undertaken to ensure NGO sector have access to Fit testing N95 masks*
1.b Emerging Frailty		
Report on key actions in community and primary care settings to improve the identification of factors associated with early signs of emerging frailty, with a focus on Māori and Pacific peoples; and put interventions in place to retain and restore the function of older people.	*WDHB has participated with Francis Health on the Regional Frailty Framework.* *General practice are looking at Implementing a frailty tool in General Practice called the Kare tool.* *This is a Comprehensive Geriatric Assessment for both Physical Frailty and Cognitive Impairment.* *The tool was developed in Waitemata in conjunction with General Practice, the DHB and Auckland University. The published research from this shows that it reduced inappropriate ED presentations, and delayed admission to ARC.* *There are three General Practices who are willing to trail this, with a focus on Māori and Pacifica.* *This tool and the general concept of Frailty has recently been presented at General Practice peer review.* *There has also been a talk on Frailty for the falls study day.*	*At the beginning of December 2021 a strategy paper was developed proposing a more formal focused approach on prevention and early intervention for older adults across the roho. The paper includes frailty including people dementia. The PHOs nurse practitioner for health of older people continues to raise awareness and is maintaining representation on the Regional Fraility Steering Group. The Kare tool has had a small trial in two General Practices. The response has been positive.*
1.c Dementia Services		

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Report on actions to implement key priorities for dementia services, including regional priorities that your DHB contributes to, that progress the New Zealand Framework for Dementia Care and the sector's priorities in Improving Dementia Services in New Zealand – Dementia Action Plan 2020-2025.	*The Whanganui District Health Board contributes to the central regions Mate wareware work programme for 2021/2022* *One of the Mate wareware workstreams was reviewing the Healthpathways for cognitive impairment.* *This is very timely for Whanganui (and Mid Central) has the healthpathway for cognitive impairment is about to 'go live'* *During the development phase it has been reviewed by a Mid Central Geriatrician and a Whanganui Gerontology Nurse Practitioner. The ADAPT-R tool has been incorporated and information on Cognitive Stimulation Therapy for Maori. Both are part of the Mate Wareware programme* *Mini Ace has been fully implemented. Links to training socialised, discussed at GP peer review as part of older adult education and included in the healthpathway* *The frailty tool that we are looking at implementing also covers off cognitive impairment and has links to the Mini Ace* *Anecdotally referrals that have a Cognitive Assessment included have used the mini ACE, though there is still the odd MOCA appearing* *The Whanganui District Health Board has been working in partnership with Alzheimer's Whanganui updating their service specifications utilising Canterbury's approach*	*Alzheimers Whanganui have a new agreement with the WDHB incorporating the new service specification. The current fuding that is being passed on for services that support people with dementia is not sufficient to meet the need. The next peice of work is to address this. The following was published in a recent Alzheimers Whanganui Summer Newsletter 'On a positive note we have had our contract with the Whanganui District Health Board (WDHB) renewed for another two years.* *I would like to thank Andrea Bunn, our Portfolio Manager at the WDHB, for her support and guidance in getting this finalised. By renewing the contract, the WDHB acknowledges the important services we provide to our members to participate in normal activities within our community'.*
1.d Early Supported Discharge Services (Please note additional questions on next tab)		
Report on key activity to improve your early supported discharge services.	• *The DHB is considering the implications of required changes to ACC – NARP and alignment of early supported discharge initiatives to improve efficiencies and effectiveness both clinically and operationally.* • *The DHB has outlined a potential test change project for early supported discharge.* • *It is proposed this project will inform process improvements to the broader services*	*The DHB continues considering the implications of required changes to ACC-NARP.* *The DHB has conducted considerable investigation into the possible Test of Change Project. A new Deputy of Allied Health - Service Improvement has been appointed and progressing this work is anticipated to commence in Quarter 4.*
Report any challenges your DHB is having in establishing rehabilitation or care services within the community and what approach your DHB is using to overcome these challenges.	*The narrative on the above action applies to this one also*	*Same*

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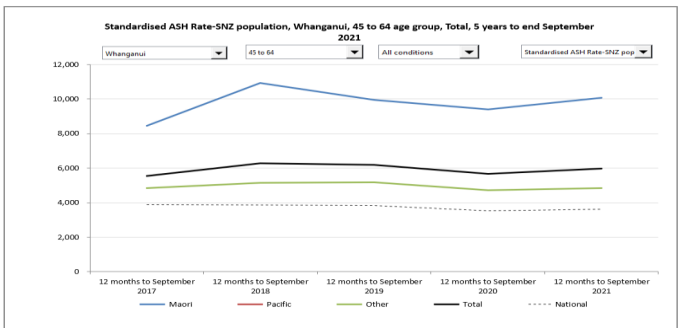
1.e DHB Identified Action Report on progress during the quarter (in brief) to deliver on one (or more) DHB-identified action (not included above that may or may not be included in the DHB's Annual Plan) that the DHB has prioritised locally to highlight implementation of the Healthy Ageing Strategy and expect to have the greatest impact on outcomes for older people locally. Older people should be included in service co-design, development and review and other decision-making processes.	*In 20/21 the DHB reported on the Pressure Injury Program* *Pressure Injuries or people at risk of pressure injury continue to be a significant issue for the DHB with the total number of patients with PI or at risk was 164 for 1 July 2021 > 30th Sept 2021* *During Covid-19 level 3 & 4 lockdown a Telehealth service was provided including photos of pressure injuries in order to determine the advice provided.* *Following a review of the service delivery for pressure injuries (and falls) a discussion Document was published in August* *The purpose of the review was to determine changes required to increase the effectiveness of the service and reduce both frequency and severity of injuries across hospital and community settings as there had been no demonstrable change since the inception of the pressure injury service.* *The feedback (released 17 October) from the discussion document has indicated that it needs to go to formal consultation on how services are delivered.*	*A MDT pressure injury programm continues but no formal process for implementation of change has occurred.*

SS05: Ambulatory sensitive hospitalisations (ASH adult)

DHB Name: WDHB Quarter two

Summary information	
Data Source:	Ministry to provide data via NSFL web site and the DHB quarterly reporting website. https://nsfl.health.govt.nz/accountability/performance-and-monitoring/data-quarterly-reports-and-reporting/ambulatory-sensitive
• ***Target/expectation: as agreed in DHB Annual Plan*** • ***Please provide your standardised and non-standardised ASH rate result for the quarter***	**SI 1: Ambulatory Sensitive Hospitalisations (ASH)** 

DHB	Ethnic Group	12 months to September 2017	12 months to September 2018	12 months to September 2019	12 months to September 2020	12 months to September 2021
Whanganui	Maori	8,451	10,924	9,962	9,392	10,058
Whanganui	Pacific	-	-	-	-	-
Whanganui	Other	4,831	5,139	5,192	4,706	4,857
Whanganui	Total	5,536	6,284	6,177	5,674	5,973
National	Total	3,903	3,874	3,836	3,537	3,609

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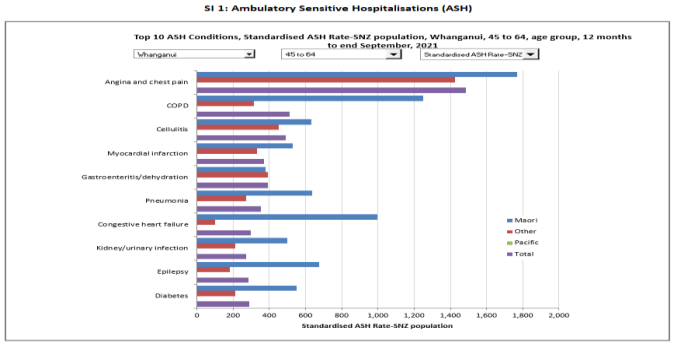
Commentary on your latest 12-month ASH data including specific actions that supported Maori and Pacific* health:	

**Pacific – for the seven DHBs with the highest number of Pacific people. These are: Auckland, Waitemata, Counties Manukau, Waikato, Capital and Coast, Hutt, and Canterbury*

SS06 Better help for smokers to quit (Hospital)

No report required this quarter

B SS07 Planned Care Measures 21/22

PLACEHOLDER_DELAYED TIMEFRAME REPORTING

SS09: Improving the quality of identity data PRIMHD

This measure is managed via TAS

SS10: Shorter stays in Emergency Departments

Reporting sections: 1. Shorter Stays in ED data 2. Actions to improve SSED 3. Acute Demand actions from Annual Plans	
DHB name: Whanganui	Quarter: 2
Name of person completing this template: Kath Fraser-Chapple	

1. Shorter Stays in ED Indicator: 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.

Whanganui District Health Board

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Quarterly results - Please use the ethnicity provided at the time of the ED presentation. Where that is not available, please use the ethnicity listed on the patient's NHI									
	Total Population			Maori ethnicity			Pacific ethnicity		
Name of facility	Number stayed less than 6 hours	Total Presentations	% managed within 6 hours	Number stayed less than 6 hours	Total Presentations	% managed within 6 hours	Number stayed less than 6 hours	Total Presentations	% managed within 6 hours
Oct	1764	1913	92%	447	477	94%	42	48	88%
Nov	1713	1910	90%	441	486	91%	43	46	93%
Dec	1810	1973	92%	484	527	92%	41	43	95%
DHB total	5287	5796	91%	1372	1490	92%	126	137	92%

Data on acutely admitted patients

a) Provide your data on target performance split by those patients who are discharged from the Emergency Department directly and those who are admitted to an inpatient hospital ward (not a statistical 'admission' based on the three-hour funding rule)

b)

	Total Attendances	In ED over 6 hrs	% over 6hrs
Not Admitted			
Admitted			
Total			
Target achievement in the next 6 months? (ie what improvement in SSED do you expect to achieve over the next two quarters?)	NA		

2. Actions to improve SSED - Please provide the Ministry of Health with further information on:

Measure	Your actions, activities, issues
1. Actions undertaken this quarter to maintain or improve the indicator	**Performance has been maintained, however is not above the target**
2. Planned work for next quarter	**Ongoing preparation to screen and stream covid potential patients through the emergency department, ensuring that the DHB maintain essential services**
3. Barriers to achieving or maintaining the indicator	**Ongoing focus on COVID preparation has limited focus on other service improvements**
What support can the Ministry provide	

3. Acute Demand actions from Annual Plans

Acute Data Capturing: Please provide an update on your plan to **implement SNOMED coding** in Emergency Departments to submit to NNPAC by 2021.

Whanganui District Health Board

Ongoing ICT development	
To **improve Patient Flow**, please report on actions from your Annual Plan that:	
. **1.** improves patient flow for admitted patients	**Implementation of the discharge navigator model is underway however staffing has been a key factor in under delivery to date**
. **2.** improves management of patients to ED with long-term conditions	
. **3.** improves wait times for patients requiring mental health and addiction services who have presented to the ED	
4. improves Māori patients experience in ED	

SS11: Faster cancer treatment (62 days)

SS11 62 Day Faster Cancer Treatment Target

Whanganui DHB – Target Not Met
For the reporting period 43 out of 50 eligible patients in the cohort met the target. The 90% target was 45 patients. All patients that breach the target timeframes have a tracer audit of contacts and delays in treatment pathway, this is analysed for themes across services and opportunities for improvement. Findings are discussed at the monthly FCT governance meeting for escalation where appropriate.

62-day indicator achievement (Health Target)

	Adjusted number of records submitted *Patients within the 62-day FCT health target cohort (excluding patients breaching with a delay code of clinical consideration or patient reason), by month of first treatment*							Number of records within 62 days							Achievement 6-month quarter	Achievement 3-month quarter
DHB	Jul	Aug	Sep	Oct	Nov	Dec	Total	Jul	Aug	Sep	Oct	Nov	Dec	Total	Jul - Dec 2021 Tracking	Oct - Dec 2021 Tracking
Auckland	22	25	30	23	27	30	157	21	23	30	23	25	28	150	95.5%	95.0%
Bay of Plenty	8	18	23	12	22	9	92	7	16	23	11	20	9	86	93.5%	93.0%
Canterbury	45	55	59	45	71	51	326	41	51	56	41	67	46	302	92.6%	92.2%
Capital and Coast	25	32	48	15	42	25	187	19	26	41	10	39	22	157	84.0%	86.6%
Counties Manukau	29	41	27	21	41	32	191	23	29	20	16	37	24	149	78.0%	81.9%
Hawkes Bay	5	8	1	0	0	0	14	5	7	1	0	0	0	13	92.9%	#DIV/0!
Hutt Valley	19	13	13	9	12	5	71	15	11	10	6	10	5	57	80.3%	80.8%
Lakes	7	9	6	7	6	7	42	7	8	5	7	5	7	39	92.9%	95.0%
MidCentral	11	8	10	14	10	14	67	11	8	9	13	10	13	64	95.5%	94.7%
Nelson Marlborough	28	27	24	17	35	29	160	26	22	18	14	34	21	135	84.4%	85.2%
Northland	25	18	20	22	30	13	128	19	14	17	19	27	13	109	85.2%	90.8%
South Canterbury	10	3	6	2	5	5	31	10	2	3	1	4	3	23	74.2%	66.7%
Southern	19	19	28	30	25	27	148	14	17	22	21	24	21	119	80.4%	80.5%
Tairawhiti	4	7	2	7	8	4	32	3	6	1	7	8	4	29	90.6%	100.0%
Taranaki	15	18	17	11	12	9	82	11	13	14	8	10	7	63	76.8%	78.1%
Waikato	24	28	24	30	29	29	164	10	15	19	21	20	20	105	64.0%	69.3%
Wairarapa	4	8	9	6	8	1	36	4	8	9	5	4	1	31	86.1%	66.7%
Waitemata	42	50	40	24	27	39	222	36	45	37	20	22	35	195	87.8%	85.6%
West Coast	6	0	1	4	3	3	17	5	0	1	4	0	1	11	64.7%	50.0%
Whanganui	7	7	8	7	13	8	50	6	6	6	6	12	7	43	86.0%	89.3%
National total	**355**	**394**	**396**	**306**	**426**	**340**	**2217**	**293**	**327**	**342**	**253**	**378**	**287**	**1880**	**84.8%**	85.6%
															0.0%	

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SS12: Engagement and obligations as a Treaty partner
Rowena Kui Q2

Please update the blue shaded Cells in the Q_2 column only.	MET
Refer to annual plan if full context is not clear	PARTIAL
	NOT MET (please provide explanation)

2.1.1 Engagement and obligations as a treaty partner

Activity	deliverable	Q2
Strategic	Maintain partnership and close working relationships between WDHB and Hauora Iwi (HAI), through:	
	Regular joint hui and chair to Chair hui	
	Enact the Mana Whenua Agreement strengthening partnership and active engagement.	
	Involvement of HAI members in all key DHB strategic discussions and decisions	
	Involvement of HAI in decision making related to the implementation of the recommendations form the H&DS review 2020.	
	Engagement of HAI in monitoring the implementation of He Hāpori Ora action plan. Regular reporting to joint board hui	
	Joint board monitoring of equity measures in WDHB Annual Plan and pro-equity implementation work plan	
	Māori Health Outcomes Advisory Group (local Māori provider executive leads) representation on all interviews for executive positions	
	HAI representation on combined statutory advisory committees and performance review for chief executive	
Waitangi Tribunal	Continue to participate in the design and implementation of the proposed Ministry of Health Treaty framework, to be set out in the new Māori Health Action Plan, to ensure WDHB meets its statutory obligations, as prescribed by the Tribunal and its interpretation of the Treaty clauses under the NZ Public Health and Disability Act 2000.	
Partnership	Six months post implementation of the WDHB consumer group Te Pūkāea new structure with at least 50% Māori membership, review progress and what further support is required.	

	Implement Term of Reference for a Māori reference group to provide Māori community and health expertise advice to key service developments, service improvements, development of Māori health policy and frameworks to ensure that we have a wider Te Ao Māori lens applied to our work. *Draft TOR completed, ELT sign off, staff survey in progress*	
	Engage and work with the Māori Health Alliance (MOHAG) to implement the recommendations from the commissioning for kaupapa Māori Health Services Work plan 2021 and review the services that are achieving the equity and health outcomes for Māori. *Review of kaupapa māori services complet, uplift identified to be completed by end of Feb 2022.*	

Whanganui District Health Board

	Develop a work programme between the WDHB and HAI boards to measure improvement in equity for Māori across annual plan equity-oriented activity indicators and the WDHB pro-equity work programme. *Workplan is focused on Health reforms, preparedness for transition and HAI on the establishment of IWMPB.*	
	Continue support for the Central Region's Iwi relationship boards Te Whiti ki te Uru forum and their alliance with the Central Region CEs and Chairs. *This forum is no longer in place as agreed by HAI.*	
	Continue participation in the Central Region GM Māori forum to influence across the region and share learnings and initiatives. *Whanganui GM Māori chairs this group.*	
	Continue participation in national Māori health leadership forum Tumu Whakarae.	
	Involve Hauora a Iwi in all decision making that is responding to the Health and Disability Review	
Pro-equity	Continue to implement the WDHB Pro-equity Implementation Plan, under He Hāpori Ora implementation, for 2021 – 2023 under the four priority areas:	
	- Strengthen organisational leadership and accountability for equity	
	- Build Māori workforce and Māori health and equity capability refer to workforce section page 98	
	- Improve transparency in data and decision making	
	- Support more authentic partnership with Māori.	
Implementing and monitoring whanau centred approaches to care and services	Ongoing implementation of Korero Mai programme – evidenced in tracer audits. *Programme under review*	

SS13: FA1 Long Term Conditions

Description	Specific actions including timeframe and milestones	Progress, gaps, challenges Quarter 2 2021-2022
Actions with an equity focus to support people with LTC to self-manage. Reference: https://www.health.govt.nz/publication/self-management-support-people-long-term-conditions	Can you please describe what programmes are in place in your region to provide **community out-reach services** to support people with long term conditions, in particular in how you are meeting the needs of our high-risk populations for Māori and Pasifika peoples and their whanau. In accordance with the Minister's Letter of Expectation for 20/21 can you describe **how PHOs have been incentivised** to improve equitable health outcomes from long term conditions, with a focus on our high-risk populations of Māori and Pasifika peoples.	• Community Funding Options Programme phase one has been embedded. Claims associated with the programme have increased overtime as clinical staff have completed IV training • COPD and Asthma pathways are in final draft with long term conditions nurse and kaiawhina role in place to support a revised approach within the community and across the continuum of care. • The revised program of care will be further refined as models of care, funding and workforce permit with the current focus on supporting people with long term conditions to be proactive

		in self-management through improved health literacy
Actions with an equity focus to build health literacy. Reference: https://www.health.govt.nz/publication/framework-health-literacy	Please outlined what health literacy approaches are used to ensure you are building capability for people with long term conditions. **What tools and resources are you using, how are you monitoring the impact of what you are doing, and how are these being tailored to meet culturally diverse needs, especially for Māori and Pasifika peoples.**	Instigated system from Medical Ward. All discharge NHI sent to LTC Clinical Lead to investigate via Clinical Portal for multiple ED presentations/admissions for respiratory conditions. Pilot running well capturing patients in need of health literacy resources and transitioned back to GP. Work completed with PHARMAC and Health Literacy NZ to revise national STOP GOUT booklet resource and Leni's story flip cards • Flip cards printed and delivered to Pacifica group • Draft local gout posters developed but capacity issues has delayed the completion of these
SPECIFIC SERVICES - OPTIONAL Gout: What specific services (if any) your DHB/PHOs are providing for gout in primary care and identify any barriers that prevent initiation or development of services. Chronic Kidney Disease (CKD): What specific services (if any) your DHB/PHOs are providing for CKD in primary care and	**Describe your programme/s to address improved gout outcomes, especially around medicine adherence**, and specifically comment on whether any **cost or other barriers** are being experienced to achieve sustained medicine adherence for optimal gout management. Describe your **approach in identifying early risk of CKD** and what systems are in place to ensure people are supported with self-management and / or have timely access to specialist services. Comment on what system changes you would like to see, to improve	Please see attached report GOUT WRHN Jan 2022.docx WRHN and WDHB Integrated plan for pulmonary rehabilitation and self-management programmes are underway. Design for virtual and telehealth groups to be completed Feb 2022 All patients to be contacted by WRHN long term conditions team for GP follow

identify: 1) any barriers that prevent initiation or development of services.2) actions with an equity focus to support people with CKD to self-manage.	integrated service delivery in this area and specific improvement initiatives you would like to see us focus on?	up facilitation, rehab, and self-management. Initial pilot plan working well.

SS13: FA2 Diabetes services

Select DHB of Domicile:	Whanganui	Period	Q2 2021-22

PP20 Improved management for long term conditions (Diabetes)

Please see the Instuctions tab and the Example Template tab

Numbers of people with diabetes

PHO register total (all PHOs)			*VDR estimate count of diabetes prevalence as at 31 Dec 2020*			*Estimated completeness of diabetes ascertainment by PHOs*		
Denominator								
	Ages 15-74 only	All ages		Ages 15-74 only	All ages		Ages 15-74 only	All ages
Maori	936	1,061	Maori	1079	1,224	Maori	86.7%	86.7%
Pacific	102	112	Pacific	114	124	Pacific	89.5%	90.3%
Other	1,720	2,426	Other	2206	3,084	Other	78.0%	78.7%
Total	2,758	3,599	Total	3,399	4,432	Total	81.1%	81.2%

HbA1c measurement data- for people aged 15-74 years inclusive

Numerator						
	Number with HbA1c ≤ 64mmol	Number with HbA1c ≥ 65mmol and ≤ 80mmol	Number with HbA1c ≥ 81mmol and ≤ 100mmol	Number with HbA1c ≥ 101mmol	Total number with any available HbA1c result	Total number with no available HbA1c result
Māori	473	189	104	70	836	100
Pacific	51	17	15	6	89	13
Other	1,113	301	125	39	1,578	142
Total	1,637	507	244	115	2,503	255

Rate based on total PHO/practice count rate						
	% HbA1c ≤ 64mmol	% HbA1c ≥ 65mmol and ≤ 80mmol	% HbA1c ≥ 81mmol and ≤ 100mmol	% HbA1c ≥ 101mmol	Percentage with any available HbA1c result	Percentage with no available HbA1c result
Māori	51%	20%	11%	7%	89%	9%
Pacific	50%	17%	15%	6%	87%	12%
Other	65%	18%	7%	2%	92%	6%
Total	59%	18%	9%	4%	91%	7%

SS13: FA3 Cardiovascular health

SS13 FA3 – Cardiovascular Disease Quarterly Reporting template 2021/22 – Quarter 2

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Reporting requirements from two sources are included under this umbrella, from the quarterly non financial reporting under SS13, Focus Area 3, and also from the *HEART HEALTH: previously known as More Heart and Diabetes* contracts, between the Ministry and the DHBs. Reporting is by narrative, with the questions from the two reporting requirements combined in the template below.

On 31 March 2021, the Ministry held a webinar for patient management system (PMS) integrators to launch the national cardiovascular disease (CVD) risk calculation tool. The tool is now available to all integrators, free of charge. Do you currently have a calculator based on the 2018 algorithms available for use? Has your PMS or CVD decision support provider indicated any time frame for integration, with the national CVD tool?
MOH: Do you currently have a calculator based on the 2018 algorithms available for use? Yes, Predict CVD Diabetes has been aligned with the 2018, and then the 2019 published algorithms since before the National free Tool was created. **Has your PMS or CVD decision support provider indicated any time frame for integration, with the national CVD tool?** N/A - No need to integrate, it is already fully compliant with the 2018 Non-DM, and subsequent DM release in 2019 evidence base. (HISO 10071:2019 Cardiovascular Disease Risk Assessment Data Standard)
Do PHOs and practices regularly report against any local CVD indicators? If so, please describe the indicators below.
Previously reported indicators continue to be available for practices though powerBi CVD Risk assessment completion rates.
Have you considered or implemented CVD risk assessment aligned to COVID vaccination? If so, how is this linked to CVD risk management conversations?
Best practice information from the ministry and via HealthPathways has been circulated to all general practice teams for discussion at their peer reviews

SS13: FA4 Acute heart services

Name of DHB: Whanganui DHB
Indicator 1: Door to cath - Door to cath within 3 days for ≥ 70% of ACS patients undergoing coronary angiogram**.** **Indicator 2a: Registry completion-** ≥95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days of discharge and **Indicator 2b:** ≥ 99% within 3 months. **Indicator 3: ACS LVEF assessment-** ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (ie have had an echocardiogram or LVgram).

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Indicator 4: Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance ≥ 85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge -

- Aspirin*, a 2nd anti-platelet agent*, and a statin (3 classes) and
- an ACEI/ARB if any of the following – LVEF <50%, DM,HT,in-hospital HF (Killip Class II to IV) (4 classes), and
- Beta-blocker if LVEF<40% ((5-classes).

* An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents.

Indicator 5a: Device registry completion ≥ 99% of patients who have pacemaker replacement have completion of ANZACS-QI Device PPM forms completed within 2 months of the procedure.

Indicator 5b: Device registry completion ≥ 99% of patients who have implantable cardiac defibrillator implantation/replacement have completion of ANZACS-QI Device ICD forms completed within 2 months of the procedure.

Notes to indicators:

Indicator 2: *The requirement for ≥ 99% completion within 3 months added in 2018/19.*

Indicator 3: *new indicator in 2018/19.*

Indicator 4: *new indicator in 2018/19, and modified in 2019/20. Patients meet the indicator if they are recorded in the ANZACS-QI ACS form as either on the particular medication or recorded as having a known contraindication/intolerance to it. This is a "minimum" indicator. It may still be clinically appropriate to use a beta-blocker in the absence of LV dysfunction, but this is not required to meet the indicator. Patients referred for in-patient coronary artery bypass grafts (CABG) are excluded because prescribing data is recorded prior to surgery when the second antiplatelet agent has been stopped. Patients are also excluded where no LVEF is recorded.*

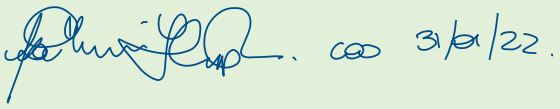
Indicator 5a and b: *new indicators in 2019/20.*

Indicator measures: Each DHB must provide a percentage measure from the most recently available quarterly ANZACS-QI report for each of the indicators, and an ethnicity breakdown.

	TOTAL	Maori	Pacific	Indian	Asian	Eur/Other
INDICATOR 1 Quarterly percentage performance against indicator 1(use KPI October 2021 quarterly detailed report)	26%	16.7%	Nil	Nil	0%	29.60%
INDICATOR 2a Quarterly percentage performance against indicator 2, (use KPI October 2021 quarterly detailed report):	100%	100%	Nil	100%	100%	100%
INDICATOR 2b Percentage performance against indicator 2, for 90 days prior (use October 2021 quarterly detailed report, and record Quarter 4, 2020/21 result)	100%	100%	100%	Nil	100%	100%
INDICATOR 3 Quarterly percentage performance indicator 3 (use KPI October 2021 quarterly detailed report)	69%	71.4%	Nil	100%	100%	66.70%
INDICATOR 4 Quarterly percentage performance indicator 4, (use KPI October 2021 quarterly detailed report)	77%	80%	Nil	100%	0%	80%
INDICATOR 5a Quarterly percentage performance indicator 5a, (use KPI October						

2021 quarterly detailed report) which reports registry completion in May, June, July).						
INDICATOR 5b Quarterly percentage performance indicator 5b, (use KPI July 2021 quarterly detailed report) which reports registry completion in May, June, July.						
Where the indicator has not been met, identify the indicator and provide narrative on the barriers to achieving the indicator and what short, medium and long term mitigation strategies are in place to improve this indicator.	**DHB comments** We have been advised of ongoing increases in demand for Cardio-Thoracic services by our tertiary centre and this is impacting on waiting times. We continue to work with them.					

Please sign your name below to confirm you have emailed your completed reporting template to your regional cardiac programme manager:



Information on who to contact for your DHB:

Northern Region (Northland DHB, Counties Manakau DHB, Auckland DHB, Waitemata DHB)

- Natasha Gartner – (Natasha.Gartner@healthshare.co.nz)

Te Manawa Taki (Bay of Plenty DHB, Lakes DHB, Tairawhiti DHB, Taranaki DHB, Waikato DHB)

- Helen McKenzie - (Helen.McKenzie@nra.health.nz)

Central Region (Capital & Coast DHB, Hawkes Bay DHB, Hutt Valley DHB, Mid Central DHB, Nelson Marlborough DHB)

- Jeanine Corke – (Jeanine.Corke@tas.health.nz)

Southern Region (Canterbury DHB, South Canterbury DHB, Southern DHB, West Coast DHB)

- As Alan Lloyd has recently left, please send your reports through to John Edmonds (John.Edmond@southerndhb.govt.nz)

SS13: FA5 Stroke services

MINISTRY OF HEALTH MANATŪ HAUORA	**SS13 FA5 (Stroke Services)** **Reporting Template**	**QTR 1** **2021-2022**

Notes:

Please either complete this template or add your report (including ALL the following points) to the database. All DHBs are expected to submit a report.

Indicator results and numbers are for the previous quarter (ie Q1 results in Q2) with narrative to include comments around indicator results also narrative for current reporting quarter activities.

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Name of DHB:			
Indicator 1: 80% of acute stroke admissions admitted to an ASU or organised stroke service with a demonstrated stroke pathway within 24 hours of their presentation to hospital – Q4 confirmed data **Indicator 2**: **12%** Reperfusion – Thrombolysis /Stroke Clot Retrieval Service provision 24/7 – Q4 confirmed data **Indicator 3: 80%** of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission – Q4 confirmed data **Indicator 4: 60%** of patients referred for community rehabilitation are seen face to face by a member of the community rehab team within 7 calendar days of hospital discharge – Q4 confirmed data			
Confirmed result indicator 1 for Q4 ASU 80%: Percentage: Total 100% Māori-100% Denominator: Total- 31 Māori-6 Numerator: Total- 31 Māori-6	**Confirmed result indicator 2 for Q4** Reperfusion – Thrombolysis /Stroke Clot Retrieval 12% 24/7: Percentage: 16 % Māori-0 Denominator: Total- 31 Māori-0 Numerator: Total-5 Māori-0	**Confirmed result indicator 3 for Q4** Inpatient Rehabilitation 80%: Percentage: Total-67% Māori- 100% Denominator: Total-6 Māori-1 Numerator: Total-4 Māori-1	**Confirmed result indicator 4 for Q4** Community Rehabilitation 60%: Percentage: Total-0 Māori-0% Denominator: Total-7 Māori-1 Numerator: Total-0 Māori-0

Indicator 1: ASU

Numerator = number of acute stroke admissions admitted to an ASU or organised stroke service with a demonstrated stroke pathway within 24 hours of their presentation to hospital.
Denominator = total acute stroke admissions (I61, I63, I64).

- Please provide narrative if any hospital in your DHB responsible for providing this service has not met this indicator, with your plan to achieve.
- Please include here a breakdown of: % numerator and denominator by hospital providing this service.

(See Minimal Standards attached for guidance)

DHB Comments:	Indicator 1= met. Code stroke, Acute fast track stroke thrombolysis/thrombectomy protocol is working well supported by tele stroke via CCDHB.

Indicator 2: Reperfusion – Thrombolysis /Stroke Clot Retrieval Service provision 24/7

Numerator = number of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval and counted by DHB of domicile.
Denominator = number of stroke admissions eligible for thrombolysis or stroke clot retrieval (ICD Codes I63, I64)

- Please provide narrative if any hospital in your DHB responsible for providing this service has not met this indicator.
- Please include here a breakdown of each hospital providing this service: % numerator and denominator.
- **NB: this is for the provision of a 24/7 thrombolysis service – if your DHB is not providing a 24/7 service please advise how/when you plan to achieve.**

DHB Comments:	Indicator 2= met The code stroke and acute stroke fast track pathway are working well in hours/afterhours ..

Indicator 3: Rehabilitation

Numerator = number of acute stroke admissions transferred to in-pt rehab within 7 days of acute admission.
Denominator = number of stroke admissions eligible for rehabilitation (I61, I63, I64)

- Please provide narrative if any hospital in your DHB providing this service has not met this indicator with your plan to achieve.
- Please include here a breakdown of each hospital in your DHB: % numerator and denominator.

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	(See Minimum Expectations attached for guidance)
DHB Comments:	Indicator 3 =67%. Out of 6 patients , 2 patients were medically unstable within first 7 days prior to transfer to rehabilitation. Our comprehensive stroke unit facilitates early access to rehabilitation services. Therefore, out of 25 patients who did not get transferred to in patient rehabilitation 16 pts dx home rom ASU not needing transfer to inpatient rehabilitation 2 patients deceased 2 were transferred to Other hospitals 3 were discharged to permanent rest home care 2 were transferred to Intermediate Care for Slow -stream Rehabilitation.
Indicator 4: Community Rehabilitation **Numerator = number of patients referred for community rehabilitation who are seen face to face by a member of the community rehab team within 7 calendar days of hospital discharge.** **Denominator = number of patients discharged from hospital with a primary stroke diagnosis (I61, I63, I64) who are referred within 2 weeks of discharge for community rehabilitation.** (See Minimum Expectations attached for guidance)	
DHB Comments:	Indicator 4 = not met. Whanganui allied health community rehabilitation staffing capacity significantly compromises our ability to deliver community rehabilitation. Currently OT/SW services are unable to respond. PT is responding utilising the day ward service (DAR) and PT group class sessions. The stroke nurse is responding quickly, mainly via phone calls and telehealth. WDHB is currently developing a pilot project to facilitate ESD and stroke community rehabilitation

Other:
- Please indicate if you have a contact person in local Iwi or Pacific Church who you could work with to support and promote the FAST message for this year's campaign. If not are these relationships that you could develop?
- Please comment on these services your DHB provides/participates in, either through services provided in your DHB or as part of an assisted regional service, or barriers that do not support your participation:
  - Telestroke activity
  - Stroke Clot Retrieval activity	

DHB Comments	WDHB has localised the CCDHB Stroke Fast track thrombolysis-thrombectomy pathway document. Whanganui DHB has code stroke emergency 777 call in place 24/7. Once activated the stroke nurse (as able the stroke consultant) responds between 0800 – 2300 hours utilising telestroke. After 2300 hours the ED nurses activate tele-stroke via CCDHB. We send our patients to CCDHB/Auckland for stroke clot retrieval (thrombectomy). Our comprehensive acute stroke unit also provides Hyper acute stroke nursing care. Patients are usually thrombolysed in CT and then directly transferred to the acute stroke unit for post thrombolysis care.

Signed off by:

Lead Stroke Physician: Dr Jan Gregson Clinical Nurse specialist Stroke : Akesh Pillai Lead Allied Health:

SS15: Improving waiting times for colonoscopies

Whanganui District Health Board

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PLACEHOLDER_DELAYED TIMEFRAME REPORTING

SS17: Delivery of Whānau Ora
No report required this quarter

3) Quarter Two Updates to the 2021-22 WDHB Annual Plan.

Status Update	Q1	Q2
Give practical effect to Whakamaua: Māori Health Action Plan 21/22		
Improving sustainability 21/22		
Improving child wellbeing 21/22		
Improving mental wellbeing 21/22		
Improving wellbeing through prevention 21/22		
Better population health outcomes supported by strong and equitable public health services 21/22		
Better population health outcomes supported by primary health care 21/22		

2.5.1 Give practical effect to Whakamaua: Māori Health Action Plan 2020-2025

Engagement and obligations as a Treaty partner		
Action(s)	**Q1**	**Q2**
Strategic Maintain partnership and close working relationships between Hauora ā Iwi (HAI) and WDHB through: *Regular joint and Chair to Chair hui.* *Enact the Mana Whenua Agreement strengthening partnership and active engagement.*	MET	MET
Involvement of HAI members in all key DHB strategic discussions and decisions.		MET
Involvement of HAI in decision making related to the implementation of the recommendations form the H&DS review 2020.		
Engagement of HAI in monitoring the implementation of He Hāpori Ora action plan. Regular reporting to joint board hui *Message from HAI included in the foreword of the WDHB 2020/21 annual report.* Annual report published *Joint board monitoring of equity measures in WDHB Annual Plan and pro-equity implementation work plan.* 6 monthly reporting *MOHAG representation on all interviews for executive positions.* *HAI representation on combined statutory advisory committees and performance review for chief executive.*		MET

Commented [KO1]: @Eileen O'Leary

Waitangi Tribunal *Plan and begin the roll out of embedding obligations under the five Treaty principles in updating key policies and procedures.* *Continue to participate in the design and implementation of the Ministry of Health's Treaty framework, to ensure WDHB meets its statutory obligations, as prescribed by the Tribunal and its interpretation of the Treaty clauses under the NZ Public Health and Disability Act 2000.*	MET	MET
Partnership *Six months post implementation of the WDHB consumer group Te Pukaea new structure with at least 50% Māori membership, review progress and what further support is required.* ▪ Implement Term of Reference for a Māori reference group to provide Māori community and health expertise advice to key service developments, service improvements, development of Māori health policy and frameworks to ensure that we have a wider Te Ao Māori lens applied to our work. ToR in place and regular hui undertaken		MET
▪ Engage and work with the Māori Health Alliance to implement the recommendations from the commissioning for kaupapa Māori health services work plan 2020-21 and review of services that are achieving equity in health outcomes for Māori ▪ Develop a work programme between the WDHB and HAI boards to measure improvement in equity for Māori across annual plan equity-oriented activity indicators and the WDHB pro-equity work programme. Work plan agreed ▪ Continue support for the Central Region's Iwi relationship boards Te Whiti ki te Uru forum and their alliance with the Central Region CEs and Chairs. ▪ Continue participation in the Central Region GM Māori forum to influence across the region and share learnings and initiatives. ▪ Continue participation in national Māori health leadership forum Tumu Whakarae. ▪ Involve HAI in all decision making that is responding to the Health and Disability Review.	PARTIAL PARTIAL MET MET MET	 PARTIAL MET MET MET
Pro-equity Continue to implement the WDHB Pro-equity Implementation Plan, under He Hāpori Ora implementation, for 2021 – 2023 under the four priority areas: ▪ Strengthen organisational leadership and accountability for equity. ▪ Build Māori workforce and Māori health and equity capability (refer to workforce section 4.3) ▪ Improve transparency in data and decision making. ▪ Support more authentic partnership with Māori.	MET	MET

Implementing and monitoring whānau centred approaches to care and services. *Include whānau hui in service delivery with the support of Te Hau Ranga Ora Haumoana Service for DHB provided services.* *-Evidenced in tracer audits*	PARTIAL	PARTIAL
Ongoing implementation and monitoring of Korero Mai. Korero Mai seeks to enable patients and whānau to communicate concerns about a patient's deteriorating condition. Evidenced in tracer audits Introduce Whakarongo Mai – listen to what we are saying as whānau to complement Korero Mai		PARTIAL
Improve transparency in data and decision making: *share equity analysis widely and include it in decision making.* Equity dashboard reported to joint boards		PARTIAL
transparency in resource allocation, including equity analysis in all publicly reported data. Evidenced in commissioning processes Evidenced in media reporting and WDHB public documents		
Leadership *Continue to provide professional development (training) for DHB leadership on the impact of racism, impact on colleagues and workforce, the impact on quality outcomes for patients and their whānau, and the use of equity tools and methodologies.*	PARTIAL	PARTIAL
Introduce on-going mechanisms to support Māori staff, if they have been victims of racism, as leadership and the organization address the impacts of racism.	Partial	PARTIAL
Continue to support equity professional development to local provider partner leaders.	MET	PARTIAL
Apply equity methodology and monitoring to decision-making processes including commissioning, service delivery models and service changes. Evidenced through commission processes		
Continue to support development and provision of education for elected board and committee members in understanding the impact of racism and colonisation on health outcomes for Māori whānau and the use of equity tools and methodologies. *Continue to provide cultural safety education as part of WDHB board member local induction programme.*		

Commented [EO2]: Kilian last quarter should have been orange not red

Support the embedding of He Hāpori Ora and the WDHB values and WDHB tikanga o Whanganui practices. Evidenced in tracer audits, accreditation review, consumer and whānau feedback – compliments and complaints		

Action(s)	Q1	Q2
Whakamaua Objective: Accelerate and spread the delivery of kaupapa Māori and whānau centred care		
Action 3.1 Māori workforce (refer Health Workforce page 6) *100% of Māori engaged in study to mahi initiatives with Youth Employment Success programme and Kia Ora Hauora are offered career progression support by Te Hau Ranga Ora (WDHB Māori health team)* *a. WDHB recruitment and retention is aligned with mahi with Kia Ora Hauora, YES kaupapa, Rangatahi focused pathways – Ara ki te mahi Hauora*		PARTIAL
Action 4.4 Kaupapa Māori Primary Mental Health & Addiction *a. Implement recommendations from the WDHB Kaupapa Māori Services Commissioning Review to ensure that kaupapa Māori contract documents support, recognise and enable the delivery of whānau ora and are:* *Enablers for equitable outcomes for Māori* *An enabler for sharing consented information across agencies* *Supportive of kaupapa providers to build and maintain capability and capacity to design and deliver services* *Aligned across agencies e.g. DHB, Te Puni Kokiri and Whānau Ora Commissioning Agencies* *b. Implement the second tranche of the Integrated Primary Mental Health and Addiction Services to kaupapa Māori general practice*		
Action 6.1 Support Māori patients and their whānau to navigate their health journeys *a. Planned clinics around telehealth options, including access in rural localities etc:* *Increase in remote consultation through video conferencing rather than patients, whānau or staff having to travel.* *Engagement and process taking into account cultural values and practices including options for whānau hui* *a. Introduction of wider suite of telehealth options for patients and clinicians included telephone, secure video conferencing and supported remote clinics.*		PARTIAL

Commented [EO3]: Focus on whānau-centred care.

Whakamaua objective: Shift cultural and social norms (refer Health Workforce page 62) Our actions are underpinned by applying an equity lens to all workforce actions including: a. *An explicit focus on addressing bias, racism and discrimination, in all its forms, across all aspects of the WDHB operations.* b. Develop – options program for all staff to access a tool kit to support their understanding of the impact of racism and basis in the workplace, for self- reflection, leadership and management of specific instances.	PARTIAL	PARTIAL
Whakamaua Objective: Reduce health inequities and health loss for Māori **Action 4.7 Smokefree** a. *Facilitate a co-designed system change to address the fragmentation across the system with hapū mama (from conception to 6 weeks) at the core through the Tobacco Advisory Group, Well Child Tamariki Ora network, Primary Care and Maternal Governance Groups.* *Insights Report developed* *Scope Implementation plan based on feedback from Insights Report* **Action 4.7 Cervical Screening** b. Invest more in successful local 'Smear your Mea' campaign across rural and urban districts *Improvement in baseline March 2021 performance*		
Action 8.2 Plans and Progress a. *Hauora ā Iwi engaged in monitoring the implementation of He Hāpori Ora including equity dashboard and mitigation actions*		
Whakamaua Objective: Strengthen system accountability settings **Action 1.4 Iwi engagement in capital business cases** b. *Iwi and community of Waimarino are actively and fully engaged in the development of the Waimarino health Centre. MoH approved capital project* c. *Iwi are engaged in the redevelopment of the Taihape Health Campus.*		
Action 4.9– Growing Māori health sector capability – locally led c. ***He Puna Ora:*** *Support ongoing development of the new kaupapa Māori service across the rohe to work with hapu mama who are affected by drug and alcohol and other drugs addiction and or who have tamariki under 3 years of age and their whānau. Designed and developed by the Māori Health Outcomes Advisory Group (leaders of kaupapa Māori services) based on a te Ao Māori model.*		

Monitor and engage and participate in ongoing evaluation of the programme		
Action 5.6 Implementing Whāia te Ao Marama 2018-22 *b. Maintain representation of people with lived experience of disability on the WDHB statutory advisory committee* *c. Refresh the WHDB action plan ensure Māori representation in working group proportionate to the population and includes representation from consumers.*		
Action 8.5 Major funding frameworks adjustment for unmet need and equitable distribution of resource *a. Support introduction of Whakarongo Mai – listen to what we are saying as whānau to complement Korero Mai – and link into commissioning processes to identify and respond to unmet need.* *b. Channel funding opportunities to the introduction of "inequity breaker" programme targeting "intensification" or "simplification" of service as appropriate*	PARTIAL	PARTIAL

Commented [EO4]: Haumoana focus on supporting staff to whakarongo and korero with whānau and patients.

2.5.2 Improving sustainability 21/22

Short term focus 2021/22

Throughout the COVID-19 response period the WDHB team participated in wide ranging community engagement. Through a process of analysis, a number of opportunities for health within our rohe were identified including the extended use of telehealth services. National analytics have highlighted two major opportunities for WDHB: high readmission rates and high standardised intervention rates. The latter will be addressed within the programme of strengthening production planning for planned care.

Action(s)	Q1	Q2
Increased use of Telehealth will provide significant positive impact on our communities and the DHBs financial sustainability. This will potentially reduce the impacts of travel and work inequities in our communities, the levels of DNAs and enable greater flexibility for clinician time and clinic administration. *Recruit a Telehealth Project Manager to drive both clinical and patient engagement to increase usage of telehealth* *Project plan in place*	MET	PARTIAL. Project manager resigned from position in October 2021. Project plan remains in draft, to be finalised following appointment of new project manager.

Uptake of telehealth has increased equitable access to communities across the rohe		
Clinical uptake and usage of telehealth has increased Estimated Financial Impact year one $84K,		
WDHB has a high rate of readmissions. A patient flow programme has been implemented with a reduction of readmission rates as one of the key objectives. ▪ Integrated Discharge Navigator A one-year pilot role for integrated discharge navigator position will be recruited. The programme is aligned to the strategic focus on Healthy at Home: Every Bed Matters. Role will ensure systems and processes are in place to aid timely patient discharges, understanding and removing barriers to discharge and reviewing complex cases to support better health outcomes. Estimated Financial Impact year one $96K,		
WDHB regularly delivers an intervention rate across some surgical specialties that is significantly higher than the national average. We are using service redesign funding to align capacity and production planning models with patient focussed service delivery and improving access to services. Year one value is not quantifiable; however capacity will be made available to regional partners via IDF inflow.		

Medium term focus (three years)

Over several years, WDHB has experience ongoing growth in acute hospitalisation. Our Thriving Communities strategy, includes the mission "Ki tāea e te whānau me te hāpori i tōna ake tino rangatiratanga: Together we build resilient communities, empowering whānau and individuals to determine their own wellbeing."

One of our strategic focus areas is "Noho Ora Pai I Tōu aka Kāinga- Healthy at Home: Every Bed Matters" setting up a principle that self-care is best. Over the medium term, this will contribute to sustainability by integrating community and hospital services more effectively and empowering people, whānau and communities to thrive.

Action(s)	**Q1**	**Q2**
Healthy at Home – every bed matters. Integrating community and hospital services driven by a core principle that the best bed for a person is their own one. A programme of work to address congestion in the hospital and collectively reduce acute hospitalisation. Elements of the programme and key actions across the next 3 years include:		

Driving effectiveness in urgent care before it reaches the hospital front door Year 1 – implement alternative care settings for non-urgent care in A&M Complete planning Alternative care settings in place for 2 client groups Year 2 - Design and implement consistent urgent care model across the district Year 3 – embed community informed wellbeing hub into primary healthcare systems This action will have a significant impact on medium term sustainability by not only reducing ED presentations, but		
reducing acute admissions through earlier intervention, and long-term cost growth. *Strengthening and integrating patient-flow systems within the hospital* Year 1 – embed integrated discharge navigator Confirm model of care and system Embed into practice Year 2 – implement regional standardised intervention rates Year 3 – integrate and standardise regional and sub-regional models		
Optimising community transitional and support services Year 1 – Complete model of care change for intermediate care services Planning complete New model of care operational Year 2 – implement nationally consistent home and community support services model Year 3 – Embed community-informed tier 1 service commissioning Positive financial impact year one $392K, year two $398 K, year three $403K.		

2.5.3 Improving maternal, child and youth wellbeing

Maternity care 2021-22

The focus for maternity services is twofold:

Integration and collaboration of services across the continuum of maternity care to facilitate early and seamless access to care, to support and protect the health and wellbeing of our wāhine/māmā's, pēpi *and whānau.*

To encourage and enable consumer engagement, especially from Māori living in our rohe, to actively participate in decisions about their health care and maternity services, to help us meet their needs and develop safe, quality services

Action(s)	**Q1**	**Q2**
COVID-19 learnings: *Importance of consistent and timely communication to support service delivery, work with COMMs to ensure messaging is consistent and clear.*	Met	
	Met	

Importance of enabling a dedicated support person to stay with the woman throughout her inpatient maternity stay	Met	
Ensure community LMC's are supported to continue with homebirths through provision of and education on correct use of personal protective equipment (PPE)		Met
The DHB will provide a homebirth kit for LMC's including disposal, laundry and sterilization of equipment *Maintain continuity of care for rural women and whānau - primary Waimarino Maternity Service is fully staffed and operating 24/7.*		Partial
Midwifery Accord actions: *Support new graduate midwives to choose DHB employment*		Met
FTE calculations are completed in accordance with CCDM		
The WDHB will support new graduate midwives: *employ at two new graduate midwives from this programme (EF)* *support and encourage participation in the Midwifery First Year of Practice programme (MFYP)* *encourage Māori new graduate midwives to engage in Te Urupounamu, cultural Supervision. (EF)*	Met	
Seek to employ a Clinical Coach as per Accord recommendations to clinically support all new graduate midwives with their hospital orientation and DHB specific competencies		
PMMRC recommendations: The Maternity Quality and Safety Programme (MQSP) will develop a detailed three-year work plan based on PMMRC recommendations prioritizing those that are urgent	Met	
Begin implementation of actions in the plan:		Met
Implementation of HQSC maternal morbidity review tool kit and SAC rating (PMMRC)		Met
Implementation of Hypertension guideline, with a review/re-stock of medications to ensure easy availability & administration in acute care settings (PMMRC)		
Interdisciplinary fetal surveillance education for all clinicians involved with intrapartum care (PMMRC) *MEWS audit and case review Associated morbidity review identified through trigger tool (MMWG recommendation)* *Further develop cultural competency in practice workshops for all Maternity Service staff (PMMRC)*		
An integration working group (includes LMCs, general practitioner, PHOs, DHB maternity, WCTO, child health services, Māori health) has been established to investigate and gain a whole of system view of equity, access issues and opportunities across the maternal and child health system (will include actions		Met

Commented [KO5]: @Lucy Pettit hi Lucy- coloured cells in Column 2- thanks

to improve access to social services, ultrasound, parenting education, WCTO and screening programs). *Develop a 3-year work plan based on the insights gained from a whole of system engagement process.*		
Ambulatory sensitive hospitalisations for children age (0-4) (SLM) *Acute hospital bed days is a measure of acute demand and patient flow across the health system. It is about using health resources effectively and maximising the use of resources for planned care rather than acute care and addressing inequities.* Develop and implement childhood asthma pathway Embed Best Start Tool across general practice		

Immunisation

Whanganui DHB is committed to ensuring all children receive their immunisation on time. Childhood immunisation rates have fallen despite best efforts from the outreach team, with Māori rates also declining. Addressing peoples' hesitancy around vaccinations, increased anti-vax media coverage have impacted on the rates. Though issues affect all DHBs, we have observed the value of collaboration across sectors as this has proven a successful approach to larger scale immunisation as evidenced in the programme of work undertaken during COVID-19 lockdown. Improved and joint collaboration along with consistent culturally appropriate messaging that is locally driven are areas that can have a positive effect on the immunisation rates.

Action(s)	Q1	Q2
Immunisation engagement and communication plan: The aim of the plan is to improve childhood immunisation coverage from infancy to age 5. Immunisation engagement and communication plan, taken from the revised engagement plan, following learnings from rollout of COVID-19. To ensure immunisation is maintained during COVID-19 rollout within the WDHB the engagement plan has a locally driven focus on: collaboration with community providers focused resourcing consistent culturally appropriate messaging *Working with key stakeholders to develop and implement an immunisation engagement and communications plan* *Ensuring plan delivers key, consistent and culturally appropriate messages.* *Develop, in collaboration with Māori, Pacific and consumer participation.* *Focus on health literacy and how we deliver our messaging in different populations, and within a context of Te Ao Māori.*		
		Partial Scoping report completed but delays due to Covid 19 – 90% vaccination prioritised for DHB & key stakeholders.
		Partial As above
COVID-19 learnings: By working collaboratively with kaupapa Māori health providers and Māori communities, the teams were able to target those hard to reach people, deliver to them in their own communities, provide mobile and pop up clinics in various locations. Develop joint work plans that will target hard to reach, high dep and Māori population and ensure that the approach is Māori-led, Māori-focused.		
Actions to improve 2-year-old immunisation uptake: *Work closely with general practices:* use practice specific data to monitor progress of uptake of immunisation, provide feedback and clinical support as required at a practice level ensure teams are focused on meeting their targets ensure resources and knowledge are available to engage with Māori whānau.		Partially met. Activities are being undertaken but competitive environment with COVID affecting outcomes.

Work with general practice teams to develop their own initiatives to increase childhood immunisations rates that focus on uptake for Māori. *Immunisation outreach will work across the system, so that childhood immunisations are prioritised when children interface with hospital services and other sector partners.* *Increase opportunistic vaccinations and education in hospital departments supported by the outreach team* (Contributory measures to monitor progress: Infants who have received all WCTO core contacts due in their first year, babies in smokefree homes at 3 months)		

Youth health and wellbeing

The Whanganui DHB will continue to work collaboratively with sector partners and whānau to provide and enhance the range of services for youth, focusing on the needs of Māori.

(SBHS = school based health service)

Action(s)	**Q1**	**Q2**
Undertake the design of a pathway in response to our gender diverse population in schools that will increase awareness of agencies and networks to students. Promote and support Rainbow friendly environments in schools.		
Action from the; 'A framework for continuous quality improvement in each school'. Facilitate Public health nurse's having protected time and dedicated resources for professional development and supervision. *Having 75% PHN's access to supervision.* *Report staff uptake of training and supervision.*		Partial- not up to 75% yet
Improve IT process by having HEEADSSS documentation to be accessed via Clinical Portal (CP). *Develop a form to improve data collection required for quality improvement in the future.* Measure: 100% of HEEADSSS assessments completed on CP form. *Improve data collection in WebPas for SBHS Ministry of Health reporting using PDSA cycle.* *Analyse clinic data to evaluate and identify changes required.*		*Partial – All HEEADSSS forms now uploaded into clinical portal. Electronic HEEADSSS form to be developed through TeamsPartial – Additional data being captured in WebPAS through interventions including referrals to other services / agencies*

Commented [KO6]: @Karmin Erueti - hi this used to be (I think) Itayi....

Commented [KO7R6]: This reporting period any activity under Itayi your main contact would be Sarah Marsh who is the interim PHN manager until the end of January

Commented [KO8R6]: @Sarah Marsh

		Partial – Additional clinical data is being collected to identify additional support needed in secondary schools
	Met	
PDSA cycle – Changes implemented in how SBHS will assess the young person's satisfaction within the service regularly. Partnering with students to obtain their voice through surveys, conversations. Priority sourcing high risk population, Māori, Pacifica student's in schools.		Partial Term 4 no nurses in schools due to covid-19 work
Identify barriers to access service. *Develop a method of creating a student focus group for feedback, two focus groups completed and reporting from PHN's survey results for evaluation.*		
Undertake work providing school leavers with information and enrolment opportunities of PHO's and other relevant agencies to improve Māori health and achieve health equity and wellbeing. (restrictions in 2020 due to COVID-19, promoting the resources will occur in 2021). *Facilitate process to distribute to each school the resources and any opportunistic times to provide to students.* -10 Schools and Alt Ed Centre's have the resources		Partial Term 4 no nurses in schools due to covid-19 work
Enhance range of health services offered by Youth One Stop Shop (YOSS) that meets the needs of our diverse community including Māori, Pasifika and Rainbow communities by partnering with other providers including Iwi and kaupapa providers and specialist mental health and addiction services		
Implement the second tranche of the Integrated Primary Mental Health and Addiction Services for General Practices and report on youth and youth Māori utilisation.		

Family violence and sexual violence		
Action(s)	**Q1**	**Q2**
Staff as victims of violence training and support – implementation of training programme for managers Māori staff at the WDHB make up 13% *Consultation to occur with training providers (SHINE) and Māori Health Team to ensure that all staff are supported appropriately and that Tikanga and protocols are followed in respect of working with our staff who are victims of family harm within the proposed training package.*		

Feedback from consultation actioned		
Purchase training package. *The training package has been purchased from SHINE and will be delivered with a People and performance staff member, and the VIP coordinator. The training package will be localised before delivery and covers the DV FREE tick for organisations to be responsive to staff who are victims or perpetrators of family harm.*	met	

Implement training package		Partially met Awaiting trainer availability New Year
Policy & Procedures are developed with People and Performance		
Policy & Procedure implemented		
Support People & Performance Manager and Te Hau Ranga Ora Kaitakitaki (WDHB Māori health services manager) to identify appropriate attendees for first responder training.	met	
People & Performance identify a staff member responsible for providing guidance to managers in dealing with difficult situations		met
People and Performance to source legal advice for managing staff who are perpetrators and victims of family harm. *First responder (up to 20 participants) training relates to family and sexual violence as staff are victims of both. There is evidence of the high correlation between physical and sexual violence. The first responders are designated people within the DHB for employees to contact if they are impacted by domestic violence (or have children living with them that have been impacted by family harm) who may want workplace safety and support. First responders may also provide support and guidance for managers who are managing an employee impacted by family harm or perpetrating family harm. The first responder roles is not to address or resolve the source of violence but rather to ensure that employees are provided with appropriate support and workplace safety planning, as well as facilitated access to specialist family harm agencies. This training is part of the DV FREE package that WDHB have purchased.*		
Ensure all employees have access to support within the workplace. 50% of managers have received training on how to support staff experiencing family harm and how to manage staff suspected or known to be perpetrating family harm during work time or using work resources. This will encompass safety planning, confidentiality and professional boundaries.		Partially met some updates required
WDHB to have received DVFREE tick and be supported by Te Hau Ranga Ora.		
The DVFREE training package (as above) includes training for first responders who are identified staff members available for impacted staff to contact. First responders will provide support to engage staff members with appropriate agencies and resources to support them to meet their needs and continue employment.		
COVID-19 Recovery and embedded key learnings	met	

Commented [KO9]: @Dianne Kerr

Commented [KO10R9]: Coloured cells in Column 2 Dianne

Executive Leadership Team (ELT) formalise process whereby WDHB provide safe alternate work-spaces for staff who have identified it is unsafe for them to work from home due to family harm. Paper provided for endorsement to ELT including procedure		

2.5.4 Improving mental wellbeing

Improving mental wellbeing by Expanding Primary Health and Addiction Support in the Community

WDHB supports the commitment to the transformation of New Zealand's approach to supporting mental wellbeing and ensuring that people are able to get the help they need, when and where they need it. This includes:

Enhanced support available in a range of settings, at no cost to the service user

Layers of support available for all people, based on what they need, including linking to ongoing support

Improved resilience and mental health, addiction and wellbeing outcomes for the DHB's population

Greater equity of access and outcomes – built on new ways of partnering – with Māori, Pacific peoples, young people and other population groups experiencing inequitable outcomes, no matter where you live in the rohe

Development of new and diverse workforces (including Kaiāwhina, Health Coaches and Peer Support Workers) to better respond to tangata whaiora / people's mental health, addiction and wellbeing needs wherever they live and work.

Action(s)	Q1	Q2
Implementing the second tranche of the Integrated Primary Mental Health and Addiction Services for General Practices including kaupapa Māori general practice.		
Expand range of General Practices that specialist Mental Health clinicians are working within		
Enhance range of health services offered by Youth One Stop Shop (YOSS) that meets the needs of our diverse community including Māori, Pasifika and Rainbow communities by partnering with other providers including Iwi and kaupapa Māori health and Māori community providers and specialist mental health and addiction services		

Improving mental wellbeing by Strengthening Specialist Services

Specialist services are essential for the health of tangata whaiora / people with complex or enduring mental health and addiction issues. WDHB is committed to seamless access to care between community services, primary care and hospital services and enhancing the range of supports such as peer support, group therapies and telemedicine.

The voices and stories of people with lived experience of specialist services, and their whānau, will be a central to decision-making to implementing change Balance providing a peer support worker as a tiered and universal added support for their existing service users.

Action(s)	Q1	Q2

Improving crisis response by scoping a peer-led community alternative to acute admissions		Partially met Balance providing a peer support worker as a tiered and universal added support for their existing service users.
Implementing Mental Health and Court Reviews through technology		
Extending the age range for specialist mental health service access for youth for 18 to 25 years to enhance access to more flexible and responsive services for the needs of this age group by youth and adult specialist mental health clinicians working in an integrated partnership approach		Not met. Too many vacancies within the service to be able to consider this at this stage.

The vision is to grow a sustainable, diverse and equitable, competent and confident mental health and addiction workforce		
Action(s)	**Q1**	**Q2**
Build understanding through workforce education based on data, including QLIK and analytics including senior medical officers	Partial – Power BI app data now available though data quality needs work, QLIK education undertaken by medical director, lockdown delayed session for full SMO group which will now occur in Q2.	MET
Engage medical clinicians with improvement projects including KPI, and HQSC initiatives	Met	
Includes Capacity Assessment in up-dated Mental Health Act training	Met	
All DHB staff working in mental health and addiction services attend cultural education which includes Hapai te Hoe, He Waka Hourua and addressing bias and racism training.		
Maternal mental health specialists provide intentional upskilling of all the district's general practice teams to include what services are available for mothers including community based kaupapa Māori services such as He Puna Ora.		

Commented [KO12R11]: thanks Jo, much appreciated

Commented [KO11]: @Joanne Stephen

Effective follow up of service users who have been discharged from inpatient services **The vision is all service users are followed up within 7 days of discharge. This follow-up is important for the prevention of suicide, self-harm, and other negative outcomes such as readmissions**			
Action(s)		**Q1**	**Q2**
All service users and their whānau receive a copy of their Transition Plan before they leave the inpatient unit following their Hui Whai Ora and the Transition Plan is communicated in a way that meets health literacy and equity standards.	partial Te Awhina Transition Plans completed by RMOs following Discharge Hui Whai Ora have been introduced. Recorded in service users electronic file with copy given to them. Currently using the Connecting Care Project to look at all forms with the Co Design Lens.		
Clinical Education (includes SMO and RMOs) has a focus on best practice for follow-ups and the importance of these activities being recorded electronically.			MET

Commented [KO13]: @Joanne Stephen

Suicide prevention Growing Collective Wellbeing: A whole of community – whole of system approach to the prevention of suicide within the Whanganui, Rangitikei Ruapehu rohe by increasing community wellbeing and to amplify and accelerate systems changes through stakeholders and community working together		
Action(s)	**Q1**	**Q2**
Work with and support Healthy Families Whanganui, Rangitikei Ruapehu to finalise the operating model and year one implementation plan for collective wellbeing.		

Section 29 To reverse the over representation of Māori compared to Non-Māori under the Mental Health Act Section 29		
Action(s)	**Q1**	**Q2**
WDHB will partner with MHOAG Māori health Outcomes Advisory Group Alliance (leaders of five kaupapa Māori provider organisations in the rohe) to progress Matauranga Māori research into the lived experience and whānau experience for Māori under Section 29 compulsory treatment orders (CTO), both those who have previously and do currently experience this form of compulsory treatment.		
A focus on supported decision making by senior medical officers with an expectation that they work closely with service user advocates, community based kaupapa Māori providers and Haumoana (WDHB Māori health service navigators).	Partial – service user advocates (lived experience present on inpatient unit and participate), however limited Haumoana availability and COVID lockdowns have impacted on the Hui Whai ora attendance as well as whanau attendance	Partial - Continue to be impacted by limited availability.

2.5.5 Improving wellbeing through prevention

Communicable diseases
activities within the WDHB district are provided by MidCentral DHB's public health unit (PHU), who are contracted by the Ministry of Health to provide Health Assessment and Surveillance services across the Manawatu-Whanganui region. Although these activities are provided by another DHB, WDHB works closely with the MidCentral PHU and is committed to supporting these activities and working collaboratively in communities across our district

Action(s)	Q1	Q2
COVID -19 Recovery Support: Ministry of Health (MoH) events sector voluntary code has been developed to outline how to safely deliver events by following best practice expectations, guidance and behaviours to prevent/reduce COVID-19 related risks. Public Health – Kaihoe Health Promotion will continue to focus on proven preventive measures and early intervention to ensure significant health gains from a population approach. Review, evaluate and make quality improvements to our large events and gathering initiatives Review & Evaluation Plan completed	MET	
Provide ongoing communication support to events happening throughout the rohe. Develop Quality improvements plan	MET	
Ensure a public health literacy approach over COVID-19 population health key information and preventative measures (provided from Ministry of Health). Ensure the community can obtain, process, understand, evaluate, and act on information needed to make public health decisions that benefit the community. New programme operational in community		PARTIAL Due to MoH guideline changes will need to review incorporating with new standards & requirements
Public Health COVID-19 information Resource		
MidCentral DHB Public Health Unit continue to undertake disease surveillance for Whanganui DHB by collecting, analysing and interpreting communicable disease data for the purpose of preventing, identifying and responding to existing and emerging communicable disease risks. PHU reports on communicable disease activity		MET
WDHB facilitate an awareness campaign in Māori and Pasifica communities of the link between streptococcus bacteria and rheumatic fever Awareness campaign delivered in Māori and Pasifica communities		

Environmental sustainability

WDHB has an ongoing commitment to ensuring that our actions consider environmental sustainability and that we seek to reduce our impact on the environment wherever possible.

Action(s)	Q1	Q2
Increasing use of video conferencing and virtual consultation to reduce patient and staff travel and reduce pool car usage. A key learning from COVID-19 is that a significant amount of travel is unnecessary. Monitoring fleet bookings and hours booked across the first 2 quarters of 2020/21 shows a steady decline in pool car usage. In addition there have been valuable savings on travel and associated costs (staff). This will continue as a focus in 2021/22. Limit staff travel by promoting virtual attendance where possible Monitor travel savings and fleet usage		
COVID-19 learnings: Prior to COVID-19, WDHB had adopted a Social Governance approach to collectively working with Iwi, community, social and government organisations to support the needs of our local communities. Our review from the rohe COVID-19 response to date has reinforced this approach and has been the catalyst for stronger relationships, ways of working and expectation for future partnership. Monitoring the implementation of He Hāpori Ora		
WDHB will meet their obligations under the CNGP, including readiness to report emissions from 1 July 2022 and set reduction targets and plans for 2025 and 2030. To achieve this WDHB will: engage an ECCA approved consultant under their Energy Transition Accelerator program to assist WDHB to transition away from using fossil fuel Develop data system monitoring		
Engage a company that specializes in converting coal boilers to a renewable resource for our Taihape site Report to be received and learnings actioned		

Antimicrobial resistance

Preventing antimicrobial resistance remains a focus for our health and safety team, driven by a multi-disciplinary infection prevention committee. Educational seminars are provided for health professionals to promote optimal use of antibiotics supported by best practice.

Action(s)	Q1	Q2
Infection Prevention and Control education is delivered to general practitioners via the PRHN monthly interprofessional forums. Information to promote optimal use of antibiotics supported by best practice is available via the WDHB intranet and staff are orientated as to where to locate this information.		MET
Increased hand hygiene gold auditors have been rolled out into the community health facilities	Met	

Commented [KO14]: @Grant Hood

Commented [KO15R14]: @Grant Hood please complete the up[dates against your name.

Commented [KO16R14]: @Kim Smith- These need to be done by grant immediately- thanks

Commented [KO17]: @kim smith – and this

Commented [KO18R17]:

Commented [KO19]: @Jacqueline Pennefather Shaded cells Jacq

AMR is a topic that is covered in the IPC study day. Immunisations are encouraged as part of AMR Develop targets to measure success of plan All areas have reached the required 80% of target		Met
Audit of antibiotic use in the WDHB occurs twice yearly. Continue education to primary care nurses and medical staff, de-labelling testing and patient education	Met	MET
Identify areas of focus in consultation with primary care and ARC for auditing to access compliance and antibiotic resistance rates		MET
Report result of audit of antibiotic usage to Clinical Governance 6 monthly		Met
Recommendations from the HQSC AMR surveillance audit will be implemented. Explore opportunities with Primary care services and ARC facilities to implement the antibiotic usage and point prevalence survey's (PPS)		
Extend the contract with CCDHB infectious diseases (ID) team so that all patients' SMO have access to ID advice and support if required. This is both inpatients and outpatients. New contract in place		Met
Equity is ensured through surveillance and identifying ethnic groups who are disproportionately affected by Methicillin-resistant Staphylococcus aureus (MRSA), Carbapenemase-producing Enterobacteriaceae (CPE), Vancomycin Resistance (VMR), C. difficile rates, TB (MDR), Drug resistant N. gonorrhoeae etc.	Met	
Reported to Clinical Governance board every 6 months		MET
AMR is a topic that is covered in the IPC study day. Immunisations are encouraged as part of AMR and this is expected to result in increased vaccination rates among the health workforce Monitor vaccination rates among health workforce	Met	Met

Drinking water A Drinking Water Technical Advice Service is co-ordinated through the health protection service within MidCentral DHB's public health unit (PHU). Note that MidCentral PHU covers the Manawatu-Whanganui region, incorporating the Whanganui DHB district.		
Action(s)	**Q1**	**Q2**
Mid Central DHB – PHU will ensure the supply of high-quality drinking water by undertaking drinking water duties as required by the Health Act 1956. Activities and associated reporting will be delivered in with the Drinking Water section of the Environmental and Border Health exemplar Narrative report on delivery against exemplar measures as per reporting template		MET

Commented [KO20]: @Karmin Erueti

Mid Central DHB - PHU to identify and develop improvement plans requirements for rural areas across Manawatu-Whanganui with a high proportion of Māori populations, to improve the quality of water supply Three rural communities and key stakeholders are identified		PARTIAL - As in accordance with the MoH Midcentral DHB has engaged with Taumata Arowai as the new water services for Aotearoa New Zealand. All rural communities under the MDHB Public Health Services rohe including Whanganui have been identified as key stakeholders in the service and will be consulted in all ongoing work. Taumata Arowai became the new drinking water regulator effective 15/11/2021
Three consultation completed and requirement identified		
Three improvement plans in place by 30th June 2022		

Environmental and border health

Environmental and border health is a public health function, provided to Whanganui district by the health protection service within MidCentral DHB's PHU. Note that MidCentral PHU covers the Manawatu-Whanganui region, incorporating the Whanganui DHB district.

Action(s)	Q1	Q2
MidCentral DHB's PHU will undertake compliance and enforcement activities relating to the Health Act 1956 and other environmental and boarder health legislation by delivering on the activities and reporting using the vital few report on the performance measures contained in the Environmental and Border Health exemplar	Met	MET
MidCentral DHB's PHU to review that Whanganui DHB has adequate and appropriate sufficient numbers of statutory officers and other health protection staff to carry out service delivery and capacity to respond to incident and emergencies 24 hours per day Review report completed		MET
MidCentral DHB's PHU to engage and work in collaboration with Whanganui DHB Emergency Planner and Māori communities during the review process for Whanganui Public Health Plans. (EOA) Review report completed		

Commented [KO21]: @Helen Connole

Healthy food and drink environments

WDHB is committed to promoting and leading implementation of healthier food and drink environments as a protective factor to preventing health loss in our district. Strengthening community responses and reducing health inequities requires a multifaceted approach engaging all sectors of the community for overall improvement in the WDHB rohe.

Action(s)	Q1	Q2

Public Health – Kaihoe Health Promotion to communicate and consult with all staff across the DHB about changes to local policy that will align with National Healthy Food and Drink Policy 2019 Implement changes to local DHB food policy in consultation with staff, that is consistent with the National Healthy Food and Drink Policy		PARTIAL Structural delays a brief in development to address any concerns
To ensure all new, qualifying funder contracts with health service providers include a clause that stipulates an expectation that they develop a Healthy Food and Drink Policy will be required to align with the Ministry of Health's *Healthy Food and Drink Policy for Organisations*. Full compliance confirmed		NOT MET Due to changes apart of the health reform
Continue to implement Healthy Active Learning (HAL): WDHB to engage with Sport Whanganui to develop a collaborative approach to deliver healthy eating and physical activity in schools, kura, kohanga reo and early learning services to create supportive environments priority populations and settings. Plan agreed and actioned		

Smokefree 2025

The ongoing commitment of WDHB to Smokefree 2025 will focus on reducing inequities in smoking prevalence, particularly for young Māori women (includes pregnant women, babies and their whānau). Working with the community through a co-designed approach, we want to build the foundation for supporting whānau across continuums and providing more support to targeted groups to quit and prevent uptake in a way that best matches their needs and aspirations.

Action(s)	Q1	Q2
Complete Needs Assessment to inform Tobacco Control planning, investment and commissioning of new services and activities contributing towards achieving a Smokefree Whanganui and the Government Goal Smokefree Aotearoa 2025. Needs Analysis Report completed and published by 31 December 2021		Partially Met Work underway
In collaboration with key partners develop an integrated Tobacco Control Strategic Plan to provide leadership, coordination and service development across all local Smokefree/Tobacco Control activities for the period 1 July 2021 – 30 June 2025 Tobacco Control Strategic Plan endorsed by MoH and Joint Boards Hauora ā Iwi and WDHB by 31 March 2022		
Facilitate a co-designed system change to address the fragmentation across the system with hapū mama (from conception to 6 weeks) at the core through the Tobacco Advisory Group, Well Child Tamariki Ora network, Primary Care and Maternal Governance Groups. Insights Report developed		

Commented [KO22]: @Ruphi Hermes Hi- call me if you are not clear on what is req'd, thanks, Kil

Commented [KE23R22]: Change this back to me please Kilian
Karmin Erueti

Commented [KO24]: @Karmin Erueti

Commented [KE25R24]: The lead for all these SF 2025 activities is Candace

Commented [KO26R24]: Done

Scope implementation plan based on feedback from Insights Report		

Breast Screening		
Action(s)	**Q1**	**Q2**
During the COVID-19 lockdown the Outreach Service was delayed which impacted on the uptake of screening across the region. In mitigation of the delay, the following actions will be undertaken: Proactive collaboration between breast screening programme and outreach services Ensure flexibility of appointments Support for Wāhine to attend appointments (EOA) Quarterly monitoring of increase in performance against national target	Met	Met
Focus on a campaign to raise the awareness within their population regarding the importance of screening, early intervention and early warning signs of cancer. Invest in Kaupapa Māori services – wraparound and support (EOA)		Partially met
Invest in a campaign developed with other stakeholders		
Monitor uptake screening locally against the national target of 70% (EOA)		Met
Increased focus on health promotion for priority population groups (Māori & Pacific) across community settings. Engage with local networks i.e. Samoan Churches, Pasifika Early Childhood Centre and schools, community events and Kohanga Reo Monitor improvement locally against the national target of 70% BreastScreen Coast to Coast equity role committed to support the local outreach team		
Raise awareness among whānau in the community – to encourage women to be screened including engagement of local champions in messaging Improvement in national target from 63.8% (Sep 20)		

Commented [KO27]: @Candace Sixtus

Cervical Screening (EOA)
WDHB is committed to a long-term strategic goal of being healthy at home with a priority that health care is accessible in the right setting and environment. Our integrated approach is expected to reduce barriers for women alongside robust health promotion and messaging which will support screening for priority group women (Māori, Pacific Island and Asian women).

The equity ratio is improving between Māori and non-Māori women eligible for cervical screening between ages of 25-69 years. Reduced from 1.12 in 2017 to 1.10 in 2018 to 1.07 in 2019 and 1.08 in 2020 (noting the impact of COVID-19)

Action(s)	Q1	Q2
Expand opportunistic screening outreach services in other settings including introduction of the mobile outreach service/bus to the community Increase access to screening after work hours Focussed support provided to general practices with the highest outstanding smears Invest in Māori screener training Expected outcomes are an improvement against baseline March 2021 performance of 2% (EOA) ***Baseline December 2020** **Ethnicity** / Screens completed / Population / 3 year coverage **Māori** 2,847 4,265 66.8% **Pacific** 248 377 65.8% **Asian** 510 750 68.0% **Other** 8,507 11,858 71.7% **All** 12,112 17,250 70.2% **The baseline is measured using available data in late 2020 or early 2021 from DHB colposcopy units.*		
Focus a robust health promotion on priority population groups (Māori & Pacific) such as through community events and networks i.e. Samoan Churches, Pasifika Early Childhood Centre and schools, community events and Kohanga Reo Develop simple, clear localised screening messages and information appropriate for Māori, Pacific and Asian women based on consumer survey feedback. Include raising awareness among tane in the community to encourage women to screening Invest more in successful local 'Smear your Mea' campaign across rural and urban districts Expected improvement against baseline February and March 2021 performance		
Access by priority groups to colposcopy services will be analysed, and an understanding of drivers of failed appointments will be developed. Using co-design principles with iwi, service providers and service users' barriers to access will be removed, with a focus on younger women where significant disparities in access exist. Improvement in equitable access to diagnostic and treatment colposcopies for priority groups referred with a high-grade result		

Reducing alcohol related harm

Alcohol contributes to a wide range of health and social harms, including injuries, road accidents, fetal alcohol spectrum disorder (FASD), long term conditions, cancer, violence and other crimes. Māori and people living in high deprivation areas face a disproportionate burden of disease due to alcohol availability and exposure, sale, supply and consumption. Preventing harm from alcohol is a priority, and cross-government collaborative strategies and actions are identified in the National Drug Policy 2015-2020 and 'Taking Action on Fetal Alcohol Spectrum Disorder 2016-2019'.

Action(s)	Q1	Q2
Public Health to lead and coordinate raising awareness of FASD and the risks of drinking during pregnancy to increase preventive and population health approaches within Primary, Secondary and Community Providers. Completed two FASD presentations within Primary Care, Secondary Care and Community Providers		MET
To scope, develop FASD training to support lead maternity carers and undergraduate midwifery students including: Te Pou's 'An Introduction to Fetal Alcohol Spectrum Brief Intervention Training' aligned with 5+ Solutions reducing alcohol related harm Local implementation of the FASD training		
Collaborate with MidCentral and police-led Controlled Purchase Operations (CPOs), to reduce sale of alcohol to minors within Whanganui DHB priority populations and settings. (Note: One CPO equals one total organised operation that targets a number of premises). CPO completed within Whanganui DHB.		MET
Strengthen WDHB partnership with MidCentral Health Protection Licencing applications procedure for all on-, off-, club, renewals and special licencing application within Whanganui DHB district. Include Whanganui Health Promotion within their checklist procedure ensuring a population equity health lens. Whanganui DHB established within the Licencing Application checklist procedure	NOT MET	

Sexual and reproductive health

Whanganui DHB is committed to ensuring access to sexual and reproductive health services with a focus on ensuring equitable access for Māori and rural communities

Action(s)	Q1	Q2
WDHB National Syphilis Plan shared with primary care clinicians on national syphilis screening guidelines for service delivery consistency. Education sessions delivered within the primary health care practices through up skilling of RMOs and GPs and practice nurses with annual updates provided. Improved syphilis referral processes form primary to secondary specialist's care with evidence of required clinical information		partially met, delivered a Syphilis education session with the RMOs in April/May 2021. We would also normally do

Commented [KO28]: @Chester Penaflor Update please Chester

Commented [KO29]: @Chester Penaflor ... and here, thanks,

		a WIPE session with the GP practices due to COVID this was unable to go ahead. spoken individually with some practice nurses and GPs
Increase access to sexual health services for Māori across the WDHB rohe. Focusing on the 15 -24-year-old Māori age group, increase service options through a kaupapa Māori sexual health service Scope kaupapa Māori sexual health service	NOT MET (working to engage with services but process has been delayed due to COVID	
HPV catch up programme completed for 15-24-year-old Māori 95% of all Māori clients aged between 12-24 will be screened and offered the HPV immunisation	Met	Partial SBHS met but not for over 18 y limited SBHS clinics in term 4 due to Covid-19
Develop pathway across primary secondary services to establish one contact point for gender diverse clients in the WDHB rohe: Develop the pathway	Met	
Review uptake		
Increase access to Pre-exposure Prophylaxis (PrEP) implement clinical guidelines in accordance with the NZ Sexual Health Society 80% of HIV presenting client receive PrEP	Partially MET (due to new sexual health guidelines to be implemented in November 2021)	

Commented [KO30]: @Karmin Erueti Hi- used to be Itayi- please advise??

Cross Sectoral Collaboration including Health in All Policies
Cross-sectoral collaboration is a cornerstone of Whanganui's strategic direction He Hāpori Ora Thriving Communities and the three strategic focus areas: Pro-equity, Social Governance and Healthy at Home: Every bed matters.

We are focusing DHB activity to have a clear community orientation and the DHB is strengthening its participation in cross-sector collaboration.

Health and wellbeing for the population of WDHB rohe is influenced by the wider determinants of health such as income, education, employment, housing and quality health care. Improvement in health status of those identified with disadvantaged determinants of health in the WDHB rohe can be prioritised and addressed through implementing collaborative cross sectoral approaches in population health and health promotion activities including community strategies, operational deliverables and influencing public policy in all levels (local, regional and national).

Action(s)	Q1	Q2
Thriving Together Impact Collective: The Integrated Recovery Team continue to engage with Whanganui DHB communities and undertake the analysis of the completed focus group sessions, community and organisational surveys. Complete the analysis report		NOT MET. Completion of analysis report delayed due to impact of Covid-19 in Quarters 1 & 2 and challenges with recruitment of resource to support the project. Revised date of 30th June 2022 now in place for completion of report and other milestones.
Identify insights, including COVID-19 learnings		
Report to the WDHB and HAI joint boards		
Whanganui PHU will utilise a HiAP approach to enhance and improve equity and health outcomes in planning processes with Whanganui district councils, Regional council and other agencies (e.g., Police, MSD, iwi) including active transport, urban planning. Kaihoe health promotion maintains relationship and engagement in Safer Whanganui. Provide leadership and support to community partners for health promotion activities	MET	
Development of the Safer Whanganui HiAP project plan		NOT MET Due to Covid 19 light system established and WDHB were in the Red Zone meetings WDC postponed meetings until the New Year
Implementation of the plan		
Scope and determine public health – health promotion cross sectoral collaboration opportunities with a focus on determinants of health, particularly in rural centres (Marton, Taihape, Ohakune, Raetihi and Waiouru) Scoping report completed	NOT MET due to prioritising scoping report	

Commented [KO31]: @Ben McMenamin

Commented [KO32]: @Karmin Erueti

Engagement with community Project identified and plan developed	(Imms 0-5 yrs)	

2.5.6 Better population health outcomes supported by strong and equitable public health and disability system

Delivery of Whānau Ora WDHB Vision, Mission and Strategic Focus Areas (Pro-equity; Social Governance; and Health at Home) are all underpinned by the DHB's commitment to whānau-centred care and whānau-centred services. Our organisational whakatauki is 'Ko au ko toku whānau, ko toku whānau ko au: Nothing about me without me, and my whānau/family'. WDHB's approach to whānau-centredness has been reinforced from the key findings from reviewing the COVID-19 response. Our communities expect us to work with iwi, across sectors and agencies, to provide equitable services as close to the communities as possible. Services that recognise and build on potential and are strength-based and whānau-led.		
Action(s)	**Q1**	**Q2**
Implement recommendations from the WDHB Kaupapa Māori Services Commissioning Review to ensure that kaupapa Māori contract documents support, recognise and enable the delivery of whānau ora and are: Enablers for equitable outcomes for Māori An enabler for sharing consented information across agencies Supportive of kaupapa providers to build and maintain capability and capacity to design and deliver services Aligned across agencies e.g. DHB, Te Puni Kokiri and Whānau Ora Commissioning Agencies		MET
This approach is endorsed by the Māori Health Outcomes Advisory Group (MHOAG). Kaupapa Māori commissioning process is completed in partnership with MHOAG. Implementation commenced		
In conjunction with the Whanganui rohe Collective Impact Group and Māori providers, localise the whānau ora outcomes framework using the seven elements of Whānau Ora. Outcomes framework developed and agreed Ensure provision of information for Māori whānau meets the guidelines for health literacy.		
	Partial	Partial

Commented [KO33]: @Candace Sixtus

Care Capacity and Demand Management (CCDM)		
Action(s)	**Q1**	**Q2**
Key results : Implementation 87% as at June 2021		
Key actions: Governance The governance and operational meetings are well structured and well attended. This is in a partnership approach with unions.	Met	
Patient acuity data The patient acuity data and tool (TrendCare) is well embedded and utilised throughout the hospital. IRR testing is done yearly with good compliance and data accuracy. TrendCare champions have been set up as per last year's annual plan.		
Core data set Core data set measures are in place moving towards an embedded local data council within wards/units. Data is transparent and accessible through 'Power BI'. These are discussed at ward meetings, minutes to reflect evidence.		
Automation of CCDM core data sets: CCDM measure have been automated for 'live' and easy accessibility to all staff Areas of opportunity Local data councils to be embedded in towards/units as business as usual **Variance response management** Fully implemented. Reporting methodology has improved with the use of live data. Formal weekly and monthly reporting is in place and under constant review. Staff are deployed daily to support patients' needs and this is controlled through the operations meeting and duty manager leadership.		
FTE calculations Continue CCDM FTE Methodology. Endorsed by executive. 6 FTE calculations have been completed Q4 2021 Maternity requiring an FTE increase. Executive agreed to implementation. 2.03 FTE (actual) required in maternity and to be recruited to, recruitment of midwives remains a challenge.		

Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025 The WDHB's Pacific population remains at around 3% of the total population with 55% currently living within our rural communities. The development of a WDHB Pacific Health Action Plan will outline priorities which align with our own strategy He Hāpori Ora, Thriving Communities where we work together for the wellbeing of the whole community.		
Action(s)	**Q1**	**Q2**

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Develop in partnership with Pacifica communities a WDHB Pacific Health Action Plan that is culturally responsive Implement the plan	Not Met- Discussions underway to develop Plan	

Health outcomes for disabled people Ensure disability represented in all strategy and workforce planning within the DHB		
Action(s)	**Q1**	**Q2**
Establish an Executive Lead for disability		
Establish working group led by the Executive Lead for disability. Ensure Māori representation in working group proportionate to the population and includes representation from consumers. Group established		
Develop a disability action plan for the DHB action plan is complete and written in accordance with Te Tiriti o Waitangi principles		

Planned care Whanganui DHB will continue with our Three-Year Planned Care Plan, supporting the overall vision of planned care "New Zealanders receive equitable and timely access to Planned Care Services in the most appropriate setting, which supports improved health outcomes"		
Action(s)	**Q1**	**Q2**
Planned Care Three Year Plan action Strategic Priority #1 Improve understanding of local health needs: Use the results of the post-COVID-19 consumer engagement surveys to highlight community preference Engage meaningfully with our community and iwi to understand what and where services will meet their needs and aspirations of health care Gap analysis of where we need to implement service and model of care change. Service model design in a co-design environment with stakeholders including community care partners, service users and iwi		
Strategic Priority #2: Balancing national consistency and local context Development of service delivery options and models of care in a co-design environment Maintain delivery rates that are consistent with national standard intervention ratios Assessing models of care and how these are delivered in context of our local community Define options for requisite adjustments, ensuring a focus on the equity impacts of changing delivery		

Understanding and documentation of: where our services vary from nationally delivered, impacts on equity and access service change required CONTRIBUTORY MEASURE – STANDARD INTERVENTION RATES FOR SURGICAL SERVICES		
Strategic Priority #3: Support consumers to navigate their health journeys Planned clinics around telehealth options for patients, including access in rural localities etc: Increase in remote consultation through video conferencing rather than patients, whānau or staff having to travel. Engagement and process taking into account cultural values and practices including options for whānau hui Introduction of wider suite of telehealth options for patients and clinicians included telephone, secure video conferencing and supported remote clinics. CONTRIBUTORY MEASURE – SECONDARY CARE SERVICES - PATIENT EXPERIENCE OF CARE		Project manager vacancy
Strategic priority #4: Optimising sector capacity and capability Deliver services in least intensive setting – continue to review what procedures can be undertaken in outpatient and community settings where patients have fewer barriers to access. Work with secondary services, general practice and community providers to shift volumes Assessment of what services can be moved to community provision, and understanding of patient preferences Shift of delivery including contracting with providers		
Strategic Priority #5: Ensure the Planned Care system and supports are sustainable and designed to be fit for the future Understanding of where early intervention will make a difference to outcomes for patients Develop pathways that reduce reliance on secondary services. Engage with stakeholders including SMO's, primary care and community services. Develop and assess potential pathways and service delivery plans including changed location and mode of delivery Moving service delivery including service development and funding options		

Commented [KO37]: @Katherine Fraser-Chapple

Acute demand

Whanganui DHB is committed to strengthening pro-equity through partnering with Māori and other partners in care to develop systems for ongoing service improvement to manage acute patient flow across primary & community, and emergency care in secondary services, reducing demand for acute services. This will be achieved and enhanced by implementing the findings from the Integrated Response Team Report - Community Engagement findings.

Action(s)	Q1	Q2
Acute Data Capture: SNOMED data will advise WDHB on improving health pathways for long term conditions e.g. diabetes, respiratory conditions that could be managed in the community with a focus on equity. WDHB continue to develop plans with MidCentral Health and Waiarapa DHBs and will introduce SNOMED standards with careful planning and change management	MET	met
Acute Hospital Bed Days per Capita Acute hospital bed days is a measure of acute demand and patient flow across the health system. It is about using health resources effectively and maximising the use of resources for planned care rather than acute care and addressing inequities. Develop and implement childhood asthma pathway Embed Best Start Tool across general practice		
WDHB will continue to streamline patient flow between emergency department presentations, and lower acuity urgent care. The focus will be on implementing the Hospital Patient Flow Plan. Working closely with partners in care across the system. Streamline triage processes in ED		
Continue to develop streamlined processes and protocols for early identification of patients that are likely to be an acute admission with direct referral from GP and fast tracking them to a ward and specialist team		
Explore the potential to expand the interprofessional disciplinary resource in ED		
WDHB to work in collaboration with Primary care partners to develop appropriate and timely diagnostic access pathways Redirect appropriate patients from ED to Whanganui Accident & Medical		
WDHB to work in partnership with Primary care to Implement COPD/Asthma health pathways and associated programmes of care. Embedding changes to COPD management through revision of cross systems approach; Health pathway development completed		
Implementation of health pathway and associated programme of care including socialisation and linking of Kaiawhina and Clinical Nurse Specialist role, and ambulance services		
COVID-19 Response - Improvement to acute flow in respond to COVID-19 recovery Post community engagement develop pathways to support community response for vulnerable and deteriorating patients in the community in partnership with iwi, Primary care and NGOs.	MET	
Continue to enable clinicians to deliver care using virtual consultations		
Explore the feasibility of expanding a Clinical pharmacist's role to focus on outreach for intermediate care patients in rest homes.		

Explore funding models to enable a more preventative model of care in primary care at first point of contact. e.g. MSK to reduce unnecessary diagnostic imaging/specialist referrals.	MET	
Through prioritising and developing MSK pathways using a co-design methodology		
Development of a frailty pathway, led by general practice, using a co-design approach with Māori, Pacifica and secondary services to recognise and respond to frailty.		
Primary care partners to take a lead in promoting frailty screening at all touch points with health and social care providers to identify patients most likely to present as an acute admission and provide proactive advice and information to prevent admission.		
Avoid unnecessary hospital admission and improve population health outcomes in partnership with primary health care, strengthening support in the community		
Support the PHO to create a new community wellbeing hub to ease the burden of a diminishing GP workforce and divert volumes of inappropriate urgent care away from accident and medical service		
Support primary health care providers to establish connector roles to guide and enable patients in managing their own health and social needs and reduce the likelihood of acute presentations e.g. MSD Community connector roles		
Strengthen urgent care services across the district focusing on access and equity in-hours and after hours Work with PHOs and general practices to embed a redesigned model for urgent care Continue to develop community transitional models of care, using service redesign with partners in care, social services, and NGO's i.e "wrap" around patients discharging who require greater support at home and short-term reablement services		
Continuing to embed gout programme (refer to SLM, Appendix 1) Refer 2.5.7 Primary Care Refer 2.5.7 Pharmacy		
Mental Health presentation to ED: Improve access to mental health services and wait times for patients requiring mental health and addiction services who present to ED or who access community-based providers:		
Appoint a 0.4 FTE Educator role in Emergency Department		Not met due to staff shortage issues
Continue to provide support and education to the staff in the Emergency Department (ED), engaging with Māori and Pacific health leaders in the development		
Delivery and evaluation of the education programmes		
Explore opportunities for non-clinical staff to undertake the Mental health foundation MH 101 training		
Identify and develop resources to support training and education for staff and tangata whaiora who present to ED		
Improve access to Community Mental Health Crisis Team through supporting and monitoring telephone crisis service		
Improve access to services through ethnicity and cultural competence training and inclusion of Māori models of health and wellbeing in service planning and delivery		
Explore establishing a pilot which will have a Mental Health Clinician located with the local Police to improve responsiveness to patients in crisis		

Rural health

Approximately 40% of WDHBs population live in rural settings across a relatively large geographical area across the rohe. WDHB is committed to addressing the needs of rural populations and to improve access to a range of services in these areas through enhanced integration of services and increased use of technology, in partnership with our communities.

Action(s)	Q1	Q2
Waimarino (EOA) Continue to support community led and engagement with iwi, staff and community providers for the redesign of the Waimarino Health Centre, (Wellness Centre), building on work undertaken to date that supported greater integration and enhanced models of care to improve access to health and support services for the Waimarino community Progress service redesign and models of care as part of finalising the Wellness Centre facility design, including telehealth facilities		Met
Telehealth for Rural Communities Continue to improve access to telehealth service through increased use of telehealth for rural communities based on Clinical and Patient Telehealth experience survey findings. Identify and address any barriers for patients/family/whānau to accessing telehealth Measure and monitor the access rates to telehealth services, and associated improvement in appointment attendance and health outcomes for rural communities		
Community/Specialist nursing Implement recommendations from review of specialist nursing teams working with primary care Explore development of community-based rehabilitation programmes that will be self-sufficient to support those with LTC focussed on Māori and Pacifika. Support the use of Telehealth for GPs and Nurse Practitioners to complete case reviews via virtual consultations.		

Commented [KO38]: @Jennie Fowler Q2 only jen

Commented [KO40R39]: @Jevada Haitana

Commented [KO41R39]: @Alex Kemp This needs to be resolved- can we put something in here?

Commented [KO42R39]: @Jevada Haitana Hi- last one of everyone- Met/Partial/ or Not Met??

Commented [KO39]: @Jevada Haitana

Implementation of the Healthy Ageing Strategy 2016 and Priority Actions 2019-2022: Aging Well

WDHB's goal is a whole of system approach for our population from prevention and wellness through actively promoting the LifeCurve approach to improve the populations aging journey by adding 'years of able life'

Action(s)	Q1	Q2
Strengthen the Healthy Aging Service Level Alliance integrate with the district's Councils' Positive Aging Forums, engage with Māori and Pasifika communities and intentionally include younger people, aged from 30s onwards Develop a messaging campaign based on the LifeCurve for the promotion of prevention and wellness	Partial	Partial

Commented [KO43]: @Andrea Bunn Just a heads up

Implement the recommendations of the WDHB Falls Service Evaluation focus on prevention of injury from falls		Partial
Community services that serve older people are fully prepared for a pandemic outbreak: Expand telehealth roll out to include Aged Residential Care providers Identify and engage with local aged residential care providers who are early adaptors of telehealth and use of the WDHB telehealth solution with these providers first.		
Develop and implement a coordinated district wide Advance Care Planning/Serious Illness Action Plan based on the DHB's strategy Includes consistent messaging and communication plan for vulnerable people by using ACP communication tools especially during COVID-19 pandemic		Partially Met. Preliminary plan finalised, COVID has disrupted progress but work underway again now
Implement the COVID-19 Contact Assessment as appropriate for the district's vulnerable populations	Met	
Fully implement the Mini-ACE as the cognitive impairment screening tool		
Engage with key kaupapa Māori providers to be early adopters of the cognitive assessment tool MANA for Māori Support people with dementia who have behaviour and psychological symptoms of dementia, their whānau and services have access to behaviour consultation at the right time		Met
Acute and Restorative Care The DHB will have an integrated system across primary, community and specialist services care for older people and their whānau with a restorative/rehabilitation partnership approach beginning at discharge and including Māori and kaupapa providers Implementing the new home and community support services, ensuring meeting the needs of Māori Implementing Non-Acute Rehabilitation Pathways Adapt to change based on the learnings from the WDHB pilot of an Integrated Discharge Navigator role with a focus on equity		

Health quality & safety (quality improvement)		
WDHB are working with partners in care to develop system level measures to improve the quality and safety of the services we deliver. Preventing antimicrobial resistance remains a focus and this is driven by a multi-disciplinary infection prevention committee. Our work is informed and shaped by the values and belief systems of our community.		
Action(s)	**Q1**	**Q2**

HQSC QSMs are monitored and results are available on the national dashboard, first upload 31 March 2021(EOA)	MET	
monitor ethnicity variations and develop plans to improve equity where inequities are identified action plans are developed where results are below the national average	MET	
Use data gained from the national inpatient survey to drive quality improvement activities. action plans are developed where results are below the national average		met
Monitor and measure the consumer engagement quality and safety marker (QSM): progress the actions of the WDHB consumer engagement review 2020	MET	
continue to engage with consumers and apply co-design principles in all service improvement activities.	PartialCo-design limited by Covid and reconfiguration of consumer group Te Pukaea	Partially met Consumer Council formed
Reducing seclusion Staff continue to work in a trauma informed way		
Improve use of sensory modulation, as evidenced through increased episodes Use of Māori sensory modulation kits Evaluate the effectiveness of this intervention.		Partially met HQSC project underway
Continue to monitor the national KPI for seclusion hours and events		met
Service transition Monitor the implementation of the connecting care project Effectiveness of the transition role from Community Mental Health & Addiction Services to General Practice		met
Integrated Discharge Navigator Monitor effectiveness of the collaboration with key stakeholders to influence and remove barriers to discharge		
Adverse events Continue to undertake CSA/RCA/Case/London Protocol review for all SAC1/2 adverse events		met
Enact learnings and recommendations from adverse events to improve practice		

Te Aho o Te Kahu – Cancer Control Agency

Te Aho o Te Kahu is a stand-alone departmental agency hosted by the Ministry of Health reporting directly to the Minister of Health. These new arrangements provide the foundations for strong central leadership and oversight of cancer control, and better recognise the impact that cancer has on the lives of New Zealanders.

Te Aho o Te Kahu is equity-led, knowledge driven, person and whānau-centred and outcomes focused, taking a whole-of-system focus on preventing and managing cancer. Our commitment to the goal of achieving equity is central in all Te Aho o Te Kahu processes and work programmes.

Cancer is the leading cause of death in New Zealand and presents unique challenges to the health system. The number of people diagnosed with cancer is projected to double in the next two decades, the costs and complexity of care and the pace of change present major challenges for our system and services. Cancer survival is improving in New Zealand, but our rate of improvement is slower than other comparable countries, so we are at risk of falling behind.

When diagnosed with cancer, survival is poorer for Māori than for non-Māori. Te Aho o Te Kahu is committed to an equity first approach to our work. This will ensure improved health outcomes for those disadvantaged.

Whanganui DHB will continue to work with Te Aho o te Kahu and the regional hub on the implementation of the New Zealand Cancer Action Plan. This will be in conjunction with MidCentral DHB as our regional cancer treatment service and Capital and Coast DHB as our tertiary partner.

Action(s)	Q1	Q2
New Zealanders have a system that delivers consistent and modern cancer care – He pūnaha atawahi		
Whanganui DHB will work with Te Aho o Te Kahu to plan and implement the adoption of the cancer-related Health Information Standards Organisation (HISO) standards, to be issued via Data and Digital, Ministry of Health Our DHB will demonstrate evidence of implementation and compliance of the HISO standards as they are rolled out starting with the published Cancer Multi Disciplinary Meeting data standard, by ensuring all required patient data is presented to the MDMs as appropriate and any variances are identified and issues corrected.		
New Zealanders experience equitable cancer outcomes – He taurite ngā huanga		
Whanganui DHB will participate in Te Aho o Te Kahu travel and accommodation project that aims to improve cancer patient equity of access and support to cancer services/treatment for local and for inter-district patient flow. Our DHB is committed to implementing the recommendations of this project, particularly those that ensure equity of access for Māori and rural communities who currently experience inequitable access to cancer services.		
Whanganui DHB will identify at least two actions specifically to address inequity of health outcomes and access to diagnosis and care for Māori and Pacific patients. Consider Te Aho o Te Kahu report and recommendations based on feedback from 15 Māori community hui and agree an action plan. The findings from these huis will also be used to develop the future model for cancer services in Whanganui, with a focus on developing services that are culturally safe for Māori. Whanganui DHB will facilitate locally driven community-based initiatives with cancer patients and their whānau to drive service improvements. This includes the continuation of our "deep dive" case studies where clinical case review is linked with patient experience interviews to give a 360 degree view of the patient	met	

journey. This will inform our ongoing service design. This is led by our Māori health team and sponsored by our Faster Cancer Treatment steering group.		
New Zealanders have fewer cancers – He iti iho te mate pukupuku		
Whanganui DHB will undertake activities that address the modifiable risk factor for cancer as referenced in the following sections 2.5.7 Tobacco Control 2.5.10 Reducing Alcohol Related Harm 2.5.6 Healthy Food & Drink		
Whanganui DHB will also support an increase in activities and programmes aimed at improving Māori and Pacific participation in National Screening Programmes as referenced in the following sections 2.5.8 Breast Screening 2.5.9 Cervical Screening 2.6.10 Bowel Screening		
New Zealanders have better cancer survival, supportive care and end-of-life care- He hiki ake i te o ranga		
Whanganui DHB will continue to implement and report progress against our Bowel Cancer Service Improvement Plan (Bowel Cancer Quality Improvement Plan, 2020; Bowel Cancer Quality Improvement Report, March 2019). Whanganui DHB will build the five recommendations from the Bowel Cancer Service Improvement Plan into our work plan for the 2021-2022 year including: Review of patient cases where death occurred within 90 days of colorectal surgery, with the aim of identifying contributing factors and patterns in the patient journey; Development of enhanced pre-surgery assessment and education plans for those patients identified in the at risk group; Ensuring the specific needs of Māori and Pacific people and their whānau are included in our wider DNA programme – aimed at increasing attendance and improved patient journeys through engagement and education.	Not met- Due to Covid	
Revise and update our DHB Bowel Cancer Quality Service Improvement Plan following publication of the second national bowel cancer QPI's results in quarter 3 2020-21.		
Develop a DHB Lung Cancer Service Improvement Plan based on the results of the Lung Cancer Quality Improvement Monitoring Report (QPIs 2020) and the impending national Lung Cancer Quality Improvement Plan (2021). Lung cancer has been identified as a significant equity issue for Whanganui with incidence rates for Māori being significantly higher than non-Māori and health outcomes for Māori being significantly poorer (due to a combination of factors including late presentation and access barriers to out of region diagnostic and interventional services. As a result of this the Lung Cancer Service Quality Improvement Plan will incorporate a strong equity focus, identifying how service access and delivery can be improved for Māori specifically. Whanganui DHB will select the QPIs where our DHB is outside the national average (underperforming) to drive improvements. This includes low uptake of systemic therapies for both small cell and non-small cell cancers where we are below regional and national rates. WDHB is developing a local chemotherapy facility in		

conjunction with the Regional Cancer Treatment Service that will improve accessibility of systemic therapy to Whanganui domiciled patients.		
Develop a DHB Prostate Cancer Service Improvement Plan based on the results of the impending Prostate Cancer Quality Improvement Monitoring Report (QPIs 2021) and the impending national Prostate Cancer Quality Improvement Plan (2021). Whanganui DHB will select the QPIs where our DHB is outside the national average (underperforming) to drive improvements. Prostate cancer rates are higher for Māori than non-Māori and health outcomes for Māori are typically poorer. As a result of this the Prostate Cancer Service Quality Improvement Plan will incorporate a strong equity focus, identifying how service access and delivery can be improved for Māori specifically.		
Whanganui DHB will ensure that the 31-day and 62-day cancer treatment wait time measures are met. Our DHB will implement service improvements to improve timely access and demonstrate effective engagement with Māori, Pacific, our consumer network (Te Pukaea) and other key stakeholders that support local improvement initiatives. This work will be facilitated by our Faster Cancer Treatment Steering Group. We will work in partnership with Te Aho o Te Kahu and Ministry of Health to improve the FCT data quality and business rule changes as required		
Whanganui DHB will plan to implement the cancer COVID-19 guidance developed by Te Aho o Te Kahu should there be a COVID-19 resurgence to ensure minimal impact on cancer diagnostics and treatment services for patients/whānau		

Bowel screening and colonoscopy wait times		
Action(s)	**Q1**	**Q2**
Continue to monitor and report on performance against urgent, non-urgent and surveillance colonoscopy waiting times		
Include 'recommended and maximum wait time performance' as a standard agenda item at monthly endoscopy user group meetings. Identify and implement mitigations strategies		
Develop a Bowel Screening COVID-19 policy that includes a communication plan to inform internal and external stakeholders of changes to bowel screening during a COVID-19 outbreak Develop and distribute messaging to community		
Ensure 95% of bowel screening participants who return a positive FIT have a first offered diagnostic date that is within 45 working days of their result being recorded in the NBSP IT system Ensure no equity gap for Māori and Pacific populations (EOA)		
Ensure at least 60% of eligible bowel screening population participate in the programme, Ensure no equity gap for Māori and Pacific populations (EOA)		

Review bowel screening participation rates and bowel screening colonoscopy wait time results by ethnicity (Māori, Pacific Island, Asian, Other) at bowel screening equity working group meetings. Identify and implement mitigation or service improvement actions (EOA)		
Facilitate the delivery of health promotion activities identified through the bowel screening equity working group, the bowel screening communication and engagement plan, and the bowel screening equity plan. (EOA)		

Health workforce

Whanganui District Health Board is committed to operating within its means and providing sustainable health services that meet the needs of our community. The WDHB is committed to strengthening our workforce and ensuring a sufficient and sustainable supply of skilled workers to deliver high-quality health services in a timely manner, driving equity and system improvement. As an equal employment opportunity (EEO) employer the WDHB is committed to further increase and develop an inclusive workforce.

The WDHB works in partnership with primary care, Māori health organisations, community health organisation and unions to support achieving equity in health outcomes for Māori and across communities.

Embracing diversity and expanding our pro-equity actions creates the foundation of our workforce plan. Recruitment, retention, development and supporting the Māori workforce are the key elements of the workforce plan. This is supported by workforce planning to:
Anticipate and predict future workforce requirements to meet changing strategic direction.
Respond to emerging models of service delivery as part of the ongoing strategic planning of the organisation.
Highlight and respond to potential workforce risks to the organisation.
Plan workforce changes required.

Applying an equity lens to all workforce actions, including an explicit focus on addressing bias, racism and discrimination, in all its forms, across all aspects of the WDHB operations underpins our actions.

Our focus on cultural safety, the health and wellness of our staff, growing leadership and embedding the values of our organisation in our work remains a priority in 2021-22.

New ways of working, providing support for vulnerable people and workers and improving our preparedness for a pandemic outbreak (and COVID-19 resurgence) are front of mind in working towards protecting our communities and services.

Action(s)	Q1	Q2
2.5% increase in Māori workforce across the region		
WDHB staff turnover rate for Māori staff is less than turnover for all staff		
Increase the proportion of Māori in the WDHB workforce to 13.5% in 2021/22.		
100% of Māori applicants who meet the minimum eligibility criteria for any role are shortlisted for interview	MET	
Planning - *Whakamaua* Develop a forecasting model to guide target determination and monitoring to grow a Māori workforce across the health district Development of a workforce planning guide with specific outcomes that support retention strategies for Māori staff		
Scope Māori workforce capacity and capability WDHB and contractor provider services		
WDHB recruitment and retention is aligned with Kia Ora Hauora, YES kaupapa, Rangatahi focused pathways – Ara ki te mahi Hauora		Met
100% of Māori engaged in study to mahi initiatives with Youth Employment Success programme and Kia Ora Hauora are offered career progression support by Te Hau Ranga Ora		

Commented [KO44]: @Hentie Cilliers Hi h- shaded cells in column 2, ta

Education committee leads workforce development plan to support students from kura kaupapa and kura auraki entering health careers		
Kinesthetic/small group learning is promoted as a different method of delivering science programmes in local schools		
Implementation of identified actions to talent identify, attract, develop and grow the Māori workforce across the WDHB district		
Explore opportunities to support Māori staff beyond nursing and utilise the model and learnings from Te Uru Pounamu		
Introduce a new model of support for Māori Nursing staff that encompasses all levels of nursing practice.		
NETP/NESP continue to use an accelerated approach to employment of Māori nursing staff		Met
Nursing recruitment has an accelerated process for Māori applying for Nursing/Health Care Assistant positions		
Review support provided to students/graduates regarding cultural safety, whānau centred care and values		Partial
Clinical staff demonstrate cultural safety competencies in their annual performance appraisal and competency review		
Develop Whānau Ora nursing models of care which are tailored to individuals and their whānau including community settings		
Expand existing programmes that build on organisation culture and values to include action on racism and institutional bias, support Whakamaua Action Shifting Cultural Norms and enable employees to reflect on how their own views and biases impact on their clinical interactions and the care they provide to patients	Partial – COVID impact completion of this action	
KPI's for clinical leaders are evident in WDHB Patient and whānau Centred Care Quality Framework. Seventy percent of current professionals meet standards of cultural competence and safety		
Leaders/managers have yearly performance reviews that assess how they have supported Māori into the workforce and into leadership/management roles.		Not met
Managers and leaders actively use pro-equity tools/data to ensure the care we are providing is whānau centred and supports a community centred approach to care delivery – sustainability		Partial
Committee leads workforce development plan, education and professional development pathways.		Met
Continue to work alongside central region to standardise programmes, education and training opportunities		

Partner with regional DHBs and learning institutions to deliver training		
Workforce development plan incorporates priority areas in the He Hāpori Ora Thriving Communities Strategy and MoH Raranga Tupuake – Māori Workforce Development Plan		
Workforce plan developed for clinical staff across the region - Population Health Outcomes/Union Engagement		
Determine specific action plans at HUB/Service level to implement COVID learnings (i.e. staff redeployment, repurpose and mobilisation)		
Clinics using collaborative workforces are planned, in community settings, rural areas and up the Awa to ensure that communities who are isolated and/or high decile can access COVID vaccination. Measurable by uptake of vaccination by ethnicity, decile and geo code.		
Leaders/managers have yearly performance reviews that assess how they have supported Māori into the workforce and into leadership/management roles		
Māori nurse leaders are supported to attend Ngā Manukura o Āpōpō	Met	
Review support provided to students/graduates regarding cultural safety, Whānau centred care and values		Partial
Cultural Supervision available for Māori staff once employed	Met	

Increase the number of health and safety representation from the various areas in the WDHB.		Not met
Develop a local health and safety strategy aligned to the national DHB approach.		
Sustainable workforce – health and safety wellbeing, including mental wellbeing Trialling an occupational health Clinical Nurse Specialist role for 9 months to support health and safety and return to work.		

Data and digital enablement

Whanganui DHB is committed to digital transformation to enable new ways of health service delivery in response to changing technology and clinical needs. Our digital goals align with the national and regional strategic direction for Data and Digital.

New initiatives will follow our strategy of Cloud First with Infrastructure and Software as a Service as the default. This will improve access, timeliness and having data available at the right place. Cloud based systems will provide tools to empower our staff and give us the ability to better manage our infrastructure, security and compliance and enable us to respond more quickly to changing business requirements.

Business Intelligence tools will allow us to present our data to provide better insights into our business and the automation of manual tasks will assist in optimising a right sized workforce.

Action(s)	Q1	Q2
Microsoft Office and Teams Progress report quarterly to updated Microsoft Office and Teams rollout project MS 365 E5 providing collaboration tools and access from anywhere on any device. Promotes working remotely. Provides advanced threat protection features. Microsoft Telephony (Cloud) with Vodafone to replace the PBX system improving communication with chat and desk to desk video. All staff working in Office 365 rather than on previous Office products Decommission the old PBX with all staff using MS telephony Project rollout complete which will enable: Opens new collaboration channels with primary and community across the sector through use of "Teams". Promotes telehealth through desk to desk video, improved access to service for patients and whānau Enables improved working remotely for staff Reduces the need for staff to travel for regional and national meetings Follows national recommendations to move to cloud. Has the potential to create the conditions for equity through facilitating the design and delivery of services that impact on equity of health outcomes for Māori, people living rurally, people with lived experience of disability or for other people who face barriers to their access of health services.		MS 365 E5 licensing applied to all users Old PBX switched off and being decommissioned All staff now working with office 365
Telehealth The activities outlined below have the potential to improve access to services by providing choice for remote consultation through video conferencing (Microsoft Teams) rather than patients, whānau or staff having to travel. Further it will improve digital inclusion for our communities and support the COVID-19 recovery by improving digital inclusion: Report quarterly to update progress on roll out of the Telehealth system A Telehealth solution has been built with DXC integrating workflow in the regional webPAS system with Microsoft teams. Work with clinicians to realise value from the solution		Project Manager for Telehealth still to be found.

Increase uptake of telehealth improving access for rural communities and primary and secondary clinical collaboration		
Electronic referrals and triage Phase 1 will ensure completion, legibility and standardisation of referrals by supporting GP's to provide accurate and relevant referrals. Phase 2 will remove the manually intensive effort and reduce risks associated with the current processes and align with Regional and National transfer of care, and also supports collaboration with primary and community: Implement electronic referrals and triage Phase 1 - an electronic referral form is available to GPs from within their GP practice systems and to other providers via a portal. The referral is sent to the DHB who continue with their manual practice. Phase 2 – automation of the triage and associated workflow at the DHB with integration into webPAS and Clinical Portal		Provides eReferrals from GP to DHB
• Enable Health services to support COVID-19 Move off webPAS as our booking/scheduling system for COVID 19 vaccinations onto the national booking/scheduling system once integrated to CIR Identify and action digital initiatives that been delayed by COVID-19.		
• Develop strategies that will ensure that there is no delay in initiatives owing to COVID-19		
Data enablement The rollout of Microsoft 365 to the organisation has enabled whole of organisation access to PowerBI, Microsoft's flagship business intelligence tool. Continue to develop and deploy PowerBI reporting to improve business intelligence. Include comprehensive Care Capacity Demand planning, analysis of activity across provider services, dashboards to inform executive management and reporting to the board. Expand ability to dynamically calculate age standardised rates within PowerBI deliveries. This will enable the DHB to monitor equity at a level never possible before. Increase volume of PowerBI reporting, examine impact on aging SQL Server Reporting Services delivery. Where possible, replace functionality of static SQL Reporting Services deliveries with rationalised, user-driven content.		
Key deliverables within the 2021/22 year (with target quarter for delivery): Peer review of age standardisation process with external expert to gain endorsement of new approach Q1		
Delivery of additional reporting to WDHB via PowerBI:Q3		
Workforce including sick leave, turnover, education, workforce trending, etc.Q1		
Quality, Risk and Patient Safety Q3		

Radiology Services Q2		
Inpatient Waiting List Q3		
Outpatient Services including referrals, activity, etc. Q3		Almost complete
DHB Financials Q1		
Expansion of CCDM delivery to include workforce and quality markers Q1 Implementation of new age standardisation process across all applicable reporting to enable one-click equity comparisons and insights Q3 This lays the foundations for much improved collaboration with our primary care partners. Creation of a semantic layer across many of our complex DHB datasets will facilitate consumption of that data by a wider audience and more rapid delivery of intelligence.		
Integrated deliveries will allow an improved lens to be applied to support the acute demand programme across the whole system and provide decision support for required changes.	Requires uptake by PHO	
Key deliverables within the 2021/22 year (with target quarter for delivery) are: Establishment of data sharing foundations with the PHOs for integration work Education of primary data analyst workforce within PHOs on DHB data sources Scoping of deliverables to inform improved view of acute demand within WDHB Development of outputs for analysis and decision support		

Implementing the New Zealand Health Research Strategy

WDHB will build and strengthen pathways for translating research findings into policy and practice. Research and innovation, analytics and technology are all crucial for achieving an equitable, sustainable health system and better patient outcomes.

Action(s)	**Q1**	**Q2**

WDHB commits to working with the Ministry of Health to co-design and co-invest in a programme of work to support the implementation of the New Zealand Health Research Strategy through building the capacity and capability across DHBs to enhance research and innovation.		
WDHB's research policies and procedures will be used to provide clinical staff with a supportive framework to engage in research and innovation activities. The patient safety, quality and innovation team will continue to provide support for staff engaging in research and quality improvement activities.		
WDHB will follow a research strategy which has an equity focus with clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes. This includes sign off of all research applications by a member of Te Hau Ranga Ora, Māori Māori health service. A WDHB research strategy is used, including approval by Te Hau Ranga Ora WDHB will work alongside Māori stakeholders (researchers, iwi, hapū, groups and communities) to develop an 'ara' (pathway) for Hauora Māori research. This is included within the research strategy.	Met	
WDHB will provide an annual update on progress to the WDHB Clinical Board.		
Work within local alliance structure to support establishment of community focused, kaupapa-oriented research collaborative.	Met	

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2.5.7 ..... Better population health outcomes supported by primary health care

Primary care Community health pathways are prioritised and implemented based on equity, acute demand and national work programmes. Learnings from the GoutSTOP programme (to improve the quality of life of Māori living with Gout Arthritis) will inform changes in how we improve the quality of life of Māori living with COPD/Asthma.		
Action(s)	**Q1**	**Q2**
Through implementation of an updated digital strategy in primary care, greater connectivity will occur with secondary care with the ability to work remotely and support virtual consultations.		
Implemented planned roll out new general practice and urgent care PMS (Evolution) Implement links with DHB e-referrals Migration of existing PMS systems Education and training	Partially met Q2 – all practices now onboarded	
Implementation	Ditto	Met
Iterative changes as issues arise	Ditto	Met
	Ditto	Met
The GoutStop Programme was rolled out across the WDHB region in late 2020-21. Ongoing focus and support is required to ensure the programme is embedded across the region including: Monitoring of general practice data to enable iterative changes to improve the number of Māori males receiving regular uric acid testing. Monitoring of TUKU data (patients enrolled in the programme by pharmacists and referrals to kaiawhina) to enable improvements of process/patient journey to support patients and to achieve target uric acid levels.		
	Met	Met
Monitor gout programme data		
Implement district wide community education, communications plan and resources Establish a gout consumer group to inform any changes to current programme and resources	Met	
Implement and embed COPD/Asthma health pathways and associated programmes of care building on learnings from GoutStop programme Health pathway development completed Embedding changes to COPD management through revision of cross systems approach		Not Met – Identified for phase 2 of CFOP commencing Q3
Revise associated programme of care including;		

Identify gaps in existing services Co-design a revised program of care to support improved health literacy and self-management Build and socialise cross functional teams working in partnership to support individual and whānau		

Pharmacy care Pharmacy is a critical component of an integrated health and disability system spanning primary and secondary care with clinical skills and expertise that supports people centred care for improved outcomes.		
Action(s)	**Q1**	**Q2**
Immunisation is a significant component in the effort to protect our community from serious diseases including influenza, measles and COVID-19. Pharmacy provides a skilled workforce well placed to increase opportunities for immunisation Support training and development of the pharmacy workforce to increase the number of community pharmacies providing vaccinations 40% of community pharmacies (currently 3/14) will become vaccination providers		
The GoutStop Programme was rolled out across the WDHB region in late 2020-21. Ongoing focus and support is required to ensure the programme is embedded as a pharmacy service. Build relationships between key stakeholders including general practice, community pharmacy, Māori Providers and the Kaiawhina Monitoring of TUKU data (patients enrolled in the programme by pharmacists and referrals to kaiawhina) to enable improvements of process/patient journey to support patients and to achieve target uric acid levels. Identify opportunities for hospital pharmacy to identify inpatients with gout and socialise the programme Increased % of Māori with good gout management		
Implement COPD/Asthma health pathways and associated programmes of care COPD model of care confirmed and establishment commenced Asthma model of care confirmed		
Establish mental health pharmacist role that works across primary and secondary care including medication management Position recruitment completed		Partial – position advertised but no responses. Intern filling role and will be developed as experience grows.
Explore the feasibility of expanding a Clinical pharmacist's role to focus on outreach for intermediate care patients in rest homes		

Commented [KO45]: @Megan Geertsen Hiya- Met/Not Met??

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Reconfiguration of the National Air Ambulance Service Project – Phase Two Cabinet have endorsed a two-phased 10-year reconfiguration of the national air ambulance service. Phase one is complete, preparation for phase two has begun. DHBs are expected to actively support and participate in the above project, led by the National Ambulance Sector Office (NASO).		
Action(s)	**Q1**	**Q2**
WDHB is committed to actively participating with the National Ambulance Sector Office (NASO) in phase two of the reconfiguration project and will identify a nominated person to participate in project meetings and workshops. Participation will support NASO to develop a service that is optimised to improve clinical effectiveness and standards and achieve better patient outcomes for our population.		
	Met	
DHB lead identified Ongoing engagement and participation in the project	Met	MET

Long term conditions		
Action(s)	**Q1**	**Q2**
Review the Green Prescription service model to ensure the programme is targeted to priority groups (pregnant women, Maori, Pacific with diabetes, rural communities)		
Review Cardio rehab programme including relocation to a central location to target priority groups Review complete		Partially Met
Implementation of programme		
Strengthen identification, intervention and recall of people with high and moderate risk through early risk assessment and use of PHO/practice level data to inform quality improvement and more equitable access to services. Power BI data supports general practice teams to utilise data for quality improvement. COVID-19 learning is utilisation of data to identify the most vulnerable population to inform roll out of vaccination programmes including for COVID-19 vaccination. COVID-19 Vaccination programme underway	PM All rural practices and WRHN largest urban practice on boarded and vaccinating. Covid vaccination data provided through powerBi and broken down by age and ethnicity by practice is utilised to support practices in proactively contacting patients	

▪ Continue to embed and monitor the GoutStop programme is an example of use of data to improve the quality of life for person living with gout arthritis - Monitor gout programme data	Met	Met
Improving the management of people with long term conditions through actions such as those provided by multi-disciplinary teams (including allied health and kaiawhina) to support improved service delivery in primary care, with self-management, equitable access, identification and prioritisation of high-risk groups, support and education. The GoutStop Programme was rolled out across the WDHB region in late 2020-21. Ongoing focus and support is required to ensure the programme is embedded across the region including: Monitoring of general practice data to enable iterative changes to improve the number of Māori males receiving regular uric acid testing. Monitoring of TUKU data (patients enrolled in the programme by pharmacists and referrals to kaiawhina) to enable improvements of process/patient journey to support patients and to achieve target uric acid levels. Monitor gout programme data Implement district wide community education, communications plan and resources - Establish a gout consumer group to inform any changes to current programme and resources	Met Met	Met
Supporting the delivery of the regional hepatitis C work and objectives and supporting implementation of key priorities in the National Hepatitis C Action Plan (once the plan is published). Localised Hepatitis C pathway to be developed		
Pathway developed and implementation commenced		
Continuation of vaccine programme for people over the age of 65 & vulnerable populations Ongoing vaccination programmes including COVID-19	Met	
Implement and embed COPD/Asthma health pathways and associated programmes of care building on learnings from GoutStop programme Contributory measures: Ambulatory Sensitive Hospitalisation (ASH) rate per 100,000 population for 45-64 years, by ethnicity All general practice will meet or exceed national target of 75% for >65 years for influenza vaccine Health pathway development completed		Not Met – Identified for phase 2 of CFOP commencing Q3
Embedding changes to COPD management through revision of cross systems approach		
Revise associated programme of care including; Identify gaps in existing services Co-design a revised program of care to support improved health literacy and self-management Build and socialise cross functional teams working in partnership to support individual and whānau		

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END OF REPORT

Whanganui District Health Board

Public

Combined Statutory Advisory Committee

March 2022 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Discussion Paper**
	25 March 2022
Authors	Kath Fraser-Chapple, Chief Operating Officer Maurice Chamberlain, Director of Nursing Ian Murphy, Chief Medical Officer Alex Kemp, Chief Allied Professions Officer
Subject	**Provider Arm Services**

Recommendations

Management recommends that the Combined Statutory Advisory Committee:

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

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

Appendix 1. Whanganui DHB Performance Dashboard and definitions

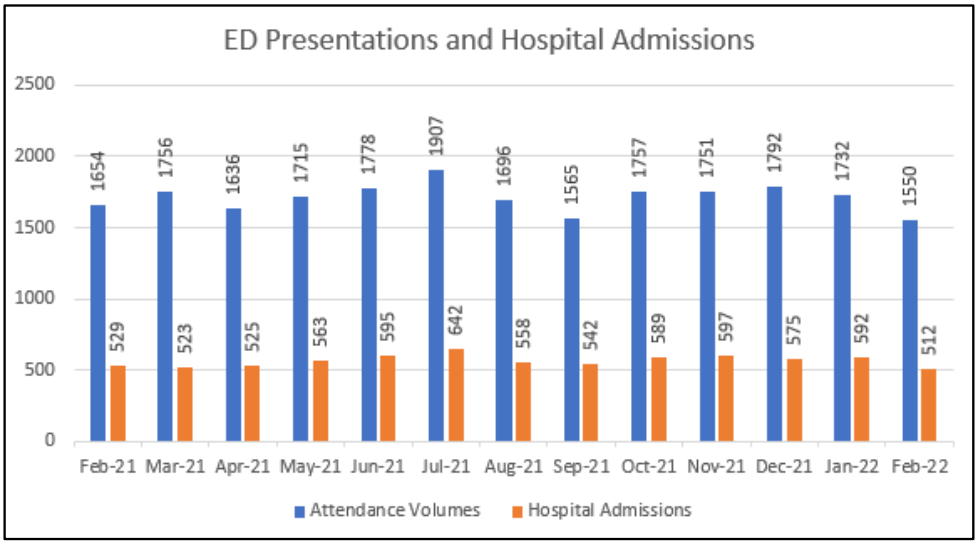
1 Purpose

To provide the Committee with a high-level overview of provider arm services; operational performance is noted for the month of February 2022.

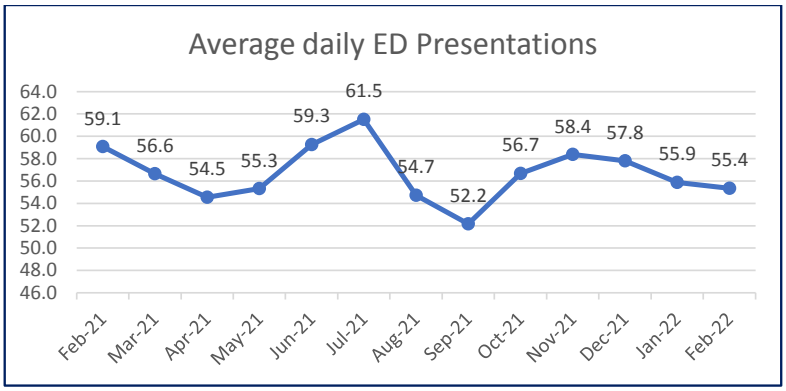
2 Hospital and Clinical Services

2.1 Service Delivery

Emergency Department Attendance Volumes



*Data extracted from WebPAS through PowerBI 10.03.22; Hospital Admissions are excluding 3-hr ED admits.

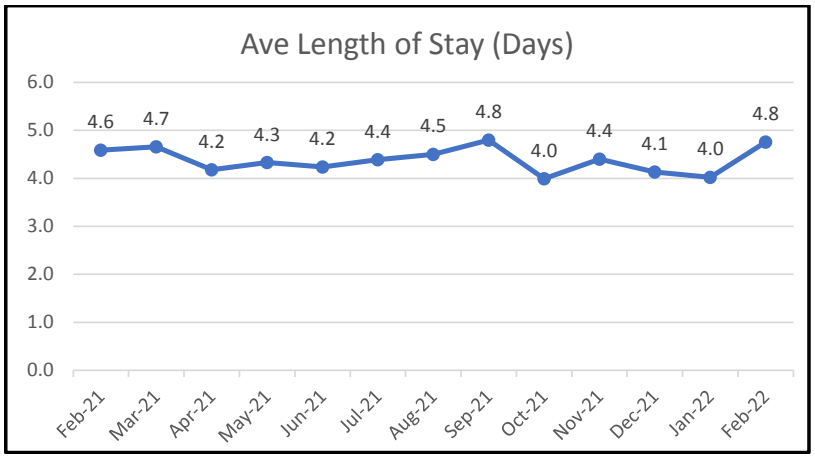


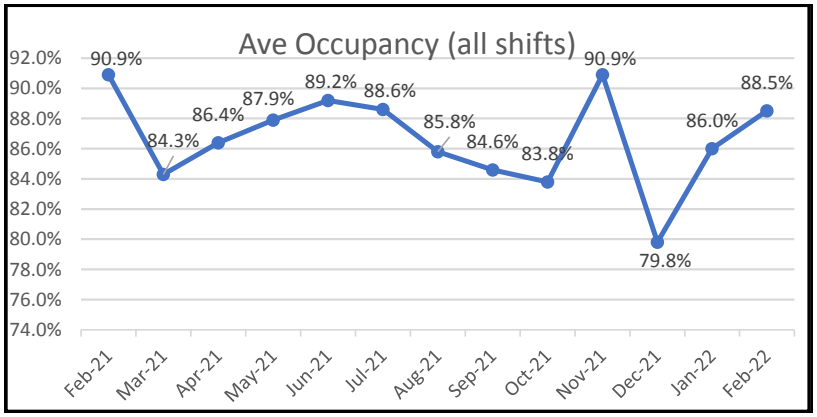
*Data extracted from WebPAS through PowerBI 11.3.22

Over the past 12 months, the percentage of presentations to ED that identify as Māori has remained steady at 25% to 28%, and Pacifica at 2% - 3%.

Hospital data

The following data includes the inpatient units of AT&R, Paeds, CCU, Medical Ward, SCBU, and Surgical Ward.





** Data extracted from WebPAS through PowerBI 11.03.22 (note that due to a data glitch when compiling the Latest WDHB Board report, the occupancy figures differed from 0.5% – 4% and are now corrected)

Acute Readmission Volumes **	AT&R		CCU		Medical Ward		Surgical Ward	
	Jan	Feb	Jan	Feb	Jan	Feb	Jan	Feb
48-hour	1	0	1	1	5	5	7	3
7 day	1	3	3	1	12	11	14	13
14 day	2	0	1	1	7	10	10	7
28 day	3	3	1	1	15	5	9	8
Total	**7**	**6**	**6**	**4**	**39**	**31**	**40**	**31**

**Data extracted from WebPAS through PowerBI 11.3.22; February figures may not reflect the total 14 day and 28 day readmission volumes.

Māori Acute Readmission Volumes **	AT&R		CCU		Medical Ward		Surgical Ward	
	Jan	Feb	Jan	Feb	Jan	Feb	Jan	Feb
48-hour	0	0	0	1	1	0	4	0
7 day	0	0	0	0	4	0	4	4
14 day	0	0	1	1	0	0	3	2
28 day	0	2	0	0	2	1	2	0
Total	**0**	**2**	**1**	**2**	**7**	**1**	**13**	**6**
Percentage of total acute readmissions	0%	33%	17%	50%	18%	3%	33%	19%

**Data extracted from WebPAS through PowerBI 11.3.22; February figures may not reflect the total 14 day and 28 day readmission volumes.

Clinical Services and Planned Care

A project manager has been appointed for the Sterile Services Department (SSD) equipment tracking system. This T-DOC system will enable tracking of reusable clinical equipment across services and patients.

In Patient Scheduling, the implementation of new systems and processes is ongoing following the completion of the booking systems review. Staff and SMOs have sought union involvement; final processes are in progress.

A review of pre-admission processes including patient assessment has been undertaken in conjunction with Outpatients and Theatre staffing; the review will be shared with stakeholders and ELT for consideration.

CCDM

Care Capacity Demand Management (CCDM) Programme provides a set of tools and processes that help district health boards better match the capacity to care with patient demand. This is currently used across nursing areas, and there is expansion into other departments and services. FTE calculations have been completed for the calendar year January to December 2021 for inpatient clinical areas - Medical, Surgical, ATR/ASU, ED, CCU, Paediatrics, Maternity, Te Awhina and Stanford House. The outcome was used inform budgeting planning for 2022/2023 financial year, with a small increase of less than 10 FTE.

The results of the calculations will have been submitted to the Whanganui DHB Executive Leadership Team for approval at the time of this CSAC meeting.

2.2 Quality Improvement

Quality Audits

A DAA audit for colposcopy will be undertaken in May; the self-assessment phase has commenced.

The results of the Bowel Screening Programme audit by the DAA is pending.

3 Primary and Community Services

3.1 General Overview and Highlights

The team have been placing most of their efforts in COVID-19 response, as well as continuing to provide care to the community. There continues to be increasing referrals across services, which causes challenges in those services providing input across community and inpatient, especially with an ongoing 10% vacancy rate overall. This has increased the urgency of needing to develop integrated models of care, both across services within the DHB and with primary care, NGO and iwi health providers.

There was also a focus within Allied Health and Scientific this month with preparation for the planned PSA Allied, Public Health and Technical Strike that was planned for 4 March. 138 DHB staff were eligible to strike with almost 100% indication of participation in the strike. Plans were established to cover essential services for this 24-hour strike, with some disruption to planned care, school dental clinics and outpatient clinics anticipated. The strike was cancelled on 3 March following a court injunction. PSA and DHBs continue to be in facilitation with no further strike notice anticipated whilst this continues.

3.2 Service Delivery

Omicron Resurgence Planning

The focus on integrated care with Primary Health Services for those most likely to experience poor health outcomes from COVID-19 continues, with 3 community facing workstreams involving staff from Primary Care as well as WDHB Primary and Community services.

The workstreams are

- A virtual hub with wraparound care for GP services, led by Whanganui Regional Health Network where DHB staff support this model of care
- Community Assessment Team to ensure integrated care for people with more complex health conditions, to avoid hospital admission
- Supported Discharge from hospital, to enable earlier successful discharge from hospital and avoid readmission

There has been increasing work to identify critical staffing shortages, clinical areas of most need and shared agreement for workforce redeployment across services. As such COVID-19 resurgence plans are being completed across the following areas.

- Whole of rohe Mental Health and Addictions Services across Inpatient, Community and Women and Child Health, NGOs and Iwi Health providers.
- All therapy services across the DHB (Social Work, Occupational Therapy, Speech Language Therapy, Physiotherapy, Dietetics)
- Community Assessment Team and District Nursing
- Pharmacy whole of community

Teams are also providing specialist training to other services to support specific help for patients with COVID-19, for example NG tube feeding regimes from Dietetics and positioning support from Physiotherapy.

Virtual Clinics

There is an increase in use of care at a distance enabled by telehealth, which is being rolled out as hardware arrives. It is anticipated all hardware to enable telehealth will be delivered by mid-March, with IT support identified to support use of this.

Of note the following services are now provided virtually

- Dietetics is now providing virtual outpatient clinics across all areas including rurals
- Triaging for District Nursing is now virtual
- The majority of Community Mental Health has moved to virtual

3.3 Risks/Mitigations

The Service as a whole continues to carry 10% vacancy, which has been relatively consistent for the last 6 months. It is of note that Community Mental Health is carrying a 20% vacancy, with vacancies here and in radiology likely to impact on rostering.

Supply issues are impacting on staff time, specifically in District Nursing, Dietetics and Pharmacy, as alternate options are sorted and risk mitigation occurs. Increased resources in services is being sought to support this

In District Nursing, there are limited staff available to complete syringe drivers/chemotherapy. All staff have been asked to complete online training for base skills, and targeted training will occur for an increased number of staff in March.

Pharmacy has been very short staffed, with the team having to significantly prioritise. Issues across Community Pharmacies are impacting on hospital services and vice versa, so a whole of community response to this is being actioned.

4 Maternal, Child and Youth Services (MCYS)

4.1 General

Since the writing of our February report to the Board, the Covid-19 Omicron variant has entered our community. The Public Health team is responding well and working with the Care in the Community Hubs to support our community.

Other MCYS teams are preparing for the impact of Covid in their areas, whilst maintaining business-as-usual to deliver services. Teams are also assisting in the development of the all-of-DHB redeployment plan. It is a challenge for managers to keep up with the frequent changes to models of care.

The MCYS remains focused on further establishing contact pathways between our services and the community. Unfortunately, the Whanganui Maternal, Child and Youth Community Alliance hui scheduled for March has been postponed due to the Omicron outbreak. We plan to run this hui as soon as it is safe to do so in an ‘in-person’ environment. The focus of this hui is youth health.

Workstreams stemming from the Primary and Maternity Interface Group are progressing despite the impact of Covid-19, but output may reduce if key staff are redeployed during the Covid response. These projects include the service guide for women, community directory of services and optimisation of the Best Start tool. We expect the Healthy Families Hapū Māmā Village project insight report in June.

The Immunisation Steering Group is shifting from an operational focus to a governance group including primary and community partners. Working is progressing to develop the governance group structure.

The Single Point of Entry project has progressed to job offer stage. Project resource is still being finalised for the Oral Health Review.

4.2 Service Delivery

Maternity

A second opportunity for LMCs to attend a specifically designed one-day Hāpai te Hoe programme has been arranged for 29 March, following postponement of the September 2021 date due to Covid-19. Seven LMC's have registered to attend.

The first Midwifery Forum for 2022 was held this month, with many LMC's attending the online platform. The main topic of conversation being Covid and the frequent changes to plans and information from the Ministry of Health (MOH).

Since the February report to the Board, Maternity FTE has improved slightly with the recruitment of 1 new graduate midwife and a further 2 nurses with previous maternity experience. However, maternity is still not staffed to budgeted FTE and recruitment plans are ongoing. A retention package for current core midwives was approved by ELT and will be funded out of the positive variance to budget due to unfiled vacancies.

In addition, ELT has also approved an unfunded 0.6FTE administration position to support the hospital run midwifery antenatal clinic for women who can't secure an LMC. This will ensure the midwife running the clinic can focus on midwifery care.

The Clinical Coach role has been appointed to, with the successful candidate commencing in February. This role supports staff undergoing return-to-practice requirements, new graduates and internationally qualified midwives. We also have four new midwifery students who commenced training through our satellite school with Otago Polytechnic. Two of these students are Māori and local to our rohe.

We have also successfully recruited a second midwife for Waimarino, with the tentative start date of March 2022. Her whakapapa links and connections to the area will be invaluable to Raetihi and the wider community.

The Newborn Early Warning score (NEWS) roll-out commenced in February. All maternity and neonatal staff, including LMCs, are completing NEWS online training.

The MOH has mandated that DHBs have an electronic maternity system. The HISO coding standards must be in place by June 2023. This will be challenging to do without an electronic maternity system/database and therefore gives us a timeframe to work towards for implementing a suitable system. This is a large project requiring significant investment and resource. A decision paper is being prepared for ELT to inform leadership and request approval to start the project.

Paediatrics

Nil new to report following the February Board report.

Public Health

As we are recently into the new school year, our public health team are actively engaging with ECEs and schools, whilst continuing to keep abreast of the continually evolving Covid Care Plan. With the arrival of the Omicron variant in the community, Public Health's primary focus will once again be on pandemic management. The team are communicating with schools about the impact of this on service delivery.

The Te Kōhanga Reo public health nurse role has progressed to contract draft. We are transferring the role to kaupapa Māori services - Te Oranganui.

Maternal Infant Child Adolescent Mental Health and Addiction Services (MICAMHAS)

The MICAMHAS team are planning how they will continue to provide services in a Covid environment, including use of Telehealth, as well as how they can support Mental Health Services across the DHB.

Scheduled conversations around access for to acute inpatient services for youth have been put on hold due to the impact of Omicron but will be rescheduled and progressed as soon as possible.

Oral Health

Our community Oral Health service will continue to operate in the pandemic environment as directed by the Dental Council and the Ministry of Health. A decrease in performance is expected due to schools being less willing and able to engage, and the anticipated impacts on the oral health workforce when staff become unwell. Oral Health forms a part of the staff redeployment plan for Hospital and Clinical services; their clinical skills may be required in key areas.

4.3 Future Focus

We will run our first Whanganui Maternal, Child and Youth Community Alliance hui once we are well through the Covid peak and able to return to BAU.

The second of Four Midwifery Forum Meetings for 2022 is scheduled for 24 May.

Options to address acute inpatient mental health service capacity issues for our rangatahi is on the workplan.

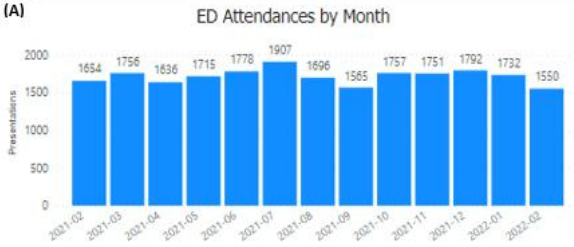
Work streams coming out of the Primary and Maternity Services Interface Group continue, most of which are anticipated to take another 8-14 months to finalise.

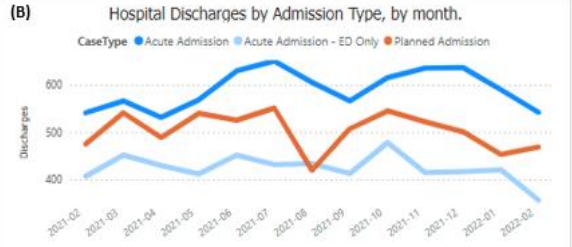
March 2022 **Public**

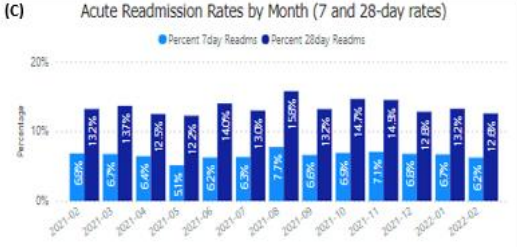
Appendix 1. Whanganui DHB Performance Dashboard

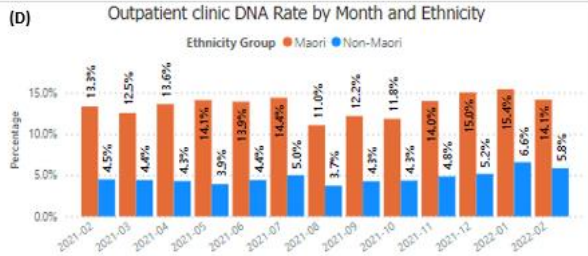
(data extracted 14 March 2022)

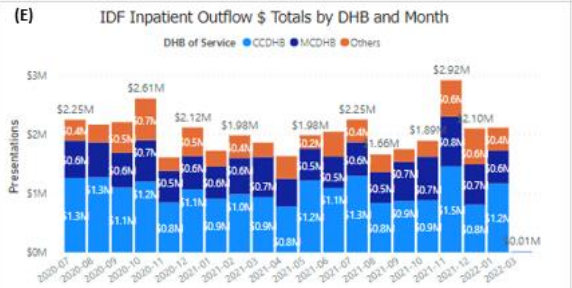
Hospital Based Care Measures

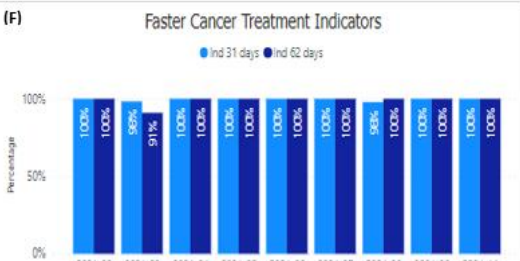




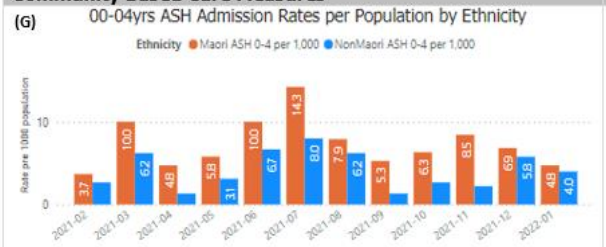


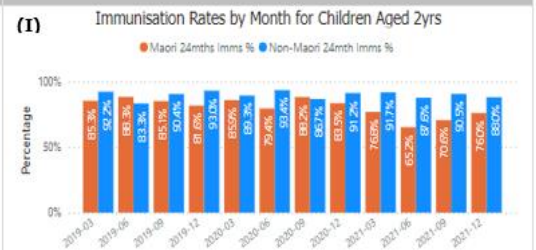




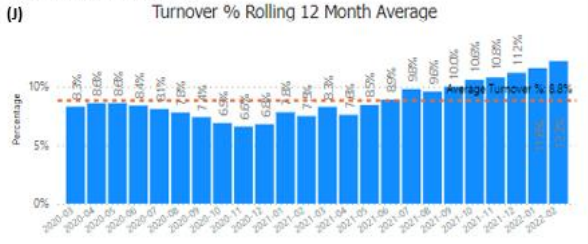


Community Based Care Measures





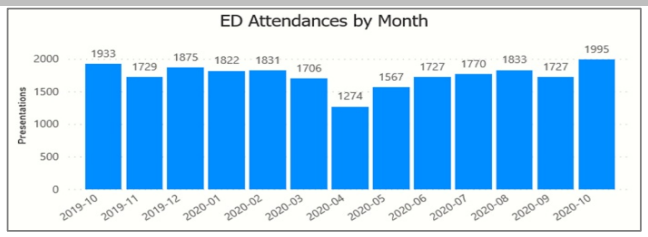
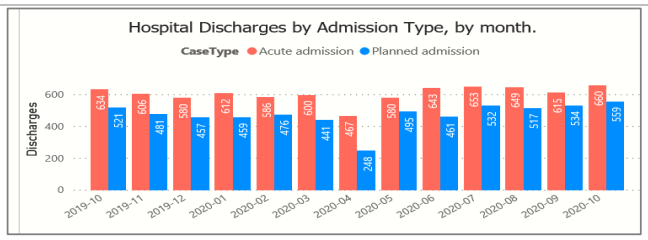
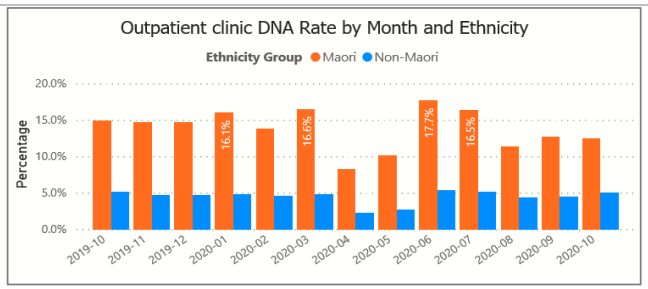
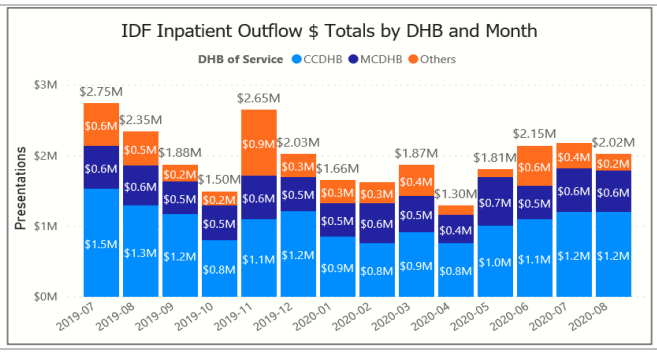
Workforce Measures



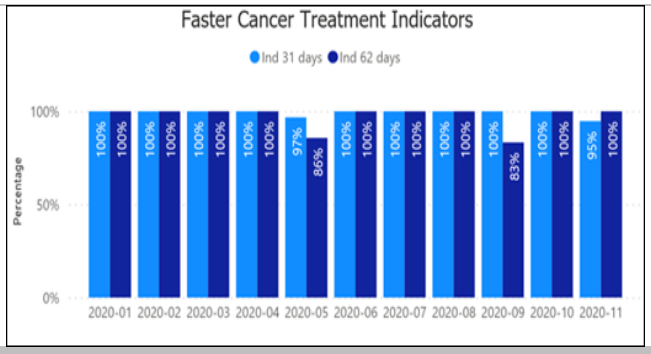
Quality

March 2022 **Public**

Whanganui DHB Performance Dashboard definitions.

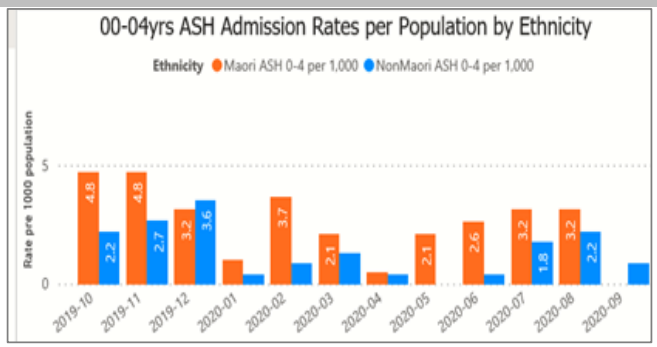
Hospital Based Care Measures	
Graph A. ED Attendances ED attendances are an indicator of acute patient demand in the system, while also identifying issues in access to primary care and potential flow issues in secondary services. **Calculation**: count of attendances.	
Graph B. Hospital Discharges Throughput of hospital-based services. This is an indicator of patients through the system as opposed to occupied beds. **Calculation:** count of patients discharged from inpatient events, and includes day stay patients in all services.	
Graph C. Readmission Rates This is the percentage of all patient discharged that return to hospital acutely within 7 and 28 days of discharge. Readmissions can be for any reason, not exclusively related to the previous event. **Calculation:** Denominator = patients discharged Numerator = patients acutely re-admitted within 7/28 days	
Graph D. Outpatient DNA Rate DNA rates indicate where we have access issues to outpatient services. Significant disparities exist between rates for Māori and non-Māori indicating equity issues in access to services. **Calculation:** Denominator = total patients seen Numerator = missed appointments	
Graph E. IDF Outflows Total value of IDF outflows to main DHBs for each month. This is a dollar value, so increasing prices need to be considered when comparing years. **Calculation:** Dollar value of services provided by other DHBs to WDHB.	

Graph F. Faster Cancer Treatment
Patients identified as high suspicion of cancer on referral receiving treatment within 62 days (further information provided within the paper).

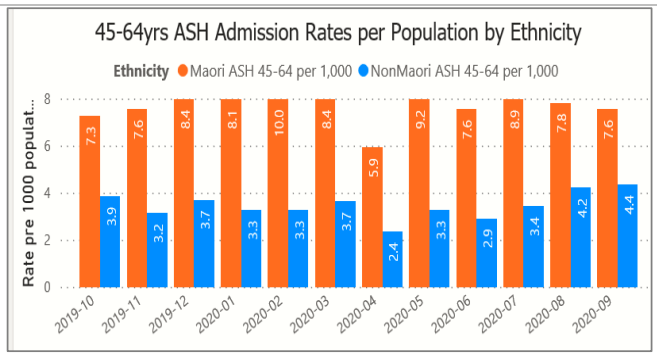


Community Based Care Measures

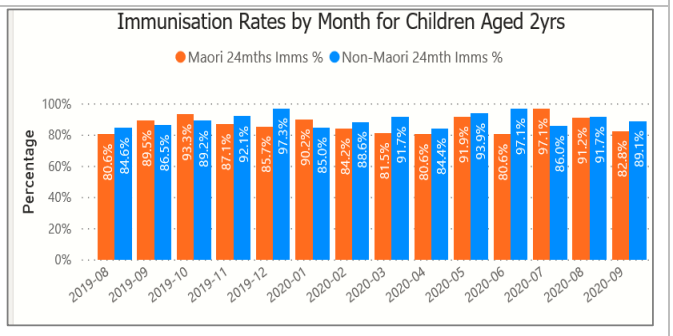
Graph G. ASH Rates 0-4 years
ASH rates are a measure of avoidable hospital admissions (Ambulatory Sensitive Hospital admissions) per 10,000 population. Significant disparities exist between rates for Māori and non-Māori indicating equity issues in access to services.
Calculation: admissions per 10,000 population for a range of standard conditions.

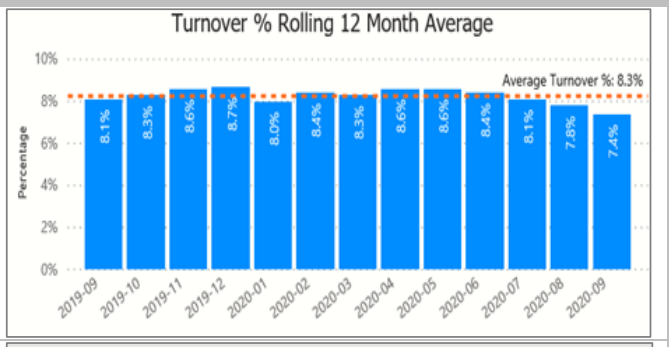
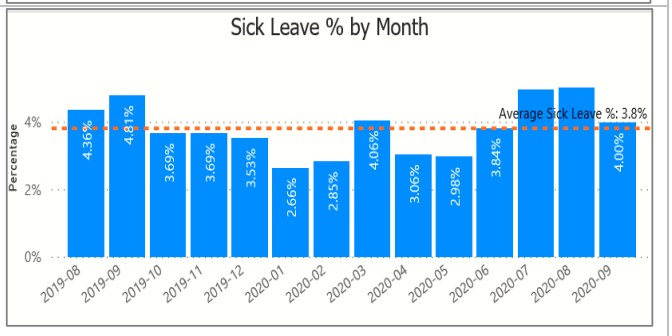


Graph H. ASH Rates 45-64 years
ASH rates are a measure of avoidable hospital admissions (Ambulatory Sensitive Hospital admissions) per 10,000 population. Significant disparities exist between rates for Māori and non-Māori indicating equity issues in access to services.
Calculation: admissions per 10,000 population for a range of standard conditions.



Graph I. Immunisation Rates for Children by ethnicity
Percentage of children with up to date immunisation at the age of two years
Calculation:
Denominator = total children enrolled
Numerator = total children with up to date immunisation



Workforce Measures	
Graph J. DHB Staff Turnover Rolling twelve month turnover rates is an indication of staff retention **Calculation:** Denominator = total staff numbers Numerator = new hires within the preceding twelve months	
Graph K. Sick Leave % Percentage of total paid hours taken as sick leave. This is an indication of illness levels and cost impacts when above average budgeted rates. Does not indicate where annual leave is used in place of sick leave **Calculation:** Denominator = total paid hours Numerator = hours paid as sick leave	
Quality	
Graph L. Pressure Injuries/Falls Patient safety and care indicators for key measures. **Calculation**: count of events each month (not individual patients)