Combined Statutory Advisory Committee - Public

26 November 2021 09:30 AM - 01:30 PM

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Interest Register

Name	Date	Interest
Annette Main *Chair CSAC*	21 August 2020	▪ Appointed to the Whanganui Community Foundation
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 7 November 2014 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 member of the Whanganui District Council District Licensing Committee. 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	▪ 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
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); ▪ 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

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

Name	Date	Interest
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

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 27/08/2021, commencing at 9.30am

Combined Statutory Advisory Committee (CSAC) members in attendance
Annette Main, Committee Chair
Josh Chandulal-Mackay
Heather Gifford
Frank Bristol
Phillipa Baker Hogan
Debra Smith
Soraya Peke-Mason – unable to attend due to technical difficulties
Te Aroha McDonnell – present but some connection issues
Christie Teki – present but some connection issues
Maraea Bellamy

In attendance for Whanganui District Health Board (WDHB)
Mr Russell Simpson, Chief Executive
Mr Graham Dyer, General Manager, Strategy Commissioning & Population Health
Ms Alex Kemp, Chief Allied Professions Officer
Mr Kilian OGorman, Business Support Manager
Ms Rowena Kui, General Manager Māori Health and Equity
Dr Ian Murphy, Chief Medical Officer
Ms Nadine Mackintosh, Executive Officer
Ms Lynn Te Ngahue, Secretariat

Members of the Public
Ms Cheyenne Potaka-Osborne - Mental Health and Addiction Services

1. PROCEDURAL

1.1 Welcome

The meeting was opened by the Chair acknowledging and welcoming Graham Dyer as the General Manager Strategy Commissioning and Population Health and Lynn Te Ngahue as his assistant.

The Chair acknowledged the recent passing of Ailsa Stewart, a highly respected member of the Whanganui District Health Board and her service to our community. Condolences were passed to Ailsa's whanau and colleagues. A moments silence was held in her honour.

DRAFT

1.2 Apologies

Resolved that The Combined Statutory Advisory Committee accepted apologies from Charlie Anderson and Hayley Robinson.

Moved: A Main Seconded: J Chandulal-Mackay CARRIED

1.3 Continuous Disclosure

1.3.1 Conflict and register of interests update

The Combined Statutory Advisory Committee accepted amendments to the interest register.

a) Amendments to the register not actioned from the previous meeting: P Baker-Hogan advised she is no longer a member of the District Licensing Committee, to be updated.

b) Annette Main advised she is a Member of the District Licensing Committee

c) Frank Bristol advised he is now co-Chair of Te **Pūkāea** (The Whanganui DHB Consumer Council) and works with the WDBH doing **'Consumer Engagement'** via a contract held by Balance Aotearoa

1.3.2 Declaration of conflicts in relation to business at this meeting

Nil

1.4 Minutes of the previous committee meeting

The Combined Statutory Advisory Committee accepted the minutes of the meeting held on 28 May 2021 as a true and accurate record.

Moved: A Main Seconded: F Bristol CARRIED

1.5 Matters arising

The following updates to the Matters Arising were noted:

26/02-2	COVID-19 Testing protocols to be clarified with local council	A Main	Completed

Wastewater was not being tested for Covid 19 previously. WDC have now confirmed that testing is currently underway. Noted as complete.

2. PRESENTATION

2.1 Healthy Families - Item was delayed as R Davis having connection issues.

3. DISCUSSION PAPERS

3.1 Healthy Families – Growing Collective Wellbeing Suicide Prevention Strategy.

Item was delayed as R Davis was having connection issues. The chair sought Committee agreement to move the item to the meeting to be held on 26 November 2021.

DRAFT

3.2 Preliminary Quarter 4 Reporting: Non Financial Performance Measures and Detailed results
G Dyer GM Strategy Commissioning and Population Health and K OGorman Business Support Manager

The paper was taken as read with the key points highlighted below:

The GM, Strategy Commissioning and Population Health, acknowledged that this was a preliminary report but overall the organisation is doing well and is on target for where it should be at this stage.

The preliminary report shows a number of areas not achieved in quarter 4 however the Ministry of Health site has been checked 27 August 2021 and most of these areas have been updated to partially achieved with the exception of immunisations.

Discussion was held regarding the struggle to achieve immunisation targets in all four quarters. It was across all ethnicities and was not considered to be caused by Covid 19. Some factors impacting include the finite capability of immunisation personnel and an increasing rate of families declining immunisation. Targets are adversely affected by a small number of people who refuse immunisation against the cost/benefit ratio to chasing these up to meet a target. The data doesn't reflect the good work being done while trying to achieve these targets.

The Chief Medical Officer commented the Covid 19 focus has been successful. Childhood immunisation is not being prioritised in that space however the WDHB used the opportunity to address this as part of this process.

The Combined Statutory Advisory Committee resolved to:

a. Receive the paper titled Preliminary Q4 Reporting: non-financial performance measures & detailed results
b. Note That while Quarter 3 results are now final, Quarter 4 results are preliminary

Moved: H Gifford Seconded: M Bellamy CARRIED

3.3 Status Report – reporting against Annual Plan 2020-2021
G Dyer GM Strategy Commissioning and Population Health and K OGorman Business Support Manager

The paper was taken as read with key points shown below:

Mental wellbeing and prevention areas show not achieved in the paper but has now been upgraded to partial on MoH website. The detail in the report shows the amount of work being done towards achieving these targets, which may not yet reflect in the results.

The Combined Statutory Advisory Committee resolved to:

a. Receive the paper titled Status update - Annual Plan 2020-21
b. Note Quarter 4 results are preliminary

Moved: A Main Seconded: H Gifford CARRIED

DRAFT

3.4 Provider Arm Services report
I Murphy, Chief Medical Officer

The paper was taken as read with a summary of the key points shown below:

Apology for the Director of Nursing/Chief Operating Officer who is currently involved in the Incident Management Team for the Covid 19 Response.

Discussion ensued on MECA negotiations and management's planning in relation to maintaining life preserving services should strike action take place.

The Combined Statutory Advisory Committee resolved to:

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

Moved: A Main Seconded: J Chandulal-Mackay CARRIED

3.5 Clinical Informatics – the development of a new role for health systems change
A Kemp Chief Allied Health Professions Officer

The paper was taken as read. Key points are shown below:

Bridging the gap between ICT and physicians resulting in a more cohesive approach to digital and data.

It was noted the meeting was changed to online due to Level 4 lockdown and the external committee members who received their papers via email attachment did have problems and may not have read all the documents. Documents were available in Diligent Board Books.

The Combined Statutory Advisory Committee resolved to:

a. Receive the paper entitled Clinical Informatics – the growth of a new role in the DHB
b. Note the importance of the role in health systems reforms and to inform models of care
c. Note the recent development of the role.
d. Note the risk stratification project currently underway
e. Note future possible projects for the 2021/2022 year

Moved: A Main Seconded: P Baker-Hogan CARRIED

The Chair referred back to items 2.1 Healthy Families and 3.1 Healthy Families – Growing Collective Wellbeing Suicide Prevention Strategy, and noted we were still unable to connect with R Davis. IT support was underway to try to rectify.

3.6 The Chair invited R Simpson, Chief Executive WDHB to update the Committee on current situation and take any questions. Key points as below:

- The Covid 19 response has impacted staff time and put significant pressure on teams.
- The environment has been challenging but we are committed to our strategic direction and leading the organisation into the new environment in a position of strength.
- Team has shown resilience.
- Vaccination data has been requested by Iwi but has been difficult to obtain the specific data relating to Māori figures coupled with the denominators that kept changing.

DRAFT

Exclusion of public

Move that committee moves to Public Excluded.

It was resolved that:

The public be excluded from the remainder of this meeting under clause 32, Schedule 3 of the New Zealand Public Health and Disability Act 2000 on the grounds that the conduct of the following agenda items in public would be likely to result in the disclosure of information for which good reason for withholding exists under sections 6, 7 or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982.

Agenda item	Reason	OIA reference
Combined Statutory Advisory Committee minutes of meeting held on 27 August 2021 (Public excluded session)	For the reasons set out in the committee's agenda of 27 August 2021	As per the committee's agenda of 27 August 2021
Annual plan for 2020/21	To enable the District Health Board to carry out, without prejudice or disadvantage, commercial activities or negotiations (including commercial and industrial negotiations)	Section 9(2)(i) and 9(2)(j)
Community Pharmacy Services Commissioning Policy	To enable the District Health Board to carry out, without prejudice or disadvantage, commercial activities or negotiations (including commercial and industrial negotiations)	Section 9(2)(i) and 9(2)(j)

Persons permitted to remain during the public excluded session

The following person(s) may be permitted to remain after the public has been excluded because the board considers that they have knowledge that will help it. The knowledge possessed by the following persons and relevance of that knowledge to the matters to be discussed follows.

Person(s)	Knowledge possessed	Relevance to discussion
Chief executive, senior managers and clinicians	Management and operational information about Whanganui District Health Board	Management and operational reporting and advice to the board
Committee secretary	Minute taking	Recording minutes of meeting

Moved: A Main Seconded: T McDonnell CARRIED

The public session of the meeting ended at 10.25am.

The Public Session was reopened at 10.50am following the conclusion of the Public Excluded Section.
Rebecca Davis unable to join virtual meeting due to technical issues.

Items 2.1 and 3.1 presented together

3.1 Healthy Families – Growing Collective Wellbeing Suicide Prevention Strategy
A Kemp Chief Allied Health Professions Officer

Rebecca Davis was unable to connect to meeting so A Kemp presented on her behalf.

The paper was tabled and taken as read.

Committee pointed out that the paper referred only to Whanganui and not the wider Rohe.

The Chair acknowledged the importance of this topic and suggested the Committee consider another opportunity to relook at this paper in more depth.

The Combined Statutory Advisory Committee resolved to:

a. Receive the paper titled Update on the Suicide Prevention Strategy Whanganui Rangitikei Ruapehu (WRR)
b. Note the publication of 3 key documents
   1 Growing Collective Wellbeing - Regional Suicide Prevention Insights Report
   2 Growing Collective Wellbeing - Regional Strategy
   3 Te Reo o te Rangatahi - The Voice of Young People
c. Note the next steps for implementation of the strategy and how this will inform changes in clinical practise
d. Action note: move item to meeting to be held on 26 November 2021

The Chair invited any further comments before closing the meeting.

R Simpson, Chief Executive acknowledged Whakauae **Research for Māori Health,** congratulating them on their success with the recent funding applications and offered ongoing support.

The Chair closed the meeting at 11.25 am.

5 Date of next meeting

The next meeting will be held on, Friday 26 November 2021 from 09:30am in the Board Room, Whanganui District Health Board, 100 Heads Road, Whanganui.

Adopted this day of 2021

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Chair

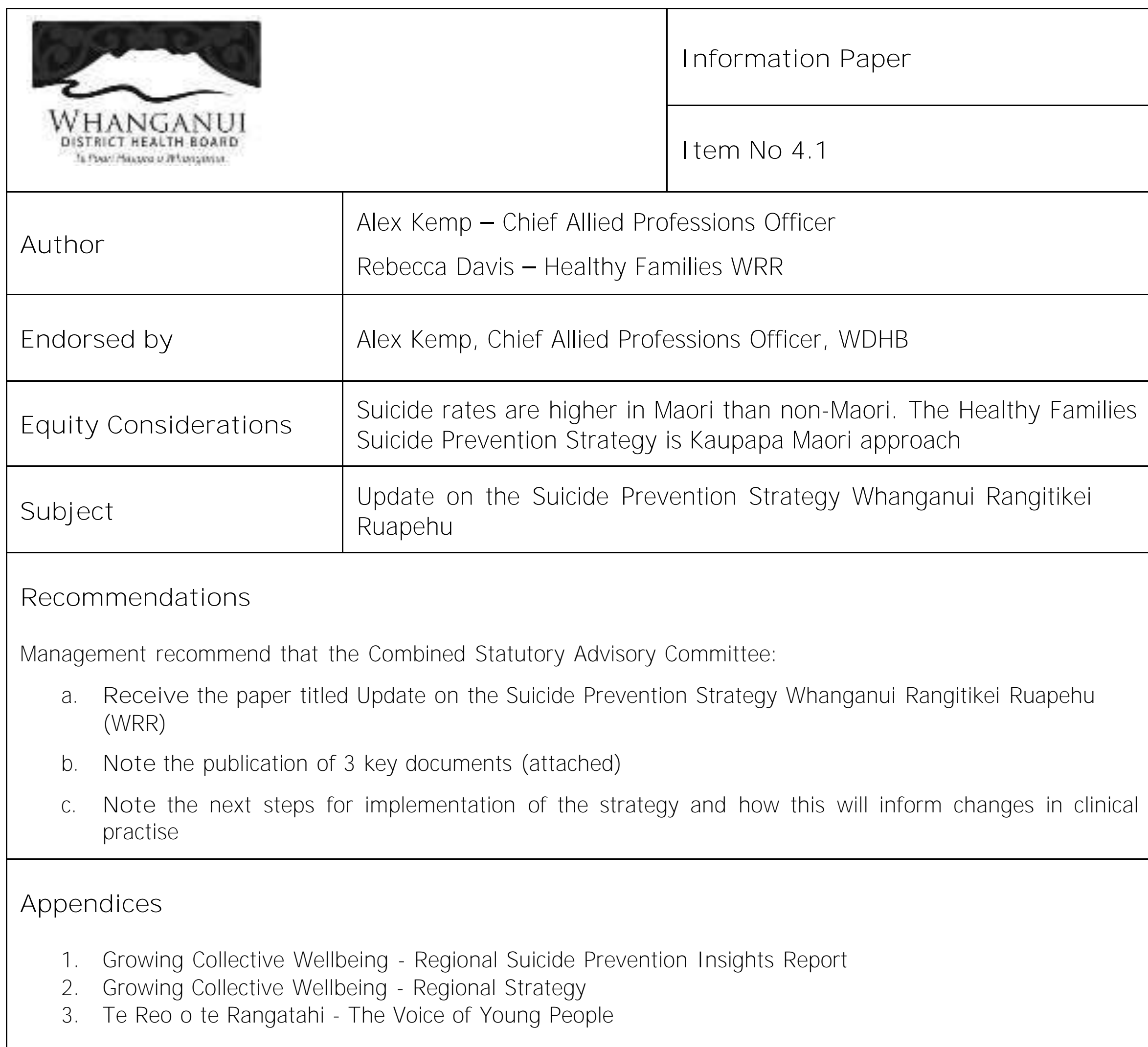
DRAFT

26 November 2021 Public

1.5 Matters arising from previous meetings

Meeting Date	Detail	Response	Status
~~27/08/2021~~	~~Update on the Suicide Prevention Strategy Whanganui Rangitikei Ruapehu – (WRR)~~	~~Move item to meeting to be held on 26 November 2021~~	~~Completed~~

August 2021 Public



WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	Information Paper
	Item No 4.1
Author	Alex Kemp – Chief Allied Professions Officer Rebecca Davis – Healthy Families WRR
Endorsed by	Alex Kemp, Chief Allied Professions Officer, WDHB
Equity Considerations	Suicide rates are higher in Maori than non-Maori. The Healthy Families Suicide Prevention Strategy is Kaupapa Maori approach
Subject	Update on the Suicide Prevention Strategy Whanganui Rangitikei Ruapehu

Recommendations

Management recommend that the Combined Statutory Advisory Committee:

a. Receive the paper titled Update on the Suicide Prevention Strategy Whanganui Rangitikei Ruapehu (WRR)
b. Note the publication of 3 key documents (attached)
c. Note the next steps for implementation of the strategy and how this will inform changes in clinical practise

Appendices

1. Growing Collective Wellbeing - Regional Suicide Prevention Insights Report
2. Growing Collective Wellbeing - Regional Strategy
3. Te Reo o te Rangatahi - The Voice of Young People

A presentation will be given to update on the progress of the project since it was last presented to CSAC in August 2020. The presentation will discuss the next steps for implementation of the strategy and how this will inform changes in clinical practise within the DHB and across the community.

The presentation will given by Alex Kemp, DHB representative on Healthy Families, and Rebecca Davis, Impact Strategist working for Healthy Families (WRR).

COVID Resurgence and Resilience

WDHB 26 November

Objectives

1. To manage COVID in the community and in the hospital
2. To ensure healthcare services are accessible and delivered whilst living with COVID
3. Approach driven by our strategic objectives:
   1. Social Governance
   2. Pro-equity
   3. Every bed matters

National Approach and Local Implementation

Public Health

Welfare and Wellbeing

Primary Care Clinical Support

Secondary Care

Managing COVID-19 Care in the Community
National Service Model concept

Welfare and wellbeing
Supporting COVID-19-positive whānau to be cared for at home means providing support with other important things in life, like staying connected, having your daily needs met, and feeling safe.
- Income support
- Home and community support services including options for care delivered in the home
- Provisions
- Whānau Ora support
- Child wellbeing
- Mental health
- Disability support services
- Aged care
- Family and sexual violence support
- Continuity of care and communications

Public Health
As we care for whānau at home, we care about protecting everyone in the community. This means ensuring that having COVID-19-positive people at home does not increase spread in the community. Our public health response is critical in supporting this approach, from identifying people and tracking the path of infection, to preventing further spread.
- Quarantine/isolation (MIQF and home)
- Testing
- Genome sequencing
- Vaccination
- Contact tracing
- Clearance/assessment of end of infectious period

Primary care clinical support
COVID-19 can make people very unwell, very quickly, but not everyone who is COVID-19 positive will need the same type or intensity of care. Primary and community care needs to be enabled to drive approaches to care at home, with effective pathways to hospital care when needed.
- Clinical pathways for COVID-19, and for safely managing other illness in the home
- Resources/supplies - equipment, medicines, safe options and alternatives for in-person care
- Continuation of care – co-morbidities, treatment plans
- Triage and escalation pathways - ambulance and home visits
- Continuity of care throughout the experience – lead professional, health information, long-COVID

Secondary care
When someone with COVID-19 requires transfer to hospital, for a COVID-19-related need or not, the transfer needs to be coordinated across the system.
- Avoid unnecessary hospital presentations
- Ensure people needing hospital care get there safely and in good time
- Clinical pathways in hospital
- Safe and supported discharge, with appropriate communications

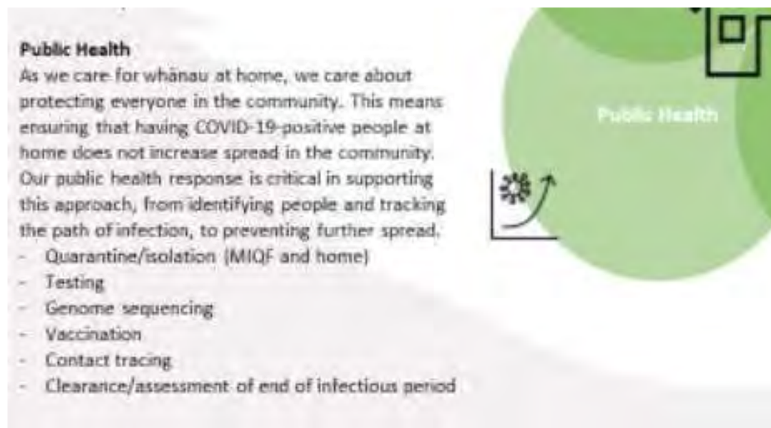
Public Health

National public health response across all public health units

- Management of contact tracing software and process
- Holder of information on positive COVID cases
- Testing as per protocols
- Legislative ability to order isolation quarantine

In Progress

- Ability to share contact information - looking at manual processes for informing Primary Care and Welfare
- Back up measures for non-compliance of COVID positive patients



DHB Lead - Ian Murphy
- Patrick O'Connor (Public Health)

Partners
- MCDHB Public Health
- National Public Health Response

Welfare and Wellbeing

Welfare and wellbeing

Supporting COVID-19-positive whānau to be cared for at home means providing support with other important things in life, like staying connected, having your daily needs met, and feeling safe.

- Income support
- Home and community support services including options for care delivered in the home
- Provisions
- Whānau Ora support
- Child wellbeing
- Mental health
- Disability support services
- Aged care
- Family and sexual violence support
- Continuity of care and communications

DHB Lead - Steve Carey

Partners - MSD

- Te Ranga Tupua
- Iwi Health Providers
- Kāinga Ora
- Police
- Horizons/CDEM
- Primary Care

Community led and Clinically supported response

- Supporting individuals and families with COVID positive results to isolate in the community
- Developing Self Isolation capacity in the community (SIQ).
- Integrated hub models at Raetihi, Taihape, Marton and Whanganui

In progress

- Improved communication systems between providers / identification of lead provider
- Identification of further SIQ and MIQ facilities across the geographical areas

Primary Health

DHB Lead - Alex Kemp

Partners - Te Ranga Tupua

- Iwi Health Providers
- Primary Care
- Aged Residential Care, HCSS
- Other community providers

Primary care clinical support

COVID-19 can make people very unwell, very quickly, but not everyone who is COVID-19 positive will need the same type or intensity of care. Primary and community care needs to be enabled to drive approaches to care at home, with effective pathways to hospital care when needed.

- Clinical pathways for COVID-19, and for safely managing other illness in the home
- Resources/supplies - equipment, medicines, safe options and alternatives for in-person care
- Continuation of care – co-morbidities, treatment plans
- Triage and escalation pathways - ambulance and home visits
- Continuity of care throughout the experience – lead professional, health information, long-COVID

Community led and Clinically supported response

- Clinical management of COVID positive people in the community
- Informed of positive COVID cases through Public Health post welfare check
- Initial supply of clinical equipment and following clinical pathways

In progress

- Community provision for increasing mental and physical health acuity and complexities
- Pathways on admission/discharge to hospital
- Supporting rural hubs including supply chain
- Identifying wider workforce to support clinical care

Secondary Care

Hospital response for those needing higher level of care

- Hospital and local plans aimed at preventing transmission of COVID-19 are developed, tested and remain live documents
- Management of patients with COVID who cannot be managed in the community
- Maintaining planned care remains a focal point
- Preparing and supporting staff remains critical

In Progress

- Strengthening screening and streaming processes, to reflect the National Hospital Escalation COVID framework and adopt recommendations defined within the MoH Clinical Management of COVID-19 in Hospital adults
- Support a regional health response that would enable the central region to support each other during surge responses.

DHB Lead Lucy Adams

Partners - Central Region DHBs

- Te Ranga Tupua
- Iwi Health Providers
- Primary Care
- Police

Secondary care

When someone with COVID-19 requires transfer to hospital, for a COVID-19-related need or not, the transfer needs to be coordinated across the system.

- Avoid unnecessary hospital presentations
- Ensure people needing hospital care get there safely and in good time
- Clinical pathways in hospital
- Safe and supported discharge, with appropriate communications

Secondary Care

- Hospital and local plans aimed at preventing transmission of COVID-19 are developed, tested and remain live documents
- Management of patients with COVID who cannot be managed in the community
- Maintaining planned care remains a focal point
- Preparing and supporting staff remains critical

In development

- Strengthening screening and streaming processes, to reflect the National Hospital Escalation COVID framework and adopt recommendations defined within the MoH Clinical Management of COVID-19 in Hospital adults
- Support a regional health response that would enable the central region to support each other during surge responses.

DHB Lead Lucy Adams (DHB)

Partners

- Te Ranga Tupua
- Iwi Health Providers
- Primary Care
- Police

Secondary care
When someone with COVID-19 requires transfer to hospital, for a COVID-19-related need or not, the transfer needs to be coordinated across the system.
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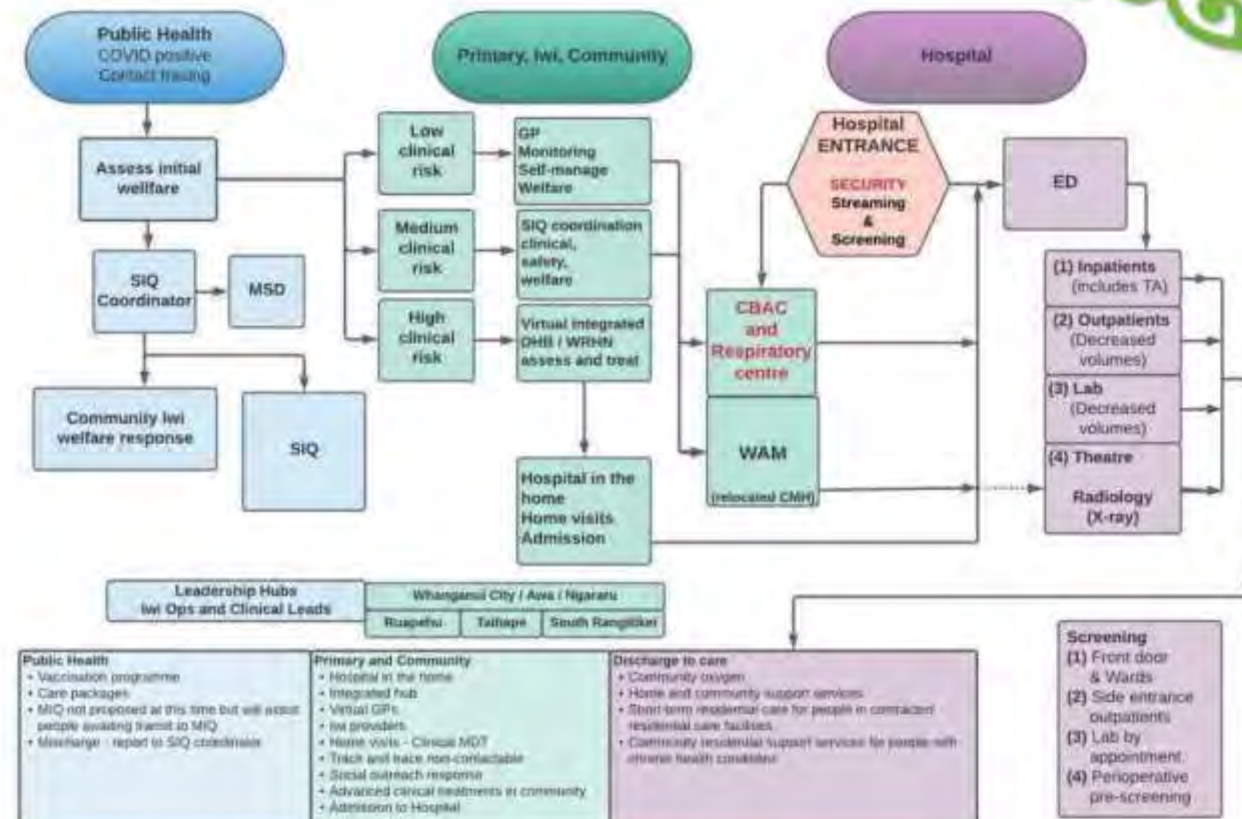
Patient Flow



November 2021 Public

	Information Paper
	Item No.

Author	Lucy Adams, Chief Operating Officer and Director of Nursing
Endorsed by	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 months of August, September and October 2021.

2 Service Delivery Overview

2.1 Industrial Action

The DHB NZNO Nursing and Midwifery MECA has been ratified. Members have received a revised offer.

2.2 COVID-19

At all levels, National, Regional and Local, DHBs are reviewing and strengthening plans. WDHB has executed exercises whereby a notional infected patient journey is created, and staff play out their responses. An external lens is critiquing and intervening so that participants are aware of the appropriate healthcare practices and staff are aware of plans. WDHB is contributing to workstreams that are regional and national focusing both on resilience and resurgence.

COVID-19 Exercise

On Wednesday, 8 September 2021, some of our clinical team simulated a person with COVID (Delta) coming in by ambulance right through to admission in the Medical Ward. This tested our COVID plans, infection control techniques in practice and gave us some opportunities to improve.

A second exercise was held on 6 October 2021 which followed a COVID patient from ED to CCU; this provided a chance to build on learnings from the first exercise and further test our plans. The staff involved were very engaged and enjoyed the exercises. There are more simulations planned over the month of November to test other areas such as Paediatrics and Maternity.

Planning for an Emergo Train System (ETS) pandemic simulation exercise is also underway. The simulation will take place on 14 December 2021 and will involve hospital, primary and community, and public health.

Covid vaccinations

As of 9 November 2021, vaccinations given to the Whanganui region population totalled 88,152; of that, there were 47,156 first doses and 40,996 final doses. This is good progress from 10 August, where vaccinations given totalled 31,644.

As of 8 November 2021, Whanganui DHB staff vaccination rates (in percentages):

	1st dose	2nd dose	Fully Vac.	Head Count	% Fully Vac.
Allied	201	190	190	208	91.3%
HCA	123	120	120	134	89.6%
Midwifery	31	29	29	35	82.9%
Nursing	459	428	428	478	89.5%
Other	270	251	251	292	86.0%
RMO	50	49	49	51	96.1%
SMO	57	56	56	58	96.6%
Total	1191	1123	1123	1256	89.4%

In summary, 95% of all staff have had their first dose; 89.4% have had their second dose and are fully vaccinated.

2.3 Optimisation and Efficiency Programme

Scheduling

A formal roster review of theatre and SSD has been done by TAS; results are pending.

Excellent progress is being made on the booking project that was funded through the sustainability funding from the Ministry of Health. The report and recommendations have been presented to ELT and accepted. Planning for the implementation of recommendations is underway.

Bowel screening

An audit of the bowel screening programme and endoscopy will be done by the DAA Group on 27 and 28 October 2021. Whanganui DHB is working to standards and looking into optimising the current space and maintaining safety for patients and staff. Overall comments from the audit team were positive and we await the draft audit report.

Theatre utilisation

Some gains are being made on the theatre optimisation workplan this is due partially to not having a dedicated project resource within the department. The continuous improvement cycle will become a focus area once COVID planning and agreed projects are completed.

T-Doc is currently going through the business case process and will require project management and investment into technology. Roster review findings are being collated by TAS the report has yet to be received.

2.4 Emergency Department and Inpatient Services

Emergency Department triage data

ED Data	Total Attendances	Triage 1	Triage 2	Triage 3	Triage 4	Triage 5	% Maori	% Pacifica	Did not waits	Ave daily attendances
Aug	1861	10	239	1047	490	75	26%	2%	162	60.0
Sept	1671	5	193	1007	423	43	24%	1%	106	55.7
Oct	1914	5	200	1149	498	62	25%	2%	156	61.7

*Data extracted from WebPAS through SQL Server Reporting Services 4.11.21

November 2021 Public

During the months of August, September and October 2021, the average daily ED attendances have trended downward from the July 2021 figure of 66.9.

Hospital data

	AAU			AT&R			CCU			Medical Ward			Surgical Ward		
	Aug	Sept	Oct	Aug	Sept	Oct	Aug	Sept	Oct	Aug	Sept	Oct	Aug	Sept	Oct
Total monthly admissions *	193	188	208	30	39	33	43	38	54	134	138	171	147	154	128
Total monthly discharges **	133	125	143	23	31	24	27	21	31	191	186	223	232	257	256
Average Length of Stay (Days) **	0.43	0.32	0.29	16.57	16.23	15.13	2.6	2.9	1.7	5.54	5.53	4.2	3.55	3.82	3.51
Average Occupancy (all shifts) **	105%	91%	91%	94%	91%	96%	80%	89%	80%	92%	91%	93%	92%	92%	86%
Average Occupancy (YTD from 1 July 2021)	101.8%			92.0%			83.1%			93.4%			90.4%		

* Data extracted from TrendCare; note: (1) one represents an episode of care, [includes transfers between wards, theatre etc.] Total admissions compared to discharges: August 547/606; September 557/620; October 594/677. Variance will be attributed to those who cross over from end of month to beginning.
** Data extracted from WebPAS through PowerBI 5.11.21

Acute Readmission Volumes **	AAU			AT&R			CCU			Medical Ward			Surgical Ward		
	Aug	Sept	Oct	Aug	Sep	Oct	Aug	Sep	Oct	Aug	Sep	Oct	Aug	Sep	Oct
48-hour	9	6	7	1	2	0	2	1	3	4	5	6	3	8	9
7 day	8	6	7	0	0	2	1	0	3	11	8	20	18	10	20
14 day	1	4	5	0	2	0	0	0	4	6	13	13	9	9	8
28 day	10	6	6	1	1	0	1	0	1	20	16	10	17	17	7
Total	**28**	**22**	**25**	**2**	**5**	**2**	**4**	**1**	**11**	**41**	**42**	**49**	**47**	**44**	**44**

** Data extracted from WebPAS through PowerBI 8.11.21; October figures may not reflect the total 14 day and 28 day readmission volumes.

Māori Acute Readmission Volumes **	AAU			AT&R			CCU			Medical Ward			Surgical Ward		
	Aug	Sept	Oct	Aug	Sep	Oct	Aug	Sep	Oct	Aug	Sep	Oct	Aug	Sep	Oct
48-hour	1	2	0	0	0	0	0	0	1	1	2	0	1	1	2
7 day	3	1	0	0	0	0	1	0	0	4	2	3	3	4	5
14 day	1	0	0	0	0	0	0	0	1	4	0	3	2	1	1
28 day	4	2	1	0	0	0	0	0	0	4	4	4	5	3	3
Total	**9**	**5**	**1**	**0**	**0**	0	**1**	**0**	**2**	**13**	**8**	**10**	**11**	**9**	11
Percentage of total acute readmissions	32%	23%	4%	0%	0%	0%	25%	0%	18%	32%	19%	20%	23%	20%	25%

** Data extracted from WebPAS through PowerBI 8.11.21; October figures may not reflect the total 14 day and 28 day readmission volumes.

3 Hospital and Clinical Services (H&CS)

3.1 Workforce

Nurse Entry to Practice (NETP)/ Nurse Entry to Specialty Practice (NESP)

We employed eleven (11) NETP/NESP for January 2021. Of these, seven (7) identified as Māori, and all of these NETP/NESP were employed in the hospital, two (2) were employed in General Practice and two (2) in Te Awhina. The NETP nurses will complete a post graduate paper at the end of October through Victoria University. The NESP nurses have completed their post Graduate study via Whitireia.

This year WDHB also had a midyear intake for NETP. Six (6) NETP nurses were employed, of these one identified as **Māori.** Two (2) have positions in the hospital and the rest are based in the community. They will commence work in October and begin their paper with Victoria University on 1 December 2021.

Return to Nursing Programme

WDHB is partnering with MidCentral DHB to promote a return to nursing programme. These additional nurses will support the DHB nursing workforce plan. This programme is open to all nursing staff who have been out of the profession for more than five years who are wanting to come back to the workforce. There will be open days to discuss the programme and what it entails. The programme consists of 200 hrs practicum (supported by a preceptor) and 20 hours theory. MidCentral is hosting their day in early November and ours will be later in November.

Health Workforce New Zealand

Funding is available for nurses within the hospital and community to commence study in 2022. A group of senior nurse leaders have met to review a pro-**equity framework for funding, and this has a focus on Māori** Nurses, long term conditions, child and adolescent and older adult. A group will be meeting to discuss this funding and to approve who will receive this.

Te Whare Toi

Te Whare Toi is the new education centre based in the old theatre suite at WDHB. This space has six classrooms and is available to be utilised for teaching purposes by hospital groups and our community healthcare partners. Te Whare Toi officially opened on the 12 October 2021.

3.2 Care Capacity Demand Management (CCDM)

Safe staffing, healthy workplaces is a national priority. Matching capacity to care with patient demand needs consistent, focused attention. Front line staff, managers, executives, health unions and professional leaders all have a role to play. CCDM is a whole of hospital approach for managing the capacity to care on a permanent basis.

The CCDM programme has a set of standards. To meet the standards programme implementation needs to be prioritised, appropriately resourced and sequenced.
(TAS, www.ccdm.health.nz)

WDHB continues to successfully implement the CCDM programme. We have improved to 88% implementation with the last barrier being total implementation of all local data councils.

WDHB has had a full evaluation of the programme by TAS. TAS believe areas for improvement are in the governance domain and core data set. This audit is in draft as discussions continue around the findings.

Items	Progress	Action required
Core Data Set	Partially	• Power BI and formal local data tools are all developed with transparency to staff. • Local data councils have now progressed (and require full embedding) • Staff discuss the data at ward meetings in partnership with union delegates
FTE Calculation	Completed	• ED FTE calcs have been completed
Variance Response Management	Completed	• VRM is used daily with good response. • Reporting is daily/weekly/monthly and feeds into the local data councils. • Response is analysed monthly at the CCDM operational group.

3.3 Variance Response Management (VRM) response

Daily Integrated Operations Centre used live data that is illustrated through PowerBI to inform decisions along with the 1100 and 1600 CNM/CNC meetings that confirms staffing and bed management needs.

In-patient information is entered into TrendCare, as in predicted hours of care, and then actualised at the end of the shift. This data is visible throughout the Hospital; any DHB computer has the capability to see the Hospital at a Glance (HAAG) and the in-patient areas have large screens.

Variance response management is required when there is a deficit of hours to provide care; this can be due to staffing gaps i.e. sick calls; or potentially an increase in predicted hours of care (acuity), bed utilisation (increase of admissions and discharges). This is when an in-patient area warrants tasking to support delivery of care. WDHB is currently in the process of recruiting 4.05 FTE (identified through the CCDM calculations) to work on as a variance response resource. The role will be to task, as identified above and cover breaks. The hours of work will cross over the normal shift pattern.

3.4 Mental Health Inpatient

Stanford House

Stanford house utilisation continues to be static at 106% (16 Tangata Whaiora).

No seclusion has occurred in Stanford House. No restraints have occurred in Stanford house. Rehabilitation activities with Stanford house continue with significant success, and all involved continue to give exemplary feedback.

Stanford House has had approval to hire a coordinate registered nurse Monday to Friday; this role is being advertised. This is within FTE and aligns with Nga Tapawae project and allows leadership succession planning.

3.5 Quality

Person & **Whānau** Centred Care Service Improvement Initiative

Hospital and Clinical Services has had a lens over nurse sensitive indicators and service improvement initiatives. Audits, education and a proof-of-concept change to the Mahi Tahi form have all been undertaken. Findings indicate that additional support is required in the clinical setting to continuously monitor, coach and mentor staff.

An opportunity has presented whereby clinical coach positions on the wards have become vacant and this has provided an opportunity to merge three wards clinical coaches into one role, and then align this to an existing position, supervision of students. The incumbent that supervisors the students is available to fill the merged role for a year starting on Monday 27 September 2021.

Benefits for the DHB are having an undergraduate tutor to work within our hospital to provide support to RN and students. This opportunity would allow us to understand where gaps from theory to practice may be evolving from.

Review of clinical audit schedule

Early this year, a review of the clinical audit schedule commenced as one approach to improving the quality of patient care. The aim is to use the clinical audits as a tool to discover how well clinical care is being provided and to learn if there are opportunities for improvement.

Audits in this review focus on falls, pressure injuries, fluid balance charts, early warning scores, Know Your IV Lines (KYIVL), and the newly introduced Mahi Tahi nursing assessment and patient care plan and goals. Each of the clinical nurse managers ensures the audits are completed and uploaded onto an electronic template, and results are pulled through into their monthly reports. The next step is to develop an audit summary with involvement of the key stakeholders so that the information can be presented in a meaningful manner and in a way to ensure the best outcomes for our patients.

Know Your IV Lines (KYIVL)

The 6-month KYIVL Point Prevalence audit was completed on the 3rd August, where 50 peripheral intravenous cannulas (PIVCs) were audited and patients interviewed. The ACC Know Your IV Lines (KYIVL) programme was launched earlier this year. The ACC funded programme is designed to reduce complications from peripheral intravenous cannulas.

Our project objectives:

- The proportion of patients with a PIVC for no clear ongoing reason <10%.
- The proportion of patients with a PIVC that is unused for >24 hrs <15%.
- Improved documentation of Phlebitis score monitoring by nursing staff to >90%.
- Improved patient experience as a result of education, where patients and **whānau** would speak up if their cannula has not been used in the past 24 hours >70%.
- Monitor to Staphylococcus aureus bacteraemia (SAB)

Audit results showed we are on track, but improvements could be made in the documentation and unnecessary insertions. Compared with the baseline data collected pre-project, the number of PIVCs with no clinical reason for being in place has dropped from 23% to 10%, meeting our target of <10%. All PIVC insertions should be clinically indicated. Staff are asked to question is an IV access necessary and is there an alternative?

The proportion of PIVCs unused for >24hours reduced from 32% to 20%. Staff are required to check every shift, that there a clear ongoing reason for the IV access, if not it should be removed.

There is room for improvement with our documentation. The audit showed the Visual Infusion Phlebitis (VIP) score was only documented for 149 shifts of the 309 (48%) 8 hour shifts the patients were in hospital. Staff are asked to document the VIP score, site condition, cannula patency and clinical indication each shift.

More of our patients were aware of why they have an IV access, with an increase from 66% to 88% knowing its purpose. Staff are encouraged to involve their patient and increase their awareness of PIVC complications. 50% of patients had received written information; however, not all felt comfortable about speaking up if there was a problem. 88% would speak up about a red insertion site, 90% would voice it was painful and only 72% felt comfortable questioning the need for the cannula, if not used for >24hrs.

3.6 Service Delivery

Service delivery has been significantly impacted across all areas of planned care during the COVID lockdowns at level 3 and 4. All services developed a prioritisation system to ensure that patients whose treatment could not be deferred were seen. This included those patients with cancer or high suspicion of cancer, and those where their condition would deteriorate if treatment was delayed.

A total of 89 Elective Surgeries were deferred across all services up to the week ending 5 September 2021. This included those surgeries that were not safe under COVID restrictions (for example aerosol generating procedures) and some that required complex post-operative care in HDU/CCU or long stays.

Patient prioritisation over this time followed a formula that linked clinical priority with procedure safety and maintained acute capacity for potential COVID patients. Patients were also screened to ensure they had post-operative support in their **"bubble"** and were willing to attend hospital in levels 3 and 4 lockdowns.

We are now working to clear the backlog created by this event. Patients are being seen in order of clinical priority, ensuring that there is no undue deterioration of conditions. This is having an impact on waiting lists; however, they are trending down.

The provider services have undertaken production planning across all services to determine the impacts of COVID and holiday period service reduction on waiting lists over the next six months. Initial findings were positive, with no un-expected increase in waiting list volumes. Further work on the detail behind each services continues.

4 Primary and Community Services

4.1 General Overview and Highlights

Primary and Community Services has twelve service areas. Overall positive
Gains have been made, whilst the team balance working on achieving the DHB strategy whilst dealing with the challenges of the recent COVID-19 level 3 lockdown and resurgence planning.

Primary and Community staff has been following and updating their COVID operational plans during the lockdowns. Several of the services split into workstreams to avoid possible cross transmission of COVID-19. The vulnerability of smaller services was highlighted during this time, and work within the region and across regions has commenced to ensure sustainability of service in readiness for the presence of COVID-19 in the community. There has been targeted work with primary care, specifically in the space of Aged Residential Care facilities, to support care within the facilities, avoid hospital admissions where possible, and provide streamlined care back into facilities when there is a need to attend hospital. This work is continuing with a joint community response to COVID-19 resurgence being developed as a priority.

With the lockdown there has been an increase in the offer of telehealth for patients and whanau with positive uptake. There has been a noticeable pattern of more people in the community declining telehealth this lockdown, with data suggesting a preference to defer waiting for in-person new appointments.

Many of the services noted there was a decrease in referrals during August, but are anticipating an increase as the COVID-19 lockdown levels change (this occurred in 2020).

We are currently in the process of recruiting for Clinical Manager District Nurse and Occupational Therapy.

District Nurses are currently recruiting to vacancies which will assist with the staffing as they are often short staffed and there are no casual registered nurses to fill in for sick calls etc.

4.2 Service Delivery

COVID-19 Resurgence Planning

Senior Leadership have been heavily involved in COVID-19 resurgence planning, noting that many of the teams are working across the hospital and the community. The teams have been working with WRHN, NHC, SIQ Lead, for care of COVID-19 in the community, as well as increasing ability to support more complex patients at home to avoid hospitalisations and ensure early supported discharge from hospital where needed. Work has also been progressing in the area of mental health, with plans to support both COVID-19 positive tangata whaiora and increasing complexity of acuity of tangata whaiora in the community. The Primary and Community space is complex, with over 160 different DHB contracted providers in health, as well as social providers, who will need to wrap services together to provide seamless care in our community.

Community Mental Health and Addictions Services (CMHAS)

CMHAS provided a large amount of care via telephone with success during the recent level 3 lockdown. From this, a trial of group addiction services held virtually has started.

Two psychologists have resigned recently to pursue private practise. This follows national trends for shortages of psychologists. Funding from the Ministry of Health to support an intern position has been agreed, to support growth into psychology roles.

A mental health crisis worked has been located with police two days a week, in response to concerns raised about the quality of shared working between the two services. There has also been a reduction in people presenting to the emergency department using this co-response model, and it has been decided this will continue two days a week for an extended trial.

The Mental Health Crisis team have been working closely with the Whanganui police to improve working relationships and provide coaching and training to front line officers dealing with people in distress. This has been received positively, with a significant reduction in complaints from police in the joint working space, and an increase in shared understanding of roles. A recent collaborative bid for Proceeds of Crime

funding to support new models of crisis working has been shortlisted. This bid is supported by MOH and involves Te Oranganui, Balance, and Police as well as CMHAS.

Community Assessment and Rehabilitation Team (CART)

There has been a decrease in people on the short-term services caseload by approximately 30%. This would indicate a more efficient process for people in the community, as services are reviewed more frequently and have less time waiting for assessment.

There has been an informal consultation process sent to the community, reviewing the services provided for Falls and Pressure Injuries. The outcomes of this have indicated the need to move to formal change consultation to consider a more primary focussed and equity focussed approach to prevention of falls and pressure injuries. Formal change consultation process is expected to start this month.

Therapies

Waitlists continue to decrease in some services, such as physiotherapy outpatients and Speech and Language Therapy. The service for wheelchair assessments has shown a significant improvement, with the waiting time at 18 months one year ago, now at less than two months.

The Dietitians waiting lists continue to increase mainly due to a vacancy which has been recruited to, and the waiting lists are currently being addressed. Outpatient Clinics DNAs continue to be high and the dietitians are looking at different ways of engaging with patients/whanau from a service and organisation perspective.

Inpatient pressure and complexity of inpatient presentations continues to challenge the ability for therapy services to deliver community-based care, with the risk of increasing fragility in the community leading to admissions that are potentially preventable. This is being reviewed as a priority.

The Physiotherapy team are delighted that they have offered employment to a musculoskeletal Physiotherapist, which fills a vacancy that has been present for almost two years. This role is vital for many of the services that offer a preventative model of care, such as specialist assessment prior to joint replacement, and assessment of back pain in ED and primary care.

There is shortage of administration cover across therapy services and clinicians continue to complete administration tasks which reduces patient intervention contact. The expectation is that this will be addressed with the administration review.

There are ongoing issues with home care providers unable to provide community home based support services for current and new patients and there have been episodes that the services have not commenced following the patient being discharged into the community. The clinician staff continue following up patients and the home care agencies.

Radiology

The radiology service is in the process of purchasing a large amount of equipment, including four x -ray machines (two for the hospital, and one for the Taihape, one in Waimarino), a fluoroscopy machine, and ultrasound, and an MRI machine. There are increasing issues with x-ray machines breaking down and a lack of replaceable parts for machines, so these purchases are a priority for ongoing c linical care. The service is also looking at options and process for locating one of the ultrasound machines off site.

Pharmacy

Pharmacy continue to be part of the logistics team to help distribute the vaccine and ensure the smooth implementation and roll out across the DHB. Staff shortages are placing increasing pressure on this service, which is seeing itself challenged by increasing time accessing drug alternatives and ensuring that there is no adverse effects in drug reactions for those taking these; working to replace the Pyxis machines on the wards that dispense medications and have reached end of life, and responding to increasing inpatient surges.

Rural Centres

A new leadership role in Raetihi has been developed, led by the Integrated Directors Ruapehu limited, which will provide operational management for the Primary Care Practise in Waimarino, and facilitate closer

working relationships between the DHB and other health partners in the region. The role will also work closely on developing proposed models of care for health services in the region, following on from the co-design process as part of the Ruapehu Whanau transformation plan. The new role has been welcomed by DHB staff based in Waimarino, who have been engaged regarding the formal relationship with this role. Although the role no formal operational role with staff, there is positive feedback that this will lead to closer and more seamless working relationships within the region.

4.3 Risks/Mitigations

The implementation of security tracking devices is a priority for this year for all staff working in the community, to meet legislative requirements.

Vacancies in services continue to be a challenge, and this is being addressed short term through outsourcing, with more sustainable models of care and clinical pathways being developed regionally.

There has been a surge of presentations in mental health, both in acuity and complexity, with increasing pressure for mental health crisis teams to find alternative models of care when there are shortages of beds both locally and regionally. This is progressing as a priority piece of work with inpatient services and will involve community partners in mental health as well.

4.4 Quality and Performance

Work continues with CCDM, with work identified to ensure all services have moved to TrendCare and are able to capture all data across services.

'Sit up, get dressed, keep moving', designed to encourage patients to be active when in hospital to prevent deconditioning and associated health risks. There will be a trial started soon of an exercise class, led by the Allied health assistant on medical ward.

The Joint assessment form for allied health is in the process of being upgraded and then will be sent to all teams to review.

5 Maternal, Child and Youth Services (MCYS)

5.1 General

The Covid-19 resurgence (Delta variant) has impacted on Maternal, Child and Youth Services business as usual and service delivery particularly for our Public Health team with their involvement in contract tracing, CBAC testing, COVID immunisations and assisting with MIQ facilities in Auckland. Anti-vaccination presence is an ongoing issue facing our public health staff. On a positive note, Covid lockdowns have also stifled the spread of Respiratory Syncytial Virus (RSV) in the community.

Planning of Red (Covid) and Green (non-Covid) pathways within our Paediatric and Maternity Wards is well advanced. The Covid simulation scenario exercise focusing on Maternity and SCBU scheduled for 16 November will inform plan finalisation.

The MCYS team is working to further establish contact pathways between our services and the community. Workstreams stemming from the Primary and Maternity Services Interface Group are progressing including the service guide for women, community directory of services and optimisation of the Best Start tool. The **Hapū Māmā Village project is** gathering momentum with Project Lead Pania Millar gathering information **and arranging Wānanga** with **māmā,** providers and other stakeholders over the coming months. An oversight group has been formed to support Pania in this important work. The insights of this system-wide review of maternity services will inform future maternity service provision.

Recruitment for project managers for both the Oral Health Project and Single Point of Entry Project is progressing. The development of a single point of entry into child health services is a key project for our service and some funding has been provided by the MOH. Objectives include development of clear referral and acceptance guidelines for child health services, reducing DNA rates, and identification of high risk tamariki and **whānau** so holistic health plans can be developed.

The childhood immunisation plan requested by the Ministry of Health (MOH) has been submitted, and provisionally accepted subject to review by the Immunisation Implementation Advisory Group (IIAG). The Health Promotion team are developing on a localised communications plan. There is some discussion about how we can approach immunisation differently; a whānau-centred approach that looks to engage with whānau as a whole rather in age-group silos.

The Whanganui Maternal, Child and Youth Community Alliance held a hui on 30 September 2021 at Keith Street School focused on the impact of toxic stress on children and gathering feedback on the Single Point of Entry Project. It was another valuable hui with active engagement from our community partners, including representation from local Te Kōhanga Reo.

Two of our five MCYS services have 100% of staff completed He Waka Hourua and the other services are well on the way to achieving this, with a goal of completion within six months.

5.2 Service Delivery

Maternity

We have successful recruited 1.2FTE and recruited staff will be clinically on the floor by December 2021. Interviews are planned for the Midwife Clinical Coach, and if successful, this role will commence in January 2022. This role supports staff undergoing return-to-practice requirements, new graduates and internationally qualified midwives into practice. Maternity is still not staffed to our budgeted FTE; recruitment plans are ongoing.

The unit caseload numbers for December/January/February has reached 58 and has the potential to increase further with an LMC signalling her intention not to be vaccinated and hand over her caseload of 20 women in this time period. Plans are being put in place to increase antenatal clinic FTE to accommodate the current unit clients and potential increase.

Our Primary and Maternity Services Interface Group workstreams are progressing well including the Hapū Māmā Village project facilitated by Healthy Families, service guide for women, community directory of services and optimisation of the Best Start tool.

Patient Safety Day on 17 November 2021 has a Maternity focus this year about "increasing culturally responsive care". There is a significant focus on staff education. The main promotion event will be held at Women's Network Whanganui where the HQSC videos will be showcased.
Plans to offer a Long Acting Reversible Contraception (LARC) service to postnatal women prior to discharge are progressing. We are in discussion with Family Planning and our new O&G consultant regarding the education and credentialing process.

The Maternity Early Warning Scores (MEWS) project is now business as usual. We anticipate the Newborn Early Warning Score (NEWS) will be rolled out in the first calendar quarter of the new year. All maternity and neonatal staff including LMCs will complete NEWS online training.

The Midwifery Forum held on 12 October 2021 was another valuable hui. Covid-19 readiness and vaccination were significant areas of discussion and other issues that are top-of-mind for our LMCs and core midwives were able to be raised and discussed. Next year four Midwifery Forum's will be held, with the first scheduled for 22 February 2022.

A one-day Hāpai te Hoe programme has been offered to LMCs this year. One session has been run and the second session scheduled for September was postponed but the aim is to run before year end. Going forward all new LMC's to our rohe who have not trained in our DHB will be offered attendance at Hāpai Te Hoe during orientation week.

Two of our staff, a midwife and the CNM of paediatrics, are enrolled in Ngā Manukura o Apopo Clinical Leadership training and will complete this by the end of the year (Covid permitting).

Paediatrics

The Paediatrics and SCBU Covid-19 response procedure is complete. Plans include establishing a second SCBU in the red zone of the children's ward, doors/plastic barriers between rooms two and three on the ward, rostering plans for both green and red zones and plans for Oncology patients to be seen at a different location.

The new paediatrician is on track to commence work before the end of the year. Plans to recruit another paediatrician are underway. The child health nurse practitioner is now working four days per week in child health and a clinical nurse specialist paediatrics role has been developed and recruited to.

Recruitment of a psychologist to MICAMHAS and CDS has been successful with the commencement date in early December. This appointment will allow us to develop an improved pathway for Autism diagnosis.

Renovations to the CDS gym are complete, following significant Covid-19 related delays. The team are ecstatic, and our gym is now a safer, fit-for-purpose space to serve our tamariki and their **whānau.**

Regional CDS leaders continue to meet regularly, and work is progressing on two innovation projects:

1. Regional feeding service project - led by Capital and Coast DHB - is making progress with initial data collection complete. This is being led by an experienced speech language therapist.
2. Regional neurodevelopmental therapy expert project – led by Hawkes Bay DHB. This has been successful to date with regional Neurodevelopmental Therapists (NVDT's) developing clear assessment guidelines and practice to follow. There has been excellent collaboration amongst Regional **NVDT's.** The MOH have just announced funding for one further year. This project has identified a service gap in WDHB SCBU as there is currently no allocated FTE for inpatient developmental therapy. This is initiated in the Newborn Intensive Care Unit (NICU) and requires follow-up in SCBU; however, this is not available until discharge into the community.

Funding for a quality coordinator across the central region child development services has been approved by the Ministry of Health.

STABLE Training, a combined training initiative across Maternity and Paediatric services, has been postponed for the third time due to Covid-19 and will be rescheduled for the new year.

Opportunistic immunisations and distribution of safe sleep devices to tamariki and whānau who need them remain a strong focus of our paediatric team on the ward.

Public Health

Our public health team continue to do a great job despite the sustained pressure of the Covid -19 environment and their work profile. Our public health staff are being recognised and receiving thanks and acknowledgement from fellow DHB colleagues for their hard work during the Covid response. Compliments are also being received from our community, including schools and individuals from the public that our PHN's are in contact with as part of the Covid response.

In October, the Ministry of Health requested Public Health Units decrease their BAU by 50% to assist with the nationwide surge in contact tracing. The public health nursing team are running a seven-day-a-week roster to assist with Covid-19 case investigation for the Auckland Regional Public Health Centre. Public health leadership have contacted all schools in the rohe outlining the prioritisation of contact tracing and the impact this will have on service delivery.

Our immunisation coordinator, in conjunction with the Covid-19 vaccination team, is working on the opportunity for students over the age of 12 to have their Covid-19 immunisation in an education setting.

School-based COVID-19 immunisation roll-out for 16 to 18-year-old secondary school students has commenced and work is being done to extend the service to other age groups. An electronic consent form is being developed for parents wanting their child to have access to Covid-19 vaccinations through the school-based immunisation programme. There is continued anti-vacs challenging school-based vaccination consenting and school sites as venues for vaccinations. The engagement and rapport with schools and students and the education imparted around vaccination has helped in these situations. National radio has covered this topic with a positive mention of Whanganui DHB.
(Link: https://www.rnz.co.nz/news/national/449256/students-told-anti-vaccine-campaigners-to-go-away-deputy-principal.

The school-based health service reports just over 50 percent completion rate of HEEADSSS assessments for eligible students. Assessments for lower decile schools and high-risk youth have been prioritised and are 100 percent complete. The impact of Covid-19 means we are unlikely to finish the remaining assessments by the end of the year.

The resignation of the public nurse who worked in the Te Kōhanga Reo space has created an opportunity to review whether the Te Kōhanga Reo service is best provided by kaupapa Māori services. A discussion paper was submitted to MHOAG for their consideration and following their feedback, further avenues are being explored to put an effective service in place that will enhance the benefit to the community.

A 'one-point' entry point has been formed for our under-25-year-old transgender population within the community. Referrals would be received by the Public Health Sexual Health Clinic and triaged. For clients under 25 years, we work collaboratively with Youth Services Trust (YST) who provide us with a space to conduct assessments. For clients over the age of 25 years, information, support and resources will be provided and recommendations made to the general practitioner around treatment, maintenance and screening as per the Guidelines for Gender Affirming Healthcare.

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

Staff anecdotally report that youth required an increased level of support when compared to the COVID-19 lockdown in 2020.

Access to acute inpatient services for youth remains a key issue. There are no funded acute inpatient beds within the Whanganui rohe and the central region's Regional Rangatahi Adolescent Inpatient Service (RRAIS) is often at capacity. With no planned improvement to the regional Rangatahi Unit consideration needs to be given to providing care closer to home for our rangatahi. The central region funding and planning managers group are pursuing alternative solutions closer to home.

In response to increases in serious self-harm incidents the MICAMHAS team, Community Mental Health team and community agencies have increased clinical input and risk planning which has had a notable impact on the number of incidents.

One of the MICAMHAS quality improvement groups has been meeting to investigate how to best capture the voice of young people and their whānau in service development. This includes inviting young people and their whānau to attend a hui as MICAMHAS has previously done with our reception/waiting area. The development of specific questions or an open forum is being considered as well as how to maintain the youth/whānau voice.

Oral Health

The Oral Health team (along with many other staff and groups within our DHB) exhibited the WDHB values of kōtahitanga and manaakitanga during COVID-19 lockdown – oral health staff manning the main reception entry and assisting with CBAC swabbing and administration. Telehealth appointments were initiated for the preschool group during this lockdown.

The Executive Leadership Team (ELT) have approved the business case for an Oral Health Service Review which aims to enhance and further develop our current service to provide a modern, patient focussed dental service for our community.

Our Oral Health Service is on track with the Dental Council Recertification programme. All dentist recertification is complete and dental therapist recertification occurs in March 2022.

Our preschool, school-age and adolescent arrears started to reduce in September. Our arrears rates remain one of the lowest in the country, but our team remains focused on reducing these as much as possible. Inequity of access for the 0-4 age group remains a key concern and area of focus for improvement for our oral health service.

5.3 Future Focus

Planning for engagement with our Whanganui Maternal, Child and Youth Community Alliance hui in the new year is underway. Youth Health will be the focus of our first meeting in 2022. In the interim a

communication will be sent to Alliance members to summarise the content of hui held this year, achievements, and our future focus points.

The first of four Midwifery Forum meetings for 2022 will be held at the end of February 2022.

Options are being explored to address acute inpatient mental health service capacity issues for our rangatahi. It is hoped this will be recognised in the local mental health service review being undertaken by Healthy Families.

Work streams coming out of the Primary and Maternity Services Interface Group continue, most of which are anticipated to take another 12-18 months to finalise.

Covid-19 planning and BAU take precedence in many areas as we prepare for Covid-19 in our community.

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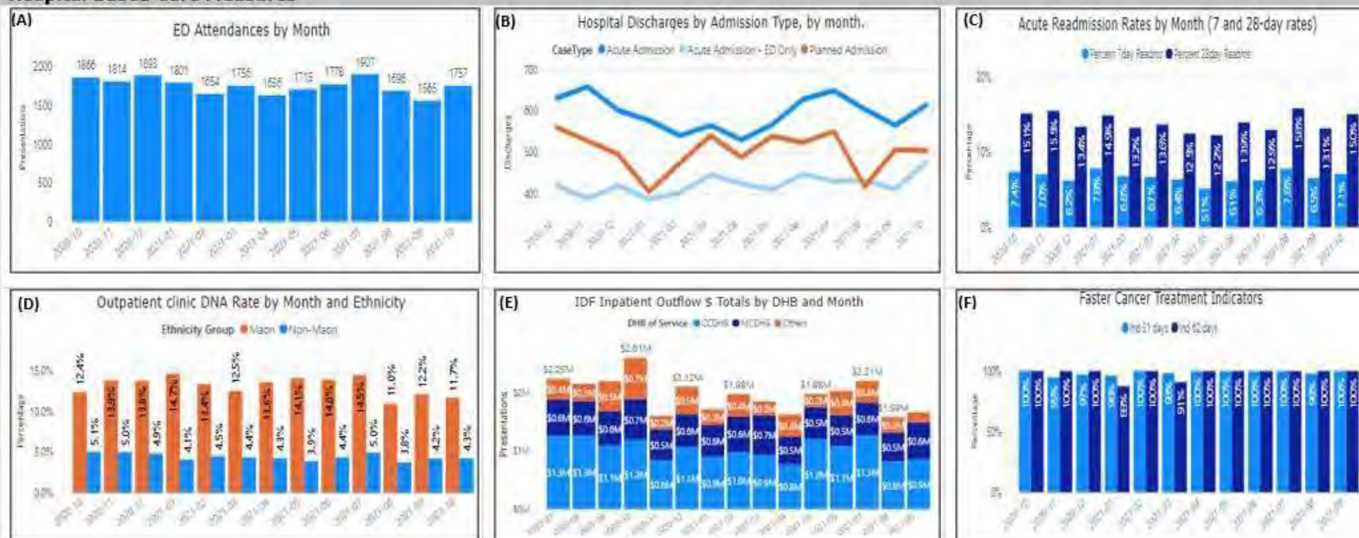
Appendix 1. Whanganui DHB Performance Dashboard

(data extracted 8 Nov 2021)

Hospital Based Care Measures



Commentary

ED commentary is within the body of the report.

(A) ED attendances were slightly down for August and September and raised slightly in October.

(B) Hospital discharges by acute admissions and planned admissions were down for August, September and October whilst the 'hospital discharges acute admission - ED only' rose slightly in October.

(C) Readmission rates, 7 and 28 days, slightly increased in August, returned to previous levels in September and slightly increased again in October. The DHB is continiuing to explore ways to capture relevant information and better understand these rates; however, hope that initiatives that are being introduced into the primary and community settings will help reduce these numbers.

(D) Outpatient clinic DNA decreased slightly in August and remained steady over September and October. Work continues to improve DNAs, of which will be referred to as missed scheduled appointments. Acitivities to improve appointment attendance rates include, text to remind, review of booking processes, improved data to reflect DNA information, telehealth.

(E) October data is not complete; September outflow was $1.67M.

(F) Faster Cancer Treatment Indicators remain steady.

Community Based Care Measures

Commentary

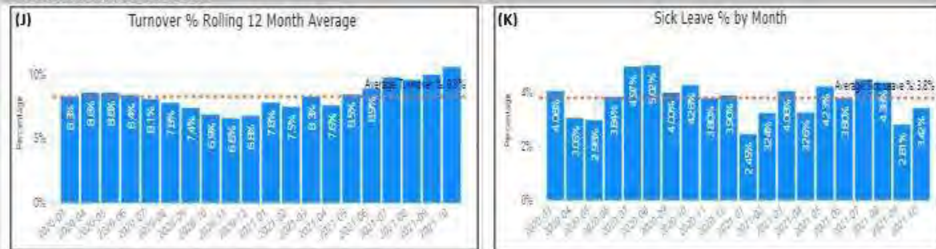
All Ambulatory sensitive hospitalisations (ASH) rates are for Whanganui Hospital. Maori are more likely to be hospitalised for ambulatory sensitive conditions compared to non-Maori.

(G) The top themes for 0-4 years are respiratory and others [nausea, wheezing]. **NB:** Commentary is correct for August, September and October; however, final October data is not available at time of report and is not included on the attached graph.

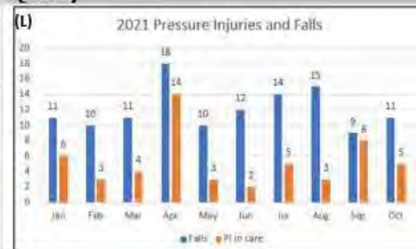
(H) The top themes for 45-64 years are respiratory, other [i.e. chest pain], and circulatory [heart disease]. **NB:** Commentary is correct for August, September and October; however, final October data is not available at time of report and is not included on the attached graph.

(I) Immunisation rates for Māori and non-Māori children increased last quarter.

Workforce Measures



Quality



Commentary

(J) The average turnover at WDHB has risen over the last three months. WDHB average turnover has risen 0.3% since July to 8.3%. Staff have moved within the Hospital or have left the DHB, i.e. left Whanganui, retired or have employment within the community.

(K) Sick leave was 4.38% in August but decreased over September and October. The rolling average remains at 3.8%.

(L) Falls and pressure injuries in care remain a focus of the quality team. (Note: This quality indicator information is gathered from Cgov.)

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Whanganui DHB Performance Dashboard definitions.

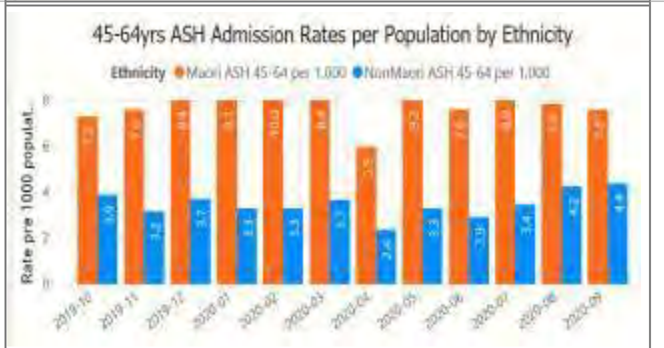
Hospital Based Care Measures	
Graph A. ED Attendances ED attendances are an indicator of acute patient demand in the system, while also identifying issues in access to primary care and potential flow issues in secondary services. Calculation: count of attendances.	ED Attendances by Month
Graph B. Hospital 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.	Hospital Discharges by Admission Type, by month
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	Acute Readmission Rates by Month (7 and 28-day rates)
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	Outpatient clinic DNA Rate by Month and Ethnicity
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.	IDF Inpatient Outflow $ Totals by DHB and Month

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

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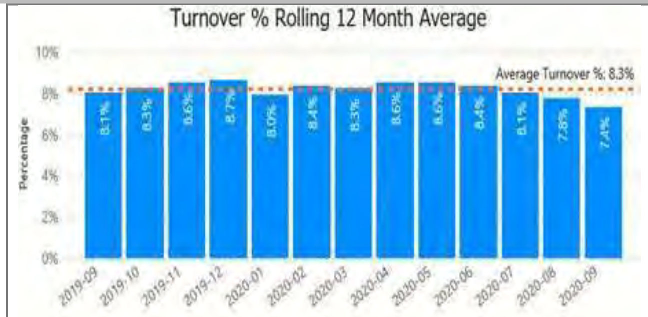
Workforce Measures

Graph J. DHB Staff Turnover
Rolling twelve month turnover rates is an indication of staff retention

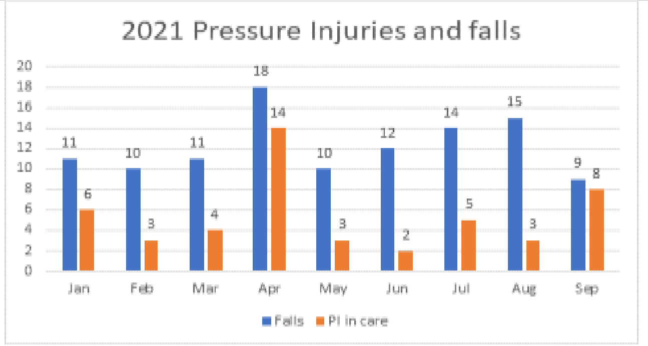
Calculation:
Denominator = total staff numbers
Numerator = new hires within the preceding twelve months



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)



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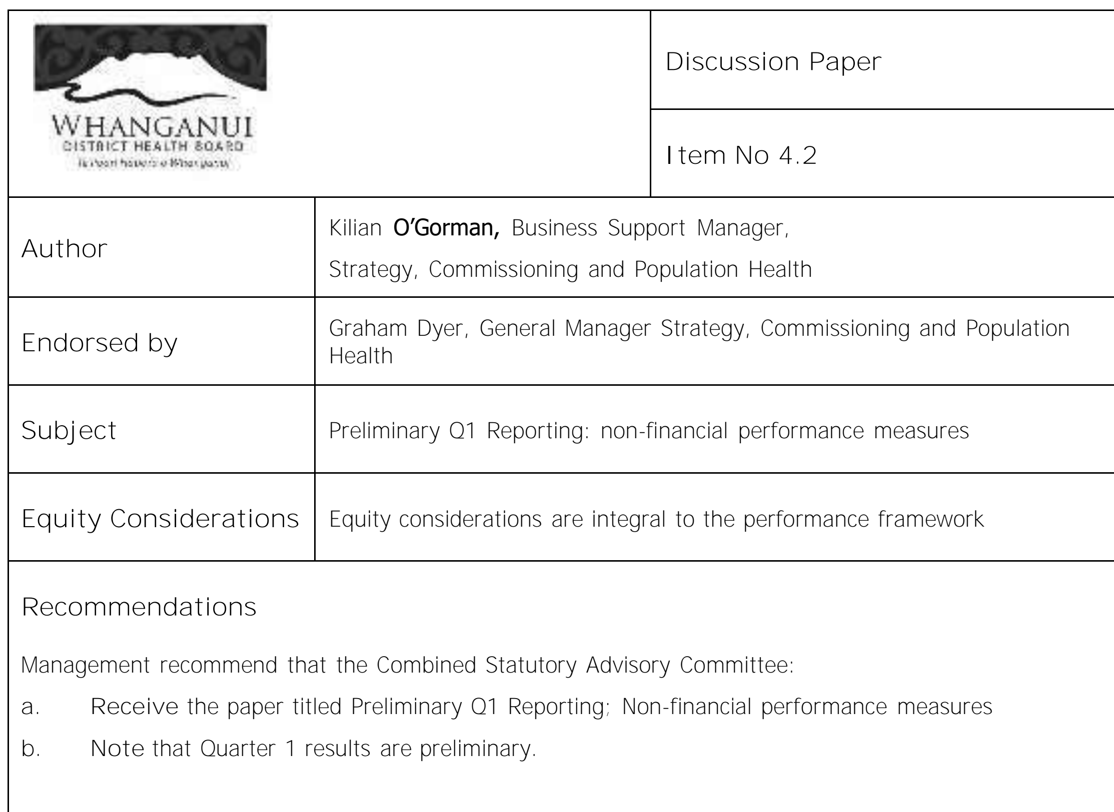

WHANGANUI DISTRICT HEALTH BOARD	Discussion Paper
	Item No 4.2
Author	Kilian **O'Gorman,** Business Support Manager, Strategy, Commissioning and Population Health
Endorsed by	Graham Dyer, General Manager Strategy, Commissioning and Population Health
Subject	Preliminary Q1 Reporting: non-financial performance 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 Q1 Reporting: Non-financial performance measures

b. Note that Quarter 1 results are preliminary.

1. Purpose

This paper provides an update on Preliminary Quarter 1 Non-Financial Performance Framework results

2. Index

2) Preliminary Ratings Quarter One Non-Financial performance framework measures

3) Detailed quarterly reports to the Ministry of Health for Quarter 1

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2) Preliminary Ratings Quarter One Non-Financial performance framework measures

Measure	Q-1	Q-2	Q-3	Q-4
Ratings confirmed?	X			
Key Achieved Partial Not achieved Not req'd Update due				11/11/21
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 General 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				

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.				
Strong and equitable public health and disability system				
SS01: Faster cancer treatment (31 days)				
SS02: Delivery of Regional Service Plans				
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	No Update			
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				

Health System Indicators	
B Health System Indicators - Access to planned care 21/22	
B Health System Indicators - Acute hospital bed day rate 21/22	
B Health System Indicators - Ambulatory sensitive hospitalisations for adults (age range **45–64)** 21/22	
B Health System Indicators - Ambulatory sensitive hospitalisations for children (age range **0–4)** 21/22	
B Health System Indicators - Immunisation rates for children at 24 months 21/22	
B Health System Indicators - Primary care patient experience 21/22	
B Health System Indicators - Under-25s able to access specialist mental health services within three weeks of referral 21/22	

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Note: The new Health System Indicators do not come into proper effect until further notice.

3) Detailed reports to the Ministry of Health for Quarter One

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)	8	4,427	0%	4	4	4	2,036	0%	4	2
Primary School Children (age 5 - Year 8)	71	7,794	1%	4	7	18	3,006	1%	4	4
TOTAL	79	12,221	1%	4	4	22	5,042	0%	4	2

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
1	170	1%	3	1	3	2,221	0%	4	3
5	275	2%	4	1	48	4,513	1%	4	2
6	445	1%	4	1	51	6,734	1%	4	8

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

We also provide coverage for 1500 adolescents who are not reported on here. We are close to completing this group.

Equity is most evident in our work with adolescents where more than half of the youngsters are Maori. They receive on-site assessment and treatment within the school sites and are very happy to come. We are close to equity with our DMFT/% caries free with our Year 8. 2020 - DMFT 0.63 other, 0.74 Maori; % caries free - 69% Other, 63% Maori. This is a real improvement over previous years.

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

April to June 2021 was a good working period and we managed to catch up with most of the arrears we had from 2020 . The August/September lockdown has increased our arrears again.
On 1st November our arrears were: Pre Schoolers 5.5%; School age - 4.3%; Adolescents - 7%. These are 12 month figures - not 14 month.
New initiatives and successes
New" text to remind" of appointments which seems to have reduced DNAs , particularly amongst preschoolers

CW05: Immunisation coverage 8 month

Indicator 1: Immunisation coverage at 8 months (B CW05, FA1) 21/22
Contact (role and name): Barbara Charuk, Portfolio Manager, WHANGANUI DHB
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						
Q3 2021/22						
Q4 2021/22						

Number	**Total**	**Māori**	**Pacific**
Opt off and declined	16 (7.7%)	7 (7.3%)	0 (0%)
Missed	21 (10.1%)	16 (16.7%)	1 (11.1%)

Progress report

- *Training of WAM staff for opportunistic immunisation education and provision – is planned for Q2. COVID activities have had an impact on being able to do this in the prior month.*
- *Decliners project – WDHB have involved health promotion team to makes sense of the "data". WRHN have been working with the qualitative data that they have collected as part of their BAU mahi and have been working with utilising the conversation prototypes that are evolving through the COVID hesitancy work, where applicable.*
- *BAU mahi includes phone text follow up, home visits when able depending on COVID alert levels, drop-in clinics, working with the GPT to advise, educate and support them in attaining target and paying attention to equity outcomes. Taking on board additional workforce to support the vaccinations efforts –across childhood, MMR and COVID.*

New initiatives and successes this quarter

- *7-week-old referrals (Q1) – initiated change and monitoring the impact that this will make on earlier follow ups.*
- *90-day upcoming report – this is being established for Q2 (unfortunate the timing of the recent COVID lock down and surge activities have disrupted this reporting. Notification to individual general practice teams will be part of this targeted report.*
- *Completed draft scoping report for childhood immunisation. Draft being tabled at ELT for discussion and at Board for information.*

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

- *COVID lockdowns and COVID Immunisation activities*

CW05: Immunisation coverage 5 year

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

Contact (role and name): Barbara Charuk, Portfolio Manager, WHANGANUI DHB

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						
Q3 2021/22						
Q4 2021/22						

Number	Total	Māori	Pacific
Opt off & declined	28 (12.1%)	16 (14.7%)	1 (7.1%)
Missed	13 (5.6%)	11 (10.1%)	1 (7.1%)

Progress report

- *Training of WAM staff for opportunistic immunisation education and provision – is planned for Q2. COVID activities have had an impact on being able to do this in the prior month.*
- *Decliners project – WDHB have involved health promotion team to makes sense of the "data". WRHN have been working with the qualitative data that they have collected as part of their BAU mahi and have been working with utilising the conversation prototypes that are evolving through the COVID hesitancy work, where applicable.*
- *BAU mahi includes phone text follow up, home visits when able depending on COVID alert levels, drop-in clinics, working with the GPT to advise, educate and support them in attaining target and paying attention to equity outcomes. Taking on board additional workforce to support the vaccinations efforts –across childhood, MMR and COVID.*

New initiatives and successes this quarter

- *7-week-old referrals (Q1) – initiated change and monitoring the impact that this will make on earlier follow ups.*
- *90-day upcoming report – this is being established for Q2 (unfortunate the timing of the recent COVID lock down and surge activities have disrupted this reporting. Notification to individual general practice teams will be part of this targeted report.*
  Completed draft scoping report for childhood immunisation. Draft being tabled at ELT for discussion and at Board for information.

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

- *COVID lockdowns and COVID Immunisation activities*

CW05 Immunisation coverage - FA4: Influenza immunisation at age 65 years and over 21/22

Indicator 4: Influenza immunisation coverage (B CW05, FA4) 21/22

Contact (role and name): Barbara Charuk, Portfolio Manager, WHANGANUI DHB

Target definition

Percentage of eligible population aged 65 years and over immunised against influenza (annual immunisation) for Māori, Pacific (where relevant), and Total populations.

The expectation of this measure is that DHBs will provide equitable immunisation coverage across their Māori, Pacific (where relevant) and total populations, aiming at coverage of 75 percent for each group.

Summary of results: Influenza Coverage 1 March – 30 September 2021
Please complete the table (optional) and provide a brief summary of the DHB's performance in the Progress Report section.

Target: 75%	Total	Māori	Pacific	Dep 9-10	Change: total	Change: Māori
Q1 2021/22	**73.8%**	**77.4%**	**97.5%**	**n/a**		
Q2 2021/22						
Q3 2021/22						
Q4 2021/22						

Progress report

- *Training of WAM staff for opportunistic immunisation education and provision – is planned for Q2. COVID activities have had an impact on being able to do this in the prior month.*
- *Decliners project – WDHB have involved health promotion team to makes sense of the "data". WRHN have been working with the qualitative data that they have collected as part of their BAU mahi and have been working with utilising the conversation prototypes that are evolving through the COVID hesitancy work, where applicable.*
- *BAU mahi includes phone text follow up, home visits when able depending on COVID alert levels, drop-in clinics, working with the GPT to advise, educate and support them in attaining target and paying attention to equity outcomes. Taking on board additional workforce to support the vaccinations efforts –across childhood, MMR and COVID.*

New initiatives and successes this quarter

- *7-week-old referrals (Q1) – initiated change and monitoring the impact that this will make on earlier follow ups.*
- *90-day upcoming report – this is being established for Q2 (unfortunate the timing of the recent COVID lock down and surge activities have disrupted this reporting. Notification to individual general practice teams will be part of this targeted report.*
  Completed draft scoping report for childhood immunisation. Draft being tabled at ELT for discussion and at Board for information.

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

- *COVID lockdowns and COVID Immunisation activities*

CW06 Improving breastfeeding rates

Whanganui DHB Q1 2021		**Reporter Name/Position: Barbara Charuk, Portfolio Manager**
	CW06 ***Improving breastfeeding rates***	
Target/Performance Expectation: 70% of infants are exclusively or fully breastfeeding at 3 months of age		
	Criteria	**Qualitative Report**

Population Baseline Performance	Total Population 21% Māori 17.3% Pacific 45.5 %	The WDHB's full time lactation consultant has been on extended sick leave over the course of this calendar year. Due to the nature of the leave, it has been difficult to predict the end of the leave and plan long term. We have been able to provide some short term solutions so women can still receive a service.
Activities	1. Supply an action plan that outlines activities that the DHB is engaging in to meet each of Outcomes 1-6 of the National Breastfeeding Strategy. 2. Describe activities that the DHB is undertaking to increase the baseline breastfeeding rate towards the target for the total population, and also specifically for Māori. Activities described must be specific, time-bound and evidence based.	Plan to be developed. WDHB has recently been re-accredited as a Baby Friendly Hospital, and this includes the rural birthing unit at Taihape. Increase access to education and support for breastfeeding in rural areas by employing a lactation consultant. This service has been operational since August 2020. The provider is receiving referrals from rural LMCs, has provided education to rural nurses as well as support to the student lactation consultant. This rural service continues to be well received and reaches those hard to service communities. We have negotiated with the provider to extend the area of coverage to include southern Rangitikei. A staff midwife has just completed her lactation consultant exams and we are awaiting the results. With this extra resource, it is planned that she will provide more home based support and education to vulnerable whanau. Increasing breastfeeding is a priority in integration workstream. The Health promotion team continues to support breastfeeding initiatives. This team has prioritised the early years as a focus and will work with the Maternal child and youth hub to develop a plan the support the increase of breastfeeding rates.

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Intervention Logic	There is a clear intervention logic outlining how the activities listed will improve Māori health outcomes and reduce health inequalities.	Working with Iwi partners, in particular tamariki ora to improve outcomes for Māori.
Monitoring/Evaluation	The DHB has outlined how they are monitoring or evaluating against the activities identified in the action plan.	The contracted provider submits quarterly reports on progress being made by lactation consultant in rural areas.

CW07 Improving new-born enrolment in General Practice

QUARTER 1 2021-2022
Period: 16 June to 15 September 2021

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

% Enrolled by 6 weeks of age
72.7%

17.7% above target of 55%.

Measure 2

% Enrolled by 3 months of age
86.2%

1.2% above target of 85%

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.

Barbara Charuk
Portfolio Manager

Combined Statutory Advisory Committee

CW08 Immunisation coverage at 2 years 21/22

Indicator 2: Immunisation coverage at 2 years (B CW08) 21/22
Contact (role and name): Barbara Charuk, Portfolio Manager WHANGANUI DHB
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						
Q3 2021/22						
Q4 2021/22						

Number	**Total**	**Māori**	**Pacific**
Opt off and declined	18 (7.4%)	13 (11.1%)	0 (0%)
Missed	26 (10,7%)	19 (16.2%)	0 (0%)

Progress report

- *Training of WAM staff for opportunistic immunisation education and provision – is planned for Q2. COVID activities have had an impact on being able to do this in the prior month.*
- *Decliners project – WDHB have involved health promotion team to makes sense of the "data". WRHN have been working with the qualitative data that they have collected as part of their BAU mahi and have been working with utilising the conversation prototypes that are evolving through the COVID hesitancy work, where applicable.*
- *BAU mahi includes phone text follow up, home visits when able depending on COVID alert levels, drop-in clinics, working with the GPT to advise, educate and support them in attaining target and paying attention to equity outcomes. Taking on board additional workforce to support the vaccinations efforts –across childhood, MMR and COVID.*

New initiatives and successes this quarter

• *7-week-old referrals (Q1) – initiated change and monitoring the impact that this will make on earlier follow ups.* • *90-day upcoming report – this is being established for Q2 (unfortunate the timing of the recent COVID lock down and surge activities have disrupted this reporting. Notification to individual general practice teams will be part of this targeted report.* *Completed draft scoping report for childhood immunisation. Draft being tabled at ELT for discussion and at Board for information.*
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*
• *COVID lockdowns and COVID Immunisation activities*

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

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

DHB:	WDHB	*please select from the drop down box*
Reporting Quarter:	Q1	*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	
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.	Our DHB have trained a maternal smokefree champion on ward who will be delivering bite size, relevant and up to date training material on ward during quite periods. These topics include maternity and vaping, how to use a smokerlyzer etc. 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.
What actions and/or projects is your DHB undertaking that reduces smoking in pregnancy, specifically for **Māori** and Pacific women?	After the success of the Heru **Hapā māmā** pilot we have engaged with the team and are planning for them to visit. Our Hepuna Ora team already provide many of these beautiful cultural practices for our wahine and whanau to participate in. We plan to use some of the Heru programmes ideas around social media,

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.

	recruitment and engagement and incorporate and localise our own imagery. Therefore, building on what we already have and working on increasing our numbers of participants and therefore quits.	
Is there anything else you would like to tell the Ministry?		

CW10 Raising Healthy Kids

Target: 95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions		
Deliverables definition: Each DHB must provide narrative comments on activities being taken to improve performance and achieve the target agreed through their 2021/22 Annual Plan. The narrative is to include: • specific activities undertaken for Māori and Pacific[1] populations		
Note: Please either complete this template or add your report (including the following points) to the website. All DHBs are expected to submit a report.		
Name of DHB: Whanganui	**Quarter reported on: Q1 2021-2022**	
Target performance to date and rate of progress based on data provided.		Action / deliverable timeframe
DHB Comments:	Result for Quarter: 89 **%.** **This made up of 72% referral acknowledged and 2% awaiting acknowledgment, 7% under care and 11% declined to be referred. 9% not referred.** **Numbers are small with only 5 checks being declined in this time frame.**	
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.		Action / deliverable timeframe
DHB Comments:	Before school check nurse are encouraged to review obese children regularly with a view to providing on-going support and advice at regular intervals. Referrals are reviewed monthly.	
Barriers to achieving the target and mitigation strategies over the next quarter by DHB and the PHOs.		Action / deliverable timeframe

[1] The requirement to report about Pacific people applies only to those DHBs with high Pacific populations. These DHBs are: Counties Manukau, Auckland, Waitemata, Waikato, Capital & Coast, Hawke's Bay, Hutt Valley and Canterbury.

DHB Comments:	None noted.	
Collective action and link to broader approach to reducing childhood obesity across government agencies, the private sector, communities, schools, families and whānau.		Action / deliverable timeframe
DHB Comments:	Raising awareness with practice nurse via electronic newsletter and face to face forums.	
What the DHB is doing to build in evaluation, measure effectiveness, and monitor outcomes over time.		Action / deliverable timeframe
DHB Comments:	On-going monitoring	

CW12: Youth Health Initiatives 2021/22

- 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
The WDHB organisational restructure was completed last year and the new maternal child and youth continuum has been established. From this, a newly developed group will be formed, known as a service level alliance. The TOR for this alliance was signed off and participants identified. Progress has been slowed due to COVID. The alliance will develop the 3-5-year strategic work plan for this continuum. Youth and youth specific service users continue to actively participate in the Maternal child and youth service level alliance. Family harm initiative (FLOW) led by the Police continues to provide leadership across sectors. The Children's Team governance group has been integrated into the FLOW strategic leadership group. A transition plan for the children's team has been implemented

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	Measure	Milestone	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

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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 complex cases. We are in dialogue with community mental health services to have a clinician see people at YOSS and also be the bridge between primary and secondary services			On Track
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
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 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			On track
Single point of entry for children and youth project to enhance access to hospital services			Yet to be launched

MENTAL WELLBEING

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

Quarter 1 Reporting -12 Month Period to 30 June 2021.

Reporting

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 June 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) 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

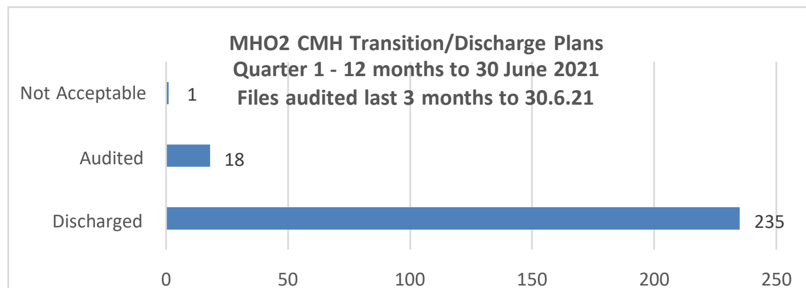
Inpatient data information extracted from WDHB MHS JCC032 Admission-Discharge with LOS report . Plans found in Transition/Discharge CP Notes. Risk Assessments.

Note

- 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.

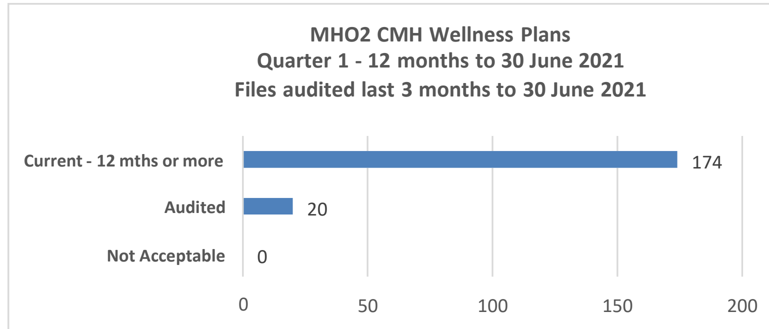
Reporting template

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
235	235	100%
Number of files audited with a transition (discharge) plan of acceptable standard (Data Source: DHB)	Number of files audited (Data Source: DHB) 3 month period to 30 June 21	Percentage with a transition plan of acceptable standard
17	18	95%



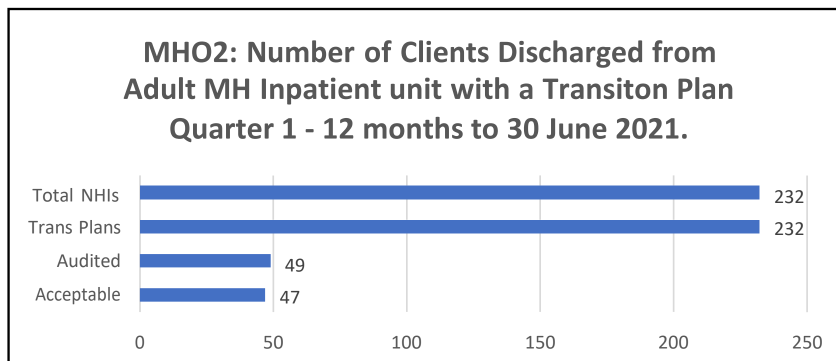
Reporting template

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
174	174	100%
Number of files audited with a wellness plan of acceptable standard (Data Source: DHB)	Number of files audited (Data Source: DHB) 3 month period to 30 June 21	Percentage with a wellness plan of acceptable standard
20	20	100%



Reporting template

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
232	232	100%
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
47	49	95.91%



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

Report Q1 2021/22

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?	The following action is in the DHB's current Annual Plan. The approach for this action is under discussion with key stakeholders. "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"

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MH04 Focus Area 1
Quarterly Primary Mental Health and Addiction reporting template

DHB Whanganui Year

1 Client Information

The number of people where the service is begun or delivered in the quarter

	People seen by service	Q1	Q2	Q3	Q4
	Clients aged 12-19				
1.1	Number of females seen	39			
1.2	Number of males seen	15			
1.3	Number of clients seen - unspecified gender	0			
1.4	Total number of youth seen	54	0	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+	Q1	Q2	Q3	Q4
1.11	Number of females seen	286			
1.12	Number of males seen	140			
1.13	Number of clients seen - unspecified gender	0			
1.14	Total number of adults seen	426	0	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	Q1	Q2	Q3	Q4
1.21	Number of referrals (12-19)	8			
1.22	Number of referrals (20+)	166			

Ethnic group

	Clients aged 12-19	Q1	Q2	Q3	Q4
1.23	NZ European	32			
1.24	Maori	22			
1.25	Pacific Island	0			
1.26	Asian	0			
1.27	Other	0			

	Clients aged 20+	Q1	Q2	Q3	Q4
1.33	NZ European	297			
1.34	Maori	106			
1.35	Pacific Island	8			
1.36	Asian	5			
1.37	Other	10			

	Kessler 10 Score	The average score at the start of care and at discharge for all clients discharged per quarter	Q1 at start	At exit
1.43	K10 average score (12-19)			
1.44	K10 average score (20+)		29	21

	PHQ-9 Score	Q1 at start	At exit
1.45	PHQ-9 average score (12-19)		
1.46	PHQ-9 average score (20+)		

	Other outcome measure	Q1 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			
1.52	Specialist CAMHS or Adult Mental Health Service (youth 12-19)	3			
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			
1.56	Specialist CAMHS or Adult Mental Health Service (adults 20+)	30			

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			
2.2	Adults (aged 20+) who received an extended consult	277			
2.3	Total	326			

2.7	General Practitioner - number of consults	254			
2.8	Practice Nurse - number of consults	64			
2.9	Total	326			

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			
3.2	Youth (12-19) average wait time from referral to first seen	NG			
3.3	Youth (12-19) DNA Rate (%)	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. Ask about the person's alcohol consumption; Brief advice is offered if there are concerns; Counselling 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			
4.2	Number of ABI sessions for adults aged 20+	113			
4.3	Number of ABI sessions for youth aged 12-19 (PH/AV)				
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			
5.2	Youth (12-19) average number of group sessions per client	3			
5.3	Youth (12-19) average wait time from referral to first seen	0			
5.4	Youth (12-19) DNA Rate (%)	5%			
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			
6.2	Youth (12-19) average number of sessions per POC	3			
6.3	Youth (12-19) average wait time from referral to first seen	14			
6.4	Youth (12-19) DNA Rate (%)	25%			
6.9	Number of POC for adults aged 20+	237			
6.10	Adults (20+) average number of sessions per POC	2			
6.11	Adults (20+) average wait time from referral to first seen	30			
6.12	Adults (20+) DNA Rate (%)	6%			
6.17	Total number of POC	268			
6.18	Total number of clients that missed any session or DNA	NG			
6.19	Total number of clients attending any sessions	NG			
6.20	Total number enrolled (if different to total attending sessions)	NG			
6.21	Total average number of sessions per POC	NG			
6.22	Total average wait time from referral to first seen	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

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. Ethnicity of 12 -19 year olds seen (38% Māori) indicates equal access for quarter 1 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).
Primary care teams can offer extended consults to youth to assess and identify primary mental health concerns. Youth may also be referred for counselling/therapy services. Virtual consults for POCs are offered via phone and video conference. Services have continued to be offered virtually during the escalated alert level change.
There were 225 contacts with rangatahi these three months including the groups that did run before the 18th

August and phone calls during Level 3 where full conversations were held not just appointments made. The response to Covid level lockdowns this year is different to 2020. Some rangatahi loved being at home so they could avoid school where thier anxieties are and others did not enjoy it all because they missed other rangatahi, even if they had social media. This year general theme is people are over it, bored and some rangatahi did not follow the rules. There was disappointment on the non availablity of the crisis respite beds in Palmerston North and the rangatahi concerned was too young for local respite (17 years).

7.2 Any major achievements/successes

New providers with expertise in working with young people added to contracted providers. Includes providers across more diverse geography e.g. in Ratana.
Readily able to capture the type of consults delivered considering the circumstances of COVID -19 and the impact of changing alert levels.
The sessions in the Whanau room at High School is working well with all Maori students Year 9 to 12 coming in groups on a Friday morning with their teachers to talk about mental health and what is it. Rangatahi are engaged in the conversations and the aim is to ensure the teachers can take over the process when they feel comfortable. This will make it more sustainable over time. The session at Tupoho Shcool are with Year 10 and have been fosused on drugs and alcohol awareness, goals and discussion about the furture careers. This is done in conjunction with SUPP.

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

POC wait times were impacted by the changes in COVID alert levels. At levels 4 and 3 our providers were working virtually but most patients preferred to wait to be seen face-to-face rather than receive virtual therapy.
Preferences to engage face-to-face have meant a delay in services being delivered during the elevated alert levels.
Covid-19 affected the face to face work of the 2 kaimahi who work in this contract. Both worked from home during Alert Level 3 connecting with rangatahi through phone and occasionally a zoom. The group programmes at Whanganui High School,Y Alt Education and Tupoho were stopped and even at Alert Level 2 the schools are not back to running these groups due to numbers.

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

No external audits have been completed in this quarter.

8 Adult PMH Narrative Report

8.1 Overall Assessment of services delivered.

Overall services appear adequate. Ethnicity of 20+ year olds seen (25% 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).
Primary care teams can offer extended consults to adults to assess and identify primary mental health concerns. Additional extended consults can be offered for proactive follow-up. Adults may also be referred for counselling/therapy services. Virtual consults for POCs are offered via phone and video conference.

8.2 Any major achievements/successes

New providers with good expertise contracted across geography e.g. in Ratana.
Readily able to capture the type of consults delivered considering the circumstances of COVID -19 and the impact of changing alert levels.

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

POC wait times were impacted by the changes in COVID alert levels. At levels 4 and 3 our providers were working virtually but most patients preferred to wait to be seen face-to-face rather than receive virtual therapy. Preferences to engage face-to-face have meant a delay in services being delivered during the elevated alert levels.

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

No external audits have been completed in this quarter.

MH04 Focus Area 2 District Suicide Prevention and Postvention

1. Training / education evaluation

There has been no training this quarter. Skylight is still being pursued for WAVES training.

2. Community initiatives evaluation

Event description	Initiated by DHB Y/N	Supported by DHB Y/N	Number of attendees	Implementation of *He Tapu te Oranga* (Action area/item)	Outcome /impact	Approach to safety
CASA visit on 2nd of August following a number of suspected suicides	Yes	Yes	30	Assisted with the formulation of a community response and identifying circles of vulnerability/vulnerable people	Development of an electronic mapping template	Continued liaison with CASA

MH04: FA3 Mental Health and Addiction Service Development CRISIS RESPONSE

The Balance service was facilitating Conversation Café as a community led, co-designing group of service users and representatives from the Whanganui DHB MHS. As a result, the Mental Health Assessment and Home Treatment Team (MHAHT) have co-designed a much awaiting information booklet that explains to the community what the service provides.

Due to COVID lockdown the peer led initiatives have been delayed.

There is a MHAHT dedicated staff member that attends the police station and educates and coaches police who are dealing with people in distress. The relationship is proving valuable with people that present to the police who have a mental health condition receiving timely and appropriate responses.

The MHAHT is under a change management process that includes opportunity for peer led innovations.

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

With Aotearoa moving into COVID19 levels 3 & 4 during this quarter, this led to disruptions of planned activities specially in the way of face-to-face trainings which had to be cancelled or rebooked for later in the year.

However, SPHC (COPMIA) presentation to the National NZNO Child and Youth Forum in Christchurch still went ahead (in September) with the move to an online zoom forum. The National CAPA forum presentation was also completed via the online Zoom medium in August. It was also possible to attend the National SPHC forum (held in September) when it was moved via zoom.

Requests for parenting support of parents experiencing mental illness and/or addiction have continued to steadily increase and for parents who were already participating in Triple P and Circle of Security parenting programs, support was offered via zoom and phone calls during the lock down period. Any new referrals were offered the Triple P online program with free access codes provided by funding from Werry Workforce and MOH. Existing parents were also offered the online program alongside, until face-to-face contact resumed for our area in September. All feedback from all programs has been positive and appreciated by parents.

Direct SPHC COPMIA education with a limited number of families continues and was particularly successful with a patient's children where the parent had an extended stay in an inpatient unit. Another was a parent who was having a planned admission to an inpatient unit and wanted some assistance to explain to her children about her mental illness, alleviate their fears and inform them regarding her upcoming hospital stay.

One Single Session Family Consultation training was implemented in August (before lockdown). Collaboration is ongoing with a local PHO who are considering SPHC (COPMIA) training for their newly implemented Health Navigators service. A collaborative children's program with a local NGO was completed.

This terms group consisted of 9 children (5 boys and 4 girls) ranging in age from 6 – 10. Each of the children have a parent or stepparent experiencing mental health or addiction issues, or mental distress. Primarily, this has been suicidal ideation with several of the parents having had recent admission to the adult acute mental health ward.

The NGO has also delivered anxiety management groups at a local secondary school. This is an ACT (Acceptance and Commitment Therapy) based 8-week programme.

Collaborative planning for 2022 SPHC (COPMIA) training schedule continues.

MH04 Focus Area 5 Improving Employment and Physical Health Needs of People with Low Prevalence Conditions Q1

Employment – Funded NGO Reports

From Quarter 1, July to September 2021, include:

- Four Paid employment outcomes for the quarter- one each for 14,15, 20 and 24 hours
- Two NZQA training outcomes
- Eight people have been referred into service since 1 July 2021
- From these referrals we have seen seven people enter the service this quarter
- Exit figures have seen four people leave the service for this quarter – all opting off because they did not require service anymore
- 20 people are currently active within the service at the end of September 2021, with a further two pending referrals
- Workwise had a long-term staff member retire, have gone through the recruitment process, hired and started a new Employment Consultant
- We have had an increased connection with Te Oranganui Trust and to present to their wider team in October

- 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, and had a combination of staff working from home wherever possible and in the community as required, while following the protocols.

Physical Health – Funded NGO Reports

- Assisting with the Covid Vaccination rates for those with Psychosocial Disability via the Ngtahi Ora Project. See www.ngatahiora.info This project has been funded out of the Ministry of Health Disability Covid Vaccination Fund. This is our focus at present and has the 0800 10 25 55 for those who use MHA services with vaccine hesitancy. See attached flyer.
- Splash Centre groups for swimming and gym use. We plan to restart these in Level 1 after stopping with Lock down.
- A walking group named **"Walk** & **Talk"** about to resume again after a break.
- Currently exploring Yoga again. We have run a yoga group for members before and currently seeking a teacher.
- The dietician from the WRHN is planned to talk to the various support groups.
- Assisting people to get to their Medical and GP appointments by providing transport and a peer support worker to go with them.
- Physical health (Te Taha Tinana) is part the Te Whare Tapa Wha self-management planning that is woven into the WRAP Planning education sessions we run on a 1:1 or group basis.

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

Numerator: to cover the 12-month period to June 2021
Whanganui number of Māori under s 29 community treatment orders 66

Denominator: as at June 2021
Whanganui Māori population 19,550

The Rate per 100,000 population of Māori under community treatment orders s29 of the Mental Health Act
Whanganui rate 338/100,000 Māori population in WHDB

WDHB Qualitative Report Quarter 1 –July 2020 to June 2021:

A focus on reducing Maori under compulsory treatment orders continues and is being led by the MHAS Medical Director.

The measures the DHB is undertaking are:

- Understanding the profiles of Maori under the MHA
- Peer review in the SMO peer review meeting of decisions regarding continuation of the MHA.
- Consumer advocate (Balance peer support) participation in section 14 or section 76 review
- Having a Haumoana navigator, Te Hau Ranga Ora (Maori cultural advisor) physically based in Te Awhina inpatient unit.

In this quarter the total number of Maori under any part of section 29 has reduced from 67 to 66 and the rate per 100 000 population from 355 to 338. Again, there has been a shift to inpatient status, (and back out again) for a small number of tangata whai ora who were formerly on section 29 orders. The challenge for these tangata whai ora is suitable accommodation and this is a persistent problem in this rohe.

Te Hau Ranga Ora Haumoana Navigators have developed a Te Ao Maori tool to help clinicians to better understand tangata whai ora. The first tranche of keyworkers was trained in its use on 1 July and the second group at the end of July 2021. Sadly, with the passing of two esteemed members of Te Hau Ranga Ora mid-year, this team is under pressure and less able to have a presence in the inpatient unit.

With small changes overall, it is hard to comment on the significance; but there appears to be a shift again towards indefinite orders. Clinicians are aware that with the "Repeal and replace" changes to the Mental Health Act, these will be subject to eventual review, but the commencement of this change has been deferred. In this relatively small community, there is still a sense that community treatment orders have utility; as keyworkers are usually able to track down tangata whai ora and ensure that they do receive their treatment. There are access and equity issues implicit in this which may actually be positive, in that they may prevent the level of deterioration that leads to readmissions and the disruption to life and relationships that ensue from a full relapse. It may be that the higher utilization of section 29 than the national average reflects this view on the part of both clinicians and whanau who are often supportive of their whanau member continuing under compulsory treatment.

As mentioned in the previous quarterly report, provision has been made for allocation of kaupapa Maori service clinicians as keyworkers for a very select number of tangata whai ora who specifically request their input. This will be specified in the responsible clinician's application to the court for consideration by the Family court judge on each occasion.

When people are admitted to the inpatient unit, they are routinely offered support from Te Oranganui trust. The partnership with the kaupapa Maori service in providing care to tangata whai ora offers hope of greater understanding between tangata whaiora, whanau, keyworkers and kaiawhina and the responsible clinician and the alliance may support engagement more effectively without the need for compulsion. That service is now at capacity, which points to the need for further workforce investment into kaupapa Maori service provision in this rohe and development of pathways into primary care.

To better understand the stories behind the data, a manual data set merged between the WebPAS PRIMHD reporting and the records kept by the MHA administrator has been obtained and has been compared with that from the last quarter.

As previously noted, those tangata whai ora with active whanau inclusion and engagement are more likely to be able to engage with services on a voluntary basis. For those estranged from whanau, including those whose whanau remain in Australia or even simply in a different level of lockdown, this is far more difficult, and they almost invariably have the added challenge of unstable

accommodation. For these tangata whai ora, active endeavours to support with the kaupapa Maori service kaiawhina are ongoing.

Clinicians would like to be able to capture data on the ongoing engagement of those who are released from compulsion and particularly to ensure that there is not a corresponding spike in activity with corrections services or alternatively a spike in admissions when tangata whai ora are released from compulsion.

In telling the story of Maori under section 29, we are telling the story of intergenerational trauma, institutional bias and discrimination and the far-reaching consequences of early life adversity. It makes sense that many of the interventions that will be most effective in the long term will be those directed towards the first thousand days of life and these will take time to bear fruit. Thus, we will be patient and maintain hope for change.

MH06 MH PRICE VOLUME SCHEDULE

DHB Price Volume Schedule 2021/22 Quarter 1

Source: DAP Production Plans 2021/22 (as at 10/9/21)

DHB	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 1Vol	Qtr 2Vol	Qtr 3Vol	Qtr 4 Vol
Whanganui	MHA11C	Mobile Intensive Treatment Service - Nursing and/or allied health	2.0	125,294	250,587	FTE	1.80			
Whanganui	MHA18C	Needs Assessment and Service Coordination - Nursing and/or allied health staff	0.6	125,294	75,176	FTE	1.00			
Whanganui	MHAD14C	Co-existing disorders (mental health & addiction) - Nursing and/or allied health sta	3.1	125,294	388,410	FTE	3.20			
Whanganui	MHD69	Alcohol & Other Drugs Service - Opioid Substitution Treatment – Primary Care Sup	45.0	2,767	124,495	Client	50.00			
Whanganui	MHD70	Alcohol & Other Drugs Service – Opioid Substitution Treatment – Specialist Service	90.0	3,663	329,629	Client	110.00			
Whanganui	MHD71C	Alcohol and other drug consultation liaison service – Nursing and allied health sta	0.2	160,682	27,316	FTE	0.20			
Whanganui	MHD74A	Community based alcohol and other drug specialist services – Senior medical sta	1.0	314,664	314,664	FTE	1.20			
Whanganui	MHD74C	Community based alcohol and other drug specialist services – Nursing and allied	6.4	125,294	801,880	FTE	6.30			
Whanganui	MHDI48C	Child, adolescent and youth alcohol and drug community services - Nursing and/o	1.0	125,294	125,294	FTE	1.10			
Whanganui	MHE30C	Community service for eating disorders - Nursing and/or allied health staff	1.2	155,943	187,132	FTE	1.20			
Whanganui	MHF81	Forensic Mental Health – Extended Secure Service	5,285.6	1,069	5,649,725	Available bed day	1,321.00	1,321.0	1,321.00	1,321.00
Whanganui	MHI44A	Infant, child, adolescent & youth community mental health services - Senior medic	2.0	314,664	629,328	FTE	2.10			
Whanganui	MHI44C	Infant, child, adolescent & youth community mental health services - Nursing/allied	12.0	125,294	1,503,524	FTE	12.20			
Whanganui	MHM90C	Specialist Community Team – Perinatal Mental Health – Nurses & allied health	1.5	136,494	204,741	FTE	1.80			
Whanganui	MHO101C	Mental Health Older People Dementia Behavioural Support – Nurses & allied heal	0.5	125,294	62,647	FTE	0.50			
Whanganui	MHO99A	Mental Health of Older People – Specialist Community Service – Senior medical st	0.5	314,664	157,332	FTE	0.50			
Whanganui	MHO99C	Mental Health of Older People - Specialist Community Service – Nurses & allied he	2.0	125,294	250,587	FTE	2.10			
Whanganui	MHW63D	Family whanau support education, information and advocacy service – Non-clinica	4.7	101,851	478,701	FTE	5.00			

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

Inpatient 7-day follow-up post discharge measure

Percentage of MH&A Total clients discharged from MH&A adult inpatient services that are followed up within 7 days.		
160	**216**	**74.1%**
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.		
66	**87**	**75.9%**
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 4 & 3 restrictions and expect to see 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 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 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.

PRIMARY CARE

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

QUARTER One
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	On track		
Acute hospital bed days	On track		
Amenable mortality	On track		
Patient Experience of care	On track		
Youth access to and utilisation of youth appropriate health services	On track		
Babies living in smokefree homes	On track		

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

Submission to the Ministry of Health – attach to your System Integration quarterly report and submit through the quarterly reporting data base for PP22.

	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**
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	**Q1**
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 has been challenging due to COVID-19 lock down and the subsequent post lockdown catch up of deferred health needs. The continued focus to on-board primary care providers to deliver and support the COVID-19 vaccination programme has also impacted on general practice resource. 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	Help for our enrolled Māori who are registered as smokers has been better from an equity perspective, with a greater

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?	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. Specialist kaiāwhina support has distributed 22 Wahakura in this quarter, 68% to Māori mama 5% to PI So in all 22 whānau were supported around SUDI, given positioning advice as well as explaining about babies airways, history of wahakura, and the changes in knowledge about SUDI over the years. All whanau are invited to share in this messaging so that everyone hears the same story. 27% were smoking hapu mama. Smoking mama and /or smoking whanau are encouraged to consider giving up and once ready to do are referred to quit services for expert support.
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?	

Strong and equitable public health and disability system

SS11: Faster cancer treatment (62 days)

Unfortunately the Faster Cancer Report cannot be included in this report due to formatting incompatibilities.

See Appendix 1 FCT

SS04 Implementing the Health Ageing Strategy

Q1

1.a COVID-19	Report on key actions to contribute to a national process to improve preparedness for a pandemic outbreak on services in the community for older people, using COVID-19 learnings (this may include, for example, workforce cover, staffing contingencies and education, how to provide support for vulnerable people and workers, new ways of working that can be used during BAU).	*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*
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.*
	Report on local and regional activity to use falls data to improve system outcomes as per the **“Live Stronger for Longer”** Outcome Framework.	*Following a review of the service delivery for falls (and pressure injuries) 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. Falls data has informed this review.* *The feedback (released 17 October) from the discussion document has indicated that it needs to go to formal consultation on how services are delivered going forward.*
	Report on activity to promote and increase programme enrolment.	*COVID has been a disruptor*

1.c Dementia Services	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*
1.d Early Supported Discharge Services	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*
	Report on key activity to deliver rehabilitation or care services in the community for patients requiring an integrated response on discharge or to prevent an admission to hospital.	*The narrative on the above action applies to this one also*
	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*

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.*

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):**	11	11	youngest 1 aged 59
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+):**	20	20	Oldest person seen age 98. During COVID 19 Levels 3 and 4 the clinicians continued to contact patients, current and from the waitlist for telehealth to ensure they where safe and had the support needed and access to food.

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):**			Due to COVID19 levels 3 and 4 the exercise groups have been unable to run. In level 2 the groups that have been able to restart are doing so with reduced capacity in order to maintain social distancing of 2 meters. Classes stopped running for half of the quarter. We have been unable to get this data frmo group providers.
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):**	19	19	33 seen 50-65 years
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):**	17	17	
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+):**	16	16	
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 years** who received a DEXA scan following identification of a fragility fracture	6	6	31 dexa ordered

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	4	
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	2	2	
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	0	0	

SS06 Better help for smokers to quit (Hospital)

From: Leigh Sturgiss <Leigh.Sturgiss@health.govt.nz>
Sent: Wednesday, 6 October 2021 8:52 am
To: Rosie McMenamin <Rosie.McMenamin@wdhb.org.nz>
Subject: Reporting on the Hospital/Secondary care indicator - Better help for smokers to quit

Mōrena Rosie

I'm really pleased to let you know that because Whanganui DHB has consistently met and maintained the Better help for smokers to quit – hospital indicator you are no longer required to report on this indicator.

Thank you for all your work in this area and please pass my thanks onto your team.

The database will be updated to reflect this change.

Reporting on the primary care and maternity indicators is unchanged.

Ngā mihi

Leigh

Leigh Sturgiss
Senior Advisor
Tobacco Control Team
DDI: 04 816 2554
Mailto: leigh.sturgiss@health.govt.nz

SS09: Improving the quality of identity data PRIMHD

Focus area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)

Indicator 1: PRIMHD data quality

Please provide date(s) of routine data quality audits and corrective actions if any.

Dates(s) of routine audit(s)	Corrective actions (if no corrective actions please indicate – NIL)
Routine audits are completed weekly throughout the year	WDHB has an exemption from the ministry of health for reporting PRIMHD data, approved to 30 June 2022. Our regional system needs to be upgraded to V11. WDHB are also working closely with Mid Central and TAS on 1 July 2021 changes due to mapping issues where valid codes have been used for activities prior to their start date of 1 July 21. Testing is ongoing.

SS10: Shorter stays in Emergency Departments

2021-22 Quarterly Reporting for Acute Demand and Shorter Stays in Emergency Departments

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

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

	Maori ethnicty			**Pacific Ethnicity**			**Total Population**		
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
July	545	587	93%	39	44	89%	1,884	2,072	91%
August	449	478	94%	43	46	93%	1,700	1,861	91%
September	374	409	91%	21	23	91%	1,518	1,671	91%
DHB total	1,368	1,474	93%	103	113	91%	5,102	5,604	91%

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)

	Total Attendances	**In ED over 6 hrs**	**% over 6hrs**

Not Admitted	3161	415	13%
Admitted	2443	95	4%
Total	5604	510	91%
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	**ED flow issues assessed in light of COVID service change**
2. Planned work for next quarter	**Ongoing assessment and planning for COVID response and maintaining flow and segregation of red/orange/green pateints**
3. Barriers to achieving or maintaining the indicator	
What support can the Ministry provide	

SS11: Faster cancer treatment (62 days)

Unfortunately the Faster Cancer Report cannot be included in this report due to formatting incompatibilities.

See Appendix 1 FCT

SS13: FA3 Cardiovascular health

SS13 FA3 – Cardiovascular Disease Quarterly Reporting template 2021/22 – Quarter 1

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.

Whanganui Regional Health Network **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)

National Hauora Coalition
NHC provides Mohio CVD Risk Assessment Tool to practices across its network. This CVD Tool is HISO certified.
NHC has rolled out the full 2018 Consensus Statement across its network from March 1st 2021.
Reporting includes all in the 2018 Consensus Statement cohort except for SMIs from 25 years.
NHC participated on the Ministry of Health Webinar in March 2021

Do PHOs and practices regularly report against any local CVD indicators? If so, please describe the indicators below.

Whanganui Regional Health Network
Previously reported indicators continue to be available for general practices though powerBi

National Hauora Coalition
NHC Whanganui Practices have access to a Daily Status Board outlining their clinical performance for CVD.
Health Target Patient Lists are also provided by age and ethnicity.

Have you considered or implemented CVD risk assessment aligned to COVID vaccination? If so, how is this linked to CVD risk management conversations?
Whanganui Regional Health Network
Not yet

National Hauora Coalition
Yes - NHC has considered this however believe that COVID Vaccinations are our single priority at this point in time.
Uptake of the 2018 Consensus Statement Cohort to date is tracking well.

Ethnicity	Screened	Eligible	% Screened	Screened	Eligible	% Screened	Screened	Eligible	% Screened
Maori	26	46	56.52%	43	58	74.14%	170	190	89.47%
Pacific	0	2	0.00%	9	9	100.00%	22	22	100.00%
Indian	3	5	60.00%	15	17	88.24%	8	10	80.00%
Other Asian							18	21	85.71%
European	7	14	50.00%	10	20	50.00%	1051	1115	94.26%
Other				1	2	50.00%	14	15	93.33%

	Male						Female			
	30 - 34		35 - 44		45 - 74		40 - 44		45 - 74	
Ethnicity	Screened	Eligible	Screened	Eligible	Screened	Eligible	Screened	Eligible	Screened	Eligible
Maori	26	46	43	58	170	190	30	40	224	244
Pacific	0	2	9	9	22	22	2	2	20	22
Indian	3	5	15	17	8	10	2	3	11	13
Other Asian					18	21			10	10
European	7	14	10	20	1051	1115	8	12	832	891
Other			1	2	14	15	1	1	11	12

Ethnicity	People with diabetes + CVD event	People with diabetes + CVD event + triple	Enrolled pop + CVD event	Enrolled pop + CVD event + triple therapy	Aged 30 - 74 people with diabetes + CVD risk > 20%	Aged 30 - 74 people with diabetes + CVD risk > 20% + dual therapy	Aged 30 - 74 enrolled pop + CVD risk > 20%	Aged 30 - 74 enrolled pop + CVD risk > 20% + dual therapy
Maori	18	10	68	38	15	9	30	16
Pacific	1	1	3	2	0	0	0	0
Indian	0	0	2	1	0	0	0	0
Other Asian	1	1	1	1	0	0	0	0
European	85	49	422	196	26	15	57	29
Other	0	0	4	1	0	0	0	0
Total	105	61	500	239	41	24	87	45

	Male						Female			
	30 - 34		35 - 44		45 - 74		40 - 44		45 - 74	
Quintile	Screened	Eligible	Screened	Eligible	Screened	Eligible	Screened	Eligible	Screened	Eligible
					3	3			2	2
0					5	6			2	2
1	3	4	7	7	137	147	2	2	98	112
2	3	4	6	6	142	153	7	7	111	115
3	2	6	7	13	213	225	3	3	162	176
4	11	20	19	25	306	321	10	16	278	295
5	17	33	39	55	477	518	21	30	455	490
Total	36	67	78	106	1283	1373	43	58	1108	1192

	CVD Risk Assessments/DAR for Patients with Diabetes			CVD Risk Assessments/DAR for Patients with Diabetes		
	Male			Female		
	25 - 74			25 - 74		
Ethnicity	Screened	Eligible	% Screened	Screened	Eligible	% Screened

Maori	37	37	100.00%	32	32	100.00%
Pacific	4	4	100.00%	1	1	100.00%
Indian	1	1	100.00%	0	1	0.00%
European	103	104	99.04%	106	109	97.25%
Other	2	2	100.00%	1	1	100.00%

	CVD Risk Assessments for Patients with Other Risk Factors (exluding patients with diabetes)			CVD Risk Assessments for Patients with Other Risk Factors (exluding patients with diabetes)		
	Male			Female		
	35 - 74			45 - 74		
Ethnicity	Screened	Eligible	% Screened	Screened	Eligible	% Screened
Maori	72	85	84.71%	103	109	94.50%
Pacific	7	7	100.00%	5	6	83.33%
Indian	8	8	100.00%	5	6	83.33%
European	286	324	88.27%	234	259	90.35%
Other	12	12	100.00%	6	6	100.00%

SS13: FA4 Acute heart services

Name of 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).
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)	15/28 53.6%	4/7	1/1	1/2	0/0	9/18
INDICATOR 2a Quarterly percentage performance against indicator 2, (use KPI October 2021 quarterly detailed report):	30/30 100%	7/7	1/1	1/1	0/0	21/21
INDICATOR 2b Percentage performance against indicator 2, for 90 days prior (use October 2021 quarterly detailed report, and record Quarter 4, 2020/21 result)	41/41 100%	8/8	2/2	1/1	1/1	29/29
INDICATOR 3 Quarterly percentage performance indicator 3 (use KPI October 2021 quarterly detailed report)	20/28 71.4%	3/6	0/1	1/1	1/1	22/28
INDICATOR 4 Quarterly percentage performance indicator 4, (use KPI October 2021 quarterly detailed report)	15/19 78.9%	4/5	0/0	0/0	0/0	11/14
INDICATOR 5a Quarterly percentage performance indicator 5a, (use KPI October 2021 quarterly detailed report) which reports registry completion in May, June, July).	N/A					
INDICATOR 5b Quarterly percentage performance indicator 5b, (use KPI July 2021 quarterly detailed report) which reports registry completion in May, June, July.	N/A					
	DHB comments					

	Acute heart services are provided by our partner DHB at CCDHB. We continue to work with them on providing fair and equitable services for our patients.

SS13: FA5 Stroke services

does not have a dedicated medical, nursing and allied health lead position filled you are not meeting the requirements for an acute stroke service.

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	Confirmed result indicator 2 for Q4	Confirmed result indicator 3 for Q4	Confirmed result indicator 4 for Q4
ASU 80%: Percentage: Total 100% Māori-100% Denominator: Total-36 Māori-2 Numerator: Total-36 Māori-2	Reperfusion – Thrombolysis /Stroke Clot Retrieval 12% 24/7: Percentage: Total 25% Māori-50% Denominator: Total- 32 Māori-2 Numerator: Total-8 Māori-1	Inpatient Rehabilitation 80%: Percentage: Total-80% Māori- 100% Denominator: Total-10 Māori-2 Numerator: Total-8Māori-2	Community Rehabilitation 60%: Percentage: Total-13% Māori-0% Denominator: Total-8 Māori-1 Numerator: Total-1Māori-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).
(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 telestroke 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)

- **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. Ongoing training is occurring to support after hours response.

<table>
<tr><td colspan="2">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)
(See Minimum Expectations attached for guidance)</td></tr>
<tr><td>DHB Comments:</td><td>Indicator 3 = met.
Our comprehensive stroke unit facilitates early access to rehabilitation services.</td></tr>
<tr><td colspan="2">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)</td></tr>
<tr><td>DHB Comments:</td><td>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</td></tr>
<tr><td colspan="2">Other:
-</td></tr>
<tr><td>DHB Comments</td><td>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.

WDHB is a priority DHB for the HPA FAST campaign roll out. WDHB stroke service is engaged in a collaborative HP activity with National Stroke Foundation, Maori HP Nita Brown, HPA – Johnny Akatapuria, WDHB HP team, WRPHN HP team and Stroke Central. We are liaising with local Maori communities regarding a kaimahi self-management programme. A hui has been held at Ratana and Raetihi. Further hui are being arranged with the Whanganui Awa community.
We are currently exploring tele-ambulance with St Johns Ambulance service in collaboration with the learnings from the Wellington Free ambulance and CCDHB pilot.</td></tr>
</table>

SS15: Improving waiting times for colonoscopies

Ministry Feedback

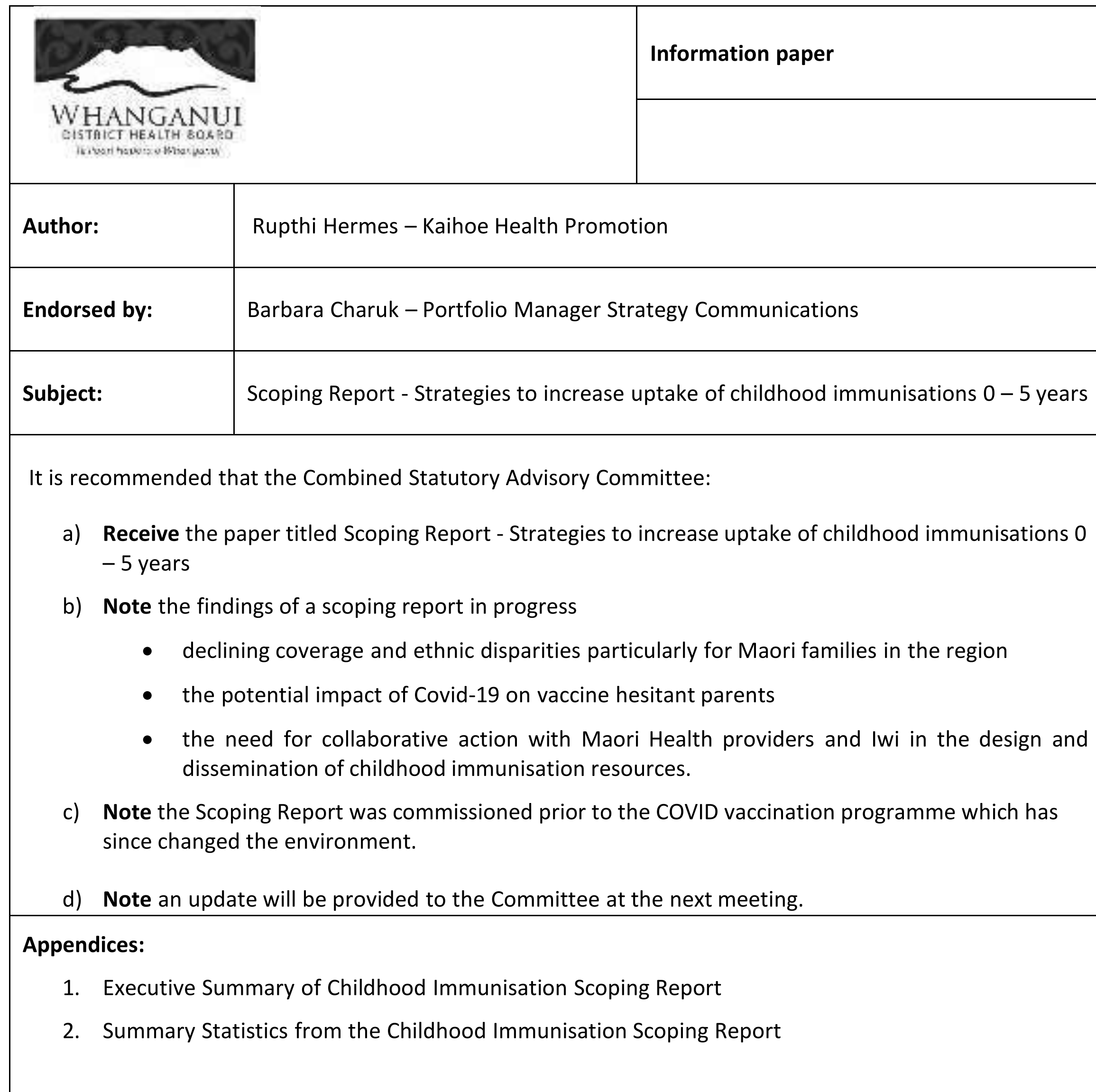
8/11/21 Initial Feedback: Ministry notes the ongoing impact of COVID-19 restrictions on the DHB's capacity to meet colonoscopy wait times and recent data integrity issues being resolved. We appreciate steady progress toward meeting maximum wait times (9 people waiting beyond maximum) and commend recovery of all recommended wait times as of Sept 2021.

Initial Rating P

Confirmed Rating NA

End of CSAC REPORT

November 2021 **Public**



WHANGANUI
DISTRICT HEALTH BOARD

Information paper

Author:	Rupthi Hermes – Kaihoe Health Promotion
Endorsed by:	Barbara Charuk – Portfolio Manager Strategy Communications
Subject:	Scoping Report - Strategies to increase uptake of childhood immunisations 0 – 5 years

It is recommended that the Combined Statutory Advisory Committee:

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.

Appendices:

1. Executive Summary of Childhood Immunisation Scoping Report
2. Summary Statistics from the Childhood Immunisation Scoping Report

1 Purpose:

This paper provides information about a scoping report evaluating childhood immunisation issues for the Whanganui-Manawatu region. The scoping report undertaken by Public Health responds to a letter from Deputy Director-General of Population Health and Prevention regarding WDHB's performance in meeting immunisation targets in 2020/21.

2 Background

Recent declines in vaccination rates in the Whanganui-Manawatu, place the region and its surrounds at risk of outbreaks of vaccine preventable disease. Current immunisation coverage levels are below the threshold for herd immunity.

Herd immunity is the proportion of a population that needs to be vaccinated in order to prevent disease spread and provide protection to those that aren't immunized. For the childhood immunisation

programme 95% of the eligible population under five needs to be immunised to achieve the target of herd immunity.

Vaccination at 8 months, 2 years and 5 years of age, is indicative of population coverage by which time children who have experienced delays to scheduled immunisations, should have completed the schedule. For Whanganui-Manawatu region, coverage levels in 2021 was 82.5% at 8 months, 87% at 2 years, 87.4% at 5 years. (Ministry of Health, National and DHB Immunisation data 2021) National coverage in the same period was 88.4%, 88.3%, 86.7% respectively (Ministry of Health, National and DHB Immunisation data 2021)

3 Summary of findings

Children missing out on immunisations include those whose parents *decline/opt-out* of the entire schedule of childhood immunisations, and children whose immunisations fall outside the date for any particular age milestone – *missed timely immunisation.*

Public Health has undertaken scoping work through a review of National Immunisation Register (NIR) data focussing on children that have missed timely immunisation and those that have declined all immunisations. In 2020/21 families missing timely immunisations for milestones are predominantly Māori - 65% . Likewise, families declining all immunisations are also predominantly Māori – 63%.

A file review of Outreach Service files for families that have missed timely immunisations in 2021, has been undertaken to characterise those families that are under-vaccinated. Findings show that 25% of clients missing timely immunisation have underlying housing and accommodation issues with associated transience*;* Social issues including domestic violence, was present in 13% of the cohort; 16% of families subsequently declined or were hesitant when visited by the Outreach team, whilst 9% poorly connected and engaged with health systems. (see attachment for a more complete breakdown of missed vaccinations)

3.1 Impact of Covid-19

Prior to Covid-19, a national survey on vaccine attitudes shows that during 2013-2017, 30% of respondents had decreased vaccine confidence in all vaccinations. (Lee et al, 2020) The commencement of a Covid-19 population vaccination programme has reproduced some of the same disparities seen in childhood immunisations and may have increased anxiety for parents who are already vaccine hesitant.

Increase in children missing timely immunisations and parents declining/opting-out of all immunisations peaked in the 3rd and 4th quarter in WDHB. The aftermath of Covid-19 and lockdowns has adversely affected the social determinants of health for families in the Whanganui region. Housing woes, increased mobility, and social issues with secondary impacts on accommodation has contributed to declining coverage, particularly amongst Maori populations. (see attached summary statistics)

Sub-populations described in the scoping report missing out on childhood immunisations, are probably representative of families missing out on other scheduled immunisations across the age-spectrum. Other scheduled immunisations beyond childhood period include year 11 and 12 Human Papilloma Virus (HPV) and Boostrix (combined tetanus, diptheria and whooping cough), adult boostrix, influenza and shingles for the elderly. Therefore, a whanau-centred approach involves service delivery encompassing the needs of the whole family.

The scoping report has caused us to question the need for a separate communication and engagement strategy and recommend a combined approach that is developed collaboratively with local Iwi and Māori Health providers. This ensures Whanau, hapu and iwi have Tino Rangatirangatanga over the design and deliver support and resourced appropriately by the WDHB.

November 2021 **Public**

4. Recommendations

a) 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

b) Note the scoping report was commissioned using 1 April 2020 to 30 June 2021 statistics. The immunisation environment has evolved with the COVID vaccinations taking precedence. The request to relaunch the MMR Vaccination programme as well as introducing COVID vaccinations to 5-12 year olds in January 2022 will be the focus.

c) Note an update will be provided to the Committee at the next meeting.

5. Bibliography

1. Ministry of Health National and DHB Immunisation data October 2021 Accessed 29/09/2021 https://www.health.govt.nz/our-work/preventative-health-wellness/immunisation/immunisation-coverage/national-and-dhb-immunisation-data

2. Lee, C., & Sibley, C. G. (2020). Attitudes toward vaccinations are becoming more polarized in New Zealand: Findings from a longitudinal survey. *EClinicalMedicine*, *23*, 100387

November 2021 Public

WHANGANUI DISTRICT HEALTH BOARD	**Information Paper**
	Item No

Author	Eileen O'Leary, Kaitakitaki Equity
Endorsed by	Louise Allsopp, GM Patient Safety, Quality and Innovation Rowena Kui, Kaiuringi, GM Māori Health and Equity
Subject	**Update on Whanganui DHB's Consumer Engagement Council – Te Pukaea**
Equity	Equity is reflected both in the make-up of the reconstituted Te Pukaea and in the planning for more authentic consumer engagement, fundamental to the pro-equity agenda.

Recommendations

Management recommend that the Combined Statutory Advisory Committee:

a. **Receive** the paper titled: Update on Whanganui DHB Consumer Engagement Council – Te Pukaea.

b. **Note** 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.

iii. Develop work programme.

Appendix

1. **WDHB Consumer Engagement Strategy**
2. **Te Pukaea Terms of Reference**

1 Purpose

The purpose of this item is to provide the committee with an update on Te Pukaea which has been reconstituted in line with recommendations from the consumer engagement review undertaken in 2020 by Baker Consulting Ltd.

2 Background

In 2015 Whanganui DHB set up a consumer advisory group, Te Pukaea, to provide a 'consumer/family perspective in planning, implementing and evaluation services, systems and processes to improve the quality and safety of patient care'.

In 2020 Baker Consulting reviewed the DHB's wider approach to consumer engagement and recommended Te Pukaea be reconstituted with a broader role and more representative membership as part of the overarching approach to consumer engagement. This also required re-considering the consumer roles on other DHB advisory groups and setting clearer expectations of DHB staff to ensure a consistent whole-of-system approach to consumer engagement across Whanganui DHB.

Te Pukaea was temporarily disbanded and a consumer network, comprising of consumers in various roles across the DHB, was formed and met regularly to provide on-going consumer advice during the process of formally reconstituting Te Pukaea. This included developing a strategy (Appendix One), agreeing a structure and overarching principles and writing Terms of Reference. An Expression of Interest and interview process was undertaken to identify suitable members.

3 Health Reforms

All the indications from the Government and Transition Unit are for a stronger role for consumers in future with the Health Quality and Safety Commission providing strategic advice on embedding consumer engagement. The Pae Ora (Healthy Futures) Bill, which will provide the legislative foundation for the reforms, refers to a Code of Consumer Participation, 'which will support consumer participation and enable the consumer voice to be heard'.

Whanganui DHB is fortunate in having Frank Bristol on the Health Quality and Safety Commission consumer advisory group (CAG) and able to share his knowledge and keep the development of WDHB's consumer engagement aligned to the national planning.

4 Te Pukaea Reconstituted

4.1 Terms of Reference

The Terms of Reference is included in Appendix 2 for information. Te Pukaea forms part of the Patient Safety, Quality and Innovation Team and will be supported by the Clinical Manager, with the GM Patient Quality, Safety and Innovation as the executive sponsor with GM Māori Health & Equity.

Te Pukaea is equivalent in standing to the Clinical Board, providing consumer leadership by working collaboratively with WDHB governance and leadership. Te Pukaea brings the consumer / whānau voice to the design, function and monitoring of equitable, effective whānau/patient-centred health services in the WDHB rohe.

Te Pukaea is primarily focused on:

- the achievement and demonstration of equity in health outcomes as set out in He Hāpori Ora and the DHB's pro-equity strategic focus
- providing consumer leadership to WDHB
- supporting safe services, quality improvement and providing advice to encourage and achieve best practice and innovation for WDHB
- providing a strong, representative and viable voice for the consumers and their whānau on health service planning and delivery.

Through the Co-Chairs, Te Pukaea will provide twice-yearly of reports of Te Pukaea activities and recommendations to the Kaihautu Hauora/CE, through the GM Patient Safety, Quality and Innovation. These reports will be sent through WDHB leadership to the Combined Committee and respective WDHB boards.

4.2 Membership

In line with the Terms of Reference two co-chairs were appointed, one Māori and one non-Māori and then these two people: Bonnie Sue and Frank Bristol, were involved in identifying the best candidates for remaining Te Pukaea membership.

Te Pukaea was to be comprised of eight members excluding the co-chairs but in the interviewing process nine high calibre candidates were identified and therefore the new Te Pukaea will have 11 members. The new membership includes more than 50% Māori, one person with strong tangata Pasifika

knowledge, two people with strong disability knowledge, both male and female representation and a good rural / urban coverage of experience.

The full membership is:

- Bonnie Sue (co-chair)
- Frank Bristol (co-chair)
- Annie Neho
- Carla Donson
- Christie Teki
- Hawea Meihana
- Hellen Puhipuhi
- Marilyn Vreede
- Ruth Bennett
- Sue Kenny
- Susan Haynes Veart

5 Orientation

Hapai te Hoe, tailored for the group was held in October to powhiri Te Pukaea members and begin the orientation to the organisation, the commitment to consumer engagement and their roles.

6 Next Steps

Next steps include:

- Complete orientation
- 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.
- Develop work programme.

COVID Vaccination

WDHB – 12 November 2021

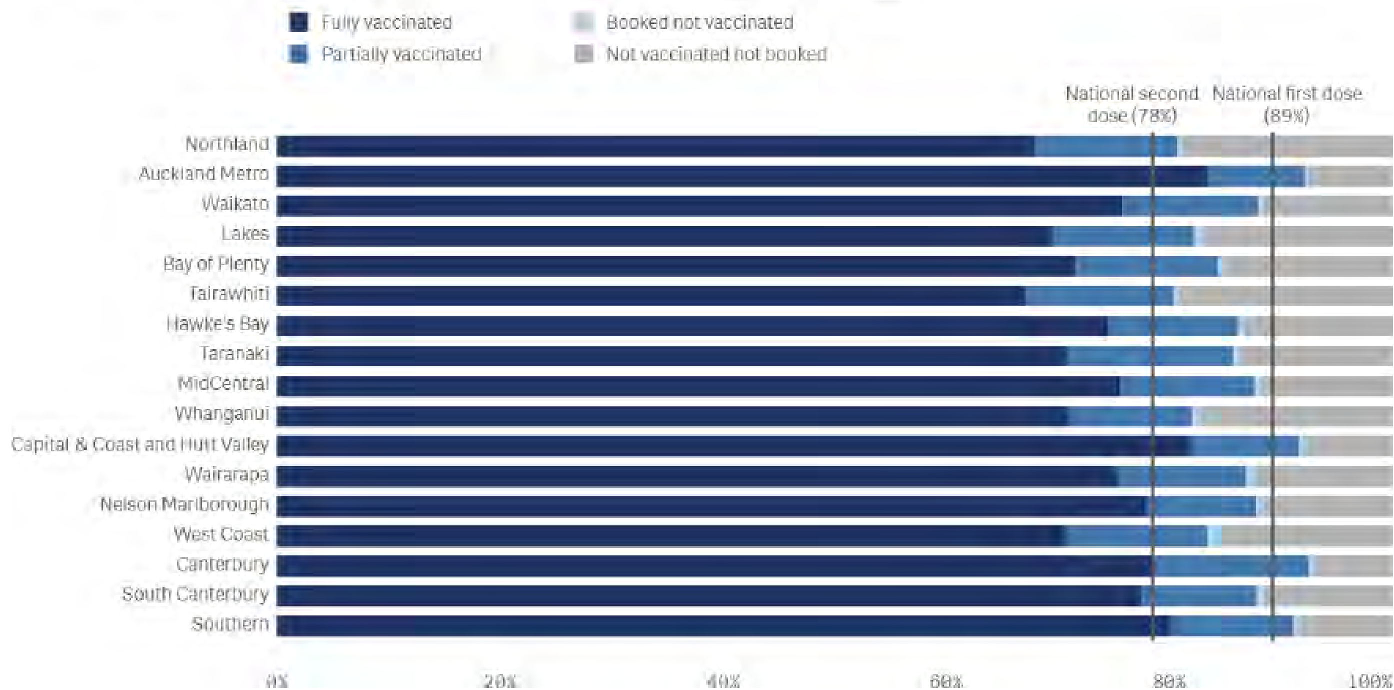
Objectives

1. 90% vaccination of population
2. Pro – equity – 90% for Maori, Pacific, disability sector etc
3. 100% staff first vaccination by 15 November 2021
4. 100% staff second vaccination by 01 January 2022

Followed by

5. 5-11 role out from Jan 22
6. Booster program from April 2022

Progress to date of all DHB’s



DHB’s with high Maori, low socio-economic and high rural spread are slowest.

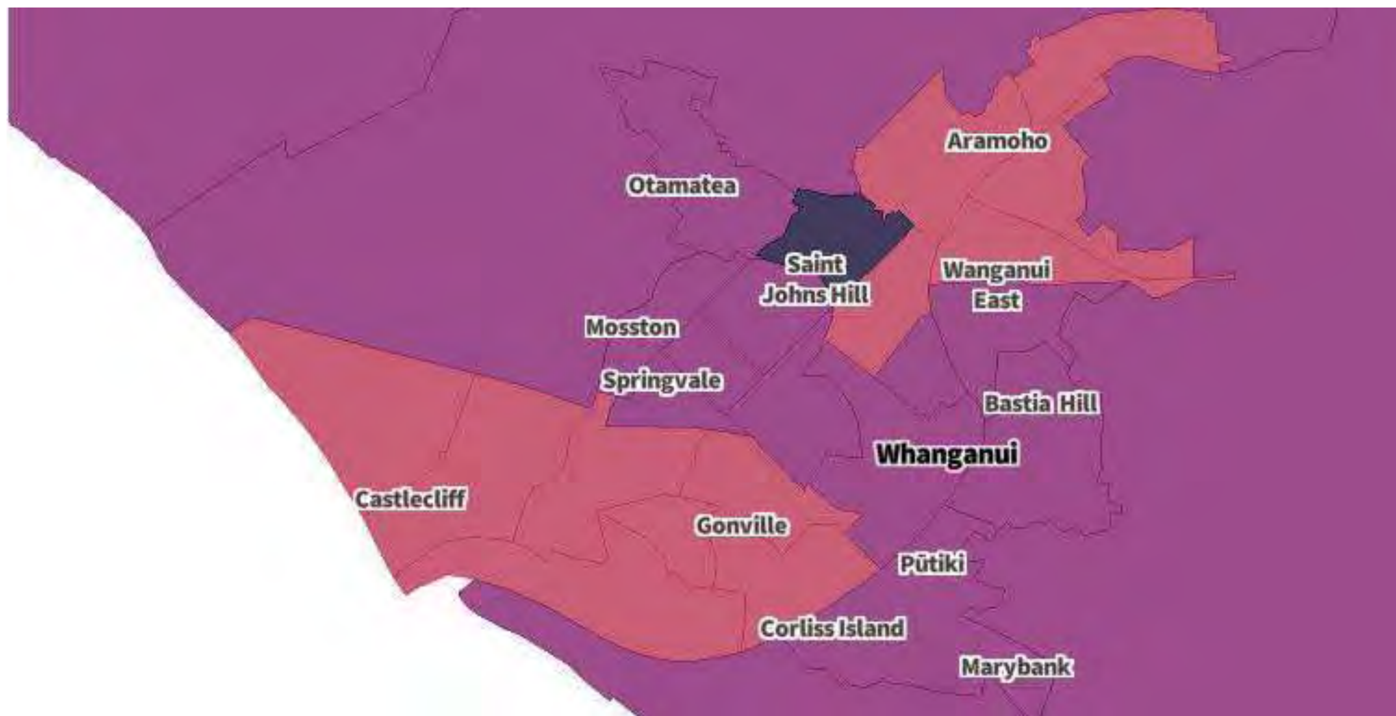
WDHB Current Position

Vacinations to 90% - 8 Nov	First doses	First doses %	First doses to 90%	Second doses	Second doses %	Second doses to 90%	Population
All Ethnicities Wanganui	47,444	83%	4,078	41,688	73%	9,834	57,247
All Ethnicities New Zealand	**3,779,577**	**90%**	**32,601**	**3,366,819**	**80%**	**421,332**	**4,209,057**
Maori - Wanganui	9,353	69%	2,808	7,411	55%	4,750	13,512
Maori - New Zealand	**432,062**	**76%**	**81,885**	**338,442**	**59%**	**175,505**	**571,052**
Pacific - Wanganui	1,099	80%	144	910	66%	333	1,381
Pacific - New Zealand	**250,660**	**87%**	**7,353**	**213,175**	**74%**	**44,838**	**286,681**

Progress in 3/7: 4078 firsts to go (down from 4500 at Exceptional Board meeting)

2808 of the firsts are for Maori to get to 90% (was 3000 at Exceptional Board meeting). This is the target area

Locations to target



We have data to a suburb and street level street level

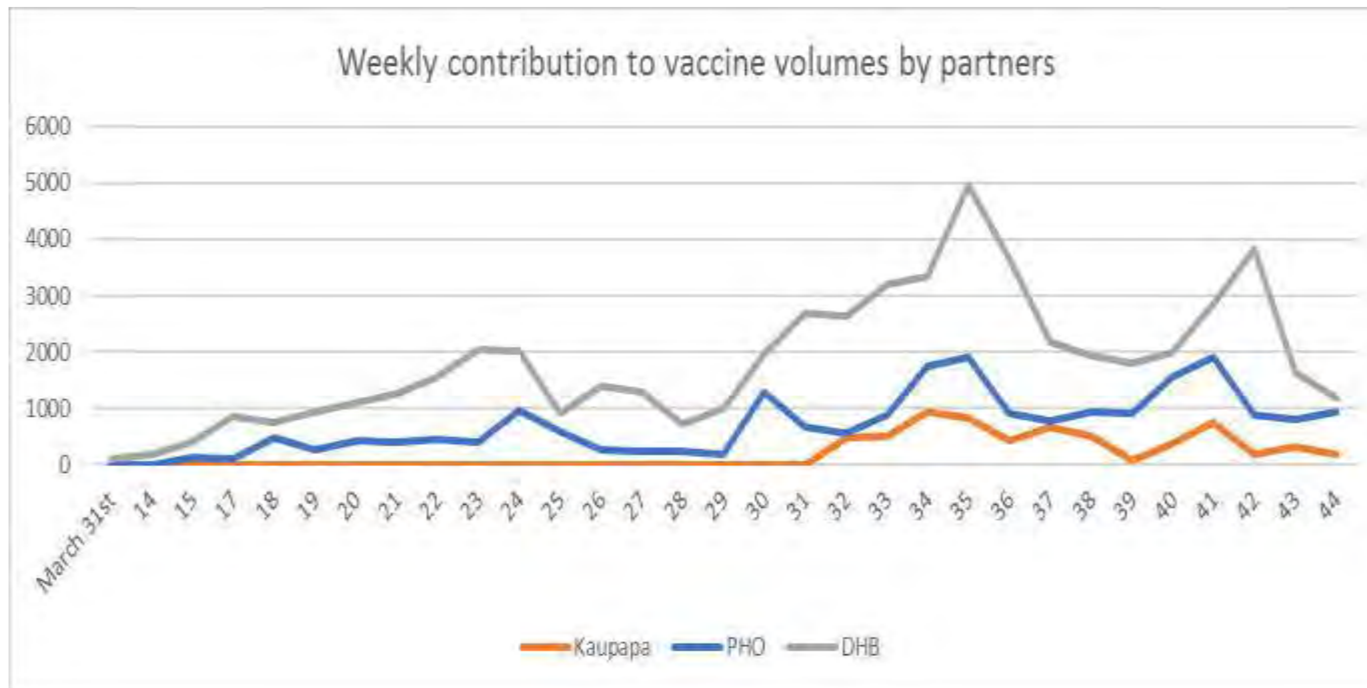
What are we doing now?

- This week, 18 pop ups occurred, plus three workplace vaccination sites, three mobile house to house teams (one Maori Health team), primary care, kaupapa and DHB clinics across the district.

- Next week multiple pop ups are planned across the district, plus the house to house teams with increased vaccinations planned in primary care.

- The operations team are working to support Te Ranga Tupua to stand up a vaccination service (see separate slide)

Weekly contribution by DHB and partners



Decreasing DHB input and increasing primary and kaupapa

What are we planning for the next month?

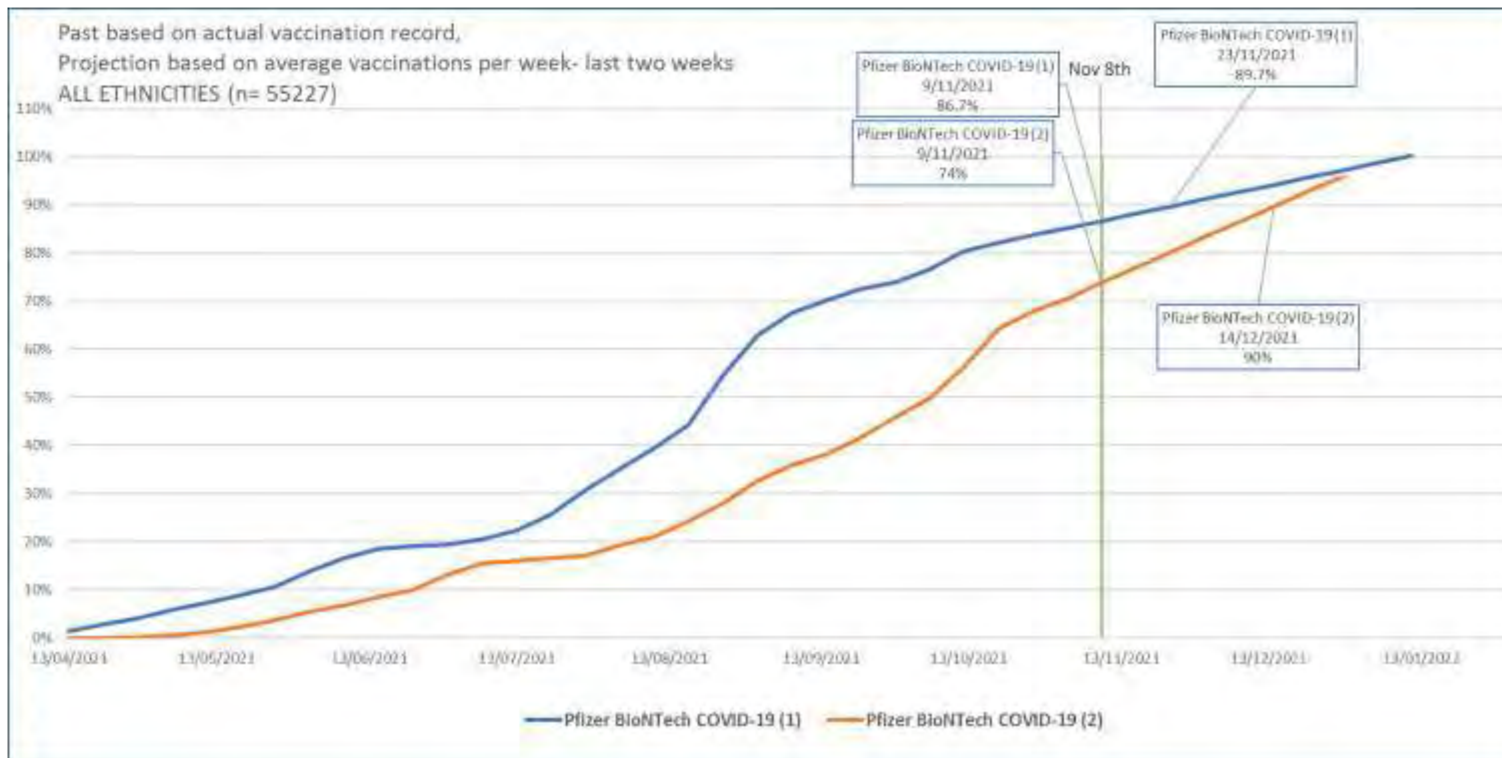
- We are continuing to engage with gang whanau, through Ned Tapa and Rangi Maniapoto (DOC) and have further pop-ups planned in locations with low uptake, including Gonville, Castlecliff, Aramoho and Whanganui East. We are planning at street level based on data provided by MoH.

- A Te Ora Hou event is planned for 20 November and vaccinations will be offered at this event. On the same day, Te Oranganui and Mokai Patea are supporting a marae based drive through clinic in the Taihape area.

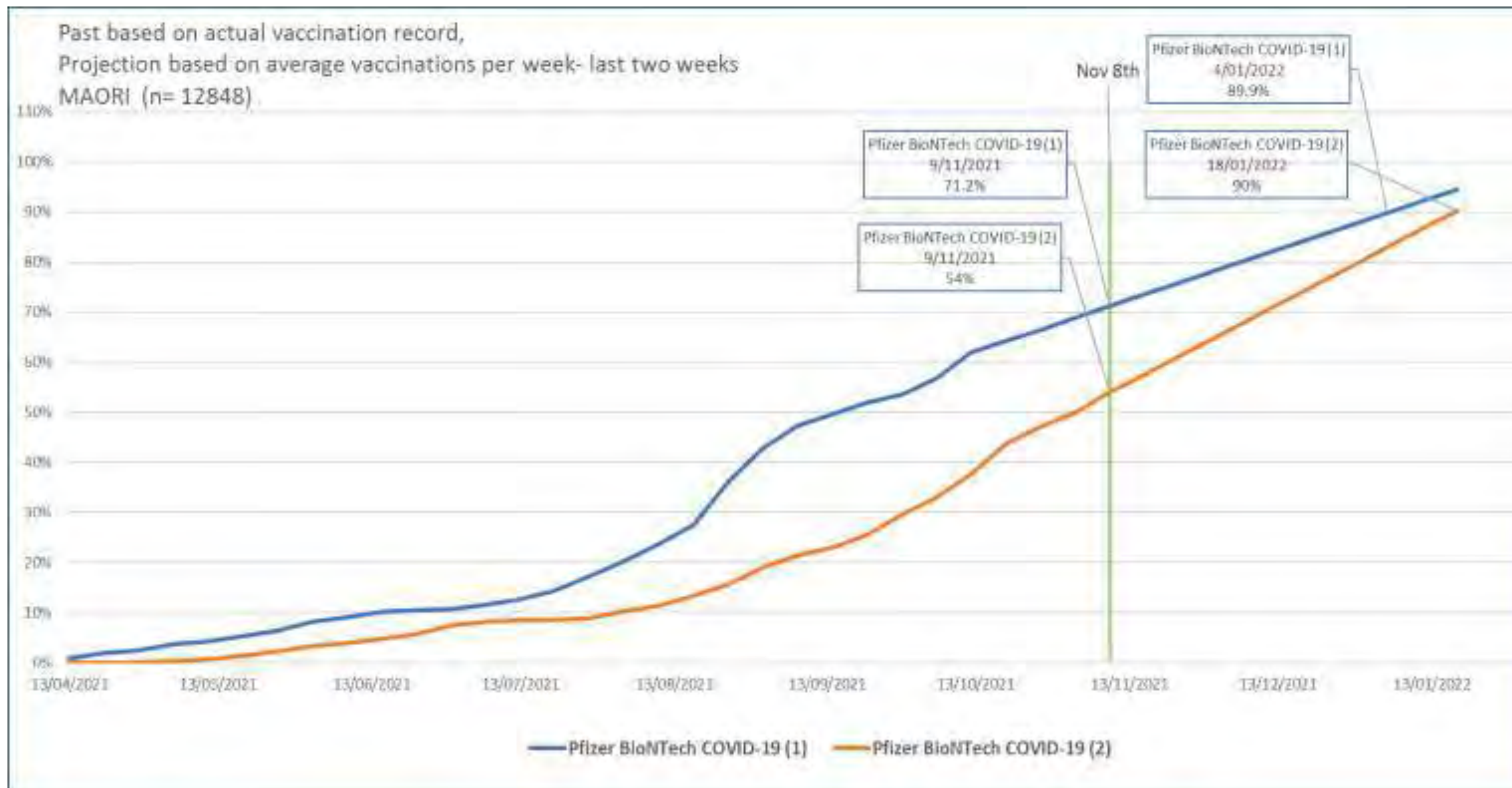
Current strategy and alternatives proposed

- We continue to plan pop ups and home visits based on suburb and street level data. The main focus is on those areas with the lowest uptake, in particular for Maori.
- On-boarding of remaining primary care providers, in particular supporting Gonville Health and Te Waipuna, who have the highest urban Maori enrolment.
- We have one Maori Health home to home team who started on the road last week, and plan to add a second.
- CCDHB have offered vaccinator support to the Whanganui vaccination effort and these staff have been offered to primary care in the first instance.
- MedPro have offered a mobile vaccination clinic using a Plunket vehicle to be stationed at the Warehouse 2+ days a week.
- Supporting rural hubs based on the identified needs of the communities

Projection to 90% vaccination



Projection to 90% for Maori



Te Ranga Tupua proposal

- Proposal made after $120m announced to improve Maori vaccination
- WDHB asked to support proposal by ministers office
- Te Ranga Tupua successful in accessing $2.8m (02 November)
- Proposal includes vaccination and crisis management response
- Starting to work with Te Ranga Tupua to address hard to reach population. The first operational hui was held on 12 November
- They are wanting to be active ASAP

Regional Partners

- Meeting of the Impact Collective on 02 November
- Kainga Ora (Housing NZ)
- Regional Leadership Group (Horizons led)
- MoH - Information sent at street level of low levels of vaccination
- Addressing
  - Increasing overall capacity and capability
  - Planning for crisis management
  - Potential loss of care workers

Our staff situation- an updated version will be available at the meeting

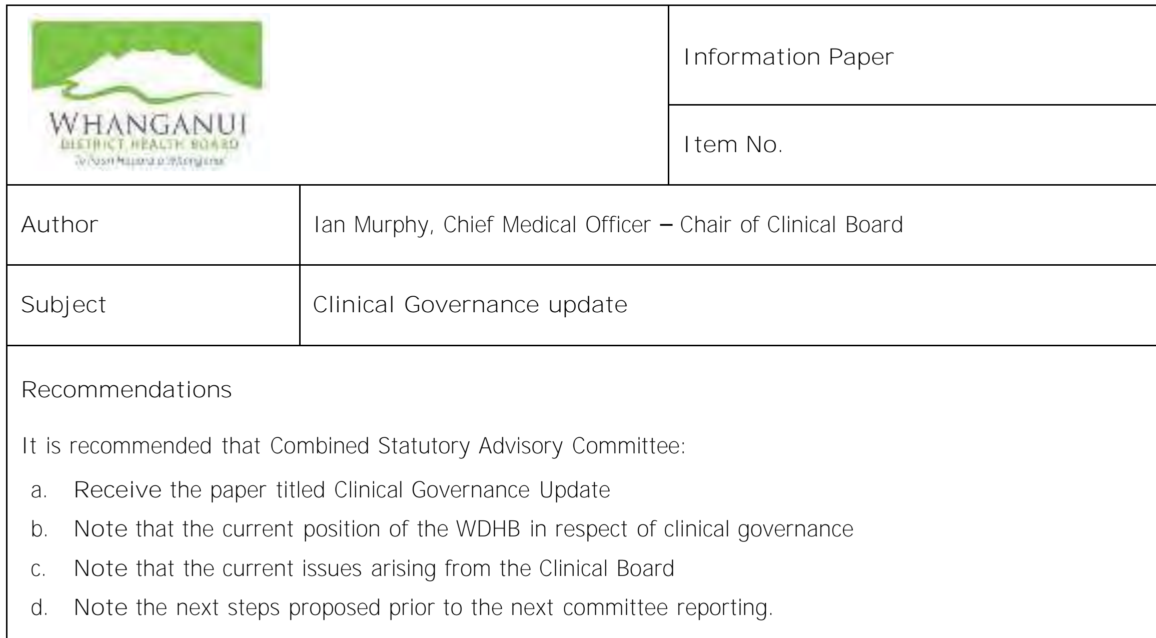
MOH Group	1st dose	2nd dose	Head Count	% First Dose	% Fully Vac
Allied	200	189	208	96.2%	90.9%
HCA	124	118	134	92.5%	88.1%
Midwifery	31	29	35	88.6%	82.9%
Nursing	459	422	478	96.0%	88.3%
Other	271	247	292	92.8%	84.6%
RMO	50	49	51	98.0%	96.1%
SMO	57	56	58	98.3%	96.6%
Total	1192	1110	1256	94.9%	88.4%

Indications are that:

- Thirty percent of the unvaccinated staff will be vaccinated
- Four percent will apply for medical exemptions
- Twenty-four percent will potentially choose not to be vaccinated
- Intentions of forty-two percent is not yet known.
- Impacts outside of DHB employees is not fully understood.

Questions

November 2021 Public



WHANGANUI DISTRICT HEALTH BOARD	Information Paper
	Item No.
Author	Ian Murphy, Chief Medical Officer – Chair of Clinical Board
Subject	Clinical Governance update

Recommendations

It is recommended that Combined Statutory Advisory Committee:

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

1 Purpose

The purpose of the paper is to provide the Combined Statutory Advisory Committee with an update on the approach to clinical governance activity in 2021 and detail the future intent of the Clinical Board.

2 Background

Clinical governance can be defined as **'ensuring** the provision of high quality and safe healthcare to consumers on a consistent **basis'.** This should be undertaken with constant improvement mindset.

It is a fundamental right of all consumers to expect this and it the responsibility of all those who work in in a healthcare organisation, from frontline healthcare workers to governors, to ensure this right is upheld.

The Health, Safety and Quality Commission (HQSC) is a crown entity providing leadership and co-ordination of this in the health and disability sector within New Zealand.

The objectives of the HQSC are:

(a) monitor and improve the quality and safety of health and disability support services; and

(b) help providers across the health and disability sector to improve the quality and safety of health and disability support services.

Considerable guidance across all aspects of clinical governance from both governance and operational perspectives is provided by the HQSC to support this.

Fundamental amongst this guidance is a document entitled *'Clinical Governance – Guidance for health and disability providers'*. This document details the establishment of a clinical governance framework itself within an organisation delivering health and disability services.

The remainder of this paper will outline relevant parts of this framework as it relates to the Whanganui District Health Board (WDHB) in respect of both governance and operational delivery currently and future intentions.

3 The current position of the WDHB

3.1 Clinical Governance Framework

The WDHB has a current Clinical Governance Framework (CGF) that details the approach to clinical governance within the organisation. It provides guidance on the structure of reporting required within the WDHB and the responsibility that different individuals and groups play. Alignment with the updated HSQC framework and WDHB strategic intent is underway with a balanced reporting on assurance and improvement imperatives.

It establishes the Clinical Board, the internal governance entity within the WDHB but doesn't provide it with clear direct line of sight reporting to the organisational governance structure – CSAC and FRAC.

Discussions with the CEO has agreed that this should occur alongside maintaining expected reporting the executive leadership team through the responsible executive lead. Currently this is the Chief Medical Officer.

This is critical to both enable the organisational governance to have the visibility it should of clinical activity and to improve clinician engagement.

A revised clinical government framework is currently being drafted by the Chair of the Clinical Board and this will be made available to the committee for review and comment when a final draft is available.

Updating the reporting framework and ensuring an increased focus on the community is also part of proposed revisions.

3.2 Clinical Board

The Clinical Board has the mandate and responsibility to enact the clinical governance framework across the rohe in relation to the WDHB activity.

Like the clinical governance framework, its Terms of Reference (ToRs) have become dated and are being updated. This outlines its purpose, functions, membership, and meeting and reporting protocols. A first draft has been consulted on and feedback is being collated into a final draft now.

The Clinical Board has responsibility (within its current TORs) for ensuring that at least every three years there is a stocktake of the structural components, responsibilities and accountabilities of the clinical governance structure to ensure the components are fit for purpose and are continuing to add value.

Alongside the review of the ToRs for the Clinical Board, there is a progressive review of the ToRs of some of the committees that report to the Clinical Board. A number of these are preventing good reporting from coming through.

The Clinical Board has been meeting monthly. Current membership is made up of a diverse mix of professions and additionally includes consumer and equity representation. Reporting has been consistent with the reporting work plan albeit with a range of reporting styles and content. There has been an increased focus on deeper discussion on topics of particular interest rather than review of information reports.

3.3 Patient Safety, Quality, and Innovation

The Patient Safety Quality & Innovation (PSQI) business unit acts as the operational arm of the clinical governance framework. It has responsibility for co-ordinating quality and risk activities. It plays an organisation-wide role in promoting and supporting staff in all quality improvement/patient safety endeavours and representing these to the Clinical Board.

PSQI also has responsibility for contributing to the organisation's improvement priorities, strategies and expectations being effectively communicated across all areas of the organisation and for supporting management to implement these.

PSQI includes the quality coordinators and clinical risk team and the risk advisor who provide the Clinical Board, clinical leaders and management with the formal linkages required to ensure the organisation takes a co-ordinated approach to the delivery of quality improvement.

The Clinical Board has excellent engagement with the PSQI team through its leadership and receives an update on its operational activity at each Clinical Board meeting.

4 Current Issues

4.1 Information and Communications Technology

Recent concerns regarding ICT - communications systems in particular have been raised by clinicians. The ICT Manager provided an update to the Clinical Board and outlined a number of factors including ageing infrastructure and the introduction of a new telephony platform and system. This was well-received. Mitigations for these were outlined including simple immediate measures. The Clinical Board noted that this issue had been prioritised by the Data and Digital Governance Group.

4.2 COVID

The Clinical Board are monitoring the significant focus that is currently on COVID. Whilst very understandable given the magnitude of this event, nevertheless, there is a need to ensure that systems, processes, and resources remain available to the wider clinical governance function that the DHB must deliver on. The Clinical Board is receiving assurances from PQSI leadership that this remains in place. The Clinical Board will continue to remain vigilant to this concern from the quality of care perspective.

4.3 Clinician Engagement

Clinician involvement in clinical governance activity is critical to ensuring active clinician engagement in the clinical government framework activity.

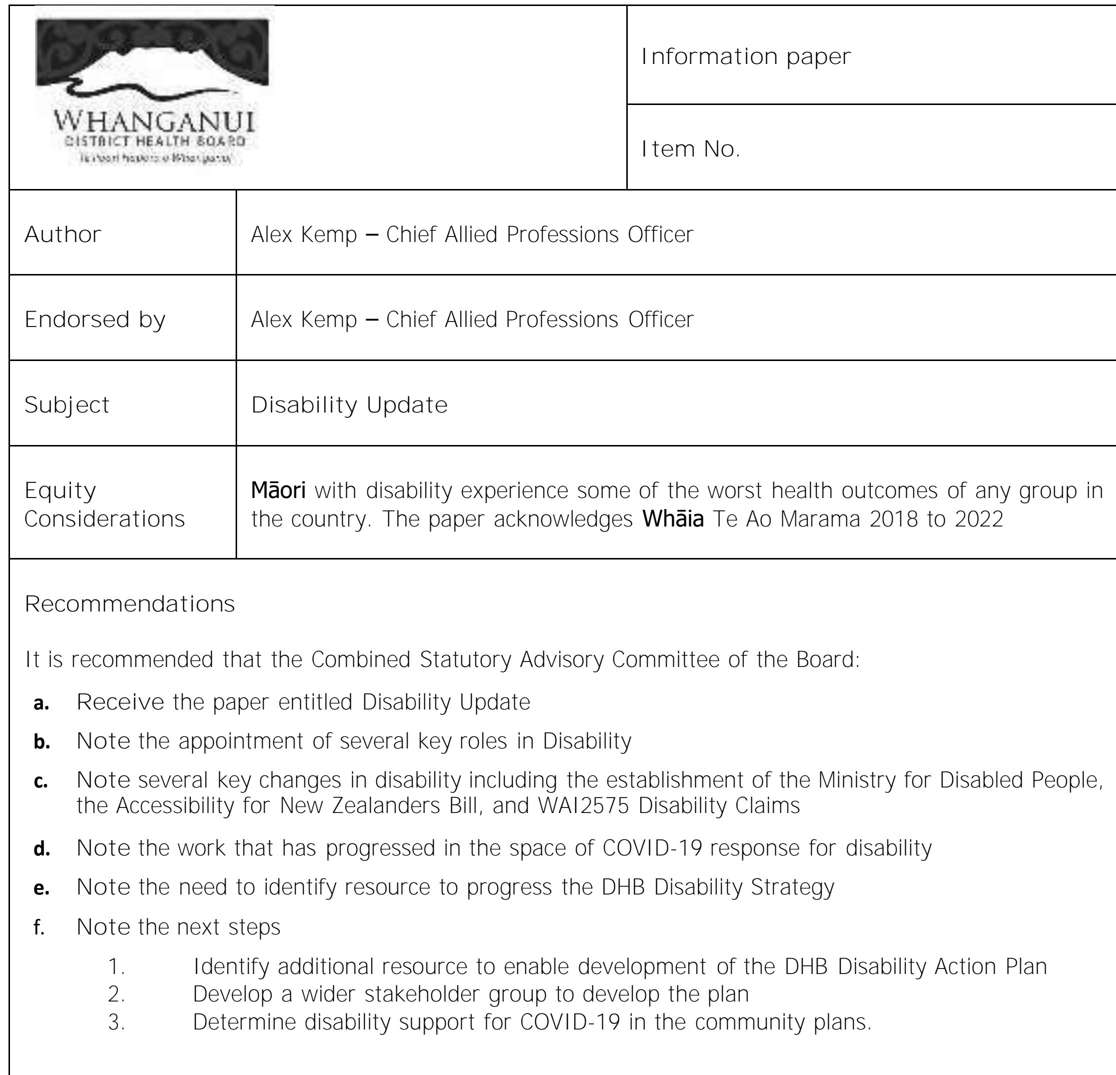
Without clear line of sight to governors and decision makers engagement can be challenging. It is envisaged that moving forward there will be regular reporting to the Board committees and that there will be scope to have frontline clinicians participate in this capacity. It is viewed that this will be mutually beneficial and should serve to strengthen the quality of care to our community.

5 Next steps

Complete the review of the clinical governance framework and Clinical Board ToRs, ensuring we are aligned with the HQSC framework and the WDHB strategic direction.

Re-establish regular Clinical Governance updates to Board committees.

November 2021 **Public**



WHANGANUI DISTRICT HEALTH BOARD	Information paper
	Item No.
Author	Alex Kemp – Chief Allied Professions Officer
Endorsed by	Alex Kemp – Chief Allied Professions Officer
Subject	Disability Update
Equity Considerations	Māori with disability experience some of the worst health outcomes of any group in the country. The paper acknowledges Whāia Te Ao Marama 2018 to 2022

Recommendations

It is recommended that the Combined Statutory Advisory Committee of the Board:

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

f. Note the next steps

1. Identify additional resource to enable development of the DHB Disability Action Plan
2. Develop a wider stakeholder group to develop the plan
3. Determine disability support for COVID-19 in the community plans.

1 Background

It is estimated that 1.1 million people in New Zealand have a disability – 632,000 with a physical impairment, 484,000 with a sensory impairment, and 89,000 with a learning disability. In the 2013 Disability Survey, 26% of the Māori population self-reported as disabled.

Stats NZ surveys consistently show disabled people experience poorer outcomes across multiple domains, including income, employment and health compared with non-disabled people. Disabled people are generally at higher risk of illness than non-disabled people. People with intellectual disabilities and Māori with disability have some of the poorest health outcomes of any group in the country and are at higher risk of illness, disease, disability and early death. Almost twice as many Disabled Māori than non-Māori have no formal education qualifications.

Disability within Health is currently guided by Whāia Te Ao Mārama 2018-2022 - The Māori Disability Action Plan. This outlines six goals for tāngata whaikaha, in that they will

1. Participate in the development of health and disability services
2. Have control over their disability support
3. Participate in Te Ao Māori
4. Participate in their community
5. Receive disability support services that are responsive to Te Ao Māori
6. Have informed and responsive communities

2. Recent Key Changes

The Health and Disability Review found disabled people have not been well served by the existing health and disability system. In response to the Review, there will be a newly formed Ministry for Disabled People from 1 July 2022, and a framework for improving accessibility for disabled people. The announcement surrounding this clearly pointed to the extension of Enabling Good Lives as its backbone, with the philosophy of disabled people always being at the centre of decision making about their lives. The messaging has also been strong around Te Tiriti relationships being principal to this so tāngata whaikaha Māori are able to exercise rangatiratanga. The Ministry for Social Development will host the new Ministry for Disabled People whilst it is in development.

The Ministry for Disabled People has outlined the key areas it will be ensuring the system achieves as follows

- gives full effect to the voice of disabled people, families, and whānau, and to Te Tiriti o Waitangi
- is consistent with the United Nations Convention on the Rights of Persons with Disabilities and the United Nations Declaration on the Rights of Indigenous Peoples
- aligns with the principles and approaches of Whānau Ora
- strengthening disability rights approaches across government strategies, including the Child and Youth Wellbeing Strategy, Better Later Life – He Oranga Kaumātua, the New Zealand Disability Strategy, and Mahi Aroha – the New Zealand Carers' Strategy
- improving cross-government disability data and information
- developing a disability-focused research and evaluation strategy

In addition to this, the Accessibility for New Zealanders Bill has been introduced at the same time, which will have an accessibility framework and have an Independent Accessibility Governance Board. The focus will be equal access to housing, transport, information, communication, technology, public buildings and spaces.

This year, the WAI2575 Tribunal has begun grouping claims that raise disability issues for the inquiry. So far, the Tribunal has identified four claims as consolidated, which means that all the allegations in those claims relate to disability. The Tribunal has also, on a preliminary basis, aggregated approximately a further 45 statements of claims (named in the directions below) that raise some disability issues. An aggregated claim means that some allegations within the claim do not relate to disability but that they may fall within the scope of later phases of the inquiry programme.

The above changes will undoubtedly guide how health provides services and support to those with disabilities.

3. Local context

According to the latest Stat NZ data from 2013 the national prevalence of disability was 26% for Māori and 24% for non-Māori. The prevalence in the Manawatu – Whanganui region was 27%. Given the forecast year-on-year increase in prevalence, the higher incidence for Māori, for people living rurally, and as people age, it is reasonable to estimate an even higher prevalence amongst our population. The DHB can collect data on some disabilities but does not consistently do this within its patient management systems. It is therefore not possible to identify how many people who receive services from the DHB have a disability.

The DHB has recently reviewed and restructured Te Pukaea, the DHB consumer engagement group. The terms of reference on this ensure there is disability representation. Currently 2 members identify as having a disability.

There is an expectation of DHBs to report on disability through the Disability Service Advisory Committee (our version is CSAC) and within the Annual Plan. WDHB's structure now disperses responsibility for disability across hubs. The Ministry of Health is requiring DHBs to have a Disability Action Plan and this is an action in our 2021/22 Annual Plan.

November 2021 **Public**

4. DHB Actions to date

Action from Annual Plan	Status	Comment
Establish an Executive Lead for disability	Completed	Alex Kemp, the Chief Allied Professions Officer is Executive Lead for Disability. Louise Allsopp is named as the Executive Lead for disability in COVID-19 to align with her wider role as DHB Executive Lead for COVID-19
Establish working group led by the Executive Lead for Disability	In progress	Agreement by the current members Disability leads for COVID-19 Executive Lead Disability Co-Chairs of Te Pukaea Kaitakitaki Equity Wider stakeholder group to be identified
Develop a disability action plan for the DHB	Not started	Resourcing needs to be identified

To achieve the development of a Disability Action Plan that follows the principals of the NZ Disability Strategy and Whāia Te Ao Mārama, wider engagement from the disability community will be needed, and this will require resource. It is of note that resource to achieve this and to continue to roll out any recommendations from this has yet to be identified. The experience to do this is available within members of the working group.

COVID-19 response to Disability

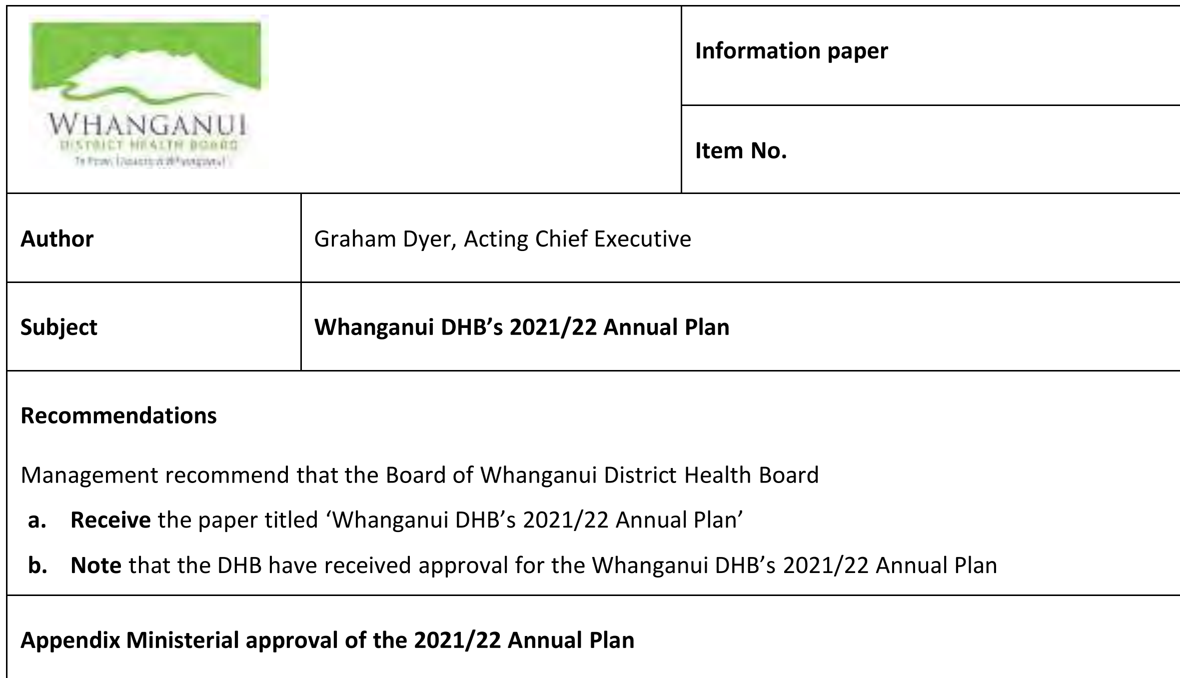
The DHB has appointed 2 people with disabilities to a shared role to support the DHB COVID -19 disability response. The DHB has been provided with a list of people receiving funded disability supports including from ACC and this has formed the basis of determining who requires support. The role has been active in supporting people with disabilities ensuring equal access and extra support for COVID-19 vaccination by

- Working with clinics to ensure clinics understand disability and access
- Enabling access for people with disability to clinics and supporting them through the vaccination process
- Enabling access to information and additional support
- Working with the National Booking system to ensure access to the system for people with disability

The feedback on this support has been very positive.

5. Next Steps
   1. Identify additional resource to enable development of the DHB Disability Action Plan
   2. Develop a wider stakeholder group to develop the plan
   3. Determine disability support for COVID-19 in the community plans.

November 2021 **Public**



WHANGANUI DISTRICT HEALTH BOARD	**Information paper**
	Item No.
Author	Graham Dyer, Acting Chief Executive
Subject	**Whanganui DHB’s 2021/22 Annual Plan**

Recommendations

Management recommend that the Board of Whanganui District Health Board

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

Appendix Ministerial approval of the 2021/22 Annual Plan

1 Purpose

The purpose of this paper is to confirm to the committee that Whanganui DHB received advice from the Ministry on 1 October 2021 that our annual plan has received ministerial approval.

APPENDIX 1

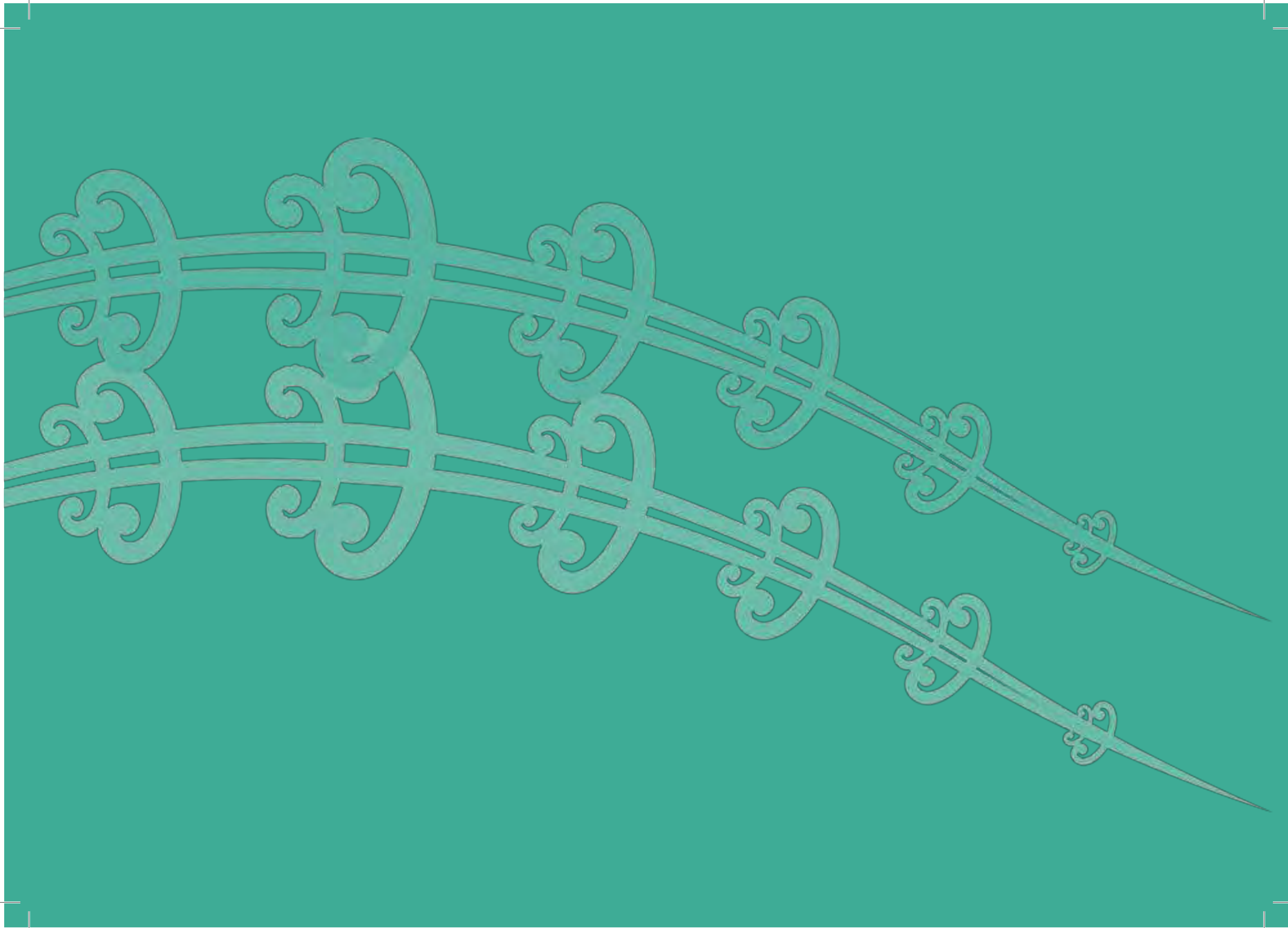
Insights Report

Growing Collective Wellbeing

Whanganui, Rangitīkei, Ruapehu rohe

A whole of community – whole of systems approach to the prevention of suicide

2020/2021



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Whakataukī

Tangi wheoro te hau i waho **rā**, tangi momori te **ngākau** a **tāngata**,
Pūtongatonga te ao, **Pūwatawata** te ao,
Ngā mate **ōku** ake o mua **rā** e

Winds howl outside my dwelling, as if to give voice to my heart's mournful regret,
(That like my skin) the world outside is scarred, and pockmarked,
(Etched) lessons of self-afflictions past...

These words convey both despair and at the same time hope for a better future focused on self-responsibility. They areacomposite of words expressedthrough *pao* – short, impromptuandtopical songs sung by kuia that one might hear at any given hui where emotions are stirred by a political proposition. Hence the observation of the composite kuia that the world's state corresponds with her life's experience. In so doing she accepts her place as both victim and perpetrator of the frail state of humankind. Her scars, both literal and figurative, serve as reminders of the folly we must avoid continually repeating.

The honesty and sense of self-responsibility is inspiring. As indigenous people, how easy would it be to place blame solely at the feet of the coloniser? Fault lies there, certainly. The message for us all is that change will only come about if we all accept our role and responsibility to bring about that change. If the victim is capable of such honesty, what does that say to us all?

Gerrard Albert
Chair, Ngā Tāngata Tiaki o Whanganui

Purpose

This document is intended to provide an understanding of suicide and prevention of suicide by capturing the voice of **whānau**, communities and professionals.

We know that In order to be more effective and to accelerate success we will need to transform and change our approach to suicide prevention. This new approach moves toward a community-wide response that requires a multi-level and systemic change.

The insights and the hypotheses that emerged from our community engagements have informed the co-design of a regional strategic approach and traction plan.

Background

Healthy Families NZ is a large-scale initiative that brings community and community leadership together in a united effort for better health. It aims to improve people's health where they live, learn, work and play by taking a systems approach for prevention. Healthy Families NZ has an explicit focus on equity, improving health for Māori and reducing inequities for groups at increased risk of preventable chronic disease.

In 2019 Whanganui District Health Boardcommissioned Healthy Families Whanganui, Ruapehu, Rangitīkei to facilitate the co-design of a whole of community, whole of system approach to the regional suicide prevention strategy and action plan.

We acknowledge the foresight and bravery of the Whanganui District Health Board's Board and CEO to put the development of this strategic approach into the community and for valuing their collective wisdom and experience.

This report is the outcome of many community conversations.

Acknowledgement

To the communities of Whanganui, Rangitīkei, Ruapehu rohe we thank you for joining the conversation, sharing your thoughts, experiences and ideas. To those whānau, families with lived experience who shared your stories of loss and sorrow, confusion and pain – we hold your stories gently and respectfully. We are grateful to have shared this space so others can learn from you and be inspired to act differently.

COVID-19 Pivot

We want to acknowledge our Iwi, Māori leaders, public sector executives and community champions for mobilising so quickly to protect our region from the full impact of COVID-19.

We, like many of our collaborators, continued to work through the alert levels pivoting from kanohi ki te kanohi engagement to online platforms. We extend our gratitude to our critical friends who supported the continuation of this piece of work during the first wave of the pandemic so momentum wasn't lost.

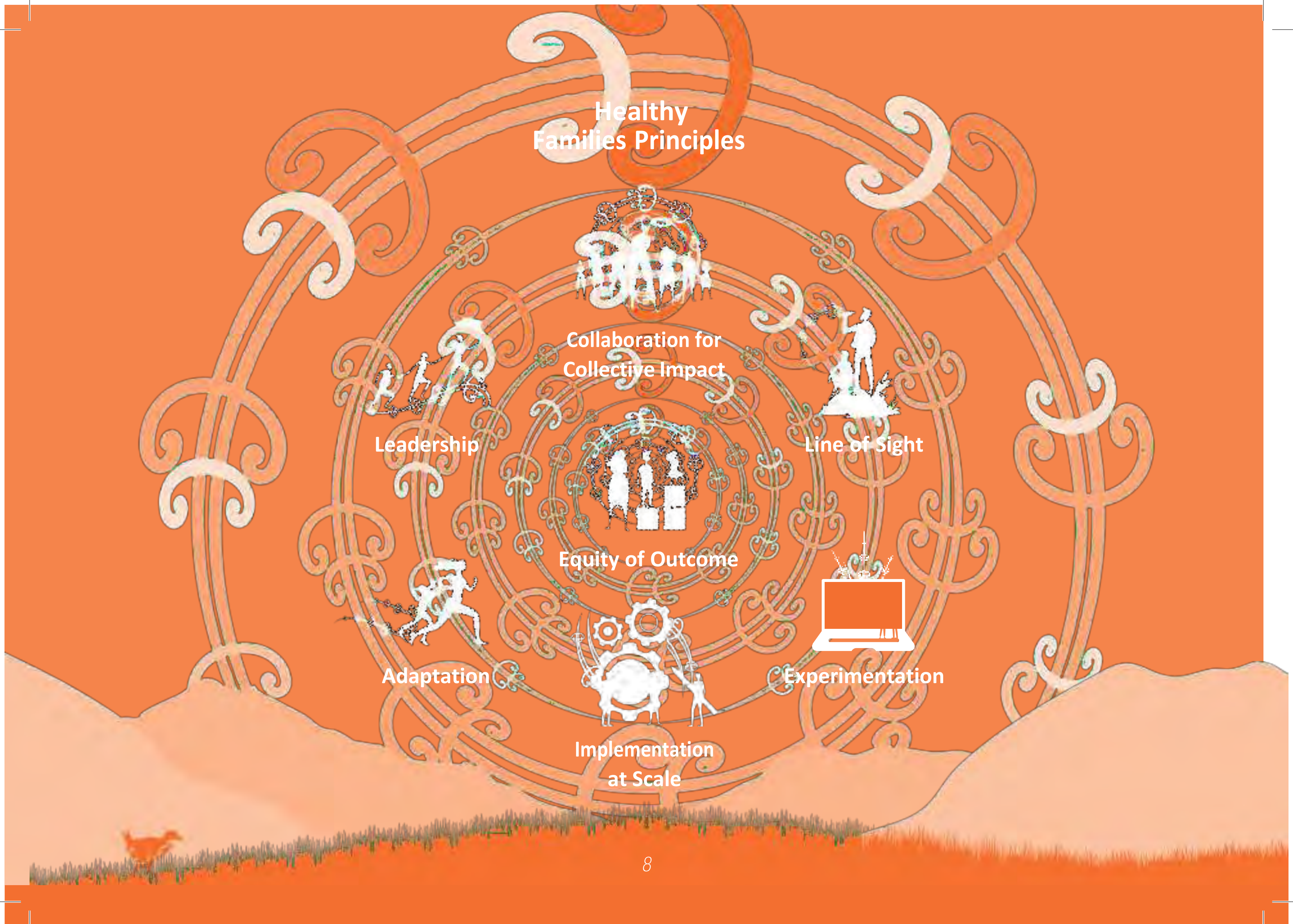
We are grateful to Barry Taylor from Taylor-made, Frank Bristol from Balance, Wheturangi Walsh-Tapiata, Mel Maniapoto and Hayden Bradley from Te Oranganui, Jude MacDonald from the Whanganui Regional Health Network, Dr. Cherryl Smith, Te Atawhai o te ao Māori Research, and Pauline Humm-Johnson from the Whanganui District Health Board for your guidance and contribution to this kaupapa during the first wave of COVID alert levels.

Methodology

The first phase of this process was to connect with communities to hear their thoughts, experiences and ideas. A strategic framework was then developed to provide a holistic frame for coordinating the strategic planning and activity.

To ensure a genuine regional approach we connected with communities living in rural and urban settings, collating 5,000 comments as points of data. Our engagements included interactive workshops, participation at community events, peer-to-peer interviews, lived experience interviews, and small group sessions.

In Healthy Families Whanganui, Ruapehu, Rangitīkei we foster an innovation mind-set, where we are adamant that people are the experts of their own solutions, this is consistent with the mātāpono (principles) of rangatiratanga. As a result of working with community champions and experts we agreed to flip the narrative from suicide prevention to enquiring how we (as a region) grow individual and collective wellbeing.


Healthy
Families Principles
Collaboration for
Collective Impact
Leadership
Line of Sight
Equity of Outcome
Adaptation
Experimentation
Implementation
at Scale
8

Insights at a glance

1. Young people are looking for positive role-models, experiences and environments where they feel loved, valued and free from judgement. They believe this will help them to become confident, well young adults.

2. Communities are seeking wellbeing solutions that connect to their culture. A Māori worldview supporting preventable approaches can help nurture identity, wellbeing and connectedness.

3. People struggle to reach out for help and share through fear of being judged, shamed, or bullied.

4. Health practitioners are aware they are not coping with the growing demand for mental health services. The sector feels overwhelmed.

5. Communities are not sure how to get support and where to go for support. People feel services are difficult to find and then hard to relate to.

6. People find it almost impossible to express their thoughts and ask for help when they are feeling distressed and unwell. Often people are unable to articulate their needs.

7. People feel restoring community spirit, increasing connectivity and commitment to each other can help to increase collective well being

8. Many people are living in an extreme state of stress and trying to cope on their own. Intergenerational trauma, financial burden, or violence are some of the common stressors communities are worried about.

9. Men are struggling to fit into a particular type of male narrative that has been historically prescribed. Engulfed in the shame of not fitting in amongst their peers is a contributing factor to harmful behaviours.

10. Families want support when navigating the grieving process. They need to share what they are going through.

Critical Learning and Observations

We think it is important to include some of the critical learning and observations from our time in this mahi (work).

The referral process – Finding Support

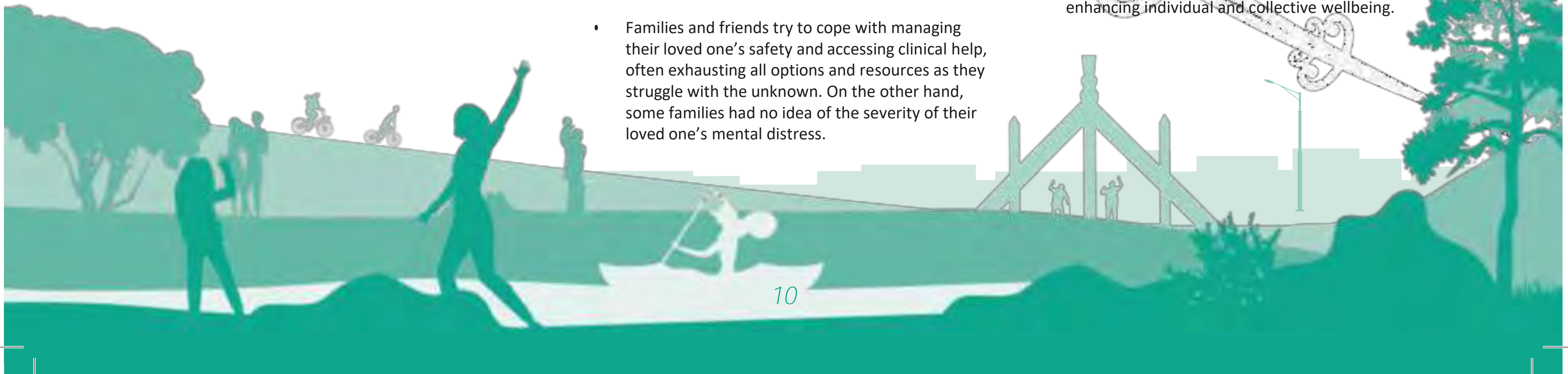
- There are a plethora of referral pathways and templates. There is no common pathway to enter the support system.
- The referral process is often managed through a clinical lens. The process was initially developed for the 3–4 % of people seeking professional mental health services. In today's world however, the rates of people experiencing diminished wellbeing and living with complex issues, has risen dramatically.
- The starting point for finding professional support has not adapted to meet the growing demand.
- A common referral process and common narrative is required to ascertain a more compassionate response and also the best response for the individuals and their support people.
- Those with lived experience (attempts) found great refuge and help at the crisis end – although they were isolated and disconnected as they spiralled between at-risk behaviour and suicidal thoughts.

Trust and protection

- Communities are not aware of the benefits of protective factors, what they are, and how they create wellbeing and grow resilience. This also means whānau are not aware there are two forms of protective and risk factors: modifiable, or fixed – characteristics that can or cannot be changed.
- We heard many stories from whānau (families) about their loved ones who had been living with more than four risk factors. Many professionals recognise the signs of toxic stress, but may not understand the neurological impact the compounded weight of risks has on someone.
- We heard stories where Dads do not trust their communities to protect and keep their kids safe. This comes from their own personal experience and upbringing in these communities.
- Through COVID-19 we have noticed that anxiety is contagious. The more anxious the services and practitioners (the ecosystem) become the more anxious communities become.
- Families and friends try to cope with managing their loved one's safety and accessing clinical help, often exhausting all options and resources as they struggle with the unknown. On the other hand, some families had no idea of the severity of their loved one's mental distress.

Trauma and shame

- Trauma and unresolved childhood trauma was prevalent in many stories shared by whānau/families and those with lived experience (attempted).
- We heard shame festered throughout peoples' lives because of unresolved, unhealed childhood trauma. This shame emerged as anger, feeling unloved and unlovable, or untrusting of people.
- Whānau/families talked about a mix of experiences when they entered the health system for help. That first point of contact can be abrupt and unkind (wait-times, wrong door, not listening, bias and assumptions). Some people talked about the amazing help at the crisis intervention end of the support continuum. However, communities and social services feel this level of help and understanding should happen much earlier.
- Social and economic deprivation is a contributing factor. Productivity, prosperity, citizenship, and healing trauma are fundamental in the process of enhancing individual and collective wellbeing.



Insights #1

Young people are looking for positive role models, experiences and environments where they feel loved, valued and free from judgement. They believe this will help them to grow resilience and become confident well young adults.

Research says

Mentoring recognises that a young person's development can be positively influenced by relationships with those around them, particularly adults that the young person can look up to and learn from. (A, Davies et al (2009) Confidence and competency development provide the foundation for agency and leadership. There is a highlighted need for improvement for cultural responsiveness in programming and an improvement of the skills and characteristics of the people working with the young people. (K, Deane. H, Dutton. E, Kerekere (2019)

Community say

"Raised in a toxic environment affects everything like your attitude in school, can easily become the norm, like I see the kids that were brought up in that environment and now their kids are in that environment. Breaking cycles is so important it's like the difference between our kids tapping into their talents and gifts or just becoming alcoholics and druggies just because that's the norm and all they know."

"Whanganui needs big brother, big sister programmes"

"I've no father and no role models in my life"

"Allocate mentors to our tamariki"

"When I was growing up, dad and uncles weren't uplifting. There were the generational trauma from World War 2 - taking their pain away with drugs and alcohol. I was always looking for and wanting role models to go diving with or camping, farming, going bush and mahi kai"

"Unless they have had the chance for someone to show them, to let them think about it, envision it and paint that picture for a future, it's actually just a lost thought"

"We need more male influencers to stop suicide. There is a lack of leadership or role models in services"

We heard

Bullying is rife in schools and in our community. Online bullying and being judged negatively is common and can escalate quickly at scale (viral). Because of the speed and scale of this negative culture tamariki / rangatahi have a fear of being judged and ridiculed, which can cause, or add to extreme anxiety.

Our challenge questions for Co-designers, Investors and Decision-makers

How do we grow capacity for a youth mentoring community?

How do we support young people to co-design solutions for reducing bullying in schools?

Insights #2

Communities are seeking wellbeing solutions that connect to their culture. A **Māori** worldview, supporting preventable approaches, can help nurture identity, wellbeing and connectedness.

Research says

A paradigm shift is needed towards a system grounded in tikanga in Māori values; one that is holistic, whānau-centred - which takes a life-course approach to wellness. The medium of wairua facilitates the expression of relationships, the maintenance of balance and healing. (Valentine, 2009)

Community say

"Tikanga Māori and having a reverence for the whenua, people, birds, trees returning to our intuitive natural tikanga, holistic values and systems"

"People come to stay with me at the maunga. We whakatau them into the workshop. Share ancient kōrero from 1800s to where we are now. We then take them around the maunga to our waterfalls and share with them what makes me happy. This seems to make people hungry for wairua. I've spent the last 3 years using gifts, maara kai, marae, ngahere"

"But maybe we need to look at what other help we can get. And the thing that comes through to me is the help was all mainstream help. A tikanga Māori perspective is what was needed, working with our own in a different way"

"It's a 100% Pākēhā system and there's lots of things that don't fit, you feel inadequate a lot of the time"

"Māori are doubly short-changed (disadvantaged) in that they/we have historic issues to cope with"

"Suicide would be exacerbated by a sense of purposelessness, lack of meaning coupled with a loss of culture"

We heard

Communities and practitioners think the combination of being connected to one's culture, able to access indigenous forms of support, and clinical experts would provide a holistic approach that communities can respond well to.

Communities will use their cultural values and practices, incorporating them into the way they care for their loved ones. This is very important for valuing indigenous ways of being and thinking. Even the process of grieving for Māori, through tangi, allows whānau to grieve, heal and grow – to celebrate the person's life.

Our challenge questions for Co-designers, Investors and Decision-makers

How might we encourage greater connection to culture and indigenous approaches as prevention solutions?

Insights #3

People struggle to reach out for help and share through fear of being judged, shamed, or bullied.

Research says

We need to focus on building connections within whānau or Iwi networks, sports clubs, churches, Marae and through relationships with formal or informal ties (Sewell, Morris, McClintock, & Elkington, 2017) as prevention is supported by our closest social circle – partners, family members, peers, friends and significant others – who have the most influence and can be supportive in times of crisis (WHO, 2018).

Community say

"The negative thoughts in my head usually stop me from asking for help, when I need it. If I asked for it, will I be able to trust that person? Are they going to judge me?"

"Building each other up, supportive people around, decreasing stigma, making it more common for men in particular to talk about their issues is needed."

"We knew that he was feminine, that he was a young man who more self identified as being a woman and his sexuality - he was attracted to males, but I think the stigma of that was that he wasn't necessarily accepted"

"When our kids die from suicide people seem to blame the parents"

"We need volunteer groups within the community, practical help and more community connection"

"Allow them to understand at a young age so we can prepare them for any future struggles. We need to reduce the stigma associated to mental health – we need people to speak out more when they are not ok."

We heard

People play multiple roles within the community, including leadership roles, and some people feared that sharing their story would affect their leadership and people would judge them for their choices. The impact of scandal, gossip, and doubting someone's ability, becomes widespread in small communities. Knee-jerk reactions to someone's behaviours can be swift and fierce leaving people feeling ashamed.

Our challenge questions for Co-designers, Investors and Decision-makers

How might we strengthen and develop the informal networks of support, so communities understand the positive influence they can have?

Insights #4

Health practitioners are aware they are not coping with the growing demand for mental health services. The sector feels overwhelmed.

Research says

Problems of access, wait times and quality... Having to fight and beg for services, not meeting the threshold for treatment... gaps in services, limited therapies, a system that's hard to navigate... added up to a gloomy picture of a system failing to meet the needs of people (Mental Health Enquiry, 2018).

Community say

"DHB Crisis line can be busy. Te Awhina is full. Doctors are not available for two weeks. Two weeks ago I attempted suicide and rung the crisis line - they said they would ring me tomorrow but they rang back two days later."

"Tried to ring 1737 but felt like I was getting shafted again"

"Nothing worse when someone has reached out and has been made to wait nearly two weeks - the fear of them being high risk put strain on the whānau"

"The gap in the care for young people is a chasm – my boy died 10 days after assessment for suicidal thoughts"

"Need someone based here (rural community) that can offer instant tautoko (support) instead of being referred and waiting weeks to hear back "

"Our professional development training was put on hold because our organisation didn't have any putea (money)"

"9 out of 10 of us (professionals) are too busy to do professional supervision so we cancel our sessions."

We heard

Health practitioners feel like they are in a box – confined by rules and regulations that restrict the help that should be offered. Practitioners also felt the over compliance can mean a loss of kindness in service and inconsistency of continuity of care. Therefore, practitioners think they are unable to do everything they can to support whānau who are in desperate need of help. We heard some professionals feel defeated by the system.

Our challenge questions for Co-designers, Investors and Decision-makers

How can we reorganise access to support services to meet the demand?

How might we enable front-line staff to feel confident and capable to provide what is most needed for people in a distressed state?

Insights #5

Communities are not sure how to get support and where to go for support. People feel services are difficult to find then hard to relate to.

Research says

People want support in the community, so they can stay connected and receive whānau wrap around support. (Mental Health Enquiry 2018)

Community say

"Not knowing what to do and where to go at that time for my daughter. I was working in the health system and I didn't know. How are others supposed to know?"

"I didn't know where to get that (information) beforehand. It wasn't until I was in crisis that I realised I could actually get help"

"At the time that this happened I seemed to be limited with choices - the Police and the crisis team. There has to be something else!"

"Tried to get help when needed it for her suicidal thoughts, but couldn't when trying to ring the numbers so went to see GP. They offered medication, antidepressants and painkillers"

"My doctor was of no value at all, but the Mental Crisis team were really good and they put me on to the community helpers and they would call you and you could call them"

"We need to re-organise the mental health system by putting clients and whānau at the core of the re-design process, understand their journeys and map their path to recovery"

We heard

Information is not readily accessible for communities, in particularly when people are distressed. Even professionals who are able to navigate systems struggled to find the right services that could support their families. In the rural area this issue is heightened. Unless you know someone who knows someone, then finding the right type of support at the right time is almost impossible.

Our challenge questions for Co-designers, Investors and Decision-makers

How do we make it easier for whānau to find the right type of support at the right time?

Insights #6

People find it almost impossible to express their thoughts and ask for help when they are feeling distressed and unwell. Often people are unable to articulate their needs.

Research says

Our mental health system is set up to respond to people with a diagnosed mental illness. It does not respond well to other people who are seriously distressed. Even when it responds to people with a mental illness, it does so through a lens that is too narrow. (Mental Health Inquiry 2019)

Community say

"I wasn't able to ask the right questions when in that state of un-wellness. Thought the processes aren't good when you're feeling down"

"I as a Māori male do not feel confident to ask for help when I am feeling depressed at mahi. It's a closed door, kind of place. You're going to get your head on the chopping block"

"Your brain has gone haywire and your trying to communicate to people. They don't even know what to say because I didn't even know what to ask. How do you get clarity?"

"I don't know how to ask for help, how to connect when I'm in pain. Teach me how to ask for help"

"My feedback to people now is if you are worried about someone ask them if they are in danger of taking their life!"

"Walking beside whānau and tangata whaiora as opposed to directing them"

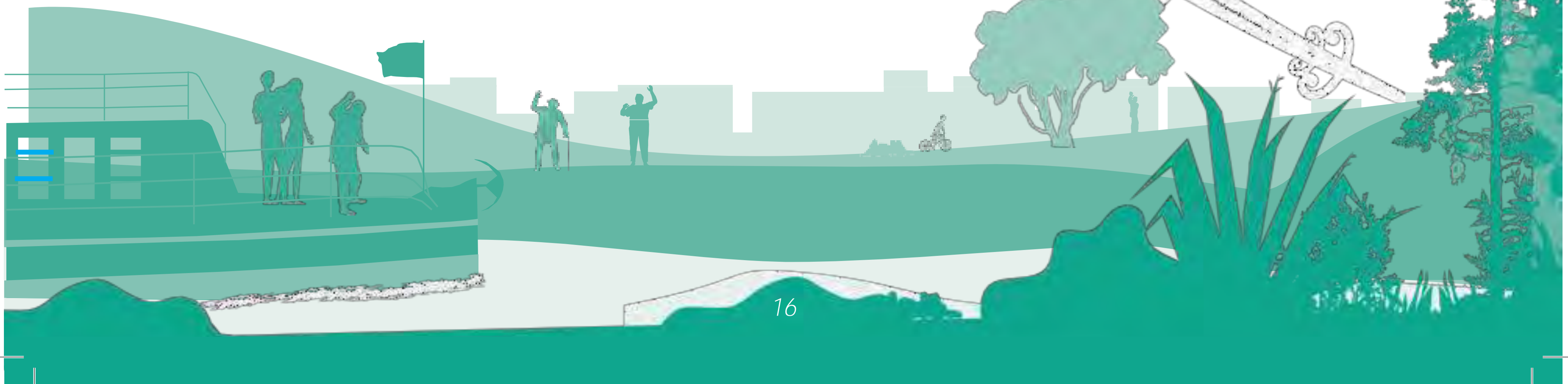
"Informal hui (meeting) first with first-time clients. Explain the process in their language. I have learnt that this helps our whānau (families) have a better understanding and better engagement with us"

We heard

In times of distress many people don't know how to ask for help. People struggle to describe to their loved ones what they are feeling, let alone explaining what they need from clinical experts. They bottle it up and hope that it goes away. People also feel they don't want to overburden their friends or family by sharing their problems. They end up going inward to try and cope on their own.

Our challenge questions for Co-designers, Investors and Decision-makers

How can we ensure people can get support earlier before it becomes too difficult to ask for help?



Insights #7

People feel restoring community spirit and increasing connectivity and commitment to each other can help to increase wellbeing

Research says

Neighbourhoods help to shape people's lives because they do more than house people. They form a base for wider activities, providing many of the social services that link individuals with each other, giving rise to a sense of community. Thus neighbourhoods provide a basic line of support to families. Neighbourhoods form the most immediate environment for children to socialize outside the family to build confidence and develop coping skills. (Power 2007: 22)

Community say

"Families are not spending time together and the relationships are diminished. Children are having to work and under pressure because of supporting the family"

"As kids we needed space to wananga - we just had fighting and drinking. There was rugby league but everyone was drinking straight after the game. Violence was used to harden us up but instead it was traumatising. They were always drinking and at the stove and fighting in the marriages. This was normal. We wanted the community to step in at these times but they never did. How do they do that?"

"People feel isolated in the workplace, or being isolated on the farm. Parents are too busy working. We've gone backwards. We've lost our community spirit?"

"Create spaces for people to ask the questions to ensure others don't follow the same path"

"Normalise informal kōrero about mental health within whānau, communities, education, peers and different social groups"

We heard

Communities feel community cohesion has gone, and they no longer feel a sense of trust and safety – there isn't a neighbourly connection anymore. People think the lack of structured coordination is missing from their communities – there are not enough things that create support and connection to look out for each other and other peoples' children. That sense of loyalty to, and responsibility for, each other has disappeared.

We heard and saw community spirit, social inclusion, connectivity, trust and safety occur during the COVID alert levels.

Our challenge questions for Co-designers, Investors and Decision-makers

How do we reinvigorate community connectivity and social inclusion?

How might we support community-led neighbourhood regeneration?

Insights #8

Many people are living in an extreme state of stress and trying to cope on their own. Intergenerational trauma, financial burden, or violence, are some of the common stressors communities are worried about.

Research says

Harvard University research has shown that these experiences: poverty; unemployment; neglect; and addiction creates a "toxic stress" response, which can affect brain architecture and brain chemistry. Extensive research on the biology of stress now shows that healthy development can be derailed by excessive or prolonged activation of stress response systems in the body and brain. Such toxic stress can have damaging effects on learning, behavior, and health across the lifespan. (https://developingchild.harvard.edu/science/key-concepts/toxic-stress/)

Community say

"It's the pressure from social media, unemployment, bad employers, dysfunctional family life, parental pressures, living up to social standards"

"Everyone thinks that farming is a buoyant community - it's not - the banks own everything"

"Alcohol didn't help, trying to find plasters to solve things, with the issues I was dealing with, and my finances - that had a huge impact on me - huge!"

"We were brought up around alcohol. I went to the pub as a kid and was diagnosed as an alcoholic at the age of 9"

"I thought it was normal to get hidings. My sister was abused a lot and the system came and took her. As an adult I found protection in my husband, I needed to feel that protection. He protected me and our children from the things I didn't want us around - alcohol, abuse from whānau members"

"Intergenerational behaviours – tamariki (children) now doing what their parents and elders have always done, and it's becoming normalised"

We heard

We heard stories of adults talking about the negative environments they were brought up in and how this influenced the pathways they chose – it was all they knew. We heard of the toxic experiences people lived through and feeling they were in constant flight or fight mode.

Our challenge questions for Co-designers, Investors and Decision-makers

How can we help families to reduce the compounded weight of toxic stress, and increase their protective factors?

Insights #9

Men are struggling to fit into a particular type of male narrative that has been historically prescribed. Engulfed in the shame of not fitting in amongst their peers is a contributing factor to harmful behaviours.

Research says

Empirical studies of increasing rates of male suicide in rural Australia have identified hegemonic masculine norms of stoicism as an important causal factor in the context of severe economic stress. Understanding the influences of race, ethnicity, socioeconomic status, religion and other cultural factors on stoic ideologies may help explain past research findings on delays in help seeking. (Pathek, E. B., Wieten, S. E., & Wheldon, C. W. (2017))

Community say

"It is interesting, particularly from a Māori perspective, I think sometimes there is quite a lot of harden up kind of behaviour, you know boys don't do this and don't do that and really all you are doing is making kids push down their feelings and so they don't talk"

"I think Māori men in their 50s have been brought up in a particular way of what a man does and how they act and so seeking help is hard, but that is the mantra of the day I get it but I know that when I'm down I won't be calling ayone. The funny thing is I would find it difficult to call my mate because I will go "no, no he's got his own issues. I don't want to be a burden him with my problems. I don't want to be an inconvenience." So what that does is isolates me further"

"He was a seven year old boy he suddenly realised that he wasn't like other boys and that never left him, that feeling never left him. I think he covered it up, as we learn to do as an adult with his intelligence and his whatever else, but think that when he went into a state of depression and stress, that little boy was still very present and he came out. I think that was quite a factor and I believe that we need to be looking at how we bring our boys up because it is such a problem for our men"

" The holy grail is getting men in a group wanting to come together to discuss this and very rarely does that ever happen consistently. So for me it's about - Im gonna get in contact with three of my closest mates. We're gonna go have coffee, we're just gonna check in on one another"

"Accept boys for being who they are and not forcing them into a box of maleness! I'm no longer frightened of my vulnerability, to let that go and to seek help about it"

We heard

Communities want to give permission for men to talk and share their stories and experiences - knowing how important this is to creating connection and healing. Being present and listening to each other, being open to talking is a real challenge in our communities, and yet it is such a powerful and empowering experience for many men to be in.

Multiple roles in the community; burn-out; not taking care of themselves physically and mentally, and holding on to traditional stereotypes are just some of the challenges that men shared with us.

Our young men need really good mentors who can assist them to navigate through life and the different milestones.

Our challenge questions for Co-designers, Investors and Decision-makers

How do we change the narrative to value vulnerability as courage and strength?

How can we support the movement of men as positive roles models and navigators to younger generations?

Insights #10

Families want support when navigating the grieving process. They want to share what they are going through.

Research says

Topic avoidance can cause added stress, as well as hinder one's ability to develop and maintain meaningful and satisfying interpersonal relationships (Afifi, Caughlin, & Afifi, 2007). However this is problematic in the context of bereaved youth, as maintaining social roles and ties and feeling socially connected can serve as protective factors when coping with a death-loss (Droser, 2020, Worden, 2009)

Community say

"There should be a support group running pretty much anytime, for anyone who has dealt with it. Through the support group you could support people through the post problems that you strike like having to deal with all the practical things. If there was a group and there was someone there you might make a relationship with and say 'I've got to make this awful phone call do you want to come and do it with me?' Or, 'I've got to go to the bank, can someone come with me?', 'I've got to go to the undertakers and pick up the ashes. I've got to go and get the death certificate...'...all of those sorts of things"

"Don't silence our loved ones. We want people to talk about them and celebrate them. Tell their story and be genuine - we want people to ask us how we are getting on"

It's a constant battle to get help. We are not being able to hear or remember things properly because we are grieving. We need to be navigated through the different processes. These are our four top priorities we need:

1. Navigators;
2. Support group for those with lived experience;
3. To be armed with knowledge for our own whānau,
4. A tool to remember things.

Suicide is not like any other death. We want to talk to other people about what we are going through.

We heard

Families don't want their experience to be silenced - like it's the elephant in the room. They want communities to learn how to have empathetic conversations rather than avoiding talking about it, avoiding them, or behaving awkwardly. It is unnecessary for grieving families to make other people feel comfortable.

People do not know how to behave, or what to say to families who have lost someone. People want to be a source of comfort but don't want to risk being insensitive, or insulting.

We heard how difficult it was for families to manage their loved ones affairs – having to close bank accounts, notify agencies of change of circumstances, withdraw enrolments, and so forth. People felt front-line staff were apathetic and lacked compassion and patience. Grieving famlies assumed the processes would not be business as usual, expecting more flexibility and understanding.

Our challenge questions for Co-designers, Investors and Decision-makers

How do we equip communities to provide good support to grieving families?

How might we ensure organisations are open and compassionate when dealing with grieving whānau (families)?

Hypotheses

The feedback from community and the emerging themes prompted the consideration of a number of issues and challenges, which in turn led to the development of a series of hypotheses for inclusion in the strategic framework.

The hypotheses we explored were:

- Reframing the problem - the traditional problem is framed as "how do we prevent suicide?" The response to that question is to focus on intervention. Therefore, we reframed the problem definition to suggest that suicide is an indicator and the real challenge is how do we improve individual and community wellbeing? This led to a broader and rebalanced approach.

- The hypothesis that suicide prevention requires early intervention, including greater activity and focus upstream than has previously been the case. Conceivably, some protection measures can be implemented well before a person presents as suicidal.

- Emerging research and practise points to concepts of toxic stress, particularly in young people from 'deprived' backgrounds. There is a correlation between toxic stress and suicide. Hypothetically, mitigation strategies for each of the stress risks could be developed. The ability to recognise the stress risks that an individual is exposed to could allow/trigger appropriate supports that help avoid the cumulative stress reaching toxic levels (presentation of four risks) for that individual.

- Resilience and wellbeing are helped by the presence in an individual's life of a mentor who is caring, non-judgemental and able to offer guidance on dealing with setbacks, stress and life challenges. Effectively these role models could act as 'wellbeing navigators.' The support system could ensure young people, especially at-risk individuals are connected to, and have access to 'well-being navigator(s)' as part of their personal network or alternatively, via the service system.

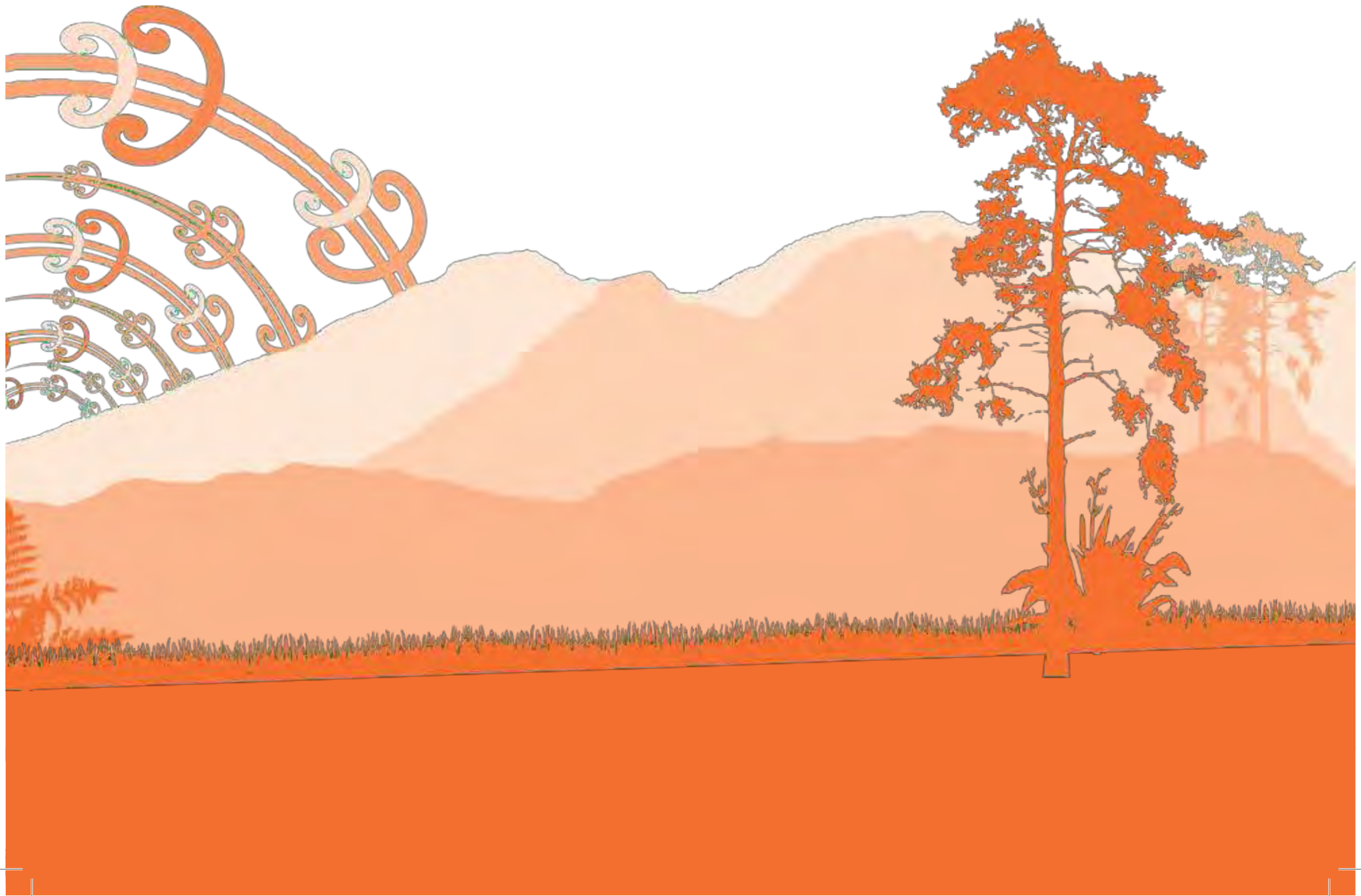
- Identity (cultural), connectedness to people and place, economic and social participation, is commonly important for wellbeing. Māori men feature prominently in suicide rates. Could the effects of colonisation be the irreparable damage to these sources of wellbeing (cultural identity, connectedness to people and place, economic and social participation)? A greater response to help individuals recreate or strengthen these sources of wellbeing via a holistic approach that incorporates elements and principles of Te Ao Māori or includes a Māori-world view is important.

Call to act

Our value proposition is that we can amplify and accelerate our impact through stakeholders and community working together across the system.

The challenge-questions we pose are useful starting points for those who want to mobilise brave action.

It will take a whole of community-whole of system approach to grow individual and collective wellbeing.



Insights Report

Growing Collective Wellbeing
Whanganui, ***Rangitīkei,*** *Ruapehu rohe*

If you are interested in partnering and would like to find out more about this kaupapa please contact:

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Like us on Facebook: www.facebook.com/HealthyFamiliesWRR
and follow us on twitter www.twitter.com/HealthyWRR
or for further info www.healthyfamilieswrr.org.nz

APPENDIX 2

Growing Collective Wellbeing

Whanganui, Rangitīkei, Ruapehu

A whole of community
whole of systems approach to the prevention of suicide

2021–2024

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Tangi wheoro te hau i waho **rā,**
tangi momori te **ngākau** a **tāngata,**
Pūtongatonga te ao, **Pūwatawata** te ao,
Ngā mate **ōku** ake o mua **rā e...**

Winds howl outside my dwelling, as if to give voice to my **heart's** mournful regret, (That like my skin) the world outside is scarred, and pockmarked, (Etched) lessons of self-afflictions **past...**

These words convey both despair and at the same time hope for a better future focused on self-responsibility. They are a composite of words expressed through pao – short, impromptu and topical songs sung by kuia one might hear at any given hui where emotions are stirred by a political proposition. Hence the observation of the composite kuia that the world's state corresponds with her life's experience. In so doing she accepts her place as both victim and perpetrator of the frail state of humankind. Her scars, both literal and figurative, serve as reminders of the folly we must avoid continually repeating.

The honesty and sense of self-responsibility is inspiring. As indigenous people, how easy would it be to place blame solely at the feet of the coloniser? Fault lies there, certainly. The message for us all is that change will only come about if we all accept our role and responsibility to bring about that change. If the victim is capable of such honesty, what does that say to us all?

Gerrard Albert
Chair, Ngā Tāngata Tiaki o Whanganui

He mihi aroha

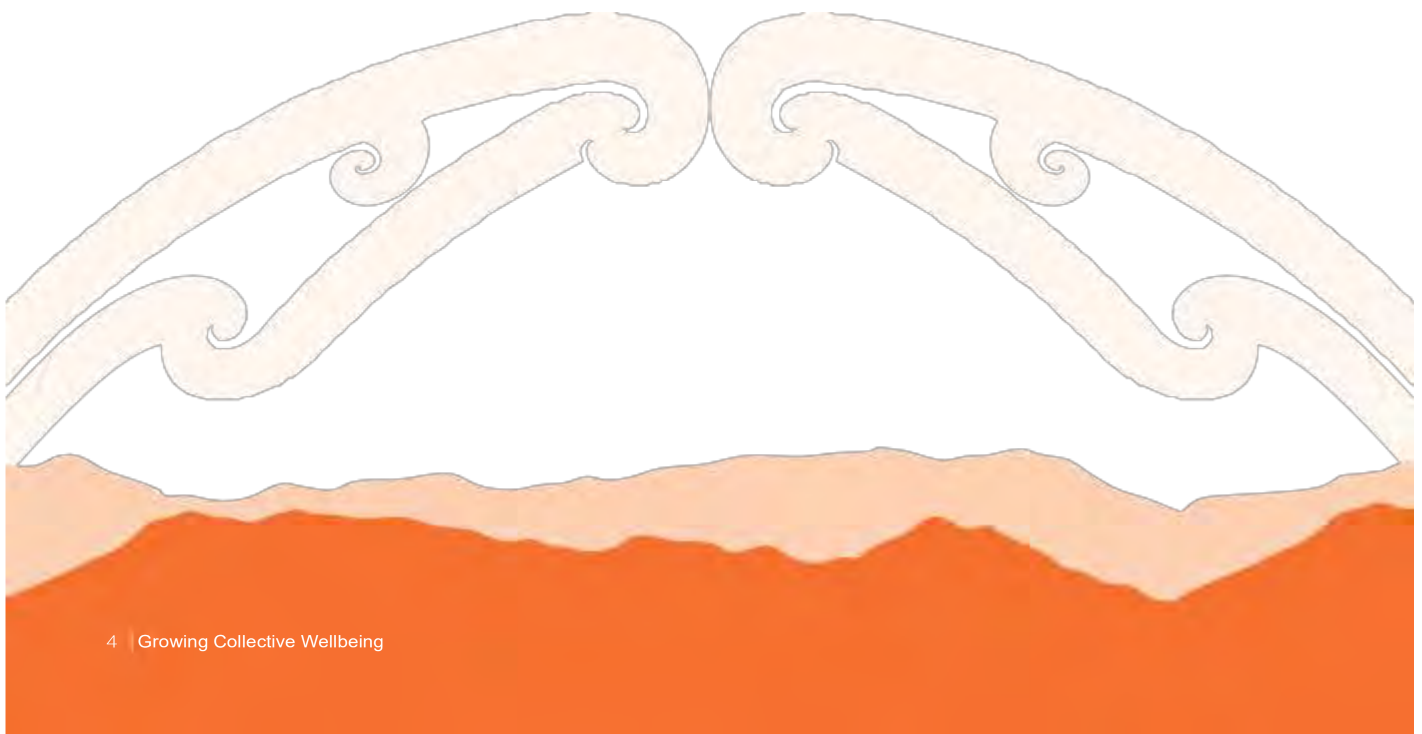
Ka **haumārō** te **mōteatea** ake ki te ranga tupua ka **rūpeke** ki te waro hunanga.
Tiraha ake i te mahora o **Rangiātea** ki runga.

To the communities of Whanganui, Rangitīkei, Ruapehu rohe we thank you for joining the conversation, sharing your thoughts, experiences and ideas. To those whānau, families with lived experience who shared your stories of loss and sorrow, confusion and pain – we hold your stories gently and respectfully. We are grateful to have shared this space so others can learn from you and be inspired to act differently.

To Iwi, Māori leaders, community champions, front-line professionals – thank you for being open to the conversaton, being honest about the professional challenges and systemic issues overshadowing any good work being done at the coal-face. We appreciate your genuinue concern and commitment to serve your communities.

To the Whanganui District Health Board CEO and Board – for your brave decision to shift the development of this approach into the community – to value the communities' experience and perspective so a new way of thinking and designing prevention could be found.

We were humbled by the consistent showing up of people to join this conversation, fuelled by a deep concern and compassion for their community.



Hope

This approach to suicide prevention holds hope within it. It is not the plan of all plans that solves the wicked issue of suicide. It would be crude to think we could find all the answers to that in just 18 months. It is however, an approach that reflects a collective willingness to shift the dial, to do something different and to ensure we understand this is a call for real radical change. Radical change means changing our thinking, narrative, and practices – from welfare to wellbeing, from loss to love, from intervention to prevention. To that end, this plan is co-designed and coordinated through a social innovaton lens.

To craft a truly community-led response we ensured funding was not the driver of anyone's commitment. Not yet anyway. Instead we focused on leveraging the existing willingness, strategies and movements of change. Woven together by the community voice and the lived realities of whānau, families.

There are a lot of moments in the design of this plan where the journey took a few detours and made some massive pivots. In our years of working with community champions, leaders, and changemakers the pivots end up becoming the biggest learning curves. COVID-19 has been one of them. We are grateful a whole of community – whole of systems approach requires agility and adaptability.

No such co-design process would exist without that type of mindset!

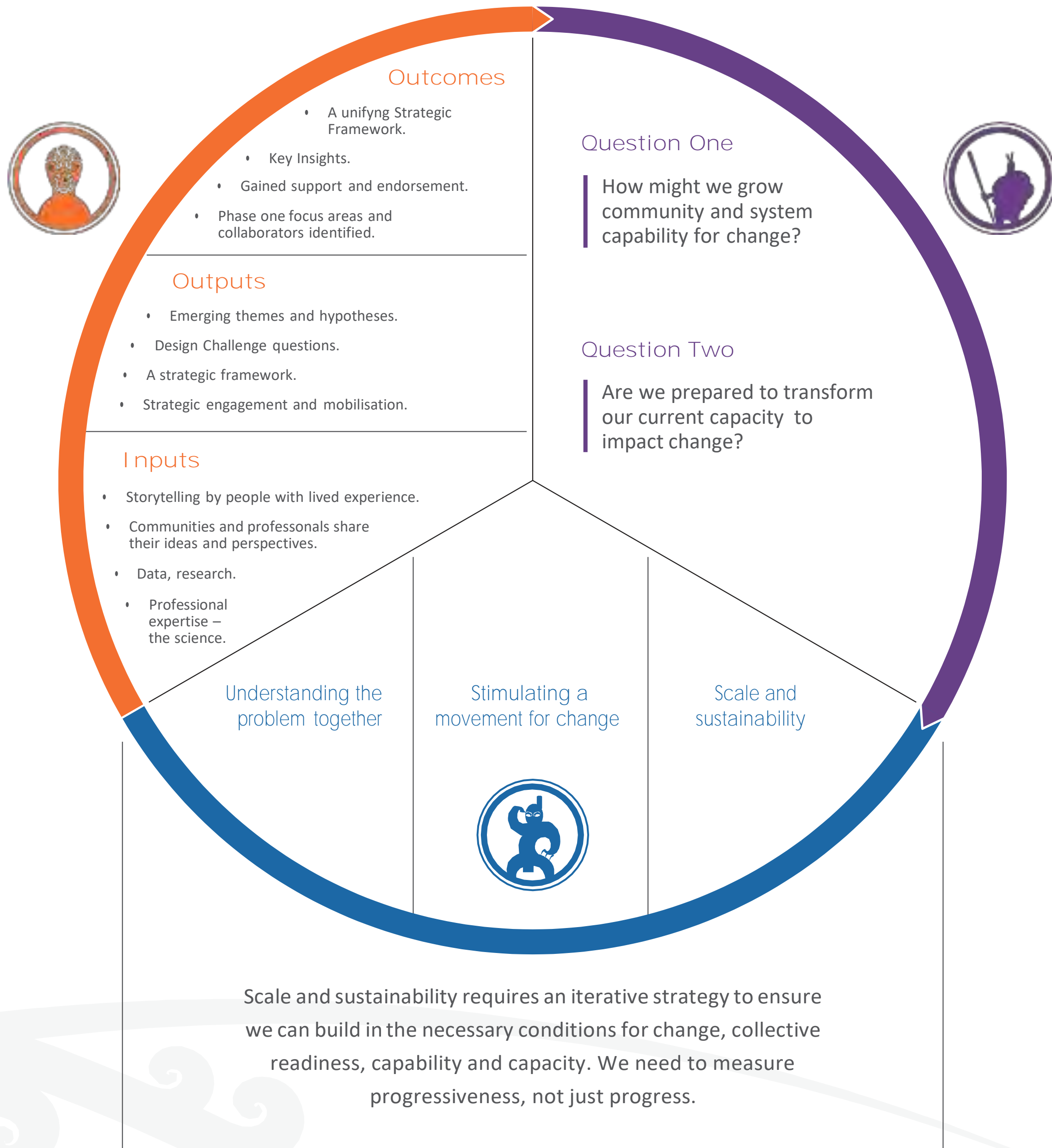
Let us never under-estimate what it takes to create a movement for positive change.

Our Co-Design Challenge Questions

How might we grow community and system capability for change?

Are we prepared to transform our current capacity to impact change?

Our Co-design Journey



Scale and sustainability requires an iterative strategy to ensure we can build in the necessary conditions for change, collective readiness, capability and capacity. We need to measure progressiveness, not just progress.

New **Zealand's** Reality

The total number of suicides in NZ is unacceptable.

- The total number of suicides in NZ is unacceptable.
- With a total of 654 deaths in 2019-20 the provisional suicide rate was 13.01.
- The suicide rate for men in 2019 -20 was 19.03 (471) while for women the rate was 7.18 (183).
- However, the attempted suicide rates for women were significantly higher, compared to attempts by men.
- Suicide rates amongst Māori are disproportionately high and increasing. At 20.4 (157) per 100,000 pop.
- European and other are at a rate of 12.08 (414) per 100,000 pop. significantly lower than that of māori.
- There appears to be a significant correlation between deprivation (social & economic) and suicide. Suicide rates amongst the lower socio-economic groups are substantially higher and increasing.
- Suicide rates are higher in rural areas of 16 per 100,000 pop, people compared with 11.2 in cities.
- Youth suicide rates are increasing.
- Rates for serious self-harm are increasing.

Our Current Reality

This approach of co-designing this strategy signals a change in how we address suicide prevention. Suicide is known as a 'wicked' problem. It is complex. It requires numerous concurrent approaches that are nuanced and carefully calibrated, along with effort and focus that is highly coordinated and sustained.

As it stands, suicide rates in the Whanganui District are too high. The wellbeing of citizens and their whānau/families in the District is not where we want it to be. Despite good intentions, hard work and dedication, we are not achieving the results that we want to. We need to do better.

Over all context June 2019/June 2020 provisional statistics by numbers and rates per 100,000 population

- Whanganui 10/14.62.
- Māori 3/16.06.
- Māori men rate 25–29 was highest.
- Pasifika have very low rates of suicide in Whanganui.

Intentional self harm is a mal-adaptive coping mechanism indicating young people in distress and coping with the distress in an unhealthy way

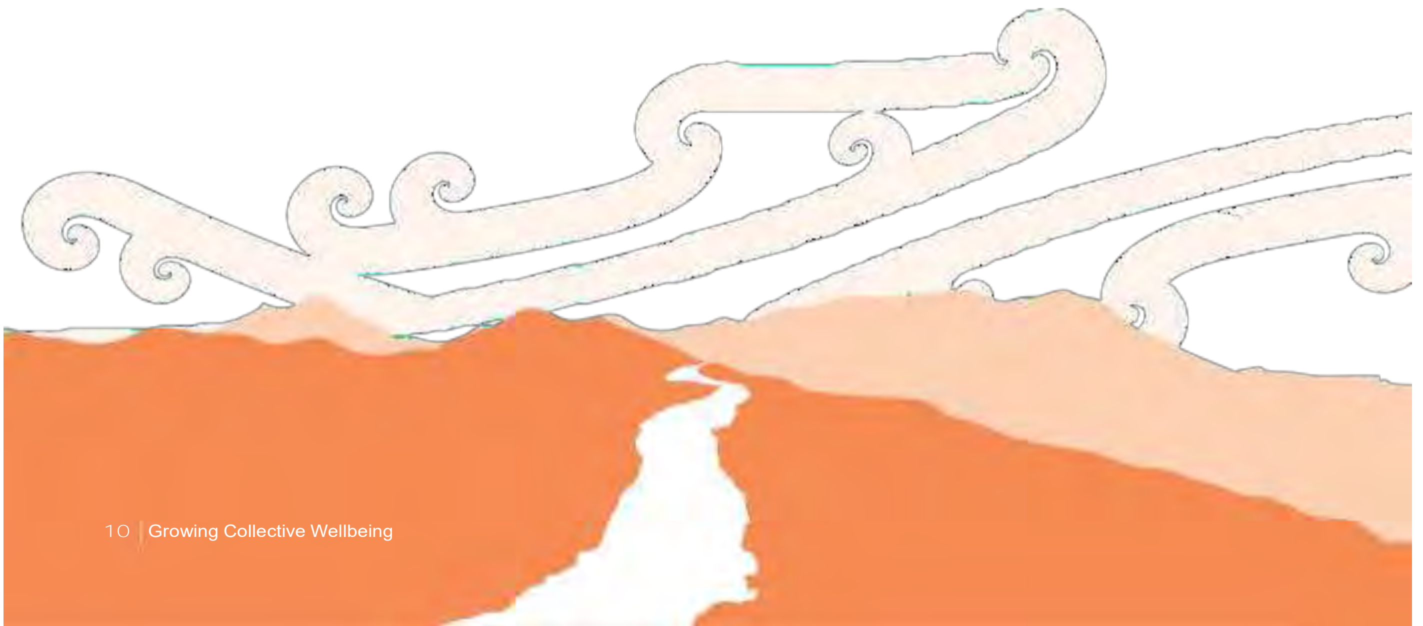
The following statistics are serious self harm hospitalisation rates for youth 10–24, Whanganui Regional Health Network

- Self harm has been rising since 2018 amongst 15-19 with 42 incidents in 2020.
- Females are most prevalent as they are in attempted suicides.
- Māori are most prevalent as they are in attempted suicides and suicides.
- Between the ages of 10–14 we had 3 in 2020, zero prior.
- 20–24 yrs has been variant with 21 in 2020.

Source:

- National minimum Dataset (NMDS, Estimated N.Z resident population within statistics NZ projections, WHO Standard population (Self harm hospitalisation rates).
- Annual Provisional suicide statistics for deaths reported to the coroner 2020.

Key Insights at a Glance



1 Young people are looking for positive role-models, experiences and environments where they feel loved, valued and free from judgement. They believe this will help them to become confident, well young adults.

2 Communities are seeking wellbeing solutions that connect to their culture. A Māori worldview supporting preventable approaches can help nurture identity, wellbeing and connectedness.

3 People struggle to reach out for help and share through fear of being judged, shamed, or bullied.

4 Health practitioners are aware they are not coping with the growing demand for mental health services. The sector feels overwhelmed.

5 Communities are not sure how to get support and where to go for support. People feel services are difficult to find then hard to relate to.

6 People find it almost impossible to express their thoughts and ask for help when they are feeling distressed and unwell. Often people are unable to articulate their needs.

7 People feel restoring community spirit, increasing connectivity and commitment to each other can help to increase collective well being.

8 Many people are living in an extreme state of stress and trying to cope on their own. Intergenerational trauma, financial burden, or violence are some of the common stressors communities are worried about.

9 Men are struggling to fit into a particular type of male narrative that has been historically prescribed. Engulfed in the shame of not fitting in amongst their peers is a contributing factor to harmful behaviours.

10 Families want support when navigating the grieving process. They need to share what they are going through.

Our Strategic Approach

Our Vision and Outcomes

Our people are enjoying high levels of wellbeing. This is evidenced by the reduction in suicides and suicidal behaviours.

Our system of support for those at risk is joined up, responsive, accessible, and highly effective.

Our approach and impact are sustainable.

Outcome One

More Wellbeing

Vulnerable people live in well communities. Communities have increased protective factors and the professional sectors have increased understanding of how to reduce the compounded weight of risk factors.

Outcome Two

Less Suicides

Through the strategy we are seeking to reduce suicide numbers in our region, the rate of suicide, the level of suicidal behaviour, and the level of serious intentional self-harm. In doing so we not only materially help those at risk, but we also ease the burden and negative impacts these behaviours can have on whānau/ families and the broader community.

Our Mission

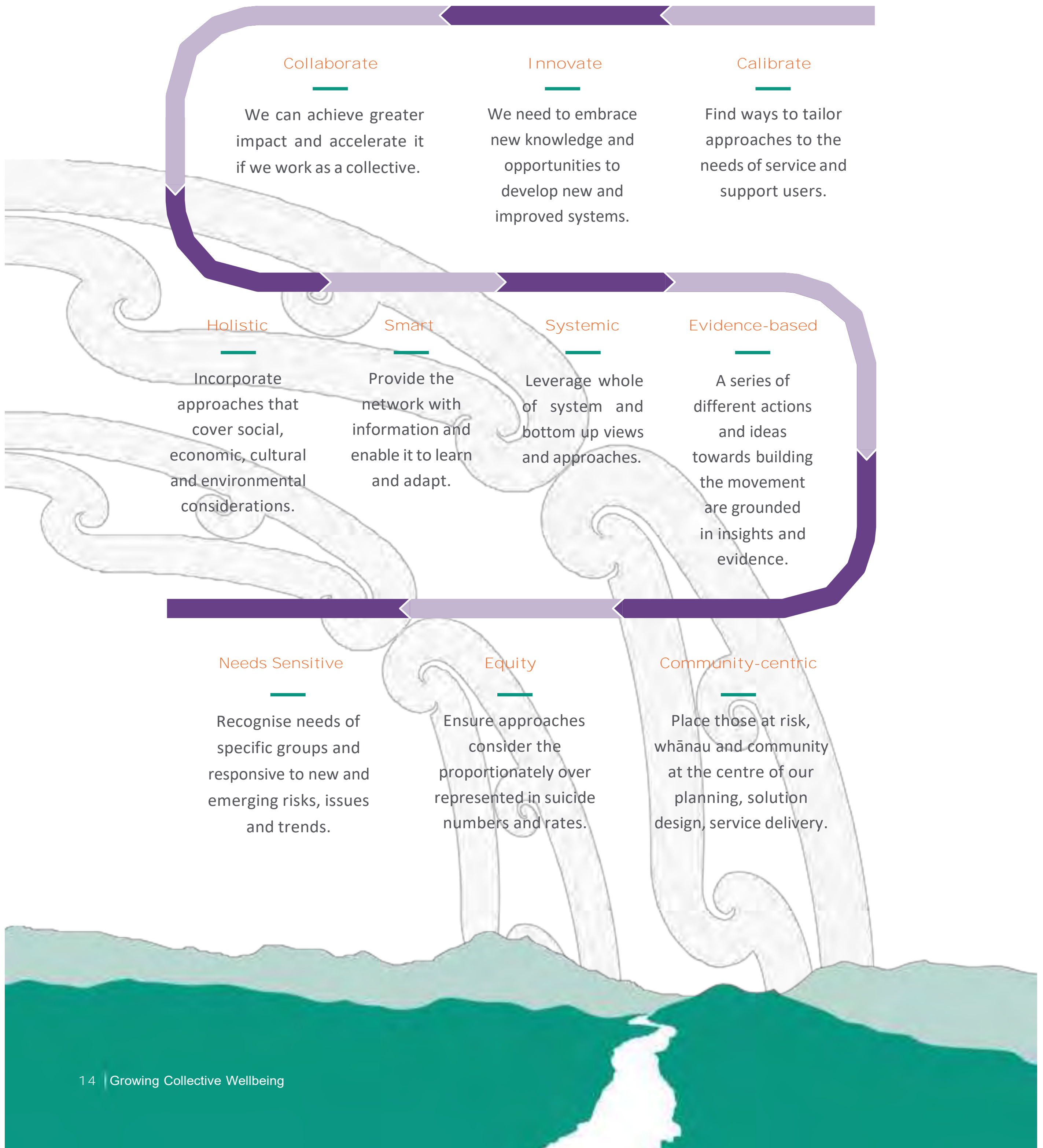
We are the wellbeing movement, courageous in our collective efforts to reduce suicides in our region.

Delivering Value Together

This approach offers value in numerous ways

- It allows us to bring more resource to bear on this important challenge.
- It allows us to leverage local knowledge and local lived experiences.
- It allows us to leverage individuals and organisations who are better positioned to achieve influence and impact.
- It allows us to leverage a greater number of networks and relationships. We get greater and richer contributions from a wider range and a deeper pool of people.
- It allows us to share and distribute the workload.
- It allows us to better align the different aspects of the system toward common goals.
- By considering the value we can create through each of the building blocks we can map the aggregated value to understand whether we are delivering to the vision.
- Allows different stakeholders to see where they contribute and their part in the movement.

Our Shared Values



Collaborate

We can achieve greater impact and accelerate it if we work as a collective.

Innovate

We need to embrace new knowledge and opportunities to develop new and improved systems.

Calibrate

Find ways to tailor approaches to the needs of service and support users.

Holistic

Incorporate approaches that cover social, economic, cultural and environmental considerations.

Smart

Provide the network with information and enable it to learn and adapt.

Systemic

Leverage whole of system and bottom up views and approaches.

Evidence-based

A series of different actions and ideas towards building the movement are grounded in insights and evidence.

Needs Sensitive

Recognise needs of specific groups and responsive to new and emerging risks, issues and trends.

Equity

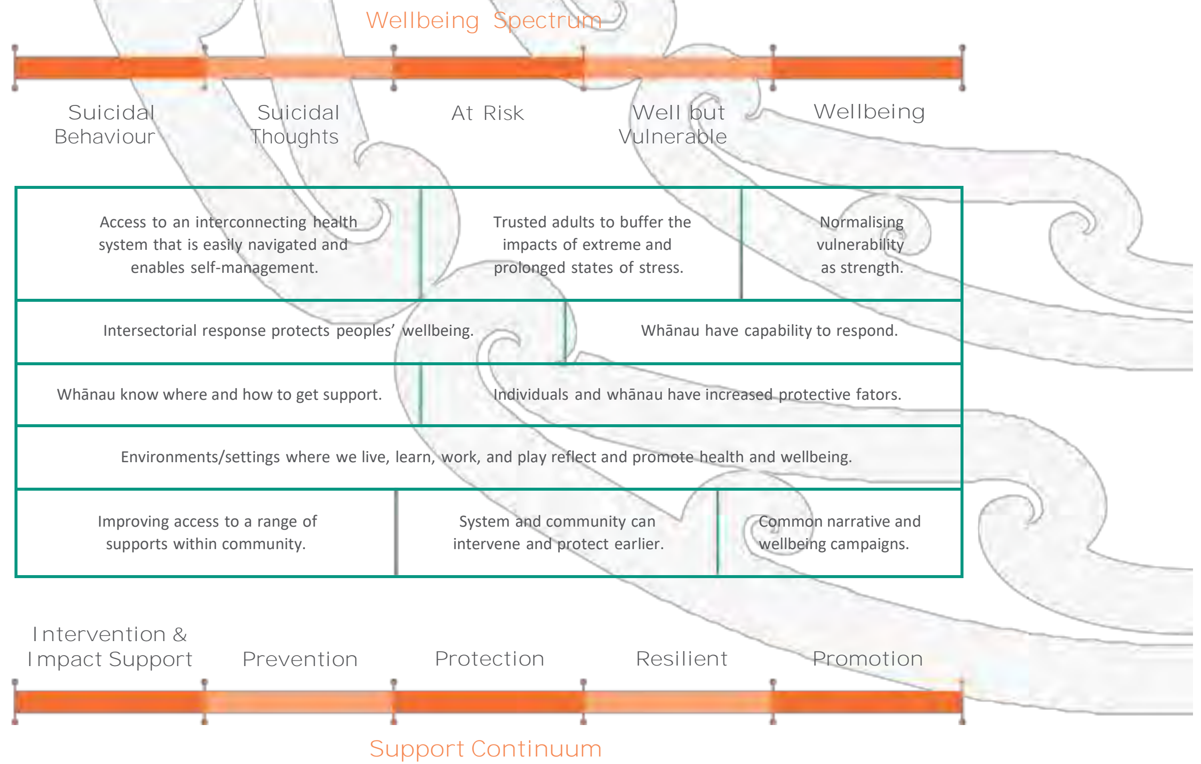
Ensure approaches consider the proportionately over represented in suicide numbers and rates.

Community-centric

Place those at risk, whānau and community at the centre of our planning, solution design, service delivery.

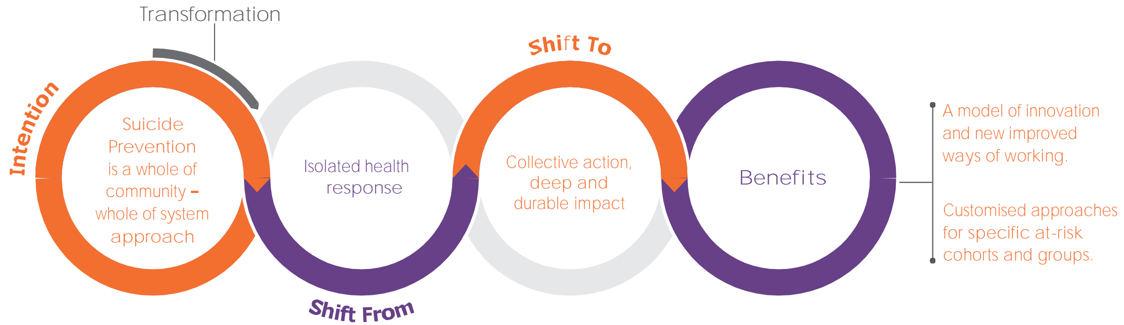
Our Future Reality

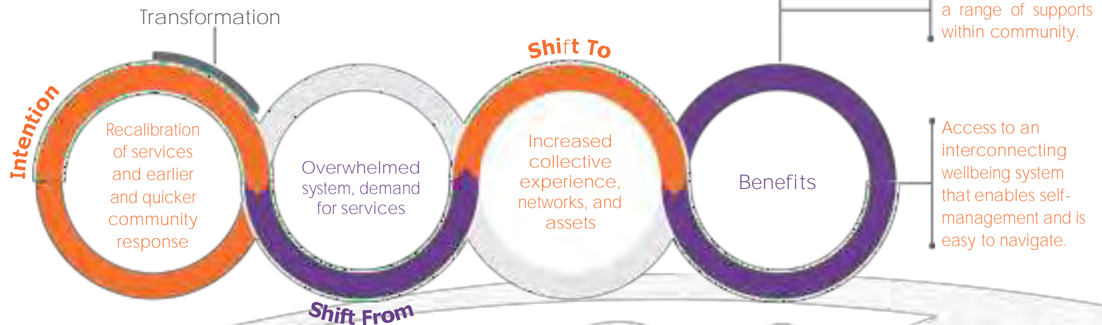
We can amplify and accelerate our impact through stakeholders and community working together across the wellbeing spectrum and the continuum of support.

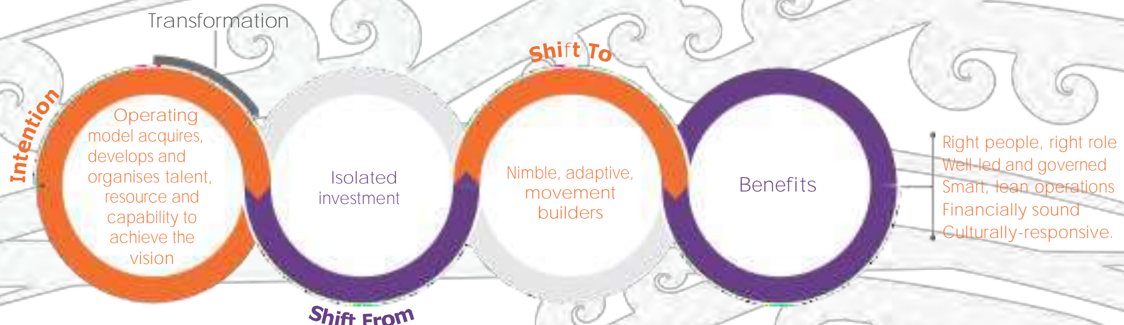


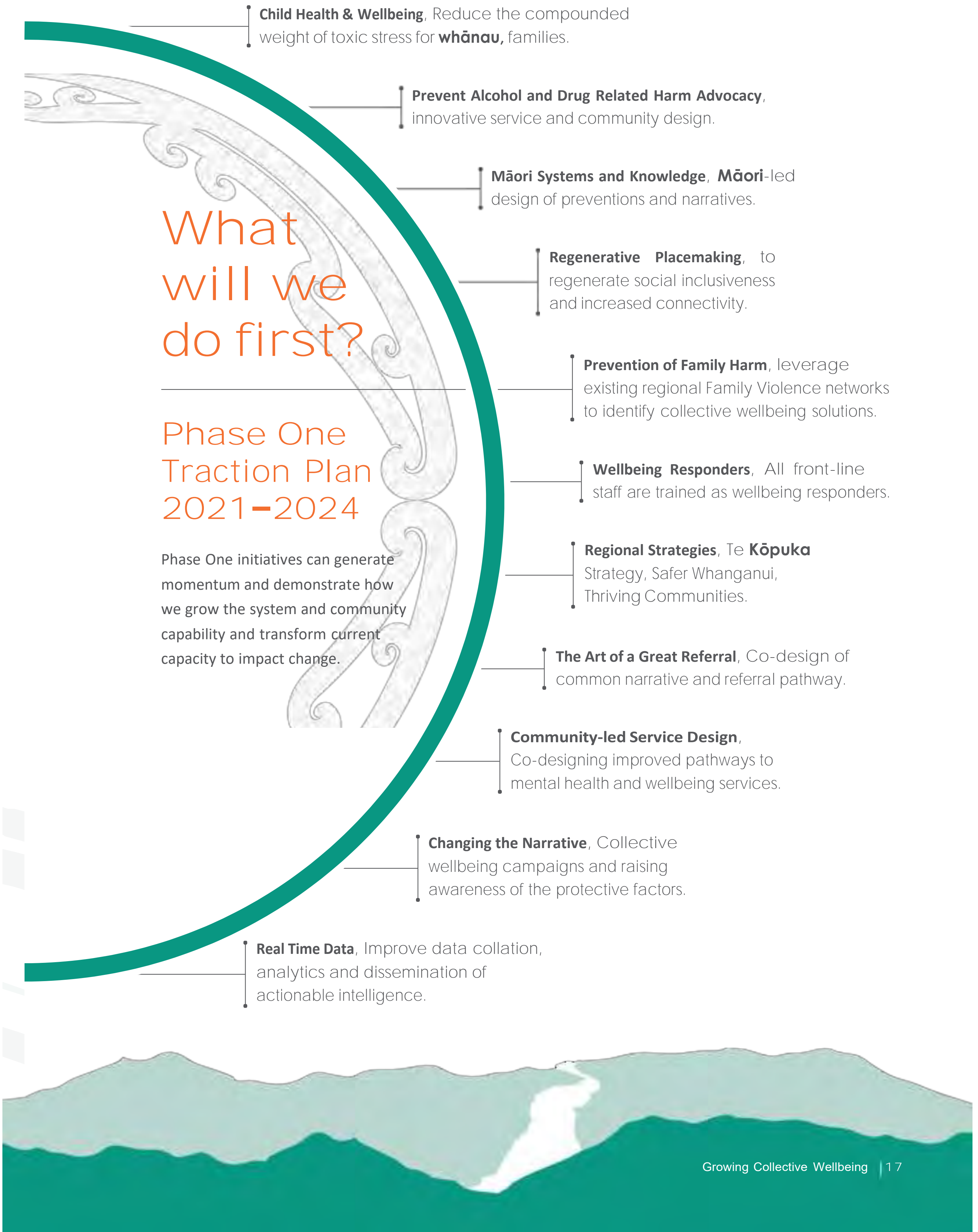
Strategic Shifts

For a more coordinated response to occur a series of strategic shifts is described and prescribed.









What will we do first?

Phase One Traction Plan 2021–2024

Phase One initiatives can generate momentum and demonstrate how we grow the system and community capability and transform current capacity to impact change.

Create the Conditions for Change

The Traction Plan (Phase One) includes the enablers for launching and scaling the collective approach.

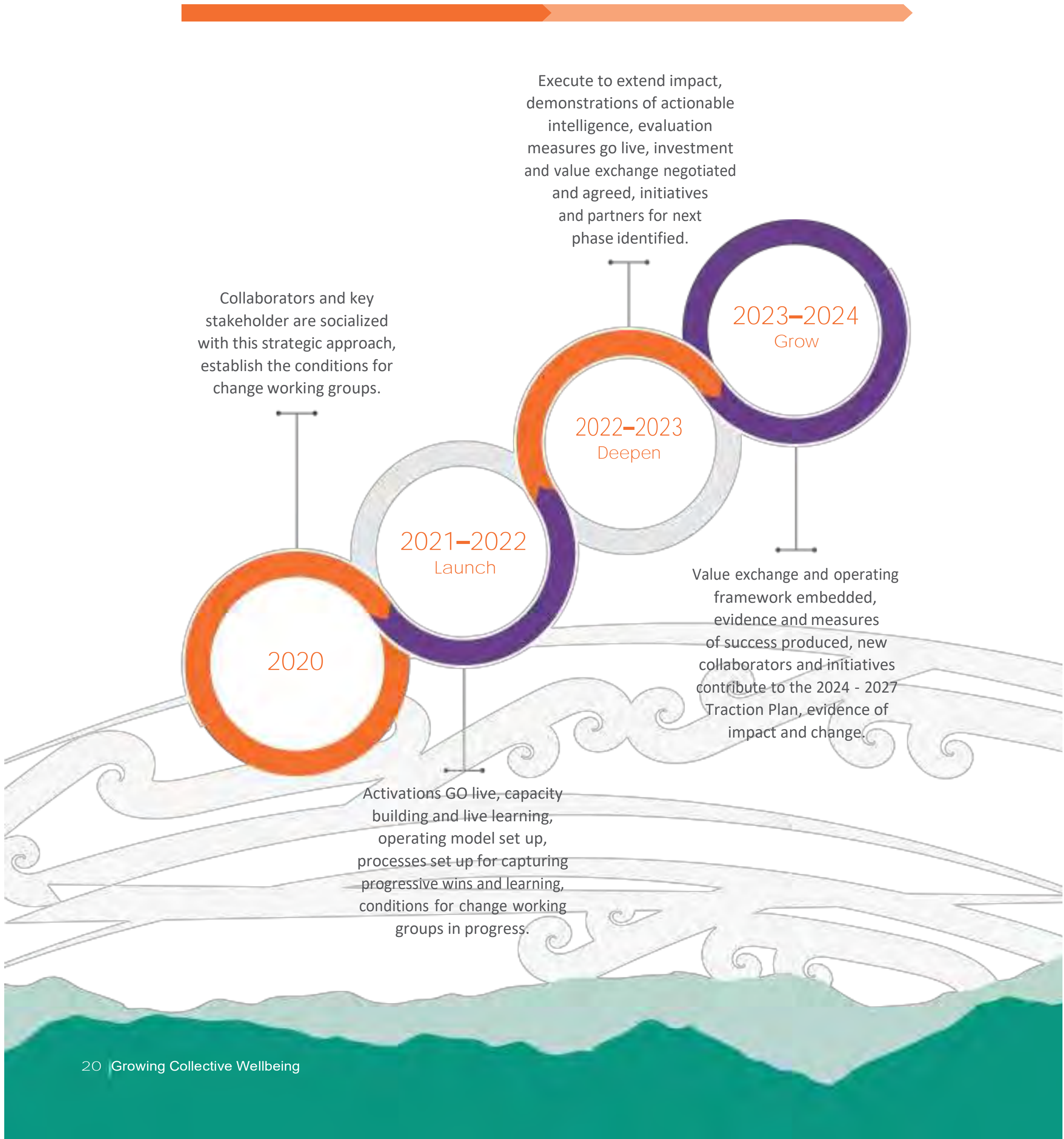
Backboning movements for impact

Containers for Change	Community Aspiration	Authentic Engagement & Partnership	Leverage and Momentum	Strategic Learning & Reflective Practice
Kaupapa-driven.	"Nothing about us without us!".	High trust, non-competitive principled.	Removes bureaucracy so pace and depth become viable choice.	Has real time feedback loops.
Values diversity, creates brave space.	Based on community values and goals.	Negotiates the exchange of value rather than funding-only approaches.	Understands and works to address systems change.	Maps the progressive wins.
Deeply cares about and works with those who have lived experience.	Includes those not in traditional seats of power.	Enables power-sharing.	Prioritises actions that generate movement.	Acknowledges assumptions and mental models.
Fails forward, learns by doing, disciplined in the chaos.	So ambitious it cannot be mistaken for BAU.	Facilitates collective intelligence and collective action.	Leans in to tension, positive disruption.	Regular quality reflection to improve practice and wellbeing.
Storytelling.	Creating new narrative to inspire positive change.		Produces artefacts.	Disseminates actionable intel.
Biodegradable.				

Collective Impact 3.0 adapted to Aotearoa New Zealand context by CALLED and CIA (The Change & Innovation Agency).
Cabaj, M., & Weaver, L. (2016). Paper: Collective Impact 3:0. Tamarack Institute.

Horizon Setting

For the Growing Collective Wellbeing strategy to scale beyond the short term an iterative approach is needed to build capability and capacity beyond the start up phase. To ensure momentum is maintained the horizons overlap, or run concurrently.



Call to act

Our value proposition is that we can amplify and accelerate our impact through stakeholders and community working together across the system.

It will take a whole of community-whole of system approach to grow individual and collective wellbeing.

If you are interested in joining the movement then contact Marguerite McGuckin.

marguerite.mcguckin@teoranganui.co.nz

Growing Collective Wellbeing

Whanganui, **Rangitīkei,** Ruapehu

If you are interested in partnering and would like to find out more about this kaupapa please contact:

Marguerite McGuckin marguerite.mcguckin@teoranganui.co.nz

Like us on Facebook: www.facebook.com/HealthyFamiliesWRR
and follow us on twitter www.twitter.com/HealthyWRR
or for further info www.healthyfamilieswrr.org.nz

APPENDIX3

Te Reo o Te Rangatahi

the voice of young people

Insights Report

2019 - 2020

Te Reo o te Rangatahi engaged rangatahi in conversations about the things that matter most to them at the moment. We believe that rangatahi voice is vital in nurturing the development of rangatahi wellbeing.

Prepared for
Te Puni Kōkiri
Te Tai **Hauāuru**

Document Purpose

It is intended to give policy and investment advisors at Te Puni Kōkiri an insight into what is important to rangatahi Māori. The intent is then for the agency to assess their current priorities and processes to enable better investment in the health and wellbeing of rangatahi in the Whanganui, Ruapehu, Rangitīkei rohe.

To Te Puni Kōkiri Te Tai Hauāuru – we acknowledge you for daring greatly to value our rangatahi voice and then being prepared to think and act differently about how you might invest in meaningful initiatives and innovations that support rangatahi health and wellbeing.

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Background

Healthy Families NZ is a large-scale initiative that brings community and community leadership together in a united effort for better **health. It aims to improve people's health where they live, learn, work** and play by taking a systems approach to preventing chronic disease. Healthy Families NZ has an explicit focus on equity, improving health **for Māori and reducing inequities for groups at increased risk of** preventable chronic disease.

In 2019 Te Puni Kōkiri commissioned Healthy Families Whanganui, Ruapehu, Rangitīkei (WRR) to develop this insights report. The rangatahi insights help to better understand the perceptions, thoughts and lived experiences of rangatahi from across the rohe (region). These insights are to inform what may prevent suicidal behaviour and suicide. Therefore, Healthy Families WRR has focused the kōrero with rangatahi on wellbeing.

This is phase one of this process. In phase two Healthy Families WRR will walk alongside Te Puni Kōkiri to capture their journey of change. We agreed it is important we uphold the integrity of this process by first listening, then acting on these insights.

It has been a privilege for Healthy Families WRR to hold this space with key collaborators. We thank Troy Brown (Te Puni Kōkiri), Hawea Meihana (Ngā Waiariki – Ngāti Apa) Justin Gush (Te Rūnanga o Ngā Waiariki – Ngāti Apa), Rua Marshall-Ponga (Ngā Taura Tūhono – Whanganui Stop Smoking Service WRHN), Sam Beatson-Shaw (Whanganui District Health Board), Hayden Bradley (Te Oranganui) for co-facilitating the engagement alongside Healthy Families WRR. Your talents, energy and commitment to ensuring safe space for rangatahi to share their truth is next level exceptional!

Poipoia te kākano kia puāwai

Nurture the seed and it will blo

Methodology

A rapid assessment of the rangatahi data and literature gave us an indication of what might inform some of the discussions. This helped to develop the enquiry framework, which then evolved after the first engagements.

We partnered with local stakeholders, community champions and engaged with rangatahi 12 – 24 years of age, living in Whanganui, Marton, Ohakune, Raetihi and Taihape. Our engagement included interactive workshops, peer to peer interviews, online digital village forum, small group interviews and surveys.

We captured over 1500 rangatahi comments as points of data, then synthesized them to develop the key insights outlined in this report. We have also included our observations and critical learnings as a part of working across the region with rangatahi, community champions and system influencers.

We foster an innovation mind-set, where we are adamant that people are the experts of their own solutions, this is consistent with the **mātāpono** of rangatiratanga.

COVID-19 Pivot

The COVID-19 pandemic heavily disrupted Te Reo o Te Rangatahi. Like everything else, suddenly the kanohi-ki- te-kanohi engagement with rangatahi came to a halt. The great thing about Healthy Families way of working and the advancement of digital platforms meant we could vot, like our **tūpuna** did in their time, and adapt to the environment accordingly.

We, like many of our collaborators worked through the COVID-alert levels and so it was easy to convene partners to co-design this new challenge. As a result we developed a digital platform prototype and called it **He Pā Matahiko – the Rangatahi Digital Village**. Rangatahi were invited into the Village to participate in online forums, **pūrākau,** oup challenges, and meet guest speakers. Rangatahi also icipated in designing their own messaging and narratives r topical issues such as the five ways to wellbeing, alcohol harm and COVID-19 youth response.

We thank our Digital Village rangatahi and collaborators: anganui District Council, Community Action on Youth and gs (CAYAD), Te Oranganui Trust, Health Promoting Agency and Whanganui District Health Board.

Healthy Families

Principles

Collaboration for Collective Impact

Leadership

Line of Sight

Equity of Outcome

Adaptation

Experimentation

Implementation at Scale

Insights

at a glance

Rangatahi want to be in environments that create a sense of personal and collective connection - a place where they feel they belong - environments that encourage self-efficacy, personal security and where they are free from judgement and stigma.

Rangatahi feel Te **Āo Māori** perspectives and Te Reo **Māori** should be more important in Aotearoa.

Rangatahi want more activities in holistic leadership, personal learning and development. **They're** looking for opportunities to be active, engaged and more connected with other like-minded groups.

Rangatahi are looking for opportunities to be productive citizens in their communities. They want to contribute their ideas and help think of solutions.

Rangatahi want to feel loved and cared for. Those special connections, or moments of bonding are significant for young people. They create love, trust, compassion, time and **ūkaipōtanga.**

Rangatahi want to learn and develop in safe to fail environments alongside trusted adults they have a meaningful connection with.

Rangatahi have great aspirations and goals for their future, but they are really concerned about the impact of COVID, climate change and their **whānau** health and wellbeing.

Emerging Hypotheses

In addition to this piece of important mahi we were at the same time leading the co-design of the Regional Suicide Prevention Strategy for the Whanganui District Health Board, and prototyping with connection to taiao, culture and wellbeing. As a result we have identified emerging hypotheses from our observations and critical learnings. We think they are important to share as a part of this Insights Report:

Trauma, shame

- Childhood trauma and unresolved childhood trauma was prevalant in the many stories whānau have shared with us.
- Shame internalised over time can result in feeling unloved and unlovable.
- Rangatahi do not necessarily know about the different ways we express love. This can cause a distorted perspective of what healthy, or unhealthy love is.
- Being vulnerable and sharing our vulnerability in safe environments is an important part of a healing process. Vulnerability is also about being courageous. We need to encourage a mind-set shift from vulnerability as a weakness to vulnerability is strength.
- We should be OK for our rangatahi to deal with adversity – we have heard many stories of how adversity builds courage and stamina, but it is the relentless hurt of trauma that our rangatahi can do without!

Social Media

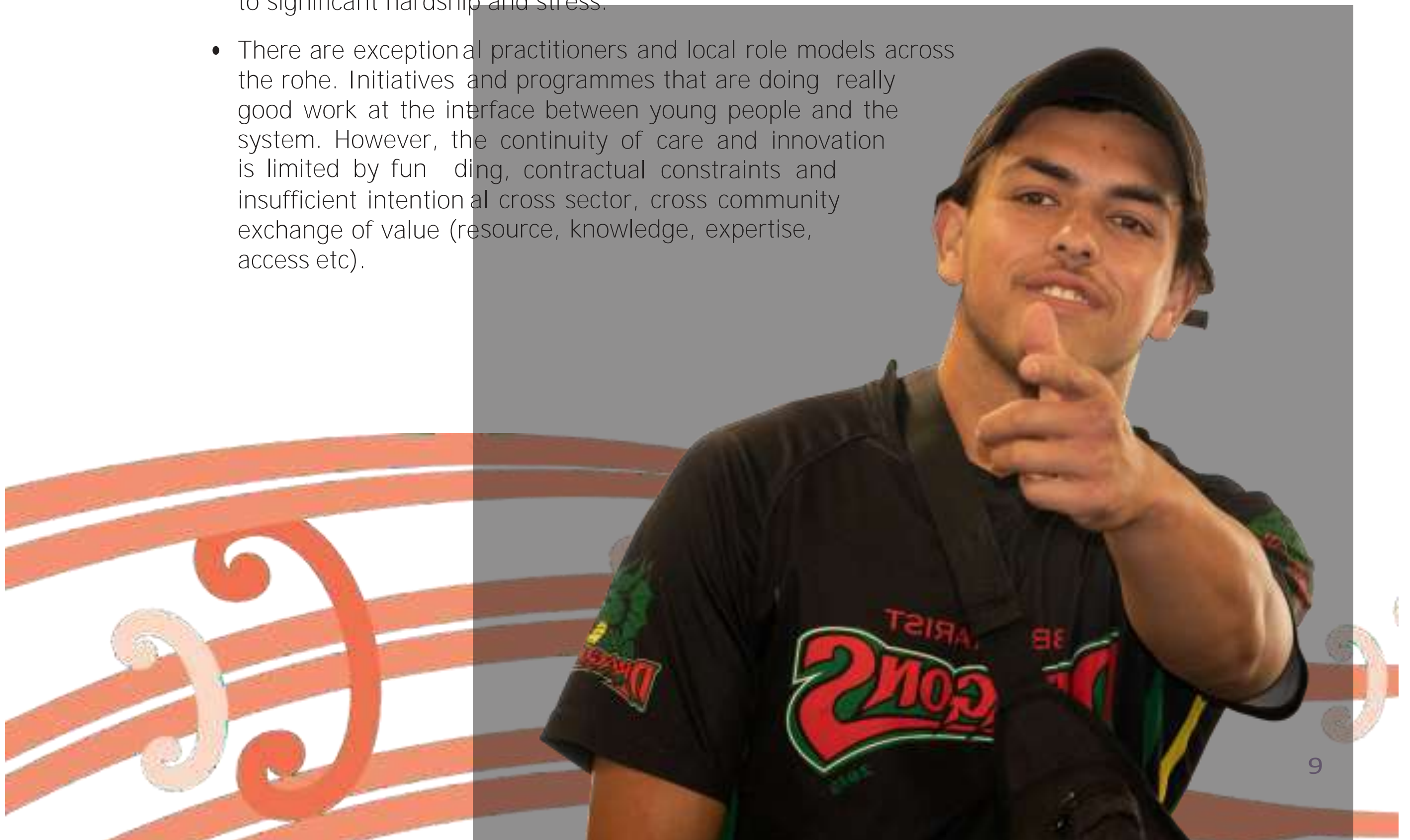
- If social media or gaming goes unchecked, taitamariki will not get the required sleep they need to maintain healthy development. Lack of sleep affects focus and concentration levels. Sleep hygiene is an important protective factor for health and wellbeing (suicide prevention).
- Online bullying and judgmentalness is rife and can escalate quickly at scale (viral). Because of the speed and scale of this negative culture rangatahi have a fear of being judged and ridiculed, which can cause, or add to extreme anxiety.
- Excessive use of social media means excessive exposure to shallow and vain versions of humanity in body image, relationships, risks, wealth, humour, and various forms of bias. Young people are easily triggered via this over exposure. On the flip side many Māori social media influencers today are promoting positive health and wellbeing messages.
- If parents, caregivers, grandparents are not technology savvy then monitoring technology usage, let alone understanding how social media works makes things harder. During COVID rāhui alert levels we noticed the generations coming together so rangatahi could teach their Kuia and Koroua how to use technology to keep in touch with their loved ones. We strongly recommend investing in the exchange of intergenerational knowledge and skills to close the digital age divide.

Anxiety

- We noticed healthy whānau relationships where anxiety is talked about and well understood. We think it is important we support rangatahi to recognise what anxiety is, how to manage anxiety, and what works specifically for them. Young people need to know how to self-manage anxiety and what their self-managing tools are.
- The more open and honest we are about anxiety the greater opportunity we have to focus more on growing self-efficacy and self-agency.
- We noticed that rangatahi are not learning about the spectrum of feelings versus the spectrum of reactions. For example some rangatahi could only name three feelings such as happy, sad, and angry.
- We need to focus on grit and not just resilience. Our whānau are resilient. Our generational stories would attest to having an abundance of resilience. However, we have recently been learning about grit – resilience, passion, and persistence.

Role Models and Navigators

- Rangatahi want to connect with role models who can share their knowledge and experience in meaningful ways, but more importantly role models become trusted advisors. We have learnt that nurturing and stable relationships with people who care are essential to healthy development.
- Role models and navigators who walk alongside rangatahi, especially those young people who do not have healthy relationships with their caregiver, can help the young person to develop cooperative interaction, love of learning, confidence in self and sense of self, and positive social skills, to name but a few. Trusted safe relationships become buffers to significant hardship and stress.
- There are exceptional practitioners and local role models across the rohe. Initiatives and programmes that are doing really good work at the interface between young people and the system. However, the continuity of care and innovation is limited by funding, contractual constraints and insufficient intentional cross sector, cross community exchange of value (resource, knowledge, expertise, access etc).



Insights
Kei ia tangata, kei ia iwi tōna ake mana me āna ake whakatau

Insight #1

Rangatahi want to be in environments that create a sense of personal and collective connection - a place where they feel they belong - environments that encourage self-efficacy, personal security and where they are free from judgement and stigma.

Research says

A sense of belonging is a vital nutrient for positive youth development and it is not only the people but the climate of the places young people inhabit that matters in this regards.

Deane, K,Dutton, H & Kerekere, E. (2019)

Rangatahi say

"Connections to whakapapa and whenua are important to me because I've been in the position of not knowing who I am and where I belong to – loss of identity and connections to whenua is a feeling of being lost in life and it's something I don't want my tamariki to go through"

"I want to get my moko kauae at some point of my life but I'm afraid of what others would say."

"Create environments that encourage love, care and connection in order to break generational trauma."

"It (workshops) was actually fun. I thought it would be boring but it's not, I love it, I felt welcomed, the non-stop engagement from the facilitators towards rangatahi is what I liked most about today."

"I've had to ground myself at the moment, there's so much noise in the world. I find that going back to my marae, going to the awa, going to Tangaroa, that helps me"

We noticed

Young people respond positively in environments where they feel they belong and are safe.

Young people become more connected to their environment when the kaupapa and then those who are holding the space are non-judgemental, open and relevant. While rangatahi talked about wanting more youth relevant spaces where they can hang out - we noticed that being connected to other like-minded people, being heard, feeling value and being valued, is far more important.

We heard

Rangatahi are looking for youth friendly environments where they feel safe to be Māori, young, and uniquely them.

Some young people talked about their wellbeing is strongly connected to their awa, maunga, and whenua. Not all young people can make this whakapapa link to space or place, but still want environments that reflect their culture and are welcoming of young people. We noticed rangatahi are more engaged when the environments they are invited into, and the people holding these spaces for them, create meaningful connections to people (each other / others) and place.

Questions for Co-designers, Youth Champions and Investors

How do our built environments positively reflect rangatahi?

How might we grow the intentional connection between taiao (natural environment) and the wellbeing of all rangatahi?

Insight #2

Rangatahi feel Te Ao Māori perspectives and Te Reo Māori should be more important in Aotearoa.

Research says

Western models sit in tension with traditional **Māori** views and do so in a way that can disrupt young **people's** understanding of the kaupapa. Youth participation and development that is inherently tied to **Māori** development need youth participation to involve cultural participation.

Deane, K, Dutton, H & Kerekere, E. (2019)

Rangatahi say

"We need a lot more Te Reo incorporated in school and everyday life. Teach our younger generation the cultural background of New Zealand."

""Learn more about Māori culture and other things and share it with families. Get to know more about my culture"

"What is knowledge if it's not shared?"

"Everyone has a role at the marae and you just get on and do the mahi. Everyone has a role and everyone is valued. How do we move those values outside the gate (Marae)?"

"We should be celebrating Matariki, Waitangi day and Kapa Haka festivals just like we celebrate Christmas parades and highland games"

We noticed

Rangatahi can see and want others to see the value in Te Ao Māori and Te Reo Māori as a vital part of New Zealand.

Young people wonder why there isn't a balanced appreciation of Māori perspectives and more use of Te Reo Māori. We noticed young people think this kind of acceptance would make New Zealand a better place for everyone.

We heard

Rangatahi want ahurea Māori and Te Reo Māori to be equally important to the mainstream as mainstream values and English language is to New Zealanders.

We heard young people talk about how important culture is. We heard young people talk about the value of Māori and its importance in today's world because in Māori contexts, such as the marae setting where everyone has a role to play, everyone is valued and Māori mobilise quickly to support each other - whether tangi, celebrations, or even during COVID - how can we move these values and practices outside of the marae gate. They are interested in retaining these values and ensuring wider New Zealand appreciates this.

Social media and media influencers have raised awareness of the critical issues we face in the world and as a country, so rangatahi can see the global indigenous movements encouraging a change in attitude and behaviour. We heard rangatahi support the call for change.

Questions for Co-designers, Youth Champions and Investors

How might rangatahi voice encourage wider understanding and appreciation of ahurea **Māori** and Te **Reo Māori?**

Insight #3

Rangatahi want more activities in holistic leadership, personal learning and development. They're looking for opportunities to be active, engaged and more connected with other like-minded groups.

Research says

Confidence and competency development provide the foundation for agency and leadership. There is a highlighted need for improvement for cultural responsiveness in programming and an improvement of the skills and characteristics of the people working with the young people.

Deane, K, Dutton, H & Kerekere, E. (2019)

Rangatahi say

"Being able to openly address rangatahi issues, express things that we as rangatahi contemplate and over think about and getting to know and understand others point of views"

"Our generation speaks up and I think that's why it's so noisy because we all want to share our opinions"

"It's good to have this opportunity, we're always looked over a lot. I feel like I had to become a leader or have a head role at school just to have a voice and have input"

"What I liked most about this is the fact that we have a voice and our ideas could be taken in to consideration"

We noticed

Rangatahi value participating in activities where individuality and team spirit are encouraged and developed concurrently. The confidence of our rangatahi grew during this engagement because the facilitators were empathetic listeners – treating the rangatahi respectfully - listening to understand.

Rangatahi met new people and made good connections with other rangatahi, which they really enjoyed. For most, they felt comfortable to share with each other. We noticed that rangatahi were able to find common ground. We noticed the safe environment and relevancy of the kaupapa encouraged rangatahi to be confident, even discovering and allowing their own leadership style to come through in this forum, which they applied in the workshop setting.

We heard

Rangatahi enjoyed coming together in the workshops, the trust that was gained in such a short time - being able to meet new people in a safe space – made them more attentative about what others were going through, listening to their stories and opinions, which became important for feeling empathy. We heard rangatahi are craving this cooperation and social interaction with other rangatahi but also faciliators and leaders who can create the right conditions for open, non-judgemental sharing and brainstorming.

We heard rangatahi want to learn more about how to do adulting - how to transition from school to work, or training, from home to flatting, from dependance to independant. Young people want to learn about practical things such as how to get a job, how to write a CV, and what are the transferrable skills rangatahi will need as they move from school to the world of work.

We heard young **māmā** sharing their vulnerability. Once one shared then it opened the floor up for group sharing. As a result they found common interests and practices such as the use of Maramataka as a practical resource and tool for guiding their lives. Peer to peer learning encourages rangatahi to pull down their barriers, open up to each other, listen and share with each other and create important connections.

Questions for Co-designers, Youth Champions and Investors

How do we encourage services and communities to recognise rangatahi as leaders and activators?

How do we maximise the opportunities to bring rangatahi together to create intentional learning, development and networks?

Insight #4

Rangatahi are looking for opportunities to be productive citizens in their communities. They want to contribute their ideas and help think of solutions.

Research says

Many young people ultimately want a kinder, fairer world and they want to make a difference but require support to do this. They have a need for agency in their lives and a right to be involved in decisions that affect them. Organisations are still struggling to provide authentic opportunities for youth voice and youth participation.

Deane, K,Dutton, H & Kerekere, E. (2019)

Rangatahi say

"Not only does our wellbeing matter towards ourselves, but it also has an impact on our peers, family, friends and society. How we choose to express ourselves is contributing and portrays society. It is important that we do our share best to do everything that we possibly can"

"If rangatahi didn't have a voice, what purpose do we have as rangatahi?"

"Meeting new people, making new whānau and allowing my voice to be heard"

We noticed

Young people want to be invited to participate in conversations that contribute to their wellbeing and are looking for opportunities where they can be active citizens. Rangatahi were positive about taking up different leadership roles so they can contribute positively in their communities.

We noticed how surprised rangatahi were when we asked for their thoughts and ideas about what matters to their wellbeing. We noticed young people do not feel their voice and ideas are valued by their communities, yet we saw rangatahi quickly adapt in the workshops and easily adopt some of the key innovation mindsets we promote in design – being curious, leaning in, valuing diversity.

We heard

Rangatahi want to be engaged and connected but the forums and convenors are not always effective in their engagement and creating connections. Rangatahi think in such a busy information-overloaded world it is hard for rangatahi to be appreciated at the table as designers and decision makers. And when they are invited in often their value is given lip-service and no one ever really takes their ideas and thoughts seriously.

We heard rangatahi talk about leadership in today's world is not a one-size-fits-all. That there are a diverse range of personalities and leadership styles, which young people appreciate. Yet they think adults do not always recognise these alternative leadership styles when determining who has access to different youth opportunities. We heard rangatahi say they felt they were not often asked for their ideas or opinions, and yet they want to be involved in their communities and in particular to be actively included in issues that are relevant to young people. We heard rangatahi think their stories and experiences can help others, and that they have lots of ideas that they want to share and test.

How might we co-create more authentic platforms for rangatahi to lead?

Insight #5

Rangatahi want to feel loved and cared for. Those special connections, or moments of bonding are significant for young people. They create love, trust, compassion, time and ukaipōtanga.

Research says

Thriving communities depend on the successful development of the people who live in them, and building the foundations of successful development in childhood requires responsive relationships and supportive environments.

Center on the Developing Child (2013)

Rangatahi say

"Supportive family is one of my biggest things. Being around people keeps me going and growing up. My mum was always real busy, she was the one doing everything for our family. So, trying to sort myself out so I can give back to her, is a big thing."

"Seeing my family being nice, hanging out with Dad, Mum and Nan keeps me well. I get to play basketball with my Dad on his days off. He only gets one day off a week and we play for about an hour."

"My whānau is important to me because they guide me, teach me and I am who I am because of them. My overall wellbeing is important to be able to love and care for myself and my whānau"

"Seeing Nan and Koko allows me to connect with them a lot more than just over the phone. Having conversations with Nan and Koko is a good day to me"

"At home, I've become the role model for my whānau especially for my little sister after losing Dad, I'm parenting my siblings and my mum."

"Raised in a toxic environment - that affects everything, like your attitude in school, can easily become the norm. I see kids that were brought up in that environment and now their kids are in that environment. Breaking cycles is so important, it's like the difference between our kids tapping in to their gifts or just becoming alcoholics and druggies just because that's the norm and that's all they know"

We noticed

How moved rangatahi are when talking about the importance of **whānau** and being able to spend quality time with their **whānau.** We noticed rangatahi love moments of connection with family valuing deeply the special bonds that they have and how some relationships are more significant than others.

We noticed some young people are searching for deeper connection **with their whānau.** We noticed that rangatahi want to feel loved, cared for and encouraged by their **whānau.** Rangatahi feel a huge sense of loyalty, responsibility and commitment to their family even when there are problems at home. **Whānau** connections are significant for young people. However, we noticed that when **whānau** relationships are filled with tension or unrealistic expectations and anger rangatahi feel a sense of hopelessness and sadness. We noticed that a bad day for rangatahi is often when there is a **whānau** breakdown of some kind.

We heard

Rangatahi talk about the importance of quality time with their **whānau.** We heard about rangatahi understanding the challenges their parents face when they are so busy working, and not just in paid jobs, but also in their other roles within the wider whānau and community. Rangatahi sometimes feel they have to compete to get time with their parents and it is not always quality time especially as parents are often stretched and distracted by other commitments.

On the other hand, we heard some rangatahi are not living in responsive environments, with minimal child-adult responsive relationships. Therefore, we heard rangatahi talk about the symptoms of a non-supportive environment. For example, fights, loud music, parties, being hungry and cold, and poor sleep hygiene. Because rangatahi require and expect more responsive relationships with their **whānau** we heard sadness, hopelessness and loss when they talked about the challenges they face in their **whānau.**

Many young people were grateful for COVID alert level 4 because it meant **whānau** were forced to spend that time together. We heard more young people enjoyed cooking and eating kai together, going for walks, playing games and even doing jobs around the house, together as a family.

Questions for Co-designers, Youth Champions and Investors

How might we ensure trusted adults are valued as part of creating the buffers young people need?

How might we reduce the compounded weight of toxic stress that **whānau** are experiencing so tamariki and rangatahi wellbeing flourishes?

Insight #6

Rangatahi want to learn and develop in safe to fail environments alongside trusted adults they have a meaningful connection with.

Research says

Experiential learning was an important methodology in the development of taiohi in traditional **Māori** communities. The practice of urungatanga involved education through exposure where young people were put in authentic learning situations and expected to work out solutions without adult guidance.

Baxter et al (2016) Te Ora Hou (2011). NZYMN (2019)

Rangatahi say

"Rangatahi aren't always given the opportunity to koha their voice, therefore feel undervalued. If rangatahi are exposed and active in life, their minds and ideas expand. The more exposed they are to relevant experiences, the more positive they become."

"Right now we don't have a foundation as rangatahi. We have to pave out the next phase of what's coming out, let's start now and build our foundation to the next step"

"When I have failed in the post, I've been judged for it, that's why I hate failing."

"Workplace relationships have a huge impact on your productivity. Young people are stigmatised by adults in their environments making it an uncomfortable place to be."

"Fear of failing comes from my lack of encouragement from my parents. You don't just want encouragement from anyone, you want encouragement from your people."

"For me, it's the lack of role models for specific goals. There's role models here but where do we go to if we want to see engineers? Where do we see them?"

We noticed

Rangatahi are looking for role models and positive experiences that demonstrate authenticity and support them to become confident well young adults.

Young people feel the huge pressure to not fail - where in fact failure is the ripe ground for great learning and development. When learning and development environments make it OK to test, fail, iterate, reflect and adapt then young people are encouraged to give things a go and become accustomed to failing safely without the negative connotation.

We heard

Practical learning and effective engagement from tutors sharing their lived experiences relating to rangatahi, creates a positive learning environment and willingness from rangatahi to learn. We heard young people say they hate failing because when they've failed in the past they have been judged for it - this continues to compound their own self-judgement and therefore lowering their self-efficacy. We heard rangatahi thinking they are scared of what other people think of them and the impact of the shame narrative 'who do they think they are.'

We heard rangatahi think there needs to be a range of role models they can access but they are just not that accessible. Therefore, rangatahi need more exposure to certain pathways, experts, and opportunities so they know how to find those important connections.

Questions for Co-designers, Youth Champions and Investors

What could we do better in our region to flip the narrative from failure to safe?

How might we demonstrate the importance of meaningful connections with young people for improving their learning and development?

Insight #7

Rangatahi have great aspirations and goals for their future, but they are really concerned about the impact of COVID, climate change and their whānau health and wellbeing.

Research says

Young people in Aotearoa New Zealand face too many systemic risks and violations of their human rights. Too many young people in New Zealand are not getting their basic needs met. They exhibit many strengths but are too often the targets of hostility, harm and more insidious forms of prejudice and discrimination. The neoliberal policies of **the 1980's have exacerbated the inequities** created by colonisation, the effects of which continue to be felt by young people.

Deane, K, Dutton, H & Kerekere, E. (2019)

Rangatahi say

The power to create my own future, allows me to see where the future takes me and gives me a choice to what I can do"

"I'm excited to see how we progress as a (Māori) people. I look back and think, we actually are doing well"

"In 10 years' time, my partner and I would have built our whānau whare on our whenua. Our whare is self-sustaining with a Maara and orchids"

"My purpose in life was to achieve big goals such as getting a degree, getting a good job and travelling. I now have my son who encourages me more to continue chasing my goals"

"I look forward to being in the workforce, working for the Awhi bee company, role modelling for my younger siblings"

We noticed

Rangatahi are looking for opportunities that encourage them to manifest incredible, rich experiences and people that empower them to achieve their dreams and aspirations.

Rangatahi are well informed about the global issues we currently face. We noticed that rangatahi have real heart for these global issues because they can relate to the social media influencers who are advocating for more action. We noticed rangatahi are worried about taiao and how we treat her, climate change and the lack of real collective action that shows New Zealand is really doing something about this.

We heard

Rangatahi are really inspired to pursue their dreams and goals and they have had really good support from either a **whānau** member, support worker, mentor, or teacher who has guided and encouraged them to be the best they can be. However, they became more worried about their futures, especially with the impact of COVID and the lack of significant effort toward climate change.

…will there be major limitations in their future lifestyles and choices?

Will the impact of COVID and the state of the world reduce their options?

For some rangatahi hearing about how COVID is affecting people around the country they begin to worry about what this means for their parents and siblings. They are also concerned about what their future will look like – will there be major limitations in their future lifestyles and choices? Will the impact of COVID and the state of the world reduce their options?

We heard rangatahi were worried about global leadership especially because of the types of leaders in other countries who are not prioritising the health of their people, especially minority groups. Rangatahi liked the New Zealand Prime Minister was visible during COVID - her approach showed that she cared and they perceived her judgement was trustworthy. Rangatahi were worried about the impact of what was happening in America.

Rangatahi were making the links between the two different types of leadership and were grateful **New Zealand's leadership** was vastly different.

Many of our rangatahi are connected with taiao through fishing, swimming, hunting, going on the maunga - they are intimately connected with these spaces where they live, learn, work, and play. We heard them talk about the impact of pollution, the lack of climate change action, and their desire to ensure their ideas and perspectives are valued in the solutions.

Rangatahi think the biggest health issue of our people is the health of our awa – that people are not taking care of our awa.

Questions for Co-designers, Youth Champions and Investors

How might we encourage rangatahi to become active designers of local solutions to global problems?

Questions

at a glance

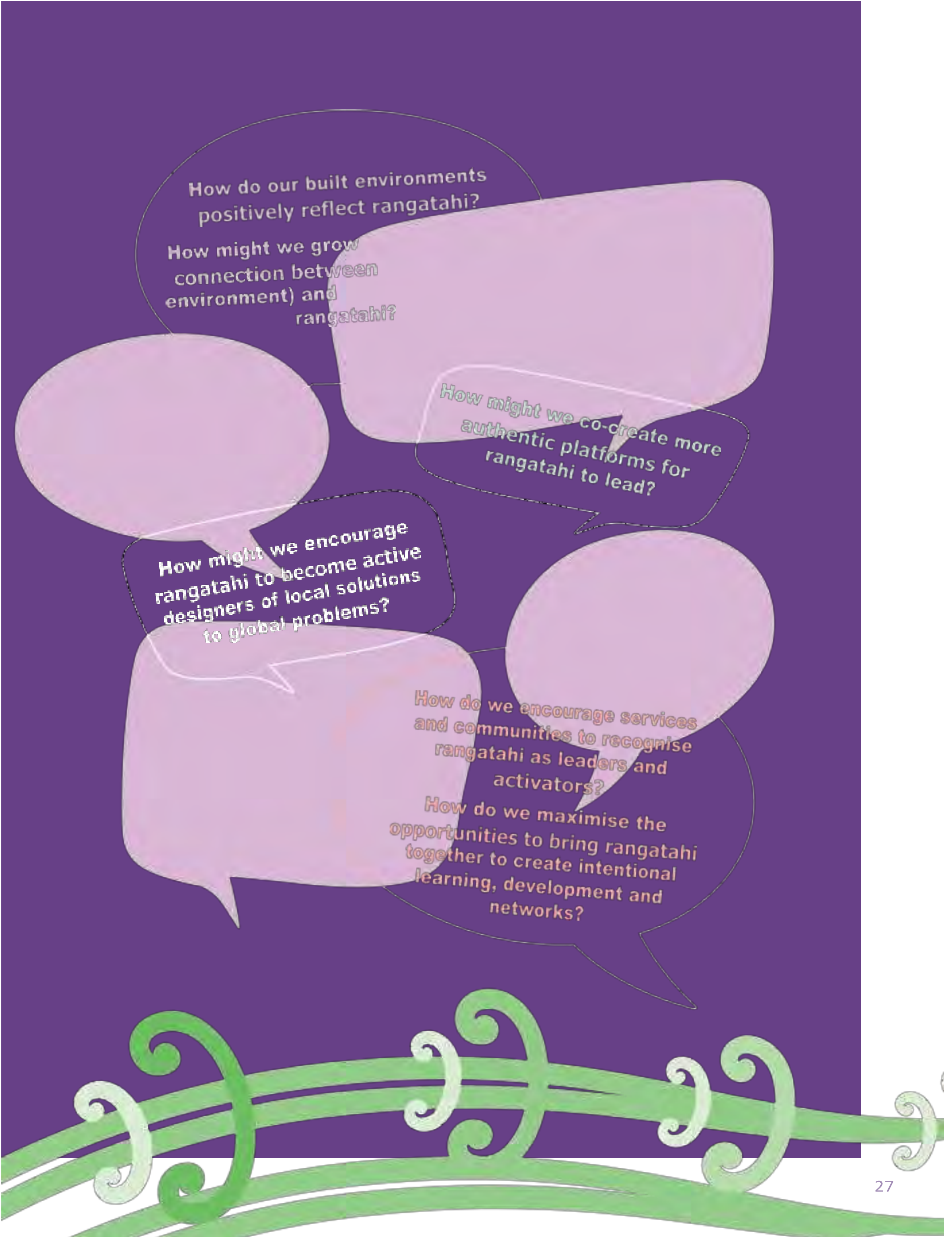
What could we do better in our region to flip the narrative from failure to safe?

How might we demonstrate the importance of meaningful connections with young people for improving their learning and development?

How might we ensure trusted adults are valued as part of creating the buffers young people need?

How might we reduce the compounded weight of toxic stress that whānau are experiencing so tamariki and rangatahi wellbeing flourishes?

How might rangatahi voice encourage wider understanding and appreciation of ahurea Māori and Te Reo Māori?


How do our built environments positively reflect rangatahi?
How might we grow connection between environment) and rangatahi?
How might we co-create more authentic platforms for rangatahi to lead?
How might we encourage rangatahi to become active designers of local solutions to global problems?
How do we encourage services and communities to recognise rangatahi as leaders and activators?
How do we maximise the opportunities to bring rangatahi together to create intentional learning, development and networks?
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Te Puni Kōkiri
MINISTRY OF MĀORI DEVELOPMENT

If you are interested in partnering and would like to find out more about this kaupapa please contact;

Lee-arna Nepia lee-arna.nepia@teoranganui.co.nz

Like us on Facebook: www.facebook.com/HealthyFamiliesWRR
and follow us on twitter www.twitter.com/HealthyWRR
or for further info www.healthyfamilieswrr.org.nz

WHANGANUI DHB

Consumer Engagement Strategy Overview

Consumer engagement is fundamental to achieving an equitable, patient/whānau-centred health and disability system across the Whanganui DHB rohe

Te Tiriti O Waitangi

WDHB will demonstrate its commitment to te Tiriti o Waitangi in all of its work, including through applying five principles of te Tiriti to its work in consumer engagement:

- *Tino Rangatiratanga*
- *Equity*
- *Active Protection*
- *Options, &*
- *Partnership*

OUR VALUES

We foster an environment that places the patient and whānau at the centre of everything we do.

Guided by 4 strategic & 8 closely related operational values:

Aroha
Love, respect and empathy.
– Rangimarie & Mauri

Kōtahitanga
Collaboration & integration
– Whanaungatanga & Mana tangata

Manaakitanga
Treating others, the way we want to be treated
– Kaitiakitanga & Tikanga Māori

Tino Rangatiratanga
Empowerment & proactivity
– Wairuatanga & Whakapapa

OUR VISION

He Hāpori Ora - Thriving Communities

The people in Whanganui District Health Board rohe live their healthiest lives possible in thriving communities

OUR MISSION

Kia 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.

OUR STRATEGIC FOCUS AREAS

Mana Taurite
– Pro-Equity

Kāwanatanga Hāpori
– Social Governance

Noho ora pai I tōu ake kāinga
– Healthy at home; every bed matters

WDHB CONSUMER ENGAGEMENT REVIEW

Baker Consulting Ltd (2020)

Main Recommendations:
(endorsed for implementation)

1. WDHB document a single overarching approach to consumer engagement that is endorsed by both Hauora ā Iwi and the DHB Board.
2. Te Pukaea be reconstituted with a broader role and more representative membership as part of the overarching approach to consumer engagement. This also requires re-considering the other consumer roles on other DHB advisory groups.
3. Whanganui DHB set clearer expectations of DHB staff to ensure a consistent whole-of system approach to consumer engagement across Whanganui DHB

Te Pukaea "The trumpet – voice of the people". (Name gifted to the group providing a voice for whānau/consumers for WDHB.)

WDHB CONSUMER ENGAGEMENT STRATEGY

This strategy outlines the foundation and direction for consumer engagement for WDHB funded and provided services.

LINKS TO

Nationally:

- He Korowai Oranga
- Whakamaua
- Health Quality & Safety Commission guidance

Within the Rohe:

- Primary care & community consumer engagement
- Social Governance and cross-sector community engagement:
  – Collective Impact

Within WDHB:

- He Hāpori Ora - Thriving Communities
- Pro-equity implementation
- Commissioning & procurement
- Workforce development - recruitment, orientation & education
- Project management & service improvement
- Communications

ROADMAP

Applying an approach which:

- ***Engages with Māori***
- ***Strengthens engagement from governance to direct care levels***
- ***Addresses power imbalances.***

1. Review endorsed by ELT & Hauora Ā Iwi for next steps
2. WDHB consumer network set up to meet regularly
3. Engage key partners including consumer networkon on draft strategy & implementation
4. In consultation finalise the strategy & develop:
   - Scope & definitions
   - Overarching principles
   - Structural diagram with links across the system
   - Te Pukaea and Consumer Network ToR
   - WDHB Consumer Engagement Policy
   - Accountability measures
5. WDHB contracts change to include principles
6. Reconstitute Te Pukaea with at least 50% Māori membership
7. ELT informed of new Te Pukaea membership
8. Board & Hauora Ā Iwi informed
9. Implementation:
   - On-going sponsor/s & administrative support
   - Orientation & development of TP Work Programme
   - Safe environment for consumer input

AREAS OF FOCUS

Structural linkages for consumer engagement across WDHB:

- Executive Leadership Team
- Clinical Board
- Impact Collective
- Service Level Alliances
- Patient Safety, Quality & Innovation
- WDHB Consumer Network
- Disability planning
- Project management

Te Pukaea:

- ToR

Health Literacy:

- Procedure for production of WDHB communications with whānau/patients
- Clinicians' training

Consumer Engagement & Feedback Channels

- Funded consumer roles
- HQSC QSM framework
- HQSC patient experience surveys
- Direct patient surveys
- Provider reporting
- Marama Real Time
- Complaints & compliments
- Conversation cafes

WDHB Policies, Procedures & Terms of Reference

OUTCOMES

The principles of consumer engagement are applied across WDHB funded and delivered services so that:.

- WDHB systems and contracts ensure meaningful consumer engagement
- WDHB is moving to consumer engagement practised at Partnership & Shared Leadership level across engagement, responsiveness and experience on the HQSC Quality Safety Marker Framework
- Transparent processes are used for consumer recruitment, renumeration & on-going development & support
- There are a range of options & levels for whānau/consumer experience capture, engagement & providing feedback
- Care and communications are patient & whānau-centred.

Resulting in:

- Consumers as 'partners in care' - patient & whānau-centred care
- Culturally safe care
- Options for care
- Empowered & informed consumers.

He Hāpori Ora – Thriving Communities

UNDERPINNED BY TE TIRITI O WAITANGI: Guarantee of Tino Rangatiratanga | Equity | Active Protection | Options | Partnership

Ko au toku whānau, ko toku whānau ko au – Nothing about me without me and my whānau/family.

Terms of Reference

TE PUKAEA	
Applicable to: Whanganui District Health Board	Authorised by: General Manager Patient Safety, Quality and Innovation (GM PS,Q&I)
	Contact person: EA to GM PS,Q&I

1. Background

Te Pukaea is set up by Whanganui District Health Board (WDHB) as the organisation's consumer governance oversight group.

The name 'Te Pukaea' was gifted by WDHB Kaitakitaki Cultural Advisor and Educator Ned Tapa, and supported by Kaumātua John Maihi, and means 'trumpet carrying the voice of the people'.

In 2020 consumer engagement in WDHB was reviewed and one of the key recommendations of that review was the reconstitution of Te Pukaea with a broader role as set out in these terms of reference.

Aligned to Te Pukaea, WDHB also has a less formal Consumer Forum for the networking, education and support of anyone in a consumer role for WDHB and to provide feedback to Te Pukaea.

These Terms of Reference were developed during the transition period for the national health and disability system. They recognise that changes will take effect to organisational structures from July 2022 onwards. However, there will still be a strong role for consumers going forward:

> *'People should be at the centre of our future health system that is listening and acting on the voices of consumers, whānau and communities in the design and delivery of health services.'*
>
> Department of Prime Minister and Cabinet Transition Unit, April 2021.

2. Definition

WDHB distinguishes between 'consumers' and 'community' engagement along a continuum from the individual receiving care or treatment to the collective of people in the rohe.

Consumer engagement covers the continuum from: the individuals receiving direct care; to their whānau and carers who support the individual and to groups of consumers and their organisations who often have an advocacy role.

Community engagement covers end of the continuum where members of a community and citizens are not directly involved in care but have a future interest in services and the benefits of a thriving community.

Consumer engagement covers:

- individuals receiving direct care
- whānau and carers who support an individual
- groups of consumers working in partnership with health providers to improve consumer experience.

WDHB's strategy document He Hāpori Ora Thriving Communities 2020-2023 focuses on, and seeks to strengthen, consumer and community engagement. The mission states: Kia 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. The stated priority areas include:

Whanganui District Health Board controlled document. The electronic version is the most up-to-date version. WDHB will not take responsibility in the event of an outdated paper copy being used which may lead to an undesirable consequence.

- Empowering **whānau**-centred care, and
- Empowering consumer engagement.

3. Purpose

Te Pukaea's key purpose is to provide consumer leadership by working collaboratively with WDHB governance and leadership. Te Pukaea brings the consumer **/ whānau** voice to the design, function and monitoring of equitable, effective **whānau/patient**-centred health services in the WDHB rohe.

Te Pukaea is primarily focused on:

- the achievement and demonstration of equity in health outcomes as set out in He **Hāpori** Ora and the **DHB's** pro-equity strategic focus
- providing consumer leadership to WDHB
- supporting safe services, quality improvement and providing advice to encourage and achieve best practice and innovation for WDHB
- providing a strong, representative and viable voice for the consumers and their **whānau** on health service planning and delivery.

4. Te Tiriti o Waitangi

Throughout its work, Te Pukaea will recognise and honour **WDHB's** obligation to Iwi and **Māori** in line with the five principles outlined in He **Hāpori** Ora:

- Guarantee of Tino Rangatiratanga
- Equity
- Active Protection
- Options
- Partnership.

The work of Te Pukaea is underpinned by He Hāpori Ora Thriving Communities and the organisation's values. Members of Te Pukaea are expected to uphold the values and be culturally confident in how they work and what they do.

5. Responsibilities

The General Manager Patient Safety, Quality and Innovation and Kaiuringi Māori and Equity jointly sponsor Te Pukaea on behalf of the WDHB Kaihautu Hauora/Chief Executive and the Executive Leadership Team (ELT).

Te Pukaea has the responsibility, through the sponsors, to give advice and make recommendations, from a consumer leadership perspective, to the Kaihautu Hauora/Chief Executive, Executive Leadership Team and the Board.

Te Pukaea has the responsibility for listening to consumers directly, and through its networks, and faithfully conveying the voice of consumers to the organisation for communications, education, policy development, strategy formation and implementation, research and governance.

6. Functions

Te Pukaea has the role of providing governance oversight for consumer leadership and engagement for WDHB. Te Pukaea receives the Applications for Consumer Representation to consider and either recommend approval of the suggested representatives or provides further advice on finding the right consumer/s for a committee, group, project or initiative.

The functions of Te Pukaea are to:

- Monitor, coordinate and enable appropriate consumer engagement across WDHB provided services
- Ensure consumer engagement in policy development and project management
- Represent local consumers at the regional and national level, as required
- Receive, consider and disseminate information from and to WDHB and other consumer networks
- Be responsive to the diverse voices of consumers
- Be involved in WDHB contracting processes to ensure consumer engagement for WDHB funded, externally provided services including primary and community-based care
- Advise and promote a 'Partners in Care' approach to the provision of person and whānau centred care, including input into the development of health service priorities and the enhancement of consumer engagement, patient safety and health literacy
- Participate, review and advise on reports, developments and initiatives relating to health and the availability and/or dissemination of health-related information
- Ensure regular communication and networking with a representative spread of consumers and relevant consumer groups
- Link with communities of interest, as required, for specific issues and problem solving
- Support the Patient Safety, Quality and Innovation team with consumer input as required
- Participate in the promotion and education of the community on consumer leadership and engagement.

Te Pukaea does not provide clinical oversight of health professionals.

7. Membership

There shall be ten (10) members on Te Pukaea, with a minimum of 50 percent Māori. The total membership will be representative of diverse backgrounds, contacts, knowledge and skills. All members must be passionate about consumers being able to access the best possible services and care.

Although appointed to reflect the consumer voice in a particular area of interest, they will not be regarded as representatives of any specific organisation or community.

It is recognised that a group of 10 people cannot directly represent the full diversity of the rohe, however the members are expected to be cognisant and a voice for all including:

- Māori health
- Pacific health, Asian and other cultures, including recent immigrant health
- Maternal, child and youth health
- Older persons' health
- Women's health, Men's health, Transgender health
- People with Long-term conditions
- Mental health, Alcohol and other drugs
- Disability
- Rural health, primary and community health
- Other high deprivation populations.

8. Officers and their responsibilities

Co-Chairs

- Two members of Te Pukaea will be appointed as Co-Chairs, with at least one of these people being of Māori descent.
- The Co-Chairs will be appointed by the ELT sponsors in consultation with the WDHB Kaihautu Hauora/Chief Executive.
- The initial appointment will be for 12 months.

- The Co-Chairs may be paid additional fees and allowances, depending on the level of commitment involved in addition to Te Pukaea and other consumer networking meetings they need to attend.
- The Co-Chairs will work with the ELT sponsors, with operational responsibility through the GM Patient Safety, Quality and Innovation who will assign a designated role to provide administrative support from their team.
- The Co-Chairs will convene and facilitate meetings, set agendas, approve minutes and reports.
- At least one of the Co-Chairs will be a consumer representative on the WDHB Clinical Board.
- At least one of the Co-Chairs will attend the Consumer Forum meetings.

Members

All members have responsibility for modelling the organisation's values and being:

- patient and whānau centred
- oriented to learning and continuous improvement
- respectful and non-judgemental
- demanding in holding the system to account
- transparent
- respectful of privacy and confidentiality
- work in partnership with others to achieve equitable, safe, quality care
- regular and punctual attenders of Te Pukaea meetings and promptly inform the administrator if unable to attend.
- well connected to consumers and attend other consumer networking meetings, as required.

A significant breach of the expectation set out in these Terms of Reference, including regular meeting attendance, may be investigated and could result in an appointment being replaced.

Appointments

When making appointments, consideration will be given to ensuring members have the listening and communication skills to carry out the responsibility and good networks and connections.

Members will be appointed by the ELT sponsors in consultation with the ELT and endorsement from the WDHB Board and Hauora Ā Iwi.

Term

Members shall be initially appointed for 12 months, to enable review once the new health and disability system is in place. It is expected that going forward the term of appointment for Co -Chairs and members would be two years with a right of two years plus two years renewal of membership, with a maximum of six years.

Remuneration

Remuneration shall be paid based on the State Services Commission Fees Framework applicable to WDHB Statutory Committees. Actual and reasonable other expenses including travel will be funded, as approved by the GM Patient Safety, Quality and Innovation.

Confidentiality

- Members may be involved in, or hear conversations that include confidential information about patients, staff, whānau/visitors and may also become aware of confidential or sensitive information about WDHB.
- WDHB expects that members will not discuss or disclose any such information with, or to, any unauthorised person, or third parties, who are not lawfully entitled to receive it. If you are unsure whether you can discuss or disclose, ask one of the ELT sponsors in the first instance
- Any documents, software or other intellectual property that you receive, or have access to in your role remains the property of WDHB and must not be published or used without consent.

Orientation

All Te Pukaea members will be given adequate orientation including:

- attending the two day Hapai te Hoe cultural education programme

- receiving initial training in consumer information and available data reporting including the Health Quality and Safety Commission (HQSC) data reporting and Consumer Engagement matrix
- receiving an overview of the WDHB strategy to He Hāpori Ora Thriving Communities
- being trained in information technology platforms and administrative systems to support their work
- adverse events management.

Health and Safety

WDHB is committed to maintaining & promoting the health and safety of all its staff, contractors, volunteers & patients. In nregard to health and safety all members need to:

- Not do anything that puts their own or other's health and safety at risk
- To follow all reasonable health and safety instructions
- Report any hazards, incidents / accidents immediately to the Te Pukaea administration support.

Administration Support

Administration support for Te Pukaea will be provided by the Patient Safety, Quality and Innovation team including:

- Booking meeting and venues
- Managing reimbursements
- Set up meetings as required
- Sending out agendas
  - Agenda and papers to be distributed the week prior to a meeting
- Recording meeting attendance, and minutes
  - Minutes will be approved by the Co-chairs and circulated to all members within one week of the meeting taking place
  - Minutes of those parts of any meeting held in 'public' shall be made available to any member of the public, consumer group, community etc, on request.

WDHB Staff

The Co-Chairs and the ELT sponsors can request other DHB staff to attend meetings as required.

9. Meeting structure

- Meetings will be held monthly, excluding January, or more frequently at the request of the Co-Chairs. Members should expect meetings to be up to two hours long unless notified that additional time is required.
- Meetings will generally be open to the public (who will not have speaking rights at the meeting unless already arranged with the Co-Chairs) but may move into 'public excluded' where appropriate and shall be conducted in accordance with WDHB Board Standing Orders as if Te Pukaea was a Board Committee.
- A standing reciprocal invitation is extended to the Clinical Board for a representative to attend Te Pukaea meetings.
- There will be standing agenda items including reports from the Health Quality and Safety Commission and Patient Safety, Quality and Innovation.
- Te Pukaea will receive reports from the Service Level Alliances and the themes coming through conversation cafes and other consumer channels of feedback.
- At least five members must be present to reach a quorum with a spread of representation.

10. Reporting

Through the Co-Chairs, Te Pukaea will have monthly contact with the GM Patient Safety, Quality and Innovation and provide twice-yearly of reports of Te Pukaea activities and recommendations to the Kaihautu Hauora/CE, through the GM Patient Safety, Quality and Innovation. These reports will be sent through WDHB leadership to the respective WDHB boards.

Once approved these reports of Te Pukaea activities and recommendations will be placed on the WDHB website.

11. Key Documents

- He **Hāpori** Ora Thriving Communities
- NZ State Sector Commission Framework for fees for statutory bodies
- Health Quality and Safety Commission Consumer Engagement Matrix

12. Review/amendments

These terms of reference will be reviewed by WDHB working in partnership with Te Pukaea in May 2022 to ensure alignment with the new health and disability systems and structures.

The Kaihautu Hauora/Chief Executive will review the performance of Te Pukaea annually.

Executive summary

Context & Objectives

This report responds to declining childhood immunisation coverage in the region and associated issues that will inform a communication and engagement strategy.

Population vaccination programmes are a polarising issue. There are complex global challenges achieving population vaccination with localised nuances that have common themes amongst sub-populations around trust and safety.

Whanganui District is experiencing declining coverage with an increasing proportion of families *declining* all childhood immunisations. There is also a rapidly growing number of parents that are *missing timely immunisations*. No singular strategy will resolve these trends quickly. A combined approach would include leveraging activities already underway in the current Covid-19 population vaccination campaign, collaborative actions with Iwi, social media, enhancing general practise capacity.

Part of the scoping process involved analysing trends in recent NIR data for the region. The report also focusses on those families that missed timely vaccinations through a file review of Outreach Team files for 2020-21 (n=143). This formed the basis of recommendations for a communications and engagement strategy.

Families declining all immunisations are hard to reach since they have already done their own research and made an informed choice. Descriptive data in this report provides context around events for those families that have led to missed timely immunisations. This is likely to be representative of a portion of decliners who share similar characteristics.

Covid-19 has introduced new complexities. Whilst Whanganui has been relatively sheltered from the worst effects of the pandemic, the crisis has also created economic and social upheaval. Those effects are evident in the lives of families described in this report.

Stressors that were present for families that missed vaccination include housing/accommodation issues with associated transience - 25% of families in this cohort. Other social issues including domestic violence – 13%, also led to secondary housing issues. The true severity of the determinants of health will be a limiting factor for increasing vaccine uptake.

The introduction of the Covid-19 population vacation programme may have increased uncertainty amongst those parents that are already hesitant about childhood vaccination

Simply telling people the facts and truth won't be enough. People need to feel connected. Families described in this report live in high levels of deprivation and are disengaged from healthcare systems. These sub-populations, predominantly Maori, are in need of quality information and resources, that will empower their decision-making.

Recommendations for reaching those that are under-vaccinated include:

1. Leverage the existing DHB campaign for Covid-19 to promote uptake of childhood immunisations

Public Health has already provided urgent recommendations for capitalising on events in the current environment; the nation is in the midst of the largest population vaccination programme. Since families described in this report are likely to be similar to those that miss their Covid jab, any final push on Covid-19 vaccinations should include the childhood immunisation message.

2. Hui with Iwi leaders through existing networks

Missed immunisations for parents in this report, was a function of competing priorities and attitudes held by the wider family. The descriptive data tells a story of how extended family enabled healthcare or created barriers to timely vaccinations. The DHB should utilise existing connection through the Maori Health Advisory Group or attempt to connect with the umbrella Iwi organisation for the region - Hauora a Iwi. Information and issues need to be shared including the determinants of health, and how the wider family can influence health outcomes.

3. Negotiate with Iwi to promote childhood immunisations directly through existing Iwi communications

Iwi have communication channels separate to Maori Health providers and employ a single media company for all their communications. Existing immunisations resources can be adapted and piggybacked with Covid-19 messaging or as a stand- alone that goes out with other standard Iwi communication, without the need to allocate significant funding to create new campaigns or resources.

4. Deploy social media and other technology to harness the power of story-telling

A literature review supports the use of *trusted community voices* encouraging members to receive vaccinations. Social media has the potential to provide face to face – kanohi ki te kanohi, communication that can be amplified and reach those that are hard to reach. (see examples provided in the relevant sections)

5. Collaborate with WRHN to explore existing communications and capacity within the general practice space

This report lacks a perspective from primary health care providers. Anecdotally the pandemic has had impacts on providers and their capacity to provide care. The literature review confirms the essential nature of the provider-patient relationship for addressing vaccine hesitant parents. This should be explored separately through existing relationship with the Regional Health Network.

6. A nationally refreshed set of resources designed by MOH

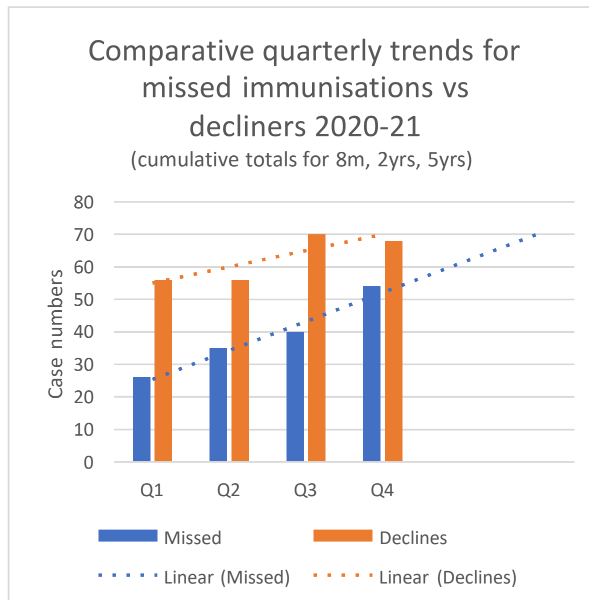
None of these issues are unique to WDHB therefore it would be more efficient for the Ministry to provide a toolkit of cutting-edge media resources that can be used by all DHB's similar to the 'Make Summer Unstoppable' campaign for Covid-19.

Summary Statistics from the Immunisation Scoping Report

WDHB 1st April 2020- 30th June 2021

Data presented here was obtained from an analysis of National Immunisation Register (NIR) data and a file review of Outreach Service files for families that missed vaccines in 2020/2021

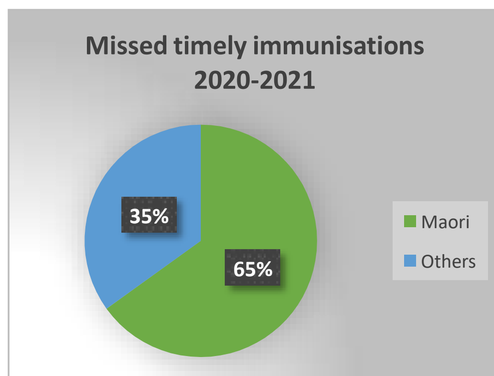
Comparative quarterly trends for missed and declined immunisations WDHB 2020-2021



Families declining/opting out are a larger group, compared to those missing timely immunisations. Children missing out on timely immunisations are increasing at a greater rate and will equal decliners at a future time without intervention.

Figure 1 Quarterly trends in missed and declined immunisations WDHB 2020-21

Ethnic differences in missed timely and declined immunisations 2020-21



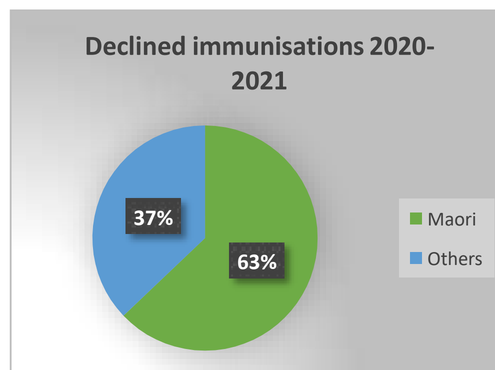


Figure 2 Quarterly trends in declined immunisations Maori vs others *Figure 3 Declined immunisations Maori vs Others*

During the 12month period ending 30th June 2021, 65% of children who were not immunised on time were Maori. Maori children contribute to 63% of all children who declined all immunisations in 2020-21.

Summary of reasons for missed timely immunisations

Reasons for missed timely immunisations	
no reason, immunised later or to be done	24%
housing/accommodation/transience	25%
social issues including DV	13%
poor engagement with health system	9%
declined/hesitant	16%
overseas records need to be chased up	6%
illness	4%
access to GP	5%
unaware of changes to schedule	2%
Total	100%

Figure 3 Summary of reasons for missed timely immunisations 2020-21

Families described in the following section, were clients of the Outreach Service, for the milestones of interest – 8m, 2yrs, 5yrs. During a 12month period ending 30th June 2021 there were 143 families that Outreach staff attempted to make contact with.

Housing, accommodation and associated transience was the most common reason for missing timely immunisations – 25%. Children that were late for no reason and on a catch-up schedule, contributed to 24% of late immunisations. Parents that subsequently declined or were hesitant when Outreach team staff visited, were the third highest grouping - 16%. Social issues that included secondary housing issues – contributed to 13% of reasons for missing out. Families arriving from overseas – 6%, were in the process of obtaining proof of immunisation. 5% of families experienced access issues including delays in the context of Covid-19 lockdowns. Intercurrent childhood illness was an uncommon reason - 4%, provided by parents for missing out, and 2% of parents were unaware of schedule changes.

See completed Scoping Report for a more comprehensive analysis and detailed methodology of all data. (Contact PHC.admin@wdhb.org.nz)

Hon Andrew Little

Minister of Health
Minister Responsible for the GCSB
Minister Responsible for the NZSIS
Minister for Treaty of Waitangi Negotiations
Minister Responsible for Pike River Re-entry

Ken Whelan
Chair
Whanganui District Health Board
kenwhelan57@outlook.com

30 SEP 2021

Tenā koe Ken

Whanganui District Health Board 2021/22 Annual Plan

This letter is to advise you that we have jointly approved and signed Whanganui District Health Board's (DHB's) 2021/21 annual plan (Plan) for one year.

When setting expectations for 2021/22 it was acknowledged that your Plan would be developed in a period where our COVID-19 response, recovery and immunisation programmes remained a key focus and therefore planning requirements were streamlined towards your DHB's work to improve equity and to embed lessons and innovations from COVID-19. Thank you for providing a strong plan for these areas.

Your Plan for 2021/22 will be delivered in an environment where this work continues to be of critical importance and where our system transition process is underway. We acknowledge that providing clarity on the critical areas for improvement through transition is helpful and, on that basis, we are confirming the top challenges that will be of focus for us through 2021/22:

- Keeping COVID-19 out of communities.
- Supporting the mental wellbeing of people, particularly of youth and young people.
- Ensuring child wellbeing, particularly through increased immunisation.
- Managing acute demand.
- Managing planned care.

More broadly, we also acknowledge the importance of your Board delivering on the Plan in a fiscally prudent way.

We invite you to work closely with your regional Chair colleagues to share your skills, expertise, and problem-solving efforts to ensure progress is achieved in these top challenges. As performance progress is discussed through the year, we will look forward to hearing about your joint efforts and progress.

Please note that approval of your Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health (the Ministry), including changes in FTE. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases or requests for equity support that have not been approved through the normal process.

Your 2021/22 Plan provides an important foundation to ensure our health system delivers for New Zealanders during the period of system transition and we expect all DHBs will be disciplined in delivery of their plans.

Please ensure that a copy of this letter is attached to any copies of your signed plan made available to the public.

Ngā mihi nui

Hon Andrew Little
Minister of Health

Hon Grant Robertson
Minister of Finance

Cc Russell Simpson
Chief Executive

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