Combined Statutory Advisory Committee - Public session

Combined Statutory Advisory Committee (Public)

27 August 2021 09:30 AM - 11:30 AM

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27 August 2021

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

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 in the Board Room, Fourth Floor, Ward/Administration Building, Whanganui Hospital, 100 Heads Road, Whanganui
on Friday 28 May 2021, commencing at 9:30am

Combined Statutory Advisory Committee (CSAC) members in attendance
Ms Annette Main (Chair)
Ms Christie Teki
Ms Debra Smith
Mr Graham Adams
Mr Josh Chandulal-Mackay
Ms Te Aroha McDonnell
Ms Phillipa Baker-Hogan
Ms Sorya Peke-Mason
Mr Frank Bristol
Ms Hayley Robinson

In attendance for Whanganui District Health Board (WDHB)
Mr Russell Simpson, Chief Executive
Ms Kath Fraser-Chapple, Acting General Manager, Strategy Commissioning & Population Health
Mr Ian Murphy, Chief Medical Officer
Ms Deanne Holden, Secretariat

1. Procedural

1.1 Karakia & Welcome

The meeting was opened by the Chair with an acknowledgement to both Paul Malan and Mal Rerekura, two WDHB senior staff members who had passed suddenly in recent weeks. One minutes silence was held in their honour.

The Chair acknowledged the dedication Paul Malan had shown to the Committee as the Executive lead and passed condolence to his colleagues and whānau. Mal Rerekura was a highly respected member of the Māori Health & Equity team, again condolences were passed to his whānau and colleagues. The knowledge and mana of both men will be missed by all.

Kath Fraser-Chapple was then welcomed to Committee as Acting General Manager, Strategy Commissioning & Population Health. The Chair acknowledged the work carried out by Kath Fraser-Chapple and the Strategy & Commissioning team in preparing for the meeting, at a time of such sadness.

The Chair reminded committee members she is available either prior or post meeting to discuss any concerns or questions. All were encouraged to speak with the Chair, or Kath Fraser-Chapple directly, if there were items they would like placed on upcoming agendas.

The Chair then welcomed Hayley Robinson, Ngati Rangi, to the Committee as the final representative from Hauora ā Iwi.

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1.2 Apologies

It was resolved that apologies be accepted and sustained from the following:

Mr Charlie Anderson, Mr Ken Whelan, Ms Maraea Bellamy, Ms Heather Gifford

1.3 Conflict and register of interests update

1.3.1 Amendments to the register of interests

Sorya Peke-Mason provided the secretary with a written update noting the following:
Remove:
- Chair, Te Totarahoe o Paerangi – Ngāti Rangi (Ohakune-Raetihi)
- Labour Candidate

Add:
- Whanganui Health Network Board Member

Frank Bristol requested the following be added "advisor to consumer engagement working party"

1.3.2 Declaration of conflicts in relation to business at this meeting

There were no declaration of conflicts in relation to this part of the meeting.

1.4 Minutes of the previous committee meeting

The minutes of the public session of the meeting of the Combined Statutory Advisory Committee held on 26 February 2021 were accepted as a true and correct record with the following amendment:

1. Note that Debra Smith attended the meeting via zoom.

An error on the approved minutes of a meeting held on 21/8/2020 was noted, in relation to the confirmed attendance of Phillipa Baker-Hogan at that meeting. Ms Baker-Hogan's attendance was noted on the attendance sheet, however, not on the list of attendees. It was agreed the error would be amended and the relevant addition made to the minutes.

Moved: A Main **Seconded**: D Smith

1.5 Matters Arising

The following updates to the Matters Arising were noted:

Item 26/2-01: noted as complete
Item 26/02-3: noted as complete

Item 26/02-2: A Main advised the information has been requested from the Whanganui District Council, however, no response received as yet. Item to be carried forward.

1.6 Committee Chair's Report

The Chair advised WDHB had been well presented at the recent Hui Whakaoranga that took place on 18 May in Wellington. The hui was well attended by iwi and representatives from the Māori health and disability sector, providing an opportunity to connect and share aspirations and challenges toward delivery of a successful Whakamaua: Maori Action Plan 2020-2025.

The discussion was thought provoking, with the Chair noting the insightful the work being carried out at WDHB is not standard practice across all DHB.s She felt Whanganui DHB is a clear exemplar of excellence in its acknowledgement and connection with local Iwi and the shared vision to progress Māori health advancement.

In relation to the Health Sector Reform, the Chair noted that although it is an exciting opportunity for our community to better health outcomes, there will be challenges for WDHB staff and CE in the months to come. The Chair thanked both for their continued mahi and support during this time of upheaval.

I Murphy joined meeting: 9.45am

2. Chief Executive Report Russell Simpson

The Chair introduced R Simpson, Chief Executive WDHB. Mr Simpson provided a verbal update with a brief overview of key points shown below.

Mr Simpson thanked the Chair for her acknowledgment of Paul Malan and Mal Rerekura's passing. He also acknowledged the recent passing of Robert Bartley, a generous supporter of the WDHB who contributed significantly to the community with his recent donation which had allowed the purchase and development of a community health bus.

Mr Simpson acknowledged the mahi carried out by Alisa Stewart QSO, former Principal Nurse, Whanganui District Health Board member, Whanganui District councillor and a community support of numerous organisations. Ms Stewart was honoured as the recipient of the "Paul Harris Fellow Award" award at a recent Rotary North meeting. The award was in appreciation of the tangible and significant assistance given for the furtherance of better understanding and friendly relations among peoples of the world.

The He Hapori Ora – Thriving Communities strategy has now been launched with the values and goals being integral to all we do. The Annual Plan 2021-22 is focused on the vision outlined in the strategy and collectively places Whanganui DHB in a strong position to offer excellent health outcomes to our community, in line with the expected outcomes of the Health Sector review.

The Committee viewed the 6 minute launch video, which can be found on the WDHB website at the following link: https://www.wdhb.org.nz/about-us/he-hapori-ora-thriving-communities. Mr Simpson asked all to support the distribution of the strategy throughout their networks.

Mr Simpson confirmed a submission has been made to the Whanganui District Council for the Long Term Plan regarding the He Hapori Ora strategic vision. Council are now are working through their processes and will provide feedback in due course.

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Health and Disability Review (H&DR)

R Simpson and R Kui attended the announcement of the H&DR in March. Key aspects of the review and change to sector include:

- MOH will be the steward of the new Health System
- A new Crown Entity will be created, likely named Health NZ
- A new Crown Entity will be created, likely named Maori Health Authority (MHA). The MHA will hold responsibility commissioning of Maori Health contracts
- Public Health Units will be incorporated with Health NZ
- Funding & Planning arms of DHBs will be networked across regions with employment of all DHB staff transferring to Health NZ on 1 July 2022.
- A regional commissioning framework will be developed with the MHA authority working alongside local governance & iwi

Current DHB districts will be re-defined as Regions with stakeholder engagement a key part of conversations over next few months. Further details will follow in due course to enable DHB's to operationalise the changes ensuring best health outcomes for our community and staff.

Royal assent is expected in July 2022

Risks identified:

- retaining talent.
- disruption to service delivery & performance
- undergoing major change whilst managing COVID-19 pandemic

It was noted the WDHB He Hapori Ora strategy aligns with the governments vision with S Peke-Mason confirming the Hauora a Iwi mandate captures the voice of Iwi across the catchment.

Mr Simpson asked all Committee and Board members to support the dissemination of the He Hapori Ora strategy within their networks, including Iwi and Council, to ensure awareness and a united voice throughout the region

ICT Security

Following a recent issue at Waikato DHB relating to a cyber security breach, Mr Simpson advised all WDHB systems and processes have been reviewed with extra security measures enabled. This includes Cloud based software solutions which quarantine attachments, scan for threats and release for staff to open only when deemed safe.

WDHB receives daily SitRep reports with information being shared and recommendations enacted daily throughout all DHB's.

Mr Simpson did reiterate however, that notwithstanding the above, vulnerabilities to ICT networks throughout the sector remain.

COVID-19 Vaccinations

Mr Simpson confirmed, as at 27 May 2021, locally a total of 8153 people have been vaccinated, which includes 1145 Māori. We continue to vaccinate those in groups 2 and 3. Group 3 includes:

- Over 65 or
- Those with relevant underlying health conditions or
- Māori & Pasifika aged 50 & over

In early June a major vaccination facility will open centrally with the aim for WDHB being to vaccinate more than 54,000 people in Whanganui with 2 doses by end of 2021.

Mr Simpson also noted that Maori Health Provider, Te Oranganui, (with support from WDHB), have arranged clinics in Whanganui, Waverly and Rangitikei for Group 2 members. This will soon to be expanded to extend up the Awa and include group 3.

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NZNO Strike

Mr Simpson advised that formal notification was received regarding a strike by NZNO members on the 17th May 2021. The strike will take place from 1100am -1900pm. WDHB has formally requested Life Preserving Services Nursing staff to NZNO (these are WDHB nursing staff who will come and work as per agreement with the union) with senior staff currently working on rosters to ensure enough base staff to work. Communications have gone out to staff with communications to the public due to go out next week. Senior staff are meeting 3x weekly with a large planning team and the managers of the units/wards with WDHB being supported nationally by the strike contingency team.

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3 Discussion Papers

3.1 Progressing pro-equity: Kaitakitaki work streams
R Karena, Kaitakitaki, Māori Health and Equity

A paper titled Progressing pro-equity: Kaitakitaki work streams was tabled by R Karena, on behalf of R Kui. The paper was taken as read with feedback on information provided and/or questions welcomed.

R Karena recognised the contribution to the Te Hau Ranga Ora (THRO) team and Kaitakitaki made by both Paul Malan and Mal Rerekura.

It was noted that the paper was tabled at the Board meeting on 21 April 2021. T-A McDonnell thanked those involved for the well laid out and insightful paper. Discussion following regarding the work being undertaken around addressing racism and bias. It was agreed this is not totally the responsibility of THRO and that the foundation for conversations going forward would be formed, in part, via outcomes of the H&D review.

It was resolved that the committee:

a. **Receive:** the paper titled Progressing Pro-Equity: Kaitakitaki Work Streams

b. **Note:** the challenges and opportunities articulated in the paper

DRAFT

3.2 Preliminary Q3 Reporting: non-financial performance measures & detailed results
K Fraser-Chapple, Acting GM Strategy Commissioning and Population Health

A paper titled Preliminary Q3 Reporting: non-financial performance measures & detailed results was tabled by K Fraser-Chapple and taken as read with the key points highlighted below:

Results are preliminary with final feedback not yet received from MOH. At the time of print not all areas were rated, however, where stated "not rated" it should be noted that results were now available and all are either partially met or met.

It was noted challenges remain against the measure "MH04: MH&A CRISIS RESPONSE" although a number of changes have taken place in this workstream. There appears to be a high percentage of "abandoned calls", which may in part be due to a change in process for overnight calls to the Crisis team. A meeting to review this change in approach will take place in June.

S Peke-Mason noted residential care for MH is not available in Whanganui and there can be long waiting lists for residential care out of district. Management noted the concern.

F Bristol highlighted favourable results against suicide measures. The suicide prevention plan, which has been codesigned with community leadership and 9 different interconnected modules is due to be rolled out soon. Significant change is expected as a results of this plan.

Clear and concise message is imperative relating to influenza immunisations, COVID-19 vaccine. Mr Simpson confirmed that WDHB social media accounts are monitored daily and we do publish reputable facts on our website, however, we have no ability to control what is said over social media.

WDHB supports a national campaign to promote the importance of child immunisation as rates are dropping nationally. Development of an Immunisation Communication Plan is included in the Draft WDHB Annual Plan for 2021-22.

It was agreed the committee:

a. **Receive** the paper titled Preliminary Q3 Reporting: non-financial performance measures & detailed results

b. **Note** that while Quarter 2 results now final (section 1), Quarter 3 results are preliminary.

DRAFT

3.3 Status update - Annual Plan 2020-21
K Fraser-Chapple, Acting GM Strategy Commissioning and Population Health

A paper titled Status update – Annual Plan 2020-21 was tabled by K Fraser-Chapple and taken as read with key points shown below:

Initial feedback received from the MOH has been overwhelmingly positive with 7 sections from the annual plan assessed by ministry as all either met or partially met. This is testament to the excellent work that is taking place thought the WDHB.

Mr Simpson acknowledged the Strategy Commissioning & Population Health team in collating the report for MOH and committee following the passing of Paul Malan and thanked them for their mahi.

Committee members confirmed the depth of information provided was very useful.

It was agreed the committee:

a. **Receive** the paper titled Status update - Annual Plan 2020-21

b. **Note** that while the Quarter 2 results are now final (section 1), Quarter 3 results are preliminary

3.4 Provider Arm Services report
I Murphy, Chief Medical Officer & A Kemp, Chief Allied Professions Officer

A paper titled "Provider Arm Services report" was tabled by I Murphy. The paper was taken as read with a summary of the key points shown below.

Mr Murphy confirmed a second Paediatric SMO has now commenced employment with a third recently interviewed.

A question was raised regarding clinical support being offered to Waikato DHB in relation to planned care in light of their recent ICT issues. Mr Murphy confirmed we would provide any supports required, however, had not received any request to do so. It was noted however, that WDHB is using ESPI capacity currently to support the Taranaki region.

G Adams noted is support for using new models of care in oral preschool such as potential use of the healthcare bus. Mr Murphy confirmed that a variety of caravans are used throughout the region including smaller caravan units. Mr Simpson advised work continues at national level around sugary drinks pressure being placed on the government for legislative changes.

It was agreed the committee:

a. **Receive** the paper titled Provider Arm Services Report – May 2021

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

The Chair moved that action points for all Discussion Papers, as recorded above, be accepted:

Moved: A Main **Seconded:** S Peke Mason

DRAFT

4. Information papers

4.1 Overview of WDHB Art & Archives Group Activity
Rowena Kui, GM Māori, Te Hau Ranga Ora / Art & Archives Group Sponsor

A paper titled "Overview of WDHB Art & Archives Group Activity" was tabled by the Chair on behalf of R Kui, with the paper taken as read.

A Stewart, a committee member of the art group, was introduced to Committee and available for questions. S Peke-Mason, via the Chair, thanked the art committee for their dedication and noted the improvement made to the clinical feel of the hospital by the art on display.

It was agreed the committee

a. **Receive** the paper titled Overview of WDHB Art & Archives Group Activity

4.2 Update on activity to improve appointments attendances
Rowena Kui, Kaiuringi Māori Health and Equity, Te Hau Ranga Ora Sponsor

A paper titled "Update on activity to improve appointments attendances" was tabled by the Chair on behalf of R Kui, with the paper taken as read.

It was noted the paper was tabled as a response to matters arising point: 26/02-03

It was agreed the committee

a. **Receive** the paper titled Up-date on activity to improve appointment attendances.

The Chair moved that all action points for Information Papers, as recorded above, be accepted:

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

DRAFT

5. Date of next meeting

The next meeting will be held on, Friday 27 August 2021 from 09:30am in the Board Room, Whanganui District Health Board, 100 Heads Road, Whanganui.

6. Reasons to exclude public

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 the meeting held on 26 February 2021 (Public – excluded session)	For the reasons set out in the committee's agenda of 26 February 2021	As per the committee's agenda of 26 February 2021

Persons permitted to remain during the public excluded session.

That the following person(s) may be permitted to remain after the public has been excluded because the committee considers that they have knowledge that will help it. The knowledge is 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 and senior managers and clinicians present	Management and operational information about Whanganui District Health Board	Management and operational reporting and advice to the board
Committee secretary or executive assistant	Minute taking	Recording minutes of committee meetings

Moved: A Main
Seconded: T-A McDonnell

The public session of the meeting ended at 11.32

Adopted this day of 2020

…………………………………………………

Chair

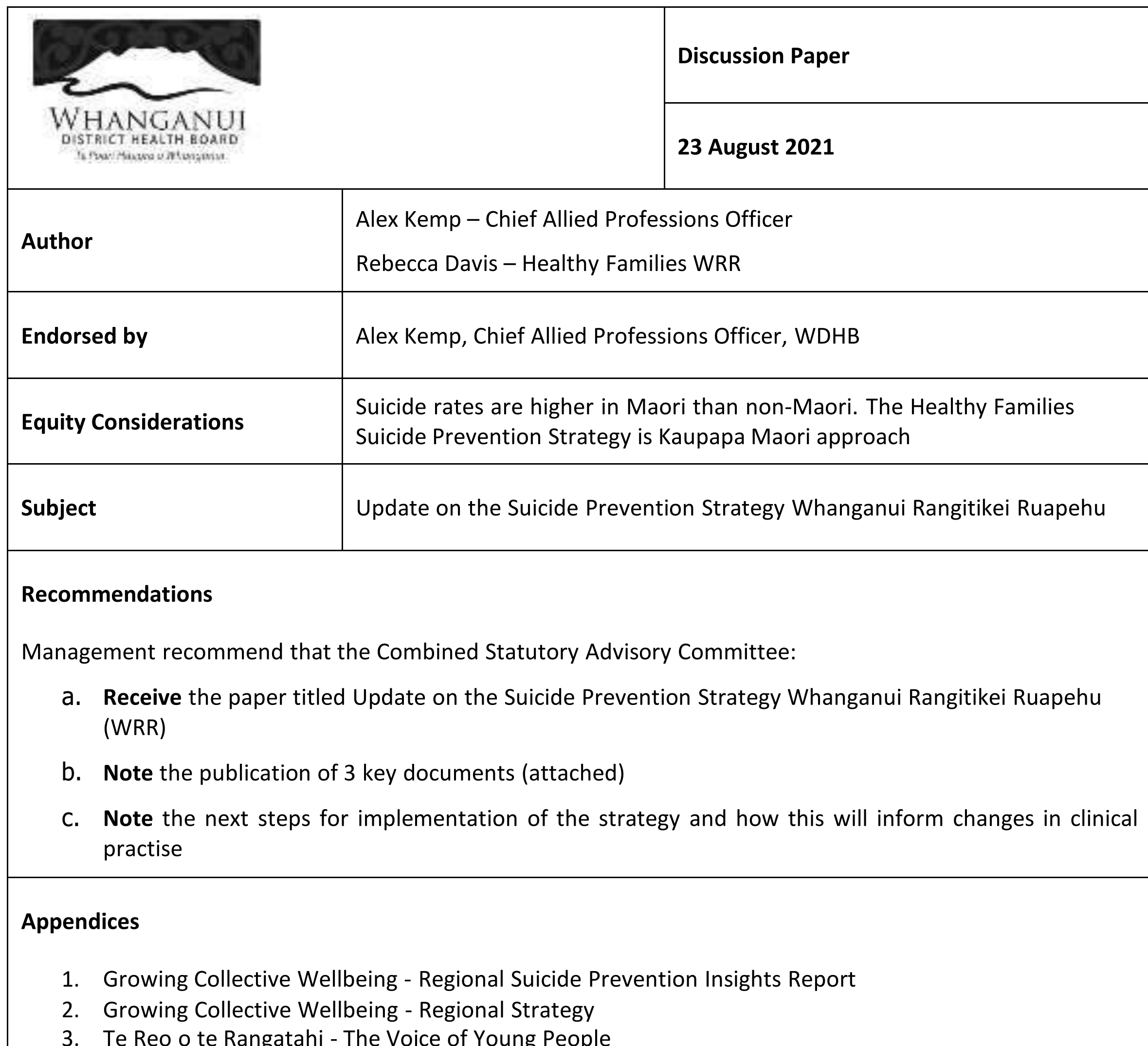
DRAFT

28 August 2021 **Public**

1.5 Matters arising from previous meetings

Meeting Date	Detail	Response	Status
~~10/18-01~~	~~Draft commissioning cycle framework be re-visited by committee for further discussion following inclusion of any response and comment from HAI Board~~	~~Confirmation paper presented to Hauora A Iwi who confirmed they are comfortable the framework aligns with the values under which we operate and had no suggested changes.~~	~~Complete~~
~~11/22-01~~	~~Faster Cancer Treatment: BSS11 to include ethnicity breakdown.~~	~~Item 4.2 for discussion on Agenda, 21 August 2020~~	~~Complete~~
~~03/13-01~~	~~Access to "Diligent Board Books" requested for all committee members~~	~~Roll out not implemented due to cost implications. WDHB Board members to receive papers via Diligent, nominated members via email (PDF).~~	~~Complete~~
~~05/15-01~~	~~"Oral Health update – u5" to be added as item on next agenda~~	~~Research referred to in minutes 15/5/20 due to be presented end August 2020. Item carried forward.~~	~~Complete~~
~~08/21-01~~	~~Health Protection Team to provide insight on the drinking water assessment component, what is captured and how it can inform discussion~~	~~Item on agenda for meeting dated 13/11/20~~	~~Complete~~
~~08/21-02~~	~~Faster Cancer Treatment Results to be provided to WDHB communications department for dissemination~~	~~Complete~~	~~Complete~~
~~11/13-01~~	~~Roving microphone to be used for further hui's held at Racecourse Conference Centre as speakers difficult to hear~~	~~Noted~~	~~n/a~~
~~11/13-02~~	~~"Equity Considerations" be added to CSAC Paper Template~~	~~Actions~~	~~Complete~~
~~26/2-01~~	~~LifeCurve presentation to be distributed to committee~~	~~Actioned~~	~~Complete~~
26/02-2	COVID-19 Testing protocols to be clarified with local council	A Main	Ongoing
~~26/02-03~~	~~Update Committee on progress to improve DNA rates~~	~~Agenda item 4.2, Information Paper, 28 May 2020~~	~~Complete~~
28/5-01	Correction to attendance record for meeting held 26/2/21	Corrected	Complete

August 2021 **Public**



WHANGANUI DISTRICT HEALTH BOARD	**Discussion Paper**
	23 August 2021
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).

APPENDIX 1

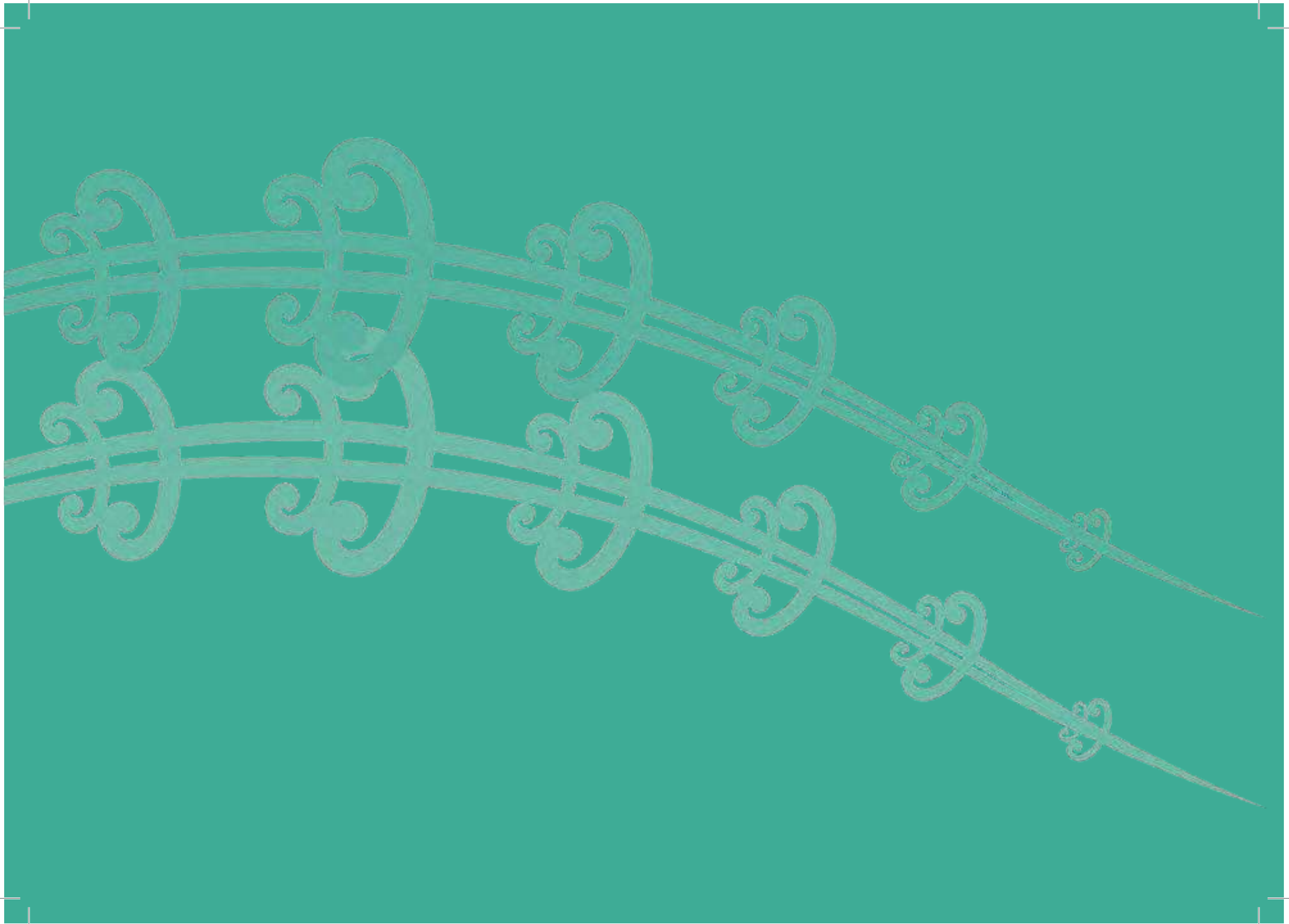
Insights Report

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 are a composite of words expressed through *pao* – short, impromptu and topical 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 Board commissioned 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.

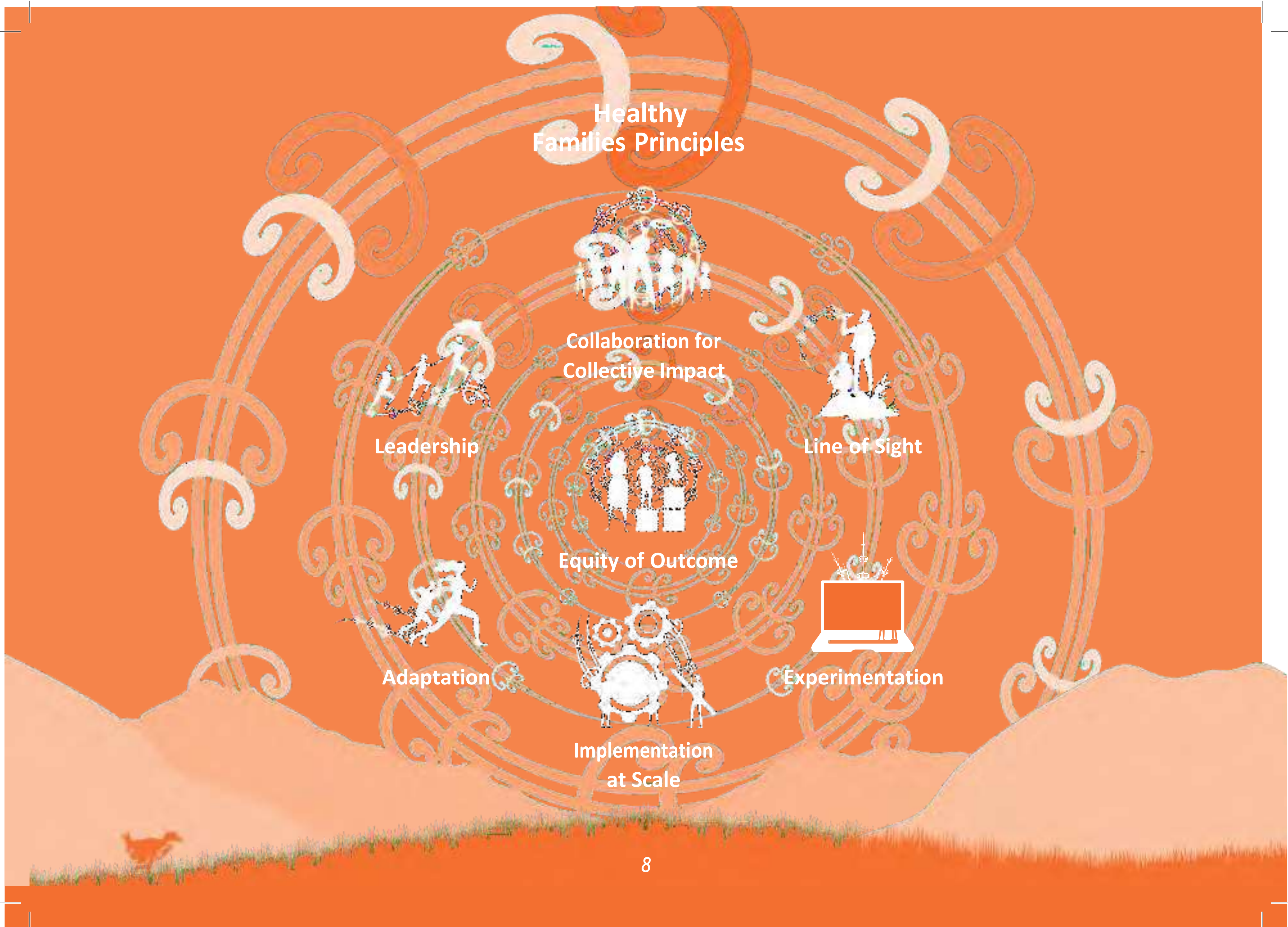
We are grateful to Barry Taylor from Taylor-made, Frank Bristol from Balance, Wheturangi Walsh-Tapiata, Mel Maniapoto and Hayden Bradley from Te Oranganui, Jude MacDonald from the Whanganui Regional Health Network, Dr. Cherryl Smith, Te Atawhai o te ao Māori Research, and Pauline Humm-Johnson from the 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

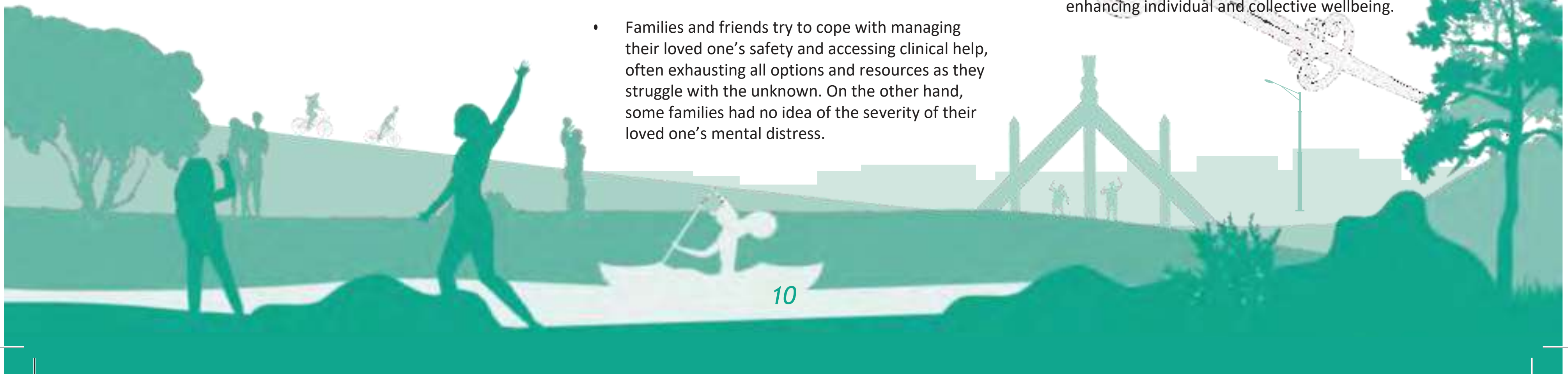
- There are a plethora of referral pathways and templates. There is no common pathway to enter the support system.
- The referral process is often managed through a clinical lens. The process was initially developed for the 3–4 % of people seeking professional mental health services. In today's world 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?

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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"

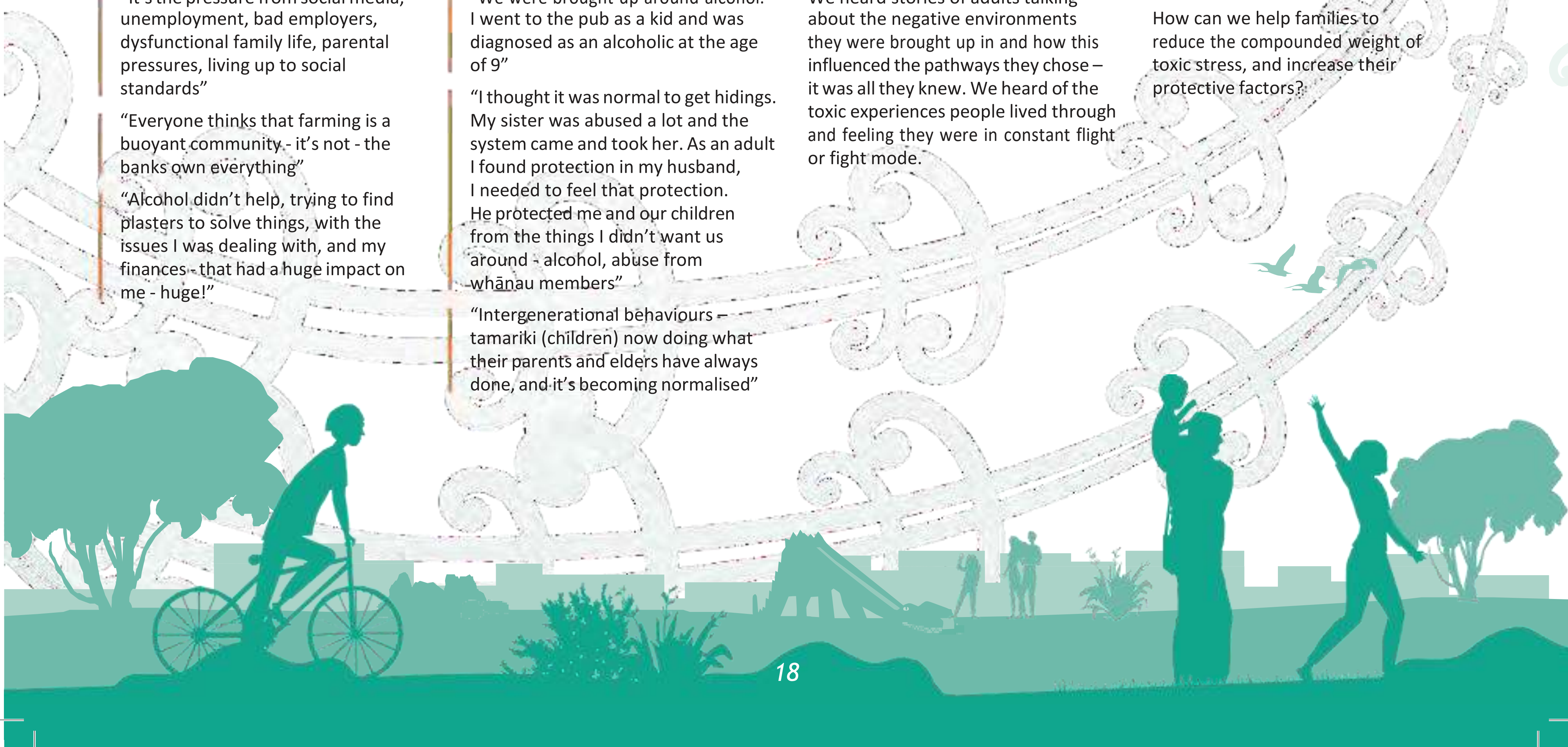
"Intergenerational behaviours – tamariki (children) now doing what their parents and elders have always done, and it's becoming normalised"

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.

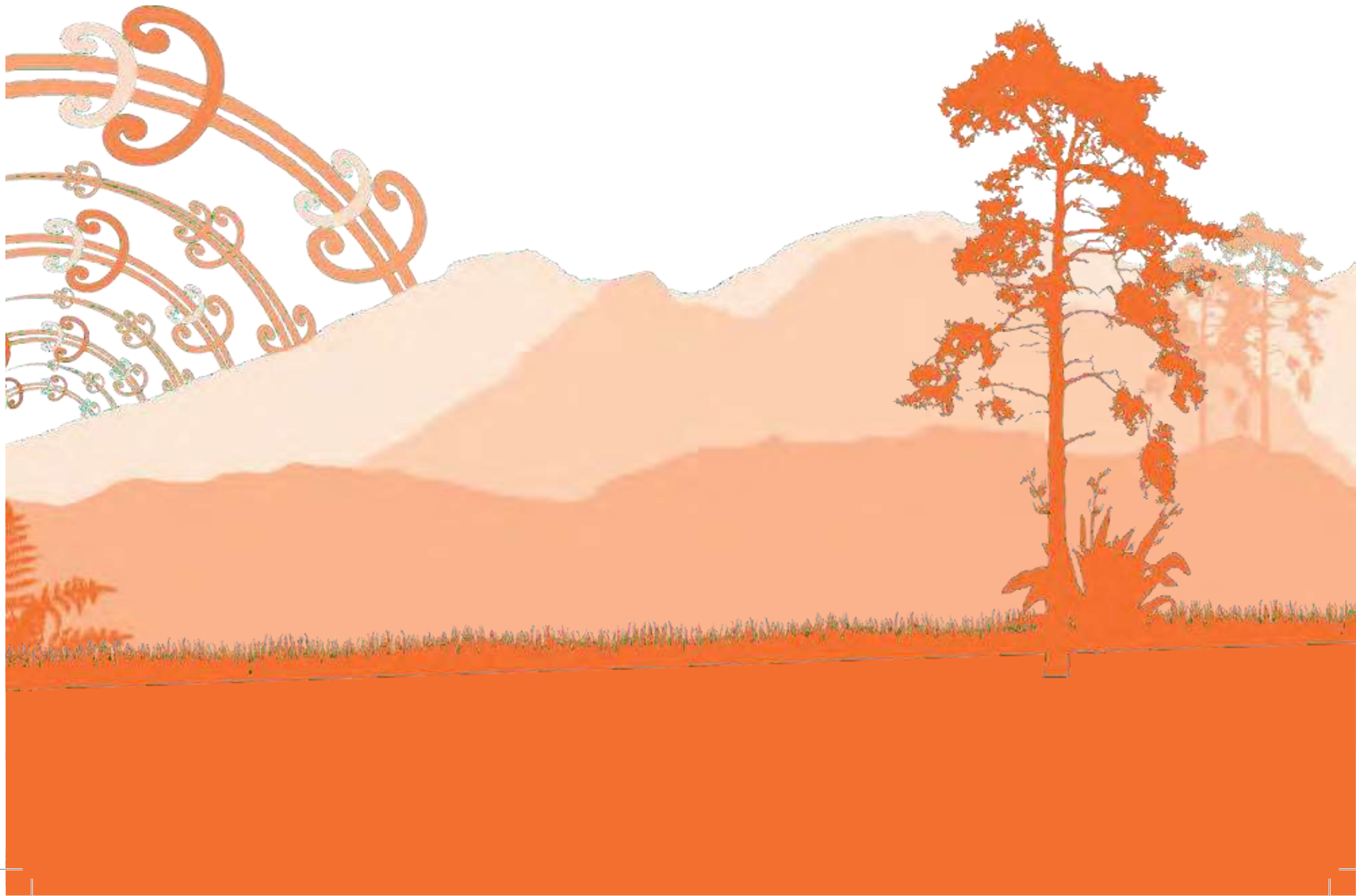
- Identity (cultural), connectedness to people and place, economic and social participation, is commonly important for wellbeing. Māori men feature prominently in suicide rates. Could the effects of colonisation be the irreparable damage to these sources of wellbeing (cultural identity, connectedness 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

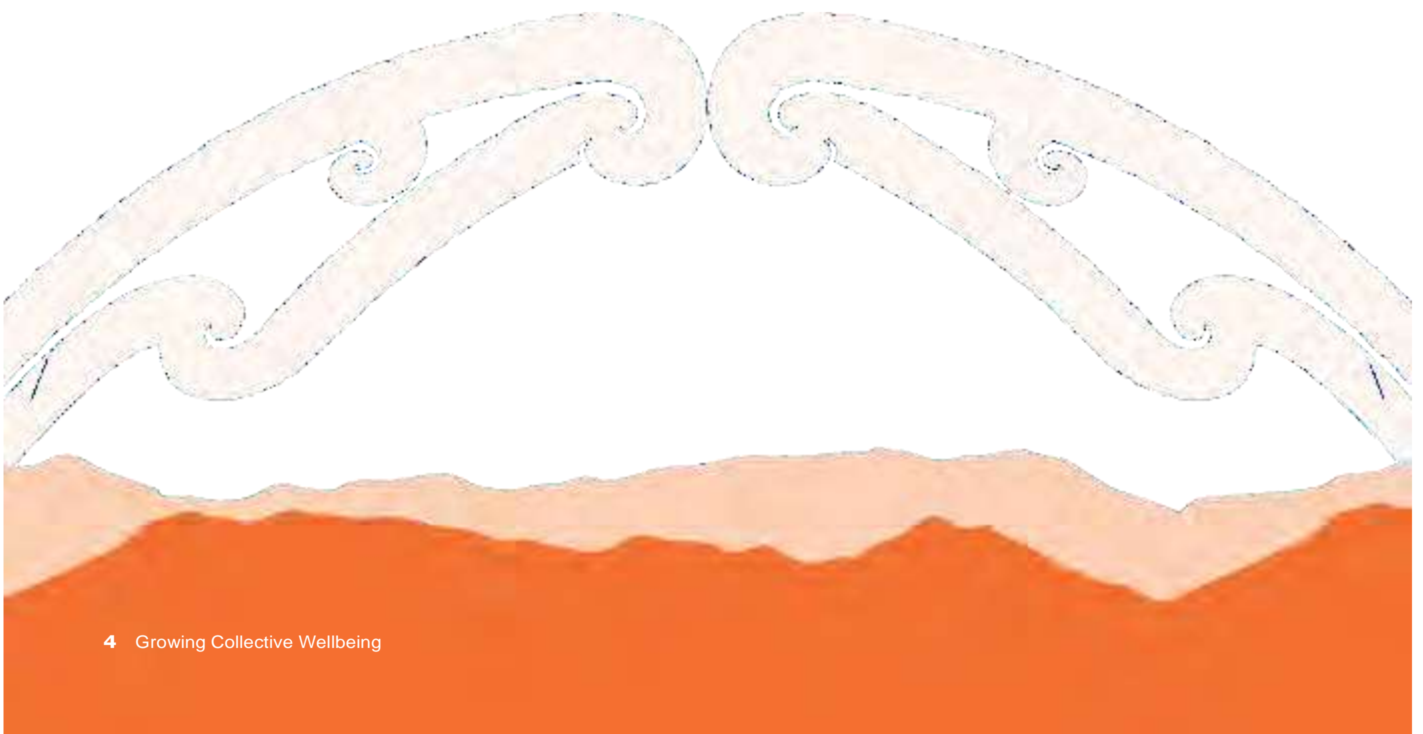
Ka haumārō te mōteatea ake ki te ranga tupua ka rūpeke ki te waro hunanga.
Tiraha ake i te mahora o Rangiātea ki runga.

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.

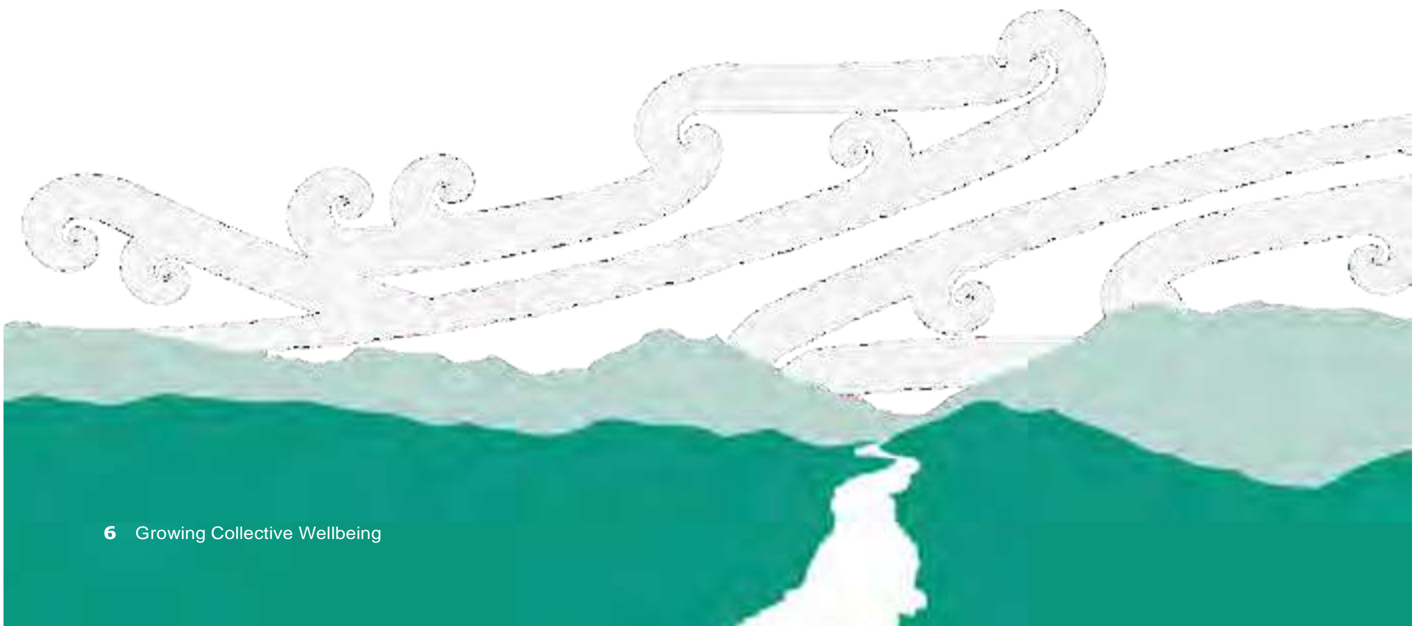
No such co-design process would exist without that type of mindset!

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

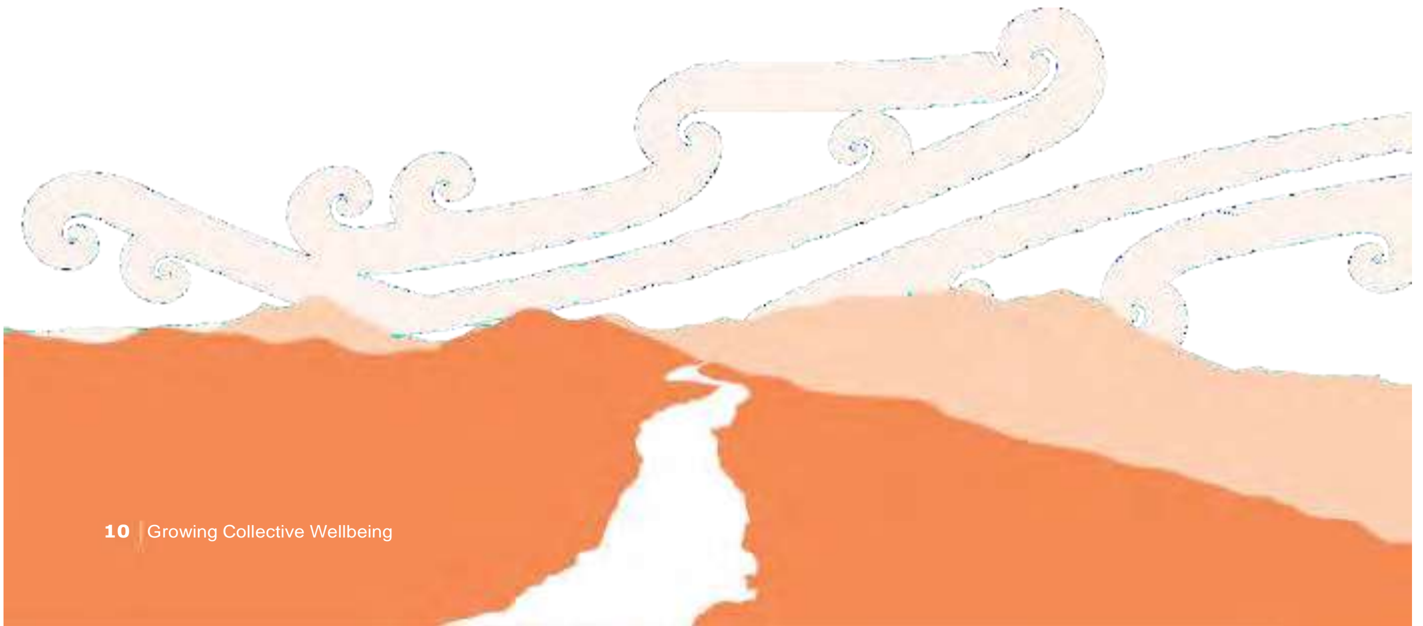
The following statistics are serious self harm hospitalisation rates for youth 10–24, Whanganui Regional Health Network

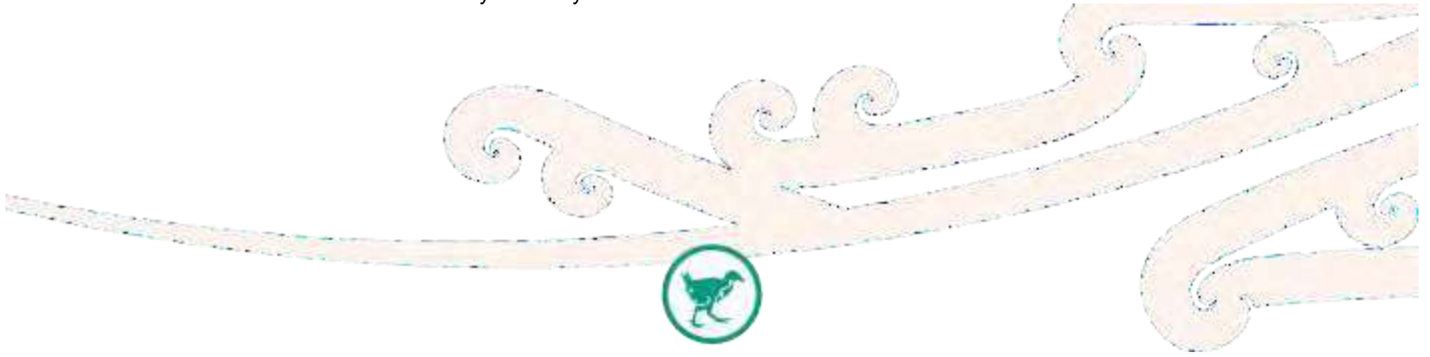
- Self harm has been rising since 2018 amongst **15-19** with **42 incidents** in 2020.
- Females are **most prevalent** as they are in attempted suicides.
- Māori are most prevalent as they are in attempted suicides and suicides.
- Between the ages of **10–14** we had **3** in 2020, zero prior.
- **20–24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

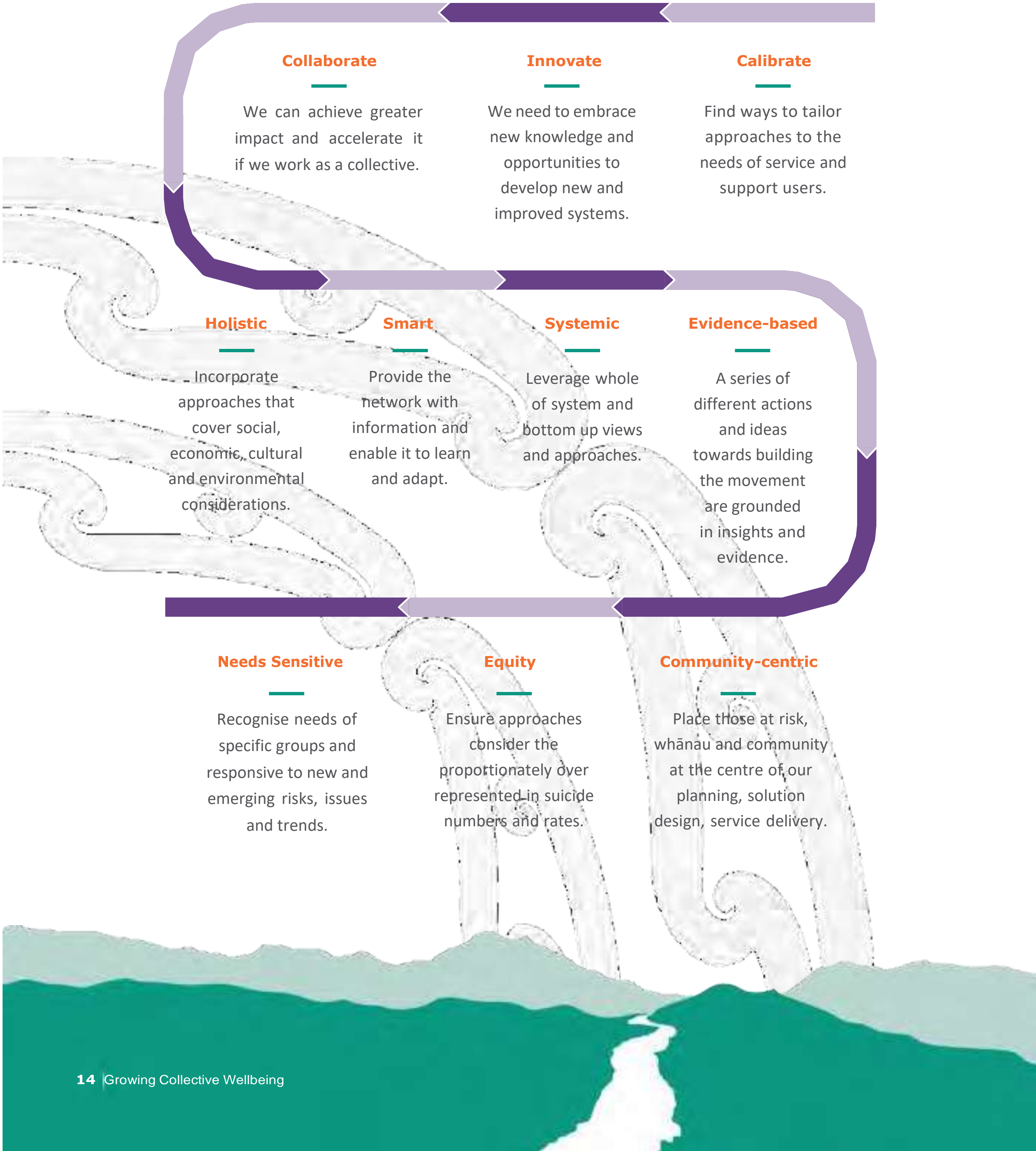
We are the wellbeing movement, courageous in our collective efforts to reduce suicides in our region.

Delivering Value Together

This approach offers value in numerous ways

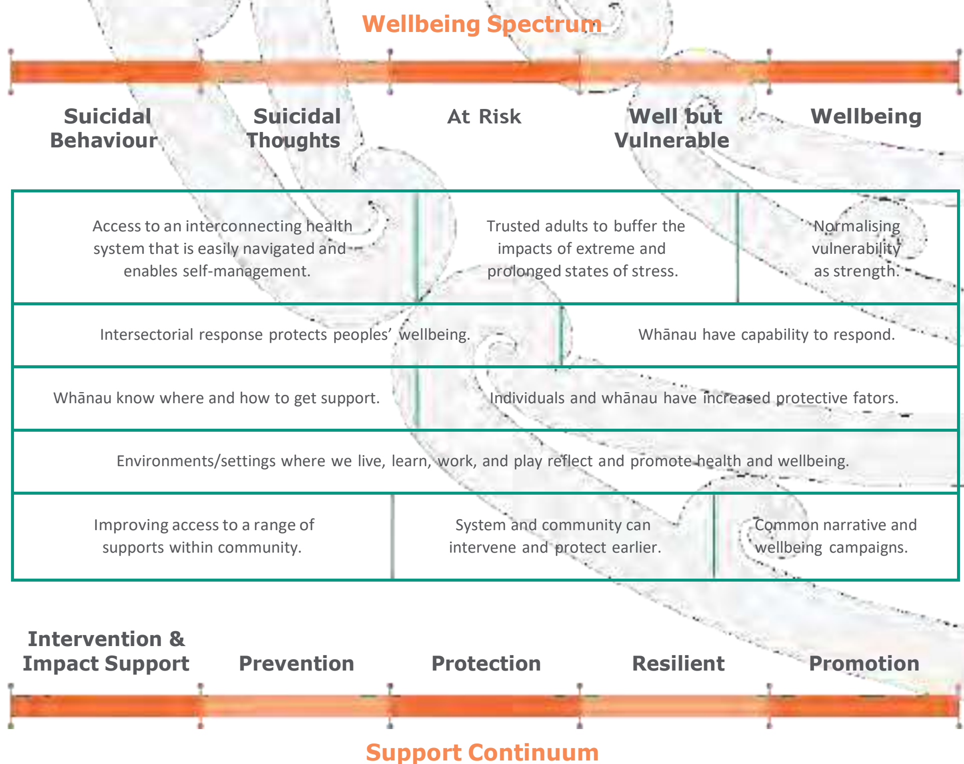
- It allows us to bring more resource to bear on this important challenge.
- It allows us to leverage local knowledge and local lived experiences.
- It allows us to leverage individuals and organisations who are better positioned to achieve influence and impact.
- It allows us to leverage a greater number 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



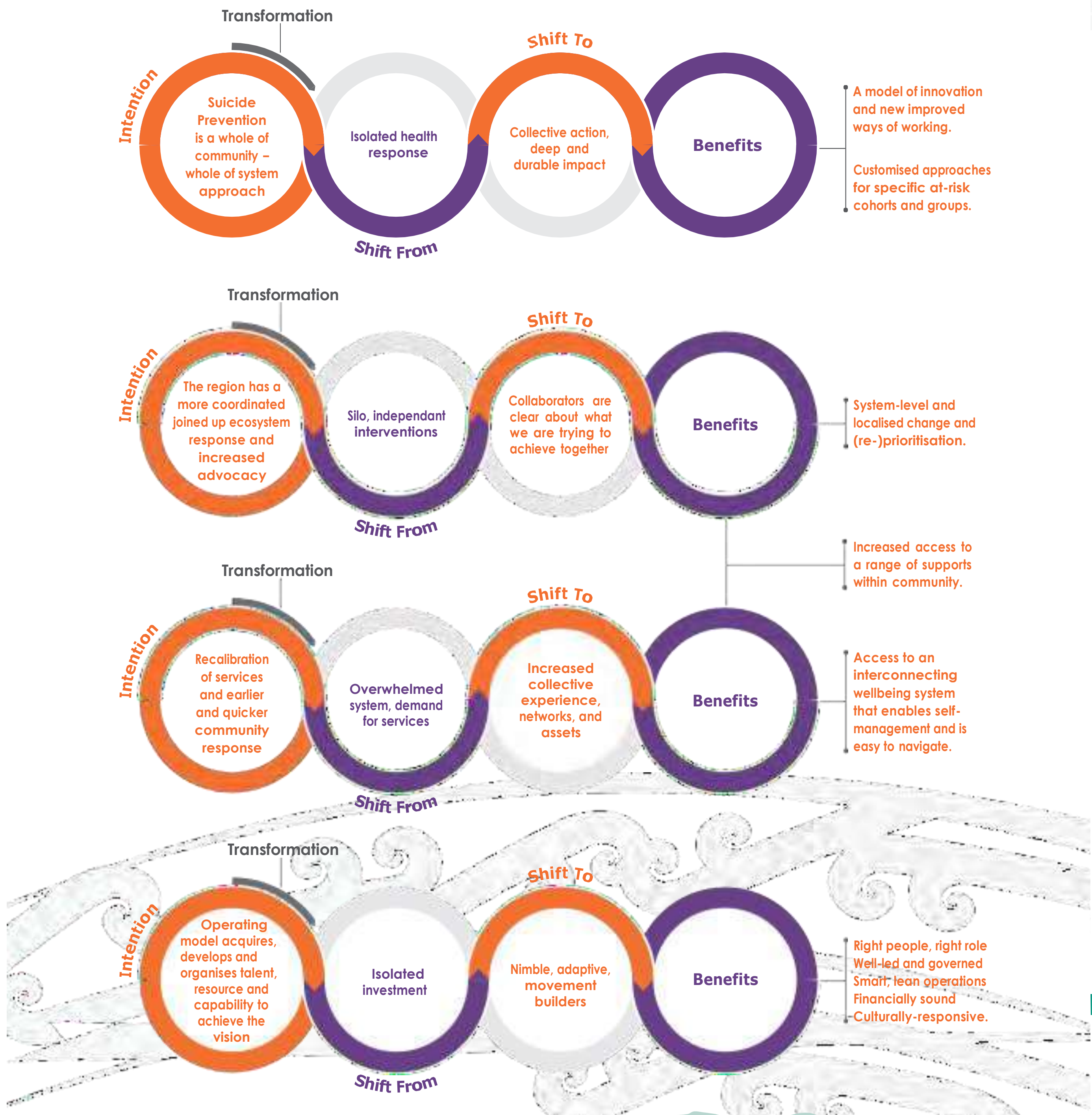
Our Future Reality

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.

- **Child Health & Wellbeing,** Reduce the compounded weight of toxic stress for whānau, families.
- **Prevent Alcohol and Drug Related Harm Advocacy,** innovative service and community design.
- **Māori Systems and Knowledge,** Māori-led design of preventions and narratives.
- **Regenerative Placemaking,** to regenerate social inclusiveness and increased connectivity.
- **Prevention of Family Harm,** leverage existing regional Family Violence networks to identify collective wellbeing solutions.
- **Wellbeing Responders,** All front-line staff are trained as wellbeing responders.
- **Regional Strategies,** Te Kōpuka Strategy, Safer Whanganui, Thriving Communities.
- **The Art of a Great Referral,** Co-design of common narrative and referral pathway.
- **Community-led Service Design,** Co-designing improved pathways to mental health and wellbeing services.
- **Changing the Narrative,** Collective wellbeing campaigns and raising awareness of the protective factors.
- **Real Time Data,** Improve data collation, analytics and dissemination of actionable intelligence.

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

- Kaupapa-driven.
- Values diversity, creates brave space.
- Deeply cares about and works with those who have lived experience.
- Fails forward, learns by doing, disciplined in the chaos.
- Storytelling.
- Biodegradable.

Community Aspiration

- "Nothing about us without us!".
- Based on community values and goals.
- Includes those not in traditional seats of power.
- So ambitious it cannot be mistaken for BAU.
- Creating new narrative to inspire positive change.

Authentic Engagement & Partnership

- High trust, non-competitive principled.
- Negotiates the exchange of value rather than funding-only approaches.
- Enables power-sharing.
- Facilitates collective intelligence and collective action.

Leverage and Momentum

- Removes bureaucracy so pace and depth become viable choice.
- Understands and works to address systems change.
- Prioritises actions that generate movement.
- Leans in to tension, positive disruption.
- Produces artefacts.

Strategic Learning & Reflective Practice

- Has real time feedback loops.
- Maps the progressive wins.
- Acknowledges assumptions and mental models.
- Regular quality reflection to improve practice and wellbeing.
- Disseminates actionable intel.

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.

Phase One

Collaborators and key stakeholder are socialized with this strategic approach, establish the conditions for change working groups.

2020

2021–2022
Launch

Activations GO live, capacity building and live learning, operating model set up, processes set up for capturing progressive wins and learning, conditions for change working groups in progress.

2022–2023
Deepen

Execute to extend impact, demonstrations of actionable intelligence, evaluation measures go live, investment and value exchange negotiated and agreed, initiatives and partners for next phase identified.

2023–2024
Grow

Value exchange and operating framework embedded, evidence and measures of success produced, new collaborators and initiatives contribute to the 2024 - 2027 Traction Plan, evidence of impact and change.

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

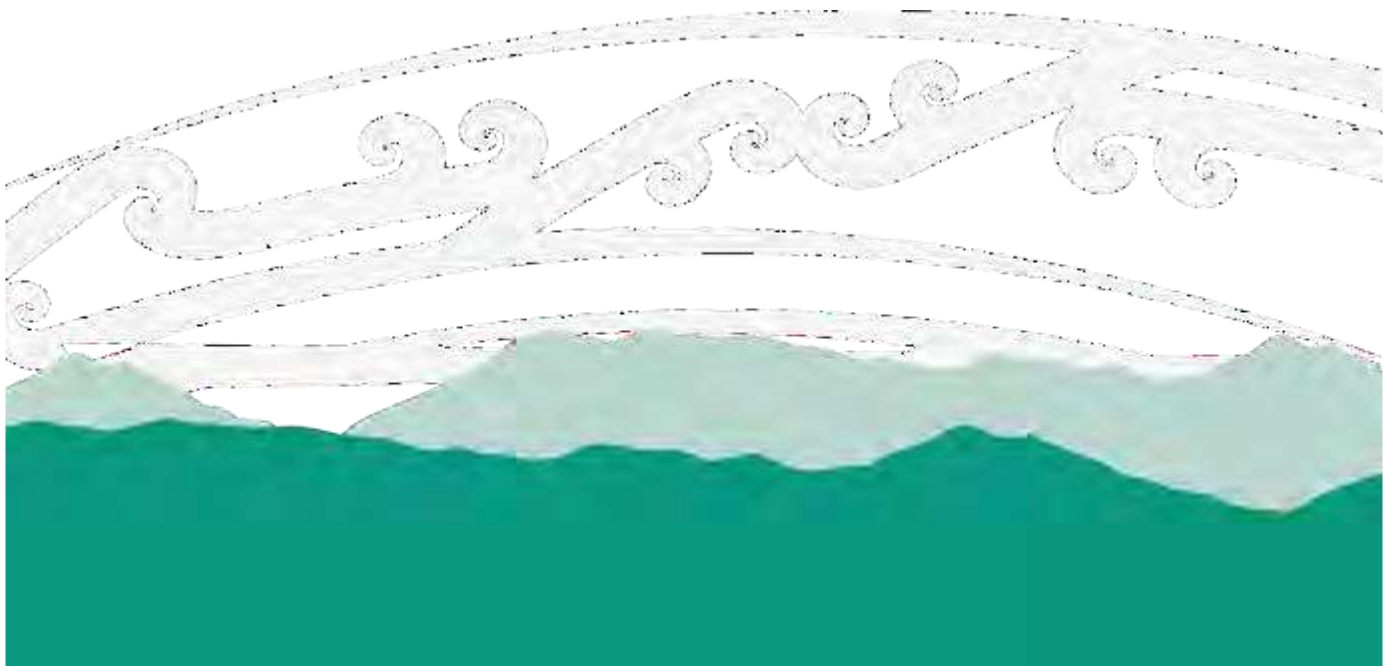
Growing Collective Wellbeing

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

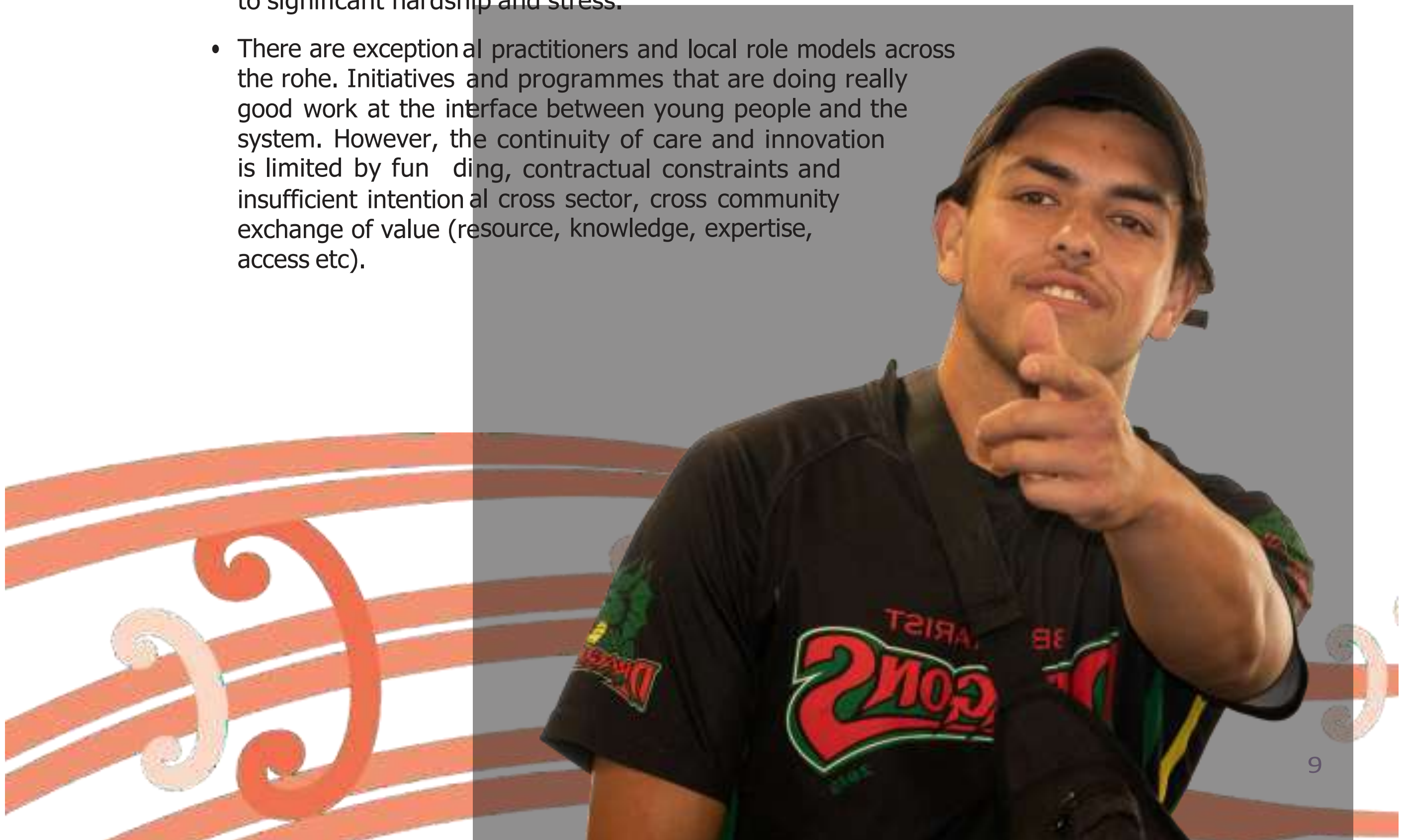
- If social media or gaming goes unchecked, taitamariki will not get the required sleep they need to maintain healthy development. Lack of sleep affects focus and concentration levels. Sleep hygiene is an important protective factor for health and wellbeing (suicide prevention).
- Online bullying and 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.

Questions for Co-designers, Youth Champions and Investors

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

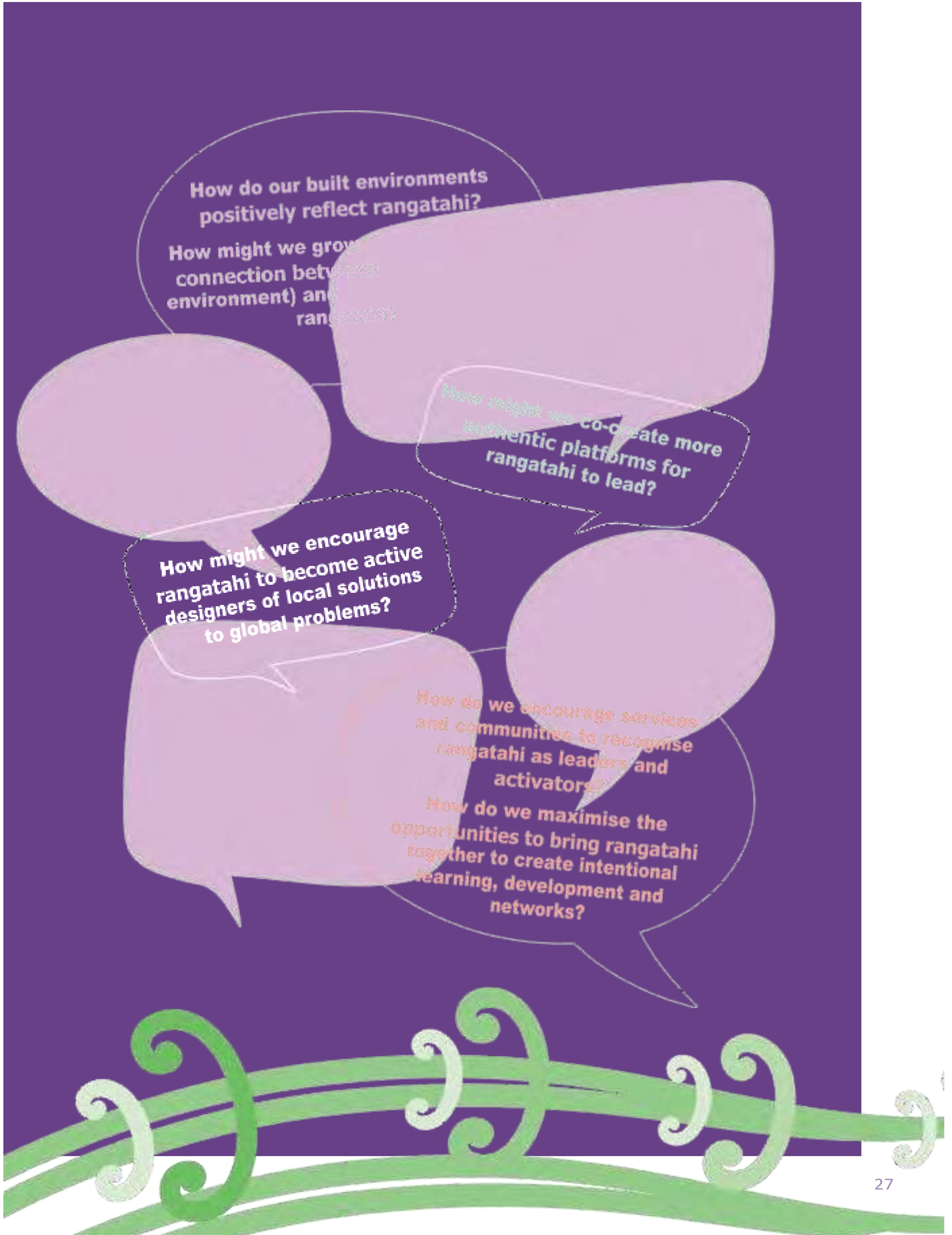
What could we do better in our region to flip the narrative from failure to safe?

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 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?

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

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Q		**Discussion Paper** **27 August 2021**
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 Q4 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 Q4 Reporting: non-financial performance measures

b. **Note** that while Quarter 3 results now final, Quarter 4 results are preliminary.

1 Purpose

This paper provides an update on Preliminary Quarter 4 Non-Financial Performance Framework results

2 Index

2.1 Preliminary Ratings Quarter Four Non-Financial performance framework measures

2.2 Detailed quarterly reports to the Ministry of Health for Quarter Four

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2.1 Preliminary Ratings Quarter Four Non-Financial performance framework measures

Measure	**Q-1**	**Q-2**	**Q-3**	**Q-4**
Ratings confirmed?	✓	✓	✓	✗
Key — Achieved — Partial — Not achieved — Not req'd — Update due				11/08/21
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				NO RATING
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				NO RATING
MH04: Mental Health and Addiction Service Development EMPLOYMENT & PHYSICAL NEEDS				
MH05: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders				
MH06: Output delivery against plan				
MH07: Improving mental health services by improving inpatient post discharge follow-up rates				

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Measure	Q-1	Q-2	Q-3	Q-4
Primary health care				
PH01: Improving System Integration & SLMs				
PH02: Improving the quality of data collection in PHO and NHI registers				
PH03: Improving Maori enrolment in PHOs to meet the national average of 90%				
PH04 :Better help for smokers to quit (primary care)				NO RATING
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				
SS07: Planned Care Measures				
SS09: Improving the quality of identity data NHI				
SS09: Improving the quality of identity data NATIONAL COLLECTIONS				
SS09: Improving the quality of identity data PRIMHD				
SS10: Shorter stays in Emergency Departments				
SS11: Faster cancer treatment (62 days)				
SS12: Engagement and obligations as a Treaty partner				NO RATING
SS13: FA1 Long Term Conditions				
SS13: FA2 Diabetes services				
SS13: FA3 Cardiovascular health				
SS13: FA4 Acute heart services				
SS13: FA5 Stroke services				
SS15: Improving waiting times for colonoscopies				
SS17: Delivery of Whānau Ora				

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2.2 Detailed reports to the Ministry of Health for Quarter Four

Child-wellbeing

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

Whanganui

Measure 2 (CW03b): Number of enrolled pre-school and primary school children overdue for their scheduled examinati 2021

	ALL ETHNICITIES					MĀORI ONLY				
				Longest waiting time					Longest waiting time	
	Number of Children Overdue	Total Number Enrolled	Percentage Overdue	Duration (in months)	Number Affected	Number of Children Overdue	Total Number Enrolled	Percentage Overdue	Duration (in months)	Number Affected
Pre-School Children (age 0 - 4)	176	4,427	4%	7	3	88	2,036	4%	7	1
Primary School Children (age 5 - Year 8)	483	7,794	6%	12	1	217	3,006	7%	6	4
TOTAL	659	12,221	5%	12	1	305	5,042	6%	7	1

	PACIFIC ONLY					OTHER				
				Longest waiting time					Longest waiting time	
	Number of Children Overdue	Total Number Enrolled	Percentage Overdue	Duration (in months)	Number Affected	Number of Children Overdue	Total Number Enrolled	Percentage Overdue	Duration (in months)	Number Affected
Pre-School Children (age 0 - 4)	13	170	8%	5	1	75	2,221	3%	7	2
Primary School Children (age 5 - Year 8)	15	275	5%	8	1	251	4,513	6%	12	1
TOTAL	28	445	6%	8	1	326	6,734	5%	12	1

	PACIFIC ONLY					OTHER				
				Longest waiting time					Longest waiting time	
	Number of Children Overdue	Total Number Enrolled	Percentage Overdue	Duration (in months)	Number Affected	Number of Children Overdue	Total Number Enrolled	Percentage Overdue	Duration (in months)	Number Affected
Pre-School Children (age 0 - 4)	13	170	8%	5	1	75	2,221	3%	7	2
Primary School Children (age 5 - Year 8)	15	275	5%	8	1	251	4,513	6%	12	1
TOTAL	28	445	6%	8	1	326	6,734	5%	12	1

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CW04: Utilisation of DHB-funded dental services by adolescents from School Year 9 up to and including age 17 years

DHB Performance Measure CW04

Region	DHB	2017 Result	2018 Result	2019 Result	2020 Result	2020 Target Volume	2020 DAP Target %	Assessment of 2020 Result Against DAP Target (See Note 2)	Shortfall in Adolescents Served i.e. Volumes Needed to Meet Target
Central	Hawke's Bay	67%	68%	57%	**30.8%**	9,129	85%	Not Achieved	5,823
Central	MidCentral	80%	81%	83%	**61.4%**	9,082	85%	Not Achieved	2,519
Central	Whanganui	80%	69%	77%	**71.7%**	3,349	85%	Not Achieved	523
Central	Capital and Coast	79%	79%	77%	**76.3%**	14,238	85%	Partially Achieved	1,461
Central	Hutt	69%	67%	74%	**64.6%**	7,374	85%	Not Achieved	1,768
Central	Wairarapa	65%	70%	70%	**50.6%**	2,342	85%	Not Achieved	949
Total NZ		**71%**	**71%**	**71%**	**59.2%**	**239,995**	**85%**	Not Achieved	**72,978**
Waitemata/Auckland combined		72%	74%	76%	64.2%	50,405	85%	Not Achieved	12,313
Auckland Metro combined		72%	74%	74%	59.9%	82,165	85%	Not Achieved	24,259
Northern		70%	71%	71%	58.3%	91,715	85%	Not Achieved	28,785
Midland		70%	69%	66%	57.3%	49,644	85%	Not Achieved	16,156
Central		75%	74%	73%	60.6%	45,514	85%	Not Achieved	13,043
Southern		72%	72%	70%	61.0%	53,122	85%	Not Achieved	14,994
Total NZ		**71%**	**71%**	**71%**	**59.2%**	**239,995**	**85%**	Not Achieved	**72,978**

CW05: Immunisation coverage 8 month

Indicator: Increased Immunisation 8 months CW05

DHB: WHANGANUI

Reporting period: QUARTER FOUR 2020-2021

Contact (role and name): Barbara Charuk Portfolio Manager

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 2020-21	**80.7%**	**73.3%**	**81.8%**	**85.8%**		
Q2 2019/20	**85.2%**	**77.7%**	**93.3%**	**77.0%**	**+4.5%**	**+4.4%**
Q3 2019/20	**79.6%** (n=40)*	**66.7%** (n=31)*	**90.9%** (n=1)*	**77.6%** (n=19)*	**-5.6%**	**-11%**
Q4 2019/20	**81.9%** (*n=43)	**69.1%** (*n=30)	**88.9%** (*n=1)	**71.9%** (*n=20)	**+2.3%**	**+2.4%**

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% Opt off/Decline	% Missed
TOTAL: 8.4% (n=20) Māori: 11.3% (n=11)	TOTAL: 9.7% (n=23) Māori: 19.6% (n=19)

PROGRESS REPORT

There were 23 children who were not immunised on time. Eight children have now completed but after turning eight months. There are four children who have not started and two of those have shifted from this DHB with no forwarding address and the other have not been able to be contacted by Outreach. Seven children have had their 6 week vaccinations but not completed 3/5 months. There are four children who are engaged with Outreach team needing their 5 months imms but have delayed by illness.
Missed, not completed on time were mostly Māori coming from both rural and urban GPs, three had no GP and one had a GP from another DHB.
We are noting an increasing rate of decliners, particularly with Māori.

Overall, there is a slight improvement this quarter in total children immunised and for Māori in the 8 month old cohort.

- Māori continue to be over-represented in the overdue/decliners of immunisation outreach service numbers. Outreach is working with Iwi/Maori health providers to find solutions. Focus on increasing Māori immunisation forms part of a several prong approach: continued awareness within general practice by Immunisation coordination services, within WCTO providers, at pregnancy and parenting education sessions, when tamariki present at ED, paediatrics (ward, Gateway, child development) and at Whanganui Accident and Medical.
- Decliners: If we could address the issue of decliners, our percentages would greatly increase. This issue is a national one and needs to be addressed from a wider perspective. We are encountering issues whereby Maori and lower socio economic groups are doing their own research, mostly from social media and are being negatively influenced and this is having an impact on immunisation uptake.
- With the schedule change that occurred in October, there was NO MOH comms to support the change. Feedback from general practices has been that they are struggling to get families to come in early for their second MMR dose.
- There is a sense of vaccine overload within practices, vaccinators are trying to complete both COVID and CIR training, have also been doing data work for the MMR national campaign as well as BAU. It is proving to be an incredibly busy space with many competing demands.
- It is also a busy space for whanau, trying to understand all of the vaccine programmes and how it pertains to them.
- Annual plan progress: Onsite imms are being provided by various groups when able (ie Peadiatric ward, PHO weekly clinics, monthly rural clinics). QLIK was meant to provide NHI level data so analysis of data could occur.
- For the second year in a row, Immunisation week and all of its promotion has been put on hold.

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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 immunisation target and how these are being addressed*
• Providing extra support to general practices to incorporate the changes. • We have included in next year's annual plan (2021-2022), closer alignment with the WDHB's health promotion unit who will develop a local comms and engagement plan to increase immunisation rates.
New initiatives and successes
• We are hoping that with the focus on COVID vaccines, that we can leverage off those contacts to have conversations about other vaccine programmes. • Our central city COVID vaccinations centre will be used to promote childhood vaccinations and offer pop up clinics on Saturdays.

CW05: Immunisation coverage 5 year

Indicator: Increased Immunisation 5 years
DHB: Whanganui
Reporting period: Quarter FOUR 2020-21
Contact (role and name): Barbara Charuk, Portfolio Manager

Summary of results: coverage at 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 2019/20	**86.9%**	**83.3%**	**83.3%**	**69.7%**		
Q2 2019/20	**86.8%**	**82.9%**	**92.3%**	**86%**	**-0.1%**	**-0.4%**
Q3 2019/20	**85.9% (n=31)**	**84% (n=15)**	**92.3% (n=1)**	**85.5% (n=12)**	**-0.9%**	**-0.5%**
Q4 2019/20	**87.2% (n=29)***	**82.7% (n=18)***	**77.8% (n=2)***	**86.8% (n=12) ***	**+1.3%**	**-1.3%**

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(*n= number of children NOT vaccinated)

Opt off/Decline	Missed
TOTAL: 8% (n=18) **Māori: 10.6% (n=11)**	**TOTAL: 4.9% (n=11)** **Māori: 6.7% (n=7)**

Progress report

There were 11 children not immunised on time, ten of which were Māori. None of these children competed their B4SC. A total of 18 declined their immunisations, 11 of which were Māori children.

- Māori continue to be over-represented in the overdue/decliners of immunisation outreach service numbers. Outreach is working with Iwi/Maori health providers to find solutions. Focus on increasing Māori immunisation forms part of a several prong approach: continued awareness within general practice by Immunisation coordination services, within WCTO providers, at pregnancy and parenting education sessions, when tamariki present at ED, paediatrics (ward, Gateway, child development) and at Whanganui Accident and Medical.
- Decliners: If we could address the issue of decliners, our percentages would greatly increase. This issue is a national one and needs to be addressed from a wider perspective. We are encountering issues whereby Maori and lower socio economic groups are doing their own research, mostly from social media and are being negatively influenced and this is having an impact on immunisation uptake.
- With the schedule change that occurred in October, there was NO MOH comms to support the change. Feedback from general practices has been that they are struggling to get families to come in early for their second MMR dose.
- There is a sense of vaccine overload within practices, vaccinators are trying to complete both COVID and CIR training, have also been doing data work for the MMR national campaign as well as BAU. It is proving to be an incredibly busy space with many competing demands.
- It is also a busy space for whanau, trying to understand all of the vaccine programmes and how it pertains to them.
- Annual plan progress: Onsite imms are being provided by various groups when able (ie Peadiatric ward, PHO weekly clinics, monthly rural clinics). QLIK was meant to provide NHI level data so analysis of data could occur.

  For the second year in a row, Immunisation week and all of its promotion has been put on hold

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 immunisation target and how these are being addressed

- Providing extra support to general practices to incorporate the changes.
- Included in next year’s annual plan (2021-2022), closer alignment with the WDHB’s health promotion unit who will develop a local comms and engagement plan to increase immunisation rates.

New initiatives and successes

- We are hoping that with the focus on COVID vaccines, that we can leverage off those contacts to have conversations about other vaccine programmes.
- Our central city COVID vaccinations centre will be used to promote childhood vaccinations and offer pop up clinics on Saturdays.

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CW05: Immunisation coverage HPV

Quarter 4 2021

Percentage of eligible GIRLS fully immunised with HPV vaccine, total DHB population, Māori, Pacific and Other up to 30 June 2021

Māori	Pacific	Asian	Other	All
67.8%	56%	66.7%	67.5%	67.5%

Percentage of eligible BOYS fully immunised with HPV vaccine, total DHB population, Māori, Pacific and Other up to 30 June 2020

Māori	Pacific	Asian	Other	All
68.2%	64.5%	73.3%	69.5%	69.5%

National target of 75% was not achieved.

Partially achieved	Progress towards the target is acceptable relative to national coverage.

NARRATIVE:

2020-2021

This year alongside the national immunisation schedule for HPV we continued with the HPV/MMR campaign catch up programme for ages 9 to 26 years. About 1,650 students of ages 13 to 18 years were identified as not been immunised for HPV and these were to be targeted for catch up. 187 year 9-13 students received their first dose of Gardasil HPV in 2020. 140 still required their final dose two or three in 2021. 66 are still at school and are in process of being followed up this year and 74 have left school. We are in process of contacting the school leavers to ensure that they get their final HPV dose at a health centre of GP. We have also used a local weekend market and sports and concert events to reach young people with moderate success.

The table below shows our year 8 HPV immunisation statistics according to the calendar year.

Numbers HPV Vaccination for Year 8 (12years) students: January – December 2020						
	Male	Female	Maori returned forms	Total Population from year 8 school rolls	Consented vaccination	
	328	311	336	999	622 (62.3%)	

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CW07: Improving newborn enrolment in General Practice

QUARTER 4 2020-21

Period: to March 2021

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

% Enrolled by 6 weeks of age
72.4 %

Annual rate is 75.7% and an improvement from June 2020 rate of 73.9%
17.4% above target of 55%.
(Māori 61.7 % enrolled, NOT enrolled n=41)

Measure 2
Number of newborns enrolled with general practice by 3 months of age

% Enrolled by 3 months of age
86.7%

Annual rate is 87.2%, a reduction of -2.8% from 2020.
1.7% above target of 85%
(Māori 71.8% enrolled, NOT enrolled n=31)

CW08: Increased Immunisation 2 years

Summary of results: coverage at 2 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 2019/20	**90.1%**	**91.7%**	**100%**	**85.8%**		
Q2 2019/20	**88.4%**	**84.1%**	**100%**	**87.8%**	**-1.7%**	**-7.6%**
Q3 2019/20	**85.6%** (n=33)*	**78.4%%** (n=21)*	**85.7%** (n=2)*	**78.7%** (n=19)*	**-2.8%**	**-5.7%**
Q4 2019/20	**77.1%** (n=64)*	**64%** (n=32)*	**66.7%** (n=2)*	**76.3%** (n=23)*	**-8.5%**	**-14.4%**

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Opt off/Decline	Missed
TOTAL: 13.8% (n=30) Māori: 20.2% (n=18)	TOTAL: 9.2% (n=20) Māori: 15.7% (n=14)

Progress report

There are 12 children who remain with OIS who were not immunised on time: five need to complete their 2nd MMR to be up to date. Two children have left the DHB with no forwarding address. Seven children need to complete both 12 and 15 month events to be up to date.

Another increase in decliners for this age cohort with 30 declines, 18 of which were Māori. 15 declined all immunisations.

Within this group, some parents ignored reminders both from their GP and OIS believing they were up to date.

Missed appointments continue to be of concern despite reminders and many attempts by OIS to locate children. Increasing transience, housing issues, physical barriers on properties like fences, dogs, gangs prevent engagement.

- Māori continue to be over-represented in the overdue/decliners of immunisation outreach service numbers. Outreach is working with Iwi/Maori health providers to find solutions. Focus on increasing Māori immunisation forms part of a several prong approach: continued awareness within general practice by Immunisation coordination services, within WCTO providers, at pregnancy and parenting education sessions, when tamariki present at ED, paediatrics (ward, Gateway, child development) and at Whanganui Accident and Medical.
- Decliners: If we could address the issue of decliners, our percentages would greatly increase. This issue is a national one and needs to be addressed from a wider perspective. We are encountering issues whereby Maori and lower socio economic groups are doing their own research, mostly from social media and are being negatively influenced and this is having an impact on immunisation uptake.
- With the schedule change that occurred in October, there was NO MOH comms to support the change. Feedback from general practices has been that they are struggling to get families to come in early for their second MMR dose.
- There is a sense of vaccine overload within practices, vaccinators are trying to complete both COVID and CIR training, have also been doing data work for the MMR national campaign as well as BAU. It is proving to be an incredibly busy space with many competing demands.
- It is also a busy space for whanau, trying to understand all of the vaccine programmes and how it pertains to them.
- Annual plan progress: Onsite imms are being provided by various groups when able (ie Peadiatric ward, PHO weekly clinics, monthly rural clinics). QLIK was meant to provide NHI level data so analysis of data could occur.

For the second year in a row, Immunisation week and all of its promotion has been put on hold.

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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 immunisation target and how these are being addressed*
• Providing extra support to general practices to incorporate the changes. • We have included in next year's annual plan (2021-2022), closer alignment with the WDHB's health promotion unit who will develop a local comms and engagement plan to increase immunisation rates.
New initiatives and successes
• We are hoping that with the focus on COVID vaccines, that we can leverage off those contacts to have conversations about other vaccine programmes. • Our central city COVID vaccinations centre will be used to promote childhood vaccinations and offer pop up clinics on Saturdays.

CW09 Better help for smokers to quit (Maternity)

2019/20 *Better help for smokers to quit* quarterly reporting template - Maternity

DHB:	Whanganui
Reporting Quarter:	4
Name and contact details of person completing the report	Rosie McMenamin

Please answer ALL of the questions below		*Target:* 90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.
What planning has occurred in your DHB to support the maternity health target, specifically for Māori and Pacific women? Please include information on how your DHB is supporting LMCs and/or DHB-employed midwives to increase the number of pregnant women being offered brief advice and support to quit smoking.	We are in the process of updating our maternal booking information that is used for every pregnant patient and most LMC's. Conversations are due to take place with our LMC's to try and get some consistency of recording our smoking hāpu māmā on the same form. Our maternal smokefree champion is being trained to offer short bursts of training to midwives on ward in down time We have regular engagement with our LMC's by attending the college of midwife hui's. We also Have an LMC representative on our tobacco advisory group that make all major decisions around tobacco in our region.	
What actions and/or projects is your DHB undertaking that	The local stop smoking service with support from our tobacco and sudi health promotors have set up and	

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reduces smoking in pregnancy, specifically for Māori and Pacific women?	now been running a successful Hapu mothers' group that meet regularly to do activities and discuss better health options during pregnancy.	
Is there anything else you would like to tell the Ministry?		

Whole of DHB

Number of events (a)	Number of Smokers	Brief advice given	Offered cessation support	Referred to cessation support	Smokers' gestation (weeks) (b)	% offered brief advice	% offered advice and support to quit	% accepted cessation support	Smoking prevalence (c)
4	2	2	2	0	5	100	100	0	50%

Maori

4	2	2	2	0	5	100	100	0	50%

(a) Number of events: number of pregnancies
(b) Smokers gestation: average for all events (pregnancies) included in the table
(c) Smoking prevalence is for the pregnancies that their data is included here

CW10: Raising healthy kids

<table>
<tr><td colspan="3">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</td></tr>
<tr><td colspan="3">Deliverables definition: Each DHB must provide narrative comments on activities being taken to improve performance and achieve the target agreed through their 2019/20 Annual Plan. The narrative is to include:
• specific activities undertaken for Māori and Pacific[1] populations</td></tr>
<tr><td colspan="3">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.</td></tr>
<tr><td>Name of DHB: Whanganui</td><td>Quarter reported on: Quarter Four 2020-2021</td><td></td></tr>
<tr><td colspan="2">Target performance to date and rate of progress based on data provided.</td><td>Action / deliverable timeframe</td></tr>
<tr><td>DHB Comments:</td><td>Result for Quarter Four 96%</td><td></td></tr>
</table>

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<table>
<tr><td colspan="2">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.</td><td>Action / deliverable timeframe</td></tr>
<tr><td>DHB Comments:</td><td>Whanganui’s referral decline rate of 17% for ongoing lifestyle management remain below the national average of 31% for Q4. However, our baseline obesity rate remains higher than the national average at 10.1% with Māori Tamariki obesity being 18% and Pasifika at 22%.

The child health team is continuing to network and share information between agencies and communities such as Plunket, Pasifika church groups, Iwi organisations, NIR, and general practices to locate transient children that fall within our priority groups to help reduce inequalities within our WDHB population.

Hearing and vision- Timeliness remains a concern and is under review in collaboration with the DHB and primary health organisation. Technicians have identified that updated national hearing and vision protocols using international best practice testing guidelines and better access to a peer review system nationally would provide ongoing professional development and reduce the potential of over-referring children to outpatient clinics.</td><td>Quarter 3</td></tr>
<tr><td colspan="2">Barriers to achieving the target and mitigation strategies over the next quarter by DHB and the PHOs.</td><td>Action / deliverable timeframe</td></tr>
<tr><td>DHB Comments:</td><td>Locating children: The outreach service continues to spend time liaising with the B4Sc coordinator to locate children from transient families to offer the B4Sc check. Increased pressure on housing availability particularly rental accommodation within WDHB sees many families moving several times often each month. Having the B4Sc information system updated more frequently with the health user interface/ NES demographic data could eliminate the unnecessary pursuing of families by the outreach service and in turn, save time.</td><td></td></tr>
</table>

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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:	The child health team is continuing to network and share information between agencies and communities such as Plunket, Pasifika church groups, Iwi organisations, NIR, and general practices to locate transient children that fall within our priority groups to help reduce inequalities within our WDHB population. Collaboration continues between primary care and DHB services to ensure any 4 year olds who attend gateway assessments are also booked in for a B4School check to maximise the outcomes from this assessment and provide any referrals relating to their health and development needs. The process for children who have turned 5 years old without a documented B4Sc check has been confirmed in collaboration with the Public Health Service. Upon referral, and with parental consent, this cohort of children (approx. 50-60/year) will be offered a new entrant check to screen for any health and development concerns.	**Q4**
What the DHB is doing to build in evaluation, measure effectiveness, and monitor outcomes over time.		Action / deliverable timeframe
DHB Comments:	For discussion with WRHN	**Quarter 4**

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CW12: Youth mental health

Initiative 1: School Based Health Services (SBHS)

Success is measured through regular reporting on provision of SBSH in all decile one to four secondary schools, and decile 5 as rolled out from 2020/21; teen parent units and alternative education facilities, and implementation of Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with SBHS.

Reporting requirement
In Q2 (Jan) and Q4 (July) please complete and attach CW12 2020/21: Template (to be provided) for DHB summary reports to the Ministry for Additional School Based Health Services (SBHS) If there are any issues with the SBHS reporting template for 2020/21 please contact Eilish.reilly@health.govt.nz

Intended Outcome	Measure	DHB Numerator	DHB Denominator	Disaggregation	DHB Result *(Calendar Year to Date)*
Availability of primary health care services in secondary schools	M1: Percentage of all facilities with SBHS *(providing a service as per the tier three service specification)*	14	16		87.5%
	M2: Percentage of eligible facilities with mandatory SBHS	14	14		100.0%
Youth access to appropriate primary health care services	M3: Percentage of eligible students who have access to SBHS	1,757	1,757	European / Pakeha	100.0%
		1,361	1,361	Maori	100.0%
		107	107	Pasifika	100.0%
		115	115	Asian	100.0%
		131	131	Other	100.0%
		3,471	3,471	Total	100.0%
	M4: Percentage of students eligible for a routine health assessment *(including HEEADSSS assessment)* who have had an assessment this calendar year to date *(all year 9 students and all students in TPU and AE)*	56	129	European / Pakeha	43.4%
		75	168	Maori	44.6%
		1	5	Pasifika	20.0%
		1	4	Asian	25.0%
		0	2	Other	0.0%
		133	308	Total	43.2%
	M5: Percentage of students who visited SBHS nurse this calendar year to date *(including advice or treatment, and excluding routine health assessments)*	30	1,757	European / Pakeha	1.7%
		69	1,361	Maori	5.1%
		1	107	Pasifika	0.9%
		0	115	Asian	0.0%
		1	131	Other	0.8%
		101	3,471	Total	2.9%
	M6: Student visit rate *(including advice or*	59	30	European / Pakeha	1.97 visits
		150	69	Maori	2.17 visits

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	treatment, and excluding routine health assessments)	1 0 1 211	1 0 1 101	Pasifika Asian Other Total	1.00 visits 1.00 visits 2.09 visits
Number of interventions	M7: Percentage of SBHS interventions that were for mental health concerns	120	356	Total	33.7%
	M8: Percentage of SBHS interventions that were for sexual health	87	356	Total	24.4%
Youth health population outcomes	M9: Percentage of students who had a health assessment who are within healthy BMI range	37 41 1 0 0 79	52 69 1 1 123	European / Pakeha Maori Pasifika Asian Other Total	71.2% 59.4% 100.0% 0.0% 0.0% 64.2%
Improved quality of SBHS	M10: Percentage of students who report that their last visit with a SBHS health care professional was private and confidential	8	8	*Note: survey and reporting required annually, due January.*	100.0%
	M11: Percentage of facilities (or groups of facilitites) with SBHS who have submitted a satisfactory written continuous quality improvement programme *(based on the "Youth Health Care in Secondary Schools: A framework for continuous quality improvement")*	0	14		0.0%
Best value for public health system resources	M12: Ratio of Registered Nurse (RN) FTE to number of students attending school with SBHS	0.19 1.83	30 1,231	TPU / AE All decile schools	1:162 1:672
	M13: Total cost of SBHS per student		1,261	All facilities	$0
	M14: Number of completed health assessments and student visits to RN per RN FTE	61 283	0.19 1.83	TPU / AE All decile schools	329.7 154.6

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Initiative 5: Improve the responsiveness of primary care to youth

By delivering youth mental health initiatives, DHBs will support Government's priority to make New Zealand the best place in the world to be a child and young person, and our health system outcome that we have equity for Maori and other groups. This report focuses on two of the Youth Mental Health initiatives:

- School Based Health Services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities
- the work programmes and actions of the Youth Service Level Alliances Teams (SLATs) to improve the responsiveness of primary care to youth.

DHB report
The youth SLAT is part of the Maternal Child and Youth SLA. The group has met once this past quarter. In addition, youth mental health is also addressed in the mental health SLA, met once in the past quarter. Themes emerging are around mental health addictions, increase in demand for mild to moderate mental health interventions, concerns around youth acute inpatient and access to the Rangatahi unit in Porirua. Our clinicians and community believed rangatahi should be supported in their own communities and not taken away from support and their familiar environment.
The local YOSS was given additional funding to manage the increase in referrals for mild to moderate mental health issues. With this, they are able to better triage their referrals with one dedicated social worker in place, who also deals with urgent cases, can see higher level acuity youth and refer on as appropriate. In addition the YOSS is being supported to be able to provide immunisations to its client group, participate in the MMR campaign, we are also looking to expand its ability to provide sexual health services by being trained to provide Jadelle insertion. The DHB is exploring how is can better provide sexual health services for youth in the rural areas and is in discussion with Family Planning and the Public health nurse and sexual health team. 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. This service with service the entire DHB rohe, supported by the five Maori health providers. The service has so far accepted 25 referrals and predominantly for young mamas. 3 wahakura wananga occurred over the past year with young mamas benefiting from this type of intervention.

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School Based health services (SBHS)
Narrative Reporting for period 1st January to 30th June 2021

Service

The SBHS continue to provide and deliver, as per contractual obligations, to all decile 1-5 secondary schools and alternative education providers within our WDHB catchment.

Working towards meeting the expected targets and initiatives set out in the specification and requirements of the Ministry of Health and the Whanganui District Health Board.

The PHN in a Decile 9 Whanganui Collegiate school continues to provide a weekly clinic, which is well utilised, supporting with sexual health and contraceptive advise.

Continuing support for group of students from Whanganui High School Vocational Studies Class year 11, requested Universal Assessments (HEEADSSS) a group of 30 students which will continue yearly from now on. The PHNs will complete after their high risk, maori and pacifica group have been completed looking at Term 2-3.

Assessments

Currently no changes with the rolling out of the SBHS to decile 5 secondary schools in 2021, with in our WDHB catchment, as all secondary schools are under the SBHS except for 2 private schools which are decile 9.

In 2021 a total number of 806 students were eligible for a routine universal health assessment (HEEADSSS), with 300 completed at the end of June 2021.

A total of 72 students were referred to agencies or networks, school counsellor, social workers, Alcohol & Drug support (SUPP), Nga Taura Tuhono, (Whanganui Regional Stop Smoking Service for smoking and vaping cessation support) Mental Health (MICAMAHAS), Oral health, Hearing and Vision, Oranga Tamariki. Although data entry into Webpas is not entirely accurate with PHNs underutilising the system, which continues to be a quality improvement.

Te Kura Kaupapa maori o Te Atihanui-A-Paparangi, has chosen to provide SBHS and Year 9 students Heeadsss assessments in the kura in Term 2. Currently there is one student enrolled for Heeadsss assessment.

Partnerships

Continuing to work with a Nurse practitioner (NP) who is supporting for 4 hours a week to support PHNs, Dysmenorrhoea, menorrhagia, contraceptive advise at of SBHS scope of practice, other gynae concerns – Poly cystic ovary, Skin conditions and infections, eye infection. NP has made referral and sourced advised from Paediatrics for some of the issues identified.

Initially in the high risk Pakohe Alt Ed, Sport Whanganui was frequently attending to support students. It has been noticed that the hours of attending this Alt Ed have decreased due to demands for the other schools. This is unfortunate as students require to have the stability of services attending due to the nature of the students that they are seeing. There has been a common theme with Pakohe Alt Ed that many services start to initiate contact and then withdraw due to many reasons. The key requirement in Pakohe and other Alt Ed is stability and reliability of services to form the relationships and support students with high priority risks, maori and pacifica groups attending. PHN has informed at multi service meetings just how important this is for the students that they serve in Pakohe, Alt Ed and kura.

Meeting with Whanganui Youth Collective to address the youth housing crisis, what services are available to support students, what can we do as a community to provide safe housing support, what services are actively involved supporting youth.

Quality Improvement

Ongoing quality improvement continues around standing orders, assessments, and medication safety. Evidence-based practice and up to date information supports the SBHS contract. Updating of policies in school with vaping and signage supporting role from Smokefree Health Promotor.

IT systems continue to be improved for quality data, initially IT system TEAMS was an option but due to potential human error with entering data this has been abandoned as an option. Continued work with Clinical Portal (CP) and Webpas, plan for education session Term 3.

Discussions with the Family Violence Co-ordinator, Child Protection Co-ordinator from WDHB we have started to work with the Whanganui Family Harm Team as to how we can support rangatahi who have been identified with a family harm event. Pilot project to start with Year 9 students where we envisage consent form parents/caregivers to offer this in SBHS, if this cannot be obtained then the student will be red flagged and PHNs will discuss in general, safety plans and what that would look like if it ever occurred in their life. Currently making resource for the Police to give to parents/caregivers to be provided in Term 3. In meantime will continue to flag at risk students.

Health Promotion

Continuing to meet with principals and administration to provide school leavers brochures – 'Youth support services available outside of school hours' and' Find a GP flyer'. The brochures are also given out by PHN, provided to students who have expressed thoughts of leaving school.

PHN's have been actively involved with COVID immunisations education in schools providing education sessions for students, teachers and education session in the evening for Parents, Community members Q & A. Also continued messaging and vaccination with HPV and MMR students in schools throughout Term 1 & 2 and any opportunistic conversations, including in Heeadsss assessments and clinic consults.

Smoking Cessation – vaping with nicotine in schools advise via emails, talking with teachers and principals on how they can be supported, increasing engagement of Nga Taura Tuhono (Whanganui Regional Stop smoking Service), and liaising with rural services to support. Liaise with Smokefree Promotor, resourced in the schools as requested by Principals, has been beneficial.

Working with Healthy Active Learning Health Promotor regarding Ka ora Ka Ako – quality of food in the schools reported by several PHNs quality of food provided.

Continued in schools, Sunsmart, Water only, sexual health/contraceptive, including AOD Health promotor regarding FASD advise in the Year 13, 12, and at-risk youth attending Youth Camp and vocational classes, supporting the Teacher with sessions. Sessions with SUPP at "Ball Talks" in schools safety aspect, resource for the Parents/caregivers incorporated into emails.

Pink Shirt Day – incorporated Safe Net resources, posters and provided resources and websites for the school's newsletter for students and parents reinforcing the messages throughout the week.

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SUPP

In this quarter SUPP has seen an increase in referrals as there has been for all the youth mental health service. There has been a noticeable increase of referrals for vaping. Vaping has become an issue for the schools with many taking a strict stance and suspending and, in some cases, excluding young people who are caught vaping at school. SUPP has worked alongside the smoke free team to develop an education package and have meet with schools to promote education and support rather than a punitive approach.

SUPP has succeeded in improving the relationships with and service provided to the local Kura Kuapapa school Kokohuia. There had been a reluctance to accept SUPP intervention into the school. However, SUPP have now been invited into the school and have delivered an AOD presentation and are providing clinics as needed. This has also led to a smoother pathway for young Maori to the Child and Youth mental health team.

Rural referrals have also increased without an increase in capacity. The issues for rural youth are complex and the limited resources in rural areas require SUPP to be innovative and maintain good working relationships with rural community providers. Maintaining relationships but also keeping in touch with what is happening for the youth in these communities helps SUPP in developing appropriate education and transition planning.

There has been an acknowledgement from two of the local private schools of the need to provide AOD education and clinics. SUPP have been invited into these schools and have delivered AOD education sessions to Year 9, 10 and 11. It was reported that these sessions have been well received and have provided the opportunity to expand services in both these schools.

SUPP	**Referrals**	**Discharges**
April	8	15
May	30	11
June	19	25
Total	57	51

Age and ethnicity of referrals received								
Age	11 yrs	12 yrs	13 yrs	14 yrs	15 yrs	16 yrs	17 yrs	18 yrs
April		1	2		2	1		2
May	4	1	6	8	4	4	3	
June			3	5	3	5	2	1
Total	4	2	11	13	9	10	5	3

Ethnicity	NZ Maori	NZ European	Other European	European NFD	Cook Island Maori
April	2	4	1	1	
May	18	11	1		
June	11	8			
Total	31	23	2	1	

Gender	Female	Male
April	1	7
May	13	17
June	5	14
Total	19	38

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SLAT

Reporting requirement			
Name and describe progress on concrete and targeted actions in 2020/21 to address identified gaps in responsiveness, access, service provision, clinical and financial sustainability for primary and community services for the DHB's youth population, as per your SLATs work programme *Name actions, milestones, dates and measures* • *Describe progress on milestones. If off track, please provide mitigation strategies to get on track.*			
Action	Measure	Milestone	Progress
Working with SLAT to developed workplan	3 year work plan	SLAT up and running and inputing to identify trends	On Track, working to fine tune the plan

27 August 2021 **Public**

MENTAL WELLBEING

MH01: Improving the health status of people with severe mental illness through improved access Q4 2021

Percentage %

		2020/21 Q2	2020/21 Q3	2020/21 Q4
Total Clients	Total Clients	6.2%	6.0%	6.1%
	Total Child & Youth (0-19 yrs)	5.6%	5.4%	5.3%
	Total Adults (20-64 yrs)	7.9%	7.6%	7.7%
	Total Older People (65+)	2.7%	2.8%	2.9%
Māori Clients	Total Māori Clients	7.8%	7.3%	7.4%
	Māori C&Y Clients (0-19 yrs)	5.3%	4.9%	4.8%
	Māori Adult clients (20-64 yrs)	10.7%	9.8%	10.0%
	Māori Older Clients (65+)	2.5%	2.7%	2.8%
Other Clients	Total Other Clients	5.6%	5.5%	5.5%
	Other C&Y Clients (0-19 yrs)	5.8%	5.7%	5.7%
	Other Adult clients (20-64 yrs)	6.9%	6.7%	6.7%
	Other Older Clients (65+)	2.7%	2.8%	2.9%
Pacific Clients	Total Pacific Clients	3.9%	3.6%	3.3%
	Pacific C&Y Clients (0-19 yrs)	2.1%	1.8%	1.4%
	Pacific Adult clients (20-64 yrs)	5.6%	5.2%	5.0%
	Pacific Older Clients (65+)	1.7%	1.5%	0.8%

WDHB Performance against target

		2020/21 Q2 Performance against target			2020/21 Q3 Performance against target			2020/21 Q4 Performance against target	
Age Group	**Ethnicity**	**2020/21 Q2**	**Target**	**Variance**	**2020/21 Q3**	**Target**	**Variance**	**Target**	**Variance**
0-19	**Māori**	5.29%	5.50%	- 0.21% ▼	4.93%	5.50%	- 0.57% ▼	5.50%	- 0.65% ▼
	Other	5.80%	5.50%	0.30% ▲	5.74%	5.50%	0.24% ▲	5.50%	0.19% ▲
	Total	5.59%	5.50%	0.09% ▲	5.39%	5.50%	- 0.11% ▼	5.50%	- 0.17% ▼
20-64	**Māori**	10.67%	7.00%	3.67% ▲	9.83%	7.00%	2.83% ▲	7.00%	3.05% ▲
	Other	6.95%	7.00%	- 0.05% ▼	6.75%	7.00%	- 0.25% ▼	7.00%	- 0.27% ▼
	Total	7.93%	7.00%	0.93% ▲	7.60%	7.00%	0.60% ▲	7.00%	0.65% ▲
65+	**Total**	2.68%	3.00%	- 0.32% ▼	2.77%	3.00%	- 0.23% ▼	3.00%	- 0.15% ▼

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

MH02 - **Quarter 4 Reporting – Data to cover the 12 month period to March 2021**

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

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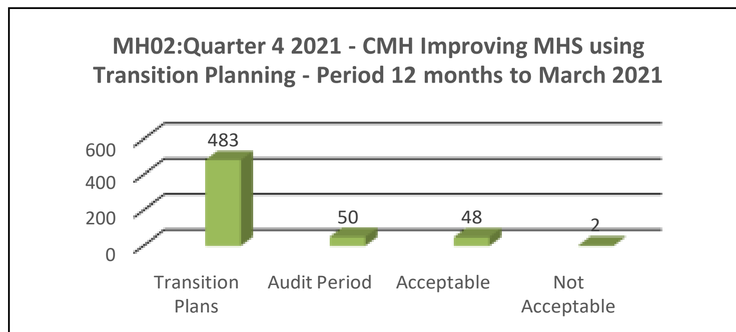
Mental health client data for this report captured from:

- WDHB MHS Reporting Service: Ethnicity – JCC036 used to extract information and confirmation of NHIs for extract period - length of time in service - discharge dates.
- Client electronic file - Clinical Portal
  - All clients have Transition/Wellness Plans in at least one of the following forms – Risk Assessments, CP Notes, Letters, Transition Plans, Discharge Summaries.
  - Wellness Plans – data information for current clients who have been in the service for more than 12 months.
  - Transition Plans – data information for clients who have been discharged from the service in this 12 month period.
  - Audit period – data to cover the 3 month period to March 2021.

Inpatient data information extracted from WDHB MHS JCC032 Admission-Discharge with LOS report .

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
483	483	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 plan of acceptable standard
48	50	96%



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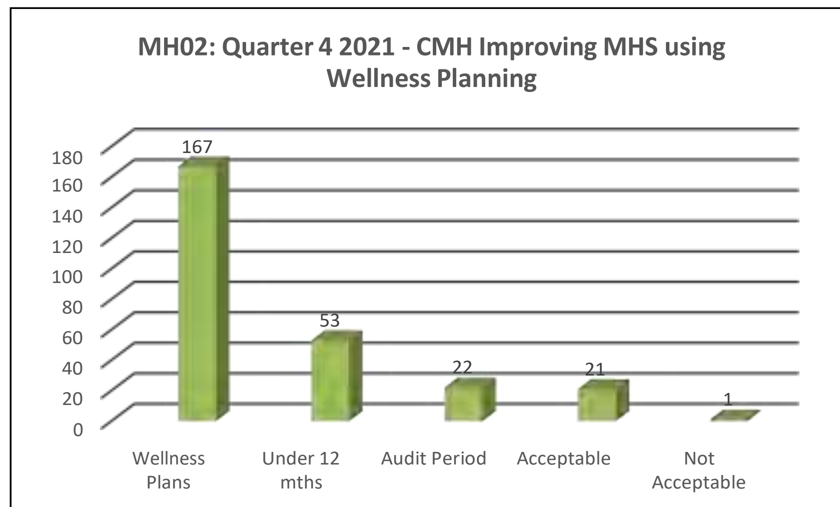
Reporting template

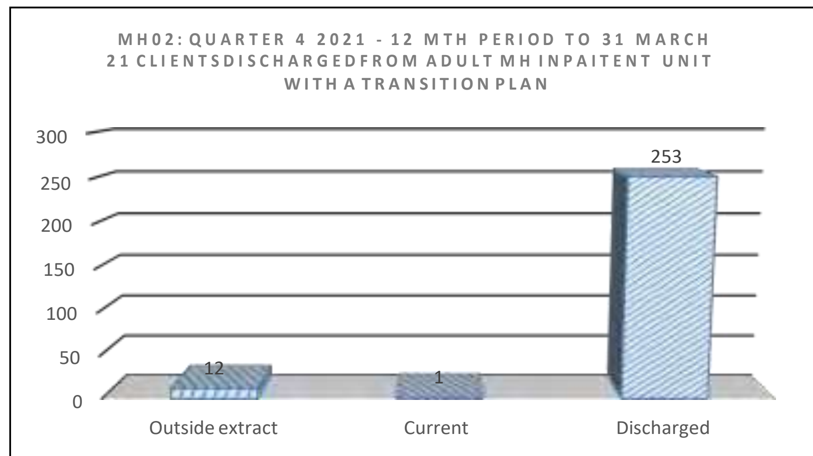
Percentage of MH&A clients open to services for greater than 12 months with a wellness plan		
Numerator	Denominator	Percentage
Number of MH&A clients open to services for greater than 12 months with a wellness plan (Data Source: DHB)	Number of MH&A clients open to services for greater than 12 months (DHB data source DHB)	Percentage of MH&A clients open to services for greater than 12 months with a wellness plan
167	167	100%
Number of files audited with a wellness plan of acceptable standard (Data Source: DHB)	Number of files audited (Data Source: DHB)	Percentage with a wellness plan of acceptable standard
21	22	95.5%

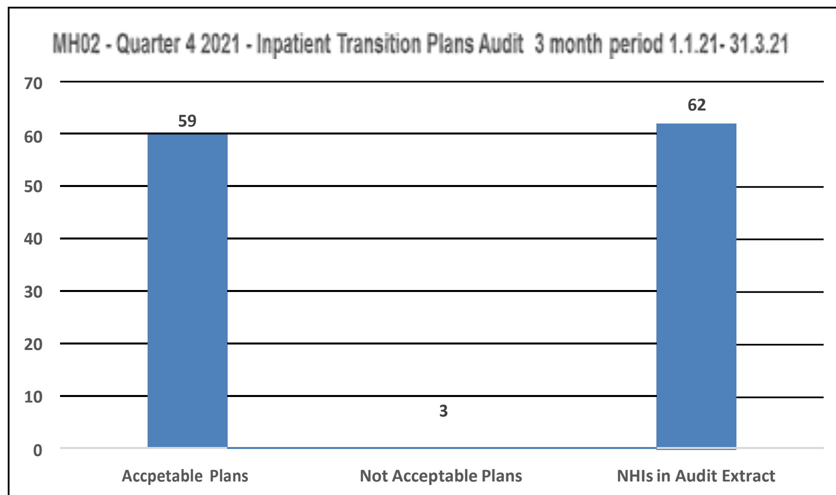


27 August 2021 **Public**

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
253	253	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
59	62	95.16%





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MH03 Improving mental wellbeing: Shorter waits for non-urgent mental health and addiction services for 0-19 year Q4 2020/21

Mental Health Provider Arm

	<= 3 weeks		<8 weeks	
Age	**target (%)**	**Achieved (%)**	**Agreed target (%)**	**Achieved (%)**
0-19	80%	89%	95%	99%

Addictions (Provider Arm and NGO)

	<= 3 weeks		<8 weeks	
Age	**Target (%)**	**Achieved (%)**	**Target (%)**	**Achieved (%)**
0-19	80%	91%	95%	100%

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

DHB: Whanganui   Year: 2020/21

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	56	51	46	56
1.2	Number of males seen	38	41	32	30
1.3	Number of clients seen - unspecified gender	0	0	0	0
1.4	Total number of youth seen	94	92	78	86
1.5	People re-presenting to service	Number of people who re-present and are seen by PMHI service within 6 months of concluding a course of treatment (note that this period is recorded across reporting years)			
	Clients aged 20+				
1.11	Number of females seen	282	281	260	283
1.12	Number of males seen	138	141	119	119
1.13	Number of clients seen - unspecified gender	0	0	0	1
1.14	Total number of adults seen	420	422	379	403
	Number of referrals				
1.21	Number of referrals (12-19)	13	15	7	19
1.22	Number of referrals (20+)	203	142	191	222
	Ethnic group				
	Clients aged 12-19				
1.23	NZ European	44	44	39	41

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1.24	Maori	29	45	37	42
1.25	Pacific Island	0	1	1	3
1.26	Asian	2	0	0	0
1.27	Other	0	2	2	0
	Clients aged 20+				
1.33	NZ European	282	249	238	272
1.34	Maori	134	140	117	112
1.35	Pacific Island	8	11	6	6
1.36	Asian	8	10	4	3
1.37	Other	6	10	14	10

The average score at the start of care and at discharge for all clients discharged per quarter

	Kessler 10 Score	Q1 at start	At exit	Q2 at start	At exit	Q3 at start	At exit	Q4 at start	At exit
1.43	K10 average score (12-19)			40	No result	36	No result	No result	No result
1.44	K10 average score (20+)	31	36	41	No result	34	No result	30	No result

The average score at the start of care and at discharge for all clients discharged per quarter

	PHQ-9 Score	Q1 at start	At exit	Q2 at start	At exit	Q3 at start	At exit	Q4 at start	At exit
1.45	PHQ-9 average score (12-19)					2			
1.46	PHQ-9 average score (20+)								

The average score at the start of care and at discharge for all clients discharged per quarter

	Other outcome measure	Q1 at start	At exit	Q2 at start	At exit	Q3 at start	At exit	Q4 at start	At exit
1.47	Average score (12-19)								
1.48	Average score (20+)								

	Number of Referrals to	Q1	Q2	Q3	Q4
1.51	Psychologist/psychotherapist (youth 0-19)	0	1	2	1
1.52	Specialist CAMHS or Adult Mental Health Service (youth 12-19)	6	7	12	2
1.55	Psychologist/psychotherapist (adults 20+)	22	10	19	36

1.56	Specialist CAMHS or Adult Mental Health Service (adults 20+)	47	42	33	43

2 Extended Consultations

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	37	45	39	30
2.2	Adults (aged 20+) who received an extended consult	288	270	211	231
2.3	Total	325	314	250	261
2.7	General Practitioner - number of consults	209	222	180	191
2.8	Practice Nurse - number of consults	111	100	95	89
2.9	Total	325	314	275	280

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		18	1	
3.2	Youth (12-19) average wait time from referral to first seen		0	0	
3.3	Youth (12-19) DNA Rate (%)		0%	0%	
3.7	Number of BIC sessions for Adults aged 20+		N/A	N/A	
3.8	Adult (20+) average wait time from referral to first seen		N/A	N/A	
3.9	Adult (20+) DNA Rate (%)		N/A	N/A	
3.13	Total Number of BIC sessions			1	
3.14	Total average wait time from referral to first seen			0	
3.15	Total number of clients that missed any session or DNA			0	
3.16	Total number of clients attending any session				
3.17	Total number enrolled (if different to total attending sessions)				
3.18	Total DNA Rate (%)				

4 Alcohol Brief Intervention (ABI)

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

The number of BIC commenced and delivered in reporting quarter

		Q1	Q2	Q3	Q4
4.1	Number of ABI sessions for youth aged 12-19	12	13	6	6

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4.2	Number of ABI sessions for adults aged 20+	113	115	122	111

4.5 Please describe the specific services being offered for the ABI service (youth)
Alcohol SBI in general practice
Alcohol and drug conversations are held as part of most brief intervention sessions and if part of the rangatahi history are checked on in packages of care sessions. Advice given includes education around AoD use, effects and supports available.

4.6 Please describe the specific services being offered for the ABI service (adults)
Alcohol SBI in general practice

5 Group Therapy

Definition: A psychotherapy/skill development or education programme designed for more than two individuals which lasts between one and three hours. Group therapy usually involves a series of sessions that are part of a programme with a particular focus.

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	22	12	13	22
5.2	Youth (12-19) average number of group sessions per client	12	9	8	14
5.3	Youth (12-19) average wait time from referral to first seen	NR	0	0	0
5.4	Youth (12-19) DNA Rate (%)	NR	0%	0%	0%
5.9	Number of group therapy sessions for adults aged 20+	NR	N/A	N/A	N/A
5.10	Adults (20+) average number of group sessions per client	NR	N/A	N/A	N/A
5.11	Adults (20+) average wait time from referral to first seen	NR	N/A	N/A	N/A
5.12	Adults (20+) DNA Rate (%)	NR	N/A	N/A	N/A
5.17	Total number of group therapy sessions	NR	NR	NR	NR
5.18	Total number of clients that missed any session or DNA	NR	NR	NR	NR
5.19	Total number of clients attending any session	NR	NR	NR	NR
5.20	Total number enrolled (if different to total attending sessions)	NR	NR	NR	NR
5.21	Total average number of group sessions per client	NR	NR	NR	NR

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5.22	Total average wait time from referral to first seen	NR	NR	NR	NR
5.23	Total DNA Rate (%)	NR	NR	NR	NR

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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	30	34	35	38
6.2	Youth (12-19) average number of sessions per POC	6	13	4	5
6.3	Youth (12-19) average wait time from referral to first seen	27	30	6	30
6.4	Youth (12-19) DNA Rate (%)	35%	20%	6%	16%
6.9	Number of POC for adults aged 20+	239	220	203	233
6.10	Adults (20+) average number of sessions per POC	3	4	3	3
6.11	Adults (20+) average wait time from referral to first seen	25	24	25	32
6.12	Adults (20+) DNA Rate (%)	12%	12%	10%	9%
6.17	Total number of POC	269			
6.18	Total number of clients that missed any session or DNA				
6.19	Total number of clients attending any sessions	19			
6.20	Total number enrolled (if different to total attending sessions)				
6.21	Total average number of sessions per POC	3		3	
6.22	Total average wait time from referral to first seen			22	
6.23	Total DNA Rate (%)	11%	12%	9%	

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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. Ethnicity of 12-19 year olds seen (41% Maori) indicates service supporting equitable access for enrolled youth population (38% Maori). Current actions include recent sharing of resource on stepped care MH resources available to support general practice and currently reviewing the delivery of MH&A education and training to be more accessible to general practice clinicians (therefore increase capability for early identification in general practice and provision of appropriate treatment). IPMHA practices also improve timely access to early brief intervention through HIPs and HCs (these contacts are not reported here).

The relationship with Whanganui High School is growing with referrals through the counsellor and an appointment with the Deans to explain the referral process and organise being part of the whanau room. Attendance continues at the Whanganui Youth Collective forums to network with youth services. Te Oranganui Rangatahi Innovations, Alt Ed and our PMH team participated in a 1/2 day at Kokohuia School. The team also continue to work with 100% Sweet working with youth looking at employment if needing Primary Mental Health input. The MICAMHS MDTs are still attended every week by 2 kaimahi. The referral pattern is quite eclectic with minimal referrals from GP Practices.The ongoing way of using 3 kamahi across.

3 contracts continues to work well with the mixture of skills and gender.

Q4: Overall youth PMH services appear adequate for the general practice setting. Ethnicity of 12-19 year olds seen (30% Maori) indicates quarter 4 did not achieve equitable access by the enrolled youth population (38% Maori). IPMHA practices also improve timely access to early brief intervention through HIPs and HCs (these contacts are not reported here).

Q4:Good enagement with Alternative Education, Tupoho and Whanganui High School through group work. Formal referrals continue to come from a variety of places including MICMAHS, Youth to Work, self and whanau. There has been ongoing connection with other youth kaimahi through the Youth Collective. One patternsnoted are rangatahi not being able to express what mental health is, they are not able to put into words which struck the kaimahi working in the field. They are using games and art to look at expression. The other issue noted from the team is the reluctance of those rangatahi using to change use of marijuana, nearly all who are using are in pre contemplation even after information on $, physical and mental health is shared.

7.2 Any major achievements/successes

There has been positive feedback from DHB mental health services about our male kaimahi working with young Māori men. For example he is working with one young man of 16 to help him do his CV for some afterschool work. Another 14 year old working with the whanau is looking at education options as he has not been to school since the beginning of 2020.The rangatahi have been invited to have input into an app for being developed for wellbeing. TheDdigital Divide project meant we had some phones with endless data for 6 months to give away to our tangata whai ora. One young person who got a phone has used it to keep in direct contact with the PMH kaimahi because in the past messages went through her mother and her mother's phone.There is now lots of communication between the pMH worker and the rangatahi. The rangatahi has used the phone to look for jobs and to keep in contact with whanau supporting a suicidal person in Wellington.

Q4: The work in the Whanau Room at High School has proved sucessful work with Maori students years 9 to 13. Every 2 weeks the students meet with Te Oranagnui and are currently looking at what is mental health. The teachers have been very supportive in their feedback and the kaimahi think they are greatful to be

learning along side the students. The aim is for the teachers to take over and the group can move to another school. Around 60 students a session are divided into 2 groups for 40 minutes. The students have told our primary mental health worker there are more students turning up the weeks Te Oranagui are there. The new service for supporting employment for young people , Youth to Work are sending referrals and these are being triaged to PMH, mental health or to services for mentoring. The group at Tupoho (which has been an on/off school to enage with) has continued with active korero about drugs. The 2 kaimahi who work in this contract have made major efforts to work with other service and schools and be seen wher young people are.

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

There are no serious issues just the ongoing battle to inform others and re inform others of the service availability. The process at MICAMHS to get to see a psychatrist is frustrating one of the kaimahi, due to the assessment by another clinician when one has been done by our clinician.
Q4: No issues have affected the delivery of this contract. For the year to date against the contact numbers for the service are 784 contacts through groups and 345 one to one mahi face to face.

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

8 Adult PMH Narrative Report

8.1 Overall Assessment of services delivered.

Overall adult PMH services appear adequate. Ethnicity of 20+ year olds seen (32% Māori) indicates service supporting equitable access for enrolled 20+ year old population (22% Māori). Current actions include recent sharing of resource on stepped care MH resources available to support general practice and currently reviewing the delivery of MH&A education and training to be more accessible to general practice clinicians (therefore increase capability for early identification in general practice and provision of appropriate treatment). IPMHA practices also improve timely access to early brief intervention through HIPs and HCs (these contacts are not reported here).

Q4: Overall services appear adequate. Ethnicity of 20+ year olds seen (28% Maori) indicates service supporting equitable access for enrolled 20+ year old population (22% Māori). IPMHA practices also improve timely access to early brief intervention through HIPs and HCs (these contacts are not reported here).

8.2 Any major achievements/successes

Data shows impact of HIPs and HCs in Gonville and Aramoho is reducing the number of referrals to counselling as issues are resolved through brief intervention in general practice. (However, the trend across the regions is increasing demand for talking therapies).

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

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

N/A

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Focus Area 2 District Suicide Prevention and Postvention Q4

1. **Training / education evaluation template**

No training to report this quarter. Note: That preliminary work is underway to ensure there is a work programme for 2021/22.

2. **Community initiatives evaluation template**

Qualitative Report:

Suicide Prevention

The following two articles were printed in the Whanganui Chronicle on 17 July 2021. They describe the work being done for Suicide Prevention by Healthy Families Whanganui, which is funded by WDHB as previously reported.

WHANGANUI CHRONICLE

Suicide prevention: 'Whole-of-community, whole-of-systems' strategy calls for radical change to help those in distress

15 Jul, 2021 09:49 AM 5 minutes to read

A community workshop in Taihape contributes to the design of the Growing Collective Wellbeing suicide prevention strategy. Photo / Supplied

By: **Moana Ellis**
Moana is a Local Democracy Reporter based in Whanganui
moana@awafm.co.nz

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A new community-led strategy for suicide prevention says many people are living in an extreme state of stress, the mental health services sector "feels overwhelmed" and health practitioners are not coping with growing need.

The strategic approach released this week by Healthy Families Whanganui, Rangitīkei and Ruapehu says youth suicide and serious self-harm are increasing, men are dying from suicide at nearly three times the rate of women, and suicide rates among Māori continue to be disproportionately high.

The initiative is calling for radical change across the health system. It wants a coalition of health providers and the community to focus on reducing the "unacceptable" rate of suicide and bring lasting change to wellbeing in the region.

"As it stands, suicide rates in the Whanganui District are too high," the report says.

"The wellbeing of citizens and their whānau/families in the District is not where we want it to be. 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."

Annual provisional suicide statistics for deaths reported to the coroner in the year to 2020 show the suicide rate for men in 2019-2020 was 19.03, nearly three times that of women at 7.18. However, attempted suicide rates for women were significantly higher than attempts by men.

The rate of suicide for Māori, at 20.24 deaths per 100,000 people, is increasing. European and other deaths show a rate of 12.08.

In Whanganui, the rate of reported suicides is 14.62. For Māori in Whanganui, the rate is 16.06. The rate for Māori men aged between 25-29 was highest, while Pasifika have very low rates of suicide in Whanganui.

According to statistics from Whanganui Regional Health Network, Māori are most prevalent in serious self-harm hospitalisation rates for youth aged 10-24, as they are in attempted

suicides and suicides, the report says.

Self-harm has been rising since 2018 amongst those aged 15-19, with 42 incidents in 2020. Females are most prevalent, as they are in attempted suicides. Between the ages of 10-14, three children in the Whanganui District were hospitalised for serious self-harm in 2020 – before that, there were no cases reported.

The strategy, Growing Collective Wellbeing, notes there appears to be a correlation between social and economic deprivation and suicide, with rates among lower socio-economic groups significantly higher and growing, and many people are trying to cope on their own with stressors such as intergenerational trauma, financial burden or violence.

Marguerite McGuckin, lead systems innovator for Healthy Families Whanganui Rangitīkei Ruapehu, says the three-year approach has been guided by local communities, partners, advisors and other stakeholders who are willing to work together to achieve change.

"We want sustainability and system change – we need to have the shift from intervention to prevention," McGuckin says.

"We want transformation, going from an isolated health response to collective action with deep and durable impact. It's those sorts of shifts that we need so that it will become sustainable for our communities.

"I think we're all hoping for solutions that will happen in five minutes, and that's not doable if we want sustainability. With a whole-of-community and whole-of-systems approach we believe that it will be sustainable as opposed to a bandaid."

The first phase of the strategy identifies 11 initiatives, including reducing compounded toxic stress for whānau, increasing social inclusiveness and connection, running collective wellbeing campaigns and training all front-line staff as "wellbeing responders".

Healthy Families Whanganui Rangitīkei Ruapehu is managed through Māori health provider Te Oranganui.

"It's a different approach, the first approach of its kind amongst any of the DHBs. We're coming at it with a preventative and a whole-of-systems, whole-of-community approach," McGuckin said.

"We have to thank the chief executive and Whanganui District Health Board for being courageous and bold enough to actually put this out to the community to design.

"On top of that, to have all of the community and our partners and stakeholders knocking on our doors wanting to be part of this approach is amazing. They've been a part of that journey for the last two years.

"We all have a part to play in keeping ourselves or our mates or our communities on the right end of that wellbeing spectrum instead of at suicide and suicidal behaviour. Our people need to know that it's ok to be well but vulnerable – it's about getting them back to being well again.

"How can we do that as a community, how can we do that as a system, how can we do that as a whānau and iwi and hapū? As a whole ecosystem, how can we do that collectively and with impact?"

Where to get help:

- **Lifeline**: 0800 543 354 (available 24/7)
- **Suicide Crisis Helpline**: 0508 828 865 (0508 TAUTOKO) (available 24/7)
- Youth services: (06) 3555 906
- Youthline: 0800 376 633
- Kidsline: 0800 543 754 (available 24/7)
- Whatsup: 0800 942 8787 (1pm to 11pm)
- Depression helpline: 0800 111 757 (available 24/7)
- Rainbow Youth: (09) 376 4155
- CASPER Suicide Prevention

If it is an emergency and you feel like you or someone else is at risk, call 111.

WHANGANUI CHRONICLE

Children's fear of bullying, judgement and ridicule causing 'extreme anxiety'

15 Jul, 2021 10:07 AM 3 minutes to read

"If we're talking about rangatahi it's not about them, it's with them," Marguerite McGuckin says. Photo / Supplied

By: **Moana Ellis**
Moana is a Local Democracy Reporter based in Whanganui
moana@awafm.co.nz

Bullying and online bullying is rife in schools and the community, according to a suicide prevention initiative in Whanganui, Rangitīkei and Ruapehu.

The new strategic approach to preventing suicide and suicidal behaviour, such as self-harm, was released this week by Healthy Families Whanganui, Rangitīkei and Ruapehu.

It says youth suicide and serious self-harm are increasing and suicide rates among Māori continue to be disproportionately high.

An earlier Insights Report highlighted issues affecting young people in Whanganui, Rangitīkei and Ruapehu. It says online bullying and being judged negatively is common, can escalate quickly and "go viral" to spread even more widely.

The report describes how the speed and scale of this "negative culture" affects tamariki and rangatahi, causing fear of being judged and ridiculed, which can lead to extreme anxiety.

Marguerite McGuckin, lead systems innovator for the new initiative, says young people are looking for positive role models, experiences and environments where they feel loved, valued and free from judgement, and believe this will help them grow resilience and become confident, well young adults.

She says rangatahi must be part of developing solutions.

"There's nothing about rangatahi without rangatahi," McGuckin says.

"We've always got to have our rangatahi at the table and have their voice to ensure that what we're doing going forward is what they're saying, not what we think they're saying. Including them in all the kōrero about what we're doing - and if we're talking about rangatahi it's not about them, it's with them."

Healthy Families Whanganui Rangitīkei Ruapehu is managed through Whanganui Māori health provider Te Oranganui. CEO Wheturangi Walsh-Tapiata says talking to rangatahi about their wellbeing was key to developing the new suicide prevention strategy.

"Often suicide is a very, very difficult conversation to have, but we went out to our communities and we gathered their voices," Walsh-Tapiata said.

"Having those meaningful conversations with rangatahi is really one of the key pieces of work that occurred in this space.

"The ability to create forums where young people can have conversations that aren't on their phone and aren't all impacted by Facebook … wherever they can find that safe space, we need to encourage that."

Where to get help:

- **Lifeline**: 0800 543 354 (available 24/7)
- **Suicide Crisis Helpline**: 0508 828 865 (0508 TAUTOKO) (available 24/7)
- Youth services: (06) 3555 906
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- Rainbow Youth: (09) 376 4155
- CASPER Suicide Prevention

If it is an emergency and you feel like you or someone else is at risk, call 111.

Suicide Postvention

The DHB funds and NGO to provide postvention support.

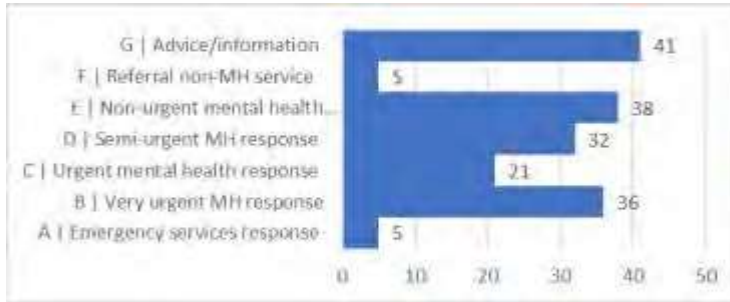
The NGO continues to also offer a support group for bereaved family members.

27 August 2021 **Public**

FA3 Mental Health and Addiction Service Development CRISIS RESPONSE

Mental Health Risk Screen staff lanyard cards, Traffic Light cards and Wellbeing Resource Cards are being monitored and counted while they have been delivered to key stakeholders and community agencies. A total of 1,520 cards have been delivered and there are more places yet to visit. Whakarongorau telephone triage line is providing a contracted service:

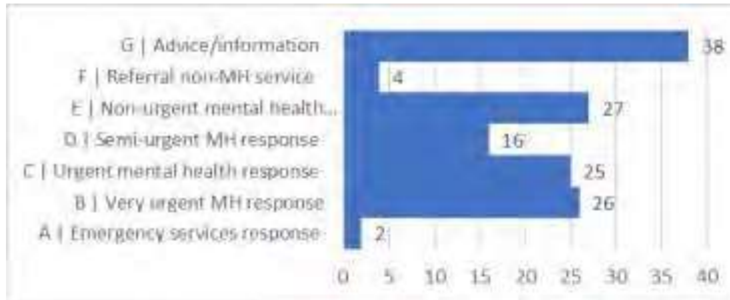
April



Contracted Volume 249
Actual volume 177
Variance contracted - Actual -72
% variance -29%

Total Ethnicity		178
European	100	56%
Maori	26	15%

May

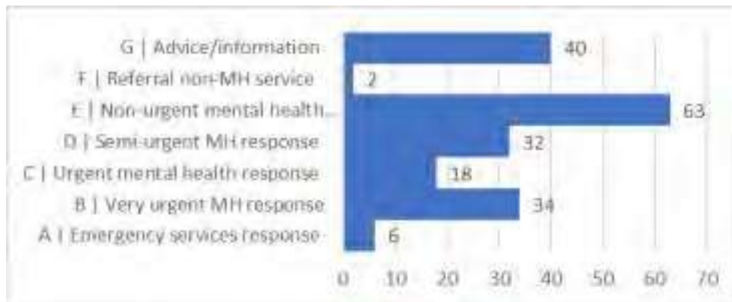


Contracted Volume 249
Actual volume 137
Variance contracted - Actual -112
% variance -45%

Total Ethnicity		138
European	69	50%
Maori	19	14%

27 August 2021 **Public**

June



Contracted Volume 249
Actual volume 193
Variance contracted - Actual -56
% variance -22%

Total Ethnicity	197	
European	93	47%
Maori	49	25%

The most recent reports from Whakarongorau provide useful data to identify types for service delivery demands, which include a high Maori ethnicity calls compared with other DHB call centres.

Learning from adverse events and responding to complaints helps to identify opportunities to improve service provision and recommendations have been actioned. The mental health assessment and home treatment team are co-designing a pamphlet that better explains what the service provides to the Whanganui community to assist meeting community expectations. A member from the mental health assessment and home treatment team (crisis) has been allocated when the roster permits, to work with the Whanganui police to improve working relationships in the response to people in the community suspected of experiencing acute mental health symptoms.

FA04 Supporting Parents Healthy Children (COPMIA)
MOH Quarterly Report 01/04/2021-30/06/2021
The focus of the WDHB and region SPHC (COPMIA) Steering group in this quarter has been ongoing training, awareness raising of community support for parents/caregivers and children/young people living in the presence of mental illness and/or addiction, increasing knowledge in schools about SPHC (COPMIA) and trauma informed care, reviewing whānau rooms within mental health and addiction services, and providing training for primary care based clinicians.
Parenting – ongoing demand for parenting support, in particular Triple P parenting (including Teen program) and Triple P online (including Teen program). In collaboration with Werry Workforce Whāraurau the online and face-to-face programs are able to be offered for free to parents and caregivers. Psychoeducation with whānau of selected parents who are inpatients continues. Increased number of maternal mental health referrals for parenting program support.

Training – positive feedback following presentation with a colleague at the international CAPA conference (based in Canada) via zoom, in May. 'Keeping Families and children in mind' and 'Let's Talk' training was facilitated locally during this quarter with participants from WDHB, Iwi health providers and NGOs.
Collaboration – School based boys resiliency group commenced in collaboration with NGO. Participation in successful Iwi Health provider led consultation day in regard to MH&AOD primary services. Providing a SPHC (COPMIA) voice in the planning of adult focussed services.

Future planning – SPHC COPMIA presentation at NZNO Child & Youth forum in Christchurch in September. National CAPA presentation in August. Presentations to NESPS (New Graduate Nurses entering specialist practice areas) (Aug) and AMH&AOD services (Sept). Single Session Family Consultation training (August) and 'Keeping families and children in mind' training (Sept). Presentation to maternal mental health professionals (Sept).

FA5 Mental Health and Addiction Service Development EMPOYMENT & PHYSICAL NEEDS Q4

Employment

The WDHB funds Link People to provide employment support and their report is outlined below:

- 40 people have been referred into service since 1 July 2020; with 10 being referred during Quarter 4.
- From these referrals we have seen 29 people enter the service; 4 during this quarter.
- One person moved into work during Quarter 4. Their hours are 40+ per week.
- Exit figures have seen 4 people leave the service for this quarter – one settled in employment; one discharged to crisis respite and two referrals were unable to be contacted after initially being engaging with us.
- 17 people are currently active within the service at the end of June 2021.

Physical Needs

Community Mental Health and Addiction Services (CMHAS) mental health liaison health professionals continue to work from four GP medical centres that also have employed Health Improvement Practitioners and Health Coaches.

Psychiatrists are visiting four GP medical centres to meet with people from secondary care services. This initiative promotes service users' access to physical health and provides availability to health coaches and health improvement practitioners as required.

The HoNOS and ADOM collection data monitors physical problems for health professionals to monitor and improve their physical health status every three months. Whanganui DHB averages 65 percent compliancy and results are shared with the CMHAS staff to encourage compliance in data collection.

The electronic patient management system called Clinical Portal has an Anthropometric electronic data collection tool that is used to monitor individual metabolic monitoring rates.

27 August 2021 **Public**

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

WDHB Qualitative Report Quarter 4 –April 2021 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 76 review
- Having the Haumoana navigator, Te Hau Ranga Ora (Maori cultural advisor) physically based in Te Awhina inpatient unit from mid-September

In this quarter the total number of Maori under any part of section 29 has reduced from 49 to 46. However there has been a shift to inpatient status 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.

Te Hau Ranga Ora Haumoana Navigators have developed a Te Ao Maori tool to help clinicians to better understand tangata whai ora (after a delay due to bereavement, the first tranche of key-workers was trained in its use on 1 July with the second group to follow before the end of July).

Discussions have also been held with the kaupapa Maori secondary service lead and the DAMHS in order to consider allocation of kaupapa Maori service clinicians as key-workers 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 now 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, key-workers 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 and development of pathways into primary care.

The data set used for compilation of this report is still manually collated as up to date information is not yet available on the informatics programmes for this quarter. 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.

An exercise of comparing these record by record is ongoing.

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, 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.

It will be important 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. Presently we do not have the capability in our data systems to track this.

In telling the story of Maori under section 29, we are inevitably 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.

27 August 2021 **Public**

MH06 Mental Health Output delivery against plan

PU Code	Description	2020/21 Vol	Contract Delivery FTE's or Available bed days 2020/21			
			Qtr 1Vol	Qtr 2 Vol	Qtr 3 Vol	Qtr 4 Vol
MHA01	Acute 24 Hour Clinical Intervention (inpatient)	2,190	547.00	547.0	547.00	547.00
MHA02	Intensive Care	2,190	547.00	547.0	547.00	547.00
MHA04C	Crisis Intervention Service - Nursing and/or allied health staff	9	8.10	9.0	9.00	9.00
MHA06	Acute Package of Care	2	2.00	2.0	2.00	2.00
MHA09A	Community Clinical Mental Health Service - Senior medical staff	4	3.10	3.0	3.50	3.40
MHA09C	Community Clinical Mental Health Service - Nursing and/or allied health staff	13	13.00	13.0	13.00	13.00
MHA11C	Mobile Intensive Treatment Service - Nursing and/or allied health	2	1.90	2.1	2.00	1.90
MHA18C	Needs Assessment and Service Coordination - Nursing and/or allied health staff	1	1.00	1.0	1.00	1.00
MHAD14C	Co-existing disorders (mental health & addiction) - Nursing and/or allied health staff	3	3.00	3.0	3.00	3.00
MHD69	Alcohol & Other Drugs Service - Opioid Substitution Treatment – Primary Care Support Places	45	48.00	47.0	48.00	50.00
MHD70	Alcohol & Other Drugs Service – Opioid Substitution Treatment – Specialist Service	90	109.00	110.0	109.00	112.00
MHD71C	Alcohol and other drug consultation liaison service – Nursing and allied health staff	0.2	0.20	0.2	0.20	0.20
MHD74A	Community based alcohol and other drug specialist services – Senior medical staff	1	1.20	1.0	1.10	1.20
MHD74C	Community based alcohol and other drug specialist services – Nursing and allied staff	6	6.10	6.3	6.10	6.30
MHDI48C	Child, adolescent and youth alcohol and drug community services - Nursing and/or allied health staff	1	1.10	1.0	1.00	1.00
MHE30C	Community service for eating disorders - Nursing and/or allied health staff	1	1.00	1.0	1.00	1.00
MHF81	Forensic Mental Health – Extended Secure Service	5,286	1321.00	1,321.0	1,321.00	1,321.00

MHI44A	Infant, child, adolescent & youth community mental health services - Senior medical staff	2	1.80	2.0	1.80	2.10
MHI44C	Infant, child, adolescent & youth community mental health services - Nursing/allied health staff	12	12.20	11.4	11.80	12.20
MHM90C	Specialist Community Team – Perinatal Mental Health – Nurses & allied health	2	1.00	1.0	2.00	2.10
MHO101C	Mental Health Older People Dementia Behavioural Support – Nurses & allied health	1	1.00	1.0	1.00	1.10
MHO99A	Mental Health of Older People – Specialist Community Service – Senior medical staff	1	1.00	1.0	1.00	1.00
MHO99C	Mental Health of Older People - Specialist Community Service – Nurses & allied health	2	2.00	2.0	2.00	2.00
MHW68D	Family whanau support education, information and advocacy service – Non-clinical staff	5	5.00	5.0	5.00	5.00

MH07: Improving mental health services by improving inpatient post discharge follow-up rates Q4 2021

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.		
Numerator 169	Denominator 226	Percentage 74.8%
Number of in-scope referrals discharged within 7 days from MH&A inpatient services (Data Source: PRIMHD/KPI)	Total number of overnight acute inpatient discharges in the reference period. (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.		
Numerator 69	Denominator 92	Percentage 75%
Number of in-scope referrals discharged within 7 days from MH&A inpatient services (Data Source: PRIMHD/KPI)	Total number of overnight acute inpatient discharges in the reference period. (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.		
Numerator 2	Denominator 2	Percentage 100%
Number of in-scope referrals discharged within 7 days from MH&A inpatient services (Data Source: PRIMHD/KPI)	Total number of overnight acute inpatient discharges in the reference period. (Data Source: PRIMHD/KPI)	Percentage of clients follow up within 7days

27 August 2021 **Public**

Narrative quarterly reporting

The data capture process improvements are in full operation now with the expectation that all face-to-face activities regarding these 7 days will be accurately recorded. Other data issues remain minimal; however, we have discovered 2 anomalies that affect less than 5 discharges that we are in the process of correcting at the source. Data issues work with 28 day readmission alongside this KPI as a balancing measure is resolving anomalies as numbers are not reflective of actuality.

Discharge follow up is improving following significant work by the adult service. The linkage with quality discharge planning is solidly in place with a team of clinicians led by a quality coordinator actively working on the process of safe and joined up transition of tangata whaiora from inpatient to the community teams which includes engagement and including of whānau. The system of booked appointments for RMO follow-up of tangata whaiora within 7 days of discharge has required some formalising to ensure that the activity is accurately uploaded at the time. We are expecting to see a significant improvement in the next quarter data. Leadership have been looking at our data on single quarter basis, and the transition team are continually auditing and scrutinising follow-up information shortly after discharge where issues outside 7 days are identified, and learnings taken back to clinicians.

Whanganui DHB inpatient and adult community teams are pleased with the direction of our numbers moving upwards at a similar rate to the national rate with the aim of rising above the target in the next quarter.

27 August 2021 **Public**

PRIMARY CARE

PH01 Improving system integration and SLMs 20/21

SYSTEM LEVEL MEASURES IMPROVEMENT PLAN REPORTING - QUARTER FOUR 2020/21

Submission to the Ministry of Health – through the quarterly reporting data base for PH01.

District Alliance: Whanganui Alliance Leadership Team

DHB submitting the report: Whanganui

Has this report been agreed by the District Alliance?	NO

Note: A report is yet to be submitted to Whanganui Alliance Leadership Team for 2020/21. Development of the report is currently underway.

PH02 Ethnicity Data Assessment Tool Report: February 2021

WRHN requires general practices to implement a regular self-audit programme to check on their compliance with enrolment requirements. A minimum expectation is that each month an audit of 20 persons on the register will be checked. As part of this monthly Audit General Practices are required to check that ethnicity information is accurately recorded.

General Practice teams are expected to participate in the orientation of new staff which incorporates the enrolment and eligibility process and training on ethnicity gathering within this process.

A WRHN Ethnicity data audit is going to be conducted in 2021 (as per the 3-year MOH expectations).

Author: Contracts Administrator

	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	**Q4**
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?	No, the percentage is sitting lower than expected. There are a number of potential reasons for this. 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. Additionally, post lockdown there have been an ongoing catchup of deferred health needs. The COVID-19 Vaccination programme is also impacting on general practice resource. What is being done? - Increased phone outreach/support with a focus on the practices with low utilisation is being provided

<table>
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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 and eLearning
Specialist education insights meeting pending from which education plan update intended.
Pregnancy smoking training addressed within Best Start context.

in the next quarter. Follow up education of smoking screening/ABC and current quit service is scheduled for the clinical education programme. Initiating remote access for a centrally based kaiāwhina resource to specifically target those enrolled smokers (this resource has been used for some years successfully, but usually sits in a practice, and they now no longer have physical space available. Access to practice management systems has impacted on their ability to support the practice to deliver on the expected targets). We are also using social media to ensure that practice populations identify this person as part of their general practice team (making subsequent contact better for all).
</td></tr>
<tr><td>Do you think you have met the target for Māori and Pacific (as noted above) this quarter? If not, what issues are preventing the target from being met and sustained? What actions are being put in place to improve performance and how will these actions be monitored?</td><td>Help for our enrolled Māori who are registered as smokers has been better from an equity perspective, with a greater percentage of Māori than non-Māori being provided with advice and referrals. We will continue to highlight the inequities in health outcomes and support increasing the volume of Maori who are being offered this advice & support to meet the MOH target.

Specialist kaiāwhina support has supported the distribution of 13 wahakura this quarter, 3 of which were primarily for smoke exposure.
The kaiāwhina has held one wananga session this quarter for WRHN. Five women attended, 2 Hapū mamas' and the rest professionals who learnt how to weave a wahakura. She has also been participating in the Hāpai Te Hauora programme and working at wānanga's nationwide to impart the safe sleep messages</td></tr>
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27 August 2021 **Public**

IMPROVING WELLBEING THROUGH PREVENTION

PV01 Improving breast screening coverage and equity for priority women 20/21

	Eligible Population	Screens	Coverage	Additional Women Screened Required to Reach 70% Target
Māori	1,823	1,240	68.00%	36
Pacific	139	99	71.20%	-
Asian	236	148	62.70%	17
Other	7,287	5,415	74.30%	-
Unspec.		2		
Non-Māori	7,523	5,417	72.00%	-
Total	9,485	6,904	72.80%	-

The result for this quarter has seen an improvement in screening for Maori, Pacific and Asian women.

The impact of COVID-19 on breast screening across all populations affected the return to screening for outreach clients however a continued focus on clearing the backlog of women is having positive results.

Referrals to Outreach
• 37 Screened • One moved out of this DHB • One declined breast screening

The appointment of the Regional Equity Coordinator for Breast Screening Coast to Coast will support participation and reduction of inequities in coverage for priority women for our DHB region.

The outreach Kaiawhina supports women to screening including home visits to engage wahine, book appointments and provide transportation if required.

Whanganui will host the Breast Screen Coast to Coast Regional Coordination Group Hui in October 2020

27 August 2021 **Public**

Strong and equitable public health and disability system

SS04 Implementing the Healthy Ageing Strategy

Deliverable Part 1: DHBs are expected to provide a progress report on:

Actions and milestones to deliver on the commitment in the DHB's Annual Plan to implement the Healthy Ageing Strategy as set out below:

Note – where the actions below are reported in the annual plan actions status updates a separate report is not required to be completed as below.

1.a National Framework for Home and Community Support services

This expectation aligns most closely to the Care Closer to Home theme from the New Zealand Health Strategy; and the Living Well with Long-Term Conditions goal of the Healthy Ageing Strategy

- Report progress during the quarter (in brief) on activity to align local DHB home and community support services (HCSS) activity to the vision, principles, core components, measures and outcomes of the national framework for HCSS.

WDHB Response:

DHB continues to be actively engaged in the national work program. The DHB has received the agreed funding methodology and analysis applied for this DHB from TAS. Understanding the implications from both a funding and system perspective is being worked through. The implications of the changes to family funded care also being considered.

1.b Integrated Falls and Fracture Prevention and Rehabilitation Services[2]

This expectation aligns most closely to the Care Closer to Home theme from the New Zealand Health Strategy; and the Ageing Well and Acute and Restorative Care goals of the Healthy Ageing Strategy.

The following measures align with the Live Stronger for Longer National Outcomes and Best Practice Framework (www.livestronger.org.nz) and ACC/DHB injury prevention partnering agreements for falls and fracture prevention. These measures enable indicators to be developed and reported nationally to all DHBs. The measures below also report a component of the quarterly reporting requirement under the ACC/DHB partnering agreements.

Using the template provided through the DHB quarterly reporting process:

- Report on local and regional activity to use falls data to improve system outcomes as per the Live Stronger for Longer National Outcome Framework (www.livestronger.org.nz)
- Report on activity to promote innovative delivery of Strength & Balance programmes
- Report on activity and implementation to deliver rehabilitation services in the community to meet the non-acute rehabilitation pathway service objectives to restore independence in the older population following a significant injury and readiness to transition onto a casemix funding contract by December 2022.
- Report on any improvements in data driven osteoporosis management especially in alliance with Primary Care
- Report the number of older people (65 and over, or younger if identified as a falls risk) for Quarter 4 that have received these services:
    - in-home strength and balance programmes (new starters)

[2] The following measures align with the Live Stronger for Longer National Outcomes and Best Practice Framework (www.livestronger.org.nz) and ACC/DHB/HQSC injury prevention partnering agreements for falls and fracture prevention. These measures enable indicators to be developed and reported nationally to all DHBs. The measures below also report a component of the quarterly reporting requirement under the ACC/DHB partnering agreements.

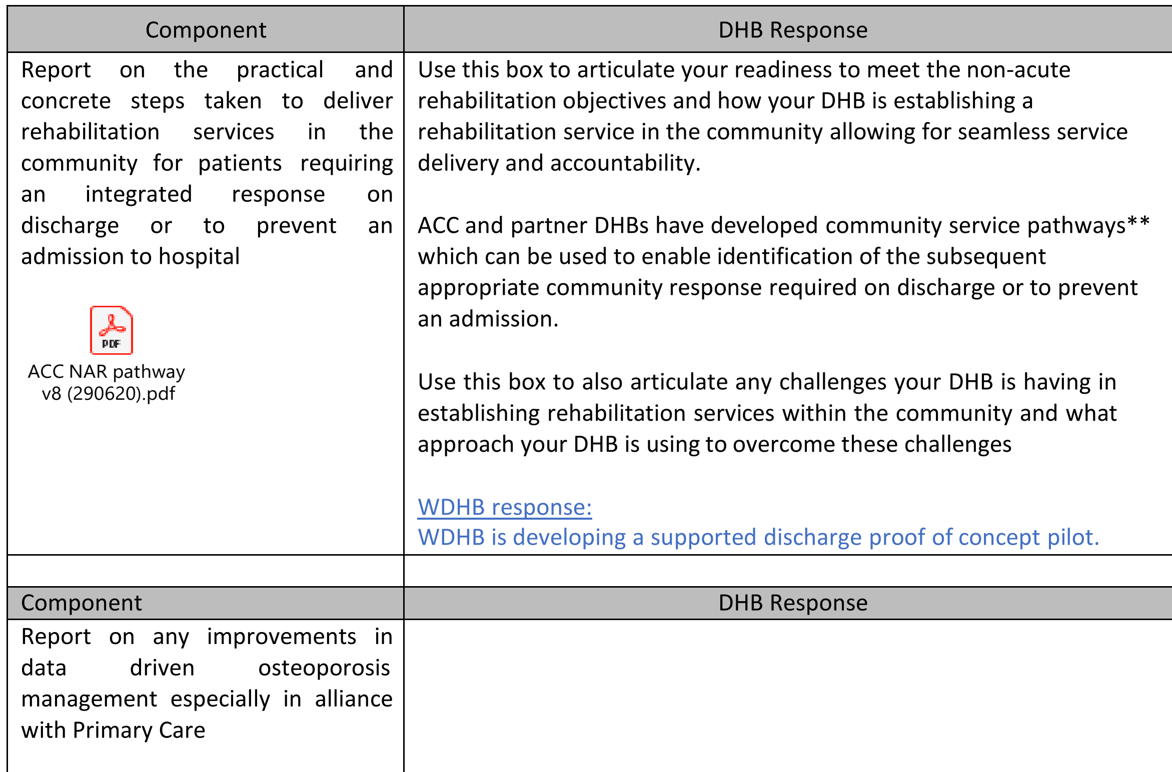
- Community/group strength and balance programmes
- Seen by the fracture liaison service or similar fracture prevention service

Please note: One of ACC's clinical leads has met with the Fracture Liaison Network and advises that people with ankle fractures should be included as fragility fractur

WDHB response:
The fracture liaison nurse (FLN) is now requesting DEXA scans for those patients who meet the criteria. This streamlined process will ensure all persons who meet the criteria at their time of presentation to the fracture clinic obtain a DEXA scan within a timely manner. It also enables services to be delivered in a more comprehensive way for screening and education of person with osteoporosis who present with a fracture. Verbal consent is obtained prior to the formal request to radiology.
The fracture liaison nurse continues to contact patients with fragility fractures: either face to face or by phone. Both approaches have improved health literacy and received positive feedback. When undertaking Fracture Screening, Bone health is also discussed enabling the FLN to assess the patient using a nationally recognised tool and to recommend the appropriate treatment from the GP.
If then FLN is unable to see the patient face to face, she posts out information to the patients on DEXA, osteoporosis, bone health management with diet and exercise, and information outlining local groups to attend and the availability of the NYMBL app.
Using the email system to recommend various bone strengthening medications to the GP's has saved invaluable time and reduced service overheads.
The fracture liaison nurse is now able to access all patient details regarding the medication they are on and to check whether recommendations have been followed up on by the GP. This is through Clinical Portal (as usual) plus Éclair.
Non fragility fractures for those over 50 years of age are also captured. There have been times for various reasons the FLN requests the GP order a DEXA scan for that patient. More than 80% come back with either osteoporosis or osteopenia, therefore are able to receive the correct bone strengthening medication.

Component	DHB Response
Provide narrative on local and regional activity to: • use falls data to improve system outcomes as per the "Live Stronger for Longer" Outcome Framework • promote innovative delivery of Strength & Balance programmes	Use this box to articulate local and regional activity to use falls data to improve system outcomes as per the "Live Stronger for Longer" Outcome Framework Use this box to also articulate local and regional activity to promote innovative delivery of Strength & Balance programmes WDHB response: Exercise providers who send out a regular Newsletter are continuing to highlight the availability of the NYMBL app and their own online resources to be used when at home or if unable to attend their regular community classes. Most of the community exercise providers have undertaken update training to ensure consistency and up to date delivery of the exercise programmes they provide.

27 August 2021 **Public**



Component	DHB Response
Report on the practical and concrete steps taken to deliver rehabilitation services in the community for patients requiring an integrated response on discharge or to prevent an admission to hospital ACC NAR pathway v8 (290620).pdf	Use this box to articulate your readiness to meet the non-acute rehabilitation objectives and how your DHB is establishing a rehabilitation service in the community allowing for seamless service delivery and accountability. ACC and partner DHBs have developed community service pathways** which can be used to enable identification of the subsequent appropriate community response required on discharge or to prevent an admission. Use this box to also articulate any challenges your DHB is having in establishing rehabilitation services within the community and what approach your DHB is using to overcome these challenges WDHB response: WDHB is developing a supported discharge proof of concept pilot.
Component	DHB Response
Report on any improvements in data driven osteoporosis management especially in alliance with Primary Care	

Using this reporting template provided, complete the following components of this Priority:

- Report the number of older people (65 and over, or younger if identified as a falls risk) that have received these services:

Component	DHB Response		
	# of People (Quarter)	**# of People (YTD)**	**Commentary / 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):	15	65	2 people under 65

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Number of people that received in-home strength and balance retraining (75+):	39	152 **Total = 217**	10 people over 90 There where another 44 people seen or contacted for falls prevention assessment and education this quarter who did not participate in the OEP for reasons such as medical or neurological conditions. Most of this group of people did require some intervention i.e. Education, information or onwards referrals to other support services i.e. Continence Nurse, Dietitian, Community Assessment Rehabilitation Team.

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):	546 (as determined by phone call to exercise group coordinators July 2021)	2067	Most exercise providers have mentioned an improved retention of participants over the last quarter. Quarterly phone contact has been maintained and coordinators were reminded about the ACC Nymbl App and the ongoing support and promotion by ACC of the Live Stronger for Longer website. All coordinators said they appreciated the quarterly phone contact and update from the Lead Agent.

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Report the number of older people (50 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 (aged 50-64 years of age):	**Total 12** NOF 0 Humerus 2 Wrist 1 Ankle 7 Vertebrae 1 Pelvis 0 Ribs 1 Other 0 3 Have history of past fracture 2 Have history of more than single fracture at time	**Total 30** NOF 1 Humerus 4 Wrist 7 Ankle 14 Vertebrae 2 Pelvis 0 Ribs 1 Other 1 6 Have history of past fracture 5 Have history of more than single fracture at time **Note: the figures for this age group have only been collected in Q3 and Q4**	Of these patients 13 were not on any bone strengthening meds at time fracture 2 were already on BSM: - 2 of them were on vitamin D **Following identification fracture** - 13 were recommended oral bisphosphonate - 0 were given aclasta - 1 was commenced on vitamin D - 1 is considering Vit D - all were recommended to have DEXA, so far 5 have been referred by FLN - 1 has had DEXA scan already - 2 are from out of town and referred to their DHB for follow-up - 5 are being processed - 0 has deceased

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<table>
<tr><td colspan="5">Report the number of older people (65 and over, or younger if identified as a falls risk) that have been seen <u>by the Fracture Liaison Service or similar fracture prevention service</u>:</td></tr>
<tr>
<td>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):</td>
<td>Total 26

NOF 3 Humerus 4 Wrist 5

Ankle 3 Vertebrae 2 Pelvis 0

Ribs 2

Other 7

Have history of past fracture 9

Have history of more than single fracture at time 2</td>
<td>Total 89

NOF 15 Humerus 8 Wrist 19

Ankle 14 Vertebrae 9 Pelvis 3

Ribs 3

Other 18

Have history of past fracture 18

Have history of more than single fracture at time 8</td>
<td rowspan="2">221

Actual is 298 from all age groups</td>
<td rowspan="2">Of these patients:
- 17 were on nil bone strengthening meds at time of fracture
- 1 was already on BSM
- 1 on riserdronate
- 4 were on vitamin D
Following identification fracture
- 1 had Aclasta in the ward
- 1 prescribed Vit D in ward
- 11 were recommended oral bisphosphonate
- 0 was recommended to start vitamin D
- 10 were recommended to have DEXA
- 4 have had DEXA scans already and 2 of those recommended for repeat
- 1 has deceased
- 11 are being processed</td>
</tr>
<tr>
<td>Number of people that have been seen by the Fracture Liaison Service or similar fracture prevention service

(75-84):

Number of people that have been seen</td>
<td>Total 16

NOF 5 Humerus 2 Wrist 1

Ankle 4 Vertebrae 2 Pelvis 1

Ribs 0

Other 1

Have history of past fracture 7

Have history of more than single fracture at time 1</td>
<td>Total 79

NOF 19 Humerus 14 Wrist 12

Ankle 9 Vertebrae 7 Pelvis 4

Ribs 7

Other 7

Have history of past fracture 27

Have history of more than single fracture at time 4</td>
</tr>
</table>

by the Fracture Liaison Service or similar fracture prevention service (85+):	Total 24 NOF 9 Humerus 2 Wrist 1 Ankle 0 Vertebrae 6 Pelvis 2 Ribs 3 Other 1 11 have history of past fracture 3 presented with more than single fracture at time	Total 100 NOF 24 Humerus 14 Wrist 5 Ankle 3 Vertebrae 19 Pelvis 14 Ribs 9 Other 12 18 have history of past fracture 3 presented with more than single fracture at time		

Component	DHB Response			Ministry of Health Guidance
	Classification	# Fall-Related Fracture	# Treated for Osteoporosis	
Report the number of older people (65 and over, or younger if identified as a falls risk) that have *been prescribed bisphosphonates (or dispensed if the number prescribed is unavailable), including 5mg/100ml Zoledronic acid infusions for treatment of osteoporosis*.	Bisphosphonate (Prescribed)	5 requested		Your DHB response should include both people who have suffered a fall-related fracture and those being treated for Osteoporosis.
	Bisphosphonate (Dispensed, if prescribed unavailable)	5	3	
	Zoledronic Acid Infusions (5mg/100) (Prescribed)	5 as inpatients		
	Zoledronic Acid Infusions (5mg/100) (Dispensed, if prescribed unavailable)			
	Vit D prescribed	10 prescribed	1	
Please note these numbers are an approximate of which box those treated fall into as the criteria is not well defined in most cases	Requested either bisphosphonate or Vit D after DEXA scan results	32		

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1.c Locally prioritised action(s)

- DHBs are to report 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 that it expects 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.

WDHB Response:

Below is the Injury Prevention Pressure Injury Management Program update.

1.d Activity in the community and primary care settings

- DHBs are to report on current activity in the community and primary care settings in particular to identify frail and vulnerable older people, with a focus on Māori and Pacific peoples, and put interventions in place to prevent the need for acute care and restore function

WDHB Response:

The DHB is actively engaged in the regional frailty program: Identify frailty best practice to support our health system to address the rising needs and changing nature of care needs for older people in our region.

Francis Health has been appointed by the Central Region Chief Executives to progress the identification of a regional system of integrated care for frail older people ensuring access and equity for Māori as a priority.
A frailty hui occurred on 5 May 2021. There was strong representation from Māori and Pacific as well as cross sector agencies such as ambulance, NASC, Corrections, Aged Care, and NGO sector. There was been subsequent testing of the ideas from the hui with regional older people's groups, interRAI Fellowes, ambulance sector and Bay of Plenty DHB and their use of the Lifecurve.

The findings and recommendations from this project will be presented to the Regional Partnership Group on July 5th 2021, where the region will consider the recommendations and priorities for implementation.

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Deliverable Part 2:

Report DHB activity to deliver on your regional commitment to a stocktake of dementia services, including:

2.a Implementation of the New Zealand Framework for Dementia Care

- Report on progress implementing your DHB's priorities for dementia services identified from the 2019/20 regional stocktake and the sector's priorities in the *Improving Dementia Services in New Zealand – Dementia Action Plan 2020-2025.*

WDHB Response:

Implement regional priorities as identified from the 2019 / 2020 National Dementia Stocktake.

The region continues to support the work of the National Dementia Framework Collaborative with the contribution of a Geriatrician with a special interest in dementia and a Planning and Improvement Manager (TAS).

The regional dementia programme will support the activities of the New Zealand Dementia Foundation and their funded 3 year work programme for the Cognitive Impairment Support for Practice and Education Refresh (CASPER).

Consultation on the regional dementia work programme is occurring with the Regional Medical Leads and the HOP Network.

Please note for reference purposes deliverables that also form part of the Health Aging performance story are being captured through reporting of Regional Service Planning Priorities as included in performance measure SS02.

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SS05: Ambulatory sensitive hospitalisations (ASH adult 45-64 years) (previously SI1)

DHB Name: Quarter four 2020/21

Summary information	
Data Source:	Ministry to provide data via NSFL web site and the DHB quarterly reporting website. https://nsfl.health.govt.nz/accountability/performance-and-monitoring/data-quarterly-reports-and-reporting/ambulatory-sensitive

• Target/expectation: as agreed in DHB Annual Plan
• Please provide your standardised and non-standardised ASH rate result for the quarter

DHB	Ethnic Group	12 months to March 2019	12 months to March 2020	12 months to March 2021
Whanganui	Maori	10,504	10,211	9,055
Whanganui	Pacific	-	-	-
Whanganui	Other	5,007	5,367	4,800
Whanganui	Total	6,154	6,380	5,691
National	Total	3,956	3,904	3,622

Commentary on your latest 12-month ASH data including specific actions that supported Maori and Pacific* health:	Rates continue to decrease, but remain high.
It would be helpful if you could provide some comments on how trends to date will inform planning for 2021/2022, including areas of focus and any impact from COVID:	Annual planning for 21-22 is completed.

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SS 06 Better help for smokers to quit quarterly reporting template - Hospital

2019/20 *Better help for smokers to quit* quarterly reporting template - Hospital (SS06)

DHB	Whanganui	*please select from the drop down box*
Reporting Quarter	Q4	*please select from the drop down box*

Results

	Events Coded	No. of people who smoke	No. of people given advice /support	Smoking rate	% of people who smoke given advice /support
ALL	2139	341	323.0%	15.9%	**94.7%**
Māori	472	145	134.0%	30.7%	**92.4%**
Pacific	40	8	8.0%	20.0%	**100.0%**

Name and contact details of person completing the report Rosie McMenamin rosie.mcmenamin@wdhb.org.nz

Please answer ALL of the questions below	
If the DHB's result for this quarter are below 95%, for any of "All", "Māori" and/or "Pacific" people, if "Pacific" numbers are sufficient, please explain why.	We have identified that a change in admin staff and process in our theatre ward has lead to not achieving our "All" or "Maori" targets this quarter. This has been investigated and I expect our DHB to be meeting or exceeding targets for next quarter.
Please identify what activities the DHB has undertaken this quarter to support this target?	We have had conversations around including the mandatory screening forms in the new "Mahi Tahi" paper based admission form in order to simplify the process for staff on the floor.
What are the barriers impeding the DHB ability reach the target and sustain it next quarter?	Staff turnover and orientation processes are different for each ward/unit/area. Consistency in approach in needed in order to make sure all staff are aware of what is expected of them in regards to mandatory screening. A new paper based admission form is being trialled in the hospital which has caused some confusion as mandatory screening is recorded separately.
Please note anything else you would like the Ministry to be aware of.	

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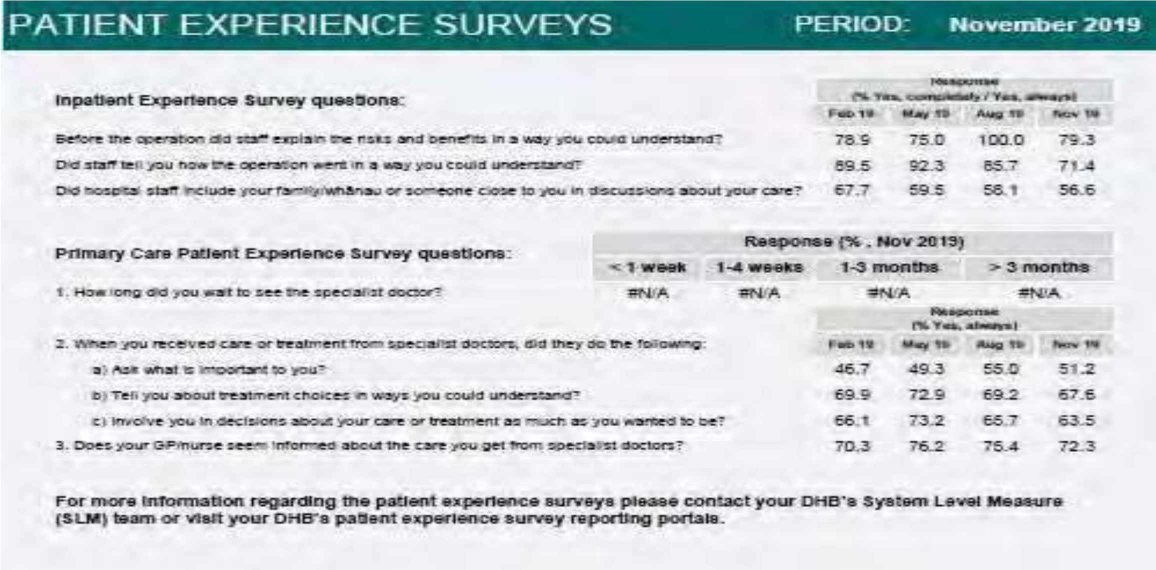
SS07: Planned Care Measures

Whanganui DHB Planned Care Performance for May 21



PATIENT EXPERIENCE SURVEYS

PERIOD: November 2019

Inpatient Experience Survey questions:	Feb 19	May 19	Aug 19	Nov 19
	Response (% Yes, completely / Yes, always)			
Before the operation did staff explain the risks and benefits in a way you could understand?	78.9	75.0	100.0	79.3
Did staff tell you how the operation went in a way you could understand?	89.5	92.3	85.7	71.4
Did hospital staff include your family/whānau or someone close to you in discussions about your care?	67.7	59.5	58.1	56.6

Primary Care Patient Experience Survey questions:	< 1 week	1-4 weeks	1-3 months	> 3 months
	Response (% , Nov 2019)			
1. How long did you wait to see the specialist doctor?	#N/A	#N/A	#N/A	#N/A

	Feb 19	May 19	Aug 19	Nov 19
	Response (% Yes, always)			
2. When you received care or treatment from specialist doctors, did they do the following:				
a) Ask what is important to you?	46.7	49.3	55.0	51.2
b) Tell you about treatment choices in ways you could understand?	69.9	72.9	69.2	67.6
c) Involve you in decisions about your care or treatment as much as you wanted to be?	66.1	73.2	65.7	63.5
3. Does your GP/nurse seem informed about the care you get from specialist doctors?	70.3	76.2	75.4	72.3

For more information regarding the patient experience surveys please contact your DHB's System Level Measure (SLM) team or visit your DHB's patient experience survey reporting portals.

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SS09 – Focus area 1 - Improving the quality of identity data within the National Health Index

DHB	Indicator 1	Indicator 2	Indicator 3
	New NHI registration in error (duplication)	Recording of non-specific ethnicity in new NHI registration	Update of specific ethnicity value in existing NHI record with a non-specific value
Northland	Outstanding	Outstanding	Outstanding
Waitemata	Outstanding	Outstanding	Outstanding
Auckland	Partial Achievement	Achieved	Achieved
Counties Manukau	Outstanding	Achieved	Achieved
Waikato	Outstanding	Outstanding	Achieved
Lakes	Achieved	Not achieved	Achieved
Bay of Plenty	Achieved	Outstanding	Outstanding
Tairawhiti	Outstanding	Outstanding	Outstanding
Taranaki	Achieved	Outstanding	Outstanding
Hawkes Bay	Achieved	Partial achievement	Outstanding
Central TAS	Achieved	Outstanding	Outstanding
Capital and Coast	Outstanding	Outstanding	Outstanding
Hutt Valley	Achieved	Achieved	Outstanding
Nelson Marlborough	Partial Achievement	Achieved	Achieved
West Coast	Outstanding	Outstanding	Outstanding
Canterbury	Achieved	Outstanding	Achieved
South Canterbury	Outstanding	Partial achievement	Achieved
Southern	Outstanding	Achieved	Outstanding

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SS09 Focus Area 2 – Improving the quality of data provided to the National Collection Systems (NCS)

DHB	Indicator 1	Indicator 2	Indicator 3
	NPF Links to NBRS, NMDS and NNPAC	**National Collections Completeness**	**Assessment of Data Reported to NMDS**
1011 Northland	Achieved	Achieved	Achieved
1021 Waitemata	Outstanding	Achieved	Achieved
1022 Auckland	Achieved	Outstanding	Achieved
1023 Counties Manukau	Achieved	Achieved	Achieved
2031 Waikato	Outstanding	Partial Achievement	Achieved
2042 Lakes	Not achieved	Partial Achievement	Achieved
2047 Bay of Plenty	Outstanding	Achieved	Achieved
2051 Tairawhiti	Not achieved	Outstanding	Achieved
2071 Taranaki	Achieved	Outstanding	Achieved
3061 Hawkes Bay	Partial achievement	Not Achieved	Achieved
3081 MidCentral	Not achieved	Partial Achievement	Achieved
3082 Whanganui	Not achieved	Not Achieved	Achieved
3091 Capital and Coast	Partial achievement	Outstanding	Achieved
3092 Hutt Valley	Not achieved	Partial Achievement	Achieved
3093 Wairarapa	Not achieved	Not Achieved	Achieved
3101 Nelson Marlborough	Achieved	Not Achieved	Achieved
4111 West Coast	Achieved	Achieved	Achieved
4121 Canterbury	Not achieved	Partial Achievement	Achieved
4123 South Canterbury	Not achieved	Outstanding	Partial Achievement
4160 Southern	Not achieved	Outstanding	Achieved

SS09 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)
Audits of the system done on a weekly basis to ensure the workflow and processes for submitting this information achieves the required pass rate.	*All errors returned from WDHB PRIMHD extract are corrected prior to the next download to the ministry. WDHB will be sending monthly extracts to allow clinicians time to record their data in the PAS. Percentages for PRIMHD have been in the 98%+ pass rates. Checking process to ensure accuracy in the system are via reports we use to cross reference the data and our Clinical Portal system.*

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SS10 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									
	Total Population			**Maori ethnicity**			**Pacific ethnicity**		
Name of facility	Number stayed less than 6 hours	Total Presentations	% managed within 6 hours	Number stayed less than 6 hours	Total Presentations	% managed within 6 hours	Number stayed less than 6 hours	Total Presentations	% managed within 6 hours
April	1576	1721	92%	388	418	93%	33	36	92%
May	1674	1812	92%	446	475	94%	43	43	100%
June	1769	1931	92%	452	490	92%	33	37	89%
DHB total	**5019**	**5464**	**92%**	**1286**	**1383**	**93%**	**109**	**116**	**94%**

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SS11 Faster Cancer Treatment

	Achievement 6-month quarter	**Achievement 3-month quarter**
DHB	**Jan - Jun 2021 Tracking**	**Apr - Jun 2021 Tracking**
Auckland	90.8%	90.7%
Bay of Plenty	84.4%	85.7%
Canterbury	93.8%	93.0%
Capital and Coast	87.0%	85.4%
Counties Manukau	84.4%	83.3%
Hawkes Bay	86.7%	100.0%
Hutt Valley	87.9%	95.8%
Lakes	90.6%	77.8%
MidCentral	89.7%	95.2%
Nelson Marlborough	84.3%	82.7%
Northland	59.2%	54.7%
South Canterbury	88.5%	90.9%
Southern	59.2%	65.4%
Tairawhiti	90.9%	86.7%
Taranaki	68.2%	66.7%
Waikato	79.4%	84.0%
Wairarapa	88.6%	88.9%
Waitemata	89.1%	90.7%
West Coast	77.8%	100.0%
Whanganui	82.1%	85.7%
National total	**83.5%**	84.6%

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SS12 Engagement and obligations as a Treaty partner 20/21

Activity	Code	deliverable	Q_4
Strategic	1	Maintain partnership and close working relationships between WDHB and Hauora Iwi (HAI), through:	
	2	Regular joint hui (EF)	
	3	Review Memorandum of Understanding (MoU) between WDHB and HAI boards in 2020 (EF)	
	4	Involvement of HAI members in all key DHB strategic discussions and decisions (EF)	
	5	Consultation with HAI and joint board endorsement of the new WDHB He Hāpori Ora Thriving Communities Strategy Document 2020 – 2023 (EF)	
	6	Message from HAI included in the foreword of the WDHB 2020/21 annual report (EF)	
	7	Joint board monitoring of equity measures in WDHB Annual Plan and pro-equity implementation work plan (EF)	
	8	HAI representation on all interviews for executive positions (EF)	
	9	HAI representation on combined statutory advisory committees and performance review for chief executive (EF)	
	10	A follow-up facilitated partnership hui, with WDHB board and HAI, to further embed responsibilities under the Treaty, the five principles, pro-equity and monitoring processes. (EF)	
Waitangi Tribunal	11	Plan and begin the roll out of embedding obligations under the five Treaty principles in updating key policies and procedures. (EF) *In progress*	
	12	Continue to participate in the design and implementation of the proposed Ministry of Health Treaty framework, to be set out in the new Māori Health Action Plan, to ensure WDHB meets its statutory obligations, as prescribed by the Tribunal and its interpretation of the Treaty clauses under the NZ Public Health and Disability Act 2000. (EF)	
Partnership	13	Implement recommendations from the WDHB consumer involvement review 2020, including Te Pukaea and grow the number of Māori members to 50% of the total membership (EOA)	
	14	Implement Term of Reference for a Māori reference group to provide Māori community and health expertise advice to key service developments, service improvements, development of Māori health policy and frameworks to ensure that we have a wider Te Ao Māori lens applied to our work (EF) *Delayed development now prioritised for Q1 &Q2 2021-2022 enabling inclusion of reforms direction.*	
	15	Develop a work programme between the WDHB and HAI boards to measure improvement in equity for Māori across annual plan equity-oriented activity indicators and the WDHB pro-equity work programme (EF) *Formal workplan not established - joint boards identify and work on key priorities areas and receive reports on equity*	
	16	Continue support for the Central Region's Iwi relationship boards Te Whiti ki te Uru forum and their alliance with the Central Region CEs and Chairs (EF)	
	17	Continue participation in the Central Region GM Māori forum to influence across the region and share learnings and initiatives. (EF)	
	18	Continue participation in national Māori health leadership forum Tumu Whakarae. (EF)	
Pro-equity	19	Continue to implement the WDHB Pro-equity Check-up Actions Implementation Plan 2019-21 report under 5 recommendations:	

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	20	Strengthen organisational leadership and accountability for equity (EF)	
	21	Build Māori workforce and Māori health and equity capability (linked to workforce development) (EOA)	
	22	Improve transparency in data and decision making (EOA)	
	23	Support more authentic partnership with Māori. (EF)	
Leadership	24	Continue to provide professional development (training) for DHB leadership on the impact of racism, impact on colleagues and workforce, the impact on quality outcomes for patients and their whānau, and the use of equity tools and methodologies. (EOA)	
	25	Introduce mechanisms that will be there to support Māori staff, if they have been victims of racism, as leadership and the organization addresses the impacts of racism (EF)	
	26	Continue to support equity professional development to local provider partner leaders (EOA)	
	27	Apply equity methodology and monitoring to decision-making processes including commissioning, service delivery models and service changes (EOA) *Training completed and staff developing confidence is using the tool.*	
	28	Continue to support development and provision of education for elected board and committee members in understanding the impact of racism and colonisation on health outcomes for Māori whānau and the use of equity tools and methodologies. (EOA)	
	29	Continue to provide cultural safety education as part of WDHB board member local induction programme (EOA)	
	30	Continue to role model WDHB values and WDHB tikanga o Whanganui practices. (EF)	

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SS13 FA1 Long Term Conditions - reporting template 2020-21 - **Quarters 2 & 4 DHB** Whanganui

Description	Specific actions including timeframe and milestones	Progress, gaps, challenges Quarter 4 F2020-2021 (April to June 2021)
Actions with an equity focus to support people with LTC to self-manage. Reference: https://www.health.govt.nz/publication/self-management-support-people-long-term-conditions	Can you please describe what programmes are in place in your region to provide community out-reach services to support people with long term conditions, in particular in how you are meeting the needs of our high-risk populations for Māori and Pasifika peoples and their whanau. In accordance with the Minister's Letter of Expectation for 20/21 can you describe how PHOs have been incentivised to improve equitable health outcomes from long term conditions, with a focus on our high-risk populations of Māori and Pasifika peoples.	Equity measured with just in time data available in all practice teams. Data is analysed and informs discussion and activity at clinical govenance, clinical forums and peer reviews. Data has informed SIA programs however reporting on these is not due until November due to the delay in starting (covid related). Working through HQSC, WRHN joined with interested colleagues nationally to revise recall guidelines recognizing that this was a national area for improvement. This work has not been completed due to competing priorities. Practice facilitators have worked with individual practitioners within practice teams to focus on system wide improvements as well as the PHO proactively pulling data to assist with identification of the districts most vulnerable population for recalls. Practice teams have access to PowerBi, and DR info to gain patient lists and data, to help then ensure equity of access for patients being recalled. Changes from national CVD and diabetes guidelines have been incorporated into Predict and practices educated on changes.
Actions with an equity focus to build health literacy. Reference: https://www.health.govt.nz/publication/framework-health-literacy	Please outlined what health literacy approaches are used to ensure you are building capability for people with long term conditions. What tools and resources are you using, how are you monitoring the impact of what you are doing, and how are these being tailored to meet culturally diverse needs, especially for Māori and Pasifika peoples.	See below

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SPECIFIC SERVICES - OPTIONAL Gout: What specific services (if any) your DHB/PHOs are providing for gout in primary care and identify any barriers that prevent initiation or development of services. Chronic Kidney Disease (CKD): What specific services (if any) your DHB/PHOs are providing for CKD in primary care and identify: 1) any barriers that prevent initiation or development of services.2) actions with an equity focus to support people with CKD to self-manage.	Describe your programme/s to address improved gout outcomes, especially around medicine adherence, and specifically comment on whether any cost or other barriers are being experienced to achieve sustained medicine adherence for optimal gout management. Describe your approach in identifying early risk of CKD and what systems are in place to ensure people are supported with self-management and / or have timely access to specialist services. Comment on what system changes you would like to see, to improve integrated service delivery in this area and specific improvement initiatives you would like to see us focus on?	GOUT: The GOUT STOP programme has a pro equity system wide approach with a focus on building knowledge and awareness of gout and its management, dispelling myths, increasing health literacy, and improving access to information and support across the Whanganui district. General practice's role is to identify patients who are untested and/or have poor management. Using PowerBi data practices have undertaken these audits and recalled patients to get them tested and on the right medication dosage. Using an advanced form and a set medication regime on Medtech (can be modified by GP based on individual patients) consistency of testing and prescribing is showing patients with poor management is decreasing. For those patients not engaged with their general practice the community pharmacies have all completed training and been resourced to have gout consultations with patients, do uric acid tests when appropriate and refer onto general practice if they are not on any form of gout prevention medication. When the patient returns with their prescription the pharmacies continue to engage with the patient over a 3 month period, providing further education, blister packs, uric acid testing as a motivation to continue and referral to the kaiāwhina if patient would like extra support. The kaiāwhina provides support to patients to; • Support them to go to their general practice rather than buying OTC pain relief and/or accessing WAM for acute attacks. • Whanau support by contacting patients and going to them to provide gout education, uric acid testing and an opportunity to work with the wider whanau. • Operating an 0800 number for easy access 24/7 for advice and support • Liaising with pharmacies and receiving referrals from them The wider community education is also part of the kaiāwhina role however may also include others dependent on the needs of the group, workplace, sport etc that have made contact e.g., recently the gout team engaged with a workplace outside of Taihape to provide a workshop to their 45 male employees. The workshop was based on men's health using Te Whare Tapa Wha model of health with breakout groups comprising gout, smokefree, blood pressure, flu vaccinations and mental health. Another example is a gout workshop that was held by a whanau ora worker at the top end of the Whanganui awa with whanau has also led to a partnership with the local practice to work alongside a workplace where the workers are unable to access the practice due to their remote location and work hours, so team members are going onsite to work with staff and get medications etc to them. This is not focused solely on gout but looking at the bigger picture again of employee health and access to health services. Raetihi health are leading this co-design approach with the support of the WRHN team and WDHB Nurse Practitioner Renal. Whanau were identified through uncontrolled diabetes and hypertension and invited along to an initial get together with their

		whanau members in March. These get togethers are monthly (to date 8-15 whanau have attended each session) and have a focus for each month however conversations are led by stories from those present and invited local guests to tell their story (in relation to topic). Raetihi health staff run an open clinic alongside these sessions for all those present to update ob's and have conversations if they want to and each session is ended with kai and mingling. To date conversations have covered dialysis, gout, physical activity, general wellness (weather prevented dietician from getting there) and nutrition is the next one. Chronic kidney disease: Chronic kidney disease Ruapehu project to reduce progression of CKD for identified patients with high BP, diabetes, uric acid: (EOA) A WRHN team member facilitates and ensures the sessions meet community needs. Following stories/speakers the conversation is drawn back to the participants and what their needs are, what matters to them, what they would like to see next and how best that support can be provided. The approach dictates how health professionals interact with individuals and their community. Consumers and their whanau drive topics of relevance where stories are discussed, and myths dispelled. This has demonstrated greater awareness and engagement within the community and has led to proactive activities being initiated by those who attend for example a walking group has been established, there is greater participation in working with the practice team nurses and iwi providers and GP team is working collaboratively out in the community with workplaces and remote communities. The intention is to take a continuous quality improvement approach gaining feedback from participants and whanau members improving upon the approach being taken. This approach was later than anticipated in commencing due to the impact of COVID 19 lockdown. However monthly blood pressure results are being reviewed at a practice specialist and patient level with HBA1C data being reviewed 3 monthly. Overall comparisons will be analysed in November to see if clinical markers for those participating have been influenced in any way and learnings form this will inform further changes in the approaches used.

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SS13: FA2 Diabetes services

Select DHB of Domicile:	**Whanganui**	**Period**	**Q4 2020-21**

PP20 Improved management for long term conditions (Diabetes)
Please see the Instuctions tab and the Example Template tab

Numbers of people with diabetes

PHO register total (all PHOs)			*VDR estimate count of diabetes prevalence as at 31 Dec 2019*			*Estimated completeness of diabetes ascertainment by PHOs*		
Denominator								
	Ages 15-74 only	**All ages**		**Ages 15-74 only**	**All ages**		**Ages 15-74 only**	**All ages**
Maori	915	1,034	Maori	1010	1,142	Maori	90.6%	90.5%
Pacific	100	109	Pacific	103	110	Pacific	97.1%	99.1%
Other	1,696	2,377	Other	2081	2,931	Other	81.5%	81.1%
Total	2,711	3,520	**Total**	3,194	4,183	**Total**	84.9%	84.2%

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

	Numerator					
	Number with HbA1c ≤ 64mmol	**Number with HbA1c ≥ 65mmol and ≤ 80mmol**	**Number with HbA1c ≥ 81mmol and ≤ 100mmol**	**Number with HbA1c ≥ 101mmol**	**Total number with any available HbA1c result**	**Total number with no available HbA1c result**
Māori	432	182	112	78	804	**111**
Pacific	42	21	14	6	83	**17**
Other	1,064	326	128	48	1,566	**130**
Total	**1,538**	**529**	**254**	**132**	2,453	**258**

Rate based on total PHO/practice count rate

	% HbA1c ≤ 64mmol	**% HbA1c ≥ 65mmol and ≤ 80mmol**	**% HbA1c ≥ 81mmol and ≤ 100mmol**	**% HbA1c ≥ 101mmol**	**Percentage with any available HbA1c result**	**Percentage with no available HbA1c result**
Māori	**47%**	**20%**	**12%**	**9%**	**88%**	**11%**
Pacific	**42%**	**21%**	**14%**	**6%**	**83%**	**16%**
Other	**63%**	**19%**	**8%**	**3%**	**92%**	**5%**
Total	**57%**	**20%**	**9%**	**5%**	**90%**	**7%**

SS13 FA3 – Cardiovascular Disease Quarterly Reporting template 2021/21 – Quarter 4

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.

What, if any calculator, based on the 2018 algorithms, do you have available for use, or are you waiting for the national calculator solution?
• NZ Health Equation through the updated predict electronic tool
How will the funding provided under the "Heart Health contracts" be used in the year 2020/2021
• Supporting practice facilitators in supporting general practice teams with CVD recalls • Community health worker/ phlebotomist assists practices with capturing screening data and track and trace of hard-to-reach community • Contributing to annual costs of predict electronic tool
How are PHOs supporting practices to risk assess (for the first time) people in new groups that are now included in the denominator? e.g people with a severe mental illness, or younger aged Maori and Pacific patients.
There are not any changes to the previous quarters report with practice teams focusing on vaccination programmes for the coming months. • Raised awareness of equity at each primary care forum • Practices have been educated about change and expansion of recalls to include these groups • Raising awareness through planned training days with practice nurses • Education with health coaches and health improvement practitioners (Integrated mental health and addictions programme) to improve health literacy and self-management) • Clinical governance updates through e newsletter • Most practices have identified these new groups as a key focus area under their Services to Improve Access (SIA) quality plans.
How is annual recall of high-risk patients co-ordinated?

SS17 Annual Planning Quarter 4 Reporting for Whānau Ora

Whānau Ora approaches to service delivery

The Ministry is keen to promote (to Ministers, across the Ministry and the health sector) the positive work DHBs are doing and/or undertaking to provide whānau-centred approaches within their regions.

Could the DHB please provide 4-5 highlights (bullet points), or more, of specific whānau-centred approaches to service delivery that are currently in place within the DHB, in partnership with the health sector, or that the DHB is in the process of developing or contracting, for 2020/21; and the impact these are having on Māori health outcomes.

These highlights should show how the DHB has made progress and measurable impact for whānau by:

- contributing to the strategic change for whānau ora approaches within DHB systems and services, across the district, and demonstrate meaningful activity moving towards improved service delivery
- supporting and collaborating, including through investment, the Whānau Ora Initiative and its Commissioning Agencies and partners, and identification of opportunities for alignment. (All Pacific priority DHBs need to include Pasifika Futures in their activity).

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Progress on delivering Whānau Ora	*Impact for Māori*
1 Opportunity to partner: amalgamation of DHB funded Māori health provider and Commissioning agency funded Māori health provider – korero has begun to integrate the funded services into one service that better meets the needs of the Waimarino community. Includes exploring opportunities with other agencies. Focused work in 2021-22.	▪ Māori led; community led service to effectively meet the needs of a rural Māori community. ▪ Outcomes based contract to meet the aspirations of the Iwi and the community aligned with the DHBs Strategy Document He Hāpori Ora – *inserted below*
2 Moving beyond partnership: Long term relationships has enabled officers of the Whanganui DHB to work 'beyond partnership' that is to shift the power from funder to provider led. Achieved through a provider alliance, Māori health Outcomes Advisory Group undertaking the planning, design, funding, implementation and evaluation of services that are focused on Māori or Māori population groupings across communities. Building Māori provider capacity and capability. A recent example is the He Puna Ora service, funded as the fourth such DHB initiative by the Ministry of Health.	Shifting leadership and power to Māori providers from funder leadership.
3 Māori designed and led service for hapū Mama and wahine with children under three years impacted by drug and alcohol abuse and their whanau. He Puna Ora. Purpose: is to work assertively in our communities with whānau and others, driven by Mātauranga Māori to ensure that an integrated service is established and implemented using a mix of wānanga and case management. Service Focus: is on hapū māmā, and/or whānau with pēpi/Tamariki who have significant issues with alcohol and other drugs, to increase and facilitate access to health and social support services and mitigate harm to both themselves, their pēpi, future tamariki and whānau. Service objectives: Expected (but not limited) to: ▪ Extensive outreach and support to hapū māmā, and/or whānau with pēpi/tamariki, and who have significant issues with alcohol and other drugs, to increase and facilitate access to health and social support services and mitigate harm to both themselves, their pēpi, future tamariki and whānau. ▪ Using a whānau ora model to work with whānau to address the needs as identified by them to strengthen the whānau environment. ▪ Deliver care with a skilled workforce (noting that "skilled" includes the skill and expertise pertaining to kaiawhina/kaitiaki, Tohunga and other non-clinical roles) supported by leadership and other robust management structures.	Services designed for Māori whānau and delivered though a te Ao Māori lens, whānau centred and based on the seven elements of whānau ora. As above. Independent evaluation is continuing and will be shared with the MoH in 2021-22.

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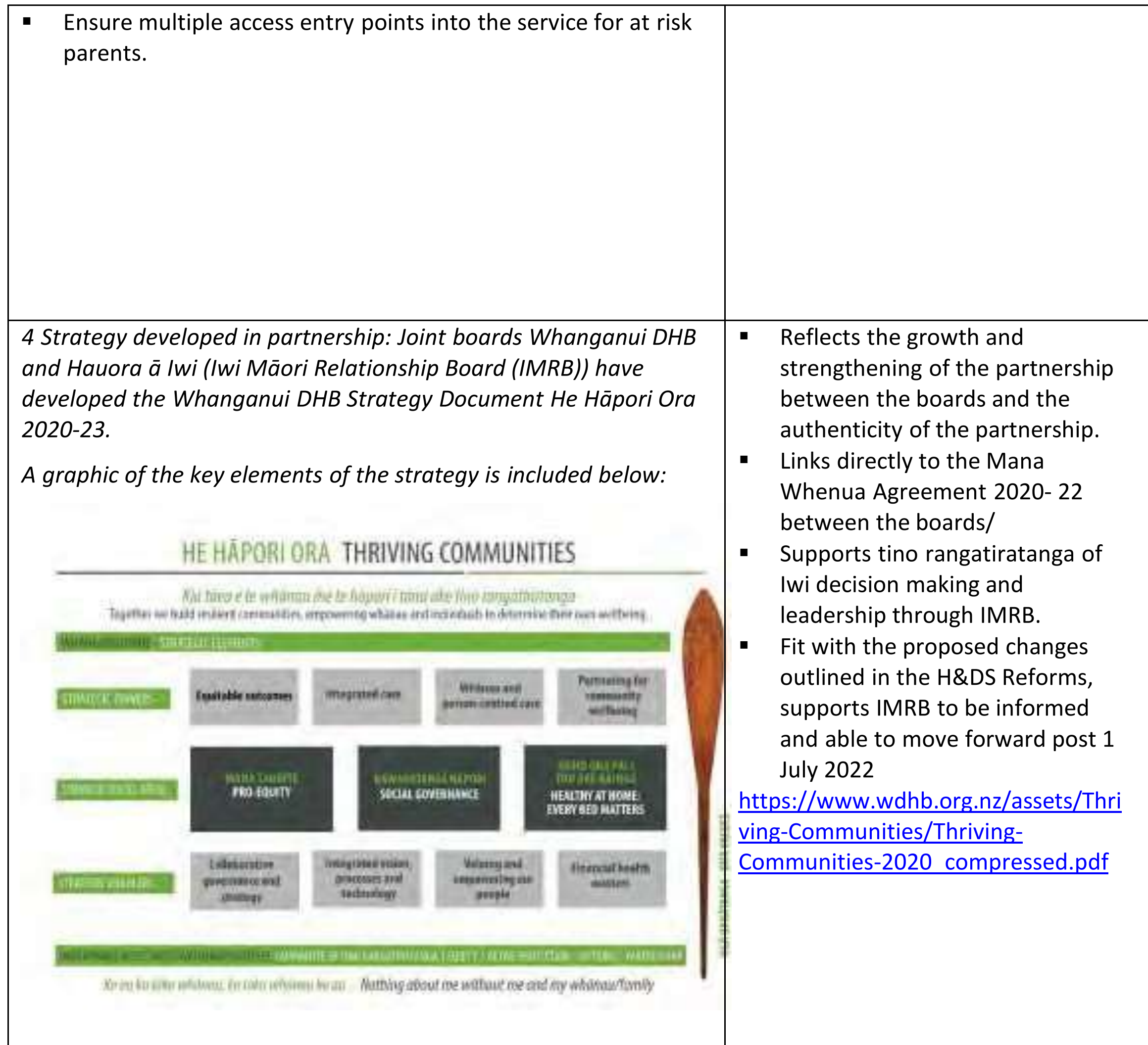
▪ Ensure multiple access entry points into the service for at risk parents.	
4 Strategy developed in partnership: Joint boards Whanganui DHB and Hauora ā Iwi (Iwi Māori Relationship Board (IMRB)) have developed the Whanganui DHB Strategy Document He Hāpori Ora 2020-23. *A graphic of the key elements of the strategy is included below:*  	▪ Reflects the growth and strengthening of the partnership between the boards and the authenticity of the partnership. ▪ Links directly to the Mana Whenua Agreement 2020- 22 between the boards/ ▪ Supports tino rangatiratanga of Iwi decision making and leadership through IMRB. ▪ Fit with the proposed changes outlined in the H&DS Reforms, supports IMRB to be informed and able to move forward post 1 July 2022 https://www.wdhb.org.nz/assets/Thriving-Communities/Thriving-Communities-2020_compressed.pdf

End of report.

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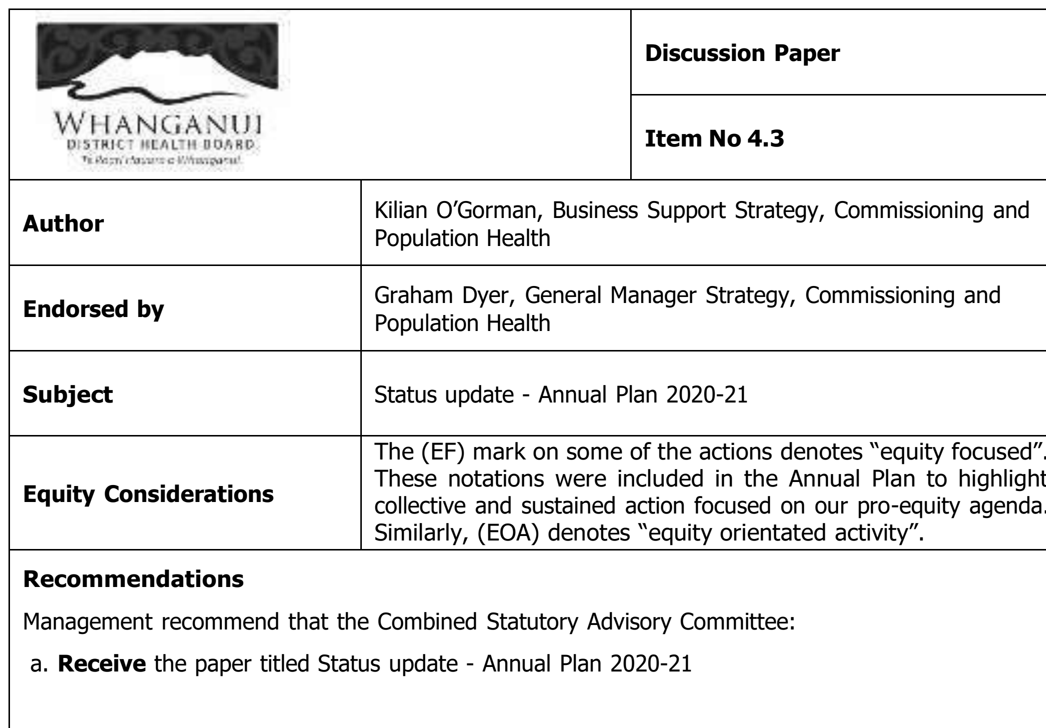

WHANGANUI DISTRICT HEALTH BOARD	**Discussion Paper** **Item No 4.3**
Author	Kilian O'Gorman, Business Support Strategy, Commissioning and Population Health
Endorsed by	Graham Dyer, General Manager Strategy, Commissioning and Population Health
Subject	Status update - Annual Plan 2020-21
Equity Considerations	The (EF) mark on some of the actions denotes "equity focused". These notations were included in the Annual Plan to highlight collective and sustained action focused on our pro-equity agenda. Similarly, (EOA) denotes "equity orientated activity".

Recommendations

Management recommend that the Combined Statutory Advisory Committee:

a. **Receive** the paper titled Status update - Annual Plan 2020-21

1. Purpose

This paper provides a comprehensive status update on Quarter 3 milestones against various initiatives within the 2020-21 Annual Plan. The table below shows the Ministry of Health's overall ratings for Quarters 1 to 3 and Preliminary ratings for Quarter 4.

Not applicable	Other / Note	Achieved overall	Partially achieved	Not achieved

Policy Area	Quarter 1	Quarter 2	Quarter 3	**Quarter 4 Preliminary Ratings**
Better population health outcomes supported by primary health care	Partially achieved	Partially achieved	Partially achieved	Partially achieved
Better population health outcomes supported by strong and equitable public health services	Partially achieved	Not achieved	Partially achieved	Partially achieved
Give practical effect to He Korowai Oranga – the Māori Health Strategy	Achieved overall	Achieved overall	Achieved overall	Achieved overall
Improving Child wellbeing	Partially achieved	Partially achieved	Partially achieved	Partially achieved
Improving Mental wellbeing	Achieved overall	Partially achieved	Partially achieved	Not achieved
Improving Sustainability	Achieved overall	Achieved overall	Partially achieved	Partially achieved
Improving wellbeing through Prevention	Partially achieved	Partially achieved	Partially achieved	Not achieved

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Give practical effect to He Korowai Oranga – the Māori Health Strategy

Subsection	Activity	deliverable	Q_1	Q_2	Q_3	Q_4
2.1.1 Engagement and obligations as a treaty partner	Strategic	Maintain partnership and close working relationships between WDHB and Hauora Iwi (HAI), through:				
		Regular joint hui (EF)				
		Review Memorandum of Understanding (MoU) between WDHB and HAI boards in 2020 (EF)				
		Involvement of HAI members in all key DHB strategic discussions and decisions (EF)				
		Consultation with HAI and joint board endorsement of the new WDHB He Hāpori Ora Thriving Communities Strategy Document 2020 – 2023 (EF)				
		Message from HAI included in the foreword of the WDHB 2020/21 annual report (EF)				
		Joint board monitoring of equity measures in WDHB Annual Plan and pro-equity implementation work plan (EF)	Scheduled for next joint boards	Partial, preliminary work under way	Partial, preliminary work under way	
		HAI representation on all interviews for executive positions (EF)				
		HAI representation on combined statutory advisory committees and performance review for chief executive (EF)				
		A follow-up facilitated partnership hui, with WDHB board and HAI, to further embed responsibilities under the Treaty, the five principles, pro-equity and monitoring processes. (EF)	COVID. To be actioned 2021.			
	Waitangi Tribunal	Plan and begin the roll out of embedding obligations under the five Treaty principles in updating key policies and procedures. (EF)				
		Continue to participate in the design and implementation of the proposed Ministry of Health Treaty framework, to be set out in the new Māori Health Action Plan, to ensure WDHB meets its statutory obligations, as prescribed by the Tribunal and its interpretation of the Treaty clauses under the NZ Public Health and Disability Act 2000. (EF)				

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	Partnership	Implement recommendations from the WDHB consumer involvement review 2020, including Te Pukaea and grow the number of Māori members to 50% of the total membership (EOA)				
		Implement Term of Reference for a Māori reference group to provide Māori community and health expertise advice to key service developments, service improvements, development of Māori health policy and frameworks to ensure that we have a wider Te Ao Māori lens applied to our work (EF)				Delayed development now prioritised for Q1 &Q2 2021-2022 enabling inclusion of reforms direction
		Develop a work programme between the WDHB and HAI boards to measure improvement in equity for Māori across annual plan equity-oriented activity indicators and the WDHB pro-equity work programme (EF)				Formal workplan not established - joint boards identify and work on key priorities areas and receive reports on equity
		Continue support for the Central Region's Iwi relationship boards Te Whiti ki te Uru forum and their alliance with the Central Region CEs and Chairs (EF)				
		Continue participation in the Central Region GM Māori forum to influence across the region and share learnings and initiatives. (EF)				
		Continue participation in national Māori health leadership forum Tumu Whakarae. (EF)				
	Pro-equity	Continue to implement the WDHB Pro-equity Check-up Actions Implementation Plan 2019-21 report under 5 recommendations:				
		Strengthen organisational leadership and accountability for equity (EF)				
		Build Māori workforce and Māori health and equity capability (linked to workforce development) (EOA)				
		Improve transparency in data and decision making (EOA)	Not In progress.	Draft developed to be refined – in progress	In progress	
		Support more authentic partnership with Māori. (EF)				
	Leadership	Continue to provide professional development (training) for DHB leadership on the impact of racism, impact on colleagues and workforce, the impact on quality outcomes for patients and their whānau, and the use of equity tools and Methodologies. (EOA)		Planning under way		

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		Introduce mechanisms that will be there to support Māori staff, if they have been victims of racism, as leadership and the organization addresses the impacts of racism (EF)		Current approach needs refinement in line with education programme		
		Continue to support equity professional development to local provider partner leaders (EOA)				
		Apply equity Methodology and monitoring to decision-making processes including commissioning, service delivery models and service changes (EOA)		In use – needs further refinement	In progress	
		Continue to support development and provision of education for elected board and committee members in understanding the impact of racism and colonisation on health outcomes for Māori whānau and the use of equity tools and Methodologies. (EOA)				
		Continue to provide cultural safety education as part of WDHB board member local induction programme (EOA)				
		Continue to role model WDHB values and WDHB tikanga o Whanganui practices. (EF)				
2.1.2 Māori Health Action Plan (MHAP) - accelerate the spread and delivery of Kaupapa Māori services	Identify initiatives and opportunities to accelerate the spread of kaupapa Māori services and commissioning for whānau ora outcomes by:	applying equity Methodologies to commissioning process across all new and expiring contracts for service and identify initiatives and opportunities to confirm and maximize investment that meets the needs of Māori (EOA)		In use – needs further refinement		
		continuing to work in partnership with Iwi health organisations through the Māori Health Outcomes Advisory Group (MHOAG) to develop services that meet the needs of Māori whānau (EOA)				
		review (MHOAG) Terms of Reference (EF)				
		continuing to contract with kaupapa Māori service providers to maximise the use of whānau ora outcomes focused contracts:				
		maximise opportunities presented through the COVID -19 response to improve funding models and models of care and delivery (EF)				
		implement any changes (EF)				
		constantly seeking opportunities to provide a service in a kaupapa Māori setting/way, especially with any new initiative and funding opportunities (EF)				

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2.1.3 MHAP – shifting cultural and social norms	Addressing bias in decision making:	initiate a more focused programme on biases in best practice that affects patient outcomes – building on the examples from medical bodies and programmes in other DHBs. Establish an ongoing forum for Māori staff to meet and feedback on activities that achieve equity in health outcomes for Māori whānau, WDHB Māori health strategy and policy initiatives and whānau focused models of service delivery – monitoring and audit (EF)				
		continue to provide a professional development (training) for DHB leadership and staff on the impact of racism, impact on colleagues and workforce, the impact on quality outcomes for patients and their whānau (EF)				
		include learnings from other DHBs on programmes, speakers and tools to support staff. (EF)				
	Enabling staff to participate in cultural competence and cultural safety training and development:	continue Hāpai te Hoe programme – WDHB policy confirms mandatory attendance for all WDHB staff and board members (EF)				
		enable the role of Kaitakitaki, Te Hau Ranga Ora (WDHB Māori health services team), in providing advice and support to executive leads and their teams (EF)				
		maintain the role of the Haumoana service (WDHB Māori health service) across all services to support whānau (Māori and non- Māori) and provide cultural support for staff 24 hours, seven days per week (EF)				
		ensure leaders 'walk the talk 'and more specifically addresses racism and discrimination within the frame of the organisation's values and expectation that racism and discrimination of any sort is unacceptable. (EF)	Education ongoing to support leaders	Planned approach – tested with staff – to be finalised	In progress	
	WDHB Pro-equity Check Up implementation plan identifies a programme of work that builds on what the DHB is already undertaking to shift cultural and social norms.	continue to deliver Hapai te Hoe to all new staff prior to commencing work and as the first two days of the DHB orientation programme (EF)				
		continue to include key community partners and external agencies i.e. St John, Hospice Whanganui, UCOL Tutors Nursing Faculty, UCAL Nursing students, NZ Police, Coronial Transport Services and Local Funeral Directors (EF)				
		develop and implement Hāpai te Hoe extension course (Te Waka Hourua) that builds on orientation HTH and focusses on whānau ora models of care and DHB values (EF)				
		support the implementation of health discipline specific cultural frameworks to support professional development and best practice. (EF)				

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2.1.4 MHAP – reducing health inequities – the burden of disease for Māori	Data	develop and implement pro-equity tools and Methodology to guide decision making for investment and procurement (EF)		Needs more refining – in progress		
		support development of a dashboard to monitor progress towards equity for Māori across priority indicators. (EF)	In progress			
	Reporting	reporting for equity to the statutory advisory committees and the Joint boards of WDHB and HAI. (EF)	Reporting tool to be developed	Draft developed to be refined – in progress	In progress	
2.1.5 MHAP – strengthening system settings	Activity	Driving a commitment to pro-equity approach through governance support and executive leadership. (EF)				
		Development of clearer prioritisation frameworks that embed equitable outcomes actions, ethnicity in all data and equity in all data analysis which have governance endorsement and that inform annual prioritisation planning. (EF)		Work has started – needs refining		
		Use contractual opportunities to increase equity-based reporting from contracted providers	Not Met. To be progressed	Not Met work will be progressed Q3 Q4	In progress	

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Improved Sustainability						
Subsection	**Activity**	**deliverable**	**Q_1**	**Q_2**	**Q_3**	**Q_4**
2.2.1 Improved out year planning processes	Improving sustainability	Development of clearer prioritisation frameworks that have governance endorsement and that inform annual prioritisation planning		Partial Prioritisation framework has been developed for certain class of assets. Needs to be enhanced for all asset classes. Prioritisation of new investments is embedded in the organisational strategy and implementati on plan		
		Prioritisation framework agreed		Partial See above		
		Development of 3 to 5 year rolling operational plans that can inform integrated annual planning with clearer impacts on capital, workforce requirements and opportunities for service redesign		Partial Sustainability initiatives for cost savings have 3 year plans and targets and are tied into 20/21 annual plan. Capital planning takes a five		

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				year view of asset replacement and new capital asset purchases required to meet annal plan objectives.		
		Draft completed				
		Finalised for 2020/21 view			Still working on developing plans. Will be ongoing development over the next 12 months.	
		Quality review across Provider Arm service level agreement (price volume schedule) to confirm accuracy of data collections and better inform monitoring and planning		Partial Monthly reviews are completed of provider arm volumes but further work continuing to improve the robustness of the review process to improve the quality and reliability of data on an on-going basis across all parts of the provider arm.		

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		Enhanced senior management involvement to ensure planning assumptions are robust and that executive leadership is clear on the business impact of outer year forecasts.				
		Co-ordinated project management for clearer alignment of strategic activity, improved allocation of resources and better monitoring of the strategic agenda		Partial WDHB has appointed a project manager to provide project mngment framework over strategic projects. BA has been seconded to support the project manager. The project mngment function is expected to be operating fully in Q3-4		
	Enhanced decision support tools and improved forecasting and budgeting to achieve better stakeholder engagement	Better and more consistent monitoring across service groups				
		Consistent service group dashboards in place				
		Better decision support informs forecasting and budgeting for 2021/22			Financial dashboards have been developed. Improved financial reporting and sustainability reporting provides better insights to inform decisions.	A system approach to strengthening primary care response proposal has been endorsed by key parties and successful in accessing DHB / MOH

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						innovations funding 1
2.2.2 Savings plans	"69,000 Beds"	Avoid unnecessary hospital admissions	On-going. A single team will be stablished to provide immediate assessment and intervention for the deteriorating patient	A system approach to strengthening primary care response proposal has been endorsed by key parties and successful in accessing DHB / MOH innovations funding	Ongoing, a system approach to strengthening primary care response proposal has been endorsed by key parties and successful in accessing DHB/MOH innovations funding	A system approach to strengthening primary care response proposal has been endorsed by key parties and successful in accessing DHB / MOH innovations funding
		Streamline line care across Community Health Providers to reflect patient and Whānau centred health care system	On-going. Referral pathway for frailty and deteriorating patients will be agreed and shared with all GP practises within the Whanganui region.	On-going. Referral pathway to identify frailty and deteriorating patients will be agreed and shared with all GP practises within the Whanganui region. Reshaping how at risk older people are managed, link with demand at the front door.	Ongoing. Referral pathway to identify frailty and deteriorating patients will be agreed and shared with all GP practices within the region. Reshaping management of at risk older people and looking at demand management.	On-going. Referral pathway to identify frailty and deteriorating patients will be agreed and shared with all GP practises within the Whanganui region. Reshaping how at risk older people are managed, link

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						with demand at the front door.
		Increase access to Community Care and reduce waitlist for community support	On-going. Increase of referrals from GPS for frailty/deterio rating patients will be observed. Increased use of telehealth to improve access.	Ongoing . Increased use of telehealth to improve access, roll out across rural areas.		Ongoing . Increased use of telehealth to improve access, roll out across rural areas.
		Implement wellness/prevention model of care for reducing future cost including those at risk of hospital admission/readmission	On-going.	A strategy has been endorsed by WDHB / WRHN PHO / Iwi stakeholders. Moving into development of operational measures and outcomes		A strategy has been endorsed by WDHB / WRHN PHO / Iwi stakeholders. Moving into development of operational measures and outcomes.
		Hospital in the home models of care, partnering across social services/NGOs other partners.	On-going. WRHN will report as per agreed contracting schedule to identify opportunities for primary community integration and establish	Process has been confirmed for progressing joint initiatives and a focus will commence on Medical Skeletal presentations with primary		Process has been confirmed for progressing joint initiatives and a focus will commence on Musculo Skeletal presentations with primary

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			models of care to reflect this.	care intervention engaging physiotherapy, urgent care and general practice working collaboratively		care intervention engaging physiotherapy, urgent care and general practice working collaboratively
	FTE Management	WDHB has an average annual FTE turnover of 7.33%. By carefully managing the replacement of staff as they resign or retire, previous growth can be reversed. Target 2.5% in FTE management improvement per annum – adjust by 50% for timing. All staff appointments to be signed off by Finance, ELT member and Chief Executive. Opportunities will be sought for combining of roles & better use of technology to gain efficiency.	Ongoing. All staff appointments (new and replacements) are required to be justified with final approval to recruit signed off by Chief Executive. FTE reporting is being reviewed for Q1 to improve transparency and accountability through both cost centres and line of business.		All recruitment requests and requests for change in FTE are signed off by Finance, ELT member, the Workforce Sustainability Committee reviews all applications prior to CE approval. Process working well but due to patient volume and clinical need, FTE numbers are still yet to decrease.	MET
	Intensive IDF Management	WDHB will intensively manage its IDF inflows and outflow to maximise the use of resources within the WDHB and minimise the cost of out of region care.				Met
		Intensify management of monthly IDF results to ensure accuracy of in- & outflow monthly data and inform care decisions				Met

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		Reduce elective IDF net outflow & return care to WDHB in support of local surgical productivity				Met
		Redesign community care & regional arrangements to reduce out of district travel where possible				Met
		Enhanced planning of non-washed up elements with improved annual reconciliation, redesign and renegotiation				Met
	Radiology efficiencies	Reduce costs associated with out of hours radiology Monday-Friday by initially extending general x-ray on site hours to 11pm, and reducing out of hours CT examinations that are not considered urgent.				Met
		Streamline pathway for Community Radiology referrals by establishing joint service improvement groups between Radiology, Emergency department and community including GPs.	On-going. Reviewed and socialised co mmunity refe rred guidelines. All referrals received are appropriate and are triaged against criteria.			Met
		Reference to National Criteria to Access Community Radiology	On-going. Engaging with CMO to highlight variability and local use of CT compared to National rates			Met
	Theatre facility capacity management	Review acute theatre utilisation with a view to reduce cancellation and OT costs; includes reduce readmissions	Engaged exter nal subject matter expert to			Met

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			complete a site visit			
		Review throughput per session by speciality to maximise resources.	Findings and actions included in completed action plan included			Met
		Preference standardisation				Met
		Manage medical devices and consumables to budget				Met
		Complete a theatre production plan to ensure DHB drives efficiencies and meets compliance rates.	Action plan and timelines developed, completed and circulated			Met
		Create a flexible workforce, and reconfigure the working day (activities, ie ward rounds/OP etc).				Met
2.2.3 Consideration of innovative models of care and the scope of practice for the workforce to support system sustainability	Dual purpose clinic supports winter plan and readiness for re-establishment of COVID testing capability	Continue to run the central community based assessment centre (CBAC) using primary care capacity at the hospital front door through to September 2020				Met
		Clinic deals with all influenza-like illness as a pre-urgent care and pre-emergency department pathway				Met
		Screening of patients in their cars before guiding to definitive treatment in the clinic or referral to urgent care or emergency department				Met
		Provides capacity for ad hoc or regular COVID testing if necessary				Met
		Re-evaluate for continuation and consideration of role in future winter plan				
	Establish kaupapa Māori service response for intensive pregnancy and parenting support	Using principles of Waitemata model of intensive outreach service for women (see mental health and addictions sections)	Substantive progress has been made in line with MoH timelines and expectations			Met
	Establish peer support model to	Respond to anticipated RFP for acute mental health solutions	Peer support does exist			MET

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	support a more sustainable and holistic response to tangata whaiora in acute and emergency mental health settings		with a local provider. Te A whina is looking to work in partnership with them to look at how peer support can be provided more effectively in a genuine manner.			
	Expand regional telestroke service	In 2017, the Central Region established an after hours regional telestroke service whereby stroke physicians at Capital & Coast DHB were able to provide after hours clinical oversight remotely to local emergency departments to carry out thrombolysis on eligible stroke patients. The scheme has been so successful that currently rates of thrombolysis after hours are better than those in-hours. The Central Region is now expanding the service to cover all hours. This will increase the capacity of the sub-specialty at some hospitals in the region so that thrombolysis can be guided at all the region's hospitals at any time of the day or night using remote technology.	.			Met
	Introducing the role of Clinical Informatician to drive clinical engagement in informatics	Reallocation of resources to support a role that works between clinicians, data specialists and information technology to enhance clinical engagement and leadership in digital and data developments				Met
	Partner with Arthritis NZ and the PHO to trial a kaiawhina role supporting a targeted approach	In 2020/21 we will progress a proposal for a gout management programme combining culturally appropriate education along with a kaiawhina approach that will support improved access to medication management and engagement with pharmacy and general practice				Met

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	to gout management					
	Support the roll out of early responses to mental health needs in primary care settings	Our district mental health and addictions service level alliance co-designed a response to the primary mental health RFP in 2019 and were successful in gaining funding for an approach that will see two local general practices having health coaches and health improvement practitioners support enrolled populations				Met
		Respond to any further RFPs and evaluate impact for consideration of expansion	On-going	No RFPs received		Met

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Improving Child Wellbeing

Subsection	Activity	deliverable	Q_1	Q_2	Q_3	Q_4
2.3.1 Maternity and Midwifery workforce	Activity	Attract and recruit an appropriately skilled Director of Midwifery (DoM) to manage workforce development and drive governance across midwifery services.	Lucy Pettit , Director of Midwifery (DOM) was appointed on 20th July and is now in position.			
		Develop a plan for the Whanganui rohe recruitment and retention of Lead Maternity Carers with a focus on recruiting Māori LMCs. (EOA)			Five new graduate midwives are now working in the Whanganui rohe, two are Lead Maternity Carers (LMC), both Māori and three are core midwives, one is Māori. Ongoing work with Otago Polytechnic to support midwifery students (50% of 2021 third year students are Māori) continues.	
	The WDHB will support undergraduate	facilitate and support Otago Polytechnic's satellite midwifery school		Quarterly meeting commenced with Otago Polytechnic's		Met

	midwifery students:			satellite midwifery school Kaiako, CMM, DoM and Mid Ed. All midwifery students have a prepared roster with named preceptors. Successfully recruited one new grad midwife engaged in the MFYP. Currently advertising for a second new grad midwife. Only one Māori new graduate midwife qualified 2020 and she has chosen LMC practice.		
		named preceptor for all midwifery student on placements				
		student offered equal opportunities to participate in any local midwifery education				Have now successfully recruited three new graduate midwives into the core midwifery workforce, one of whom is Māori. The Māori new graduate midwife is engaged in Te Urupounamu, cultural

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						Supervision and has received support from our MCY's Kaitakitaki
		employ at least one new graduate midwife from this programme (EF)				Continue to have regular meetings with Otago Polytechnic's satellite midwifery school Kaiako, to plan and support our student allocations
		support and encourage participation in the Midwifery First Year of Practice programme (MFYP)				Met
		encourage Māori new graduate midwives to engage in Te Urupounamu, cultural Supervision. (EF)				Met
		Activities that address service delivery due to predicted seasonal changes in service demands:		LMC capacity and leave dates confirmed and DHB primary midwifery service recommenced in December 2020. This service is for re-evaluation after 6 months. All women assisted to secure LMC postnatal care. Core midwifery staffing adequate.		Met
		establish LMC capacity and leave dates for December/January/February				Met

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		re-establish DHB primary midwifery service for women unable to secure LMC services				Met
		ensure maternity service staffing establishment is adequate for additional unit labours & births, using the CCDM framework				Met
		establish LMC capacity to provide postnatal care for women under the DHB primary service or establish a DHB postnatal service (EF)				The DHB managed a small primary midwifery service throughout the year (between 5-10 women). However, with the expected Christmas/holiday season short fall of LMC's this number has grown significantly (now 32 women) and has warranted an increase in FTE to manage this growing caseload. Local LMC's are agreeable to picking up the postnatal modules for these women
		communicate to the local community. (EF)				Current core midwifery has an FTE deficit,

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						despite recruitment of new graduate midwives and an overseas recruitment plan is being developed following unsuccessful recruitment of experienced NZ midwives.
	When the DoM appointment is in position (hospital and community) establish a project team to:	develop longer-term midwifery workforce plan that has an equity focus including cultural competency and increased Māori participation in the workforce (EOA)		Project team assembled and first meeting held		
		ensure service delivery mechanisms make the best use of other health workforces to support pregnant women and midwifery roles (EOA)			A weekly MDT and Te Rerenga Tahi – Maternal Care & Wellbeing Group, is well attended by those directly involved with maternity care	
		implement the midwifery workforce plan (EOA)			The Midwifery Workforce group meet monthly and midwifery is key component of the DHB's Workforce	Partially Met The aim to be fully recruited to regarding LMC and core midwifery workforce has not been achieved.

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					Development Plan. FTE calculations for CCDM have been agreed Midwifery Career Pathway released and socialized with midwifery workforce.	The national workforce shortage has made this extremely challenging. This plan remains ongoing and will now include an overseas recruitment strategy.
		evaluate the midwifery workforce plan. (EOA)				Partially Met Ongoing – working with MOH to implement recommendations
2.3.2 Maternity and early years	Activity	Implement the recommendations of the WCTO review. (EOA)	Still awaiting the feedback from MoH regarding the outcome of the review.	The MoH have not released any outcomes or recommendations from the WCTO review at this time.	On going Awaiting direction from MOH	
	Develop and implement a Maternity and Early Years Key	develop baseline database that has ethnicity in all data and equity in all analysis including: (EOA)				
		number of current stakeholders engaged with Maternity and early years		To be completed Q3		

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	Stakeholder database (community and services) for the WDHB region :	number of Māori and Non-Māori community stakeholders		To be completed Q3		
		number of Māori and Non-Māori service providers		To be completed Q3		
		number of kaupapa Māori services.		To be completed Q3		
		evaluate baseline database for gap stakeholders: (EOA)		To be completed Q3		
		identification and number of gap stakeholder.		To be completed Q3		
	Provide intensive intervention to pregnant women and whānau with children under 3 years with co-existing alcohol and other drug issues with a using on a kaupapa Māori model: (EOA)	develop kaupapa Māori service model	Collaborating with MHOAG to develop, design & implement an iwi led kaupapa Māori service, delivered across the five iwi health providers.Development and design is almost complete and we are now beginning the implementation phase of the project. A service manager is in the process of appointment and advertising for the remaining FTEs will begin early October with their proposed start date in November/December 2020. Once all staff are appointed, they will complete inductions with their Providers as well as He Puna Ora and begin intense training with the aim to		2 six-week classes, 2 weekend classes, and 2 Hapu wahine and mama days were held, with between one and seven women booked for each session held. Numbers of referrals received have been lower this quarter and a disturbing trend has been the numbers referred after thirty-six week of gestation. Efforts are made to create a class, but this has been	

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			be fully operational by March 2021.		unsuccessful in some cases owing to time constraints and pregnancy complications. Considerable time and effort have gone into putting supplementary class information on the WRHN website. We have recorded 65 hits on the pregnancy and parenting section of our website which is reassuring that this information is being accessed. WRHN continues to offer flexible options for women and whanau. The rural CBE continues to offer a flexible programme designed to meet the needs of our	

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					rural population and distributes safe sleep spaces as part of the total package of support. Individualised sessions have been offered and accepted by the rural communities via phone or email. There appears to be a trend in rural areas with women preferring individual sessions rather than group classes this quarter.	
		implement new service tranche 1				
		implement new service tranche 2 & 3.				Met New service He Puna Ora is fully implemented and receiving referrals, 25 in the Q4.
		Use quality improvement processes with equity lens to examine, implement, review and evaluate newborn enrolment and transfer of care processes within the WDHB region. (EOA)				Partially Met Primary Secondary

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						Interface Group and been set and specific workstreams established. In progress.
		Women with risk factors are identified early in pregnancy and referred to appropriate services.				Partially Met Best Start has been offered, installed and socialized to most practices. The Best Start module automatically links maternal immunization and sets recalls. The tool supports finding of hapu mama with mental health and addiction red flags which facilitates referral to appropriate services. Training and care pathways are being further developed. Have a submitted a formal research proposal to evaluate the Best Start and uptake of Maori wahine.

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						Primary Secondary Interface Group is now established. Membership includes, LMC's, GP's, WCTO, He Puna Ora, Kaitakitaki (Te Hau Ranga Ora), senior health managers and Chaired by the Director of Midwifery. A mapping process has been completed and driver diagrams developed with shared purpose and aim. From this work project groups have been formed that will: • Engagewith Healthy Families – to help us understand consumer needs and co-design future services • Create a service guide for women and whānau, then

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						distribute and socialize • Create a professional's care pathway/user guide of roles and responsibilities to better facilitate timely and appropriate referrals • Integrate the 'Best Start' tool in GP practices and socialize/share with local LMC's • Standardize referral forms and processes to GP's, WCTO etc. – with the aim to improving enrolment and immunization and dental services uptake
		Local implementation of Generation 2040 early pregnancy tool in general practices. (Note: links to Immunisation and Te Rerenga Tahi service). (EOA)				Same as above
		Develop PDSA that focuses on reducing inequity of access to ultrasound scanning.				
		Target 10% increase in newborn enrolments at 6 weeks. (EOA)				Partially Met New-born enrolment: AT end of Q4 Maori sitting

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						at 57.9% at six weeks and 71.9% at three months. Total is 72% at six weeks and 89% at three months. Working with Maternity Workforce Alliance with a view to review processes around new-born enrolment.
		Target 10% increase in newborn enrolments at 6 weeks. (EOA)				
		Implement safe sleep activities/strategies delivered through wānanga in alignment with the Whanganui Sudden Unexpected Death in Infancy (SUDI) Plan for the WDHB rohe. (EOA)				
		Implement safe sleep activities/strategies delivered through wānanga in alignment with the Whanganui Sudden Unexpected Death in Infancy (SUDI) Plan for the WDHB rohe. (EOA)				Met Increase in distribution. All pregnant who attend pregnancy and parenting classes, have safe sleep spaces, involved in health homes , Outreach services, are offered referrals for stop smoking services as normal.
		increase number of safe sleep devices distributed to Māori whānau with risk factors.				Same as above

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	Shaken Baby Prevention Programme (Power to Protect) (EOA)	Establish and document identified Power to Protect related activities including education, training, key messages and community programmes with a focus on Māori providers and working collaboratively with them on meeting their population's needs. (EOA)				Met WRHN- 58 hapu mama with accompanying support people attended antenatal classes – all receive power to protect video and discussion. Prison initiative inmates received P2P information. 134 Safe sleep spaces were distributed (not including wananga info as we have no records). Power to protect is included in this korero. (some will also have attended antenatal classes)
		Power to Protect programme implemented for service and community providers/support providers.			Best Start has been offered, installed and socialized to most practices and the Early Pregnancy Assessment Tool is no longer in use – would be users are	Met WRHN- 58 hapu mama with accompanying support people attended antenatal classes – all receive power to protect video and discussion.

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						redirected to the Best Start Module. This automatically links maternal immunization and sets recalls.	Prison initiative inmates received P2P information. 134 Safe sleep spaces were distributed (not including wananga info as we have no records). Power to protect is included in this korero. (some will also have attended antenatal classes)
	increase number of pregnant women and/ their whānau referred to Stop Smoking Service	increase number of safe sleep devices distributed to Māori whānau with risk factors.				As above	

2.3.3 SUDI component	Implement safe sleep activities/strategies through wānanga in alignment with local SUDI plan for the Whanganui DHB region:	three hapu mama and whānau wānanga will be delivered throughout the DHB rohe over the year, includes two rurals and one urban setting: EOA				Met
		increase the number of hapu mama and their whānau referred to stop smoking services (EOA)				
		increase number of safe sleep devices distributed to Māori whānau with risk factors. (EOA)				3 Urban and one rural wahakura wanagna took place.
		Health promotion activities promote SUDI messaging and overall safe sleep, smoke free and breastfeeding messaging that is designed to reach priority populations. (EOA)				All hapu mama who attend WRHN pregnancy and parenting education classes are

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						offered referrals to stop services. 94 whanau were provided with safe sleep spaces because of smoking, of that 69 were Maori and offered a referral to stop smoking services.

2.3.4 Immunisation	COVID -19 Response	work alongside general practices to establish what the new normal is for COVID -19 level one for immunisation. (EF)			As above	
		highlight safety of the new normal and communicate to whānau using multi media/joint communications (WDHB and PHOs) to encourage and have confidence in returning for immunisation and focus on priority population (complements the national campaign). (EOA)				
		work with general practices to identify, trial, pilot innovative approaches to reaching target populations, ie different places, times. etc. Review and evaluate success of approaches. Feedback data in a responsive way via practice facilitators (EF)				No Report
		Whanganui Regional Health Network and Te Oranganui health provider are trialing Saturday wellness clinics at				Partially Met One clinic occurred and was moderately successful, though unable to carry on due to staffing changes and shortages in the workforce. Difficult to measure

						whether this would be successful going forward with only one clinic having occurred. Will re-visit in new financial year.
		Te Oranganui that will include immunisation, though targeted for high needs populations and Iwi based, it is open to all. Includes a media campaign. (EOA)				
	Provide HPV immunisation catch up for year 9-13 students in conjunction with the National MMR Campaign: (EOA)	develop and implement plan				
	Regional immunisation communication plan aligns to Immunisation week 2020/2021 and influenza season. Protected Together #Immunise:	develop a joint health promotion and communication plan with the WDHB and the Whanganui Regional Health Network that covers Immunisation week and a long lead in time using various tech and channels to reach priority populations. (EOA)		In progress, working with team to develop awareness campaign, as well as MMR/HPV catch up programme.		
		undertake review of media files including social media available for use in the regional communication plan (EF)		To be reported on in Q3, huge focus of work diverted to MMR/HPV catch up, COVID response		
		evaluation use of social media in the community and views recorded. (EF)		To be reported on in Q3, huge focus of work diverted to MMR/HPV catch up, COVID response		
		Conduct opportunistic childhood vaccination with a focus on Māori when they interface with community and secondary services. (EOA)				

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		Undertake a data review on the number of children under 5 years presenting at Whanganui Accident and Medical (WAM) and the WDHB emergency, paediatric and dental departments. (EOA)				
	Work alongside interagency networks, communities, to support an increase in Māori childhood immunisation coverage. (EOA)	undertake review of participants immunisation status				
		provide onsite immunisations when able				
		provide statistics for both WINZ and WDHB.			Onsite immunisations are being provided by various groups when able in an attempt to widen the chances for opportunistic vaccines i.e. Paediatric ward, PHO weekly clinics, rural monthly clinics. Working with ED and Accident and Medical to increase these opportunities.	
		facilitate discussion between WINZ young parenting course and immunisation services to focus on the immunisation uptake of the young participants and their children	Initial discussions, on-going networking.		QLIK was meant to provide NHI level data so analysis and follow up could occur. Analysis across imms and GP enrolment would be useful for	Met Working with sector partners to enhance uptake

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					purposeful follow up by the outreach team.	
		facilitate resources to support the implementation of this programme				Met Brochures were developed, school assemblies attended, social media, radio, newspaper coverage was undertaken
		provide immunisation clinics between July-November 2020.				Met Clinics occurred during July – November, catch up clinics occurred in March/April 2021

2.3.5 School based health services	Activity	Provide quantitative reporting on the implementation of school based health services (SBHS) in decile 1 to 4 secondary schools, and decile 5, teen parent units and alternative education facilities. (EOA)				Met Reporting continues
		Promote health messages and awareness of health services available to youth, inclusive of where to access emergency contraception, after hour's medical care and surrounding agencies and networks.				Met Posters and Brochures for local and rural designed for students and disseminated and given to students, teachers,

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						parents/caregivers, other agencies
		Provide school leavers with information and enrolment opportunities of PHOs, agencies and networks available in their surrounding communities. (EF)	Progressed awaiting approval by the Document approval Committee			Partial Due to pandemic, delay with resources, continue activity into next Quarter DAP for all schools/kura to have the opportunity to have resources.
		Contribute to the rohe-wide youth services networks by attending and collaborating at a multidisciplinary level to ensure that health of our youth population is at the centre of their care. (EF)				
		Increase appointment attendance rates for students, in particular Māori students attending appointments at MICAMHAS and Youth Services Trust. (EOA)				
		Increase service access to students using telehealth. Lesson learned from COVID -19, the nurses will pilot alongside students to get their views on expanding service delivery and engagement via telehealth. (EOA)				
		Collaborate with SBHS providers to identify three areas of quality improvement and develop a plan to advance. (EF)				
		Youth Service Level Alliance Team to be incorporated into new Maternal child and youth service level alliance. TOR developed and recruitment of members in process, youth population priorities identified. (EF)				
	Psychosocial/well being assessments post COVID -19:	Priority population of students with high risk needs in all schools has been identified from the SBHS data, collated and actions to support them prioritised. For the identified priority population students, HEADSSS assessment will continue to be carried out and students have: (EF)				
		referred to counsellors, MICAMHAS and other relevant providers				
		hygiene issues have been identified as of concern and the nurses working with schools and some church groups to put together hygiene packs and supply these to students in need				

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		sanitary products have been ordered and will be made available to students in need				
		exploring the possibility of breakfast clubs in schools.	School have decided to put project on hold due to other Covid priorities			
		in order to catch up on the assessments, 2 additional FTE for 6 months will be employed. Teams of nurses will prioritise HEEADSS assessments for the identified priority populations, including alternative education students. (EF)				
		resource detailing all WDHB region youth health services will be updated and made available to all students at consultation time, and be available in school canteens, libraries, schools, alternative educations centres, school web sites etc. (EF)	Awaiting document committee approval of resources			
	Public Health Nursing actively involves secondary school students in partnering with them to get their voice through surveys.	student's ideas and recommendations will be incorporated in planning ensuring that the services that are provided for youth are youth friendly, confidential and private as desired by students and culturally appropriate. (EOA)	Student surveys have been sent out, meetings with Council Youth Committee and Youth Collective Committee have been held recommendations are for implementation in the next planning.			Met Surveys throughout each Quarter obtained and continues. Also engaged with At Risk Youth Camp and WHS Vocational Class Year 12 & 13.
2.3.6 Family violence and sexual violence	All pregnant women who are present when Police attend a family harm incident, are referred to the Te Rerenga Tahi (vulnerable pregnancy) group with the aim of providing wrap around support for them. (EOA)	Better life outcomes for children and whānau.				
		Ensure that processes and responses are equitable for hapū wāhine and whānau				
		Develop enhanced relationships and referral pathways with iwi, whānau ora providers and Kaupapa Māori services				Initially all pregnant women who police attended a family harm event were referred to WDHB vulnerable pregnancy group Te Rerenga Tahi. However it soon

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						became evident that some of those women were being supported already by other community services. Polive will now only refer a pregnant woemen if she is not supported by another service or if she is consenting to the referral to be done. Other Government, non government and iwi agencies can also refer if necessary
	Cross-sectoral collaboration: (EF)	MoU with the Police and Oranga Tamariki for information sharing and integrated work around child abuse and neglect to be reviewed by National leads. Ensure WDHB has had input into the National MoU review.				National leads have reviewed this MOU and changes are in process. WDHB child protection team have been able to feedback into this process
	Elder abuse & neglect training	integrate WDHB trainings with a specific focus on the elderly including a focus on the context for Māori				WDHB have an elder abuse and neglect training package which is offered to WDHB
		work with other service providers who work with the elderly to deliver specific focused training to WDHB staff and, Māori health services and community partners				
		increase workforce capacity and capability across our community				

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		build strong relationships between Māori and other community providers and WDHB staff.				and external staff working with this demographic. Dates are available in our WDHB training calendar.Age concern come to present an element of this and the training programme was presented at the Kaumatua Konihera monthly meeting and approved as being responsive and equitable.
	FLOW: (EF)	Police lead a community response to family harm in our community. This has been supported by WDHB VIP co-ordinator who has been on the working party to operationalise this new initiative.			Following the resignation of one of the social workers who attended the FLOW meetings twice a week, we do not have capacity to respond on 2 days that were previously covered. There are other days that the DHB	With the resignation of 1 of the social workers who attended the FLOW meetings 2 x per week this has meant that we do not have capacity to respond on 2 days that were previously covered. There are other random days that the DHB can not participate due to work demands

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					cannot participate due to work demands within our own DHB at times. A scoping document has been presented to Louise Allsop and Russell Simpson recommending that a .6 position be created so that a consistent person attend this meeting to provide health responses.	within our own DHB at times. A scoping document has been presented to Louise Allsop and Russell Simpson with the recommendation that a .6 position be created so that a consistent person attend this meeting to provide health responses.
		Regular meeting with police, Iwi and community attended by WDHB with changes implemented and reviewed in 6 months.			As above	
		Report on` the number of hours and days a week the coordinator and other staff are participating in these meetings.			As above	
		Strategic Leadership Group (SLG) oversees the work that is being done in this area along with an interagency management group from the community sector. We are committed to providing opportunities for service development and integration across sectors (EF)				
		Ensure FLOW referrals to Te Rerenga Tahi as appropriate				
		Ensure Māori health and social service representation at Te Reretanga Tahi				

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	Staff as victims of violence: (EF)	ongoing work developing WDHB response to staff as victims of violence				
		review current guideline with Te Hau Ranga Ora equity workforce development officer		Staff as victims of violence: This work is continuing with People and Performance taking a strong lead with support from VIP coordinator. EMT have approved the purchase of the training package via SHINE. The guideline has been reviewed by Te Hau Ranga Ora our Māori health team and approved.		
		implementation of training package for managers to respond to staff victims of violence, which is being led by People and Culture.				
		training plan for managers in place and implemented				
		introduction of a flow chart for staff which will guide acceptable responses.				
	Violence Intervention Prevention (VIP) Reference Group: (EF)	Clinical managers identify opportunities for VIP development within their teams minutes.				

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Improving Mental Wellbeing

Subsection	Activity	deliverable	Q_1	Q_2	Q_3	Q_4
2.4.1 Mental health and addiction system transformation	Establish the Whanganui Mental Health and Addiction Service Level Alliance to address challenges in mental health and addictions outcomes with a specific focus on Māori, by enabling a system-wide and multi-perspective approach to service design/redesign	build on the foundation set in Whanganui Rising to the Challenge, which outlined the future development of the district's whole-of-system mental health, addiction and wellbeing options				
		consider the full continuum of need for the Whanganui rohe				
		include participation and perspectives of people with lived experience	ongoing			
		enable co-design and iwi/community engagement from diverse communities	ongoing			
		provide recommendations to primary and secondary fund-holders.	ongoing			
	Placing people, whānau and tangata whaiora at the centre of all service planning, implementation	support mechanisms that enable real time feedback from tangata whaiora and their whānau into quality programmes by improved utilisation and uptake of Marama Real Time Feedback and participation in the Conversation Cafe (EF)				
		ensure that individual care planning meetings involve a supported decision making focus which enables feedback from tangata whaiora and their whānau directly into their own care (EF)	ongoing			

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	and monitoring programmes:	focus on how we address equity for Māori, Pacific, young people, rainbow community and other population groups who experience disproportionately poorer outcomes (EF)	ongoing	Further education to raise awareness for clinicians has been scheduled		
		actively partner with the Māori Health Outcomes Advisory Group (MHOAG) to facilitate efficacy of the Matauranga Māori qualitative research (EF)	ongoing			
		development of a mental health and addiction measures dashboard to enable effective monitoring including of equity. (EF)	ongoing	Development of dash board continues		
	Embedding a wellbeing and equity focus:	strengthen our focus on mental wellbeing through healthy active learning, (sleeping, physical activity and healthy food and drink) by health promotion, prevention, identification and early intervention (EF)	ongoing			
		work with the Health Quality Safety Commission (HQSC), wellbeing focus for people with serious mental illness including the tangata whaiora in forensic units in our district inpatient unit and wider community (EF)	ongoing			No Report
		implement 'Supporting Parents, Healthy Children' to support early intervention in the life course (EF)				
		collaborate and work with the Ministry, the Mental Health and Wellbeing Commission, the Suicide Prevention Office and other leadership bodies and key partners to drive transformation in line with He Ara Oranga. (EF)				
		Target people with low prevalence conditions to be a priority for DHBs funded employment, education and training resource (EF)	ongoing			
		resuming the Equally Well project to improve the physical health outcomes for people with mental health and addiction conditions (EF)	To commence	Project deferred by HQSC. To be reactivated 21/22	Project deferred by HQSC. Note: CMHAS are being proactive to improve physical health	Not met Project was being led nationally by HQSC, but COVID-19 disrupted this workstream. HQSC is now working with Te Pou on maximising physical health to define

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					outcomes for their service users by other means. Practice nurses work alongside the psychiatrist in the practice to ensure physical aspects of care & undertaken at the time of consultation. Where health coach and HIP roles are in place wellbeing is considered from a physical and mental health perspective with individuals.	specific project(s) to commence at the start of 2022
		improving responses to co-existing problems via stronger integration and collaboration between other health and social services. (EF)	ongoing			
	WDHB's Mental Health Service Level Alliance will: Increasing access and choice of sustainable, quality, integrated	work in partnership with the Ministry, Māori, Pacific people, young people, rainbow community and people with lived experience, NGOs, primary and community organisations, and other stakeholders to review and strengthen the integrated approach to mental health, addiction and wellbeing	ongoing			
		pass on maximum cost pressure funding to DHB funded mental health and addiction NGOs as of 1 July 2020				
		enhance respite options to include an emphasis on therapeutic programs and smooth transitions of care				

	services across the continuum:	support the roll out of new primary level responses (EOA)				
		strengthen and increase focus on mental health promotion, prevention, identification and early intervention (EF)	ongoing			
		support our Community Mental Health and Addictions Service (CMHAS) team to: (EF)	ongoing			
		remodel crisis team to improve response time and enable service users direct and timely contact with a clinician	ongoing			
		review the current delivery of home treatment and assertive outreach and consider day therapeutic programme options		delays due to union involvement & late implementation of home care medical	The Mental Health Assessment Home Treatment (MHAHT) having newly introduced Whakaronogo Rau telephone triage line provided from 1630 to 0700 hrs seven days a week. The Microsoft platform the Whanganui DHB has introduced has supported electronic innovations so that telehealth can be an option for service users who have compatibility to down load the Microsoft app.	

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		implement commitment to resourcing Emergency Department with a specialist mental health and addiction educator to build capability of front line staff				
		work alongside other colleagues to modify the Whakataketake combined risk assessment screening questions to incorporate mental health risk screening for depression and suicidality				
		in the Network model of care, clinical psychologists in each hub provide support to primary care clinicians in order to				
		share knowledge and expertise and increase access.				
		will develop use of virtual consultations to expand access and to include the health improvement practitioners as these are appointed to primary provider practices, with effective triage through the SPOE (Single Point of Entry) matching tangata whaiora need and most appropriate level of service provision.				
	Suicide prevention	co-design high level action plans with community leaders and communities	ongoing			
		implement from 1 July 2020 applying equity thinking and hodology at every touch point.	ongoing			
	Workforce (note links to section 2.6.13 and 4.3):	work towards developing a workforce that reflects the community (EOA)				
		encourage the use of Supported Decision Making (SDM) principles by all mental health clinicians across all practice settings in preparation for the changes which are forecast in the Guidelines to the Mental Health Act				Met The DAMHS has met with both the SMO and RMO group (including trainee psychiatric registrar) as well as running a course for the DAO (duly authorized officers) updating

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						on the changes forecast in the Guidelines to the Mental Health act and those understood to be coming by the end of 2021. Senior clinicians are preparing for a shift away from the use of indefinite treatment orders. A meeting has also been held with the WRPHN and representatives of CMHAS and WDHB workforce team to explore shared workforce education and planning across into primary care. RMO education and trainee intern education focuses on a trauma informed and consumer rights approach with preparations

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						made for education being provided by the mental health and addictions team clinicians, lived experience expert and nurse educator to all RMOs and trainee interns across the WDHB in the coming month.
		require all psychiatrists, psychiatry SMOs and trainees to improve their education and training in the use of SDM principles including consumer rights, to clearly identify differences between shared and supported decision-making either via the training package, online training module or other suitable training opportunities.				
		prioritise workforce education and upskilling of clinicians in psychological therapies as well as supporting primary care clinicians to upskill (EF)				
		continue to build the knowledge of all WDHB staff in Te Tiriti o Waitangi, pro-equity and impacts of racism (EF)	ongoing			
		ensure all staff have completed the WDHB cultural education programme Hapai te Hoe (EF)	ongoing			
		encourage participation in WDHB run Te Reo courses require all front-line staff to complete and implement learning on addressing bias in decision making. (eg via HQSC website) (EF)	ongoing			
		enable staff to participate in cultural competence and cultural safety training and development, including supporting clinicians in the implementation of the Medical Council of NZ Statement on Cultural Safety (October 2019) and MCNZ He Ara Hauora Māori: A Pathway to Māori Health Equity (EF)				

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		work in partnership with workforce centres to strengthen current workforces, including a focus on retention, recruitment, training, and wellbeing (EF)				
		support workforce development of the appropriate knowledge and skills to support people with mental health and addiction needs, including those with co-existing needs, for example through use of the Let's Get Real framework. (EF)				
	Forensics	Work with MOH and DHBs to improve and expand the capacity of forensic responses from budget investment.	Not lead by WDHB		Preliminary stages of planning with CCDHB for Nga Tapuwae project and also in set up stage with transfer of step down facility from Palmerston North to Whanganui with Emerge Aotearoa. This response was received from Peter de Roo but this was marked as in Q2	Regionally and Nationally led
	Commitment to demonstrating quality services and positive outcomes:	Explore options for health informatics using platforms such as Power BI or similar (Qliksense) to enable collection of data regarding practice and to permit the measurement of outcomes. (EF)	ongoing			
		Develop new measures alongside providing reporting on priority measures, and addressing equity, including: (EF)	ongoing		N/A	
		access	ongoing			
		comparative data to allow for assurance of equity for Māori and youth	ongoing			

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		reducing waiting times	ongoing			
		completion of transition/discharge plans and care plans				
		mental health and addiction service development	ongoing			
		reducing inequities	ongoing			
2.4.4 Maternal mental health services	Activity	Engage the Pasifika community especially, in rural areas, to improve their access to MH&A Services. (EF)		Not currently able to engage rural Pasifika community		
		Continue engagement with the regional MMH team for ongoing training and knowledge sharing opportunities e.g. via Perinatal Anxiety and Depression Aotearoa (PADA) (EF)		No report		
	Develop intensive intervention for pregnant women and whānau with children under 3 years with co-existing alcohol and other drug issues using a kaupapa Māori model: (EOA) (Note: link to 2.3.1)	develop kaupapa Māori service model	Collaborating with MHOAG to develop, design and implement an Iwi led kaupapa Māori service delivered across five Iwi health providers. The development and design is almost complete and we are now beginning the implementation phase of the project. A service manager is in the process of being appointed and advertising for the remaining FTEs will begin in early October with their proposed start date in November/December 2020. Once all staff are appointed, they will complete			

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			inductions their providers as well as He Puna Ora and begin intense training with the aim to be fully operational by March 2021.			
	Provide the Perinatal Ministry of Health report:	Provide the Perinatal Ministry of Health report:				
		collect ethnicity data to measure effectiveness of programmes targeted at equity (EF)				

Improving wellbeing through Prevention

Subsection	Activity	deliverable	Q_1	Q_2	Q_3	Q_4
2.5.12 Cross sectoral collaboration including health in all policies (HiAP)	Development of more intensive support for HiAP will require professional development. In 2020/21 WDHB will investigate:	Increasing professional development of Public Health staff in Policy and Legislation	Delays due to Covid 19	Delays due to Covid 19 priority initiatives		MET
		Identify and recruit a student undertaking current health policy studies	Delays due to Covid 19 rea	Delays due to Covid 19 priority initiatives	Current environment will not proceed	NOT MET
		Scoping report completed for student Internship for a Policy Assistant position at Public Health (EF)	Delays due to Covid 19	Delays due to Covid 19 priority initiatives		MET
		Approval of internship and criteria for Policy Assistant completed by January 2021 (EF)	Delays due to Covid 19	Delays due to Covid 19 priority initiatives	Current environment	NOT MET

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					will not proceed	
		Establish Student Internship for a Policy Assistant position at Public Health by June 2021 (EF)	Delays due to Covid 19	Delays due to Covid 19 priority initiatives	Current environment will not proceed	NOT MET
		Increasing expertise in the HiAP model and its applicability to other areas of WDHB activity	Delays due to Covid 19	Delays due to Covid 19 priority initiatives		MET
		Identify subject matter expert	Delays due to Covid 19	Delays due to Covid 19 priority initiatives	Current environment will not proceed	MET
		Scope relevant consultation and engagement pathways	Delays due to Covid 19	Delays due to Covid 19 priority initiatives	Current environment will not proceed	MET
		Draft action plan	Delays due to Covid 19	Delays due to Covid 19 priority initiatives	Current environment will not proceed	NOT MET
		Develop a strategic analysis by 31 March 2021 to highlight the opportunities for supporting inclusion of HiAP across the public sector.				MET
	Ministry of Health and WDHB contracted providers	Ensure that opportunities for HiAP is promoted through our own contracting processes. Where appropriate, we require contracted providers to develop policies that promote and support good health amongst their own staff and through the services that they provide. (EF)				PARTIAL

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		Facilitate the utilization of Health Equity Assessment Tool (HEAT) with HAL partners Ministry of Education and Sport Whanganui to prioritise schools/Early Learning Services (ELS), Kohanga Reo and Kura within deciles 1-4. (EF)		Delays due to MoH resourcing other partners for our region	Delays due to MoH HAL processes	
2.5.2 Antimicrobial Resistance (AMR)	**Activities**	WDHB has a contract in place for infectious diseases support from CCDHB.				
		An annual antibiogram is produced by Medlab Central microbiologists indicating resistance and sensitivity patterns. This is shared with all prescribers, including general practice and infectious diseases physicians CCDHB.				
		All antibiotic resistance results from the community and hospital are sent to infection prevention CNS for alerts to be added to the national file an alert added to the patient's file.				
		Monthly meetings will be held, a minimum of 10 times per year				
		An annual antibiogram is produced by Medlab Central microbiologists indicating resistance and sensitivity patterns. This is shared with all prescribers, including general practice and infectious diseases physicians CCDHB.				
		Hand hygiene is audited by gold hand hygiene auditors in secondary care. This training has been extended to primary care including Hospices, GP practices, aged care and home based support providers.				
		A minimum of two gold hand hygiene training sessions will be offered to primary care providers each year. One training will be offered in Q1/2 and one in Q3/4				
		All staff at WDHB are required to complete hand hygiene training though hand hygiene New Zealand site with 95% of clinical staff to have attended hand hygiene training and completed the end of training test.				
		All antibiotic resistance results from the community and hospital are sent to infection prevention CNS for alerts to be added to the national file an alert added to the patient's file.				
		Community resistance numbers and patterns will be monitored and reported through the infection control committee. Action plans will be developed around any trends.				

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	Biannual monitoring of antibiotic compliance to guidelines completed in WDHB	This audit is reported by ethnicity (EF) and includes:				
		Level of compliance with guidelines by ethnicity				
		The report is shared with drug and therapeutic committee, infection prevention committee and all heads of departments.				
		Action plans will be developed around any variances (none seen in 2019/20)				
	Monitoring of the following with all infection rates are within national benchmarks: (EF)	hospital acquired Staphylococcus aureus bacteremia				
		surgical site infections				
		treatment injuries – infections				
		daily monitoring of multi-drug resistant organisms				
		IV site infections and IVC removals				
		infections in Māori and Pacific patients				
	All infection prevention reporting is based against the New Zealand Health and Disability Standards	Infection prevention policies and procedures are available to prevent antibiotic resistance spread.				
		Infection prevention is a member of the regional collaborate for collaborate approach to infection prevention:				
		switch campaigns from IV to oral prescription running at WDHB, with pharmacists reviewing each patient prescriptions daily				
	Working proactively with ARC providers and general practice to ensure appropriate antibiotic use by:	Access for all ARC to WDHB policies and procedures and antibiotic guidelines on the intranet				
	Use of the annual	catheter related cares and UTIs with prevention hods				
		antibiotic resistance education				

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	infection prevention study day, which is open to all community health providers including ARC providers this day will provide education on:	New Zealand Healthcare standards				
		immunisation				
		outbreak management				
		antibiotic guidelines are current and based on CCDHB.				
2.5.5 Healthy food and drink	Across community settings:	We will work alongside a Kohanga Reo initiative creating supportive and enabling environments from a holistic approach that empowers and encourages the health and wellbeing of tamariki and whānau (EF)				
		to develop a Results Based Accountability (RBA) pilot project. evaluation and communication plan				
	Across contracted providers:	use contracting mechanisms to influence development of healthy food and drink policies amongst other health-related services (EF)				
		identify those contracts that are relevant for a healthy food and drink clause.				
		Ensure the next contract renewal date is noted and flagged for the change				
		Report on percentage of contracts that have a healthy food and drink clause included.				
	Implement Healthy Active Learning (HAL):	use the Health Equity Assessment Tool in collaboration with key stakeholders to determine which schools/Early Learning Services (ELS), Kohanga Reo and Kura they will engage with				
		identify what Healthy Food & Drink policies is already in place to support active and healthy food environments (EOA)				
		Determine baseline number of schools/Early Learning Services (ELS), Kohanga Reo and Kura with a policy within the Whanganui region (EOA)				
		To achieve a 10% increase in the number of Early Learning Services, Kura, Kohanga Reo and schools that have healthy food and water-only (including plain milk) policies (EOA)				70% prioritised settings have a HF & WO policy. The

						remainder this is not their priority and this action will continue into 2021/22
		provide specialist nutrition advice and support to enhance staff and caterers practice to increase the number of healthy food and drink environments and policies consistent with the Ministry of Health Healthy Food and Drink Guidelines (EF)				
		partner with other key HAL providers to ensure a coordinated collaborative approach including with the HAL Evaluation provider (EF)				
		provide health promotion support and guidance to the Regional Sport Trust HAL advisors (EF)		Sport Trust HAL advisor currently not operation due to funding allocation		PARTIAL RSP yet to recruit this position
		collaborate with other providers – NGOs, local government, Healthy Families, Heart Foundation that are working in schools and learning services (EF)				
		leverage onsite health services such as Public Health Nurses and Community Oral Health services, to promote benefits of relevant policies in educational services (EF)				
		work with and complete required reporting to the HAL National Coordination Service (EF)				
	WORKWELL	review the WDHB Nutrition Policy to ensure WDHB is compliant with the National Healthy Food and Drink Policy and identify any opportunities to strengthening our local policy and make amendments				
		review and revise WDHB Workwell advisory group and programme and develop a Workwell action plan to progress from Bronze to Silver accreditation				
	TOBACCO	Education visits carried out with retailers prior to Controlled Purchase Operations (CPOs), and as new legislation requires				

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		Carry out CPOs in the Whanganui region to monitor and enforce the provisions in the SFE Act relating to the sale of tobacco smoking products to minors				
		6 monthly reporting on the % tobacco Control retailers that are compliant at CPOs				

2.5.6 Smokefree 2025	Activity	To complete a Needs Assessment to inform Tobacco Control planning, investment and commissioning of new services and activities contributing towards achieving a Smokefree Whanganui and the Government Goal Smokefree Aotearoa 2025		Delays to ensure a collaborative approach and robust quantitative & qualitative analysis. A paper of recommended options to be tabled at next TAG meeting		
		Needs Analysis Report completed and published by 31 December 2020				
		To support regional and local stop smoking services to ensure an effective integrated approach for wrap around stop smoking services for Māori, Pacific people and hapū wāhine				
		Increased engagement, referrals and outcomes for Māori, Pacific people and pregnant women				
		Support priority settings where Māori live, learn, work and play to create supportive health promoting environments	Delays due to Parental Leave			
		Advocate and support the development of healthy public policy that supports smokefree and vapefree environments	Delays due to Parental Leave			
		To promote and raise the awareness and knowledge of a Smokefree Aotearoa 2025 goal			MoH Draft Tobacco Action SF 2025 in currently consultation phase with the Sector	
		Smokefree Aotearoa 2025 logo and messages included across Smokefree projects, communication and resources	Delays due to Parental Leave		MoH Draft Tobacco Action SF 2025 in	

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					currently consultation phase with the Sector	
		Review hospital based current services procedures all patients who smoke are Asked about their smoking status, given brief advice to stop smoking and are offered/given effective smoking cessation support.				
		Review Lead Maternity Carers (LMCs) procedure's that support a systematic process to ensure pregnant women who smoke are Asked about their smoking status, given brief advice to stop smoking and are offered/given effective smoking cessation support.				
		Explore and agree options with the PHO to review current activities to achieve and maintain 'Better help for Smokers to quit'.				

2.5.7 Breast screening	Significant inequity in screening rates persist in Whanganui rohe despite achieving the national target overall. To improve equity we aim for a 10% increase for priority populations in completed screens on the previous 12	Identifying barriers and address the needs of Māori & Pacific women through: (EF)				
		data analysis of general practice registers, Trendly and Breast screen Coast to Coast data to identify Māori & Pacific women who need screening and identify focused approaches				
		proactive follow up by general practice, outreach service and Iwi health providers				
		Māori health providers located across the region to support women to screening including offering transport, information				
		Improving access to Pacific women through community networks focused on Rangitikei population: (EF)				
		consider Pacific 'kaiawhina role' including completing population profile and needs and scoping requirements with key stakeholders			Pacific Kaiawhina role appointed with Te Kotuku Hauora	

	months by: (EOA)	Increase screening rates for Asian women through identification of practice registers and providing targeted outreach approach: (EF)				
		develop relationship with Asian nursing workforce to inform approach				
		Use population-specific health promotion approaches to encourage uptake of screening opportunities: (EF)				
		develop one communication flyer with key messaging in Te Reo, Pacific and Asian				

2.5.8 Cervical screening	Significant inequity in screening rates persist in Whanganui rohe. To improve equity we aim for a 10% increase in completed screens by priority populations on the previous 12 months by:	Explore development of a mobile outreach service for rural and isolated communities to provide screening, assessment and vaccination services based from a mobile unit (based on learnings from COVID -19) (EOA)				
		Concept paper developed for Executive Leadership Team & next steps confirmed				
		data analysis of general practice registers, Trendly and NSU data to include age, ethnicity and location of women to inform targeted approaches for Māori & Pacific women		Discussion with one school community is progressing		
		identification of appropriate screening venues e.g. workplaces, Marae & community settings				
		Develop / pilot an iwi led clinic (once a month over six months) including Māori smear takers as an alternative entry point for screening on weekends and after hours. Promoted widely across social/media and networks. (EOA)		Clinic undertaken with future clinics scheduled		Partial Development of a pilot underway with Te Oranganui Inc.
		Develop Māori health professional smear takers to reflect GP population and increase number of Māori screen takers against baseline: (EF)				
		liaise with MOH & Family Planning NZ to identify and confirm educators to undertake accessible training sessions & confirm training calendar				
		engage with Māori nursing workforce including Te Uru Pounamu and other nursing roopu to support upskilling				

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		Review investment into cervical screening against equity tool to inform development of appropriate model and align provider agreements with confirmed approach. (EF)				
2.5.9 Reducing alcohol related harm	Activity	Cohesive relationship between Public Health, Health Protection and the Alcohol Licensing Cluster Group for monitoring and surveillance of the Whanganui District Alcohol Licensing accord and related activities				
		Quarterly monitoring and reporting surveillance of alcohol-related hospital presentations including improving maintaining the processes of data capturing within the DHB				
		Determine activities develop an action plan that aligned with the 5+ Solution approach to alcohol related harm within WDHB position statement on alcohol by 30 June 2020				
		In partnership with community probation service, community Mental Health & Addictions, Te Oranganui and WDHB develop a sustainable Brief Intervention Programme for Community Corrections (EOA)				
		To consult and co-design a Brief Intervention programme with key stakeholders and other interested parties				
	Raising awareness on preventing Fetal Alcohol spectrum disorder (FASD)	Public Health, Kaihoe-Health Promotion to Facilitate FASD) Network Group				
		To deliver FASD Awareness presentations within the community for identified priority populations (EOA)				
		In collaboration with partner's support FASD Awareness Day on the 9 September 2020				

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Better population health outcomes supported by strong and equitable public health services						
Subsection	**Activity**	**deliverable**	**Q_1**	**Q_2**	**Q_3**	**Q_4**
2.6.1 Delivery of Whānau Ora	Establish effective relationship with Te Puni Kokiri locally. (EF)	Support and explore collaborative opportunities with Te Pou Matakana and partners, and alignment of initiatives with local Whānau Ora initiatives. (EF)				
	Implementing and monitoring whānau centred approaches to care and services.	Include whānau hui in service delivery with the support of Te Hau Ranga Ora Haumoana Service for DHB provided services. (EOA)				
		Explore opportunity to partner with the PHOs to establish two whānau centred general practice and social service wrap around, one of which is kaupapa Māori, implemented through a whānau ora model of care. (EF)		Yet to be formally considered due to other priorities		
		Ongoing implementation and monitoring of Korero Mai (EF)				
		Korero Mai seeks to enable patients and whānau to communicate concerns about a patient's deteriorating condition				
		Reporting of results				
	Pro-equity priority areas:	Improve transparency in data and decision making: (EF)		In progress – more work required		

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		share equity analysis widely and include it in decision making		Needs more refining and consistency		
		transparency in resource allocation, including equity analysis in all publicly reported data		In progress – further work required		
		Support more authentic partnership with Māori: (EF)				
		meaningful participation in the design of services and interventions to support Māori self-determination and whānau ora.				
		Ensure provision of information for Māori whānau meets the guideli nes for health literacy. (EF)				
	Waimarino development	Co-develop design work and complete business cases (EF)				
		Establish project group				
		Service redesign and models of care completed				
		Facility design completed.				
2.6.2 Pacific health action plan	Pacific	Scope population profile and health needs to inform development of a Pacific Health Action Plan through a collaborative approach with the Pasifika community. (EF)		Initial research into Pacifica demographics completed, currently under discussion		

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2.6.3 Care Capacity Demand (CCDM)	Governance	There has been a change in the governance structure at WDHB. This includes a change in the chair for CCDM council, a change in the coordinator role to the ADON and a review of roles and responsibilities and systems and processes. This will strengthen the programme and support the 2021 deadline.				
	Activity	Ongoing monitoring of CCDM and TrendCare work plans through CCDM Council. (EF)				
		WDHB is employing an allied health informatics role which will be the key link to advance allied health CCDM further.				
	Focus: Improved variance response management (VRM)	Operations centre is running and shift reporting done actively and in a 'live' manner. Live data is being used.				
		Review analytics to ensure we are collecting the correct data to respond appropriately to staffing deficit.				
		Align VRM to emergency response plans.				
		WDHB has a programme (Health Careers Day) to educate and enhance nursing/midwifery/allied and medical as a career. The focus is particularly for Māori as we recognise that the percentage of Māori clinical staff employed does not reflect our population.				
2.6.4 Disability Action Plan	Disability	Identify and engage with key stakeholders across the district, including tāngata whaikaha / people with lived experience of disability, and Iwi health providers, to scope what is required in a disability plan for the Whanganui district and whether a regional or district plan would be advised approach. (EF)			Disability Lead from Executive appointed	
2.6.5 Disability		Review the use of webPAS to record if a patient has a disability and communicates this to staff. (EF)				

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2.6.6 Planned Care	Strategic Priority 1 - Improve understanding of local health needs, with a specific focus on addressing un need, consumer's health preferences, and inequities that can be changed. (EF)	Analyse and benchmark intervention ratios to show potential focus areas				
		Include equity analysis within intervention ratios				
		Use the results of the post-COVID consumer engagement surveys to highlight preference where applicable				
	Strategic Priority 2 - Balance national consistency and the local context	Maintain delivery rates that are consistent with national standard intervention ratios – this includes assessing models of care and how these are delivered in context of our local community.		See narrative reporting - SS08	See narrative reporting - SS08	
		Engage governance and clinical leadership on the potential impact of the national consistency approach		See narrative reporting - SS08	See narrative reporting - SS08	
		Define options for requisite adjustments		See narrative reporting - SS08	See narrative reporting - SS08	
		Work with sub-regional partners to consider mutually beneficial approaches		See narrative reporting - SS08	See narrative reporting - SS08	
	Strategic Priority 3 - Support consumers to navigate their health journeys:	Review systems for booking and contacting patients regarding inpatient and outpatient events to ensure timely advice of pending treatment and reducing missed appointments (EOA)		See narrative reporting - SS08	See narrative reporting - SS08	
		Review service models and identify potential services for change		See narrative reporting - SS08	See narrative reporting - SS08	
		Review completion with recommendations		See narrative reporting - SS08	See narrative reporting - SS08	
		Understand impacts and plan for implementation of accepted recommendations		See narrative reporting - SS08	See narrative reporting - SS08	
		Collaborative Community Health Pathways				
		Localise 70 pathways for use in general practice				
	Strategic Priority 4 - Optimise sector capacity and capability	Deliver services in least intensive setting – continue to review what procedures can be undertaken in outpatient and community settings where patients have fewer barriers to access: (EF)				

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		Work with secondary services, general practice and community providers to shift volumes				
		Review the process used to allocate operating times for surgeons. This will assist in list planning as one component of improving service delivery:				
		Develop Terms of Reference				
		Agreed practices for surgeons and nursing perspectives completed				
		Plan for implementation from Q3 2021/22				
	Strategic Priority 5 - Ensure the Planned Care systems and supports are sustainable and designed to be fit for the future	Commission a comprehensive theatre productivity review to ensure theatre use is optimised and emerging opportunities for improved planned care can be implemented				
		Review throughput				
		Reduce cancellations				
		Develop robust production plan				
		Consider flexible working arrangements and better integration with other hospital activity				

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	Acute data capturing	Switch over to SNOMED – still to be scoped as a regional project to meet 2020/21 timeframes.				
	Patient flow activity	In the post-COVID environment we will continue to run an "influenza" clinic/workstream at the hospital front-door. This will be based on the CBAC model that existed through alert levels 2 – 4 and will ensure better streaming of patients, isolation of winter ills and the ability to re-establish a swabbing regime if necessary	CBACs remain in place	CBACs remain in place	CBACs remain in place	
		Continuing with the dedicated haumoana (family/whānau navigator) service in the Emergency Department. This service operates 24 hours each day to support Māori whānau while they are in hospital from acute presentation to discharge. On site accommodation is available for the family/whānau of patients to enable them to be with patients during their stay.				
		Developing streamlined processes and protocols for early identification of those patients that are likely to be acutely admitted to hospital from ED and fast tracking those patients directly with the appropriate specialist team.				
	Understanding demand during COVID 19 and responding in new ways	Post-COVID 19, the district has embarked on an intensive community engagement process along with our recovery partners. Together we are asking the community for feedback on their experiences of the COVID pandemic across health, social and economic perspectives. The pandemic resulted in many acute services having a significant drop in attendance that we need				
		to understand. Alternative hods of serving that demand or of avoiding it altogether will be identified.				
		A significant amount of acute demand was responded to through virtual consultations – WDHB will be embedding the ability for DHB clinicians to safely deliver virtual consultations	Telehealth roll out across all services			

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	Community/Specialist Nursing	Taking a whole of sector approach explore further the development of a new model of care for Community/Specialist Nursing teams working with GPs, practice teams and community providers. (EF)				
		Improved Management for long Term Conditions, (CVD, Acute heart health, Diabetes and Stroke).				
		Support people with LTC to self-manage and build health literacy.				
2.6.8 Rural Health	Telehealth for Rural communities	Establishment of a pilot to improve access to Massey Psychology services as part of the Central Cancer Network	The Massey Cancer Psychology service provides telehealth access where appropriate to rural communities. Covid-19 enabled this to occur which has become business as usual			
		Develop new model of care to test with other services		CMAHS Psychologists are currently engaging with telehealth in the Marton and Taihape area. There is work underway to engage with the rebuild of the Waimarino Health Centre to create a telehealth space that allows for patient and Whanau centred care. Ongoing engagement with DN's, CNS's, community OT and physiotherapy is occurring to encourage services via telehealth to rural areas.		
		Explore feasibility to extend telehealth services to other rural communities such as Taihape, and Marton				NO REPORT
		Project Group Established				

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	Support community led consultation, and engagement with iwi, staff and community providers for the redesign of the Waimarino Health Centre. The focus will be on identifying the needs of the Waimarino community, building on work undertaken as part of the Ruapehu Whānau Transformation Plan to develop a Wellness Centre that supports greater integration and enhanced models of care to improve access to health and support services for the Waimarino community – (see also section 2.6.1 Whānau Ora): (EF)	Service redesign and models of care are determined as part of finalising the Wellness Centre facility design				
		Wellness Centre design are completed.				NO REPORT

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2.6.9 Healthy Ageing	ACC Non-Acute Rehabilitation (EF)	Support non-acute rehabilitation that helps older people regain or maintain their ability to manage their day-to-day needs following an acute injury by:				
		Develop pathways/service for rehabilitation in the community and align with other community-based developments to encompass ACC non-Acute rehab (NAR).		work underway	Work in progress	
	Addressing Frail and Vulnerable Older People (EF)	Supporting primary and community care settings to identify fail vulnerable older people (younger for Māori and Pacific) as part of a broader three-year work programme of keeping people well in their own home and communities by better prevention and management of long-term conditions and reducing acute demand by:				
		review with St Johns Ambulance service directly into ED by developing clinical pathways and models of care including home based support services, community providers and non-acute rehabilitation (supported discharge and transitions of care)		work underway	Mate wareware app circulated to primary providers. Focus on recognizing dementia and raising awareness through MOHAG and iwi providers. Revised fragility early detection tool being trialled in two GP teams before being implemented across primary care. Dementia pathway in development.	
		implement Health Pathways supported by planned care and community care funding options		work underway		
		continue to work closely with HQSC and support locally Advance Care Planning and Serious Illness Conversations				
		implement frailty health pathway		Health Pathways being implemented as prioritized		Partial. Work being led regionally sponsored by CE's
		ensuring quality ethnicity data is included and results interrogated for equity in Māori Health outcomes				

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	Carer Strategy (EF)	Work in partnership with Ministry of Health and other keys stakeholders to progress locally three national priority areas that include:			N/A	
		more accessible respite		COVID	This is part of national work with both DHB's and MOH DSS.	Partial DHB has been working with Alzheimers Whanganui to identify opportunities for supporting whanau who have a family member with dementia
		management of continence		COVID	This was to be lead by MOH nationally but was disrupted by COVID 19	Met WDHB has completed a continence survey sponsored by MOH
		Funded Family Care				
	Home and community support – 69,000 beds (EOA)	Over the next two years partner with an inclusive range of representatives from our communities to redesign through co-design an integrated and coordinated community model incorporating home and community support, iwi providers, community NGOs, district nursing, specialist nursing and allied health, working in partnership with general practice teams focused on keeping people well in the community.		work underway	Work in progress, this is a 2 year project.	Partial
		The model will be informed by the Home and Community Support Service Framework and Service Specification outcomes from Live Stronger for Longer and Pressure Injury Review				Met
		Other funders such as ACC will be included. This work will also be a major contributor to assisting the DHB to address the drivers of acute demand for people aged 75 plus presenting at ED and urgent care services (including at lower ages for disadvantaged populations).			PHO and DHB working with ACC osteoporosis NZ on fracture	Met

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					liaison and early intervention. CfOP programme implemented, commencing with IV therapy in the community	
		The approach will include a kaupapa Māori approach for kaumatua and includes working in partnership with interRAI NZ as they undertake a national review of interRAI by Māori and include other key stakeholders. (EF)		depends on interRAI NZ	This is being led nationally	Partial
		The first steps are to scope this commissioning project and agree the national standard bulk funding approach for home and community support services.				Being led nationally
	Implementing Dementia Framework (EF)	Support a regional approach to implementing the Dementia Framework locally.				
	Live Stronger for Longer – Falls Prevention and Fragility Fracture Management (EF)	Continue to work with ACC, HQSC and the Ministry of Health to promote and increase enrolments in strength and balance programs and improvement in data driven osteoporosis management the as reflected in the 'Live Stronger for Longer' Outcome Framework, Healthy Ageing Strategy and DHB district whole of system approach.				
		The DHB in partnership with ACC and other key stakeholders will be undertaking an evaluation of the current programs for falls prevention and fragility fracture management. This evaluation will include identifying options for innovative delivery for community strength and balance and data driven bisphosphonate prescribing by primary care. This will be completed prior to December 2020 (EF)				
	Pressure Injury Prevention and Management (EF)	The DHB is working in partnership with ACC to progress pressure injury prevention and management programme across the WDHB district. This initiative includes linkages with age residential care, general practice and community providers.				
		The DHB in partnership with ACC and other key stakeholders will be undertaking an evaluation of the programs currently being offered. This will be completed prior to December 2020				

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2.6.10 Improving Quality	Adverse events	Continue to undertake CSA/RCA/Case/London Protocol review for all SAC1/2 adverse events				
		Implement the national mental health adverse event template/process when this is available				
	Implement the new national inpatient survey once this is released by HQSC:	Implement the new national inpatient survey once this is released by HQSC:				
		action plans are developed where results are below the national average (EF)				
		action plans have been developed to address inequities identified in the survey returns and results. (EF)				
	Implement, monitor and measure the consumer engagement quality and safety marker (QSM):	implement the actions of the WDHB consumer engagement review 2020 (EF)				
		continue to engage with consumers and apply co-design principles in all service improvement activities. (EF)				
	Monitor all HQSC QSMs, including falls, pressure injuries and safe use of opioids and develop improvement plans where results are below the national average. HQSC QSMs are monitored and results are available on the national dashboard:	monitor ethnicity variations and develop plans to improve equity where inequities are identified (EF)				
	Reducing seclusion	Staff continue to work in a trauma informed way				
		Improve use of sensory modulation, as evidenced through increased episodes (EF)				
		Use of Māori sensory modulation kits (EF). Application of PDSA to implementation.				
		Continue to monitor the national KPI for seclusion hours and events				
	Service transition	Continue to implement connecting care projects				
		Transition role from CMHAS to GP is in place				
		Implement a discharge nurse position (general health)	FTE was disestablished by finance as part of the wash up last financial year; the fte was vacant.			
2.6.11 New Zealand Cancer Action Plan 2019-2030	Current Performance Actions	WDHB will continue the patient tracer audit programme and implementation of continual quality improvements identified in patient journeys that breach the 62-day target. (EF)				
		WDHB has a Haumoana specifically to work with Māori and Whānau to provide support to assist them to navigate health services through their journey and to ensure equitable	Underway	Underway	Underway	

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		outcomes. This work will be led by a clinical team and include the cancer nurse coordinator and the Māori health team. (EF)				
		Further planning initiatives will be developed in line with the National Cancer Action Plan and national cancer agency guidance.	Underway	Underway	Underway	
	Local cancer services	Service business case completed	Underway			
		Facility business case completed				
		Tender for build				
2.6.12 Bowel screening and colonoscopy wait times	In 2019/20 WDHB was allocated capital funding to develop a local chemotherapy and infusions unit. Planning is underway to have this established by 2021/22. It is anticipated that the current limited local chemotherapy options will be expanded significantly by having a local service and that this will reduce the need for WDHB residents to travel to Palmerston North for those procedures. Radiation oncology will continue to be based at the RCTS.	Continue to monitor and report on performance against urgent, non-urgent and surveillance colonoscopy waiting times (EF)			Surveillance 57.3% (not achieved).	
		Discuss recommended and maximum wait time performance as standard agenda item at monthly endoscopy user group meetings. (EF)				
		Develop policy for management of endoscopy waiting list that includes escalation process for patients at risk of exceeding maximum wait time. (EF)				
		Develop report that identifies all patients that are waiting for colonoscopy by ethnicity and triage category. Include acuity index calculation, so that patients at risk of exceeding maximum wait time can be easily identified. (EF)				
		Ensure 95% of bowel screening participants who return a positive FIT have a first offered diagnostic date that is within 45 working days of their result being recorded in the NBSP IT system, with no equity gap for Māori and Pacific populations (EOA)				Accurate data not available following transition to new bowel screening register (BSR).
		Ensure at least 60% of eligible bowel screening population participate in the programme, with no equity gap for Māori and Pacific Island populations (EOA)				
		Review and discuss bowel screening participation rates and bowel screening colonoscopy wait time results by ethnicity (Māori, Pacific Island, Asian, Other) at bowel screening equity working group meetings. (EF)				
		Facilitate the delivery of health promotion activities identified through the bowel screening equity working group, the bowel				

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		screening communication and engagement plan, and the bowel screening equity plan. (EF)				
2.6.13 Workforce	Grow leadership across administration and non-clinical professional staff.	Ongoing individualised development of tier 3 and 4 employees				
	Activity	Develop an Action Plan based on the priority focus areas of the 'He Hāpori Ora Thriving Communities' strategy.				
	Adoption and implementation of 'He Hāpori Ora Thriving Communities ' strategy.	Social, economic and pro-equity factors considered in the wider determinants of health.				
	Align staff development with health gain areas for the district.	Include health literacy as core component of staff training. (EF)		Yet to be included in mandatory training and orientation		
	Be guided by the MoH Raranga Tupuake – Māori Workforce Development Plan. (EF)	Guidance is reflected in actions				
	Continue to grow clinical leadership across medical, nursing and allied health, scientific and technical staff.	Complete Talent Mapping for WDHB tier 2 employees completed		New Leadership group		
	Continue with placing training interns at the WDHB.	Work with managers and executives to support expansion of the programme placing training interns at the WDHB.	Training interns in place. Expansion of the number of interns an ongoing process.			
	Create environments where our people are well supported and enabled to thrive and deliver the best care to our patients, whānau and communities. (EOA)	Create environments where our people are well supported and enabled to thrive and deliver the best care to our patients, whānau and communities. (EOA)				

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	Deliver on the WDHB pro-equity plan where the conditions for equity are created. (EF)	Equity KPIs agreed for all leadership / management roles	In progress			
		Agree equity targets to proactively grow Māori workforce across the health district that reflects proportionally for our Māori population by 2030	In progress – scoping underway to determine current status in district.			
		Use of Te Reo Māori reflected in all WDHB communication and formal interactions	In progress – ongoing work to further expand use of Te Reo.			
	Develop a retention and recruitment strategy that includes health providers across the district that is focused on Māori staff. (EOA)	Recruitment and Retention strategy for Māori staff developed		DHB recruitment Strategy revised and approved by executive Dec 2020- to be socialised with staff		
		Implement the WDHB recruitment and retention strategy focused on Māori staff. (EOA)		DHB recruitment Strategy revised and approved by executive Dec 2020 - to be socialised with staff		
		o Increase number of Māori staff working in health across the district		Ongoing - Slow increase in number of Māori staff over past two quarters		
	Develop a sustainable approach to nursing career pathways.	Equitable funding for professional development for nurse practitioners				
	Develop a strategy to support employment of a Māori workforce:	that reflects the Māori population proportionality for the WDHB region by 2030 (EOA)				Policy developed, implementation and procedure and required
		with occupational groupings that reflect the Māori population proportionality for the WDHB region by 2040 (EOA)				Regular reporting by occupation in

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						hand – further work required
		Strategy developed that focus on ensuring strong local supply to meet future health needs				Strategy to be developed
	Develop a sustainable approach to nursing career pathways.	Equitable funding for professional development for nurse practitioners				
	Develop an Integrated Social Governance framework to minimise the impact on service delivery that results from matters such as COVID-19.	Integrated Thriving Communities Team will support leading the WDHB's Integrated Social Governance framework (collaborative team comprising of representation from Whanganui District Health Board, Whanganui District Council, Rangitikei District Council, Ruapehu District Council, Whanganui Regional Health Network, iwi and supporting agencies)				
		Feedback from the community on the impacts of COVID-19 and the lessons learned from the response to the virus, as well as what keeps their communities healthy and well.				
		Develop a scoping report that outlines through qualitative and quantitative analysis an outline of our communities.				
		Integrated Social Governance framework developed based on three specific areas of recovery – economic, health and social.				
	Develop mechanisms to measure retention within the health system beyond DHB employment. (EOA)	100% of Māori applicants who meet the minimum eligibility criteria for any role are shortlisted for interview. (EOA)				
		Turnover for Māori staff will be no greater than the DHB turnover for all staff				
		Staff with occupational groupings that reflect the Māori population proportionality for the WDHB region by 2040				

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		Mechanisms and measures agreed.				
	Development	Meet all of our training and facility accreditation requirements from regulatory and professional bodies, including New Zealand Nursing Council, Medical Council of New Zealand, New Zealand Dental Council, Pharmacy Council and Medical Colleges	Most areas comply. Awaiting confirmation following actions implemented.	Two corrective actions to be finalised		
		Accreditation requirements .				
		Education committee actively leads training at all levels within the DHB.				
	Expand Te Uru Pounamu to encourage connection between Māori health professionals. (EOA)	Three wānanga held for Māori staff per year		Yet to be progressed - planning underway		
	Gender Equity.	Implement equity and pay parity agreements as per the agreed settlement timeframes.	Bargaining / Negotiations continues	First equity settlement due in Q3 2020/21		

	Health Literacy (EF)	Health literacy is integrated across all patient-interaction with services in the DHB but is specifically recognised in the following:				
		The Collective Communications work				
		Delivery of whānau ora and whānau centred models of care				
		Workforce development (for non-clinical; and clinical; staff)				
		Health promotions messaging				
		Screening programmes				
		Appointment-related communications				
		Posters, brochures and other leaflets				
		Wayfinding signage and maps				
		Website, social media and media				

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		Long-term conditions information for patients and whānau				
		Mental Health Suicide prevention				
		Maternal and child work				
		Healthy Ageing activities				
		Pharmacy initiatives				
		Rural health initiatives in telehealth				
		Korero Mai				
		Shorter Stays in the Emergency Department				
	Make our environment conducive to greater uptake by Māori to improve recruitment and retention of Māori. (EOA)	Increased interview rate for Māori applicants – 100% of Māori applicants who meet the minimum eligibility criteria for any role are shortlisted for interview (EOA)	Final consultation on recruitment policy and procedure updated.	Recruitment policy and procedure approved. Roll-out and education plan for managers in Q3 2020/21		Revised recruitment policy in place , implementation and procedure in development
	Proactively promote Ministry of Health funding for Māori particularly in kura kaupapa and kura auraki settings. (EOA)	Monitor awareness and uptake of Ministry of Health funding by kura kaupapa and kura auraki settings	MOH funding is promoted, continues to be promoted - building of awareness of funding available to rangatahi / tauira when they leave school. Data would be collected from KOH registrations			Criteria requirements of MOH funding is not met by tauira within the school setting, however, can be picked up on leaving school
		Increase the number of Māori students from kura kaupapa and kura auraki entering health careers				This work is ongoing alongside development of a wider careers pipeline
	Provide tuākana tāina support for new graduate Māori nurses through Te Uru	All new graduate Māori nurses receive formal support				

	Pounamu programme. (EOA)					
	Realise cultural safety throughout the entire workforce. (EOA)	All staff, Board , management and leadership will continue to demonstrate participation in cultural competence training				
		Cultural safety monitored against changes to individual clinical practice which ensures Māori receive optimum care				Tool to be developed and introduced to leadership staff
		Expand existing programmes that build on organisation culture and values to include action on racism and institutional bias				
	Strengthen and maintain focus on Kia Ora Hauora. (EOA)	All Kia Ora Hauora graduates that wished to work in the WDHB are employed.				
	Support and remind staff to update their ethnicity status. (EOA)	Review and update ethnicity collection so that the DHB has 0% employees who have their ethnicity recorded as unknown.				
	Understand barriers experienced at schools hindering delivery of science programmes. (EOA)	Work with schools and education providers to identify alternative delivery hods for science programmes.				This is a barrier within the education system that requires a wider piece of work
	Wellbeing.	Develop a preventative model of health care for the WDHB district health carers.				

28 May 2021	Alignment to regional strategy (ISSP) :	Contribute at workshop and executive level to optimise service delivery through a new regional operating model	Ongoing work by Central region DHBs with external consultants and TAS			
		Have representation on regional clinical governance to ensure measurable clinical value				
		Involved in a refresh of the regional strategy with a modern digital context	Ongoing work by central region DHBs with external consultants and TAS			
	Collaboration across community, primary and secondary care:	eReferrals will digitise, streamline and optimise the referral process between primary and secondary care				
		MS Teams supports greater collaboration with community and other external agencies				
		Data sharing with main PHO generates shared insights				
		Shared electronic health record makes primary care patient portal available to hospital clinicians				
2.6.14 Data and digital	Consumer access to health information:	Deliver technology solution				
		Change management completion				
	DHB ICT investment portfolio:	WDHB commit to providing quarterly reports to Data and Digital directorate				
	Digital Maturity Assessment programme	WDHB commit to commence taking part in this programme at the earliest opportunity.				
	Embedding gains from changes introduced during Covid-19:	Roll out of Microsoft Office and Teams				
		Creating technical capability for roll-out of telehealth within DHB-provided services	Telehealth system utilised in some areas continuing with the roll out			
	Fax machines. In removing fax machines WDHB will:	Provide secure email supported by SMS text messaging				
		Utilise secure links through MS teams to provide collaboration access to files	Follows roll out of teams			
		Deconfigure fax access in multifunction printers with fax components.	Work underway			
		Implement eReferrals to replace the current fax process.	Generic referral form out for consultation. DXC system on the Service Now platform links to Medtech Evolution			
		Recommendations from Security Assessments will be reviewed and implemented where possible.				

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	IT security. To improve our security across digital systems:	Enhanced security features available through our MS e5 licensing will be implemented	Some features turned on others require further testing			
		Upgrade operating systems and replace aged hardware.	Follows roll out of new hardware			
		WDHB commits to working with the Ministry of Health to co-design and co-invest in a programme of work to support the implementation of the New Zealand Health Research Strategy through building the capacity and capability across DHBs to enhance research and innovation. (EF)				
		WDHB will identify regional networks to create research and analytics networks to support staff engaged with research and innovation and build capacity and capability. (EF)		Research is being supported at a local level as per the WDHB research strategy		
		Regional networks will report to ELT and Clinical Board		Not		
		WDHB's research policies and procedures will be updated to provide clinical staff with a supportive framework to engage in research and innovation activities. The patient safety, quality and innovation team will continue to provide support for staff engaging in research and quality improvement activities. (EF)				
		WDHB will develop a research strategy which has an equity focus with clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes. This will include sign off of all research applications by a member of Te Hau Ranga Ora, Māori Māori health service. (EF)				
		A WDHB research strategy is in place, including approval by Te Hau Ranga Ora				
		WDHB will work alongside Māori stakeholders (researchers, iwi, hapū, groups and communities) to develop an 'ara' (pathway) for Hauora Māori				

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		research. This will be included within the research strategy.				

Better population health outcomes supported by primary health care						
Subsection	Activity	deliverable	Q_1	Q_2	Q_3	Q_4
2.7.1 Primary health care integration	Better population health outcomes supported by primary health care	Improving patient flow through hospital services to allow a community focus with interprofessional practice as a priority (EF)				Partially Met
		Broadening use of the workforce in community settings (EF)				Partially Met
		Implementation of supported discharge, transition of care and coordination of home and community support services for older persons (disability) (EF)				Supported discharge opportunities have been identified and are being 'worked up' This work is linked with transitions of care. Implementing the new national home and community support service specification

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						for older people and bulk funding home and community providers will impact on co-ordination of home and community support. The modelling and analysis of this approach is being progressed
		Develop understanding of, and develop strategies to address, barriers to broadening primary care workforce to reflect the population and create the conditions for equity of health outcomes for Māori. (EF)		Work in progress understanding the capacity and capability of the primary, allied health and community nursing teams for the provision of an integrated connected primary and community-based service (inclusive of NGOs and home health agencies). Networking with other providers nationally to gain an understanding of		

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				alternative delivery models.		
		Review service models where appropriate to identify changes that would better serve the population and create conditions for equity including seeking opportunities for development of kaupapa Māori services in consultation with Māori Health Outcomes Advisory Group (MHOAG) (EF)		Work in progress		Partially Met We continue to work with our Māori Health Outcomes Advisory Group (MHOAG) to identify services models which are able to be changed including women's health
		Health Pathways supported by planned care and community care funding options (EF)		Community funding options programme contract agreed December 2020. A phased approach will taken with the initial phase being the implementation of IV therapy in the community. WRHN will administer for the district with expressions of		Partially met Community Funding Options programme implemented for IV therapy or Oral antibiotic follow up care.

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				interest sought from GP teams and Urgent care.		Of these 35 were urban and 12 from rural teams. The COPD pathway is in its first draft, a kaiawhina role has been established to work alongside individuals with COPD and their whanau. As a result of learnings from work to date LTC nurse specialist roles are being devolved into the community to support education and early intervention in primary care. The cardiac respiratory rehab programmes will also be reviewed to improve early access into

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						these programmes. Pathways developed that address health conditions that are significant for Maori, or where standardised management will deliver health gains include the local roll out of Best start, Community Funding Options Programme, Gout, Diabetes, Congestive Heart Failure. COPD is in development. As pathways are developed innovative services approaches to improve access have been implemented e.g. Pedialyte for children

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						available free at community pharmacies for children with gastroenteritis.
		Implement the RFP mental health services and addictions - See mental health section.				
2.7.2 Pharmacy	Implement community pharmacy component of MMR Campaign Strategy (EF)	Monitoring and MOH reporting requirements are in line with WDHB Project Plan				
		During COVID -19, relationships were developed across secondary and community services to support a whole of systems approach which will continue to be developed through the co design of a local pharmacy alert response framework. (EF)				
		Review of current emergency planning completed to inform framework				
		Framework developed and agreed				
	Provision of education and process links to general practice to develop the capacity of community pharmacies forre gout, COPD, MUR and vaccination (EF)	Online Gout training course completed by participating pharmacies				
		Implementation of health pathways and associated quality improvement activities for adult asthma and COPD	Stop Gout programme being implemented COPD Health Pathways under development	Adult asthma and COPD pathways currently under development (timelines have been delayed due to alignment with national guidelines by Lead pathways district DHB)	Kaiawhina role employed and working with respiratory CNS and ED, WAM to support improved health literacy/coaching and delivery of wrap around services to support persons with COPD Asthma.	
	Review community pharmacy facilitation	Ensuring Aged Residential Care have access to medicines optimization expertise of pharmacists				

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	roles to ensure alignment with identified priorities including: (EF)	Recommendations agreed and updated service agreement completed			Review not yet progressed due to other priorities	
		Consider community pharmacy group respiratory health & gout proposals with an equity lens and identify equity outcomes. (EF)	*Gout Stop programme currently being implemented with an equity lens as Māori experience higher prevalence of gout arthritis.	Equity workshop held with Gabrielle Baker and Leanne Te Karu with funders, providers, and consumers. Workshop discussion informed changes to programme overarching goal that better reflect pro equity approach. Participating consumers will be engaged in new year to develop consumer information. Cultural training programme available for all community pharmacists and staff.		
		Gout service model confirmed & establishment commenced	The Whanganui GOUT STOP Programme is currently being implemented. This programme is a district wide collaborative between WDHB, Arthritis NZ and WRHN and involves the development and delivery of a new service			

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			involving Community Pharmacy, General Practice, Whanganui Accident and Medical (WAM) and a Kaiawhina, to decrease the high rates of poorly managed gout arthritis within the Whanganui district, by improving awareness, health literacy, medication adherence and long term management.			
		Respiratory service model confirmed		Adult asthma and COPD pathways currently under development (timelines have been delayed due to alignment with national guidelines by Lead pathways district DHB)	PARTIAL	
		Explore the feasibility of establishing a mental health pharmacist to work across primary and secondary health (EF)				
		Complete consultation with psychiatric and pharmaceutical services and other relevant parties				
		Develop job description				
		Complete recruitment process				Recruitment underway. Job currently being advertised
2.7.3 Long term	Chronic kidney disease Ruapehu project to reduce progression of	Develop service model through a co-design approach with communities		Workshop held with consumers, providers, and iwi. Co design		

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conditions including diabetes	CKD for identified patients with high BP, diabetes, uric acid: (EOA)			approach agreed. Group education sessions begun.		
		Progress implementation of new service model				
	Explore the delivery of retinal screening in the community including identification of appropriate service model: (EF)	Consider use of other staffing groups (e.g. non-regulated) to undertake parts of the screening				
		Consider use of artificial intelligence to identify those screenings that require secondary reading from an Ophthalmologist.				
		Implement new service model				
		Data analysis completed to inform activity				
		General practice service to improve access programme confirmed, implementation progressing and outcomes analysed.			Data analysis completed to inform activity General practice service to improve access programme confirmed, implementation progressing and outcomes analysed Data available within each practice and several teams have requested specific data to assist them in the delivery of services.	

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					Communications / marketing role commissioned to support improved presentation of information and practice facilitation role advertised to support practices to better understand and utilise tools and equity data available.	
	Review LTC approach, information and programs to ensure it supports whānau ora, meets health literacy guidelines, and best practice: (EF)	Consider proposal for Gout management programme combining culturally appropriate education along with a kaiawhina approach will support improved access to medication management and engagement with pharmacy and general practice				
		Implement programme across the region				

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WHANGANUI DISTRICT HEALTH BOARD		**Discussion Paper**
		27 August 2021
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 June and July 2021.

2 Service Delivery Overview

2.1 Industrial Action

On the 9th of June NZNO members (nurses) went on strike. DHBs have received a further strike notice for the 19 August, 1100-1900. Contingency planning covers defining life preserving services [LPS] and reducing services for the strike period.

2.2 Optimisation and Efficiency Programme

Scheduling

Scheduling project is in the final stages and the project manager will be ready to present the findings in the next two weeks.

Theatre utilisation

Theatre roster review is underway. Questionnaires have gone out to relevant staff and interviewing will begin in the next few weeks.

CSSD

The audit is well over halfway and we are seeking an external party to assist with the remaining component of the audit.

A business case is being developed to support project management rollout for the T-DOC instrument tracking system [CSSD equipment being etched with identifier numbers supported by a tracking system]. This is an ISO standard requirement.

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2.3 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
June	1934	9	247	1137	466	75	25%	2%	153	64.5
July	2074	3	249	1178	572	72	28%	2%	165	66.9

*Data extracted from SQL Server Reporting Services

During the months of June and July 2021, the average daily ED attendances have increased from the May 2021 figure of 58 to an average of almost 66 daily ED attendances.

Hospital data

	AAU		CCU		Medical		AT&R		Surgical	
	Jun	Jul	Jun	Jul	Jun	Jul	Jun	Jul	Jun	Jul
Total monthly admissions *	221	240	48	43	151	127	33	42	137	161
Total monthly discharges **	146	161	29	24	205	193	27	33	259	294
Average Length of Stay (Days) **	0.37	0.23	1.6	1.5	5.3	6.0	15.6	13.7	3.2	3.4
Average Occupancy (all shifts) **	114%	120%	91%	84%	98%	98%	93%	87%	91%	92%
Average Occupancy (July 2020 – June 2021)	118.5%		91.1%		98.3%		91.2%		94.3%	

* Data extracted from TrendCare; note: (1) one represents an episode of care, [includes transfers between wards, theatre etc.]

Total June admissions compared to discharges 590/666. Total July admissions compared to discharged 613/705. Variance will

be attributed to those who cross over from end of month to beginning.

** Data extracted from WebPAS through PowerBI 09.08.21

Acute Readmission Volumes **	AAU			CCU			Medical			AT&R			Surgical		
	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul
48-hour	2	6	5	0	1	1	3	1	7	0	0	1	5	4	3
7 day	7	8	10	0	2	0	10	19	14	0	1	0	9	12	17
14 day	7	3	7	1	0	0	15	14	16	0	1	0	5	5	4
28 day	10	10	7	1	0	0	15	13	13	1	3	0	15	8	8
Total	**26**	**27**	**29**	**2**	**3**	**1**	**43**	**47**	**50**	**1**	**5**	**1**	**34**	**29**	**32**

** Data extracted from WebPAS through PowerBI 10.08.21; July figures may not reflect the total 14 day and 28 day readmission volumes.

Māori Acute Readmission Volumes **	AAU			CCU			Medical			AT&R			Surgical		
	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul
48-hour	0	1	0	0	0	0	1	1	2	0	0	1	0	0	1
7 day	2	2	2	0	0	0	2	3	6	0	1	0	1	0	3
14 day	0	0	3	1	0	0	6	6	4	0	0	0	1	1	0
28 day	1	2	3	1	0	0	4	4	1	0	0	0	3	3	1
Total	**3**	**5**	**8**	**2**	**0**	**0**	**13**	**14**	**13**	**0**	**1**	**1**	**5**	**4**	**5**
% of total acute readmissions	**12**	**19**	**28**	**100**	**0**	**0**	**30**	**30**	**26**	**0**	**20**	**100**	**15**	**14**	**16**

** Data extracted from WebPAS through PowerBI 10.08.21; July figures may not reflect the total 14 day and 28 day readmission volumes.

Covid vaccinations

As of 10 August 2021, vaccinations given totalled 31,644; of that, there were 19,757 first doses and 11,887 final doses. This is good progress from 11 June, where vaccinations given totalled 13,508.

Row Labels	Pfizer BioNTech COVID-19 (1)	Pfizer BioNTech COVID-19 (2)	(blank)	Grand Total
Aramoho Health Centre	1940	1719		3659
Home Based Service One	154	89		243
Home Based Service Two	1	2		3
Hunterville	181	5		186
Living Waters Medical VC	456	6		462
Raetihi	122	3		125
Rural Mobile Site One	587	196		783
Rural Mobile Site Two	141	104		245
School Based Mobile - Whanganui	171			171
Taihape Health Limited	485	282		767
Te Oranganui St Mary?s	7	3		10
Te Waipuna Health	989	1068		2057
Urban Mobile Site One	387	112		499
Victoria Ave	8419	4498		12917
Whanganui hospital (inactive)	184	28		212
Whanganui Hospital VC	5533	3772		9305
(blank)				
Grand Total	**19757**	**11887**		**31644**

3 Hospital and Clinical Services (H&CS)

3.1 Workforce

Nurse Entry to Practice (NETP) AND Nurse Entry to Specialty Practice

Nurse Entry to Practice (NETP) AND Nurse Entry to Specialty Practice nurses (NESP) have completed assessments/presentations and are on their final assignments for post graduate papers via Victoria University and Whitirea Polytechnic. In June we advertised another cohort of NETP and most of those who applied indicated a preference for working in the community. This differs to what has occurred in the past and is consistent with what is happening throughout the rest of the country. The process of employment has not yet been completed, so cannot provide employment details at this stage.

Orientation Manuals

Clinical areas within the hospital have been working on updating all orientation manuals to align with our Professional Development and Recognition Programme (PDRP). This will ensure that nurses continue to develop in their roles from a competent level nurse to expert level.

Professional Development and Recognition Programme (PDRP).

Nurses across the region continue to utilise the PDRP programme in recognition of the work they are doing and as a career development tool. WDHB are planning to move to a national e-portfolio to align with some of the other DHBs in New Zealand.

As of 29 June 2021, there were 210 DHB nurses enrolled in the Whanganui DHB PDRP programme. The breakdown is as follows:

RN's		EN's	
Competent	74	Competent	1
Proficient	86	Proficient	5
Expert	29	Accomplished	1
Senior	14		

Resilience Study Days

There has been a resounding request from both hospital and community staff to have resilience training. This prompted an educator to develop and deliver resilience training. All training places have been full, with waitlists. It is envisaged we will increase the number of training days next year as the feedback has been extremely positive and those attended have provided excellent feedback.

Health Workforce New Zealand (HWNZ)

The funding round for semester two has enabled us to provide funding to more nursing staff than envisaged due to some underspend in semester one. This year we have funded all those that identify as Maori, those on career pathways for specialist or prescribing nurses, a range of community nurses and nurses in leadership positions. The next funding round will begin in October for 2022.

3.2 Mental Health Inpatient

Te Awhina

July utilisation of Te Awhina was 118% and Te Awhina Intensive Patient Care (IPC) was 159%. Acuity and demand were up since previous reports with a variety of presentations. No physical staff harm or staffing injuries noted. Some tangata whaiora have required constant watches which has required an increase in staffing to ensure safety for all.

Transition into the community for tangata whaiora has been working well as partnership with community services and other mental health services grow. Accommodation requirements remains a discharge factor; the unit also carries a social worker vacancy.

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. Activities with Stanford house continue with significant success, and all involved continue to give exemplary feedback.

Stanford House has had approval to remodel the nursing staff to include a Monday to Friday nurse coordinator. This is within FTE and aligns with Nga Tapawae project and allows leadership succession planning.

3.3 Care Capacity Demand Management (CCDM)

Safe staffing, healthy workplaces is a national priority. Matching the 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. For the DHB to meet these standards the 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 submitted evidence of full implementation to TAS and a site visit is scheduled in September to determine whether the DHB has fully implemented the programme.

CCDM programme:

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 in principle, these to be understood formally before FTE/roster shifts.
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 analyses monthly at the CCDM operational group.

3.4 Quality

<u>DAA Group Surveillance Audit</u>

DAA conducted the DHB surveillance audit on the 6-8 July, the findings were favourable; 9 actions from the previous audit have been closed out and we now have 5 new actions. The final report will not be available for several months.

<u>Falls and Pressure Injuries</u>

Staff efforts to reduce falls and fall injuries while increasing safe mobility are focused on risk assessment followed by multidisciplinary responses. Examples include:

- Adhering to bed rest orders.
- Instituting a toileting schedule to assure that a patient has help walking to and from the bathroom at regular intervals.
- Frequent walks.
- Frequent reorientation if confused.

- Providing a safe environment, including good lighting, a bed that lowers to the floor, appropriate assistive devices and removing clutter.
- Reducing drugs that may cause dizziness, drowsiness, or confusion.

3.5 Service Delivery

The purpose of this section is to provide a planned care update.

Care with dignity programme - Kia tu rangatira ae, kia mana te tangata

A review has been completed on the WDHB Care with dignity - Kia tu rangatira ae, kia mana te tangata programme. This model provides very close observation and preventative nursing care to reduce the incidence of patient harm occurring (Cook et al, 2020; Nadler-Moodie et al, 2009, Wood et al, 2018).

The close care procedure, education programme and documentation are currently undergoing minor enhancements with a particular focus on measuring, monitoring, and reducing the cost of close care.

Emergency Department – current focus

For the month of July 2021 an audit has been undertaken gathering data from the Emergency Department (ED) nursing staff when a patient breaches the 6-hour length of stay (LOS) in ED. The purpose of the audit is to further understand trends and causes for breaches of the LOS, and associated specialities. Initial findings show that delay with ED treatment being completed or referred onto speciality teams was the highest reasons for 6-hour LOS breach in July 2021, followed by Radiology delays.

In August 2021, a large television screen will replace the traditional "whiteboard" with patient details in the Emergency Department (ED) workstation. This will then enable the 'map view' function which is an alternative way of interacting with Emergency as part of the WebPAS patient administration system. It provides a graphical representation of the Emergency Department as:

- patients are displayed as icons in their current locations
- summary details about patients are displayed on their icons
- clicking on a patient icon shows their details
- moving a patient to a location in the department involves dragging the patient's icon to that location.

Reduced hours during the Christmas period

Dates for reduced hours during the Christmas period have been established and communicated to enable planning to begin within departments and across service areas. Issues that require planning are the timing and make up of theatre lists, outpatient scheduling and staffing requirements over this period.

It has been decided that the final day for full-service provision for 2021 will be Thursday, 23 December, noting that some areas may instigate reduced services prior to this this date to ensure planned care support requirements are minimised beyond the 23rd (i.e. theatres may not undertake any major procedures after Tuesday, 21st December).

The first day of full-service provision for 2022 will be Thursday, 6 January. This will allow service provision to begin for individual departments from this date.

These dates will see all non-rostered staff have a 13-day holiday season break. This is made up of 4 public holiday days, 4 weekend days, and 5 annual leave days. It was noted that staff retained the right to take a longer period of leave should they wish, and if it can be accommodated.

The aim is to reduce our overall annual leave deficit as well as ensure staff are well rested before 2022.

Elective Services and Planned Care Indicators

ESPI's Two and Five are both compliant for July, based on local data, with 6 patients waiting longer than 120 days for First Specialist Assessment (ESPI2) and 7 patients waiting longer than 120 days for planned inpatient treatment (ESPI5). This is a significant recovery from June 2021, where 1.4% of patients waited too long for FSA and 7% waiting too long for inpatient treatment. National results will be released in early September; however, we expect these to reflect similar outcomes.

The national picture around elective services are approximately 12% of patients waiting too long for First Specialist Assessment, and 26% of patients waiting too long for planned inpatient treatment. The Ministry of Health are putting considerable focus on reducing wait times throughout the 2021-22 year, with additional incentive funding for meeting waiting time trajectories and project delivery.

Caseweight Throughput

Caseweight and patient discharges for July were higher than for the previous 12 months, with total discharges 110% of average, and caseweight 112% of average. Patient complexity was also higher for unplanned patients (acute care), indicating higher resource requirements per patient. This is illustrated in [data set 1]. The two other graphs [data set 2] are a subset of planned and unplanned care; the case weight total is divided by discharge totals to reflect the level of patient complexity. This is relevant when we align other system data, as in July saw an increase in the daily ED attendance average 69.9 and increase in patient complexity, whilst readmission rates remain high. Unplanned discharges were particularly high in paediatric medicine, this was a result of RSV virus and winter admissions; whilst adults showed that respiratory conditions were a contributing factor.

Data set 1.

	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Planned Discharges	261	261	250	269	266	225	189	243	273	226	278	266	285
Unplanned Discharges	674	670	619	681	704	607	564	535	579	535	592	632	696
ACC Discharges	43	52	63	41	51	42	14	49	53	47	52	61	35
Total Discharges	**978**	**983**	**932**	**991**	**1,021**	**874**	**767**	**827**	**905**	**808**	**922**	**959**	**1,016**
Planned CWD	31	298	285	303	321	259	214	256	315	260	321	280	286
Unplanned CWD	634	571	567	612	619	556	554	496	578	487	578	568	710
ACC CWD	52	86	73	47	67	58	18	72	59	65	61	88	49
Total CWD	**1,004**	**955**	**925**	**962**	**1,007**	**873**	**786**	**824**	**953**	**812**	**960**	**936**	**1,045**
Planned Complexity	1.22	1.14	1.14	1.13	1.21	1.15	1.13	1.05	1.15	1.15	1.15	1.05	1.00
Unplaned Complexity	0.94	0.85	0.92	0.90	0.88	0.92	0.98	0.93	1.00	0.91	0.98	0.90	1.02
ACC Complexity	1.21	1.66	1.16	1.15	1.31	1.39	1.29	1.47	1.12	1.38	1.17	1.44	1.41
Overall Complexity	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

*Pink indicates greater than 110% of 13-month average

Data set 2.

August 2021 **Public**

4 Primary and Community Services

4.1 General

The Primary and Community service report needs to acknowledge, first and foremost, the retirement of Shona Kirkby, after 50 years' service to the DHB. Shona was most recently the Clinical Manager for the District Nursing service and we wish her well on her retirement. We are recruiting for a replacement manager, with Mary Stanford, Clinical Nurse Manager of CART, providing interim leadership.

Winter months have seen an increase in sick leave, which, combined with vacancies, has impacted on service delivery, most noted in physiotherapy with 3 current vacancies. One social worker started in July and one in August. The recruitment process has followed a strong pro equity approach working closely with Te Hau Ranga Ora, ensuring that strong community knowledge was also important, and that cultural support was available to any staff who identify as Māori who start within the team. The number of social workers who identify as Māori within the social work team has increased from 1 out of 12 staff to 4 out of 12 staff. The Allied Health services are also welcoming the start of assistants in both social work and occupational therapy in August. There is continued reliance on casual employees and contracted staff for service delivery.

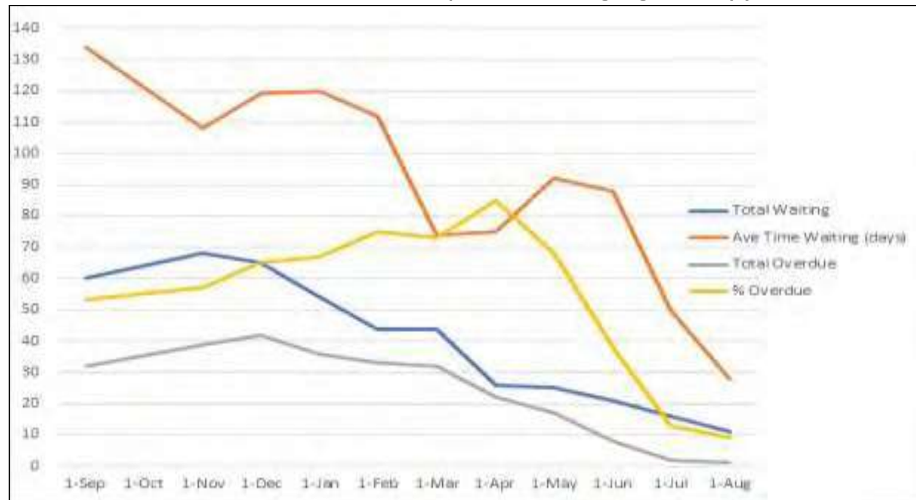
A focus on staff wellbeing and development has seen all Primary and Community Leaders begin a 6-month leadership programme with Dr Peter Blyde from Catalyst 4. There has also been a focus on the wellbeing off all staff, particularly those in Community Mental Health and Addictions and the Mental Health Crisis Team (MHAHT), following on from a cluster of suicides in the region. Both local self-care training for staff in mental health, and a national wellbeing tool are being explored – the latter in conjunction with people and culture.

The personal alarm system has been trialled successfully in both district nursing and Community Mental Health services and will be rolled out to other services who work in the community.

4.2 Service Delivery

There have been highest referral levels this year to most services, noted in both inpatient and community settings. Delivery of services has increased, with District Nursing noting its highest volumes this month, and Physiotherapy showing a 106% delivery on targets despite 3 vacancies. This does mean waitlists have increased despite best efforts in most areas; however, it is pleasing to highlight that the Speech and Language Therapy service has decreased its waitlist from 4 months to 4 weeks through use of changes to service delivery, including improving triage and setting up groups such as Parkinson's group.

12-month Referral Statistics – Speech and Language Therapy Service



Radiology has shown pleasing improvements in CT waitlists, now working to target. Ultrasound waitlists are predicted to decrease with a third sonographer starting and approval for purchase of a third ultrasound machine which we hope to position in the community. MRI waitlists continue to grow, and this will be looked at with urgency. The RFP for orthotics is out for tender with closing date for submissions 20 August.

4.3 Quality Improvement focus

Primary and Community have been progressing with many projects.

- Joanne Cormack has started as telehealth lead and established a draft project plan that is being developed, with a strong focus on equity. The project plan is still being developed with partners and will be shared once fully developed.
- The Clinical Informatics Lead is working on a risk mapping project to ensure there is a shared IT and Clinical understanding of risks with systems, and responses in case of emergency including cyber-attack.
- The falls project lead has successfully established the "Get up Get Dressed Get moving" project within the hospital for falls prevention.
- There is a community consultation document being released to seek views on the recent review of services for pressure injuries and falls, that will guide future service delivery.
- There is heavy Allied involvement in the planned care space, and in osteoarthritis pathways.
- The purchase of radiology equipment across the region has been agreed and the purchase process is underway.
- A tracking system for loans equipment has also been approved and will be implemented with IT imminently.

4.4 Maternal, Child and Youth Services (MCYS)

4.5 General

Maternal, Child and Youth Services had a successful 2020/21 year both fiscally and in non-financial endeavours. The five service areas are well embedded, and some exciting initiatives are underway.

This year the WDHB MCYS team will further establish contact pathways between our services and the community. We will progress the work streams originating from the Primary and Maternity Services Interface group, and engage with our community through various channels, including Healthy Families engagement around maternity services, and the Whanganui Maternal, Child and Youth Community Alliance. The 'Child Health Referral' project - developing a single point of entry into child health services - is another key project, currently in scoping phase.

Neonatal transitional care is an area of potential future development. The questions raised by the Board in relation to the 'Transitional Care for the Neonate' paper at the June 2021 Board meeting are addressed later in this paper.

The Ministry of Health (MOH) has requested a childhood immunisation action plan due to the declining rates within our rohe and nationally. This has been developed with our community partners and forwarded to the MOH. The following statement was recently released by the World Health Organisation (WHO) "*even as countries clamour to get their hands on COVID-19 vaccines, we have gone backwards on other vaccinations, leaving children at risk from devastating but preventable diseases like measles, polio or meningitis," said Dr Tedros Adhanom Ghebreyesus, WHO Director-General. "Multiple disease outbreaks would be catastrophic for communities and health systems already battling COVID-19, making it more urgent than ever to invest in childhood vaccination and ensure every child is reached."*

Contingency planning around NZNO and MERAS strike action is ongoing.

4.6 Service Delivery

Maternity

Recruitment to the 2.0FTE core midwife positions has been successful, although it will be a while before filled positions are practising on the floor. Two of the midwives commencing in October and November are coming into the core from LMC practice, which means two less LMC's in the community.

We have a further 2.8FTE generated through the CCDM calculations to recruit to and have received a 0.6FTE resignation for September. Overseas recruitment is being strongly considered due to the nationwide Midwifery shortage.

The Taihape maternity service has been affected by the retirement of a midwife. This service is managed by WRHN and the Director of Midwifery has met with WHRN to assist with contingency planning. We will assist where we can, however, our capacity to support Taihape is limited by our own FTE shortfall. Midwifery workforce demands are ongoing. Staff wellbeing is a priority, including management of their leave entitlements, and is critical to a successful, sustainable midwifery service for our rohe.

Recruitment to the full-time Obstetrics and Gynaecology consultant role is complete. The new consultant starts in late September 2021.

The number of women booked into the DHB Primary Antenatal Service has risen significantly in the last month from 5 to 35. This service is predominantly for women unable to secure an LMC for December 2021 and January 2022 due dates. This has necessitated an FTE increase for the WDHB midwife providing this care.

The Midwifery Forum on 13 July 2021 was another positive hui providing core midwives and LMCs with an opportunity to raise issues, formulate solutions and improve services to the community. This hui seeks to strengthen relationships between WDHB and our LMC partners.

The Whanganui Maternal, Child and Youth Community Alliance on 10 June 2021 focused on the first 1000 days of life. Progress in key maternity-led projects were shared. The Alliance completed a SOAR analysis on the needs of the six-week to two-year age group and their contributions will inform the future work of our service. Employing a whānau ora approach was a strong theme, as well as community-based and kaupapa Māori services. Key opportunities and new ideas for ways to provide accessible, wrap-around care and parenting support for māmā, pēpi and whānau in our rohe were discussed. The need for health, other providers, iwi and community partners to both advocate for our community and work together to provide for these needs is evident and essential.

Paediatrics

Respiratory syncytial virus (RSV) has affected children's' wards nationwide. Our Paediatric Ward was at capacity for two weeks at the end of June and early July. Case numbers reduced during the July school holidays, but historical data shows we can expect to see presentation of RSV cases until late 2021.

Dr David Montgomery is leading the recruitment of a further paediatrician with anticipated employment commencement at end of September 2021.

A combined training initiative across Maternity and Paediatric services is scheduled for 30 and 31 August 2021. STABLES training will increase the understanding and confidence of paediatric and maternity clinicians in basic neonatal care. This knowledge will ensure consistency of care, may reduce admissions to SCBU and allow for increased synergies and support between the paediatric and maternity teams.

Public Health

Public Health Nurses continue to support national COVID-19 contract tracing efforts and are attending comprehensive in-service training for contact tracing run by MidCentral Public Health Unit. Three staff were mobilised to support Wellington CBACs following the June case of the infected Australian traveller.

Planning for the school-based COVID-19 immunisation roll-out for 16 to 18-year-old secondary school students is complete. A number of vaccination education programmes have been held with parents at school prior to commencement. 'Anti-vaxxer' campaigners have been present at two schools holding placards and handing out brochures. The Immunisation coordinator has had further conversations with the affected schools following these events.

The school-based health service has reported a 32% completion rate for HEEADSSS assessments. The prioritisation of COVID-19 related work has impacted staff capacity and there are also an additional 100 eligible students this year. A plan is being developed to bring this work up to date.

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 has been submitted to MHOAG for their consideration.

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

Demand for mental health services is high and appears to be trending upward. Referrals into ICAMHAS were 28% higher in June 2021 than previous June figures between 2015-2020 and after-hours youth presentations at ED have also increased. Access to acute inpatient services for youth remains a key issue. Finding an inpatient placement can be a stressful experience for the patient, their whānau and our clinicians. 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.

MICAMHAS staff and our community are concerned about the recent high incidence of suicides and self-harm. MICAMHAS staff have worked intensively connecting with groups of youth thought to be involved in unsafe, influential relationships engaging in unhealthy behaviours such as self-harm. MICAMHAS is holding regular team lunches to provide opportunity for collegial support.

MICAMHAS invited Mel Maniopoto Bennett to present the He Puna Ora service to MICAMHAS staff, and the team are enthusiastic about the opportunity to work alongside this valuable service.

Oral Health

The new Dental Council recertification programme for oral health practitioners commenced on 1 October 2021 for dentists and dental specialists and commences on 1 April 2022 for oral health therapists, dental therapists, dental hygienists, and dental technicians, clinical technicians and orthodontic auxiliaries. WDHB is well underway in its preparations for recertification.

The WDHB Oral Health team were commissioned by Taranaki DHB to treat Waverley children for two days in the July school holidays. The engagement with this community was very positive.

The preschool age model of care is under review, as it typically experiences high DNA rates. Taking a mobile dental unit to provide onsite care at early childhood centres is one concept under consideration.

4.7 Future Focus

The next Whanganui Maternal, Child and Youth Community Alliance hui will be held on 26 August 2021 at Keith Street School and will focus on child health.

The third and final Midwifery Forum meeting for 2021 will be held on 12 October.

Work streams in progress initiated by the Primary and Maternity Services Interface Group are noted below. Most are significant pieces of work and anticipated to take 12-18 months to finalise.

- Maternity consumer feedback project – facilitated by Healthy Families
- Service guide for women
- Community directory of services for providers
- Integration of the Best Start tool into GP practice and socialisation of this tool.

The 'Child Health Referral' single point of entry project is another key piece of work being undertaken and is currently in scoping phase with funding recently confirmed by the MOH.

Appendix 1. Whanganui DHB Performance Dashboard

(data extracted 11 August 2021)

Hospital Based Care Measures

(A) ED Attendances by Month

(B) Hospital Discharges by Admission Type, by month.

(C) Acute Readmission Rates by Month (7 and 28-day rates)

(D) Outpatient clinic DNA Rate by Month and Ethnicity

(E) IDF Inpatient Outflow $ Totals by DHB and Month

(F) Faster Cancer Treatment Indicators

Commentary

ED commentary is within the body of the report.

(A) June data shows (63) more attendances compared to May; July increased over June by (129) attendances.

(B) Hospital Discharges by acute admissions were up significantly for June and July, whilst the hospital discharges acute admision ED only and planned admissions showed a slight increase for June and July.

(C) Readmission rates, 7 and 28 days remains consistant for both June and July. The DHB is exploring ways to be able capture relevant information that can be used to understand theses rates.

(D) Outpatient clinic DNA remains high for Maori with less than a percent of flutation during June and July; whilst non Maori continues to sit around 4-5%. Work is underway 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) July data is not completed; however, for June we paid a total of $2.04M in IDF.

(F) Faster Cancer Treatment 6 monthly report was presented at the last Board meeting. This graph indicates during May we reach 100%. This is a good result.

Community Based Care Measures

(G) 00-04yrs ASH Admission Rates per Population by Ethnicity

(H) 45-64yrs ASH Admission Rates per Population by Ethnicity

(I) Immunisation Rates by Month for Children Aged 2yrs

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, dental, and others [nausea, wheezing]. **NB:** Commentary is correct for June and July; however, final July 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 June and July; however, final July data is not available at time of report and is not included on the attached graph.

(I) Immunisation rates in June show a decrease in Māori and non-Māori rates.

Workforce Measures

(J) Turnover % Rolling 12 Month Average

(K) Sick Leave % by Month

Quality

(L) Acquired Pressure Injuries/Infections/Falls During Admission by Month

Commentary

(J) The average turnover at WDHB for June was 8.9% and July was 9.8%. WDHB average turnover was 8%. 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 up 4.2% in June and July was 4.49%. Both months were above the rolling average of 3.8%.

(L) Pressure injuries have decreased during July, both hospital acquired and community. Falls were up during June however July only saw one.

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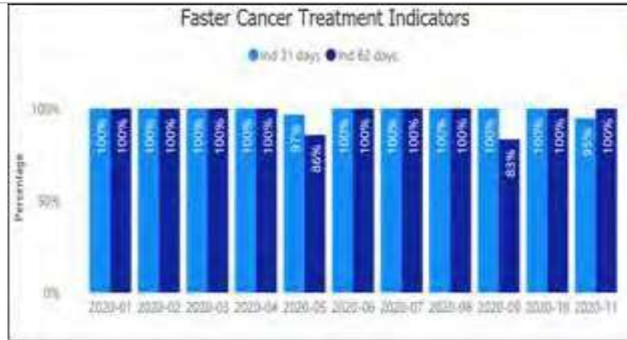
Whanganui DHB Performance Dashboard definitions.

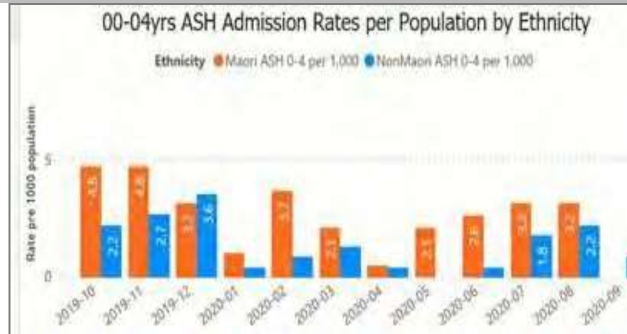
Hospital Based Care Measures	
Graph A. ED Attendances ED attendances are an indicator of acute patient demand in the system, while also identifying issues in access to primary care and potential flow issues in secondary services. **Calculation**: count of attendances.	ED Attendances by Month
Graph B. 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).

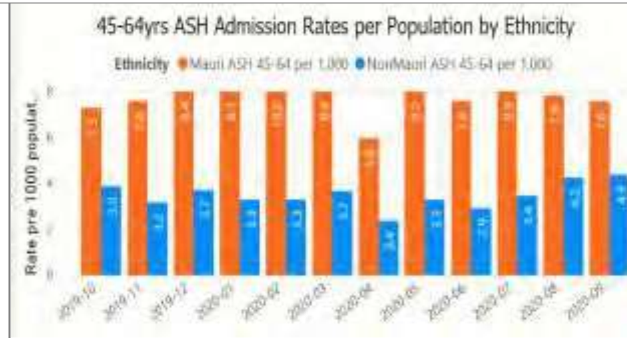


Community Based Care Measures

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		Turnover % Rolling 12 Month Average Average Turnover %: 8.3% 2019-09: 8.1%; 2019-10: 8.3%; 2019-11: 8.6%; 2019-12: 8.7%; 2020-01: 8.0%; 2020-02: 8.4%; 2020-03: 8.3%; 2020-04: 8.6%; 2020-05: 8.6%; 2020-06: 8.4%; 2020-07: 8.1%; 2020-08: 7.8%; 2020-09: 7.4%
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		Sick Leave % by Month Average Sick Leave %: 3.8%
Quality		
Graph L. Pressure Injuries/Infections/Falls Patient safety and care indicators for key measures. **Calculation**: count of events each month (not individual patients)		Acquired Pressure Injuries/Infections/Falls During Admission by Month

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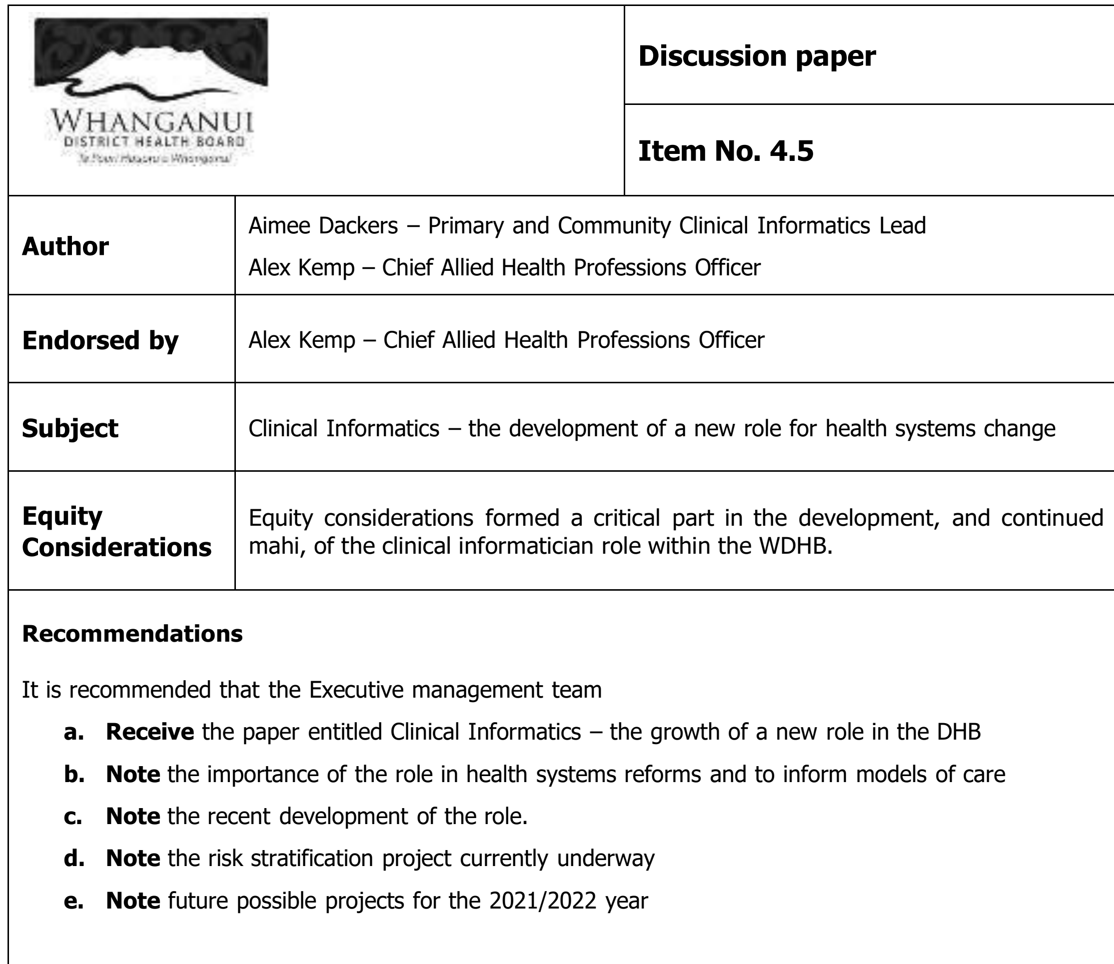

WHANGANUI DISTRICT HEALTH BOARD	**Discussion paper**
	Item No. 4.5
Author	Aimee Dackers – Primary and Community Clinical Informatics Lead Alex Kemp – Chief Allied Health Professions Officer
Endorsed by	Alex Kemp – Chief Allied Health Professions Officer
Subject	Clinical Informatics – the development of a new role for health systems change
Equity Considerations	Equity considerations formed a critical part in the development, and continued mahi, of the clinical informatician role within the WDHB.

Recommendations

It is recommended that the Executive management team

- **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

1 Background

In 2002 in the UK, a multi billion-pound digital transformation of the health systems and services was undertaken. In 2005, an audit of this process identified the lack of clinician engagement in this process as a major failing. Following on from this, a mass recruitment of clinicians in to the digital and data space was undertaken, and the role of the Clinical Informatician was developed.

Clinical Informatics is a profession that integrates a high level of knowledge of data and digital systems with clinical knowledge, to advance understanding of human health and delivery of health and social care. As a professional group they are the catalyst for digitally enabled and data empowered health care through the skills they bring of clinical experience, understanding of patient and whanau focussed health outcomes, and application of evidence-based clinical practice. The role is well established in Europe, with the role becoming more evident in the Australian and New Zealand health systems since 2015.

The New Zealand health system landscape is undergoing significant change in the field of data and digital. The number of digital tools available to support clinicians in care delivery and operational health service management is growing exponentially, from stethoscopes on phones to remote tele-measuring of degree of arm movements. The tangata whairoa and their whanau are an increasingly active partnership in health, seeking to increase self-care through self-generated data such as smart watches, mobile applications, and complex health home monitoring.
In the Health and Disability Systems Review report (2020), several challenges were identified in New Zealand's digital health sector, with the need for a more patient focussed and integrated system. A key recommendation from this report was that successful health transformation will rely heavily on effective use of digital and data. Reports on achieving equity within health speak clearly on the need to achieve

data sovereignty, and to expand our measurement of health to reflect the needs of those facing the biggest inequities in health outcomes. There are however, legitimate concerns raised about how promising advances in technology and data collection and analysis can also perpetuate health and healthcare inequities. All these challenges highlight the important value of the role of the Clinical Informatician to achieve success in integration of digital and data and patient care.

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In 2020, Whanganui DHB employed its first Clinical Informatician in the Primary and Community Team.

2 The role within Whanganui DHB to date

Over the past 8 months in post the Clinical Informatician has worked closely with the Informatics and IT teams within the DHB to understand the priorities, realities, and challenges in respective teams. In addition she has worked with clinical teams to understand perceived and real obstacles to efficient and effective use of IT systems, and to understand what data is needed to inform particular clinical queries or to measure possible changes in models of care. She has been able to map workstreams to inform process and make systems more user friendly for the clinician, whilst still fulfilling IT requirements such as security and interoperability. The role is, in essence, a translator and connector between the worlds of the clinician and those of the IT and data specialists.

An example of the value of the role is the below project that has stemmed from the cybersecurity challenges in Waikato.

2.1 Clinical and ICT Risk Stratification

Historically, Whanganui District Health Board (WDHB) IT systems prioritisation does not include a clinical perspective. This can lead to prioritisation decisions being made that are not informed regarding patient risk. In addition, only 53% of clinical services have a data and digital component within their emergency response plan (Business Continuity Plan, BCP). Due to this lack of information the WDHB response in scenarios of IT downtime, short or long term, could place patient and staff under unnecessary risk. This is a significant concern considering our clinical staff's heavy reliance on IT software and applications to provide patient care.

There is a need to develop a simple, shared understanding across clinical areas and our IT department that allows response and risk mitigation from both IT and clinical perspectives.

A risk criterion was developed by the Clinical Informatician based on a regional prioritisation framework. This forms part of a survey that will provide an overview of risk across clinical teams within the DHB, should a system stop working.

Category 1 - Critical	Application required for critical life preserving care/activities	Can safely have 10 minutes outage time	Outage could cause loss of life and limb to patients
Category 2 - Urgent	Application required for urgent care/activities	Can safely have 4 hrs outage time	Outage could cause permanent long-term disability/harm to patients
Category 3 - Planned Care	Application required for planned care/activities	Can safely have 8 hrs outage time	Outage could cause significant but not long term disability/harm to

			patients
Category 4 - BAU/Routine	Application required for business as usual care/activities	Can safely have 24 hrs outage time	Outage could cause possibility of minimal harm to patients

The immediate use of this will be to inform both IT and Clinical response in the event of prolonged system or infrastructure downtime, such as a cyber attack. For example the reliance on Clinical Portal, a patient notes system, may be critical / category 1 in ED, but category 4 in a planned routine outpatient appointment. Whereas the use of PACS (radiology) may be priority 1 in theatres but priority 3 in outpatient paediatrics. It will help guide development of business continuity plans for each team, and system based on the category classification of that system.

Longer term this stratification could be used to develop shared understanding of prioritisation of IT requests.

3. The Clinical Informatics role – the next phase

There are several projects in development for the next year, including:

1. A possible joint project with the Ministry of Health to determine clinical workforce IT competence and competence, in order to better inform the level of support needed for digital transformation
2. The development, measurement, and input of outcomes that are equity focussed, whanau centric, functional, and wellness based, in conjunction with the Informatics teams
3. Work across the rohe to support integration of clinical digital and data systems, ensuring clinical insight and engagement.

A last word congratulations to Aimee, our Clinical Informatician, has had a paper accepted at the Health Informatics New Zealand (HiNZ) Digital Health Week conference in November. Her paper is a reflection on her experience in establishing the role within the DHB.

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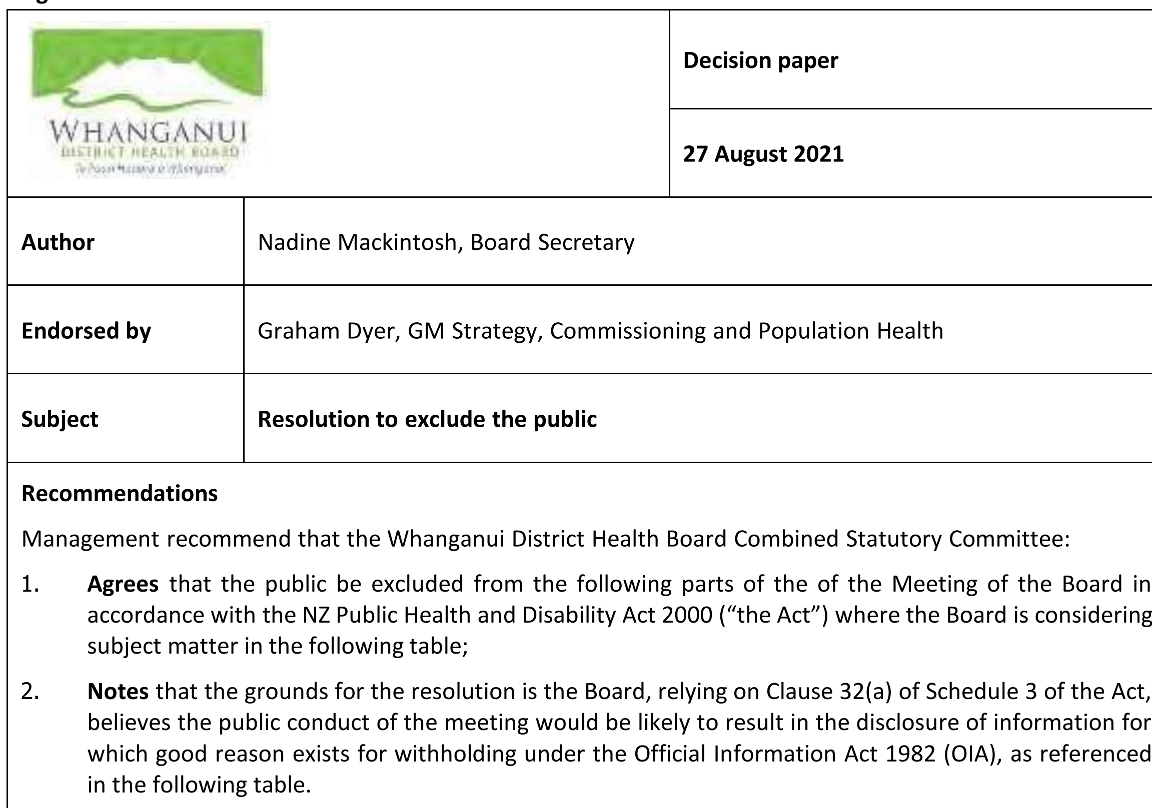

WHANGANUI DISTRICT HEALTH BOARD	**Decision paper**
	27 August 2021
Author	Nadine Mackintosh, Board Secretary
Endorsed by	Graham Dyer, GM Strategy, Commissioning and Population Health
Subject	**Resolution to exclude the public**

Recommendations

Management recommend that the Whanganui District Health Board Combined Statutory Committee:

1. **Agrees** that the public be excluded from the following parts of the of the Meeting of the Board in accordance with the NZ Public Health and Disability Act 2000 ("the Act") where the Board is considering subject matter in the following table;
2. **Notes** that the grounds for the resolution is the Board, relying on Clause 32(a) of Schedule 3 of the Act, believes the public conduct of the meeting would be likely to result in the disclosure of information for which good reason exists for withholding under the Official Information Act 1982 (OIA), as referenced in the following table.

Agenda item	Reason	OIA reference
Combined Statutory Committee minutes of meeting held on 28 May 2021	For reasons set out in the board's agenda of 28 May 2021	As per the board agenda of 28 May 2021
Pharmacy 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)
2020/21 Annual Plan Final Submission	To maintain the effective conduct of public affairs through the free and frank expression of opinions by or between or to Ministers of the Crown or members of an organisation or officers and employees of any department or organisation in the course of their duty	Section 9 (2) (g) (i)

Persons permitted to remain during the public excluded session

That 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 is 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 present	Management and operational information about Whanganui District Health Board	Management and operational reporting and advice to the board

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Person(s)	Knowledge possessed	Relevance to discussion
Executive Officer	Minute taking, procedural and legal advice and information	Recording minutes of board meetings, advice and information as requested by the board