Combined Statutory Advisory Committee (Public)

28 May 2021 09:30 AM - 01:00 PM

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
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	▪ Chair, Te Totarahoe o Paerangi – Ngāti Rangi (Ohakune-Raetihi) ▪ Director, Ruapehu Health Limited ▪ Trustee, Whanganui Community Foundation ▪ Iwi Rep, Rangitikei District Council Standing Committee ▪ Labour Candidate for Rangitikei District Council
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 26 February 2021, commencing at 9:30am

Combined Statutory Advisory Committee (CSAC) members in attendance
Ms Annette Main (Chair)
Mr Charlie Anderson
Ms Christie Teki
Ms Debra Smith
Mr Graham Adams
Ms Heather Gifford
Mr Josh Chandulal-Mackay
Ms Te Aroha McDonnell

In attendance for Whanganui District Health Board (WDHB)

Mr Paul Malan, General Manager, Strategy Commissioning & Population Health
Ms Alex Kemp, Director Allied Health
Ms Lucy Adams, Director of Nursing, Chief Operating Officer
Mr Ian Murphy, Chief Medical Officer
Ms Deanne Holden, Secretariat

1. Procedural

1.1 Karakia & Welcome

The Chair noted a quorum was present and opened the meeting with Karakia at 9:30am.

Those present, and the wider community, were thanked for the continued support of Health lead initiatives which have enabled the community to remain COVID free.

S Peke-Mason arrived 9.35

Apologies

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

K Whelan, R Simpson, F Bristol, M Bellamy

Apologies for lateness were received from P Baker-Hogan and S Peke-Mason

Moved: A Main **Seconded**: J Chandulal-Mackay

1.3 Conflict and register of interests update

1.3.1 Amendments to the register of interests

H Gifford provided secretary with written updates to the register as below:
- Withdraw as member of Tie Tira Takimano
- Add Advisor to WALT Project – "Whanganui Primary Health Research Collaborative"

T-A McDonnell advised she will provide amendments to the secretariat following the meeting.

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 13 November 2020 were accepted as a true and correct record:

Moved: A Main **Seconded**: M Bellamy

1.5 Matters Arising

It was noted there were no outstanding matters arising.

1.6 Committee Chair's Report

There was no verbal report from the Chair.

2. Presentation : The LifeCurve
A Kemp, Chief Allied Professions Officer

The Chair welcomed the presenter, Ms A Kemp, to the meeting and noted the forthcoming presentation titled "The LifeCurve" relates to Discussion Paper Item 4.4 on the agenda which was taken as read. The Chair passed the floor to Ms Kemp.

Ms Kemp introduced herself as the WDHB Chief Allied Professions Officer and advised the presentation she was about to present was initially produced by a colleague for presentation at the recent Masters Games event. Ms Kemp noted her thanks to Kathy Everitt, Bay of Plenty DHB, for granting permission to share the presentation with Committee.

A brief overview of the key points from the presentation are captured below:

The LifeCurve is an evidence based model which supports, at its core, adding 'life to years rather than years to life'. It achieves this by capturing the hierarchical nature of function loss that occurs with age.

Initially developed in the United Kingdom by Newcastle University with over 25 years of research, the licence for New Zealand is held by the Bay of Plenty DHB who hope to release a NZ version by the end of March.

The LifeCurve provides the ability for people to map their own stage of functional decline, via a downloadable app. Positive language focus provides a platform for the user to assess functionality rather age alone as a marker for age related decline. This allows for intervention at stages along the ageing journey with the ultimate goal of providing a preventative model of care.

Discussion followed with the Committee thanking Ms Kemp for her informative and insightful presentation.

It was noted that The LifeCurve is still at the early stages of roll out in New Zealand, however the potential for positive change is immense. Possible areas of concern were raised regarding equitable access in relation to access for elderly, Māori and rural communities. It was noted the WDHB He Hāpori Ora – Thriving Communities strategy will provide a platform to identify and further develop a base to support access ie: improvement of digital capabilities throughout the region and positive use of communication models to ensure hard to reach communities are engaged.

P Baker Hogan arrived 10:05

It was agreed Ms Kemp would be invited to MOHAG (Māori Outcomes Health Advisory Group) with engagement supported by Whanau Ora Navigators. Ms Kemp thanked those present for their comments which will assist in supporting preparation of the next stage to ensure the programme is tailored to work for our communities.

Action:
Secretariat to distribute presentation to the Committee.
A Kemp be invited to present at MOHAG.

It was resolved that the committee:

- **a. Receive** the paper titled "The LifeCurve"
- **b. Note** The LifeCurve is an evidence based tool that can indicate dependence on health and care systems and economic impact
- **c. Note** the Bay of Plenty DHB have purchased the right to The LifeCurve app in New Zealand and are releasing a New Zealand version of this in Marc
- **d. Note** there is research occurring to ensure The LifeCurve is appropriate for Māori, as part of the AWESSoM study headed by Professor Ngaire Kerse at Auckland University
- **e. Note** The LifeCurve provides the potential to identify people who have not yet received support from health services
- **f. Note** The LifeCurve has the potential to be used as a functional outcome measure across the health system
- **g. Support** management to proactively promote and use the LifeCurve tool

Moved: A Main **Seconded:** C Anderson

3 Discussion Papers

3.1 Quarter 2: non-financial performance framework
K O'Gorman, SCPH & Paul Malan, GM Strategy Commissioning and Population Health

A paper titled Quarter 2: non-financial performance framework was tabled by P Malan. The paper was taken as read with feedback on information provided and/or questions welcomed.

Members were reminded that the report is produced to answer specific questions asked by the MoH.

It was noted:
- The qualitative data provided is very useful as it puts a measure into perspective.
- Where a target is not achieved, a text descriptor providing more information is shown (when available).
- A 'target' may be missed by very small numbers (ie: 1-2 persons).
- A number of targets rely on other DHBs as patients can be sent out of region (ie: cardiology). This process is well supported by the regional group so that small numbers do not result in regional restrictions.
- Inequity is still a concern with confirmation that work continues in this space. Detail is recorded where available to support identification of areas requiring further action.

The Chair noted the many successes captured in the report and highlighted a recent successful event held by the Measles immunisation team at the local markets which saw a very high uptake.

Discussion was held regarding potential perceived confusion between Influenza vaccinations, Measles Vaccinations and COVID-19 vaccination programmes. P Malan clarified that the MOH has provided very clear direction that other vaccination programmes should not lax whilst COVID vaccination programme is rolled out.

J Chandulal-Mackay referred to an item on page 144 in the following paper (Status update reporting – Actions Included in Annual Plans) relating to IDF Management noting the narrative shows elective outflow has been reduced. P Malan confirmed the reduction will be captured in financial reports which will be provided to the full Board at their next meeting.

It was resolved that the committee:

a. **Receive** the paper titled Preliminary Quarter Two Ratings, Non-Financial performance framework measures

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

Moved: A Main **Seconded:** G Adams

3.2 Status update reporting- Actions Included in Annual Plans
K O'Gorman / P Malan, GM Strategy Commissioning and Population Health

A paper titled Status update reporting- Actions Included in Annual Plans was tabled by P Malan and taken as read.

Committee members, through the Chair, thanked P Malan and his team for the considerable work undertaken in producing the Quarterly and Annual Plan update reports for the Committee.

It was agreed the committee:

a. **Receive** the paper titled Status update reporting- Actions Included in Annual Plans

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

Moved: A Main **Seconded:** Graham

3.3 Covid-19 planning update
P Malan, GM Strategy Commissioning and Population Health and L Allsopp, GM Patient Safety Quality and Innovation

A paper titled "Covid-19 planning update" was tabled by P Malan. Apologies were noted from L Allsopp with P Malan clarifying, in her absence, three Executive Leadership Team staff members were in attendance and available to answer any questions committee members may have.

P Malan provided a verbal summary of the key points as summarised below:

Covid-19 testing remains available onsite at the main hospital via the CBAC, however with reduced hours. Information of alternate testing sites is readily available with sites across a number of areas and venues including CBAC, General Practitioners and if/when required temporary/rural sites.

Testing criteria remains clear. Anyone feeling unwell is urged to contact Healthline (HL) for screening. If advised by HL to attend testing station they will be tested. If anyone turns up at a testing station without first contacting HL the CBAC staff will undertake screening and test if required.

It was noted the key to continuing success is the ability to remain fluid and able to react at short notice to changing requirements, based on risk.

It was confirmed there is no intention to close the onsite CBAC at this stage.

R Kui gave a brief update on the Covid-19 vaccination programme. The same approach used previously for immunisation programmes will be applied and amplified to ensure equitable uptake. Conversations are ongoing, with it being imperative communication starts both before, during and after immunisation. It is envisaged there will be a vaccinator, immunisation coordinator and Haumoana navigator onsite at vaccination centres with the use of the onsite CBAC being a possibility, however, planning is very much in initial stages.

A Main noted as there are a number of areas who welcome visitors from outside of the region (ie: Rangitiki and Ruapehu) Covid-19 where wastewater testing could be useful. It was confirmed this testing is not carried out by DHB's, however, A Main agreed to discuss further with the local council.

Action: A Main to clarify with Council the local waste water testing protocols.

It was agreed the committee:

- **a. Receive** the paper titled Covid-19 planning update
- **b. Note** Covid-19 testing continues to be available and responsive
- **c. Note** contact tracing capacity is in place
- **d. Note** Covid-19 vaccination programme planning is underway

Moved: A Main **Seconded:** H Gifford

3.4 Provider Arm Services report
L Adams, Chief Operating Officer & Director of Nursing

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

Work is ongoing to support a reduction in readmission rates. This includes the recent recruitment of an "integrated discharge navigator" who, working alongside ICT to better support data capture, will focus on removing barriers to discharge.

Discussion regarding the discharge process from ED was discussed. I Murphy clarified that where possible and appropriate positive health outcomes are achieved by a patient returning to their own home. However, the patient and family wishes are taken into account, especially if there are concerns regarding any aspect of discharge (eg: late evening).

A national shortage of midwifes across NZ continues and has impacted on recent recruitment of a midwife to a vacancy in Waimarino. In the interim I Murphy confirmed that although no permanent midwife in located in the region, there is a midwife in residence with support provided by Whanganui staff ensuring post and pre natal services are available. Emergency plans are in place which include local General Practitioner availability and air transfer via helicopter if required.

Positive feedback was received recently from a patient on the ward who was greeted warmly but the staff member serving her meals. The staff member spoke to the patient by name and went out of their way to provide an alternate meal she was aware the patient would enjoy. It was agreed thanks should be passed to the Contractor (Venitia) who provide this service.

A trend was noted with high presentation to ED and the subsequent flow on effect to the hospital. This trend is being noted throughout all DHB's with an increase in presentations, admissions and subsequent hospital flow. Work continues within our social governance programme to identify issues within the community that may be impacting on presentation. Further, although we know readmission rates are high at present, we do not have the necessary data available to establish the cause. It was noted this in an area of focus that sits under our optimisation and sustainability programme. J Chandulal-Mackay, asked that when available, further details be provided to committee on the work and learnings being identified in this space. A Main thanked the Management Team for their proactive approach to addressing the issues raised.

A brief discussion on persistence of inequities in Did Not Attend (DNA) rates was noted. Ambulatory Sensitive Hospital (ASH) rates continuing to be monitored with oversight and trend analysis reviewed at WALT.

R Kui advised a great deal of work has been undertaken in the DNA workspace, including the implementation of "text to remind". It was agreed an item be added to the agenda for the next meeting to update committee on progress.

Action: update committee on progress to improve DNA rates.

It was agreed the 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

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

3.5 Faster Cancer Treatment targets
P Malan, GM Strategy Commissioning & Population Health

A paper titled "Faster Cancer Treatments targets" was tabled by P Malan. The paper was taken as read with a summary of the key points shown below.

Note that Quarter 2 results were not available at time of print so have not been included in paper provided, however, these are now available and show that targets continue to be met.

It was agreed the committee

a. **Receive** the paper Faster Cancer Treatment Targets

b. **Note** that Ministry of Health Faster Cancer Treatment Health Target reporting was not available at time of print, however, is now available with results showing Q2 targets have been met.

Moved: A Main **Seconded:** J Chandulal-Mackay

4. Information papers

4.1 Final Elective Services Productivity Indicator Results for December 2020

A paper titled "Final Elective Services Productivity Indicator Results for December 2020" was tabled by P Malan with the paper taken as read.

It was noted that Covid-19 is continuing to impact on ESPI results with initial expectations of compliance in December 2020 not achieved. However, full compliance is now expected by 31 March 2021 with all procedures impacted due to Covid-19 having been completed.

It was agreed the committee

a. **Receive** the paper titled Final Elective Services Productivity Indicator Results for December 2020

b. **Note** that the results for ESPI 2 is 0.4% non-compliance and ESPI 5 is 6.2% non-compliance

c. **Note** that the Ministry of Health has devolved $7M of funding nationally to improve waiting times and WDHB's share is $1.28M

d. **Note** this paper has also been provided to the Finance, Risk & Audit Committee

Moved: A Main **Seconded:** C Anderson

4.2 Annual Plan 21/22 update

A paper titled "Annual Plan 21/22 update" was tabled by P Malan with the paper taken as read.

It was noted that the next milestone for the plan will be submission of draft 1 on 5th March 2021. Committee members will be provided with a copy of the draft following submission.

It was agreed the committee

a. **Receive** the paper titled Annual Plan 21/22 update
b. **Note** the government's planning priorities have not changed
c. **Note** the Ministry will not require a Regional Services Plan this year
d. **Note** the contents of the Minister's Letter of Expectations
e. **Note** the first draft will be submitted to the Ministry of Health on 5 March 2021

Moved: H Gifford **Seconded:** C Anderson

4.3 Public Health Covid-19 - Gatherings and Events

A paper titled "Public Health Covid-19 - Gatherings and Events" was tabled by P Malan with the paper taken as read.

The committee passed thanks to the Public Health team, via the chair, for the outstanding mahi that has been undertaken in support of our community through the summer season.

It was agreed the committee

a. **Receive** the paper titled "Public Health Covid-19 - Gatherings and Events"
b. **Note** the MoH have established a voluntary code to support lowering transmission risk
c. **Note** the Health promotion team have provided support and guidance to event organisers over the summer period in line with the MOH "make summer unstoppable" campaign

Moved: P Baker-Hogan **Seconded**: J Chandulal-Mackay

5. Date of next meeting

The next meeting will be held on, Friday 28 May 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 13 November 2020 (Public – excluded session)	For the reasons set out in the committee's agenda of 13 November 2020	As per the committee's agenda of 13 November 2020

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**: J Chandulal-Mackay

The public session of the meeting ended at 11:50am

Adopted this day of 2020

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Chair

21 May 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 May 2021 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Discussion Paper**
	Item No 3.1
Author	Lisa Turia-Bennett, Kaitakitaki
Endorsed by	Rowena Kui, Kaiuringi Te Hau Ranga Ora GM Māori Health and Equity
Subject	Progressing Pro-Equity: Kaitakitaki Work Streams
Equity	Kaitakitaki roles are designed as catalysts for the DHB's pro-equity mahi

Recommendations

Management recommend that the Combined Statutory Advisory Committee:

a. **Receive:** the paper titled Progressing Pro-Equity: Kaitakitaki Work Streams
b. **Note:** the challenges and opportunities articulated in the paper

Appendices

- Te Hau Ranga Ora Service Chart and WDHB Management Structure

1. Purpose

The purpose of this paper is to provide the Committee with an overview of the Te Hau Ranga Ora Kaitakitaki team and the work they lead and contribute to that further advances the DHB commitment to pro-equity and accelerating Māori health gains.

2. Overview of Te Hau Ranga Ora – Māori Health service

The name 'Te Hau Ranga Ora' was gifted to the WDHB Māori health service and refers to the four winds (ngā hau e whā) and is symbolic of all health services within our rohe working collectively to improve health outcomes for our community.

The past seven years Te Hau Ranga Ora has led and influenced significant change in the WDHB culture and its planning and service delivery. This has been achieved through a layered approach across the organisation over time.

Te Hau Ranga Ora purposefully aims to provide enabling support to build management and staff cultural confidence and capability so that collectively we can take a pro-equity approach to planning and commissioning and provide a whānau-centred model of care to patients and whānau.

He Hāpori Ora confirms pro-equity as an organisation wide strategic focus area. Which indicates a whole of organisation responsibility for equity and achieving improved health outcomes for Māori.

Kaitakitaki roles were established following the WDHB reorganisation in 2019 and are structured as enabler roles across the wider Whanganui DHB.

Kaumātua (Kaumatua & Kuia)
Two kaumātua provide the DHB with leadership and advice on cultural practices and directly support the Kaihautū Hauora Chief Executive, Kaiuringi, GM Māori Health & Equity and the Executive Leadership Team.

Kaiuringi (GM Māori & Equity)
The leader of Te Hau Ranga Ora is the Kaiuringi GM Māori Health & Equity and a member of the Executive Leadership Team. The Kaiuringi is also the executive lead for the relationship between Whanganui DHB and Hauora ā Iwi and Māori Health Outcomes Advisory Group, the implementation of the WDHB Pro-Equity Report 2019 recommendations, Māori Health Strategic commitments in the WDHB annual plan and He Hāpori Ora and partnering with executives and teams for planning and commissioning of services and quality improvement initiatives.

Haumoana Team
Haumoana refers to the wind's that come off the sea to wrap around and support the waka and is a unique name given to this position in our DHB. In the hospital and community services, there are five Haumoana who work operationally on the ground to support patients/tangata whaiora, whānau/families and staff. The common term for this role that is more familiar is whānau ora navigator or family support worker.

The Haumoana are whānau ora practitioners and their expertise is working from a whānau/family centred approach. Their role is to work in a pro-active manner by working alongside the multidisciplinary care team involved in whānau/family hui, supporting doctor's round's, working alongside patients, whānau/family to help them understand their care plan and connecting them to community based health and social services and kaupapa Māori health provider services as needed on discharge.

The Haumoana service is managed by the Kaitakitaki, Clinical and Haumoana Service, who is a clinician and is supported by the Kaitakitaki educator/cultural advisor to lead, advise and support the team. The Haumoana are an essential enabler to high quality care and whānau ora. Haumoana are allocated to WDHB services within the hospital and DHB community services from Monday-Friday and have different portfolio's that they are responsible for within their roles such as, VIP champion, Hapu Mama Wānanga Programme, Zero Seclusion and Restraint initiative and Did Not Attend (DNA) follow up.

Haumoana are also responsible for the management of Mauri Ora Emergency/Temporary accommodation and the Whare Whakatau Mate that supports whānau/family at a time of the sudden death of a loved one in the community. Both whare are available 24/7 via the Haumoana on-call service.

There is also a part-time Haumoana who provides administrative support to the team and the cultural education programmes.

3.0 Kaitakitaki

Kaitakitaki are allocated to work alongside the organisation's hubs as enablers to support and advise each hub around their work and supporting the organisation's commitment to pro-equity and improving health outcomes for Māori. The hubs include Hospital and Clinical, Primary Community Services, Patient Safety Quality and Innovation, Corporate, Strategy Commissioning & Population Health and Maternal Child & Youth.

Collectively the teams work is underpinned by:

- Values-based principles
- Role modelling and advising on cultural practices
- Embedding whānau ora practice
- Working towards eliminating the equity gap that exists for Māori
- Reflecting He Hāpori Ora and Whakamaua (MoH Māori Health Action Plan 2020-25) in practice.
- Workstreams and service improvement initiatives.

Outlined below is a summary of the work that the team are leading or involved in. Each team member is lead for a workstream and quality improvement initiatives either within their hubs or across the organisation.

Across the organisation this may include providing:

- Regular attendance at hub leadership hui and participating in hub initiatives
- Advise on pro-equity approaches and use of tools and methodologies
- Informal cultural safety advice in ward or department settings
- Membership on interview panels for all executive and leadership positions
- Input into the development of project briefs, initiatives and services changes
- Support to raise awareness of and address bias and racism in the workplace
- Participation in local, regional and national advisory groups, projects and research
- Cultural advice and leading cultural practices
- Support to the Patient Safety, Quality and Innovation team to facilitate whānau hui as part of the clinical investigations and complaints process
- Leadership and support to key projects to address inequity such as health literacy, DNA improvement project, development of the Consumer Engagement Framework, art in hospital, campus signage and refurbishment of the mortuary
- Support for WDHB to be a culturally safe place for Māori staff to work and develop
- Leading the Māori Nursing mentorship and development programme – Te Uru Ponamu – unique to WDHB
- Ongoing relationship with the Te Puna Ora service development – kaupapa Māori health service
- Advising and supporting the WDHB Quality Awards, judging, programme and award categories.

Māori Workforce Capacity and Capability Workstream

Kaitakitaki support growing the capacity and capability of the Māori health workforce across both the organisation and the wider health system, working with community partners, schools as well as tertiary and training institutes.

An example of this work is the collaborative efforts with key partners to recruit for the COVID vaccination workforce. This work has seen efforts focused on strengthening a pathway that enables growing the capacity of the Māori health workforce, the youth health workforce and to support redeployment of Mars Petcare NZ staff alongside Work and Income, SENZ training and employment, UCOL, Workbridge, the Whanganui and Partners – Youth Employment Success initiative and school career advisors.

Funding and programmes to support career options in health

Health Workforce NZ has prioritised funding to support rangatahi and second time students to take up health as a career. The Hauora HWNZ Māori Training Fund continues to be utilised by those working in the unregulated Māori roles pursuing study at level's 3 to 7. A number of these applicants, mostly from iwi health provider organisations, have been successful in their study and continue to progress with their aspirations. The HWNZ Māori Support fund also provides applicants with an opportunity to attend cultural supervision.

The Kia Ora Hauora programme works across all DHB areas advising students on how best to choose subjects that will support them to enter health as a career at the end of their secondary study.

Kaitakitaki participate and support the local jobs expo, health careers day and national recruitment for RMO's. One of the Kaitakitaki also sits on the recruitment panel for junior doctors.

DHB targets to increase focus on Māori workforce development

DHBs have six workforce targets to report on, aimed at increasing their Māori workforce both in their own services and across their respective DHB areas as follows:

Based on the Te Tumu Whakarae Position Statement, the following targets were developed. The following up-date on the targets is provided by WDHB People and Culture.

(i) All DHBs will actively grow their Māori workforce to achieve a Māori workforce that reflects the proportionality for their Māori population

Target One - Each DHB will have 0% of employees who have their ethnicity recorded in their employee profile as "unknown" by 30 June 2020.

- Consistently met since the target was introduced

Target Two - Each DHB will employ a Māori workforce that reflects the Māori population proportionality for their region by 2030. Report annually.
- Slow progress
  - Increase in FTE from 109.23 to 113.63
  - Increase in headcount from 129 to 143

Target Three - Each DHB will employ a Māori workforce with occupational groupings that reflect the Māori population proportionality for their region by 2040. Report annually.
- Slow progress

(ii) All DHBs will set in place steps to significantly and meaningfully realise cultural competence for all clinical staff, the Board and other staff groups that have regular contact with patients and whānau.

Target Four - All DHB staff (clinical and non-clinical) who have contact with patients and whānau, Board members and those in people management or leadership roles will demonstrate participation in cultural competence training by 2022.
- All staff employed (permanent, contractors, temporary, students, casual) attend the WDHB orientation programme – Hapai te Hoe.
- Development and implementation of further additional / advanced training is underway.

(iii) All DHBs will measure and report on the recruitment and retention of Māori staff in clinical and non-clinical occupations.

Target Five - In each DHB, 100% of Māori applicants who meet the minimum eligibility criteria for any role are shortlisted for interview.
- WDHB has not yet met this target
- Systems have been implemented to enable this and will be in place from May 2021
- Actions to support this include:
  - Electronic vacancy application form to identify ethnicity at application stage
  - Review of recruitment policy and practices – to support pro-equity strategic objectives

Target Six - In each DHB, turnover for Māori staff will be no greater than the DHB turnover for all staff.
Met – see supporting documentation attached
- Met - 6.9% turnover for all staff compared with a 4.6% turnover for Māori staff

The DHB Māori workforce has increased by 1% in the last year to 13.26% of the total DHB workforce. The workforce demographic report tells us that the majority of our Māori staff are in administration and nursing roles. From an occupational grouping perspective, the data for medical and midwifery workforces reflects a headcount of 2 Māori in each of those groupings.

An example of a WDHB initiative is the Te Uru Pounamu programme to support and mentor Māori new graduate nurses in their first year of practice, providing cultural and clinical supervision. Recently a roopu of Māori nurses who have been through a national training program called Ngā Manukura o Apōpō (NMoA) was established. This program is a qualification in clinical/cultural leadership. The aim of the local roopu of NMoA leaders is to strengthen Māori nurse leadership, support Māori nurses and mentor new Māori nurses. The NMoA leads and supports the facilitation of the Te Uru programme. This enables the programme to include second and third year Māori nurses who mentor and support their junior colleagues in the workplace.

DHB Recruitment and Development

The revision of the WDHB recruitment policy will support leaders to increase the proportion of Maori staff in their teams. The policy has recently been reviewed and effort is now required to refresh the respective procedures to implement the policy such as revised advertising template, recruitment for values and interview process, competencies to reflect pro-equity and values, key performance indicators and reporting to the workforce targets by team.

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Cultural Awareness and Education Workstream

Hāpai te Hoe
Hāpai te Hoe has been operating since September 2015. It is an integral part of the organisation's orientation being the first 2 days of the programme, commencing with powhiri. The programme covers cultural components of tikanga o Whanganui (protocols, values and beliefs), the Treaty of Waitangi from a local perspective, whānau ora - whānau/family centred care, our values and the waka model of care. Participants also experience a waka journey on the awa/river, where they demonstrate working together and can reflect on the values of the WDHB and how they will be upheld in practice. The waka journey also provides a real-world encounter on the history of Whanganui. Over 96% of staff have attended the programme.

Staff from other providers and agencies attend Hāpai te Hoe such as Hospice Whanganui, Police Iwi Liaison and UCOL Whanganui Nursing Tutors.

He Waka Hourua is the newly established one-day programme for existing staff, three years after they have completed Hāpai te Hoe. The programme is designed to consolidate the learnings from Hāpai te Hoe around values, teamwork, whānau ora, leadership within our waka and further explores how staff are or can apply these learnings in practice.

Te Reo Māori Education Sessions
Te reo Māori sessions were commenced at the request of staff members who wanted to improve their pronunciation of te reo Māori particularly to ensure that patient and whanau names are pronounced correctly. In partnership with UCOL, sessions are held in Te Piringa Whānau, cycling over six weeks periods through the year, free to all staff and whānau. Several staff have gone on to further study with the Wānanga.

Cultural Practices and Advice Workstream
Formal cultural advice is provided under the guidance of the WDHB Kaumātua. This includes formal welcomes (pōwhiri/mihi whakatau), translations for signage, patient information, intranet and internet information, WDHB publications, policies and procedures.

Waiata: He Hāpori Ora – a new waiata has been composed by the Te Hau Ranga Ora team to celebrate the development of the WDHB Strategy Document 2020-23 and is included in the soon to be released video to celebrate the soft launch of the strategy.

Achieving Health Equity Workstream

With Pro-Equity as one of the three strategic focus areas in He Hāpori Ora, equity is a key responsibility across the organisation. The Kaitakitaki role is to support management to deliver on their responsibility for equity especially across the four priority areas below as outlined in the WDHB Pro-Equity Review Report 2019 and now included in He Hāpori Ora:

- Strengthen leadership and accountability for equity
- Build Māori workforce and Māori health and equity capability
- Improve transparency in data and decision making
- Support more authentic partnership with Maori.

Ensuring an Equity Lens Over Data Analysis
As identified above, to understand and achieve equity we need clear, transparent evidence. Data provides an important tool in tackling inequity. Kaitakitaki have been involved in supporting the development of dashboard presentations of data, emphasising the need for ethnicity in all data collection and presentation and equity factored into all analysis.

Addressing Bias and Racism
WDHB leadership is seeking a sustainable approach to addressing racism and bias. This is important and sensitive work which is fundamental to the realisation of He Hāpori Ora and pro-equity. Kaitakitaki have

undertaken preliminary work on this, however it is recognized overall responsibility for this sits outside Te Hau Ranga Ora.

Kaupapa Māori Provider Services – capability and capacity
The management of kaupapa Māori health service contracts sits with the portfolio lead in the Strategy, Commissioning and Population Health team. Building the capacity and capability of kaupapa Māori health services, ensuring choice and access to kaupapa Māori services and building the Māori health workforce across the WDHB district are all interconnected pieces of work.

Reviewing how kaupapa Māori health services have been commissioned locally, and working with leaders from Māori health organisations collectively to refresh current contracts, identify potential devolution of other existing contracts that are focused on Māori but not moving/meeting equitable outcomes or development of new initiatives that will meet the needs of Māori communities by locality is underway (action in the 2020-21 Annual Plan).

Opportunities

- Several influences are converging to present an opportunity to push ahead with pro-equity and improved health outcomes for Māori. For example, the clear government directive on equity provides an unequivocal direction.

- The recognition in the interconnectedness of health outcomes with other social determinants is strong in He Hāpori Ora with Social Governance a key strategic focus area. This, and the focus on Every Bed Matters and shifting provision to the community are all potential enablers to improved health outcomes for Māori.

- Te Hau Ranga Ora has worked hard to develop and sustain robust relationships across the organisation, with Iwi and the wider community. This provides the platform for improved mainstream services and further development of kaupapa Māori service delivery. A partnership approach was modelled in the work with the Māori Health Outcomes Advisory Group to develop the He Puna Ora service. Further work is underway focused on commissioning for increased kaupapa Māori service provision.

Other opportunities include:
- Increasing public awareness of tikanga Maori, use of Te Reo and deeper understanding of the Treaty and its implication for health through the Wai2575 inquiry.
- Release of the Whakatika report on experiences of racism in New Zealand and the increased focus on addressing racism and bias across medical, nursing and allied professional training and development.
- Hāpai te Hoe embedded and attended by more than 90% of staff and He Waka Hourua providing an opportunity to revisit and strengthen the practice of whānau-centred delivery models of care.
- A review and refresh of Speaking Up for Safety and Kōrero Mai.
- Commitment to a DHB wide Māori health workforce recruitment and retention strategy.

Challenges

The overarching challenge will be maintaining momentum and building on the platform and relationships we have during a time of uncertainty and change with the implementation of the Health and Disability Review.

The Kaitakitaki, working with their assigned ELT members and their teams, have a role to identify barriers and challenges to achieving Māori health goals. Teams have the responsibility to commit and work through the barriers to achieve success and collectively make change happen.

ROWENA KUI

KAIURINGI Strategic

RIHI KARENA

Haumona Manager Hospital & Clinical Services Patient Safety/ Quality & Innovation Clinical (Te Ao Māori concepts & Delivery Models), Cultural Advisor, Whānau Ora Models of Care in Services, Patient Safety: Complaints, Whānau Hui Cultural/clinical supervisor – Te Uru Pounamu Ngā Manukura o Apōpō Māori nurse leadership, Hāpai te Hoe

NED TAPA

Cultural Advisor/Educator, Mortuary, Facilities, ED, WAM, Mental Health, He Waka Hourua
Cultural Advisor to Kaihautu Hauora & Kaiuringi, DHB Cultural Activities Lead, Hapai Te Hoe Lead, Haumoana Team Lead, VIP Presenter, Whānau Hui Facilitator (Patient Safety Complaints), Speak Up For Safety Educator, Police /Hospice /Iwi /Te Oranganui Relationship & Initiatives, Bowel Screening Coordinator, Te Reo Classes

MAL REREKURA

Cultural Advisor/Educator, Website, Communications, **Te Reo Class Lead**
Hapai Te Hoe Coordinator, Te Pukaea Representative & Advisor, Cultural Advisor & Activities, Te Reo Translation,

KARNEY HEREWINI

Allied Health, Primary and Community
Māori Health Workforce Across the Wider Health System

KYLEE OSBORNE

Corporate Maternal Child & Youth Services
People & Culture (Māori Workforce: HWNZ, KoH, Inspiring Rangatahi, WDHB Māori Workforce), Maternal Child & Youth Services (Māori Workforce), Whānau Ora Models of Care in Services

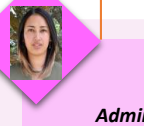
EILEEN O'LEARY

Strategy, Commissioning & Population Health Equity Lead,
Consumer Engagement Review Implementation, Equity Planning & Performance Monitoring, Equity in Dashboards WDHB Art & Archives Group

LISA TURIA-BENNETT

Kaupapa Māori Commissioning, Equity

KAITAKITAKI Leadership Team



KEITA PURU

Administrator
WDHB
Kaumatua/kuia
Trendcare
Whare oversite

BRENDA NELSON

Medical & ATR Ward CCU (Co-share) Haumoana On-Call Roster
Smoke free Champion
Falls Prevention Group
ACC Live Longer
AT&R Cultural responsive goal setting rehabilitation
Integrated Discharge Navigation Working Group

ARIA REWETI

Maternity, SCBU CCU Lead, Paediatrics Haumoana On-Call Roster
Hapū Māmā Wānanga
Te Rerenga Tahi
VIP Champion
Care & Protection

RENETI TAPA

Mental Health Services Te Āwhina, Community Mental Health Service, ED Lead, **MYCAMSHASS, Haumoana** ***On-Call Roster***
Hapai Te Hoe, Trendcare Webpas/Clinical Portal Connecting Care Programme Restraint Hui, Transitional Nurse Hui, Zero Seclusion Hui, Te Āwhina IPC Hui, MYCAMSHASS Ward

PIP THOMPSON

Community Services District Nurses, Oncology, Allied Health, Public Health, Renal Services Haumoana On-Call Roster
Stroke Circuit Class AT&R
Faster Cancer Treatment Team
DNA: Outpatient Appointments

KIRI THOMPSON

Surgical Ward, Day Unit & Theatre Services, Out Patients, Dental Unit Haumoana On-Call Roster
DNA Project
Audiology
Dental
New Born Hearing
Opthalmology
Orthapaedics

HAUMOANA Service Team

28 May 2021 **Public**

Q	**Discussion Paper**
	Item No 3.2
Author	Kilian O'Gorman, Business Support Strategy, Commissioning and Population Health
Endorsed by	Katherine Fraser-Chapple, Acting General Manager Strategy, Commissioning and Population Health
Subject	Preliminary Q3 Reporting: non-financial performance measures & detailed results
Equity Considerations	The (EF) mark on some of the actions in the Annual Plan denotes "equity focused". Similarly, (EOA) denotes "equity-oriented activity". These notations were included to highlight collective and sustained action focused on our pro-equity agenda.

Recommendations

Management recommend that the Combined Statutory Advisory 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.

1. Purpose

This paper provides an update on:
- Preliminary Quarter 3 Non-Financial Performance Framework results
- Preliminary detailed Quarter 3 non-financial reports as provided to the Ministry of Health.

2. Index

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

2) Detailed Quarter Three non-financial reports to the MoH

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

Measure	Q-1	Q-2	Q-3	Q-4
Ratings confirmed?	✓	✓	✗	
Key Achieved / Partial / Not achieved / Not req'd / Update due			08/05/2021	
Child-wellbeing				
CW01: Children caries-free at five years of age				
CW02: Oral Health- Mean DMFT score at school Year 8				
CW03: Improving the number of children enrolled in and accessing the Community Oral Health Service.				
CW04: Utilisation of DHB-funded dental services by adolescents from School Year 9 up to and including age 17 years				
CW05: Immunisation coverage 8 month				
CW05: Immunisation coverage 5 year				
CW05: Immunisation coverage HPV				
CW05: Immunisation coverage influenza				
CW06: Improving breast- feeding rates			No rating	
CW07: Improving newborn enrolment in General Practice			No rating	
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			No rating	
MH04: Mental Health and Addiction Service Development CRISIS RESPONSE				
MH04: Mental Health and Addiction Service Development OUTCOMES FOR CHILDREN				
MH04: Mental Health and Addiction Service Development EMPLOYMENT & PHYSICAL NEEDS				
MH05: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders				
MH06: Output delivery against plan				
MH07: Improving mental health services by improving inpatient post discharge follow-up rates				

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Measure	Q-1	Q-2	Q-3	Q-4
Primary health care				
PH01: Improving System Integration & SLMs				
PH02: Improving the quality of data collection in PHO and NHI registers				
PH03: Improving Maori enrolment in PHOs to meet the national average of 90%				
PH04 :Better help for smokers to quit (primary care)			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			No rating	
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				
SS13: FA1 Long Term Conditions				
SS13: FA2 Diabetes services				
SS13: FA3 Cardiovascular health			No rating	
SS13: FA4 Acute heart services				
SS13: FA5 Stroke services				
SS15: Improving waiting times for colonoscopies				
SS17: Delivery of Whānau Ora				

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2) Detailed Quarter Three non-financial reports to the MoH

Child wellbeing

CW01: Children Caries Free at 5 Years of age

59% of all children are caries free, with 41% of Maori children caries free.

MINISTRY OF HEALTH MANATŪ HAUORA — Whanganui — Select your DHB from the list in this cell

#N/A

Dental Health Status	Number of Children Examined	Number of Children Caries-Free	Number of Decayed Teeth	Number of Teeth Missing due to Caries	Number of Filled Teeth	Number of Decayed, Missing due to caries and Filled Teeth	% Caries Free	Mean d	Mean m	Mean f	Mean dmft	Mean DMFT for children with caries: Mean d	Mean m	Mean f	Mean dmft
All 5-year old Children	725	429	604	161	706	1,471	59%	0.83	0.22	0.97	2.03	2.04	0.54	2.39	4.97
All Maori 5-year old Children	256	106	375	93	350	818	41%	1.46	0.36	1.37	3.20	2.50	0.62	2.33	5.45
All Pacific 5-year old Children	28	9	53	17	51	121	32%	1.89	0.61	1.82	4.32	2.79	0.89	2.68	6.37
All "Other" 5-year old Children	441	314	176	51	305	532	71%	0.40	0.12	0.69	1.21	1.39	0.40	2.40	4.19
All Fluoridated 5-year old Children	0	0	0	0	0	0									
All Non-Fluoridated 5-year old Children	725	429	604	161	706	1,471	59%	0.83	0.22	0.97	2.03	2.04	0.54	2.39	4.97
Maori Fluoridated 5-year old Children						0									
Maori Non-fluoridated 5-year old Children	256	106	375	93	350	818	41%	1.46	0.36	1.37	3.20	2.50	0.62	2.33	5.45
Pacific Fluoridated 5-year old Children						0									
Pacific Non-fluoridated 5-year old Children	28	9	53	17	51	121	32%	1.89	0.61	1.82	4.32	2.79	0.89	2.68	6.37
Other Fluoridated 5-year old Children						0									
Other Non-fluoridated 5-year old Children	441	314	176	51	305	532	71%	0.40	0.12	0.69	1.21	1.39	0.40	2.40	4.19

CW02:Oral Health- Mean DMFT score at school year 8

The DMFT score (Drilled, Missing, Filled Teeth) for all children at Year 8 is 2.01, and for Maori children 1.99.

MINISTRY OF HEALTH MANATŪ HAUORA — Whanganui

#N/A

Dental Health Status	Number of Children Examined	Number of Children Caries-Free	Number of Decayed Teeth	Number of Teeth Missing due to Caries	Number of Filled Teeth	Number of Decayed, Missing due to caries and Filled Teeth	% Caries Free	Mean D	Mean M	Mean F	Mean DMFT	Mean DMFT for children with caries: Mean D	Mean M	Mean F	Mean DMFT
All Year 8 Children	850	571	29	5	527	561	67%	0.03	0.01	0.62	0.66	0.10	0.02	1.89	2.01
All Maori Year 8 Children	246	154	15	0	168	183	63%	0.06	0.00	0.68	0.74	0.16	0.00	1.83	1.99
All Pacific Year 8 Children	31	20	1	0	17	18	65%	0.03	0.00	0.55	0.58	0.09	0.00	1.55	1.64
All "Other" Year 8 Children	573	397	13	5	342	360	69%	0.02	0.01	0.60	0.63	0.07	0.03	1.94	2.05
All Fluoridated Year 8 Children	0	0	0	0	0	0									
All Non-Fluoridated Year 8 Children	850	571	29	5	527	561	67%	0.03	0.01	0.62	0.66	0.10	0.02	1.89	2.01
Maori Fluoridated Year 8 Children						0									
Maori Non-fluoridated Year 8 Children	246	154	15	0	168	183	63%	0.06	0.00	0.68	0.74	0.16	0.00	1.83	1.99
Pacific Fluoridated Year 8 Children						0									
Pacific Non-fluoridated Year 8 Children	31	20	1	0	17	18	65%	0.03	0.00	0.55	0.58	0.09	0.00	1.55	1.64
Other Fluoridated Year 8 Children						0									
Other Non-fluoridated Year 8 Children	573	397	13	5	342	360	69%	0.02	0.01	0.60	0.63	0.07	0.03	1.94	2.05

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CW03: Improving the number of children enrolled and accessing the Community Oral health service 20/21

99.8% of all children are enrolled, with enrolment for Maori children being 97.6%.

2019/2020

	ALL ETHNICITIES			MĀORI ONLY			PACIFIC ONLY			OTHER		
	Total Enrolled	Total Population	Percentage Enrolled	Total Enrolled	Total Population	Percentage Enrolled	Total Enrolled	Total Population	Percentage Enrolled	Total Enrolled	Total Population	Percentage Enrolled
Pre-school children (age 0 - 4)	4,311	4,320	99.8%	1,913	1,960	97.6%	194	200	97.0%	2,204	2,160	102.0%

CW05: Immunisation coverage 5 years

Indicator: Increased Immunisation 5 years						
DHB: Whanganui						
Reporting period: Quarter 3 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						

Progress report
(* = number of children NOT vaccinated)

% Opt off	% Declined	%Provisional Opt off	% Missed
0.9%	8.6%	0.0%	4.5%%

- There have been some issues between NIR services and Outreach provider in terms of the referral process, this has been rectified but has caused some delay in commencement of outreach follow up of referrals
- Māori continue to be over represented in the overdue/decliners of immunisation outreach service numbers. Working with Iwi/ Māori health providers to find solutions. A representative from our Māori Health providers group will attend the steering group hui to replace previous member who left the organisation. 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.
- 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 Paediatric 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.
- 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.

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CW05: Immunisation coverage 8 month

Indicator: Increased Immunisation 8 months CW05
DHB: WHANGANUI
Reporting period: QUARTER Three 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						

(* = number of children NOT vaccinated)
PROGRESS REPORT

% Opt off	% Declined	%Provisional Opt off	% Missed
1.5%	**11.3%**	**0.5%**	**7.2%**

- There have been some issues between NIR services and Outreach provider in terms of the referral process, this has been rectified but has caused some delay in commencement of outreach follow up of referrals
- Māori continue to be over represented in the overdue/decliners of immunisation outreach service numbers. Working with Iwi/Maori health providers to find solutions. A representative from our Māori Health providers group will attend the steering group hui to replace previous member who left the organisation. 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.
- 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.

28 May 2021 **Public**

CW06: Improving breastfeeding rates 20/21

CW06 *Improving breastfeeding rates* WHANGANUI DHB Q3 2021		
Target/Performance Expectation: 70% of infants are exclusively or fully breastfeeding at 3 months of age		
	Criteria	**Qualitative Report**
Population Baseline Performance	Total Population : 51% Māori : 47% Pacific : 39% High Dep : 40%	The WDHB lactation consultant has been on extended leave since before Christmas. The length of the leave has been difficult to predict and therefore difficult to staff the absence. We are working on a longer term plan to provide some cover for the community referrals.
Activities	Activities that the DHB is undertaking to increase the baseline rate towards the target for the total population and for Māori. Activities described are specific, time-bound and evidence based. Activities are a mixture of universal and tailored interventions.	WDHB continues to be an accredited baby friendly hospital, as is the birthing unit at Taihape Health. Increase access to education and support for breastfeeding in rural areas by employing a lactation consultant. This service has been operational since August 2020. The provider is receiving referrals from rural LMCs, has provided education to rural nurses as well as support to the student lactation consultant. Increasing breastfeeding is a priority in integration workstream. Work continues to support WCTO providers increase breastfeeding rates. The Health promotion team continues to support breastfeeding initiatives. This team has prioritised the early years as a focus and will work with the Maternal child and youth hub to develop a plan the support the increase of breastfeeding rates.
Intervention Logic	There is a clear intervention logic outlining how the activities listed will improve Māori health outcomes and reduce health inequalities.	The DHB in isolation cannot support all the needs in the community. Supporting the community to upskill is essential.
Monitoring/Evaluation	The DHB has outlined how they are monitoring or evaluating against the activities identified.	The contracted provider submits quarterly reports on progress being made by lactation consultant in rural areas.

28 May 2021 **Public**

CW07: Improving new born enrolment in General Practice

QUARTER 3 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
77.7 %

22.7% above target of 55%.
(Māori 71.2 % n=32)

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

% Enrolled by 3 months of age
86.6%

1.6% above target of 85%
(Māori 74.6% n=32)

28 May 2021 **Public**

CW08: Increased Immunisation (at 2 years) 20/21

Indicator: Increased Immunisation 2 years
DHB: WHANGANUI
Reporting period: Quarter Three 2020-21
Contact (role and name): Barbara Charuk, Portfolio Manager

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						

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Progress report
(* = number of children NOT vaccinated)

% Opt off	% Declined	%Provisional Opt off	% Missed
1.3%	6.5%	0.0%	6.5%

- There have been some issues between NIR services and Outreach provider in terms of the referral process, this has been rectified but has caused some delay in commencement of outreach follow up of referrals
- Māori continue to be over represented in the overdue/decliners of immunisation outreach service numbers. Working with Iwi/Maori health providers to find solutions. A representative from our Māori Health providers group will attend the steering group hui to replace previous member who left the organisation. 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.
- 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.
- 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.

28 May 2021 **Public**

CW09 Better help for smokers to quit (Maternity)

(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

Whole of DHB		Maori	
Number of events (a)	4	**Number of events**	2
Number of Smokers	0	**Number of Smokers**	0
Brief advice given	0	**Brief advice given**	0
Offered cessation support	0	**Offered cessation support**	0
Referred to cessation support	0	**Referred to cessation support**	0
Smokers' gestation (weeks) (b)	Null	**Smokers' gestation (weeks)**	Null
% offered brief advice	Null	**% offered brief advice**	Null
% offered advice and support to quit	Null	**% offered advice and support to quit**	Null
% accepted cessation support	Null	**% accepted cessation support**	Null
Smoking prevalence (c)	Null	**Smoking prevalence**	Null

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

DHB:	Whanganui	*please select from the drop down box*
Reporting Quarter:	3	*please select from the drop down box*
Name and contact details of person completing the report	Rosie McMenamin	

Please answer ALL of the questions below	
What planning has occurred in your DHB to support the maternity health target, specifically for Māori and Pacific women? Please include information on how your DHB is supporting LMCs and/or DHB-employed midwives to increase the number of pregnant women being offered brief advice and support to quit smoking.	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.
What actions and/or projects is your DHB undertaking that reduces smoking in pregnancy, specifically for Māori and Pacific women?	We have trained the dieticians and diabetes nurses who run pregnancy clinics and have provided them with a pregnancy smokerlyzer to use at their clinics.
Is there anything else you would like to tell the Ministry?	We are planning to complete a needs analysis which will identify gaps that need work and resources targeted at them.

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.

28 May 2021 **Public**

CW10 Raising Healthy Kids

Target: 95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions		
Deliverables definition: Each DHB must provide narrative comments on activities being taken to improve performance and achieve the target agreed through their 2019/20 Annual Plan. The narrative is to include: • specific activities undertaken for Māori and Pacific[1] populations		
Note: Please either complete this template or add your report (including the following points) to the website. All DHBs are expected to submit a report.		
Name of DHB: Whanganui	**Quarter reported on: Quarter Two 2019-20**	
Target performance to date and rate of progress based on data provided.		Action / deliverable timeframe
DHB Comments:	**Result for Quarter Three 86%. This corresponds with a national rate of 93% in referral rates for this target.**	
Your activity to support the achievement of the target and initiatives to realise a reduction in childhood obesity, as reflected in your commitments in your Annual Plan, including: • progress with getting referrals acknowledged from the B4 School Check (B4SC) • progress with the development of referrals pathways from the B4SC for assessment and family based nutrition, activity and lifestyle interventions • activity to ensure DHBs, PHOs and other primary care and community partners work together to ensure families experience seamless transition and support post referral from the B4SC • activity to support primary care and community partners having the conversation with families.		Action / deliverable timeframe
DHB Comments:	Whanganui's referral decline rate of 9% for ongoing lifestyle management remain below the national average of 31% for Q3. The local Pasifika tamariki decline rate is 0% Māori Tamariki decline rate sits at 13% compared to the national rate of 38%. 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.	**Quarter 3**
Barriers to achieving the target and mitigation strategies over the next quarter by DHB and the PHOs.		Action / deliverable timeframe

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

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DHB Comments:	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.	
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 WDHB and Sport Whanganui have had initial discussions about developing a broader approach to reducing childhood obesity. Along with the WDHB health promotion team a broader approach needs to be developed with action plan that includes nutrition and exercise that involves key stakeholders. 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 initiatives

SBHS Narrative Report: Quarter 3, 2021

Service Progress

The PHN team continues to deliver the School Based Health Service (SBHS) in the school environment of all decile 1-5 secondary schools within the WDHB (Whanganui District Health Board) catchment.

For 2021, a total of 801 students are eligible for a routine universal assessment. To date, 39 universal assessments have been completed.

In 2020, Whanganui High School requested universal assessments to a small Vocational class of 28 students to identify health related concerns which could be addressed to improve learning and incorporate them into the curriculum. The assessment was run as a pilot and the school found the pilot successful and beneficial for the students in this class that we have been asked to continue with the assessment in 2021.

Equity focussed action planning continues to progress positively. The service has engaged with a Kura which has a small Year 9 student role. The Kura has voiced interest in having the school-based health service involved within their school for the first time. Discussions and building of relationships between the Kura and PHN continue, potentially to start clinic for HEEADSSS assessments in Term 2.

Professional development via online learning platform, has been arranged for all PHNs to update their knowledge and skills with HEEADSSS universal assessment.

Bi-annual meetings with school principals to strengthen relationships have continued and this has helped with positive engagement.

Areas of Improvement

Communication with alternate education has been a challenge. The majority of communication with the Alternate Education staff and students is through social media platforms such as Facebook – messenger. This has resulted in ineffective communication for PHNs because our DHB communication with schools is by email not by Face book or any other social media platforms. Optional means of communication with Alternate Education and schools in general using social media platforms are being explored with the DHB communications department.

Themes

Te Kahui Ako Roopu (local Principals meeting together) raised concerns of the increased use of vape in schools. SBHS are working in collaboration with the WDHB Smoke Free Health Promotion officer to help support the High Schools with smoking/vaping policies and their implementation.

A number of universal assessments completed have shown continued concerns regarding BMI – above healthy weight, anxiety referrals to counsellors and MICAMHAS (Maternal, Infant, Child, Adolescent Mental health and Addiction Service), SUPP – Alcohol and Drug support.

SUPP- MICAMHAS Service- Youth mental health and addiction community service

Quarter Three 2020-2021

The first month of the quarter is quiet for SUPP as young people are away from school and supporting agencies are closed. During this time SUPP review the past year and plan for the year ahead.

As school returns, referrals increase with March often being the busiest month of the year.

In the first quarter SUPP provide AOD educational sessions to the local High Schools and re-establish themselves back into the school and alternative education environment. As well as new students often the education workforce has changed, and this introduction/education ensures easy access to the SUPP service for those youth attending school and alternative education.

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The 2.7 FTE Clinicians and 0.5 youth worker role also provide clinics for our rural areas once a week. While rural referrals are also quieter in the beginning of the quarter the limited resources in rural areas require SUPP to work alongside rural providers. Working together is important in managing issues for our rural youth. Maintaining relationships but also keeping in touch with what is happening for the youth in these communities helps SUPP in developing transition planning.

SUPP continue to provide screening of youth for the Police Youth Aid as part of a quality improvement project. This involves screening for AOD and mental health issues as well as social issues, the young person is then "handheld" to an appropriate agency as part of an early intervention focus. This was developed when the previous Police Youth Aid screening process ended and SUPP was approached for support. It has led to better outcomes for youth who come to the attention the police and a stronger links with our Police colleagues.

SUPP	**Referrals**	**Discharges**
January	7	1
February	15	7
March	28	24
Total	50	32

Age and ethnicity of referrals received										
Age	9 yrs	10 yrs	11 yrs	12 yrs	13 yrs	14 yrs	15 yrs	16 yrs	17 yrs	18 yrs
January				2	1		1		2	1
February				1	1	5	1	4	2	1
March	1	1			7	10	3	1	5	
Total	1	1		3	9	15	5	5	9	2

Ethnicity	NZ Maaori	NZ European	PAC ISL NFD	Other European	European NFD
January	5	1		1	
February	9	6			
March	22	6			
Total	36	13		1	

Gender	Female	Male
January	3	4
February	8	7
March	9	19
Total	20	30

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Age and ethnicity of closed cases										
Age	10 yrs	11 yrs	12 yrs	13 yrs	14 yrs	15 yrs	16 yrs	17 yrs	18 yrs	19 yrs
January					1					
February			1	1	1	2	1	1		
March	1		1	2	5		8	4	2	1
Total	1		2	3	7	2	9	5	2	1

Ethnicity	NZ Maaori	NZ European	Other European	European NFD	Samoan	Cook Island Maaori	Other Asian	Asian NFD
January	1							
February	3	4						
March	14	9	1					
Total	18	13	1					

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Quarterly Primary Mental Health and Addiction (PMH & A) reporting template

Please note: white cells **must** be completed and grey cells are optional (helpful data but not mandatory)

DHB: Whanganui Year: 2020-2021

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	YTD[1]	(see below note)
	Clients aged 12-19						
1.1	Number of females seen	14	13	11			
1.2	Number of males seen	12	21	15			
1.3	Total number of youth seen	26	34	26			
1.4	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+						
1.5	Number of females seen	N/A	N/A	N/A	N/A	N/A	
1.6	Number of males seen	N/A	N/A	N/A	N/A	N/A	
1.7	Total number of adults seen	N/A	N/A	N/A	N/A	N/A	
1.8	People re-presenting to service	N/A	N/A	N/A	N/A	N/A	Number of people who re-present and are seen by PMHI service within 6 months of concluding a course of treatment (note that this period is recorded across reporting years)
	Number of referrals						
1.9	Number of referrals (12-19)	9	5				
1.10	Number of referrals (20+)	N/A	N/A	N/A	N/A	N/A	

	Ethnic group	Q1	Q2	Q3	Q4	YTD[1]	(see below note)
	Clients aged 12-19						
1.11	NZ European	8	12	10			
1.12	Maori	17	22	16			
1.13	Pacific Island	0	0	1			
1.14	Asian	0	0	0			
1.15	Other	1	0	0			
	Clients aged 20+						
1.16	NZ European	N/A	N/A	N/A	N/A	N/A	
1.17	Maori	N/A	N/A	N/A	N/A	N/A	
1.18	Pacific Island	N/A	N/A	N/A	N/A	N/A	
1.19	Asian	N/A	N/A	N/A	N/A	N/A	
1.20	Other	N/A	N/A	N/A	N/A	N/A	

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

	Kessler 10 Score	Q1 at start	Q1 At exit	Q2 at start	Q2 At exit	Q3 at start	Q3 At exit	Q4 at start	Q4 At exit
1.21	K10 average score (12-19)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
1.22	K10 average score (20+)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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

	PHQ-9 Score	Q1 at start	Q1 At exit	Q2 at start	Q2 At exit	Q3 at start	Q3 At exit	Q4 at start	Q4 At exit
1.23	PHQ-9 average score (12-19)	N/A	N/A	2	N/A	2	N/A	N/A	N/A
1.24	PHQ-9 average score (20+)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

	Number of Referrals to	Q1	Q2	Q3	Q4	YTD[1]	(see below note)
	Clients aged 12-19						
1.25	Psychologist/psychotherapist	0	0	1			
1.26	Specialist CAMHS or Adult Mental Health Service	2	1	4			
	Clients aged 20+						
1.27	Psychologist/psychotherapist	N/A	N/A	N/A	N/A	N/A	
1.28	Specialist CAMHS or Adult Mental Health Service	N/A	N/A	N/A	N/A	N/A	

YTD[1] To avoid counting a referred person more than once the Year to Date is not a summation of Q1 to Q4 for reporting lines 1.1 to 1.15. The YTD counts each service user once (for each referral). For example Mr O is referred (and service is begun) and starts service in Q1 and exits in Q2 (where he also receives services). In this example Mr O will be included in the Q1 and Q2 columns but only once in the YTD[1] column. If Mr O was referred again in Q4 he would be included in the Q4 column and counted twice in the YTD[1] column (once for each referral).

2 Extended Consultations

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

		The number of consults delivered to those clients during reporting quarter.				
		Q1	Q2	Q3	Q4	YTD
	Clients aged 12-19					
2.1	General Practitioner - number of consults	0	0	0		
2.2	Practice Nurse - number of consults	0	0	0		
	Clients aged 20+					
2.3	General Practitioner - number of consults	N/A	N/A	N/A	N/A	0
2.4	Practice Nurse - number of consults	N/A	N/A	N/A	N/A	0

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.					
	People seen by service	Q1	Q2	Q3	Q4	YTD	
	Clients aged 12-19						
3.1	Number of youth seen (12-19)	0	18	1			
3.2	Average wait time from referral to first seen	N/A	0	0			Date referral received by the provider (e.g. GP) to the time of the first appointment. (Time of the first appointment may be influenced by the client choice as well as availability).
3.3	DNA Rate	N/A	0	0			Client did not turn up to a scheduled/agreed appointment, and/or did not postpone or cancel the appointment within 24 hours
	Clients aged 20+						
3.4	Number of adults seen (20+)	N/A	N/A	N/A	N/A	N/A	
3.5	Average wait time from referral to first seen	N/A	N/A	N/A	N/A	N/A	Date referral received by the provider (e.g. GP) to the time of the first appointment. (Time of the first appointment may be influenced by the client choice as well as availability).
3.6	DNA Rate	N/A	N/A	N/A	N/A	N/A	Client did not turn up to a scheduled/agreed appointment, and/or did not postpone or cancel the appointment within 24 hours

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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

The number of BIC commenced and delivered in reporting quarter to those **12-19 years**.

	Number of ABI	Q1	Q2	Q3	Q4	YTD
4.1	Number of youth seen (12-19)	0	0	1		
4.2	Number of adults seen (20+)	N/A	N/A	N/A	N/A	N/A

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

If 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.

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

N/A

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.

	People seen in Group Therapy	Q1	Q2	Q3	Q4	YTD	
	Clients aged 12-19						
5.1	Number of youth seen	22	12	13			
5.2	Average number of group sessions per client	12	9	8			
5.3	Average wait time from referral to first seen	0	0	0			Date referral received by the provider (e.g. GP) to the time of the first appointment. (Time of the first appointment may be influenced by the client choice as well as availability).
5.4	DNA Rate	0	0	0			Client did not turn up to a scheduled/agreed appointment, and/or did not postpone or cancel the appointment within 24 hours
	Clients aged 20+						
5.5	Number of adults seen	N/A	N/A	N/A	N/A		
5.6	Average number of group sessions per client	N/A	N/A	N/A	N/A		
5.7	Average wait time from referral to first seen	N/A	N/A	N/A	N/A		Date referral received by the provider (e.g. GP) to the time of the first appointment. (Time of the first appointment may be influenced by the client choice as well as availability).
5.8	DNA Rate	N/A	N/A	N/A	N/A		Client did not turn up to a scheduled/agreed appointment, and/or did not postpone or cancel the appointment within 24 hours

28 May 2021 **Public**

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

		Number of POC begun and delivered in period					
	Number of POC	Q1	Q2	Q3	Q4	YTD	
	Clients aged 12-19						
6.1	Number of youth seen	9	12	14			
6.3	Average number of sessions per POC	4	5	6			
6.4	Average wait time from referral to first seen	2	2	2			Date referral received by the provider (e.g. GP) to the time of the first appointment. (Time of the first appointment may be influenced by the client choice as well as availability).
6.5	DNA Rate	4	3	0			Client did not turn up to a scheduled/agreed appointment, and/or did not postpone or cancel the appointment within 24 hours
	Clients aged 20+						
6.6	Number of adults seen	N/A	N/A	N/A	N/A	0	
6.7	Average number of sessions per POC	N/A	N/A	N/A	N/A	0	
6.8	Average wait time from referral to first seen	N/A	N/A	N/A	N/A	0	Date referral received by the provider (e.g. GP) to the time of the first appointment. (Time of the first appointment may be influenced by the client choice as well as availability).
6.9	DNA Rate	N/A	N/A	N/A	N/A	0	Client did not turn up to a scheduled/agreed appointment, and/or did not postpone or cancel the appointment within 24 hours

7 Youth PMH Narrative Report

7.1 Overall Assessment of services delivered.

The contacts this quarter number is 176 including the group work. 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 acorss 3 contracts continues to work well with the mixture of skills and gender.

7.2 Any major achievements/successes

There has been positive feedback from DHB mental health services about our male kaimahi work 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 he mother's phone.There is now lots of communication between them, 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.

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 whenone has been done by our clinician.

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

No external audits have been completed in this quarter.

28 May 2021 **Public**

Improved Mental wellbeing

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

Quarter 3 Reporting -12 Month Period to 31 December 2020:

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

Audit of Wellness /Transition Plans in place - data to cover the 3 months to 31 December 20.
Transition Plans in audit period for this extract = 210 files
Wellness Plans in audit period for this extract = 131 files

Wellness (Relapse) Plans - data information (for those current clients who have been in the service more than 12 months) was extracted from WDHB WebPAS Referral Management All Active Referrals Search – filter by Primary.

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

Transition (Discharge) Plans - data information (for those clients who have been discharged from the service in this 12 months period) was extracted from WDHB WebPAS Referral Management Closed Referrals – filter by Outcome Measures: Treatment Completed, ToC MH Team not this DHB, Discharge – prim care.

All clients have Transition (Discharge) plans in at least one of the following forms –Transition/Risk Assessments, CP Notes, Discharge Summaries, Letters to GP

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

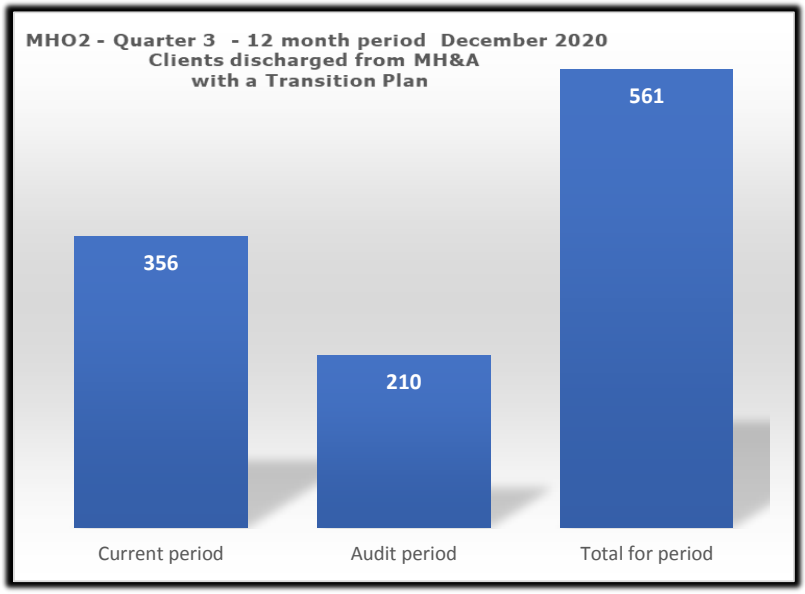
Note

- Still no one identified Transition Form with required information being utilised in CMH
- Inpatient now have identified transition / discharge form being completed by RMOs usually found in CP notes not a CP form.
- The Risk Assessment is the only common form used across all services and it would be expected that any client in the service for 3 months or more would have one in place. This form has been used for reporting wellness/ relapse and transition /discharge plans for many years while waiting for other more suitable forms to be developed and implemented.

28 May 2021 **Public**

Reporting template

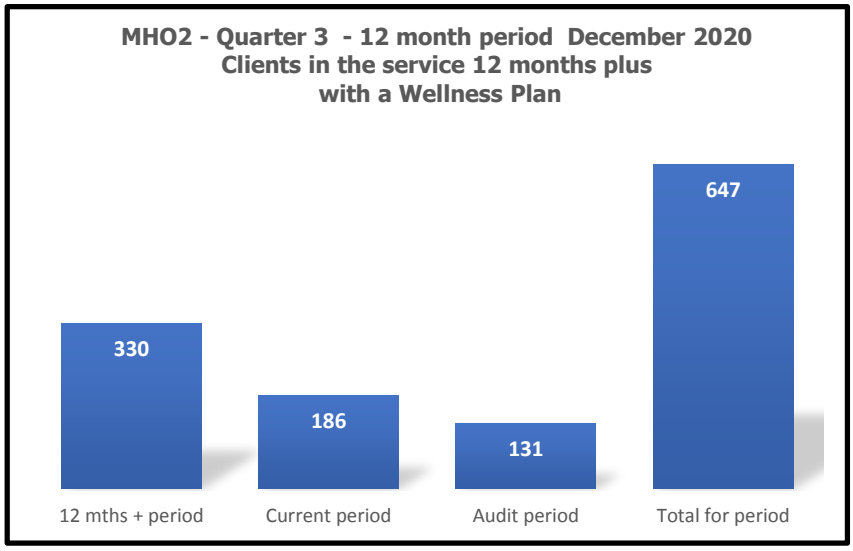
Percentage of MH&A clients discharged from MH&A community services with a transition (discharge) plan		
Numerator	Denominator	Percentage
Number of MH&A clients discharged from the community with a transition (discharge) plan (Data Source: DHB)	Number of MH&A clients discharged from the community MH&A services (DHB data source DHB)	Percentage of MH&A clients discharged from the community with a transition (discharge) plan
561	561	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
63	65 (31%)	96.92%



28 May 2021 **Public**

Reporting template

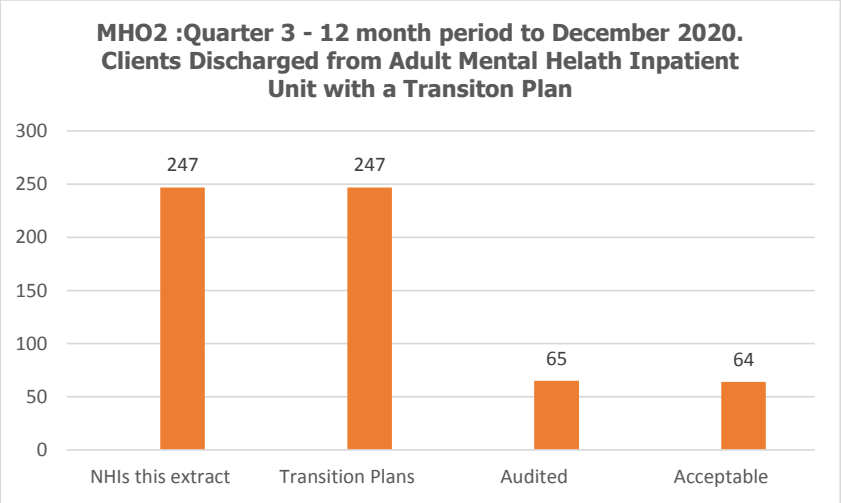
Percentage of MH&A clients open to services for greater than 12 months with a wellness plan		
Numerator	Denominator	Percentage
Number of MH&A clients open to services for greater than 12 months with a wellness plan (Data Source: DHB)	Number of MH&A clients open to services for greater than 12 months (DHB data source DHB)	Percentage of MH&A clients open to services for greater than 12 months with a wellness plan
330	330	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
62	65 (50%)	95.38%



28 May 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
247	247	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
64	65 (26%)	98.46%



28 May 2021 **Public**

MH03 Wait times: Alcohol and other drug wait times by adult, older child/youth services

Mental Health Provider Arm

	<= 3 weeks		<8 weeks	
Age	**target (%)**	**Achieved (%)**	**Agreed target (%)**	**Achieved (%)**
0-19	80%	87%	95%	99%

Addictions (Provider Arm and NGO)

	<= 3 weeks		<8 weeks	
Age	**Target (%)**	**Achieved (%)**	**Target (%)**	**Achieved (%)**
0-19	80%	75%	95%	100%

MH04: Mental Health and Addiction Service Development PRIMARY

1 Client Information

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

	People seen by service	Q1	Q2	Q3	Q4
	Clients aged 12-19				
1.1	Number of females seen	56	51	46	
1.2	Number of males seen	38	41	32	
1.3	Number of clients seen - unspecified gender	0	0	0	
1.4	Total number of youth seen	94	92	78	
1.5	People re-presenting to service				
1.6	Number of females seen (PH/AV)				
1.7	Number of males seen (PH/AV)				
1.8	Number of clients seen - unspecified gender (PH/AV)				
1.9	Total number of youth seen (PH/AV)	0	0	0	0
1.10	People re-presenting to service (PH/AV)				
	Clients aged 20+				
1.11	Number of females seen	282	281	260	
1.12	Number of males seen	138	141	119	
1.13	Number of clients seen - unspecified gender	0	0	0	
1.14	Total number of adults seen	420	422	379	0
1.15	People re-presenting to service				
1.16	Number of females seen (PH/AV)				
1.17	Number of males seen (PH/AV)				
1.18	Number of clients seen - unspecified gender (PH/AV)				
1.19	Total number of adults seen (PH/AV)	0	0	0	0
1.20	People re-presenting to service (PH/AV)				
	Number of referrals				
1.21	Number of referrals (12-19)	13	15	7	
1.22	Number of referrals (20+)	203	142	191	

28 May 2021 **Public**

Ethnic group

Clients aged 12-19

1.23	NZ European	44	44	39	
1.24	Maori	29	45	37	
1.25	Pacific Island	0	1	1	
1.26	Asian	2	0	0	
1.27	Other	0	2	2	
1.28	NZ European (PH/AV)				
1.29	Maori (PH/AV)				
1.30	Pacific Island (PH/AV)				
1.31	Asian (PH/AV)				
1.32	Other (PH/AV)				

Clients aged 20+

1.33	NZ European	282	249	238	
1.34	Maori	134	140	117	
1.35	Pacific Island	8	11	6	
1.36	Asian	8	10	4	
1.37	Other	6	10	14	
1.38	NZ European (PH/AV)				
1.39	Maori (PH/AV)				
1.40	Pacific Island (PH/AV)				
1.41	Asian (PH/AV)				
1.42	Other (PH/AV)				

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
1.43	K10 average score (12-19)			40	No result	36	No result
1.44	K10 average score (20+)	31	36	41	No result	34	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
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
1.47	Average score (12-19)						
1.48	Average score (20+)						

	Number of Referrals to	Q1	Q2	Q3	Q4
1.51	Psychologist/psychotherapis	0	1	2	
1.52	Specialist CAMHS or Adult M	6	7	12	
1.53	Psychologist/psychotherapist (youth 0-19) (PH/AV)				
1.54	Specialist CAMHS or Adult Mental Health Service (youth 12-19) (PH/AV)				
1.55	Psychologist/psychotherapis	22	10	19	
1.56	Specialist CAMHS or Adult M	47	42	33	
1.57	Psychologist/psychotherapist (adults 20+) (PH/AV)				
1.58	Specialist CAMHS or Adult Mental Health Service (adults 20+) (PH/AV)				

2 Extended Consultations

Definition: The usual consultation period is extended to allow additional time for assessment

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

		Q1	Q2	Q3	Q4
2.1	Youth (aged 12-19) who re	37	45	39	
2.2	Adults (aged 20+) who rec	288	270	211	
2.3	Total	325	314	250	
2.4	Youth (aged 12-19) who received an extended consult (PH/AV)				
2.5	Adults (aged 20+) who received an extended consult (PH/AV)				
2.6	Total (PH/AV)				
2.7	General Practitioner - numb	209	222	180	
2.8	Practice Nurse - number of	111	100	95	
2.9	Total	325	314	275	
2.10	General Practitioner - number of consults (PH/AV)				
2.11	Practice Nurse - number of consults (PH/AV)				
2.12	Total (PH/AV)				

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

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 1		18	1	
3.2	Youth (12-19) average wait time from re		0	0	
3.3	Youth (12-19) DNA Rate (%)		0%	0%	
3.4	Number of BIC sessions for youth aged 12-19 (PH/AV)				
3.5	Youth (12-19) average wait time from referral to first seen (PH/AV)				
3.6	Youth (12-19) DNA Rate (%) (PH/AV)				
3.7	Number of BIC sessions for Adults aged 2		N/A	N/A	
3.8	Adult (20+) average wait time from refe		N/A	N/A	
3.9	Adult (20+) DNA Rate (%)		N/A	N/A	
3.10	Number of BIC sessions for Adults aged 20+ (PH/AV)				
3.11	Adult (20+) average wait time from referral to first seen (PH/AV)				
3.12	Adult (20+) DNA Rate (%) (PH/AV)				
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 DN			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 (%)				
3.19	Total Number of BIC sessions (PH/AV)				
3.20	Total average wait time from referral to first seen (PH/AV)				
3.21	Total number of clients that missed any session or DNA (PH/AV)				
3.22	Total number of clients attending any session (PH/AV)				
3.23	Total number enrolled (if different to total attending sessions) (PH/AV)				
3.24	Total DNA Rate (%) (PH/AV)				

4 Alcohol Brief Intervention (ABI)

Definition: Structured assessment and screening, advice, ABC style brief intervention and/or

The number of BIC commenced and delivered in reporting quarter

		Q1	Q2	Q3	Q4
4.1	Number of ABI sessions for	12	13	6	
4.2	Number of ABI sessions for	113	115	122	
4.3	Number of ABI sessions for youth aged 12-19 (PH/AV)				
4.4	Number of ABI sessions for adults aged 20+ (PH/AV)				

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

Alcohol SBI in general practice
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

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 se	22	12	13	
5.2	Youth (12-19) average num	12	9	8	
5.3	Youth (12-19) average wait	NR	0	0	
5.4	Youth (12-19) DNA Rate (%	NR	0%	0%	
5.5	Number of group therapy sessions for youth aged 12-19 (PH/AV)				
5.6	Youth (12-19) average number of group sessions per client (PH/AV)				
5.7	Youth (12-19) average wait time from referral to first seen (PH/AV)				
5.8	Youth (12-19) DNA Rate (%) (PH/AV)				
5.9	Number of group therapy se	NR	N/A	N/A	
5.10	Adults (20+) average numb	NR	N/A	N/A	
5.11	Adults (20+) average wait t	NR	N/A	N/A	
5.12	Adults (20+) DNA Rate (%)	NR	N/A	N/A	
5.13	Number of group therapy sessions for adults aged 20+ (PH/AV)				
5.14	Adults (20+) average number of group sessions per client (PH/AV)				
5.15	Adults (20+) average wait time from referral to first seen (PH/AV)				
5.16	Adults (20+) DNA Rate (%) (PH/AV)				
5.17	Total number of group ther	NR	NR	NR	
5.18	Total number of clients that	NR	NR	NR	
5.19	Total number of clients atte	NR	NR	NR	
5.20	Total number enrolled (if dif	NR	NR	NR	
5.21	Total average number of gr	NR	NR	NR	
5.22	Total average wait time fror	NR	NR	NR	
5.23	Total DNA Rate (%)	NR	NR	NR	
5.24	Total number of group therapy sessions (PH/AV)				
5.25	Total number of clients that missed any session or DNA (PH/AV)				
5.26	Total number of clients attending any session (PH/AV)				
5.27	Total number enrolled (if different to total attending sessions) (PH/AV)				
5.28	Total average number of group sessions per client (PH/AV)				
5.29	Total average wait time from referral to first seen (PH/AV)				
5.30	Total DNA Rate (%) (PH/AV)				

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,

Number of POC begun and delivered in period

		Q1	Q2	Q3	Q4
6.1	Number of POC for youth a	30	34	35	
6.2	Youth (12-19) average num	6	13	4	
6.3	Youth (12-19) average wait	27	30	6	
6.4	Youth (12-19) DNA Rate (%	35%	20%	6%	
6.5	Number of POC for youth aged 12-19 (PH/AV)				
6.6	Youth (12-19) average number of sessions per POC (PH/AV)				
6.7	Youth (12-19) average wait time from referral to first seen (PH/AV)				
6.8	Youth (12-19) DNA Rate (%) (PH/AV)				
6.9	Number of POC for adults a	239	220	203	
6.10	Adults (20+) average numb	3	4	3	
6.11	Adults (20+) average wait t	25	24	25	
6.12	Adults (20+) DNA Rate (%)	12%	12%	10%	
6.13	Number of POC for adults aged 20+ (PH/AV)				
6.14	Adults (20+) average number of sessions per POC (PH/AV)				
6.15	Adults (20+) average wait time from referral to first seen (PH/AV)				
6.16	Adults (20+) DNA Rate (%) (PH/AV)				
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 atte	19			
6.20	Total number enrolled (if different to total attending sessions)				
6.21	Total average number of se	3		3	
6.22	Total average wait time from referral to first seen			22	
6.23	Total DNA Rate (%)	11%	12%	9%	
6.24	Total number of POC (PH/AV)				
6.25	Total number of clients that missed any session or DNA (PH/AV)				
6.26	Total number of clients attending any sessions (PH/AV)				
6.27	Total number enrolled (if different to total attending sessions) (PH/AV)				
6.28	Total average number of sessions per POC (PH/AV)				
6.29	Total average wait time from referral to first seen (PH/AV)				
6.30	Total DNA Rate (%) (PH/AV)				

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

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. The digital 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.

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.

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

No external audits have been completed in this quarter.

28 May 2021 **Public**

MH04: Mental Health and Addiction Service Development

SUICIDE PREVENTION

Focus Area 2 District Suicide Prevention and Postvention Q3

1. Training / education evaluation template

WDHB response: No training to report this quarter.

Training description	Initiated by DHB Y/N	Provider	Number of attendees	Intended audience	Outcome/impact

2. Community initiatives evaluation template

WDHB Response: note that Skylight have been extremely slow to respond to request. It is understood that they have a problem with a lack of FTE resource. The intention was that this training would occur to enable more effective lead groups.

Event description	Initiated by DHB Y/N	Supported by DHB Y/N	Number of attendees	Outcome /impact	Approach to safety

Qualitative Report:

Suicide Prevention

- The WDHB CEO has approved the next phase of the regional approach to suicide prevention. The strategy is currently with the designers.
- The Growing Collective Wellbeing Insights Report has been distributed out to stakeholders and community groups with positive feedback to date about the approach and findings.
- The Healthy Families WRR team presented the Insights Report to the WDHB Board. A following up discussion will be held to engage the Board members further in the strategic approach. Board members were presented with the strategic framework and proposed strategy in the last quarter of 2020, receiving positive support for the approach.
- WDHB, Te Oranganui and Healthy Families Whanganui, Rangitīkei, Ruapehu will be hosting Carla na Nagara, National Suicide Prevention Office on Thursday 8 April 2021 to showcase the insights and share the approach.
- The Capability budget is allocated to supporting the health and social services sector to engage in the latest relevant practices and principles for suicide prevention. Our key partner for this component is Barry Taylor, Taylor Made.
- A meeting with Barry is being scheduled to discuss setting up the evaluation and measurement working group for the Growing Collective Wellbeing approach, and exploring how we build capability across the sector and communities

Suicide Postvention

The DHB funds and NGO to provide postvention support. During this quarter a family have been supported and has had a preventative aspect. Support to a father and grandmother who are bereaved by the death of 14-year-old son/grandson at the end of 2020. Their grief is compounded by the fact that there is significant conflict between maternal and paternal sides of this young man's families. Feedback received from both father and grandmother is that support received from postvention services has been excellent, and they have found it more beneficial than the counselling service they initially engaged in.

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

28 May 2021 **Public**

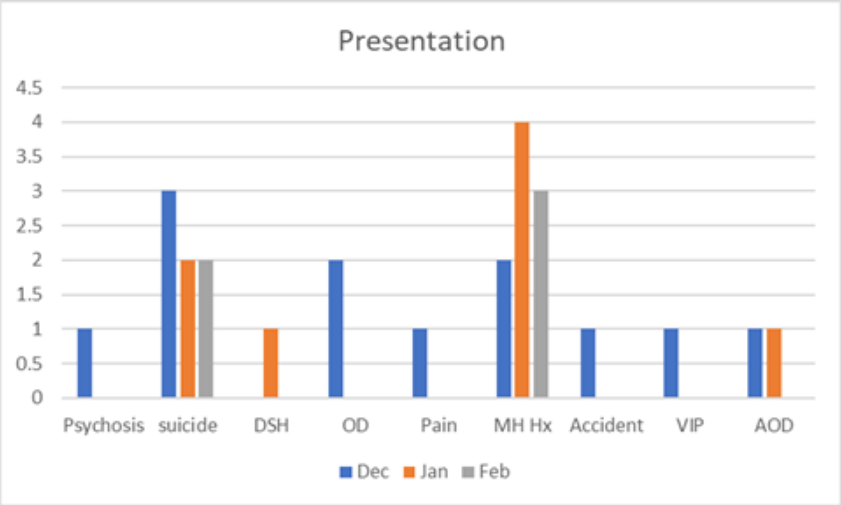
MH04: Mental Health and Addiction Service Development CRISIS RESPONSE

Mental wellbeing MH04: FA3 Mental Health and Addiction Service Development CRISIS RESPONSE

The Mental Health Assessment Home Treatment (MHAHT) are adjusting to the newly introduced Whakaronogo Rau telephone triage line provided from 1630 to 0700 hrs seven days a week. There are some deficits with response to the telephone service with an abandoned rate of 30% of calls. 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 download the Microsoft app.

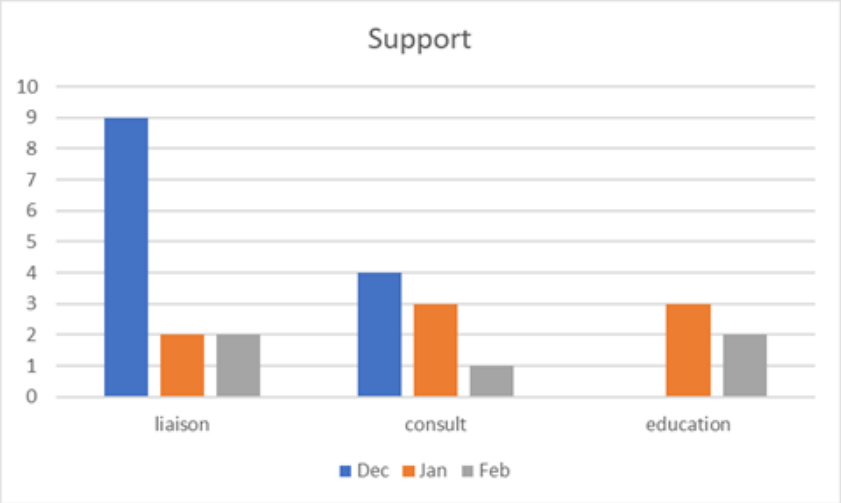
The 0.4 FTE Emergency Department Crisis support educator role commenced December 2021 and complements other organisation wide mental health innovations such as Whanganui DHB's Mental Health Risk Screen lanyard cards for general staff to use for the suicide screening question.

The crisis support educator produced types of presentations ranging between psychosis, suicide, deliberate self-harm, unmanaged pain, people with a mental health history, an accident, violence inter-partner abuse, alcohol and other drugs;



The types of crisis support included liaison with other services, providing consultation and education to ED staff.

28 May 2021 **Public**



The types of outcomes included referring to MHAHT, people who did not wait and went AWOL, service users referred to medical wards, community mental health and addiction service (CMHAS) and maternal infant community adolescent mental health service (MICAMHS), and education provided to service providers.

MHAHT work with service users and their families in their own homes supporting least restrictive interventions. Pathways crisis respite service is improving occupancy rates with service users transitioning from the inpatient service to the community using respite services as a step down strategy. MHAHT are flexible to support transition to the community as required.

28 May 2021 **Public**

MH04: Mental Health and Addiction Service Development OUTCOMES FOR CHILDREN

Mental Wellbeing MH04: FA4 Mental Health and Addiction Service Development OUTCOMES FOR CHILDREN Q 3 Report

As previously reported the WDHB funds an NGO to provide support to children and youth. Their group work was disrupted due to COVID however they have been providing 'one on one' support.

Unfortunately, the NGO have not been able to hold the Children's Group this term, due to lack of appropriate referrals. However, they have continued to provide individual support to children and youth impacted by mental health and/or addiction issues of a whanau member or due to experiencing mild-moderate anxiety, low mood, or emotional distress. This includes children in rural areas, and we will be delivering a condensed version of the children's programme to three siblings in their rural location during the upcoming school holidays.

The NGO is currently developing an Anxiety Group programme to be delivered to students at Whanganui High School. This is due to commence in week 3 of term 2, and will be an 8-week programme, with a maximum of 10 students per group. Two groups will be held each term: one group for junior students and one for senior students. It is CBT and ACT based and will be facilitated by our organisation, Mental Health & Wellbeing Support, in partnership with the school counsellor as needed. We will collect evaluations from participants at the end of the programme, and measure outcomes. If this proves successful, we will approach other secondary schools to offer them this programme.

The DHB's specialist mental health services have a dedicated clinical nurse educator supporting parents healthy children and since the new year the focus has been on training commencing with the invitation to provide SPHC COPMIA training to all new He Puna Ora staff from Te Oranganui, Ngati Rangi, Mokai Patea, Te Kotuku Hauora o Rangitikei and Te Puke Karanga Hauora. Following this, the February training 'Keeping Families and Children in Mind' involved participants from NGO Birthright, Te Oranganui Mental Health team members, WDHB CMH&AD team and MICAMHAS. More recently in March training was provided to NGO Emerge Aotearoa champions navigator group from throughout New Zealand held in Mangere, South Auckland. Feedback was received from two participants who had completed training in Whangarei and West Auckland in 2018-2019 and 2021, both very encouraging of their training experiences.

Interesting to note, International studies (Howe, Batchelor & Bochynska, 2012; Howe, Batchelor, & Bochynska, 2009; Maybery, Reupert, & Patrick, et al., 2009; Phelan, Howe, Cashman & Batchelor, 2012; Reupert, Maybery & Kowalenko, 2012) show that approximately 25-30% of all clients accessing mental health services on any given day are parents of children aged 0-18 years. In the 2019-2020 audit WDHB have shown that figure to range from 26-27% Te Awhina (AMH inpatient unit), 38-41% Community Mental Health (CMH) and 36-43% Alcohol and other Drugs (AD). This finding indicates in our region a higher rate of parents/caregivers who access MH and AD services and a higher number of children living in the presence of mental health and addiction than the Australian average. Parenting support through MICAMHAS also continues to be consistently taken up by parents, a trend particularly noticeable post COVID19 levels 3 and 4.

In the coming months there are planned collaborative projects such as a school based children's group with NGO Mental Health and Wellbeing Support, ongoing training provision inclusive of NGOs and Māori Hauora providers, an invitation to support a colleague to present as part of a national educational CAPA forum, acceptance to present at a CAPA International conference (Canada) in May (via zoom), and ongoing parenting support programs.

28 May 2021 **Public**

MH04: Mental Health and Addiction Service Development EMPLOYMENT & PHYSICAL NEEDS

Mental Wellbeing MH04: FA5 Mental Health and Addiction Service Development EMPOYMENT & PHYSICAL NEEDS Q3

Employment

The WDHB funds an NGO to provide employment support and their report is outlined below:

Points to note from Quarter 3, January to March 2021, include:

- 30 people have been referred into service since 1 July 2020; with 9 being referred during Quarter 3.
- From these referrals we have seen 25 people enter the service; 7 during this quarter.
- 6 people moved into work during Quarter 3, with one person gaining two positions. Of these seven paid employment outcomes, two were for 40+ hours per week; one for 30 hours per week; one for 24 hours per week and three were for less than 20 hours per week.
- Exit figures have seen 7 people leave the service for this quarter – two settled in employment; four opted off and one referral was withdrawn by the referrer.
- 17 people are currently active within the service at the end of March 2021.

Physical Needs

Community Mental Health and Addiction Services (CMHAS) mental health liaison health professionals are working from four GP medical centres strengthening relationships between primary and secondary teams by accepting referrals who do not meet entry criteria for secondary care service treatment and support.

The HoNOS and ADOM rates physical problems for health professionals to monitor and improve their physical health status every three months.

The electronic patient management system called Clinical Portal has an Anthropometric data that is used for metabolic monitoring.

Psychiatrists are visiting four GP medical centres to meet with people from secondary care services. This initiative promotes service users' access to physical health.

The Transition nurse continues to assist people returning to primary services from secondary care and accepts referrals from GP services when relapse indicators are noticed.

The emergency department crisis support educator role has managed to assist people who present to emergency services with an existing mental health condition and assist ED staff in managing relapse indicators during their triage process.

28 May 2021 **Public**

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

WDHB Qualitative Report Quarter 3 –January 2021 to March 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 by two, from fifty-two at the start of the period to fifty at the end of March 2021. Three tangata whai ora were released from compulsory status. In all three of these situations, whanau are involved. There are three new orders: Two people transferred into the district from a neighbouring district and one came from prison in another district. None of these tangata whai ora or whanau were previously known to the service. Two tangata whai ora moved to other districts.

As mentioned in the quarter 2 narrative, there was a change of responsible clinicians for a significant number of tangata whai ora in quarter 2 but as therapeutic relationships and engagement develop it is expected that more will be able to be engaged in treatment on an informal basis. All senior medical officers have now undergone training to develop our understanding of Te Ao Maori, with some undertaking further studies.

The initiatives commenced in 2020 continued, with input from the Balance peer support (lived experience) and Mental Health and Wellbeing support into section 76 reviews, as well as availability of a Haumoana navigator.

A Te Ao Maori tool is being developed by the Haumoana navigator team and will be launched in quarter 4. It is hoped that use of this tool across the teams will assist in understanding of the needs of tangata whai ora. Due to workload, the Haumoana Navigator, whilst based on the inpatient unit from September 2020 has been less available to the unit than was first anticipated. (He also must cover the emergency department, Community mental health and addictions and MICAMHAS).

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.

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.

An exercise of comparing these record by record is ongoing.

One clear theme which has become apparent is that 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.

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.

28 May 2021 **Public**

MH06 Output Delivery

Price Volume Schedule 2020/21 Quarter 3

Source: DAP Production Plans 2020/21 (as at 17/9/20)

PU Code	Description	2020/21 Vol	2020/21 Prices	2020/21 Total $	Unit of Measure	Contract Delivery FTE's or Available bed days 2020/21		
						Qtr 1Vol	Qtr 2 Vol	Qtr 3 Vol
MHA01	Acute 24 Hour Clinical Intervention (inpatient)	2,190	824	1,804,714	Available bed day	547.00	547.0	547.00
MHA02	Intensive Care	2,190	976	2,136,429	Available bed day	547.00	547.0	547.00
MHA04C	Crisis Intervention Service - Nursing and/or allied health staff	9	122,837	1,044,114	FTE	8.10	9.0	9.00
MHA06	Acute Package of Care	2	48,515	72,773	Occupied bed day	2.00	2.0	2.00
MHA09A	Community Clinical Mental Health Service - Senior medical staff	4	308,494	1,079,729	FTE	3.10	3.0	3.50
MHA09C	Community Clinical Mental Health Service - Nursing and/or allied health staff	13	122,837	1,596,880	FTE	13.00	13.0	13.00
MHA11C	Mobile Intensive Treatment Service - Nursing and/or allied health	2	122,837	245,674	FTE	1.90	2.1	2.00
MHA18C	Needs Assessment and Service Coordination - Nursing and/or allied health staff	1	122,837	73,702	FTE	1.00	1.0	1.00
MHAD14C	Co-existing disorders (mental health & addiction) - Nursing and/or allied health staff	3	122,837	380,795	FTE	3.00	3.0	3.00
MHD69	Alcohol & Other Drugs Service - Opioid Substitution Treatment – Primary Care Support Places	45	2,712	122,054	Client	48.00	47.0	48.00
MHD70	Alcohol & Other Drugs Service – Opioid Substitution Treatment – Specialist Service	90	3,591	323,165	Client	109.00	110.0	109.00
MHD71C	Alcohol and other drug consultation liaison service – Nursing and allied health staff	0.2	157,541	26,782	FTE	0.20	0.2	0.20
MHD74A	Community based alcohol and other drug specialist services – Senior medical staff	1	308,494	308,494	FTE	1.20	1.0	1.10
MHD74C	Community based alcohol and other drug specialist services – Nursing and allied staff	6	122,837	786,157	FTE	6.10	6.3	6.10
MHDI48C	Child, adolescent and youth alcohol and drug community services - Nursing and/or allied health staff	1	122,837	122,837	FTE	1.10	1.0	1.00
MHE30C	Community service for eating disorders - Nursing and/or allied health staff	1	152,885	183,462	FTE	1.00	1.0	1.00
MHF81	Forensic Mental Health – Extended Secure Service	5,286	1,042	5,505,413	Available bed day	1321.00	1,321.0	1,321.00
MHI44A	Infant, child, adolescent & youth community mental health services - Senior medical staff	2	308,494	616,988	FTE	1.80	2.0	1.80

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MHI44C	Infant, child, adolescent & youth community mental health services - Nursing/allied health staff	12	122,837	1,474,043	FTE	12.20	11.4	11.80
MHM90C	Specialist Community Team – Perinatal Mental Health – Nurses & allied health	2	143,215	214,823	FTE	1.00	1.0	2.00
MHO101C	Mental Health Older People Dementia Behavioural Support – Nurses & allied health	1	122,836	61,418	FTE	1.00	1.0	1.00
MHO99A	Mental Health of Older People – Specialist Community Service – Senior medical staff	1	308,494	154,247	FTE	1.00	1.0	1.00
MHO99C	Mental Health of Older People - Specialist Community Service – Nurses & allied health	2	122,837	245,674	FTE	2.00	2.0	2.00
MHW68D	Family whanau support education, information and advocacy service – Non-clinical staff	5	99,854	469,315	FTE	5.00	5.0	5.00

Mental Health 2020/21 Service Delivery Information YTD December 2020

District Health Board	Full Time Equivalents December Quarter				Overall Bed Days				
	Service Level Agreeme	Actual	Variance	Percentage	Service Level Agreeme	Available	Actual	Variance	Occupancy Rate
Auckland	488	434	54	89%	8,076	26,997	24,189	2,808	90%
Bay of Plenty	202	209	-7	103%	8,076	8,168	7,151	1,017	88%
Canterbury	463	425	38	92%	34,493	34,493	27,021	7,472	78%
Capital and Coast	316	363	-47	115%	22,566	22,566	22,768	-202	101%
Counties Manukau	480	426	55	89%	17,611	17,485	13,353	4,132	76%
Hawke's Bay	121	112	9	92%	4,563	5,740	6,009	-269	105%
Hutt	124	127	-3	102%	8,016	5,320	4,962	358	93%
Lakes	79	71	8	90%	2,555	2,576	2,528	48	98%
MidCentral	165	165	-0	100%	4,633	4,852	5,963	-1,111	123%
Nelson Marlborough	137	133	4	97%	5,567	5,567	4,259	1,308	77%
Northland	203	205	-2	101%	11,863	11,863	11,153	710	94%
South Canterbury	43	40	2	95%	1,271	1,270	1,250	20	98%
Southern	292	274	18	94%	19,270	17,261	12,608	4,653	73%
Tairawhiti	47	44	3	94%	1,725	1,725	1,662	63	96%
Taranaki	96	95	1	99%	4,275	4,310	3,887	423	90%
Waikato	319	324	-4	101%	22,742	22,433	22,987	-554	102%
Wairarapa	39	35	4	91%	-	-	-	-	0%
Waitemata	652	657	-5	101%	37,604	35,532	34,407	1,125	97%
Whanganui	64	64	-0	101%	4,833	4,834	5,049	-215	104%
West Coast	53	48	5	91%	1,825	1,840	1,274	566	69%
Total	**4,382**	**4,249**	**132**	**97%**	**221,563**	**234,830**	**212,479**	**22,351**	**90%**

28 May 2021 **Public**

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

Inpatient 7-day follow-up post discharge measure

DHBs to supply data via the templates below – data to be sourced from the KPI programme

Reporting template

Percentage of MH&A Total clients discharged from MH&A adult inpatient services that are followed up within 7 days.		
Numerator 179	Denominator 242	Percentage 73.9%
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 75	Denominator 100	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 3	Denominator 4	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

Narrative quarterly reporting

Data on 7 day follow up has minimal issues as we have been able to identify and correct problems for the most part.

Discharge follow up is improving following significant work by the adult service. This is not yet reflected due to arrears. All adults discharged and remaining domiciled in this DHB are reviewed by an RMO within the week following discharge. At discharge the person receives an appointment time and date that is suitable to them. The post discharge follow up medical appointment takes place within the week following discharge and notes are entered into the clinical portal, however, the activity to be entered into the patient management system to be picked up in the PRIMHD data is sometimes missed by RMO's new on their 3 month MH&AS rotation. The MH&AS leadership have developed a dependable and reliable way to ensure the activity from these attendances is accurately and timely recorded. Whanganui DHB believes the outcome will begin to become evident within the next quarter.

28 May 2021 **Public**

Primary Health

PH 01 SYSTEM LEVEL MEASURES

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

For this report, the Ministry would like to know if the alliance is on track with the implementation of the approved SLM plan. This is exception reporting therefore further information is only required where the alliance is off track.

QUARTER (circle the appropriate one): ~~One / Two~~ / Three
Name of District Alliance: Whanganui Alliance Leadership Team
Name of DHB reporting: Whanganui

This report has been agreed by our District Alliance	~~Yes~~ / No

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

***Please tick the appropriate column.**
Submission to the Ministry of Health – submit through the quarterly reporting data base for PH01.

PH04 :Better help for smokers to quit (primary care)

	Better Help for Smokers to Quit Health Target – Primary Care *90% of enrolled patients who smoke and are seen by a health practitioner in primary care will be offered advice and help to quit*
Name of DHB	**Whanganui**
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	**Q3**
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. What is being done? 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).
Do you think you have met the target for Māori and Pacific (as noted above) this quarter? If not, what issues are preventing the target from being met and sustained? What actions are being put in place to improve performance and how will these actions be monitored?	Help for our enrolled Māori who are registered as smokers has been better from an equity perspective, with a greater percentage of Māori than non-Māori being provided with advice and referrals. We will continue to highlight the inequities in health outcomes and support increasing the volume of Maori who are being offered this advice & support to meet the MOH target.
Is there any further support you require from the Ministry to achieve the target? If so, what support is required?	
Is there anything else you would like to tell the Ministry?	

28 May 2021 **Public**

Strong and equitable public Health and Disability system

SS01: Faster cancer treatment (31 days)

Faster cancer treatment (FCT)
Monthly Reporting Data

Background
The Ministry of Health (MoH) FCT indicators are:

31 Day Indicator - from decision to treat to 1st treatment

- Twenty-seven patients met criteria for 31-day indicator reporting

Four patients experienced capacity delays of 2, 7, 90, 94 days due to urology surgical capacity.

Ethnicity information

Nine patients of Māori ethnicity (27.3% of all patients) presented with breast, colon, lung, haematological, 'other' (2) and Head and Neck (3) cancers. No patients of Pacific Island ethnicity were reported for March.

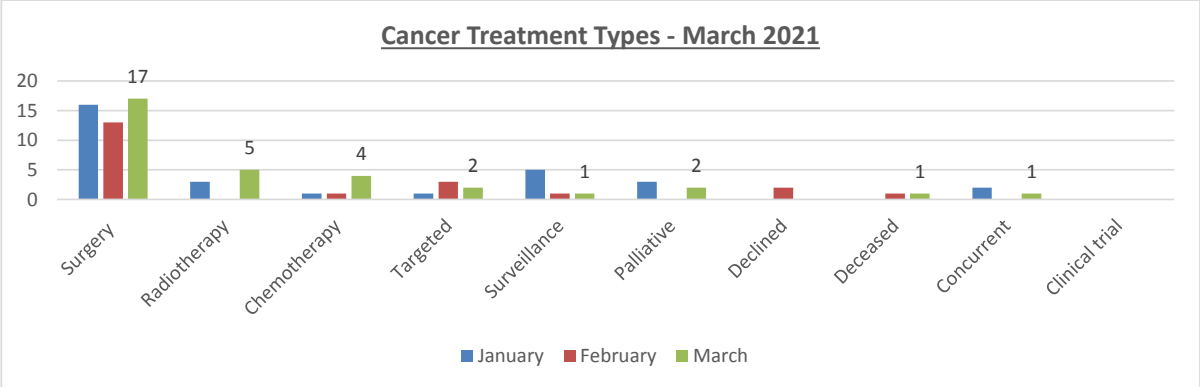
ED Presentations

Six patients presented acutely to ED (self-and/or GP referred) with Head and Neck, lung, haematological (2) and 'other' (2) cancers. One of the patients presenting to ED was referred to palliative care, the patient with lung cancer died prior to treatment

Palliative Care

Two patients were referred for palliative care (best supportive care) as their first treatment

Chart 2. 1st Treatment Types



Treatment at other DHBs:

- Sixteen patients received treatment at MCDHB – nine patients had oncology treatment, the others had surgery for ENT and urological (6) cancers.
- One patient attended CCDHB for cardiothoracic surgery.

28 May 2021 **Public**

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:

- As previously reported the DHB is actively engaged in the national work on the preferred funding case-mix methodology and the implication of this approach for the local DHB. Whanganui's financial analysis/modelling is due to be provided to the DHB in April
- Is also working on the system design that will met the needs of the WDHBs population.

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 3** that have received these services:
    - in-home strength and balance programmes (new starters)
    - 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

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28 May 2021 **Public**

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

DHB Response
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:** • The Masters games were held in Whanganui during February of this quarter. The WDHB physiotherapy department provided strength and balance exercise sessions to help promote strength and balance exercise in relation to mobility. Accredited community exercise groups with the Live Stronger for Longer movement were encouraged to come along to participate and promote their own exercise programmes with pamphlets and handouts and the opportunity to increase their participant numbers. After this event there was a small increase in new people attending community exercise groups. • Most of the community exercise providers have undertaken updated training to ensure consistency and up to date delivery of the exercise programmes they provide. • The FLS survey completed in January for ACC and the ANZ Facility Level Survey (part of setting up a bi-national Fracture Liaison Service) has broadened knowledge in providing this service more effectively to this community. • GP's are now emailed recommendations for each patient either for DEXA scans or Bone Strengthening medications which will be more efficient than posting letters. • Working through a process where the FLS Coordinator can request (with patient consent) DEXA Bone Density Scans directly from Cortex Medical Imaging via Radiology. FLS Coordinator will then get a copy of the result with the original to go to the GP, with recommendations for Bone Strengthening Medication from the FLS Coordinator to the GP. • Phone contact for patients with fragility fractures who haven't been seen face to face is now occurring. The Falls and Fracture screening tool is completed, diet and exercise are discussed, along with DEXA scan and medication – whatever is needed and appropriate.

28 May 2021 **Public**

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

DHB Response
WDHB Response: The non-acute rehabilitation within the community is being factored into the system development for home and community support
DHB Response
WDHB Response: The WDHB in partnership with ACC and Osteoporosis NZ are working through the draft standards which includes data driven primary care management

- 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:

Classification	# of People (Quarter)	# of People (YTD)	Commentary / Narrative from DHB
Number of people that received in-home strength and balance retraining (65-74, people under 65 if identified as a falls risk):	17	50	2 people under 65 4 people over 90
Number of people that received in-home strength and balance retraining (75+):	41	113 **Total = 163**	

There where another 29 people seen or contacted for falls prevention assessment and education this quarter who did not participate in the OEP for reasons such as: already participating in a community exercise group, medical or neurological reasons. 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, CART (Community Assessment Rehabilitation Team).

28 May 2021 **Public**

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:**

Classification	# of People (Quarter)	# of People (YTD)
Number of people that received community / group strength and balance retraining (65+**,** people under 65 if identified as a falls risk):	510 (as determined by phone call to exercise group coordinators April 2021)	1521

There has been an increase in the number of new people joining community exercise groups however this has been offset by an increased number of people no longer being able to participate due to ill health or change in circumstance.

Quarterly phone contact has been maintained and emails sent by the Lead Agent to the coordinators of community groups to keep them up to date with current events i.e. Promotion at the Masters games, the continuing availability of the ACC Nymbl App and the ongoing support and promotion by ACC of the Live Stronger for Longer website.

28 May 2021 **Public**

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 (FLS) or similar fracture prevention service***:

Classification	# of People (1 January – 31st March 2021)	# of People (YTD) July- 2020- March 2021
Number of people that have been seen by the FLS or similar fracture prevention service (aged 50-64 years of age):	Total 18 NOF 1 Humerus 2 Wrist 6 Ankle 7 Vertebrae 1 Pelvis 0 Ribs 0 Other 1 Have history of past fracture: 6 Have history of more than single fracture at time: 3	Total **18** NOF 1 Humerus 2 Wrist 6 Ankle 7 Vertebrae 1 Pelvis 0 Ribs 0 Other 1 Have history of past fracture: 6 Have history of more than single fracture at time: 3 **Note: the figures for this age group have only been collected in Q3**

Of these patients 18 where on nil bone strengthening meds at time fracture
2 were already on BSM:
- 1 was on calcium
- 2 were on Fosamax plus
- 2 were on vitamin D

Following identification fracture
- 10 were recommended oral bisphosphonate
- 0 were given Aclasta
- 1 was recommended to start vitamin D
- 16 were recommended to have DEXA
- 1 has had DEXA scans already
- 0 has deceased
- 7 are being processed

28 May 2021 **Public**

Report the number of older people (65 and over, or younger if identified as a falls risk) that have been seen **by the Fracture Liaison Service or similar fracture prevention service**:

Ministry of Health Guidance		
Classification	**# of People (Quarter) 65+**	**# of People (YTD)**
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):	Total 22 NOF 5 Humerus 1 Wrist 3 Ankle 4 Vertebrae 4 Pelvis 1 Ribs 0 Other 4 Have history of past fracture: 3 Have history of more than single fracture at time: 5	Total **63** NOF 12 Humerus 4 Wrist 14 Ankle 11 Vertebrae 7 Pelvis 3 Ribs 1 Other 11 Have history of past fracture: 9 Have history of more than single fracture at time: 6
Number of people that have been seen by the Fracture Liaison Service or similar fracture prevention service (75-84)	Total 17 NOF 4 Humerus 4 Wrist 3 Ankle 1 Vertebrae 2 Pelvis 1 Ribs 1 Other 1 Have history of past fracture: 4 Have history of more than single fracture at time: 1	Total **63** NOF 14 Humerus 12 Wrist 11 Ankle 5 Vertebrae 5 Pelvis 3 Ribs 7 Other 6 Have history of past fracture: 20 Have history of more than single fracture at time: 3

28 May 2021 **Public**

Number of people that have been seen by the Fracture Liaison Service or similar fracture prevention service (85+):	Total 18 NOF 2 Humerus 2 Wrist 1 Ankle 2 Vertebrae 2 Pelvis 2 Ribs 2 Other 5 7 have history of past fracture 0 presented with more than single fracture at time	Total **74** NOF 15 Humerus 12 Wrist 4 Ankle 3 Vertebrae 13 Pelvis 12 Ribs 6 Other 11 22 have history of past fracture 4 presented with more than single fracture at time

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

28 May 2021 **Public**

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***.

DHB Response			**Ministry of Health Guidance**
Classification	**# Fall-Related Fracture**	**# Treated for Osteoporosis**	
Bisphosphonate (Prescribed)	9	8	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)			
Zoledronic Acid Infusions (5mg/100) (Prescribed)	4		
Zoledronic Acid Infusions (5mg/100) (Dispensed, if prescribed unavailable)			
Vit D prescribed	12 and 1 prescribed as patient allergic to bisphosphonates	1	

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.

28 May 2021 **Public**

Whanganui DHB Pressure Injury Program Q3 Report

KPI/Deliverable	Description	Target	Due date	Responsibility	Achieved last period	Achieved this period	KPI status	Improvement and sustainability
	Primary Care/ARC/Patients/Whanau							
1) Planned education sessions	1: PIP overview • Definition • Causation • Staging • SSKINS 2: Positioning & wound care workshops • Positioning/shear/pressure • Use of positioning aids • Skin anatomy • Wound assessment (TIME) • Factors affecting healing • Dressing tips	> 90% of ARC of the 11 facilities and 4 provider agencies within the DHB catchment area will have had both sessions delivered and evaluated.	1 Dec 2021	PIP Team		Education session for 2021 underway. Continue to be well received		Combining of positioning and wound care workshops for more prompt roll out. Development of information into online modules or booklet for future reference.
	Make, edit and deliver video • Consider delivery methods e.g. internet link, eLearning platform, DVD	Complete by 31 Dec 2020		PIP Team Coms Team		Achieved		Video available to all Care providers
2) Hotline	Establish a hotline for people to contact PIP team and discuss any	Underway May 2020	May 2020	Service Manager		Continuing to promote the use of the		Make this an **0800 550 533** number for

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:

Late last year the Central Region Chairs and Chief Executives identified frailty as a priority programme.

Supporting the progress of this priority is the Francis Health Group who have begun engaging with regional health of older people network groups (Regional Medical Leads, HOP Network and Regional Dementia Reference Group) and key stakeholder in local DHBs including WDHB. The intent of this piece of work is to establish an integrated regional system of care for frailty services that ensures access, equity and the best possible outcome for the regional population. This includes the following:

- The Central region adopts best practice approaches to frailty which supports local and regional services to adopt a whole-of system response.
- Measurable improvements are made across the region, including increased access and outcomes for Māori and underserved communities (on an equity basis).
- A reduction in ED attendance rates, hospital occupancy and LOS which lessens the required investment in hospital beds in the future.

As previously reported a Frailty Hui for the region is planned for the 5th of May.

A final Report from the Francis Group is expected on the 18th of June 2021.

28 May 2021 **Public**

Deliverable Part 2:
Report DHB activity to deliver on your regional commitment to a stocktake of dementia services, including:

2a 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:

Walking in another shoes/Dementia educator continues to provide education to iHCSS front line staff, ARC staff, ARC residents and their families. The 12 modifiable risk factors for dementia are to be incorporated in future education and training.

The regional dementia programme will be focusing on pre-frailty education and explore cross sector education sessions which promote:

- Hearing tests in mid-life as a modifiable risk factor for dementia.
- Equity for Māori through promotion and education of the tools being developed out of the University of Auckland such as the Māori Assessment of Neuropsychological Abilities (MANA) tool and the App for Dementia Awareness and Prevention Through Risk reduction (ADAPT-R)
- Geographical equity through the integration of pathways for intellectual disability and dementia

28 May 2021 **Public**

SS06: Better help for smokers to quit in public hospitals

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

DHB	Whanganui	*please select from the drop down box*
Reporting Quarter	Q3	*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	2019	343	329.0%	17.0%	**95.9%**
Māori	440	143	138.0%	32.5%	**96.5%**
Pacific	30	3	3.0%	10.0%	**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.	N/A
Please identify what activities the DHB has undertaken this quarter to support this target?	Training as many staff in all areas of the hospital on the importance of referral to the stop smoking service. Including staff that work as dieticians, social workers and diabeties. Key messaging being used is "every patient, every time" and reinforcing the fact that smoking is the biggest preventable cause of death in NZ and worldwide.
What are the barriers impeding the DHB ability reach the target and sustain it next quarter?	Sustainability, we need to keep up the momentum by making sure I'm a presence on ward as a reminder that smokefree is just BAU. CNM's and smokefree champions need to encourage and support staff.
Please note anything else you would like the Ministry to be aware of.	We have achieved a 10% increase from Q1 and I'm hoping to just keep rising!

SS07: Planned Care Measures

Please refer to the WDHB Planned Care Services 2020-2023 Three-Year Plan

SS09: Improving the quality of identity data NHI

No data received for the period (MoH)

Rating – ACHIEVED

28 May 2021 **Public**

SS09: Improving the quality of identity data NATIONAL COLLECTIONS

This measure is now managed and reported via TAS

SS09: Improving the quality of identity data PRIMHD

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

Indicator 1: PRIMHD data quality

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

Dates(s) of routine audit(s)	Corrective actions – NIL
Routine audits are completed weekly throughout the year	WDHB is fully PRIMHD compliant and all extracts sent to the ministry are now automatically automated into their production environment. Full quality checks and audits occur twice weekly to ensure accuracy of the data in the reporting of outcome measures, referrals, activity contacts, diagnoses, inpatient events and legal status. All PRIMHD errors are completed within a timely manner. Extracts are sent every two weeks; this allows time for clinicians to enter their data into the system and checking mechanisms are put in place to ensure accuracy using reports and cross referencing with the system. WDHB continue to achieve pass rates of 99% or more.

28 May 2021 **Public**

SS10: Shorter stays in Emergency Departments

2020-21 Quarterly Reporting for Acute Demand and Shorter Stays in Emergency Departments

Reporting sections: 1. Shorter Stays in ED data 2. Actions to improve SSED 3. Data on acutely admitted patients 4. Acute Demand actions from Annual Plans	**Guidance:**
DHB name:	**Quarter: THREE**

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
Whanganui	5177	5649	92%	1361	1455	94%	132	144	92%

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

Measure	**Your actions, activities, issues**
1. Actions undertaken this quarter to maintain or improve the indicator	Development of ED "dashboard" to give data driven view of patient flow Understanding flow through the department for acute patients
2. Planned work for next quarter	Implementation of the Discharge Co-ordinator role – improving patient flow through services Ongoing work with Alliance leadership team on reducing acute demand for services
3. Barriers to achieving or maintaining the indicator	
What support can the Ministry provide	

3. Data on acutely admitted patients DUE TO DATA DELAYS THIS INFORMATION WILL BE DELAYED

4. Acute Demand actions from Annual Plans

Acute Data Capturing: Please provide an update on your plan to **implement SNOMED coding** in Emergency Departments to submit to NNPAC by 2021.
To **improve Patient Flow**, please report on actions from your Annual Plan that: improves patient flow for admitted patients improves management of patients to ED with long-term conditions improves wait times for patients requiring mental health and addiction services who have presented to the ED improves Māori patients experience in ED
1 and 2. **Action**: other initiatives continue to further stream-line patient flow of patients between ed presentations and lower acuity accident and medical patients. for mental health and addictions patients ae are developing options for earlier identification and rapid connection with appropriate clinical teams and treatment. long term conditions patients will be prioritised for acute care and linked back to their community and primary care teams for ongoing care requirements through development of primary care pathways and the introduction of funded community options.
3. **Action:** implement commitment to resourcing ed with a specialist mental health and addiction educator to build capability of front-line staff. **Action:** 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 the let's get real framework. **report due q4.**
4. **Action:** 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. **met for q1**

28 May 2021 **Public**

2020-21 Quarterly Reporting for Acute Demand and Shorter Stays in Emergency Departments

SS11: Faster cancer treatment (62 days)

62 Day Indicator
Length of time taken for a patient referred urgently with a high-suspicion of cancer (HSC) or a confirmed cancer diagnosis to receive their first cancer treatment (or other management). In line with national and international experience, the MoH suggests this target will apply to approximately 25 per cent of newly-diagnosed cancer patients.

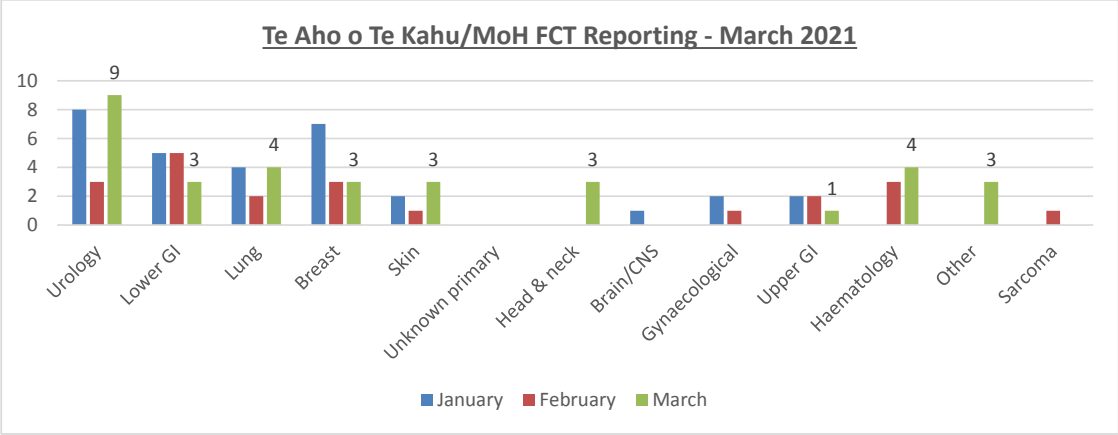
To meet this reporting criteria patients must be triaged as having a HSC and coded as TU (i.e. booked for first specialist appointment within 14 days of referral).

The DHB health target is for 90% compliance. Breaches due to 'patient choice' and 'clinical consideration (co-morbidities)' are reported to the MoH, but do not impact on DHB compliance reporting.

31 Day Indicator
Length of time taken for a patient with a confirmed diagnosis of cancer to receive their first cancer treatment (such as surgery) or other management (such as palliative care) from decision-to-treat (31 days).

March 2021

Chart 1. Cancer streams



Total cancer treatments:
Thirty-three patients are reported for 1st treatment for cancer in March 2021, twenty-one patients presented in February 2021. Six patients presented acutely to ED.

62 Day Indicator and HSC code - from referral to 1st treatment:

- **Six patients** were flagged as HSC at referral and met reporting criteria (22% of all patients).

Outcome reporting (less clinical considerations/patient choice): **100%** *MoH target of 90%.*

One patient experienced a delay of 2 days to general surgery due to clinical reasons with additional staging and biopsy prior to the MDM and decision to treat.

28 May 2021 **Public**

SS13: FA4 Acute heart services

SS13 FA3 – Cardiovascular Disease Quarterly Reporting template 2021/21 – Quarter 3

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?
Recalls are coordinated at a practice level with teams encouraged to use population health reports (through powerBi) as well as Dr info to identify specific individuals. However, with the change in national guidelines the automated 5-year recall process has dropped off and there will be targeted work in 2021 to improve recall processes taking a person-centred approach verse a disease screening approach.

28 May 2021 **Public**

SS13: FA5 Stroke Services

DRAFT – SS13 Stroke Quarterly Reporting Template 2019/20 – Quarter 3

DHBs must provide a percentage, denominator and numerator for the 3 indicators for the DHB total and separately for Māori **– Q4 confirmed data**. Where numbers are low you could provide rolling annual data eg Q2 data would be for 1 January 2018 to 31 December 2018

Reports must include the DHB total with a breakdown of % numerator and denominator of **all hospitals at your DHB where the service is being provided**. With a plan for achievement where the indicator has not been met
Reports must include indication of sign off by lead stroke physician and nurse (as long as names are included actual signature not necessary) If your DHB does not have a dedicated lead medical or nursing position filled you are not meeting the requirements for an acute stroke service

Indicator 1: 80% **of acute stroke admissions admitted to an ASU or organised stroke service with a demonstrated stroke pathway within 24 hours of their presentation to hospital – Q2 confirmed data** **Indicator 2**: 12% **Reperfusion – Thrombolysis /Stroke Clot Retrieval Service provision 24/7 – Q2 confirmed data** **Indicator 3:** 80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission – **Q2 confirmed data** **Indicator 4:** 60% of patients referred for community rehabilitation are seen face to face by a member of the community rehab team within 7 calendar days of hospital discharge – **Q2 confirmed data**
Name of DHB: Whanganui DHB

Confirmed result indicator 1 for Q2 ASU 80%: Percentage: Total = 88% **Māori = 67%** **Denominator: Total = 32** **Māori = 3** **Numerator: Total= 28** **Māori = 2**	**Confirmed result indicator 2 for Q2 Reperfusion – Thrombolysis /Stroke Clot Retrieval 12% 24/7: tPA/SCR Percentage: Total = 26%/3%Māori = 0%/0% Denominator: Total = 27/27 Māori = 2/2 Numerator: Total= 7/1 Māori = 0/0**	**Confirmed result indicator 3 for Q2 Inpt. Rehabilitation 80%: Percentage: Total = 64%** **Māori = %** **Denominator: Total = 11** **Māori = 3** **Numerator: Total = 7** **Māori = 1**	**Confirmed result indicator 4 for Q2 Community Rehabilitation 60%: Percentage: Total= 33%** **Māori= 17%** **Denominator: Total = 24** **Māori = 6** **Numerator: Total = 8** **Māori = 1**

Indicator 1: ASU Numerator = number of acute stroke admissions admitted to an ASU or organised stroke service with a demonstrated stroke pathway within 24 hours of their presentation to hospital. Denominator = total acute stroke admissions (I61, I63, I64).

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

(See Minimal standards attached for guidance)

DHB Comments: We have met this indicator – our acute stroke pathway is working very effectively. We often thrombolyse acute stroke patients in CT and then continue to the ASU unit exiting ED very efficiently. We have now changed our thrombolytic agent to Alteplase in March 2021 due to national supply chain compromise. Alteplase administration prolongs the imaging process due to the infusion requirement.
We have not met this indicator for Maori as one patient was an ICH and was transferred directly from ED to CCDHB for neurovascular intervention.

Indicator 2: Reperfusion – Thrombolysis /Stroke Clot Retrieval Service provision 24/7 Numerator = number of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval and counted by DHB of domicile. Denominator = number of stroke admissions eligible for thrombolysis or stroke clot retrieval (ICD Codes I63, I64)

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

DHB Comments: WDHB has had a very high number of patients thrombolysed this quarter. Additionally, another patient (not thrombolysed) was successfully sent for clot retrieval. This patient had a recent stroke, thrombolysis and clot retrieval so was not appropriate for repeat thrombolysis with this admission. Code stroke is the key process that facilitates a fast track process improving thrombolysis rates. Our in hours response is very fast, after hours is prolonged due to reduced access to stroke nurse/physician and telestroke access and connectivity issues. We continue to upskill ASU nursing clinical nurse coordinator role to lead code stroke in ED. We have also now moved to 24/7 telestroke, we are streamlining this process in hours trying to eliminate time barriers.

Indicator 3: Rehabilitation: Numerator = number of acute stroke admissions transferred to in-pt rehab within 7 days of acute admission. Denominator = number of stroke admissions eligible for rehabilitation (I61, I63, I64) – (see Minimum Expectations attached for guidance)

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

DHB Comments: This indicator was not met. 3 patients had prolonged acute stroke admissions due to their complex medical comorbidities. 2 patients stabilised and were subsequently accepted for rehabilitation. The other patient did not stabilise and passed away.

Indicator 4: Community Rehabilitation: Numerator = number of patients referred for community rehabilitation who are seen face to face by a member of the community rehab team within 7 calendar days of hospital discharge. Denominator = number of patients discharged from hospital with a primary stroke diagnosis (I61, I63, I64) who are referred within 2 weeks of discharge for community rehabilitation.
(See Minimum Expectations attached for guidance).

DHB Comments: This indicator was not met. We have a very compromised community rehab allied health staffing capability impacting service delivery. Recruitment has occurred and the new staff are working through the backlog of patients.
The WDHB stroke nurse works across inpatient and the community, as well as provides telehealth services.
The regional stroke rehabilitation working group process is spotlighting this inequity and strategizing currently.

Other:

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

DHB Comments We have strong links with local iwi, WRPHN, health promotion teams. WDHB is part of the FAST campaign priority roll out project led by HPA. CNM Amanda has a weekly zoom meeting with Johnny Akatapuria (HPA), Nita Browne (National Stroke Foundation), WRPHN health promoter Anne Kauika and WDHB health promoter Pania Millar developing a local strategy and response to actively promote the FAST message. We are utilising the COVID 19 vaccination programme to augment the stroke health promotion primary prevention programme as a captive audience.
We do not have established links with our small Pacific Island community. We will address this.

We have telestroke services after hours via CCDHB, now 24/7. We are exploring transitioning our telestroke machine from a static ED based machine to a portable smaller device to remove time barriers when we are moving between ED and CT. Currently we rely on phone calls with the CCDHB neurologist when we move to CT and often have to return to ED for telestroke visual assessment by the neurologist to make a final clinical treatment decision.

We have an established SCR pathway and send patients to both CCDHB and ADHB. We continue to work with St Johns Ambulance regarding transport delays, the use of the PASTA tool in ambulance and scoping the potential for telestroke in the ambulance.

Signed off by:
Lead Stroke Physician: Jan Gregson Lead Stroke Nurse: Amanda Van Elswijk

28 May 2021 **Public**

SS15: Improving waiting times for colonoscopies

Partial Achievement.

The recommended non-urgent wait time target was achieved this quarter, with result being 74.4%. The recommended urgent and surveillance wait time targets were not achieved, with results being 60.0% and 52.1% respectively. The most recently available bowel screening wait time data shows 100% of screening colonoscopies were completed within the recommended time period.

The maximum timeframe target results were urgent 94%, non-urgent 90% and surveillance 68%. A policy for management of our endoscopy waiting list that includes escalation process for patients at risk of exceeding maximum wait times has been developed and approved by our Endoscopy Users Group. We expect the percentage of patients that have their procedure completed within the maximum wait time to increase to the required level as a result of this policy.

Report End.

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WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Discussion Paper**
	Item No 3.3
Author	Kilian O'Gorman, Business Support Strategy, Commissioning and Population Health
Endorsed by	Kath Fraser-Chapple, Acting 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

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

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 & 2, and preliminary ratings for Quarter 3.

Not applicable	Other / Note	Achieved overall	Partially achieved	Not achieved

Status update reporting- Actions Included in Annual Plans	Quarter 1 MoH Ratings	Quarter 2 MoH ratings	**Quarter 3 MoH ratings**
Better population health outcomes supported by primary health care			
Better population health outcomes supported by strong and equitable public health services			
Give practical effect to He Korowai Oranga – the Mâori Health Strategy			
Improving Child wellbeing			
Improving Mental wellbeing			
Improving Sustainability			
Improving wellbeing through Prevention			

28 May 2021 **Public**

Give practical effect to He Korowai Oranga – the Māori Health Strategy					
Subsection	Activity	deliverable	Q_1	Q_2	Q_3
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)			
	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)			

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		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)			
		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)			
		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	
		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)			

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		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)			
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			

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		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)			
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	Activity	Driving a commitment to pro-equity approach through governance support and executive leadership. (EF)			

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system settings		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

Improved Sustainability					
Subsection	**Activity**	**deliverable**	**Q_1**	**Q_2**	**Q_3**
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 implementation 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 year view of asset replacement and new capital asset purchases required to	

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				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.	
		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	
		Better and more consistent monitoring across service groups			

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	Enhanced decision support tools and improved forecasting and budgeting to achieve better stakeholder engagement	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.
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
		Streamline line care across Community Health Providers to reflect patient and Whānau centred health care system	On-going. Referral pathway for frailty and deteriorating pati ents 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.
		Increase access to Community Care and reduce waitlist for community support	On-going. Increase of referrals from GPS for frailty/deteriorating patients will be observed. Increased	Ongoing . Increased use of telehealth to improve access, roll out across rural areas.	

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			use of telehealth to improve access.		
		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	
		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 models of care to reflect this.	Process has been confirmed for progressing joint initiatives and a focus will commence on Medical Skeletal presentations with primary 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.

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	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.			
		Intensify management of monthly IDF results to ensure accuracy of in- & outflow monthly data and inform care decisions			
		Reduce elective IDF net outflow & return care to WDHB in support of local surgical productivity			
		Redesign community care & regional arrangements to reduce out of district travel where possible			
		Enhanced planning of non-washed up elements with improved annual reconciliation, redesign and renegotiation			
	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.			
		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 community referred guidelines. All referrals received are appropriate and are triaged against criteria.		
		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		
	Theatre facility capacity management	Review acute theatre utilisation with a view to reduce cancellation and OT costs; includes reduce readmissions	Engaged external subject matter expert to complete a site visit		
		Review throughput per session by speciality to maximise resources.	Findings and actions included in		

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			completed action plan included		
		Preference standardisation			
		Manage medical devices and consumables to budget			
		Complete a theatre production plan to ensure DHB drives efficiencies and meets compliance rates.	Action plan and timelines developed, completed and circulated		
		Create a flexible workforce, and reconfigure the working day (activities, ie ward rounds/OP etc).			
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			
		Clinic deals with all influenza-like illness as a pre-urgent care and pre-emergency department pathway			
		Screening of patients in their cars before guiding to definitive treatment in the clinic or referral to urgent care or emergency department			
		Provides capacity for ad hoc or regular COVID testing if necessary			
		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		
	Establish peer support model to support a more sustainable and holistic response to tangata whaiora in acute and emergency mental health settings	Respond to anticipated RFP for acute mental health solutions	Peer support does exist with a local provider. Te Awhina is looking to work in partnership with them to look at how peer support can be provided more effectively in a genuine manner.		

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	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.	.		
	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			
	Partner with Arthritis NZ and the PHO to trial a kaiawhina role supporting a targeted approach to gout management	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	On-going. 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 involving Community Pharmacy, General Practice, Whanganui Accident and Medical (WAM) and a Kaiawhina, to decrease the high rates of poorly managed gout		

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			arthritis within the Whanganui district, by improving awareness, health literacy, medication adherence and long term 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	Providing liaison services from secondary heath care to assist with responding to people that present to GP practices. Anticipated they will be able to respond sooner to referrals that would not normally be accepted into secondary services thereby being able to respond in a more timely manner. Transition nurse from secondary care services is working al ongside GP practices to strengthen primary and secondary working relationships around referrals and discharges.		
		Respond to any further RFPs and evaluate impact for consideration of expansion	On-going	No RFPs received	

Improving Child Wellbeing	

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Subsection	Activity	deliverable	Q_1	Q_2	Q_3
2.3.1 Maternity and Midwifery workforce		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.		
	Activity	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 midwifery students:	facilitate and support Otago Polytechnic's satellite midwifery school		Quarterly meeting commenced with Otago Polytechnic's 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	

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				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			
		employ at least one new graduate midwife from this programme (EF)			
		support and encourage participation in the Midwifery First Year of Practice programme (MFYP)			
		encourage Māori new graduate midwives to engage in Te Urupounamu, cultural Supervision. (EF)			
		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.	
		establish LMC capacity and leave dates for December/January/February			
		re-establish DHB primary midwifery service for women unable to secure LMC services			
		ensure maternity service staffing establishment is adequate for additional unit labours & births, using the CCDM framework			
		establish LMC capacity to provide postnatal care for women under the DHB primary service or establish a DHB postnatal service (EF)			
		communicate to the local community. (EF)			

	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 Development Plan. FTE calculations for CCDM have been agreed Midwifery Career Pathway released and socialized with midwifery workforce.
		evaluate the midwifery workforce plan. (EOA)			
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	develop baseline database that has ethnicity in all data and equity in all analysis including: (EOA)			

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	Maternity and Early Years Key Stakeholder database (community and services) for the WDHB region :	number of current stakeholders engaged with Maternity and early years		To be completed Q3	
		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 be fully operational by March 2021.		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 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

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					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 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.			
		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)			
	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)			
		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 redirected to the Best Start Module. This automatically links maternal immunization and sets recalls.
	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	three hapu mama and whānau wānanga will be delivered throughout the DHB rohe over the year, includes two rurals and one urban setting: EOA			
		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)			

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	Whanganui DHB region:	Health promotion activities promote SUDI messaging and overall safe sleep, smoke free and breastfeeding messaging that is designed to reach priority populations. (EOA)			

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)			
		Whanganui Regional Health Network and Te Oranganui health provider are trialing Saturday wellness clinics at			
		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	

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				MMR/HPV catch up, COVID response	
		Conduct opportunistic childhood vaccination with a focus on Māori when they interface with community and secondary services. (EOA)			
		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 purposeful follow up by the outreach team.
		facilitate resources to support the implementation of this programme			
		provide immunisation clinics between July-November 2020.			

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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)			
		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.			
		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		
		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			
		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		

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		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.		
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			
	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.			
	Elder abuse & neglect training	integrate WDHB trainings with a specific focus on the elderly including a focus on the context for Māori			
		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			

		build strong relationships between Māori and other community providers and WDHB staff.			
	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 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.
		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			

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		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			
	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**
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		
		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 outcomes for their service users by other means. Practice nurses work alongside the psychiatrist in the practice to ensure physical aspects of

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					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.
		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 services across the continuum:	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			
		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.

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					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.
		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			

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		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)			
		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.

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					This response was received from Peter de Roo but this was marked as in Q2
	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		
		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)			
	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)	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		

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	(Note: link to 2.3.1)		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 inductions their providers as well as He Puna Ora and begin intense training with the aim to be fully operational by March 2021.		
		implement new service tranche 1			
		implement new service tranche 2 & 3			
	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)			
		support development of the new Pregnancy and Parenting service by reporting on specific activities undertaken and evidence to develop integration and referral pathways across both areas of the new service with a focus on equity. (EOA)			

Improving wellbeing through Prevention					
Subsection	**Activity**	**deliverable**	**Q_1**	**Q_2**	**Q_3**
2.5.12 Cross sectoral collaboration including	Development of more intensive support for	Increasing professional development of Public Health staff in Policy and Legislation	Delays due to Covid 19	Delays due to Covid 19 priority initiatives	
		Identify and recruit a student undertaking current health policy studies	Delays due to Covid 19	Delays due to Covid 19 priority initiatives	Current environment will not proceed

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health in all policies (HiAP)	HiAP will require professional development. In 2020/21 WDHB will investigate:	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	
		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 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
		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	
		Identify subject matter expert	Delays due to Covid 19	Delays due to Covid 19 priority initiatives	Current environment will not proceed
		Scope relevant consultation and engagement pathways	Delays due to Covid 19	Delays due to Covid 19 priority initiatives	Current environment will not proceed
		Draft action plan	Delays due to Covid 19	Delays due to Covid 19 priority initiatives	Current environment will not proceed
		Develop a strategic analysis by 31 March 2021 to highlight the opportunities for supporting inclusion of HiAP across the public sector.			
	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)			
		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	Activity	WDHB has a contract in place for infectious diseases support from CCDHB.			

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Resistance (AMR)		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.			
	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 infection prevention study day, which is open to all community health providers including ARC providers this day will provide education on:	catheter related cares and UTIs with prevention hods			
		antibiotic resistance education			
		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			

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		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)			
		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)			

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		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	
		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			
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			

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		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 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	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			

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	overall. To improve equity we aim for a 10% increase for priority populations in completed screens on the previous 12 months by: (EOA)	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
		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	Identifying barriers and address the needs of Māori & Pacific women through: (EF)		ongoing work progressing	
		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 Breast screen Coast to Coast data to identify Māori & Pacific women who need screening and identify focused approaches		Monthly electronic updates via national cervical screening have been occurring throughout this current quarter Breast screening Coast to Coast continues to be unable to data	

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	the previous 12 months by:			match general practice. A visit from the new equity breast screening person has acknowledged the barriers and is working to get data matching to commence	
		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		Discussions have started with Te Kotuku Hauora and Breast Screen Coast to Coast to undertake a smear clinic in February while the breast screening unit is visiting. A Pacific employee is working with the local church groups	
		Increase screening rates for Asian women through identification of practice registers and providing targeted outreach approach: (EF)		Discussion undertaken with nurses from the Asian community	
		develop relationship with Asian nursing workforce to inform approach		Discussion undertaken with nurses from the Asian community	
		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		A simplified smear communication flyer has been developed and currently being trialled by some practices currently this is only available in English	

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		Improving screening rates for Māori & Pacific women through: (EOA)		Monthly clinics at Rangitikei health centre gives us access to a number of Pacifica women who are offered a smear during their visit at the clinic	
		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	
		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			
		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			

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		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			

Better population health outcomes supported by strong and equitable public health services					
Subsection	**Activity**	**deliverable**	**Q_1**	**Q_2**	**Q_3**
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)			

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	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	
		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)		Further education required and improved consistency in patient information	
	Waimarino development	Co-develop design work and complete business cases (EF)			

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		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	

28 May 2021 **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.	**Public**		
	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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2.6.7 Acute Demand	69,000 beds	Streamline care across community health providers			
		Enable community and Whānau centred care			
		Reduce "doubling up" of community services by stronger integration models			
		Enable faster access to services by reducing silos created between systems			
		Home and community support services review and redesign			
		Implement wellness/prevention model of care for reducing future costs			
		Enhance support for patient groups identified at risk of hospital admission/readmission			
		Develop hospital in the home models of care, partnering across social services and NGOs.			
	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			

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		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		

28 May 2021	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)	**Public**		
		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			
	Support community led consultation, and engagement with iwi, staff and community providers	Project Group Established			
		Service redesign and models of care are determined as part of finalising the Wellness Centre facility design			

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	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)	Wellness Centre design are completed.			

28 May 2021	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:	**Public**		
		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
2.6.9 Healthy Ageing	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	
		ensuring quality ethnicity data is included and results interrogated for equity in Māori Health outcomes			
	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	

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					This is part of national work with both DHB's and MOH DSS.
		management of continence		COVID	This was to be lead by MOH nationally but was disrupted by COVID 19
		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.
		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			
		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 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
		The first steps are to scope this commissioning project and agree the national standard bulk			

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		funding approach for home and community support services.			
	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			

28 May 2021	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	**Public**		
	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)			
2.6.10 Improving Quality	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	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)			

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Action Plan 2019-2030		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 outcomes. This work will be led by a clinical team and include the cancer nurse coordinator and the Māori health team. (EF)	Underway	Underway	Underway
		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)			
		Ensure at least 60% of eligible bowel screening population participate in the programme, with no equity gap for Māori and Pacific Island populations (EOA)			

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		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 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	Create environments where our people are well supported and enabled to thrive			

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	enabled to thrive and deliver the best care to our patients, whānau and communities. (EOA)	and deliver the best care to our patients, whānau and communities. (EOA)			
	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			
	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	Three wānanga held for Māori staff per year		Yet to be progressed - planning underway	

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	Māori health professionals. (EOA)				
	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			
		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			

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	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)			
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			
	Increase the number of Māori students from kura kaupapa and kura auraki entering health careers			
Provide tuākana tāina support for new graduate Māori nurses through Te Uru Pounamu programme. (EOA)	All new graduate Māori nurses receive formal support			
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			
	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.			

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	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.			
	Wellbeing.	Develop a preventative model of health care for the WDHB district health carers.			

28 May 2021	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	
	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		
	Provide tuākana tāina support for new graduate Māori nurses through Te Uru Pounamu programme. (EOA)	All new graduate Māori nurses receive formal support			
	Realise cultural safety throughout the entire workforce. (EOA)	All staff, Board , management and leadership will continue to demonstrate participation in cultural competence training	Second phase of cultural training programme commenced.		
		Cultural safety monitored against changes to individual clinical practice which ensures Māori receive optimum care			
		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.			
2.6.14 Data and digital	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			

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		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			
	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		

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	IT security. To improve our security across digital systems:	Recommendations from Security Assessments will be reviewed and implemented where possible.			
		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			

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		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 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
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)			
		Broadening use of the workforce in community settings (EF)			
		Implementation of supported discharge, transition of care and coordination of home and community support services for older persons (disability) (EF)			
		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 alternative delivery models.	

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		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	
		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 interest sought from GP teams and Urgent care.	
		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	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

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	pharmacies for gout, COPD, MUR and vaccination (EF)				delivery of wrap around services to support persons with COPD Asthma.
	Review community pharmacy facilitation roles to ensure alignment with identified priorities including: (EF)	Ensuring Aged Residential Care have access to medicines optimization expertise of pharmacists			
		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 involving Community Pharmacy, General Practice, Whanganui Accident and Medical (WAM) and a Kaiawhina, to decrease the high rates of poorly		

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			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			
2.7.3 Long term conditions including diabetes	Chronic kidney disease Ruapehu project to reduce progression of CKD for identified patients with high BP, diabetes, uric acid: (EOA)	Develop service model through a co-design approach with communities		Workshop held with consumers, providers, and iwi. Co design 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			

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		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. 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			

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Discussion Paper**
	Item No 3.4
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 Report – May 2021

Recommendations

Management recommend that the Whanganui District Health Board:

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

Appendix 1. Whanganui DHB Performance Dashboard and definitions

1 Purpose

To provide the Board with a high-level overview of provider arm services; operational performance is noted for the months of April 2021.

2 Service Delivery Overview

2.1 Optimisation and Efficiency Programme

Integrated Discharge Navigator

The integrated discharge navigator pilot is underway. The navigator has been engaging with key stakeholders to understand barriers and constraints that may inhibit patients from returning to their place of residence within the agreed estimated discharge date (EDD).

Booking Systems Review

The ongoing work programme to ensure surgical and outpatient booking processes are more patient focused continues, with recommendations expected in late July. These recommendations are expected to be rolled out across all services where appropriate.

Theatre utilisation

Work is continuing with ensuring that all theatre sessions are fully booked.

The focus is on how we can address early starts and late finishes, to ensure that all booked patients have surgery, and there are no instances of cases cancelled due to "insufficient time". The Anaesthesia department is currently fully resourced.

TAS have been asked to conduct a Nursing Roster review of which will occur 14th June 2021.

CSSD

Theatre will have new equipment installed 14 – 21 May 2021. During this time there will be modifications to scheduled elective theatre lists, as there will be only one steriliser available for use at a time. Acute surgery

should not be affected by this installation. The theatre list modifications are being managed by the Planned Care Team.

2.2 Planned care

IDFs:
21 Taranaki DHB domiciled patients have been received by WDHB for surgery.

- 11 were removed from wait list: reasons included declined surgery, declined by Consultant, patient unable to accept dates offered, surgery not a clinical preference – trying alternative less invasive option, unable to contact patient.
- Of the 11 remaining patients, all had their surgery during December 2020 or January 2021.

2.3 Emergency Department and Inpatient Services:

Emergency Department
ED had 1721 attendances during April 2021; of which comprised of triage 1 (3), triage 2 (192), triage 3 (951), triage 4 (513) and triage 5 (62). This was similar to March presentations; the average daily presentations remained at approximately 57. 24% of presentations to ED were recorded as Māori ethnicity and 2% Pacifica. Of the 1721 total attendances, 85 did not wait.

Inpatient wards
Inpatient information such as average occupancy and readmission rates will be reported bi-monthly to ensure validity of the data.

3 Hospital and Clinical Services (H&CS)

3.1 Workforce

Nurse Entry to Practice Programme (NETP) and Nurse Entry to Specialty Practice Programme (NESP)

The NETP/NESP programmes enables nursing graduates to begin their careers well-supported, safe, skilled and confident in their clinical practice, equipped for further learning and professional development, meeting the needs of health and disability support service users and employers.

The programmes are 10-12 months duration and staff are supported by trained preceptors, managers and a nurse educator. Placements are either in the hospital or community.

The process for recruitment begins with the Nurse Educators working with hospital and community managers to seek guidance regarding the number of placements that may be available. Once there are confirmed, the Nurse Educator approaches either Te Pou or Health Workforce New Zealand to confirm funding for these placements. The Nurse Educators meet with students at UCOL our local School of Nursing and Massey to advise them how to apply and outline the process for recruitment.

Recruitment is commenced using the Nursing Advanced Choice of Employment (ACE) system, which is a national system utilised by DHBs to recruit new graduate nurses into supported first year of practice programmes. The ACE system enables graduates to apply online to multiple District Health Boards (DHBs) using one application. Graduates also identify up to three preferred practice settings including those that may not be provided by DHBs such as primary care and aged residential care. DHBs use the system to review the applications of those graduates who identified them as a preferred employer. DHBs can also supply local primary care and aged care providers with the applications of graduates who preferred those settings.

DHBs and potential employers in primary care and aged care conduct their own shortlisting process and then notify the nursing ACE system of their preferred candidates. The system then finds the best match between the graduates' preference for employer and the DHBs' preference for graduates.

A panel is selected which includes a staff member from Te Hau Ranga Ora, a Nurse Educator and a Clinical Nurse Manager. Whanganui DHB utilise an affirmative recruitment process for applicants who identify as Maori and they are automatically short listed for an interview.

The new graduates complete the year and at the end they will have completed a post graduate paper, and their Professional Development and Recognition Programme.

This year we have 11 new grads, of which 7 are Māori.

3.2 Mental Health Inpatient

Te Awhina
April 2021 utilisation of Te Awhina was 80%. Te Awhina IPC was 139%. Staffing requirements meet demand with no staff harm or staffing injuries noted. Some tangata whaiora have been acutely unwell and due to this the IPC occupancy has been up, constants have been required which, at times has required an increase in staffing to ensure safety for all.

Zero seclusion has been reported this month, taking us to 3 months zero seclusion. One restraint was reported with no harm occurring.

Transition into the community for others has been working well as partnership with community services and other mental health services grow.

A cultural review has been completed by experts from Lakes DHB with a preliminary report being completed. Verbal feedback from the visit was very positive.
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.

A cultural review has been completed by experts from Lakes DHB with a preliminary report being completed. Verbal feedback from the visit was very positive.

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. In order to meet the standards programme implementation needs to be prioritised, appropriately resourced and sequenced.

WDHB continues to successfully implement the CCDM programme. We have improved to 87% implementation with the last barrier being total implementation of all local data councils. Of the twenty DHBs, WDHB is one of the seven DHBs who have achieved 85% compliance.

Items	Progress	Action required
Core Data Set	**Partially**	• Power BI and formal local data tools are all developed with transparency to staff. • Staff discuss the data at ward meetings in partnership with union delegates. • This needs to be rolled out to all departments.
FTE Calculation	**Completed**	• ED FTE calcs have been completed in principle, these to be understood formally before FTE/roster shifts. • 'FTE Calculations' paper has been provided to ELT. The point of difference is Maternity required two FTE.
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 Service Delivery

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

Whanganui DHB is non-compliant by 36 patients waiting for FSA (ESPI 2) and 56 elective surgical bookings (ESPI 5) for March 2021. This means those patients have waited longer than 120 days for treatment following acceptance on to our waiting lists.

This non-compliancy is the result of

- consultant sick and annual leave, afterhours call outs (gynaecology);
- consultant resource not available to undertake surgery (ophthalmology);
- additional cases waitlisted, and subsequent leave (orthopaedics);
- surgical equipment issues (ENT).

4 Primary and Community Services

4.1 General

Referrals have increased across all the services, and across hospital, community and rural settings this last month. This is further complicated by unsuccessful recruitment in to key vacancies e.g mental health Pharmacist, musculoskeletal physiotherapist. Varying initiatives are being implemented to ensure that patients continue to have needs met in a timely manner.

Occupational, Speech Language Therapy Dietetics and Physiotherapy have initiated the following - Increasing use of assistants, use of casual employees, group therapy sessions, improving triage process, engagement with telehealth and ongoing partnership with therapists in private practise. It is pleasing to note that despite the challenges in referrals and staffing, Physiotherapy and Speech and Language Therapy have continued to meet Ministry of Health waitlist targets and Occupational Therapy has received compliments from patients on its initiatives.

Radiology- Extra weekend sessions in some services have been delivered with success, but are not eliminating waitlists. The team are looking at other strategies in partnership with primary care to manage the increase of referrals, including liaising with GP practices.
Pharmacy has experienced increased pressure both from the dispensing of the COVID-19 vaccine, and an international shortage of some pharmaceuticals meaning resource is diverted to ensuring that supplies of products are available and sourcing alternatives. Changes to rosters are being implemented and leadership is focussing on ensuring staff wellness with increased workload pressure.

4.2 Service Delivery

The Community Mental Health and Addiction Service (CMHAS) continues to embed the national overnight telephone service for mental health crisis, with the team from the service provider (Whakarongo Hau) coming to visit Whanganui in June to connect with DHB staff, community providers, the community with lived experience and police. Leadership from CMHAS is attending a national conference this month to ensure models of care are progressive and in line with the direction of future mental care in New Zealand. The team continue to work closely as part of the wider mental health service both within the DHB and connecting with our community providers.

The Radiology Department redesign continues to progress, and discussions have started with Eye Care Trust for MRI. Increasing demand of some services including CT and MRI is a noticeable pattern that is being addressed both by discussions with referrers to understand need, and also with rostering patterns and future proofing capacity.

The importance of collecting and understanding data across the service has been shown both in an initiative to determine inpatient needs across wards and redeploy staff to respond, and also in helping understand caseload pressures and service need within Physiotherapy.

There is an increase in Bariatric patients being seen, and the availability of appropriate equipment for discharge, as well as options for discharge into supportive care has been problematic and impacting early discharge. A bariatric working group has been established to address this issue across primary and hospital services.

A telehealth lead has been appointed and will be starting later this month, on a fixed term contract for a year. This role was previously covered by the Clinical Informatician in addition to her substantive post. A review of the telehealth project, in light of both local and national regression in telehealth use, has occurred. This has identified key areas where improvements can be implemented to ensure the success of rollout of the telehealth programme, and these have been embedded in the project plan.

The need to ensure all clinicians are enabled with the ability to use data and digital systems has resulted in the Physiotherapists on TrendCare which will help improve management of staff resources, and the Occupational Therapists on WebPAS to capture the work they are continuing in telehealth.

Work on patient and whanau centred models of care that reduce duplication and streamline processes has resulted in a multidisciplinary therapy assessment tool, that is being finalised and will be trialled this month.

4.3 Future Focus

There has been increasing work in partnership with primary health, with the known need for establishment of wellness and early prevention models of care to be available for the community. This will remain a focus in terms of priority for model of care work. The need for early osteoarthritis management in the primary care setting as a non-surgical pathway has been identified and agreed as a priority for both primary care and physiotherapy.

A recent review of how we manage pressure injuries and falls prevention work has identified a need for stronger working across primary and community services and will also form shared working across primary health and DHB community services.

There is a work plan being developed by the regional Directors of Allied Health, where key pathways that can be delivered or supported with a regional approach are being discussed. Lymphoedema services have been identified as a first initiative.

5 Maternal, Child and Youth Services (MCYS)

5.1 General

The Maternal, Child and Youth service has been fully operational for a year now and we are positive about the changes and mahi that has been completed so far. Individual child health service teams are becoming more integrated with the co-location of some services and the development of more contact pathways between the groups.

Community engagement, particularly in the maternity space, is becoming well established with workplans involving community partners being developed.

5.2 Service Delivery

Maternity

Recruitment is underway for a case-loading midwife in Waimarino. One application has been received from a highly experienced applicant who will be interviewed in May 2021. If this applicant is successful, she can only commence the role in October 2021. The contingency plan for Waimarino services remains in place.

The LMC workforce is increasing with three new LMC's in the community and a further three anticipated mid-year but two are stepping away at the end of the year. The impact of this is seen in our reducing DHB unit caseload.

Three resignations have been received from core midwifery staff – one is going to a non-practicing position, one to another DHB and one will be a local LMC. Recruitment of 2.0 FTE core midwife positions is underway.

WHRN is discontinuing its midwifery team due to lack of viability, however this has been a good collaborative exercise.

The service mapping work by the Primary and Secondary Services Interface Group has progressed to the assignment working groups. The main 'tech and channels' work stream will be led by MQSP coordinator, Rachel Taylor, and will define roles, responsibilities in the service in the maternal care continuum and produce a service directory for women to navigate services. This will be funded by MQSP and will be the main local MQSP project for the year. Other work streams include a consumer engagement project facilitated by Healthy Families (also MQSP funded) and work to integrate the Best Start tool into GP practices, socialising it with GPs, LMCs and other community stakeholders.

Positive feedback was received following the first Midwifery Forum held on 22 March 2021. The feedback is under review and will shape future forums.

Paediatrics

The Child Development Service (CDS) has been operating with skeleton staff for the past nine months, but with positions finally filled the service should be fully staffed by the end of this financial year. Team management are continuing to work with the regional CDS group and Ministry of Health team to develop the future operating model for CDS services in New Zealand.

The contracted Paediatric SMO service provider has employed a new permanent paediatrician, Dr Raj Gheevarghese, who started at the end of April 2021. He has experience as a paediatric intensivist in South Africa and is a welcome addition to the paediatric team.

A recruitment plan has been put in place to ensure the paediatric ward/SCBU are able to meet the vacancies in this area. Experienced SCBU staff are difficult to recruit and access to education for upskilling our general paediatric staff has been limited due to Covid-19 and recruitment drives in the tertiary neo-natal units.

Public Health

The public heath team continue to be active in the community, successfully carrying out promotion and delivery of MMR immunisations at events such as UCOL Orientation week, the Whanganui River Traders Market, Pride Week, Waka Ama and the Kaierau Rugby Club. The MMR campaign will reduce in intensity over the next few months with the Covid-19 immunisation roll-out taking precedence.

Plans are being developed for a school-based Covid-19 immunisation roll-out in July 2021 for 16 to 18 year-old secondary school students.

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

Access to inpatient services is for youth is a crucial issue. Janice Bowers, Clinical nurse manager of MICAMHAS, is attending the National Mental Health Conference in May entitled 'Transforming Mental Health Delivery in New Zealand' which will provide insight on this issue and the broader future of mental health services.

MICAMHAS has been recognised nationally for high performance in the CAPA model of care (the Choice and Partnership Approach for Child and Youth Mental Health) and approached to present on 'CAPA and Youth Consult Groups' at the 1st International CAPA Conference being held in Canada in May 2021. Joanne Heap and Jo Hollins have pre-recorded their presentation which showcases both Whanganui and our MICAMHAS services exceptionally to an international audience.

Oral Health

Oral Health Status data is captured within the patient examination process of the Community Oral Health Service and is reported on to the Ministry of Health annually. This data relates to two cohorts of patients:

5-year olds relating to the oral health status of their deciduous (baby) teeth at their first assessment after commencing at school
Year 8 patients which relates to the oral health status of their permanent (second) teeth as they complete their primary/intermediate schooling.

Results show that there is consistent improvement over time for both Year 8 and 5-year-old children. I believe the Year 8 oral health status results support the choice of our model of care (assessment and

management provided on site in schools). Management includes a consistent approach to prevention, restorative treatment and on-going promotion of Oral Health.

The slower and variable improvement in the preschool group is tied into the difficulties we have with 'did not attend' and 'non-attendance' amongst these youngsters. Consideration is being given to our current model of care and whether this best meets the need of this cohort. Changes might include taking a mobile dental unit provides care on site to early childhood centres, rather than expecting parents to bring their preschool children to a particular site for care.

5.3 Future Focus

The next Whanganui Maternal, Child and Youth Community Alliance meeting will be held in June 2021 with a focus on the implications for health and wellbeing on the first 1,000 days of a child's life. The Alliance is moving towards establishment of working groups that will inform our current and future service provision.

Key work streams in progress stemming from our Primary and Secondary Maternity Services Interface Group include:

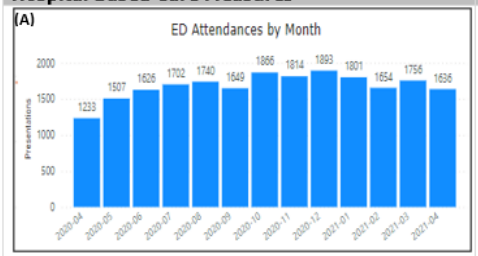
Maternity Services consumer feedback project – facilitated by Healthy Families
'Tech and channels' work, outlining 1) the roles and responsibilities and connections. between maternal services 2) producing a service directory for women.
Integration of the Best Start tool into GP practice and socialisation of this tool.

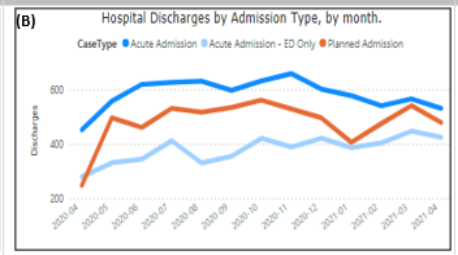
The second Midwifery Forum meeting for the year will be held on 13 July 2021. The forum is a platform for discussing issues, formulating solutions and improving services to the community, and will strengthen relationships between the WDHB and our LMC partners.

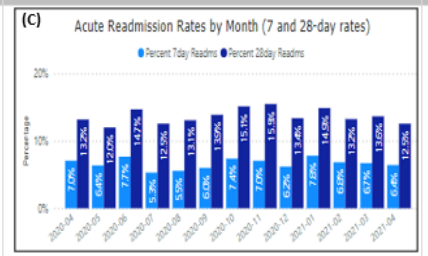
Appendix 1. Whanganui DHB Performance Dashboard

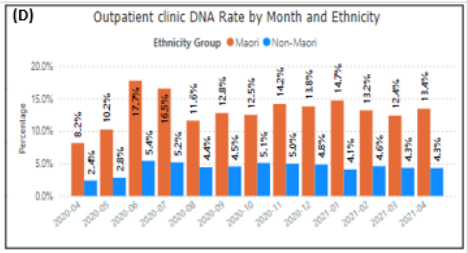
(data extracted 11 May 2021)

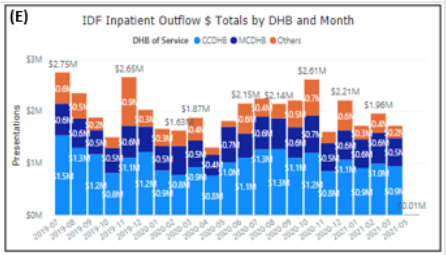
Hospital Based Care Measures

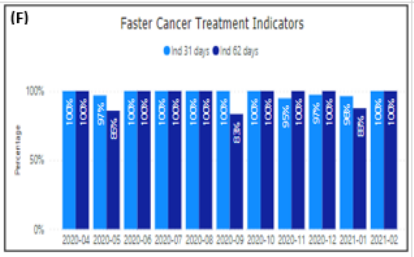










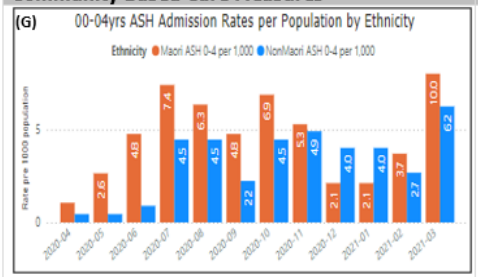


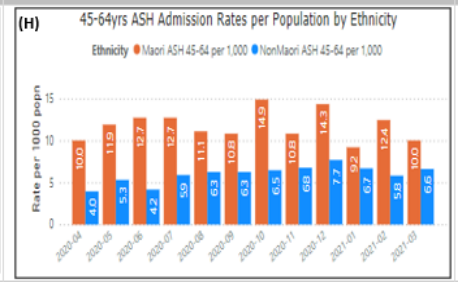
Commentary

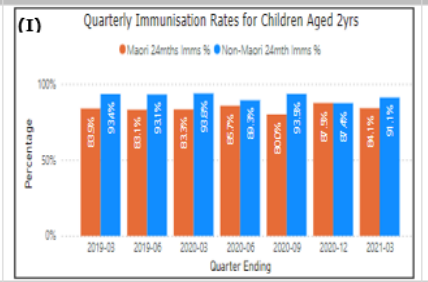
ED commentary is within the body of the report.
(B) April data shows 120 less attendances compared to last month. This decline was also reflected in the numbers for acute and planned admissions. However ED acute admissions remain high compared to year to date data.
(C) Readmission rates, 7 days remains consistant whilst there was a 1% decline in the 28 days.

(D) Outpatient clinic DNA remain high for Maori but has increased by 1 percent for April. Whilst non Maori continues to sit around 4-5%.
(E) April data is not completed; however, for March we paid a total of $1.6M in IDF.
(F) Faster Cancer Treatment 6 monthly report was presented at the last Board meeting. This graph indicates during February we reach 100%. This is a good result.

Community Based Care Measures



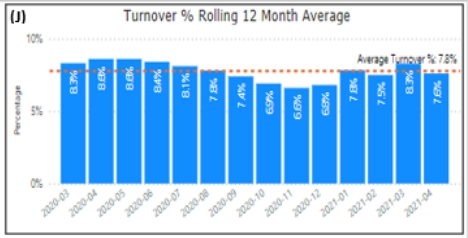


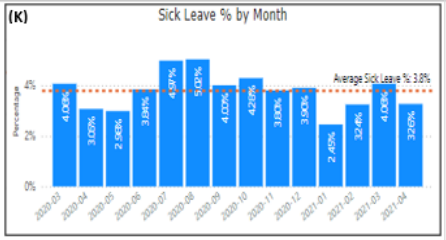


Commentary

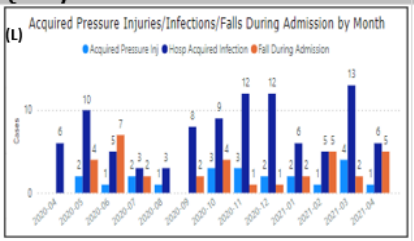
All Ambulatory sensitive hospitalisations (ASH) rates are for Whanganui Hospital. Maori are more likely to be hospitalised for ambulatory sensitive conditions compared to non-Maori.
(G) The top themes for 0-4 years are dental, gastroenteritis and respiratory. The surge in March volumes were largely driven by 10 dental admissions, 7 gastro bugs and 6 respiratory illnesses. (For perspective, overall average per month in these categories is 9.5 per month, compared with 23 events in March).
(H) The top themes for 45-64 years are chest pain, heart disease, COPD/pneumonia.
(I) March shows a slight improvement for non-Maori whilst Maori rates dropped slightly.

Workforce Measures





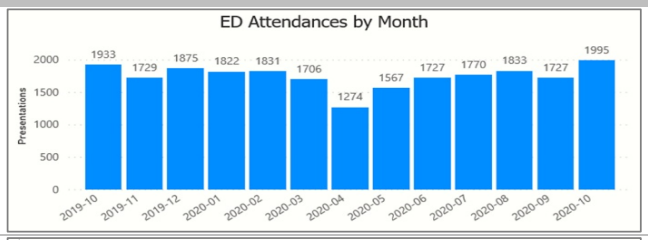
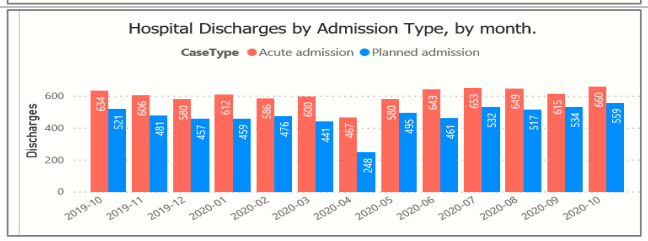
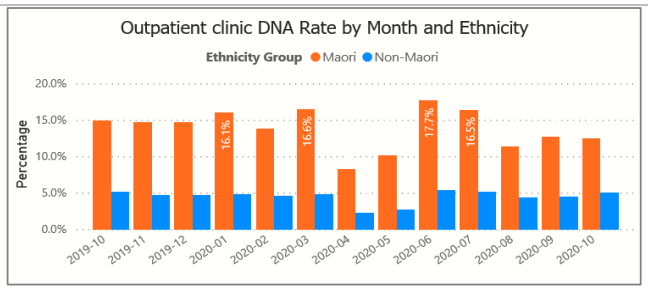
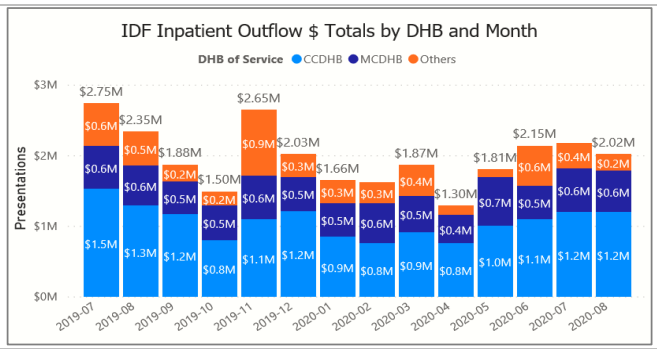
Quality



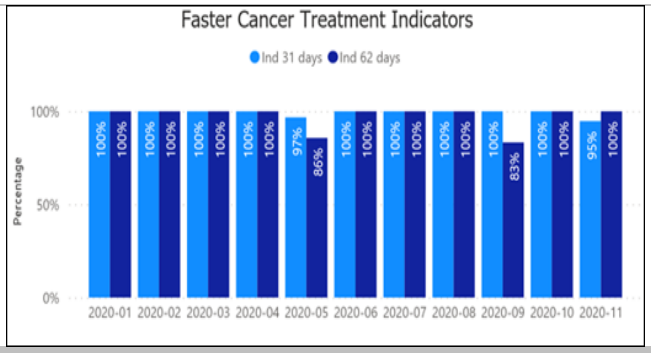
Commentary

(J) The average turnover at WDHB for April was 7.5% and this increased to 8.3% in March. WDHB average turnover is 7.8%.
(K) Sick leave was down to 3.2% compared to last month, however, was the same as this time last year. The average sick leave is 3.8%.
(L) Pressure injuries have decreased from last month, both hospital and community acquired. However, falls during admission have increased from last month and are also higher than this time last year.

Whanganui DHB Performance Dashboard definitions.

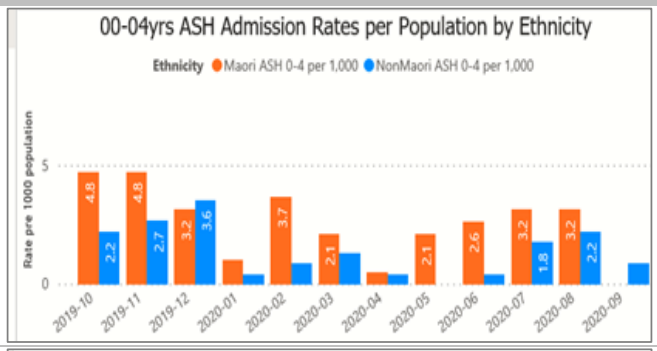
Hospital Based Care Measures	
Graph A. ED Attendances ED attendances are an indicator of acute patient demand in the system, while also identifying issues in access to primary care and potential flow issues in secondary services. **Calculation**: count of attendances.	
Graph B. Hospital Discharges Throughput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

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

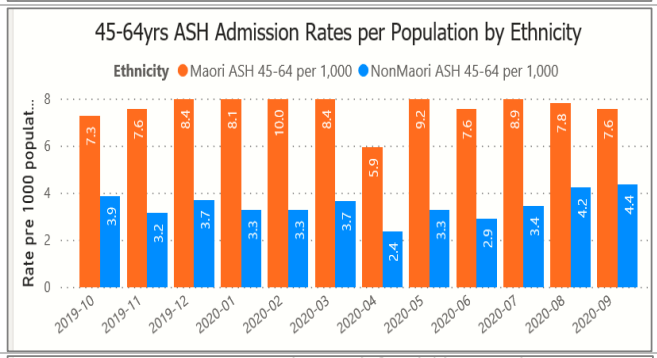


Community Based Care Measures

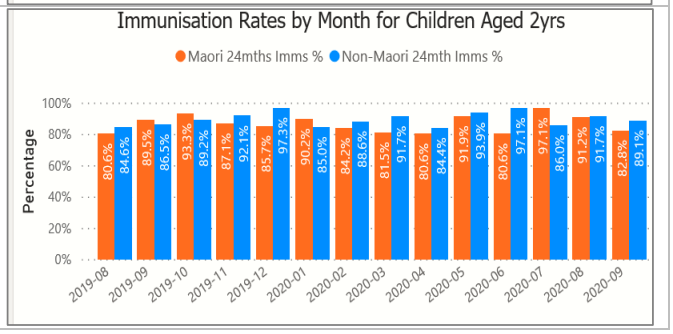
Graph G. ASH Rates 0-4 years
ASH rates are a measure of avoidable hospital admissions (Ambulatory Sensitive Hospital admissions) per 10,000 population. Significant disparities exist between rates for Māori and non-Māori indicating equity issues in access to services.
Calculation: admissions per 10,000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



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



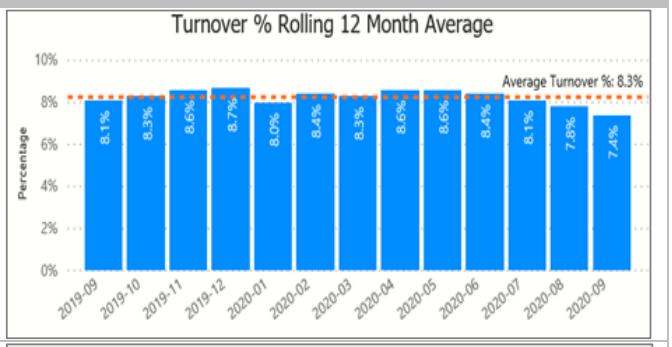
Graph I. Immunisation Rates for Children by ethnicity
Percentage of children with up to date immunisation at the age of two years
Calculation:
Denominator = total children enrolled
Numerator = total children with up to date immunisation



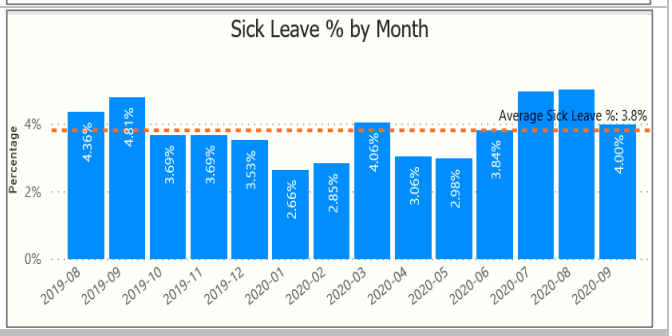
Workforce Measures

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

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

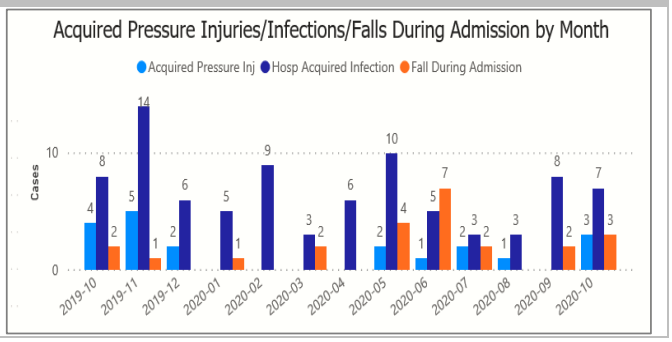


Graph K. Sick Leave %
Percentage of total paid hours taken as sick leave. This is an indication of illness levels and cost impacts when above average budgeted rates. Does not indicate where annual leave is used in place of sick leave
Calculation:
Denominator = total paid hours
Numerator = hours paid as sick leave



Quality

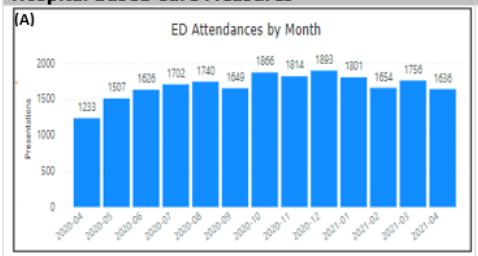
Graph L. Pressure Injuries/Infections/Falls
Patient safety and care indicators for key measures.
Calculation: count of events each month (not individual patients)

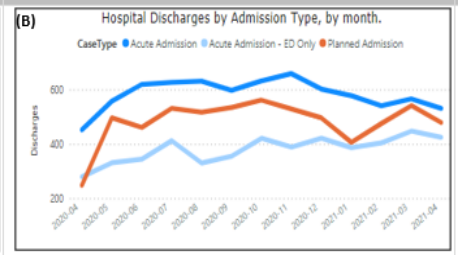


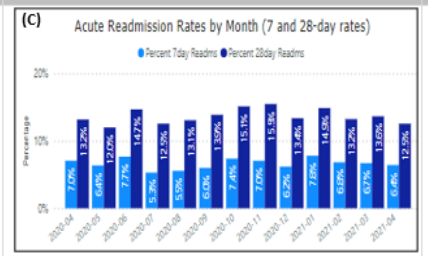
Appendix 1. Whanganui DHB Performance Dashboard

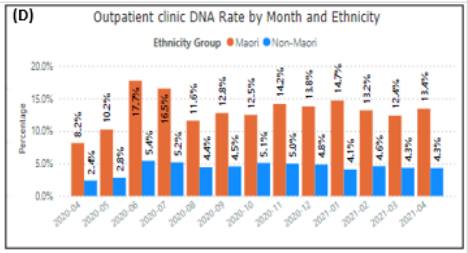
(data extracted 11 May 2021)

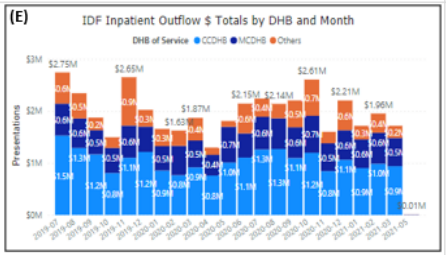
Hospital Based Care Measures

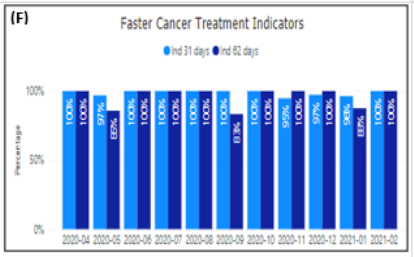










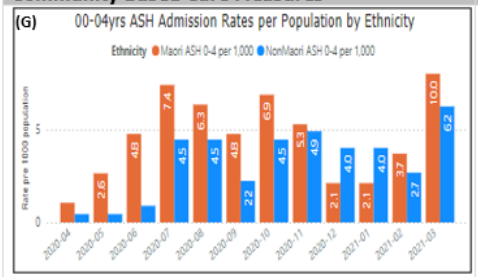


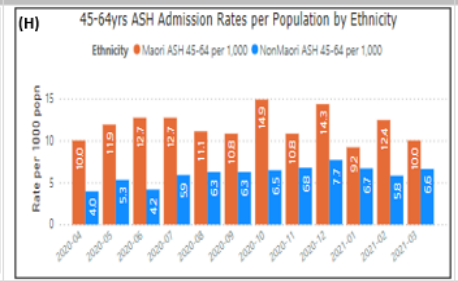
Commentary

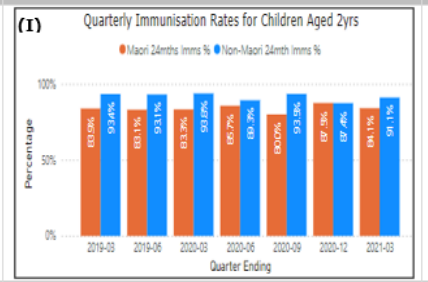
ED commentary is within the body of the report.
(B) April data shows 120 less attendances compared to last month. This decline was also reflected in the numbers for acute and planned admissions. However ED acute admissions remain high compared to year to date data.
(C) Readmission rates, 7 days remains consistant whilst there was a 1% decline in the 28 days.

(D) Outpatient clinic DNA remain high for Maori but has increased by 1 percent for April. Whilst non Maori continues to sit around 4-5%.
(E) April data is not completed; however, for March we paid a total of $1.6M in IDF.
(F) Faster Cancer Treatment 6 monthly report was presented at the last Board meeting. This graph indicates during February we reach 100%. This is a good result.

Community Based Care Measures



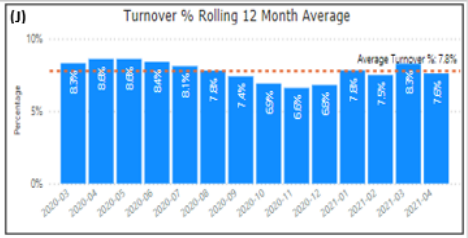


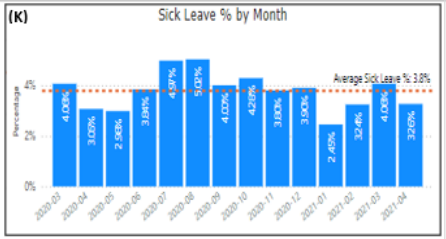


Commentary

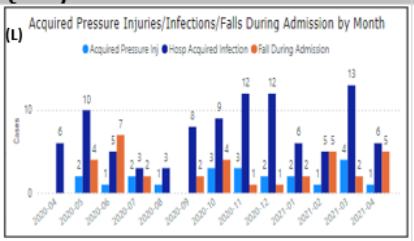
All Ambulatory sensitive hospitalisations (ASH) rates are for Whanganui Hospital. Maori are more likely to be hospitalised for ambulatory sensitive conditions compared to non-Maori.
(G) The top themes for 0-4 years are dental, gastroenteritis and respiratory. The surge in March volumes were largely driven by 10 dental admissions, 7 gastro bugs and 6 respiratory illnesses. (For perspective, overall average per month in these categories is 9.5 per month, compared with 23 events in March).
(H) The top themes for 45-64 years are chest pain, heart disease, COPD/pneumonia.
(I) March shows a slight improvement for non-Maori whilst Maori rates dropped slightly.

Workforce Measures





Quality



Commentary

(J) The average turnover at WDHB for April was 7.5% and this increased to 8.3% in March. WDHB average turnover is 7.8%.
(K) Sick leave was down to 3.2% compared to last month, however, was the same as this time last year. The average sick leave is 3.8%.
(L) Pressure injuries have decreased from last month, both hospital and community acquired. However, falls during admission have increased from last month and are also higher than this time last year.

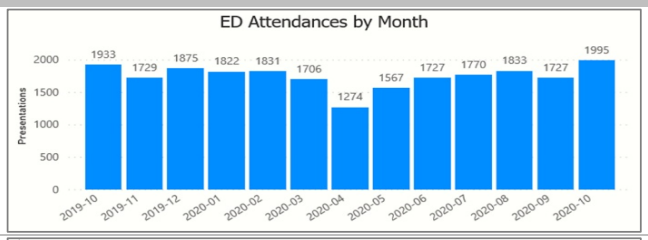
Whanganui DHB Performance Dashboard definitions.

Hospital Based Care Measures

Graph A. ED Attendances

ED attendances are an indicator of acute patient demand in the system, while also identifying issues in access to primary care and potential flow issues in secondary services.

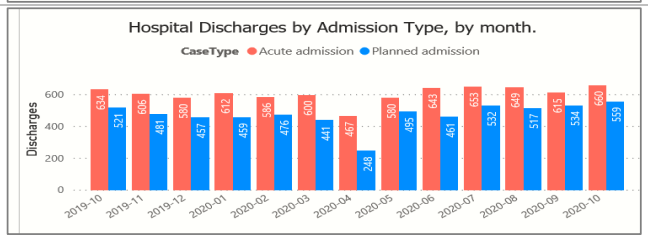
Calculation: count of attendances.



Graph B. Hospital Discharges

Throughput of hospital-based services. This is an indicator of patients through the system as opposed to occupied beds.

Calculation: count of patients discharged from inpatient events, and includes day stay patients in all services.



Graph C. Readmission Rates

This is the percentage of all patient discharged that return to hospital acutely within 7 and 28 days of discharge. Readmissions can be for any reason, not exclusively related to the previous event.

Calculation:

Denominator = patients discharged

Numerator = patients acutely re-admitted within 7/28 days

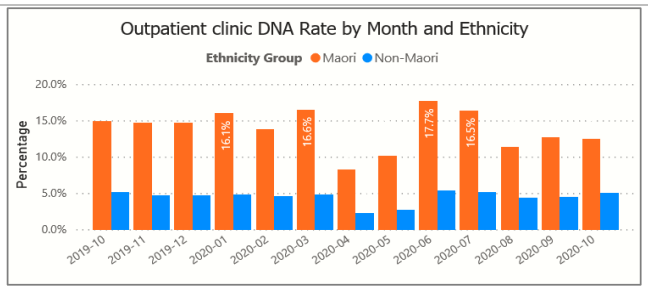
Graph D. Outpatient DNA Rate

DNA rates indicate where we have access issues to outpatient services. Significant disparities exist between rates for Māori and non-Māori indicating equity issues in access to services.

Calculation:

Denominator = total patients seen

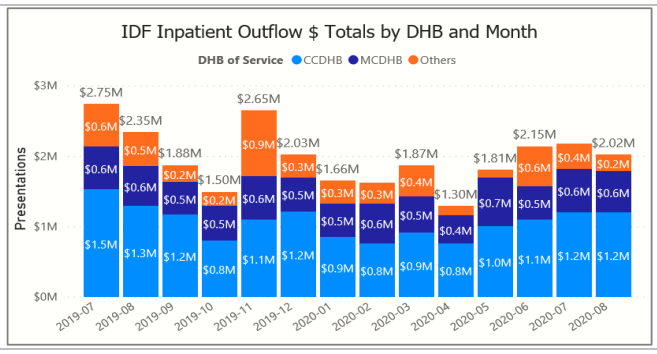
Numerator = missed appointments



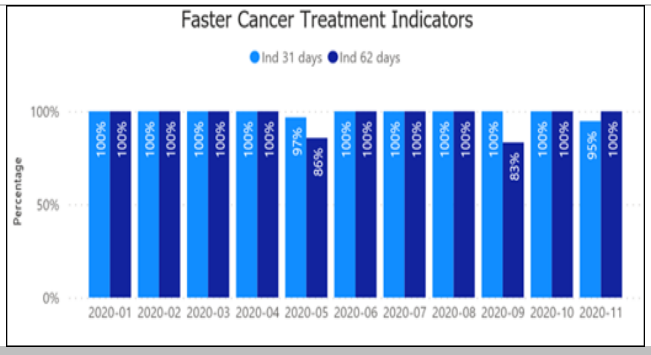
Graph E. IDF Outflows

Total value of IDF outflows to main DHBs for each month. This is a dollar value, so increasing prices need to be considered when comparing years.

Calculation: Dollar value of services provided by other DHBs to WDHB.

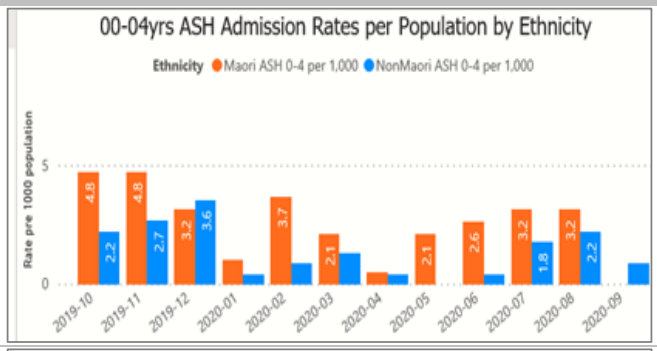


Graph F. Faster Cancer Treatment
Patients identified as high suspicion of cancer on referral receiving treatment within 62 days (further information provided within the paper).

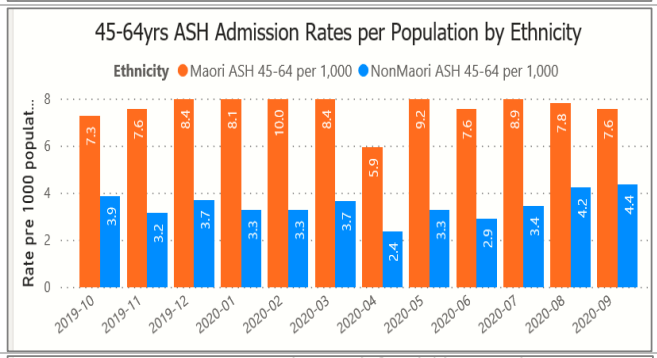


Community Based Care Measures

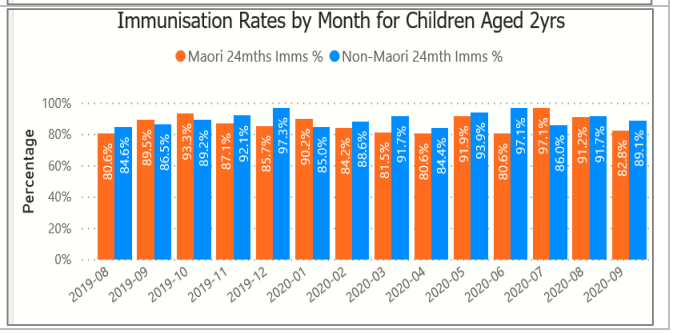
Graph G. ASH Rates 0-4 years
ASH rates are a measure of avoidable hospital admissions (Ambulatory Sensitive Hospital admissions) per 10,000 population. Significant disparities exist between rates for Māori and non-Māori indicating equity issues in access to services.
Calculation: admissions per 10,000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



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



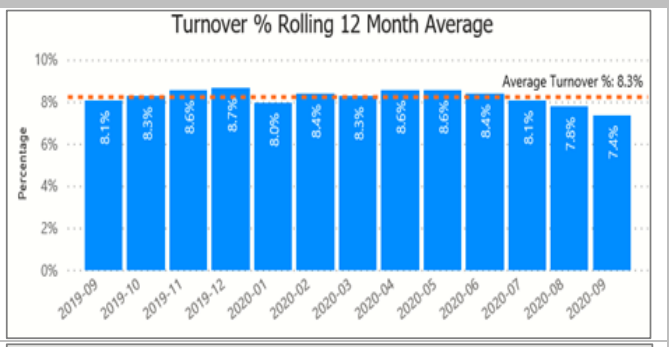
Graph I. Immunisation Rates for Children by ethnicity
Percentage of children with up to date immunisation at the age of two years
Calculation:
Denominator = total children enrolled
Numerator = total children with up to date immunisation



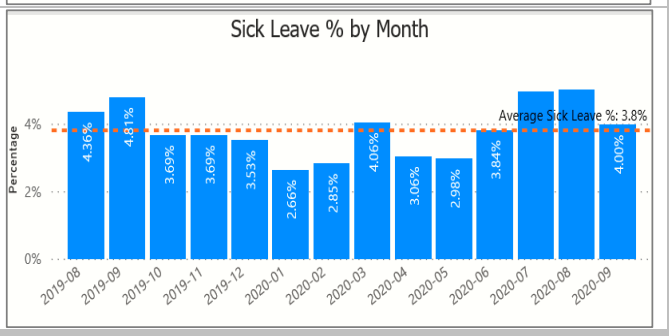
Workforce Measures

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

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

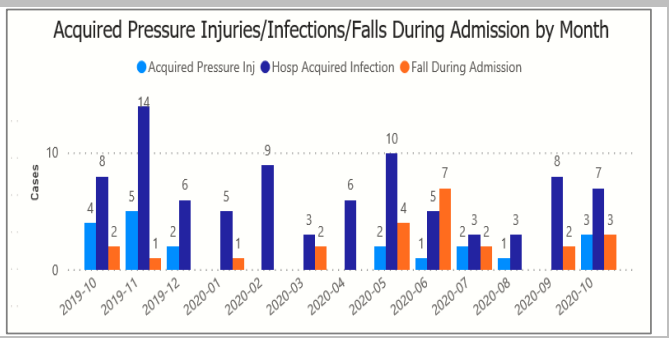


Graph K. Sick Leave %
Percentage of total paid hours taken as sick leave. This is an indication of illness levels and cost impacts when above average budgeted rates. Does not indicate where annual leave is used in place of sick leave
Calculation:
Denominator = total paid hours
Numerator = hours paid as sick leave



Quality

Graph L. Pressure Injuries/Infections/Falls
Patient safety and care indicators for key measures.
Calculation: count of events each month (not individual patients)



28 May 2021 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	Item No 4.1

Author	Eileen O'Leary, Kaitakitaki Equity / Art & Archives Group Chair
Endorsed by	Rowena Kui, GM Māori, Te Hau Ranga Ora / Art & Archives Group Sponsor
Subject	Overview of WDHB Art & Archives Group Activity
Equity	WDHB Art & Archives Group has a goal to help create a pro-equity environment enhanced by art. Art is carefully chosen to be culturally appropriate, culture promoting and is unveiled and blessed under advice from Te Hau Ranga Ora.

Recommendations

Management recommend that the Combined Statutory Advisory Committee:

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

Appendix

- History of Art & Archives in Whanganui hospitals

1 Purpose

The purpose of this item is to provide the Committee with an overview of the Art & Archives Group activities. The group members are Rowena Kui, Executive Sponsor Ailsa Stewart, Dr John Van Dalen and Eileen O'Leary.

2 Background

International research shows that once people enter a hospital, whether as an inpatient, outpatient, whānau/family or visitor, they experience a change in identity, vulnerability and loss of power. Research also shows that the experience for people in a healthcare environment can be improved when they see local art, images of nature, light and potted plants.

WDHB Art & Archives Group has a goal to help create a pro-equity environment enhanced by art. The group focuses on supporting whānau/patient-centred care by creating a sense of place and ownership for patients, whānau and staff.

The group aims to use art and archival material to improve people's experience while in the hospital - to de-clinicalise the environment and help create a sense of calm, where people feel welcomed, respected and where they see elements of their identity reflected in the surrounds. Art is used to trigger memories; help engender a sense of community and provide points of interest and diversion.

Art is also therapy for the service user/tangata whaiora in Stanford House who support the group's mahi by both producing their own art for use in the hospital and by providing a framing service for the group.

Group member and voluntary archivist Ailsa Stewart quotes Florence Nightingale as saying: "Variety of form and brilliancy of colour in the object presented to patients are an actual means of recovery".

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3 He Hāpori Ora Thriving Communities

Whilst art in the hospital pre-dates He Hāpori Ora, the selection and use of art in Whanganui Hospital is fully aligned to He Hāpori Ora, the organisation's values and the connection to the community.

4 History

The art of beautifying bare hospital walls is a long-standing tradition in Whanganui. This history is outlined in Appendix One: History of Art & Archives in Whanganui hospitals.

5 More Recent Activity

From 2017 the group has focused on improving the appearance of some of the main public thoroughfares such as major corridors, stair wells and waiting spaces. In 2018 large photographs of Mount Ruapehu over four seasons were hung in the Wards and Administration Block stair lobbies. Aerial photographs were also hung showing the campus in 1954 and more recently.

Traditional taonga have been purchased such as a wall hanging for outside the Kaihautū Hauora office, two piupiu hang above the main entrance foyer by Daisy Cameron of Atihaunui-A-Paparangi and the Tukutuku panel in the Board room by Trina Taurua of Ngā Rauru me Ngāpuhi Nui Tonu descent. The Tukutuku panel was woven to reflect the values and tohu of the DHB.

In 2019 the group ran a community photography competition and working with staff selected works for the Radiology, Physiotherapy, Speech Language and Occupational therapies' corridor. Artwork was also hung in the Children's, Medical, Surgical and AT&R wards. The group also worked with local mural artist Dan Mills to display his painting, done in the hospital on White Ribbon Day of the awa as a white ribbon flowing through the district.

Also, that year the group worked with Whanganui Regional Museum, to select historical photographs for a hub in the Assessment Treatment and Rehabilitation Ward to help stimulate patients' memories and provide therapy as well as a point of interest for people.

In 2020 the group had a large photograph of a waka on the awa hung on the ground floor outside the Outpatients Department and five new works hung in the Discharge Lounge and more photographs from the competition were hung in the laboratory corridor. Posters were also framed for the Maternity ward. Donated work by a nurse on our staff was also hung in a ward whānau room.

Some other donated artworks have been hung in the on-site accommodation.

6 Current Projects

The group has a number of projects underway:

- Art focused on woman
  - for a special room in the Maternity ward for women and their whanau when they have suffered a loss in pregnancy or a newborn baby. Funding specially tagged for women from the Whanganui branch of the National Council of Women will be used for this project. This generous donation was matched by the estate of former hospital matron Miss Catherine Scrimgeour.

- The Children's recovery area in Theatre Services.
  - Working with local artists Marty and Marilyn Vreede from Pakohe to create a space that is more whanau-centred and welcoming with safe, sustainable interactive elements. Funding for this has been secured from the Countdown Kids Hospital fund.

- Landing between the ground and first floor of the Wards and Administration Block

  - Commissioned boxed frame wall hanging using local sand from the hospital grounds and Castlecliff beach and local harakeke, including from the hospital grounds, being created by a WDHB staff person.

- Fourth Floor Corridor
  - Set of four boxed framed weavings for the corridor as you enter the WDHB offices by a staff person and service users/tangata whaiora from Stanford House.

- Emergency Department
  - 20 photographs have been selected by ED staff and being framed by service users/tangata whaoira Stanford House. Staff also have requested a larger print of an artwork that came out of Stanford of multi-coloured images of hoe which will be hung in an ED corridor space (shown at the end of this paper).

- Main Entrance multi-language entrance way on the glass
  - This project was delayed last year and we are now about to present to ELT some final design options. ED have requested the same multi-languages for their entrance and this is being considered.

- Pacific Art
  - The group has been looking for some appropriate art to reflect Pacific communities. In March we had some small pieces of tapa cloth donated and these will be framed as a start to better reflecting pacific cultures.

- Te Whare Toi
  - The group is working with Te Whare Toi the new education centre on using art in that space. A series of framed artworks from Stanford House reflecting the organisations waka values have already been selected. Ailsa is working with the Communications department to product some framed photographs, information and other images of earlier clinical staff education.

- Outpatients Department
  - Several paintings were bought and donated during the recent Whanganui Open studios and these will be used in clinics within the department. We are also looking at ideas for a more major artwork for the curved wall in the entranceway way to the department where people often sit and always walk through.

7 Donations

The work of the Art & Archives Group relies on the generous donation of art and funds from the community including from:

- Rotary North $3000
- Whanganui Community Trust $1500
- Lints Family $5000
- Rotary Club of Whanganui Trust $2000
- Anonymous Donor $5000
- National Council of Women Whanganui $1000
- Estate of the late Miss Catherine Scrimgeour $1000
- Castlecliff Charitable Community Trust $2000
- Countdown Kids Hospital fund $5000.

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8 Stanford House

Staff at Stanford have been encouraging service uses/tangata whaiora's involvement with art as a form of therapy and recovery. As part of a rehabilitation programme service users/tangata whaiora, accompanied by staff, have taken photographs of Whanganui which they then frame and gift to the art group. They also weave, carve, paint and create other forms of art. Recently examples of their work was displayed in the Stanford House Mahi Toi Art exhibition at the Community Arts Centre. This was supported by Peter de Roo, the Stanford House clinical nurse manager and Marie White, who worked with service uses/tangata whaiora on the art and was the exhibition organiser. Copies of a catalogue from the exhibition will be circulated at the Combined Committee meeting. The exhibition was also supported by the Whanganui District Council.

Some of this artwork has now been donated to Te Whare Toi and other spaces in the hospital. Plaques will acknowledge the artist under their art pseudonym.

The following two pieces of the art were accepted for the Sarjeant Gallery Te Whare o Rehua 2021 Pattillo Whanganui Arts Review exhibition which closes on 16 May.

Whāia te iti Kahurangi 'Strive for Greatness" by Awa

White Swan at Virginia Lake' by James Knight

28 May 2021 **Public**

9 Archives Up-date

Ailsa has given a number of talks in the community on the history of the hospital and DHB ie:

- History of hospitals in Whanganui District Health Board
- History of Whanganui Hospital rebuilds
- History of Karitane Hospital
- Small Hospitals of Yesteryear

On behalf of the group, Ailsa also maintains a good working relationship with the Whanganui Regional Museum, Whanganui District Council archivist and the Alexander Heritage Library.

Ailsa also responds to numerous requests from former staff members, their whānau, researchers, students and members of the public seeking information from the organisation's past.

Ailsa also creates topical historical displays in the cabinet outside the Outpatients Department such as for the International Year of the Nurse and Midwife last year a display of nursing medals from different times and countries. She has also displayed old hospital equipment and china etc. The cabinet was specially built for the hospital using Oak from Peat Park.

And for special events such as the celebration of 80 years of Te Kōpae (formerly Newcombe Ward) Ailsa prepares quality archival displays, with support from Christie Langford from the Communications Team.

The main challenge for the archives is that at present the majority of material from 165 years of history is in paper form which Ailsa is methodically categorising and filing.

Recognition

As well as positive feedback from patients, whānau, visitors and staff, the group's work has been recognised in the:

- Whanganui Regional Heritage Trust 'Outstanding Contribution to Heritage category, and the
- WDHB Te Tohu Rangatira Quality Awards winner of the Rangimarie and Aroha category.

Images from the Stanford House Mahi Toi Collection 2021

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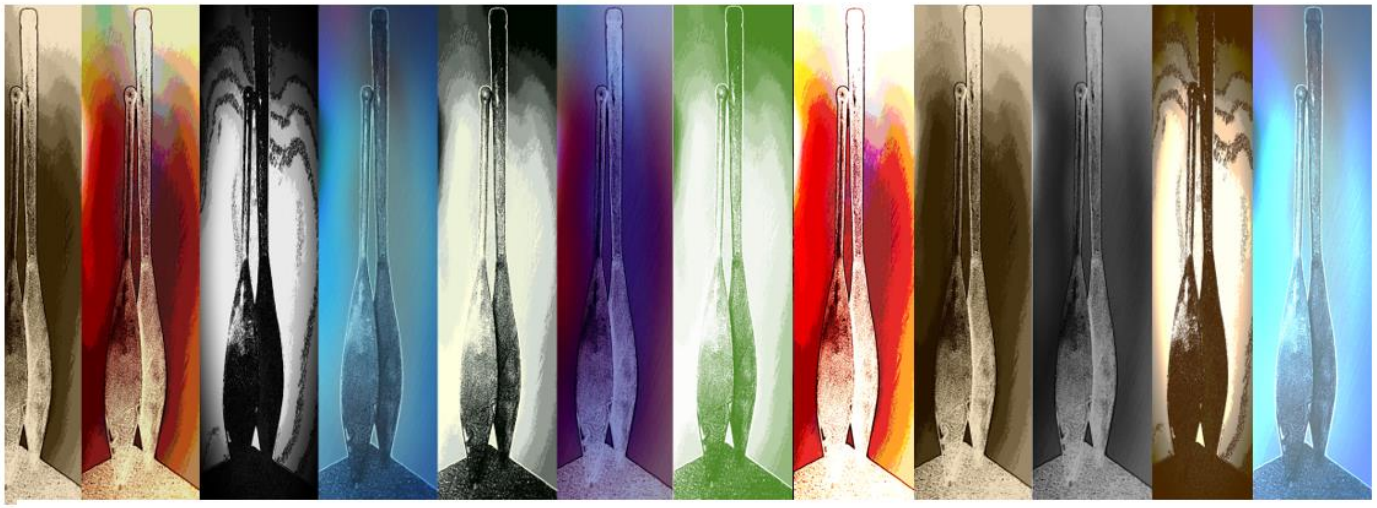

Brief History of Art & Archives in Whanganui hospitals

Background

In 1850 the Colonial Hospital was built in St Georges Gate with the first patients being admitted in February 1851. Similar efforts to encourage the recuperation of patients were made at this hospital through: 'Ornamenting the Hospital' as reported in the *Chronicle* on August 7 1883.

"A variety of carefully selected paintings were hung on the walls which had interested decorative frames. They included paints of domestic and historical subjects, animal life and Scottish lakes and mountain scenery.

Sadly the hospital was well 'passed its used-by date' and was burnt to celebrate Queen Victoria's diamond jubilee on 21 June 1897. The old, Colonial hospital was gone forever and the future of Whanganui Hospital was bright with a new building on a new site in Heads Road, which opened on 12 March 1897.

By late 1990s, plans were approved to rebuild and renew the hospital which took about 10 years to complete with an official opening on 1 March 2009.

When the rebuild was completed, archivist and then board member, Ailsa Stewart, prepared a five metre 'history' in photos. This display, opposite the Chapel, used new techniques to prevent fading.

Also during the 1980s, the rural hospitals began to close and health centres were established. A mural was prepared showing what the Hospital Board looked like for 90 years and what the Whanganui District Health Board is today.

In 2013 a grateful patient made a donation of $500 to buy a painting to Orthopaedic Surgeon Mr John van Dalen. Mr van Dalen approached Whanganui North Rotary about the concept of 'Art in Hospital'. They were, and continue to be, very supportive through fundraising. They raised about $2,500 for the initial project and the DHB agreed to support it dollar for dollar doubling the amount raised.

Following the surgical ward project, Rotary raised about $3,500 for the CCU, Maternity and Children's Ward corridor project of 23 large coloured photograph by Mark Brimblecomb. Again the hospital supported this with dollar for dollar. Rotary continue to be supportive of this project and see it as being long term.

Working with Stanford House photographs taken and framed by Stanford patients have been hung in wards and the Discharge Lounge.

Working with Terry Sarten who organised local artist Dan Mills to create a painting that captured the kaupapa of non-violence for White Ribbon Day in 2018. Dan painted the Whanganui Awa as a white ribbon flowing through the district.

The art work was hung on the ground floor corridor and blessed by Kaumatua John Maihi on 17 May 2019

Working with Whanganui Regional Museum, selected historical photographs of Whanganui have been selected for a hub in the Assessment Treatment and Rehabilitation Ward to help stimulate patients memories and provide therapy as well as a point of interest for people.

Māori Art

The Art Group recognises the hospital can be a very clinical environment and have been considering how to make it a more culturally inclusive environment to support the whānau-centred care taking place.

Rowena Kui, (Director of Maori Health and Art Group member) has hung two authentic Māori piupiu in the main entrance foyer, by Daisy Cameron of Atihaunui-A-Paparangi, and purchased several other pieces that aim to reflect Māori Te Ao Marama – a Māori world view.

One of these pieces has pride of place in the refurbished Board Room, titled 'He Waka Eke Noa' is by weaver Trina Taurua (Ngā Rauru me Ngāpuhi nui tanu). This magnificent taonga is made up of elaborately woven tukutuku panels.

3

28 May 2021 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	Item No 4.2

Author	Eileen O'Leary, Kaitakitaki
Endorsed by	Rowena Kui, Kaiuringi Māori Health and Equity, Te Hau Ranga Ora Sponsor
Subject	Up-date on activity to improve appointment attendances.
Equity	Persistent inequities exist in appointment attendance rates. All activity to reduce the rate of missed appointments is developed with the focus on improving Māori attendance as a priority.

Recommendations

Management recommend that the Combined Statutory Advisory Committee:

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

Appendix

1. Screenshot of new data analysis available to inform management of DNAs.

1 Purpose

The purpose of this item is to provide the Committee with a brief up-date on work to improve appointment attendance rates, for WDHB services, and therefore reduce 'Did Not Attends' (DNAs) – the official terminology for a missed scheduled appointment.

2 Background

WDHB approach to managing DNAs is to analyse how as an organisation we have failed to engage with a patient/whānau and then to work on ways to better empower their attendance.

Nationally DNA rates are persistently inequitable for Māori and especially for Māori children. This is also evident in WDHB rates with a fairly consistent inequity ratio of between 2 and 3.

It is however important to note that the DNA rate does not reflect the final appointment attendance especially for children where a child may miss several appointments before subsequent work enables engagement with the whānau and the child to be seen. However, DNA rates do indicate delayed access to care, lost opportunities for someone else to be seen and considerable re-work and inefficiency.

Over time the WDHB DNA rates have been slowly trending downwards except for a peak prior to and directly after the 2020 COVID lockdown, which coincided with issues with the previous Text to Remind system. While this downward trend is about 2 percent for both Māori and non-Māori the actual impact of this is greater inequity with the rates for non-Māori moving from 6 percent to 4 percent overall, while the rates for Māori reduced from 12 percent to 10 percent.

The drivers of DNA are multiple and varied but there are a number of factors which have the potential to improve DNA rates and these have been the focus.

Activity to improve appointment attendance rates:

- In 2020 a new Text to Remind system was developed and introduced which is fully integrated with the patient management system webPAS. Under this new system patients should be receiving a text message 7 days out from an appointment which notifies them that the appointment is booked and seeks confirmation. A second text is sent the day prior to the appointment. There is additional capacity in this system for patients to message the scheduling administrator and for the administrator to message them. Further training is needed to fully realise the benefits of this new system. It is expected there is potential to better capture patient cancellations in a timely manner which should enable these slots to be refilled. The text system is designed to back up the posted appointment letter. It is widely accepted that letters are increasingly ineffective means of notification, especially for younger more mobile people.
- A project is underway using Ministry of Health funding to review our booking processes across specialities with the aim of introducing a more systematic patient/whānau-centred booking across our services.
- The Outpatient Department has implemented a system where clinic nurses use the time when a patient has not arrived for an appointment to try to contact them. The aim of the conversation is to talk about the value of the appointment, ways we could support them to be seen - such as later in the day or rescheduling for another more suitable time. Nurses are also encouraged to talk about any barriers to access such as transport, work time, childcare etc. A daily monitoring of any child DNAs is carried out.
- Te Hau Ranga Ora Haumoana are integrated into the DNA process for outpatient appointments. When a DNA occurs for Māori whanau, the Haumoana are automatically emailed to support the scheduling administrators to reach the whānau. In addition to phoning and texting, the Haumoana use other messaging systems and potential other contacts of the whānau in the community. Haumoana also make cold call visits for those whānau whom they have not been able to reach through any other means. Their approach is whānau ora strengths-based and therefore involves working with the whānau to find solutions to overcome appointment barriers. They also try to find out what barriers the organisation needs to address, such as setting more suitable times/days for that whānau to come to an appointment.
- Maternal Child and Youth services are exploring a single point of entry for children's referrals which has the potential to improve coordination of their appointments and provide a more whanau-centred approach to their care and the management of their referral/s.
- WDHB health informatics team has been working on improving visibility of DNA data and have produced a new dashboard which will enable both an organisation-wide view of DNAs by ethnicity, age, speciality, clinician, days and dates etc. This also allows drilling down to individual clinicians and patients. A screen shot of this new tool in attached as an appendix. This work has just been completed and training and rolling out has begun. This will enable managers and teams to track their own clinics and the impacts of initiatives to engage with their patients.
- A review of the organisation's administration will be completed this year which aims to improve consistency and efficiency of the administration systems, many of which provide key points of interface with patients and whānau and influence their experience of scheduling and attending appointments.
- Individual clinics have also been identified as having particular issues and high DNA rates especially for Māori and special initiatives have been put in place to address barriers. For Audiology this includes intensive phoning of all patients prior to the appointments.
- Telehealth potentially provides another tool for improved access to appointments. Currently the actual number of appointments provided via telehealth is low but earlier indications are that DNA rates are very low and mainly due to issues with connectivity. A dedicated telehealth coordinator has been appointed to help embed telehealth practices across the district and improve the overall consumer experience.

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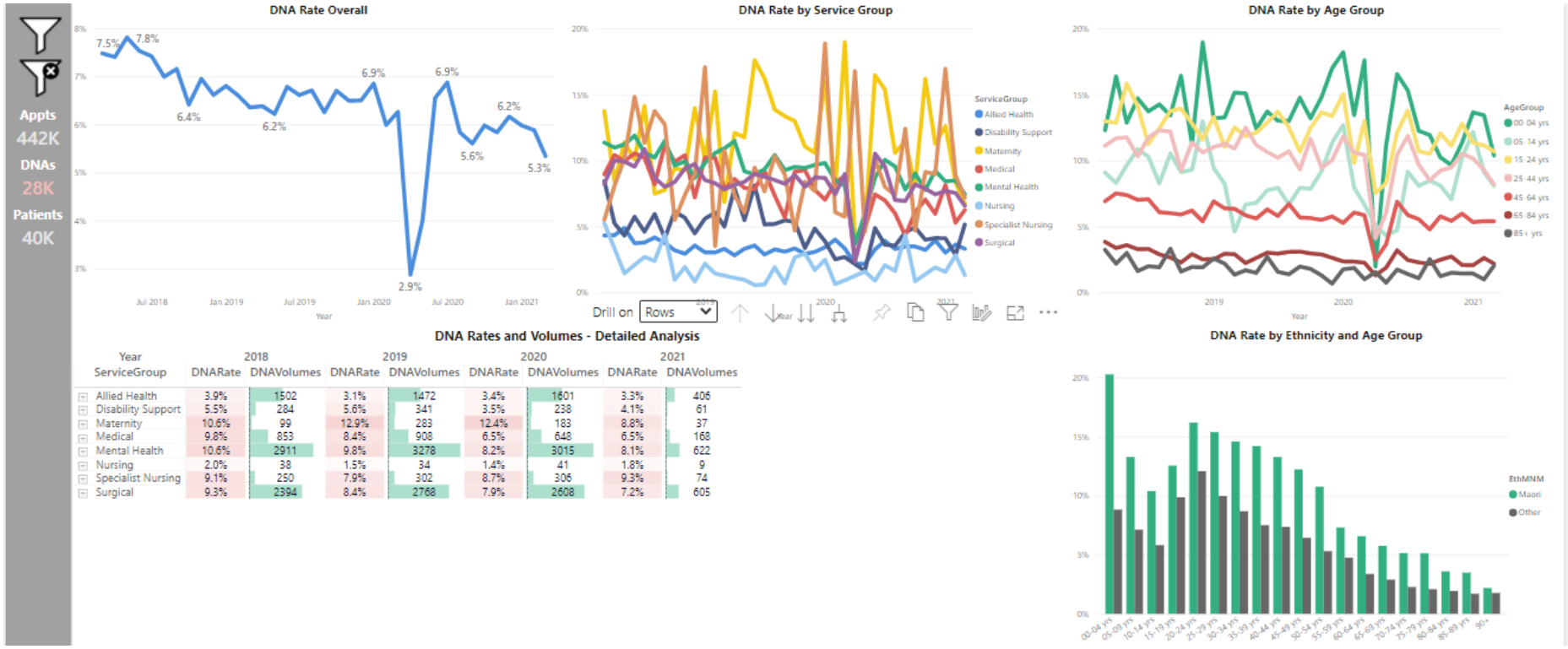
Appendix 1 - Screen shot of new data analysis available to inform management of DNAs



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Appendix 1 - Screen shot of new data analysis available to inform management of DNAs

Year	2018		2019		2020		2021	
ServiceGroup	DNARate	DNAVolumes	DNARate	DNAVolumes	DNARate	DNAVolumes	DNARate	DNAVolumes
Allied Health	3.9%	1502	3.1%	1472	3.4%	1601	3.3%	406
Disability Support	5.5%	284	5.6%	341	3.5%	238	4.1%	61
Maternity	10.6%	99	12.9%	283	12.4%	183	8.8%	37
Medical	9.8%	853	8.4%	908	6.5%	648	6.5%	168
Mental Health	10.6%	2911	9.8%	3278	8.2%	3015	8.1%	622
Nursing	2.0%	38	1.5%	34	1.4%	41	1.8%	9
Specialist Nursing	9.1%	250	7.9%	302	8.7%	306	9.3%	74
Surgical	9.3%	2394	8.4%	2768	7.9%	2608	7.2%	605

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6 Exclusion of public

Recommendation
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 13 February 2021 (public-excluded session)	For the reasons set out in the committee's agenda of 13 November 2020	As per the committee's agenda of 13 February 2021
Statement of Service Performance	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 public service agency 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 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