MidCentral District Health Board

Te Pae Hauora o Ruahine o Tararua

Part One HDAC Pack

13 July 2021 HDAC

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

Contents

Agenda

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MidCentral District Health Board

Health and Disability Advisory Committee Meeting

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

When: Tuesday 13 July 2021, from 9.00am

PART ONE

Members

John Waldon (Committee Chair), Brendan Duffy (Board Chair), Heather Browning, Vaughan Dennison, Norman Gray, Muriel Hancock, Materoa Mar, Gail Munro, Karen Naylor, Oriana Paewai, Jenny Warren.

Apologies

Lew Findlay

In attendance

Kathryn Cook, Chief Executive; Kelvin Billinghurst, Chief Medical Officer; Judith Catherwood, General Manager, Quality and Innovation; Celina Eves, Executive Director, Nursing and Midwifery; Chiquita Hansen, Interim General Manager, Strategy, Planning and Performance; Gabrielle Scott, Executive Director, Allied Health; Tracee Te Huia, General Manager, Māori Health; Margaret Bell, Board Secretary.

In attendance (part meeting)

Item 4	Operations and Clinical Executives: Scott Ambridge, Dr Jeff Brown, Dr Vanessa Caldwell, Debbie Davies, Sarah Fenwick, Dr Claire Hardie, Lyn Horgan, Dr Syed Zaman
Item 5.1	Michelle Riwai, General Manager, Enable New Zealand
Item 6.2	Scott Ambridge, Operations Executive and Dr Vanessa Caldwell, Clinical Executive, Te Uru Rauhī
Item 6.3	Keyur Anjaria, General Manager, People and Culture
Item 7.1	Angela Rainham, Locality and Intersectoral Development Manager

Please contact the Board Secretary if you require a print copy – email boardsupport@midcentraldhb.govt.nz before noon on the working day prior to the meeting

1. KARAKIA 9.00

He Karakia Timata

Kia hora te marino	May peace be widespread
Kia whakapapa pounamu te moana	May the sea be smooth like greenstone
He huarahi ma tātou I te rangi nei	A pathway for us all this day
Aroha atu, aroha mai	Give love, receive love
Tātou I a tātou I ngā wa katoa	Let us show respect for each other
Hui e taiki e	

2. ADMINISTRATIVE MATTERS 9.05

2.1. Apologies

2.2. Late items

2.3. Register of Interests Update

2.4. Minutes of Health and Disability Advisory Committee meeting – 27 April 2021, Part One

2.5. Matters arising

3. STRATEGIC FOCUS 9.10

Disability Services Strategic Direction

4. DIRECTORATE WITH CLUSTER FUNCTIONS REPORTING 9.40

4.1. Directorate Dashboard

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

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

4.4. Te Uru Whakamauora – Healthy Ageing and Rehabilitation

4.5. Te Uru Rauhī – Mental Health and Addiction Services

4.6. Te Uru Arotau – Acute and Elective Specialist Services

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

REFRESHMENT BREAK 10.15

10.30

5. PERFORMANCE REPORTING

5.1. Enable New Zealand Report

5.2. Pae Ora Paiaka Whaiora Report

6. DISCUSSION/DECISION PAPERS 10.50

6.1. Clinical Governance and Quality Improvement Framework

6.2. Equity Dashboard – Mental Health and Addiction Services Adult Indicators

6.3. Equity Dashboard – Workforce Indicators

6.4. Regional Services Plan Implementation – Quarter Three

7. INFORMATION PAPERS 11.30

Information papers for the Board to note

7.1. Locality Plan Progress Report – Ōtaki

7.2. Committee's Work Programme

8. GLOSSARY OF TERMS

9. LATE ITEMS

10. DATE OF NEXT MEETING – Tuesday 14 September 2021

11. EXCLUSION OF THE PUBLIC

Recommendation

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

Item	Reason	Reference
'In committee' minutes of the previous Health and Disability Advisory Committee meeting	For reasons set out in the agenda of 27 April 2021 meeting held with the public present	
Serious Adverse Events (SAC 1) Report	To protect patient privacy	9(2)(a)
Consumer Story – Workshop	To protect patient privacy	9(2)(a)

Administrative matters

13 July 2021 HDAC

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Apologies

Any apologies to be noted?

Late items

Opportunity to advise any late items to be discussed at the meeting

Register of Interests: Summary, 1 July 2021 (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)		
Board Members		
Name	**Date**	**Nature of Interest / Company/Organisation**
Browning, Heather	4.11.19	Director – HB Partners Limited
		Member – MidCentral Governance Group Mana Whaikaha
		Board Member and Chair, HR Committee – Workbridge
	26.7.20	Director and Shareholder – Mana Whaikaha Ltd
	23.10.20	Member – Te Aho o Te Kahu (Cancer Control Agency) Consumer Reference Group
	9.2.21	Project Manager to lead Mana Whaikaha out of the Ministry of Health; stood down from appointed role of Deputy Chair of the MidCentral Governance Group for the MidCentral prototype
		Resigned as Director of Mana Whaikaha Ltd – effective from December 2020
Duffy, Brendan	3.8.17	Chair and Commissioner – Local Government Commission
		Member – Representation Commission
		Chairperson – Business Kapiti Horowhenua Inc (BKH)
Dennison, Vaughan	4.2.20	Councillor – Palmerston North City Council
	9.2.21	Member of Palmerston North City Council Infrastructure Committee
Findlay, Lew	1.11.19	President, Manawatu Branch and Director Central District - Grey Power
		Councillor – Palmerston North City Council
		Member – Abbeyfield
	16.2.21	Vice President Manawatū Branch and Board Member of Grey Power New Zealand
Gray, Norman	10.12.19	Employee – Wairarapa DHB
		Branch Representative – Association of Salaried Medical Specialists
Hancock, Muriel	4.11.19	Sister is casual employee (Registered Nurse, ICU) – MidCentral DHB
		Volunteer, MidCentral DHB Medical Museum
	30.9.20	Sister-in-law is employed as a registered nurse at Whakapai Hauora
Mar, Materoa	16.12.19	Upoko Whakarae Te Tihi O Ruahine Whānau Ora Alliance
		Chair – EMERGE Aotearoa
		Matanga Mauri Ora Ministry of Health Mental Health and Addiction
		Chair, 'A Better Start – E Tipu Rea', National Science Challenge, Liggins Institute, University of Auckland
	11.2.20	Member of MDHB Cluster
		Member of local Child and Youth Mortality Review Group (CYMRG)
	5.8.20	Member of MDHB's Māori Alliance Leadership Team (MALT)
Naylor, Karen	6.12.10	Employee – MidCentral DHB
		Member and Workplace Delegate – NZ Nurses Organisation
	9.10.16	Councillor – Palmerston North City Council

Register of Interests: Summary, 1 July 2021 (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)		
Paewai, Oriana	1.5.10 13.6.17 30.8.18 13.4.21	Member – Te Runanga o Raukawa Governance Group Chair – Manawhenua Hauora Co-ordinating Chair – Te Whiti ki te Uru (Central Region DHB MRBs) Member Nga Manu Taiko, a standing committee of the Council – Manawatu District Council Member – Te Tihi o Ruahine Whānau Ora Alliance Board Member – Cancer Society Manawatu Appointed Member – Massey University Council Trustee – Manawatū/Whanganui Children's Health Charitable Trust Board Member – Governance Board, Mana Whaikaha
Waldon, John	22.11.18 9.2.21	Co-director and co-owner – Churchyard Physiotherapy Ltd Co-director and researcher – 2 Tama Limited Manawatu District President – Cancer Society Executive Committee Central Districts (rep for Manawatu, 1 of 2) – Cancer Society Has a contract with UCOL
Warren, Jenny	6.11.19 12.2.21 1.7.21	Team Leader Bumps to Babies – Barnardos New Zealand Consumer Representatives National Executive Committee – National On Track Network Pregnancy and Parenting Education Contractor – Palmerston North Parents' Centre Member of Locality Advisory Group for both Tararua and Ōtaki/Horowhenua for the Primary Maternity Project Enhancing NZ Clinical Trials – member of Consumer Focus Group (run by the Liggins Institute with funding from the Ministry of Health and Health Research Council)
Committee Members		
Allan, Simon (FRAC)	2.6.20	Deputy Chair – Manawatu Branch of Cancer Society MDHB Rep – THINK Hauora Palliative Care Advisory Panel (Ministry of Health advisory body) Director of Palliative Care – Arohanui Hospice Chair of Board – Manawatu Badminton Association
Hartevelt, Tony (FRAC)	14.8.16 14.8.16 14.8.16 7.10.19	Independent Director – Otaki Family Medicine Ltd Elder son is Director, Global Oncology Policy based at Head Office, USA – Merck Sharpe & Dohme (Merck) (NZ operations for Global Pharmaceutical Company) Younger son is news director for Stuff.co.nz – Fairfax Media Independent Chair, PSAAP's Primary Care Caucus – Primary Health Organisational Service Agreement Amendment Protocol (PSAAP)
Munro, Gail (HDAC)	23.3.21	Director – Eastern and Central Trust 2020 Governance Strategies Ltd 2007

Register of Interests: Summary, 1 July 2021 (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)		
Management		
Cook, Kathryn	13.4.21	Nil
Ambridge, Scott	20.8.10	Nil
Amoore, Anne	23.8.04	Nil
Anjaria, Keyur	17.7.17	Wife is a user of the Needs Assessment and Service Co-ordination Service – MDHB
Bell, Margaret	28.7.20	Nil
Billinghurst, Kelvin	6.8.20	Fellow of the Royal College of Medical Administration (RACMA) Coordinator for the Indigenous Health Programme – RACMA Member of the Rural Policy Advisory Group – RACMA Fellow of the Australasian College of Health Service Managers (ACHSM)
Bradnock, Barb	26.8.10	Nil
Brogden, Greg	16.2.16	Nil
Brown, Jeff		TBA
Caldwell, Vanessa	7.5.18	Nil
Catherwood, Judith	1.5.18	Nil
Davies, Deborah	18.5.18	Member, Alliance Leadership Team – Central PHO Daughter is an employee and works within hospital services – MidCentral DHB
Eves, Celina	14.5.18 20.4.20	Owner personal consulting company, UK – Celina Eves Limited (2020 moved into dormancy) Trustee – Palmerston North Medical Trust
Fenwick, Sarah	13.8.18	Nil
Free, Jennifer	6.8.20	Nil
Hansen, Chiquita	9.2.16 3.3.21	Employed by MDHB and seconded to Central PHO 8/10ths – MidCentral DHB CEO – Central PHO Employed by THINK Hauora as Chief Executive and seconded to MidCentral DHB as Interim General Manager, Strategy, Planning and Performance 6/10ths Husband is employed by MidCentral DHB Executive member of General Practice New Zealand (GPNZ) Executive member of Health Care Home Collaborative
Hardie, Claire	13.8.18 13.8.18 13.8.18	Member – Royal Australian & NZ College of Radiologists Trustee – Palmerston North Hospital Regional Cancer Treatment Trust Inc Member, Medical Advisory Committee – NZ Breast Cancer Foundation
Horgan, Lyn	1.5.17 18.5.18	Sister is Coroner based in Wellington – Coronial Services Member, Alliance Leadership Team – Central PHO
Howe, Jonathon	1.8.19	Nil

Register of Interests: Summary, 1 July 2021 (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)		
Matthews, Rory	20.8.20	Managing Partner, FGI (NZ) Ltd trading as Francis Health Trustee/Director Te Hopai Home and Hospital Ltd
Miller, Steve	18.4.17 26.2.19 6.3.19 1.10.19	Director. Farming business – Puriri Trust and Puriri Farm Partnerships Board Member, Member, Conporto Health Board Patient's First trading arm – Patients First Member, Alliance Leadership Team, Member, Information Governance Group – Central PHO Chair – National DHB Digital Investment Board
Ratana, Darryl	29.5.19	Nil
Russell, Greig	3.10.16	Minority shareholder – City Doctors Member, Education Committee – NZ Medical Council
Scott, Gabrielle	Dec 19	Son is a permanent MDHB employee and works within Digital Services
Tanner, Steve	16.2.16	Nil
Te Huia, Tracee	19.11.19	Nil
Wanden, Neil	Feb 19	Nil
Williamson, Nicki	Mar 20	Nil
Zaman, Syed	1.5.18	Nil

Resolution

That the Part One minutes of the 27 April 2021 Health and Disability Advisory Committee meeting be approved as a true and correct record.

MidCentral District Health Board

Health and Disability Advisory Committee Minutes

Meeting held on 27 April 2021 from 9.00am

PART ONE

Members

John Waldon (Committee Chair), Brendan Duffy (Board Chair), Heather Browning, Vaughan Dennison, Lew Findlay, Muriel Hancock, Materoa Mar (Deputy Committee Chair), Gail Munro, Karen Naylor, Oriana Paewai, Jenny Warren.

In attendance

Kathryn Cook, Chief Executive; Judith Catherwood, General Manager, Quality and Innovation; Celina Eves, Executive Director, Nursing and Midwifery; Chiquita Hansen, Interim General Manager, Strategy, Planning and Performance; Rory Matthews, Interim Director, Office of the Chief Executive; Gabrielle Scott, Executive Director, Allied Health; Margaret Bell, Board Secretary.

In attendance (part meeting)

Scott Ambridge, Operations Executive, Te Uru Rauhī; David Andrews, Acting General Manager, Enable New Zealand; Wayne Blissett, Operations Executive, Pae Ora Paiaka Whaiora; Dr Jeff Brown, Clinical Executive, Te Uru Pā Harakeke; Dr Vanessa Caldwell, Clinical Executive, Te Uru Rauhī; Mariette Classen, Consumer Experience Manager; Debbie Davies, Operations Executive, Te Uru Kiriora; Sarah Fenwick, Operations Executive, Te Pā Harakeke; Pauline Holland, Planning and Integration Lead, Te Uru Whakamauora; Lyn Horgan, Operations Executive, Te Uru Arotau; Kelly Isles, Director of Strategy; Sam Kilmister, Communications and Social Media Advisor; Andrew Nwosu, Operations Executive, Te Uru Whakamauora; Angela Rainham, Locality and Intersectoral Development Manager; Alison Russell, Planning and Integration Lead, Te Uru Kiriora; Lee Welch, Improvement Advisor, Quality and Innovation.

Media – 0; Public – 2

1. KARAKIA

The meeting opened with the organisational karakia.

2. ADMINISTRATIVE MATTERS

2.1. Apologies

An apology from Norman Gray was received and accepted.

2.2. Late items

There were no late items.

2.3. Register of Interests Update

The following updates to the Register of Interests were advised.

Oriana Paewai

Remove

- Chief Executive Officer, Rangitāne o Tamaki nui a Rua
- Coordinating Chair, Te Whiti ki te Uru
- Member, Governance Board, Te Ohu Auahi Mutunga (TOAM)
- Member, Before School Checks (B4SC) Collective
- Committee member, Nga Kaitiaki o Ngāti Kauwhata Inc
- Member, Project Alliance Board, Te Ahu a Turanga Manawatū-Tararua Highway
- Member, Pā Harakeke CAG
- Member, MDHB Māori Alliance Leadership Team (MALT)
- Member, UNISON
- Member, Alliance Leadership Steam (ALT), THINK Hauora

Add

- Member, Governance Board, Mana Whaikaha

Chiquita Hansen

Add

- Employed by THINK Hauora as Chief Executive and seconded to MDHB as Interim General Manager, Strategy, Planning and Performance 6/10ths
- Husband is employed by MDHB
- Executive member of General Practice New Zealand (GPNZ)
- Executive member of Health Care Home Collaborative

2.4. Minutes of the 16 February 2021 meeting, Part One

It was resolved that:

the Part One minutes of the 16 February 2021 Health and Disability Advisory Committee meeting be approved as a true and correct record.

(Moved John Waldon; seconded Muriel Hancock)

2.5. Matters arising from previous minutes

No discussion.

3. STRATEGIC FOCUS

Discussion to be held in Part Two of this meeting.

4. DIRECTORATE WITH CLUSTER FUNCTIONS REPORTING

4.1. Directorate Dashboard

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

Management offered to provide more detail in future reports about the challenges being faced by MidCentral DHB's (MDHB) workforce. The Health, Safety and Wellbeing reports presented to the Finance, Risk and Audit Committee (FRAC) and the Board already included the number of reported incidents of staff shortages.

The Operations Executive, Te Uru Arotau, explained the 'home warding' principles that would be used to improve acute medical inpatient flow.

4.2. Te Uru Whakamauora – Healthy Ageing and Rehabilitation

The Operations Executive and the Planning and Integration Lead, Te Uru Whakamauora presented this report, which was taken as read.

The Older People's Acute Assessment and Liaison Unit (OPAL) Community Services business case would be re-presented to the July Board meeting. Robust financial data needed to be gathered before the business case was presented to the Organisational Leadership Team (OLT) and FRAC.

The Executive Director, Allied Health noted that community Occupational Therapists (OT) used Ministry of Health guidelines to assess referrals. Non-urgent referrals had been reviewed and it was found that not everyone needed a complex assessment. The Operations Executive advised analysis was being carried out to see whether people on the community OT waiting list were presenting at the Emergency Department.

4.3. Te Uru Rauhī – Mental Health and Addiction Services

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

The Request for Proposal for the Horowhenua Community step up service was expected to be completed in May or June 2021. This iwi-led service was part of an overall model of care for an acute response that would support alternatives to ward admission if possible.

The Clinical Executive advised that the proportion of Māori engaged with or needing the Opioid Substitution Treatment service was relative to need in the community.

The Acting General Manager, Enable New Zealand, joined the meeting

4.4. Te Uru Arotau – Acute and Elective Specialist Services

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

Board members noted the increased levels of senior staff in the Emergency Department (ED) and acknowledged the successful recruitment effort. The Operations Executive explained there would now be two Senior Medical Officers (SMOs) in ED on weekend mornings, and that SMOs would work until 2am rather than midnight. Nurse Practitioners provided continuity and were able to support the Resident Medical Officer workforce.

In response to a question, it was confirmed that MidCentral DHB met quarantine costs for clinicians recruited from overseas.

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

The Operations Executive and the Planning and Integration Lead, Te Uru Kiriora presented this report, which was taken as read.

The Operations Executive advised that MDHB's COVID-19 vaccination programme was at 138 percent of target, and one-third of border workers had received their second dose of the vaccine.

A low number of women took up the cervical screening opportunity at the second Te Whara Tapa Whā Hauora Day held at the Poutu Marae in Shannon. A Committee member noted the numbers were not important, and that reaching any woman who had not previously been screened was a success. It was important to provide mobile services in the community.

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

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

Committee member, Vaughan Dennison, joined the meeting.

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

The Operations Executive and the Clinical Executive, Te Uru Pā Harakeke presented this report, which was taken as read.

The report on the Midwifery Review carried out by Emma Farmer (Director of Midwifery, Waitemata DHB) had been received and minor factual changes were required. The report would be presented to the Board when finalised.

Board members would receive an invitation to the official opening of the Milk Bank, being held on Wednesday 19 May.

Family violence intervention screening rates had improved over the last six months. Future reports will include data showing the baseline and progress made, including by ethnicity.

The base fee for providing ultrasound scans had risen slightly over the last 10 years. One provider had introduced a $40 surcharge to cover costs, and others were expected to introduce a surcharge from July. This was a national trend. It was noted that the surcharge was not applied to Community Services Card holders.

It was resolved that the Committee:

note the areas highlighted in the dashboard and associated commentary.

(Moved Karen Naylor; seconded Jenny Warren)

The Consumer Experience Manager and the Improvement Advisor, Quality and Innovation joined the meeting.

5. PERFORMANCE REPORTING

5.1. Enable New Zealand Report

The Acting General Manager, Enable New Zealand presented this report, which was taken as read. As Enable New Zealand carries out a lot of housing modifications, discussions had been held with architects and builders to understand the ongoing issues around potential shortages of building materials and labour.

It was resolved that the Committee:

endorse the Enable New Zealand Report to 31 March 2021.

(Moved Materoa Mar; seconded Muriel Hancock)

5.2. Pae Ora Paiaka Whaiora Report

The Operations Executive, Pae Ora Paiaka Whaiora presented this report, which was taken as read. The Pae Ora Team was at capacity, which reflected MDHB's commitment to an authentic Te Tiriti o Waitangi relationship.

It was resolved that the Committee:

note the progress update for the Pae Ora Paiaka Whaiora Directorate.

(Moved John Waldon; seconded Karen Naylor)

5.3. Quality and Safety Dashboard

The Consumer Experience Manager and the Improvement Advisor, Quality and Innovation presented this report, which was taken as read.

In accordance with MDHB's Variance Management Response Guidelines, incidents where harm has occurred or could have occurred should be reported. All incidents were reviewed by the service. As part of the risk review process, the Principal Risk Officer also reviewed all incident reports against risks. Workforce shortages and notifications were included in workforce reports to FRAC and the Board. All Serious Adverse Events were reviewed to see whether any workforce issues were a contributory factor.

A Committee member noted that Figure 4.2.1 'Total Incidents by Month' did not show whether the incidents related to a particular problem area or cluster. The General Manager, Quality and Innovation advised that any trends or 'hot spots' would be identified in the narrative of future reports.

It was resolved that the Committee:

note the content of the Quality and Safety Dashboard

endorse the improvement activities planned for the next quarter.

(Moved Karen Naylor; seconded Jenny Warren)

6. DISCUSSION/DECISION PAPERS

6.1. Regional Services Plan Implementation, Quarter Two 2020/21

The Director of Strategy presented this report, which was taken as read.

It was resolved that the Committee:

note the final draft Regional Services Plan for 2020/21 was submitted to the Ministry of Health in December 2020 and has not yet been formally approved by the Minister of Health

note the progress made on implementing the central region's national and regional priority programmes for the second quarter of 2020/21.

(Moved Muriel Hancock; seconded Vaughan Dennison)

6.2. Locality Health and Wellbeing Plans – Triennial Update

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

Some Committee members commented that the Palmerston North Safety Advisory Board (PNSAB) was not the best organisation to engage with. The Locality and Intersectoral Development Manager provided reassurance that PNSAB was not the only connection with the Palmerston North community.

The Chief Executive noted the recent announcement on the Government's response to the Health and Disability System Review included a focus on understanding the needs of local communities. MDHB was already well advanced with locality planning and this work should continue.

MDHB had asked iwi to develop their own health and wellbeing plans to highlight their wants and needs. MDHB would work with iwi and Pae Ora Paiaka Whaiora to ensure its locality plans complemented and built on the iwi goals. This approach meant that DHB boundaries were not imposed on iwi.

It was resolved that the Committee:

note the progress that has been made through the locality work over the last three years

note the points of interest in each locality

endorse the suggested future direction of the locality work.

(Moved Oriana Paewai; seconded Jenny Warren)

The Director of Strategy and the Locality and Intersectoral Development Manager left the meeting

6.3. Ka Ao, Ka Awatea – Annual Progress Report

The Operations Executive, Pae Ora Paiaka Whaiora presented this report, which was taken as read. He noted the Government's announcement in response to the Health and Disability System Review, which included the establishment of a Māori Health Authority. This meant that future planning for implementation of Ka Ao, Ka Awatea after 2022 may start earlier than planned.

It was resolved that the Committee:

note the report on forward implementation of Ka Ao, Ka Awatea Strategy Refresh 2020-22.

(Moved John Waldon; seconded Karen Naylor)

6.4. Māori Health Equity Dashboard – Adult Health Indicators

The Operations Executives from Te Uru Kiriora, Te Uru Arotau and Te Uru Mātai Matenga presented this report, which was taken as read.

A Committee member asked that all Māori Health Equity Dashboard reports be included in a folder on the Stellar platform.

It was resolved that the Committee:

note the equity position for each of the indicators

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

endorse the Te Ara Angitū report.

(Moved Vaughan Dennison; seconded Heather Browning)

7. INFORMATION PAPERS

7.1. Locality Plan Progress Report – Palmerston North

The report was taken as read.

It was resolved that the Committee:

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

(Moved Vaughan Dennison; seconded Materoa Mar)

7.2. Committee's Work Programme

The report was taken as read.

It was resolved that the Committee:

note the update on the Health and Disability Advisory Committee's work programme.

(Moved John Waldon; seconded Vaughan Dennison)

8. GLOSSARY OF TERMS

No discussion.

9. LATE ITEMS

There were no late items.

10. DATE OF NEXT MEETING

Tuesday, 13 July 2021 – Board Room, MidCentral District Health Board, Gate 2 Heretaunga Street, Palmerston North

Lew Findlay asked that his apology for the July meeting be recorded.

11. EXCLUSION OF PUBLIC

It was resolved:

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

Item	Reason	Ref
'In committee' minutes of the previous Health and Disability Advisory Committee meeting	For reasons set out in the agenda of the 16 February 2021 meeting held with the public present	
Health and Disability System Review	To maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and officials	9(2)(f)(iv)
Serious Adverse Events (SAC 1)	To protect patient privacy	9(2)(a)
Consumer Story – Workshop	To protect patient privacy	9(2)(a)

(Moved Vaughan Dennison; seconded Lew Findlay)

Part One of the meeting closed at 11.08am

Confirmed this 13th day of July 2021

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Committee Chair

Health and Disability Advisory Committee – MidCentral DHB

- Schedule of Matters Arising, 2020/21 as at 28 June 2021

Matter	Raised	Scheduled	Responsibility	Form	Status
Future reports on midwifery workforce to include more information around clinical risk and observations from the external advisor.	Feb 21	April 21 and ongoing	S Fenwick	Report	Scheduled
Strategic discussion on the national policy around primary care costs, availability and timeliness of appointments with GPs, and GP workforce recruitment issues	October 20	November 20 and ongoing	D Davies	Strategic discussion as required	Scheduled
COMPLETED					
Provide more detail on the increased Mental Health Client DNAs in next HDAC cluster report	Feb 21 – Board mtg	~~April 21~~ July 21	V Caldwell S Ambridge	Report	Scheduled
Invitation to Board members to attend official opening of the Milk Bank	April 21	May 21	S Fenwick	Meeting invitation	Completed
Check Performance Indicator data for 'Referrals declined due to capacity, Māori' in Te Uru Arotau cluster report.	Feb 21	April 21	L Horgan	Report	Completed
Recommend the Board consider holding a workshop with the THINK Hauora Board to determine further progress in primary health care.	Feb 21	April 21	M Bell	Agenda item	Completed – Board decision 23 February not to proceed
Slides on 'Te Tiriti o Waitangi Considerations for DHBs' referred to in letter from Minister of Health and Minister for COVID-19 response to be available to HDAC members	Feb 21	Feb 21	M Bell	Information on SharedNet	Completed
Report on Child Development Service Referral Integration Project to be loaded to SharedNet	Feb 21	Feb 21	M Bell	Information on SharedNet	Completed
When preparing next HDAC work programme, consider the level of focus on the disability strategy	Feb 20	~~April 20~~ ~~October 20~~ November 20	~~B Duffy~~ R Matthews	Report on 2021 work programme	Completed
Provide summary of the Kaupapa Māori contract mapping exercise regarding services to Board members	October 20	November 20	T Te Huia	Report	Completed
Health and Disability Commissioner (HDC) Breach Finding report to be put onto SharedNet site after it had been published on the HDC website	October 20	November 20	M Bell	Information on SharedNet	Completed
Update re Treaty of Waitangi Policy review process	Board July 19	October 20	T Te Huia	Report	Completed

Matter	Raised	Scheduled	Responsibility	Form	Status
Provide details of Community Allied Health and assistive technology wait lists and hospital length of stay	July 20	October 20	G Scott	Report	Completed
Provide update on timeframe for linear accelerators building (if information is available)	September 20	October 20	C Lucas	Report	Completed
Provide trend analysis on holiday levels above two years	Feb 20	July 20	K Anjaria	Report	Completed
Investigate why MDHB has second highest polypharmacy rates in NZ and review with similar sized DHBs	Mar 20	September 20	D Davies	In cluster report	Completed
KPI-19 – Business case on improving technology contact with clients	Mar 20	September 20	S Ambridge	Report	Completed
Consider how to include more key recommendations and trend based analysis of actions completed in future 'Potential and Actual Serious Adverse Event'	Mar 20	TBC	J Catherwood	Included in Potential and Actual Serious Adverse Event report	Completed
Cluster updates annual leave reporting – all reporting to be consistent with all percentages or all numbers reports	May 20	July 20	Cluster Execs	In cluster report	Completed
Record ethnicity data from Enable NZ in Māori dashboard.	May 20	September 20	~~J Brown~~ M Riwai	For discussion	Completed. Update September meeting; information not available
Feedback from Consumers re having a Choices contract to provide intensive wrap-around support	Oct 19	~~April 20~~ October 20	~~G Brogden~~ M Riwai	Report	Completed

Strategic focus

13 July 2021 HDAC

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For:

	Approval
X	Endorsement
	Noting

Key questions the Committee should consider in reviewing this paper and presentation:

- Are we delivering appropriate disability services to our population?
- Are we meeting the needs of the disability community?
- What improvements are still required?
- What additional disability information would the Committee like to receive?

To	Health and Disability Advisory Committee
Author	Gabrielle Scott, Executive Director, Allied Health Michelle Riwai, General Manager, Enable New Zealand
Endorsed by	Kathryn Cook, Chief Executive
Date	22 June 2021
Subject	**Disability Services Strategic Direction**

RECOMMENDATION

It is recommended that the Committee:

- **note** the presentation on the strategic direction for disability services
- **endorse** the direction of disability services.

Strategic Alignment

This report is aligned to DHB's Disability Strategy Implementation Plan. The focus is to drive an equity for our disabled population.

1. PURPOSE

To provide an update by way of a presentation on disability services at MidCentral DHB (MDHB) and explore the future direction of services under Enabling Good Lives principles and the system transformation, Mana Whaikaha. To seek the Committee's comments on how the changing disability landscape may affect the demand for MDHB's services and the outcomes needed to *'Live our best life'.*

2. BACKGROUND

The Committee last received an update on the progress against the Disability Strategy Implementation Road Map in July 2020. Updates from Enable New Zealand regarding the equipment modification services and Mana Whaikaha are presented to each meeting.

Disability services are funded by three main providers:

- Ministry of Health's (the Ministry) Disability Directorate for consumers aged under 65 years
- DHB devolved funding through the Crown Funding Agreement for those aged over 65 years
- ACC by agreed contracts.

MDHB's Disability Implementation Plan (link) and Road Map (link) share some aspects of national expectations. It reflects MDHB's community and what is currently being delivered within the disability support system transformation. The road map plan has priorities aligned with both the New Zealand Disability Strategy Framework of Outcomes and the Enabling Good Lives principles. It has a five-year view of proposed initiatives, which after year three proposes further consultation with the disability community to evaluate progress and seek further initiatives to implement.

Over the past three years, the MDHB district has been engaged in a disability system transformation pilot which the Ministry is leading. This has been an exciting innovation for the population which has been based on co-design with the disabled community with the Enabling Good Lives principles at its foundation.

3. FUTURE DIRECTION

The Health and Disability System Review was not well received by the disabled community, who felt their efforts for recognition and to have equitable access to all services to live their best lives went unrecognised. Recent communication from the Minister of Health

has noted that the disabled community has identified questions that need answering. He advised the Government has requested further advice, with a decision on the disability sector now expected in September 2021.

The Minister of Health has acknowledged that the disability sector has been underserviced and there is a desire to improve outcomes. It remains unclear what disability services will look like in the future.

The presentation will reflect on the current system deliverables and explore opportunities for service integration to meet the population needs, by Government sectors working together with DHB services.

Disability Sector Overview

"New Zealand is a non-disabling society – a place where disabled people have an equal opportunity to achieve their goals and aspirations, and all of New Zealand works together to make this happen."

NZ Disability Strategy vision

Michelle Riwai and Gabrielle Scott 13 July 2021

Our Horizon


Demographic Shift
People are living longer
More disabilities becoming recognised
Communities becoming increasingly diverse
Increasing complexity and levels of disability needs
Sector Changes
Increasing pressure on health budgets and resources
High administrative workloads on clinical staff
Growing demand for services
Low visability of disability
Responsibilities for disability support divided across the health system
Poorer health outcomes for Māori, Pacific peoples and those with disabilities
Changing Expectations
People preferring to live at home longer
Changing expectations of people toward healthcare systems designed to their needs
Increasing expectations from communities and providers for digital services
Better and more timely access to personalised services
Emerging Trends
More care delivered at home or in community settings
Multidisciplinary and shared care models
Adoption of telehealth and other remote consultations
Remote monitoring of patients and collection of health & lifestyle data on personal devices
Small scale pilots of holistic service delivery models

Disability Funding

District Health Boards

- >65 NASC
- Contracted HCSS Providers

Ministry of Education

- Learning support services

Ministry of Social Development

- Disability allowance
- Social housing allocation
- Income support
- Employment support

Ministry of Health

- <65 NASC
- Mana Whaikaha
- Child Development Services
- Contracted HCSS Providers
- Long term equipment
- Modifications
- Hearing and spectacles subsidies

Oranga Tamariki

- Funding for disabled children in care

ACC

- Accident related injuries

Funding Eligibility

Services

- Based on diagnosis not ‘need’ e.g. physical, intellectual, sensory or combination
- Impairment must last longer than 6 months

Equipment

- Tightly managed with additional eligibility rules
- Prescriptive solutions

Disability at MDHB

Road Map, implemented in December 2019, has three parts:

- National and Local Influences – NZ Disability Strategy, disability transformation and now the HDSR
- Workforce Development - Employer responsibilities as a large employer, grow knowledge of the workforce
- Intersectoral Liaison – We share the same community

- Focused on improving awareness and responsiveness
- Improve equity of access and health outcomes

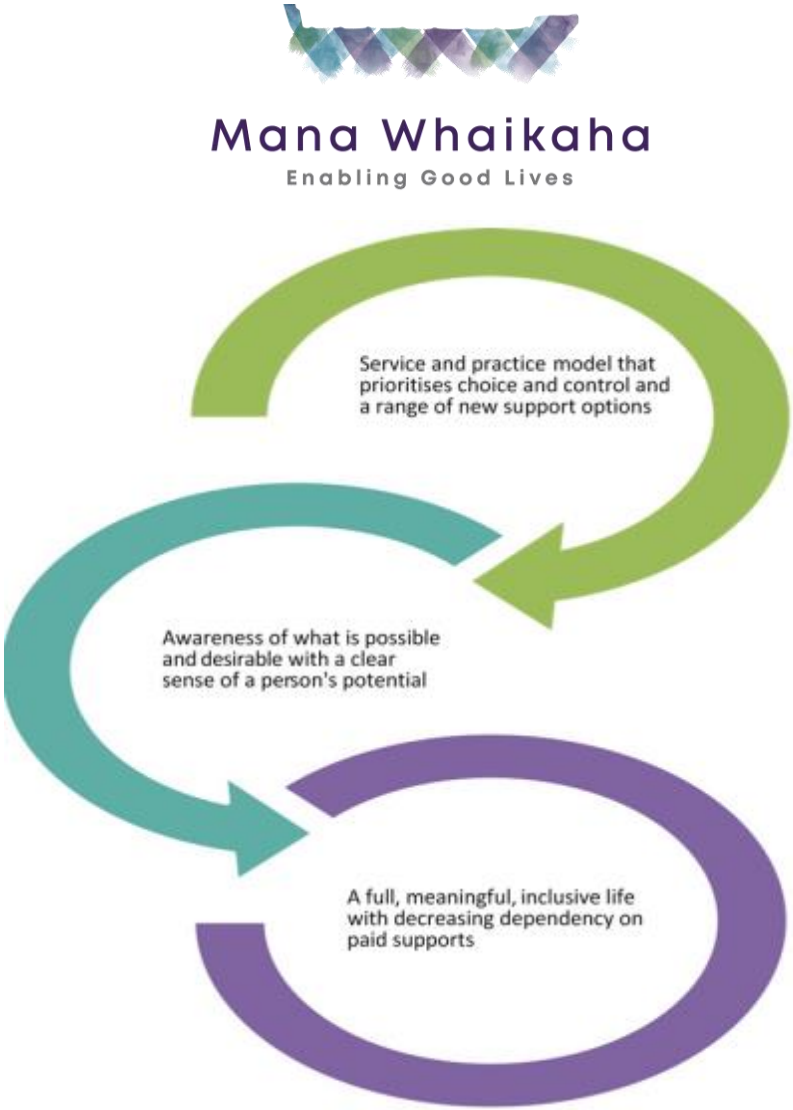
EGL Principles

Enabling Good Lives (EGL)	
Self-determination	Disabled people are in control of their lives
Beginning Early	Invest early in families and whānau to support them; to build community and natural supports; and to support disabled children to become independent
Person-Centred	Disabled people have supports that are tailored to their individual needs and goals, and that taking a whole life approach
Ordinary Life Outcomes	Disabled people are supported to live an everyday life in everyday places; and are regarded as citizens with opportunities for learning, employment etc - like others at similar stages of life
Mainstream First	Disabled people are supported to access mainstream services before specialist disability services
Mana Enhancing	The abilities and contributions of disabled people and their families are recognised and respected
Easy to Use	Disabled people have supports that are simple to use and flexible
Relationship Building	Supports build and strengthen relationships between disabled people and their whānau and community

Mana Whaikaha

Aims to:

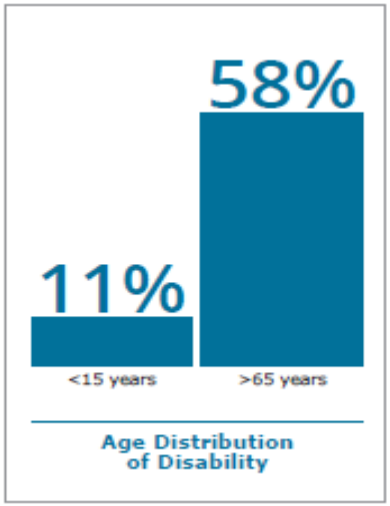
- Provide disabled people and whānau with more flexible support options
- Give disabled people and whānau greater decision making over their support and lives
- Improve outcomes for disabled people and whānau
- Create a cost-effective disability support system

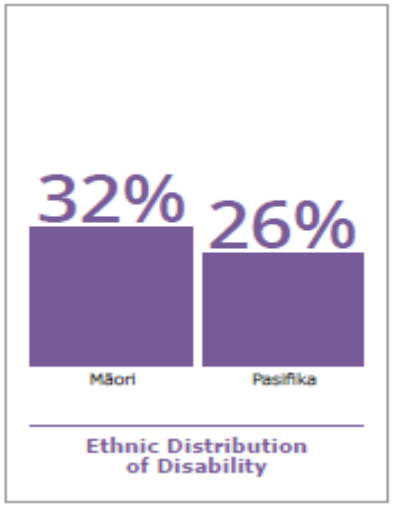


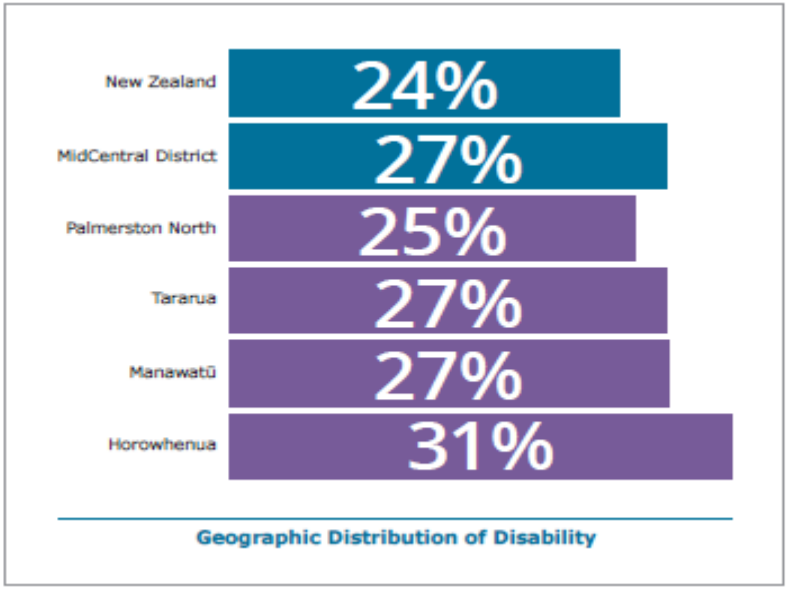
Demographics

Census data 2013
Self reported

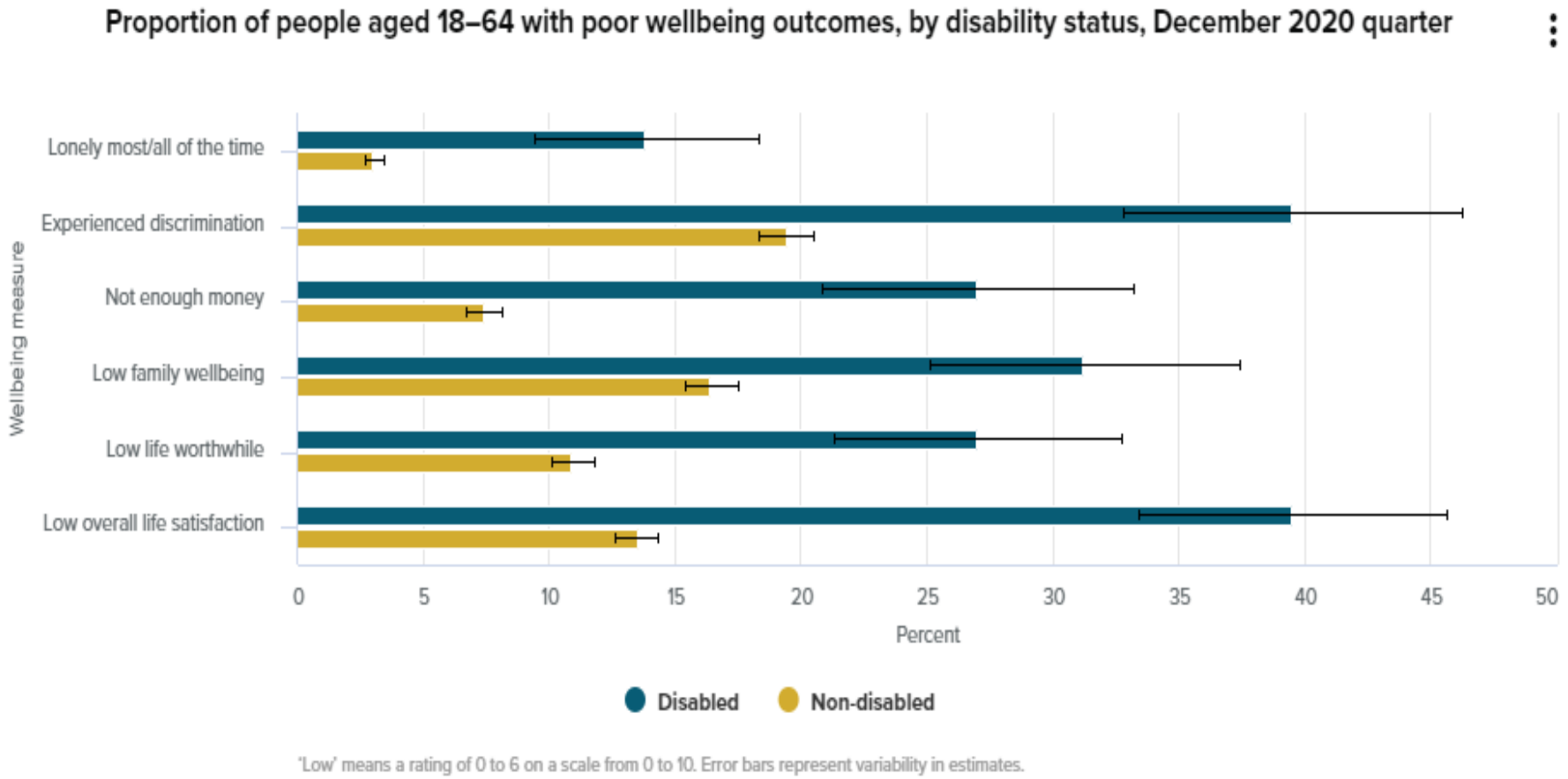
Disability is described in many ways:
Age-related vs genetic, acquired at birth, result of an accident or a progressive condition







Worse health outcomes



Supported Living Payments MDHB

Table 5: Incapacity type for recipients of the Supported Living Payment (% share of New Zealand)

	Horizons South-East region	Dec 14	Dec 15	Dec 16	Dec 17	Dec 18	Dec 19	Dec 20
Sub-category	Health Condition or Disability	5.3%	5.3%	5.3%	5.4%	5.5%	5.5%	5.5%
	Supported Living - Caring	3.9%	3.8%	4.1%	4.2%	4.4%	4.4%	4.5%
Total	**Total Supported Living Payment**	**5.1%**	**5.1%**	**5.2%**	**5.3%**	**5.4%**	**5.4%**	**5.4%**
Incapacity for health condition or disability	Psychological or psychiatric conditions	5.3%	5.4%	5.4%	5.5%	5.5%	5.5%	5.4%
	Intellectual disability	5.6%	5.6%	5.7%	5.6%	5.6%	5.6%	5.6%
	Musculo-skeletal system disorders	5.7%	5.6%	5.6%	6.2%	6.2%	6.4%	6.3%
	Nervous system disorders	4.9%	4.8%	5.0%	5.1%	5.3%	5.2%	5.0%
	Cardio-vascular disorders	5.0%	5.1%	5.1%	5.0%	4.9%	5.0%	5.2%
	Accidents	7.0%	7.2%	6.7%	7.2%	7.2%	7.1%	7.6%
	Cancer and congenital conditions	4.7%	4.4%	4.6%	4.9%	5.1%	5.2%	5.2%
	Other disorders and conditions	4.8%	4.8%	4.7%	4.9%	4.9%	5.0%	5.1%
Population share for 15 - 64 year olds		3.5%	3.5%	3.4%	3.4%	3.4%	3.4%	3.3%

Source: Ministry of Social Development

2018 Census disability questions

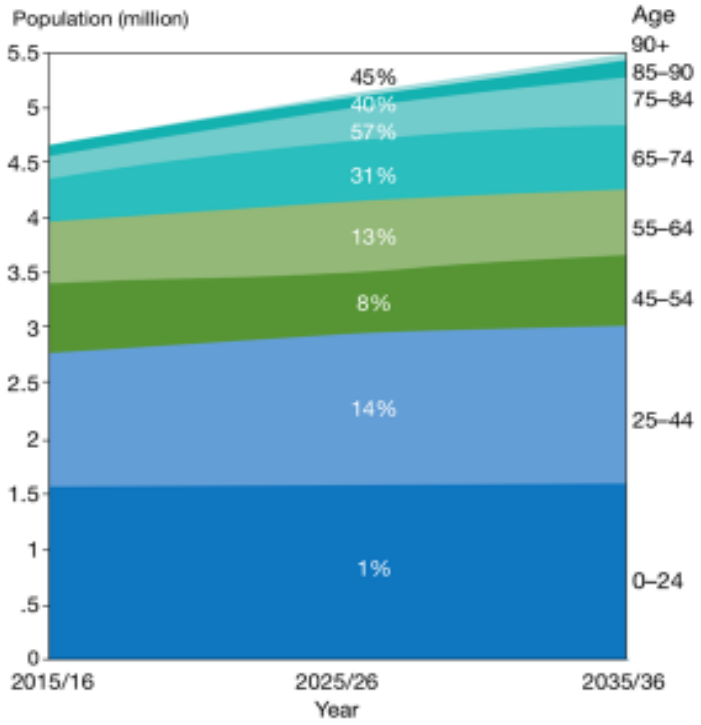
Table 6: Disabilities for the population aged 5 years and older (% of population reporting at least some difficulty)

	Age group	5-15 years	15-64 years	65 years and over	Total
Difficulty communicating using your usual language for example being understood by others	MidCentral	5.7	5.1	10.1	6.2
	New Zealand	4.9	4.3	9.5	5.4
Difficulty hearing even if using a hearing aid	MidCentral	3.9	12.5	39.5	18.8
	New Zealand	3.4	9.8	36.6	15.2
Difficulty remembering or concentrating	MidCentral	10.2	17.3	34.4	21.3
	New Zealand	9.1	13.9	32.9	17.8
Difficulty seeing even if wearing glasses	MidCentral	7.4	20.2	33.6	23.3
	New Zealand	5.8	16.9	30.6	19.7
Difficulty walking or climbing steps	MidCentral	1.9	11.1	44.7	18.9
	New Zealand	1.6	8.9	41.4	15.4
Difficulty washing all over or dressing	MidCentral	3.0	3.6	16.4	6.6
	New Zealand	2.6	2.7	14.7	5.2

Source: Statistics New Zealand

Ageing Population

Figure 2: Population projections by age group with 10 year percent change



Source: Statistics New Zealand, 2016

Consequences:

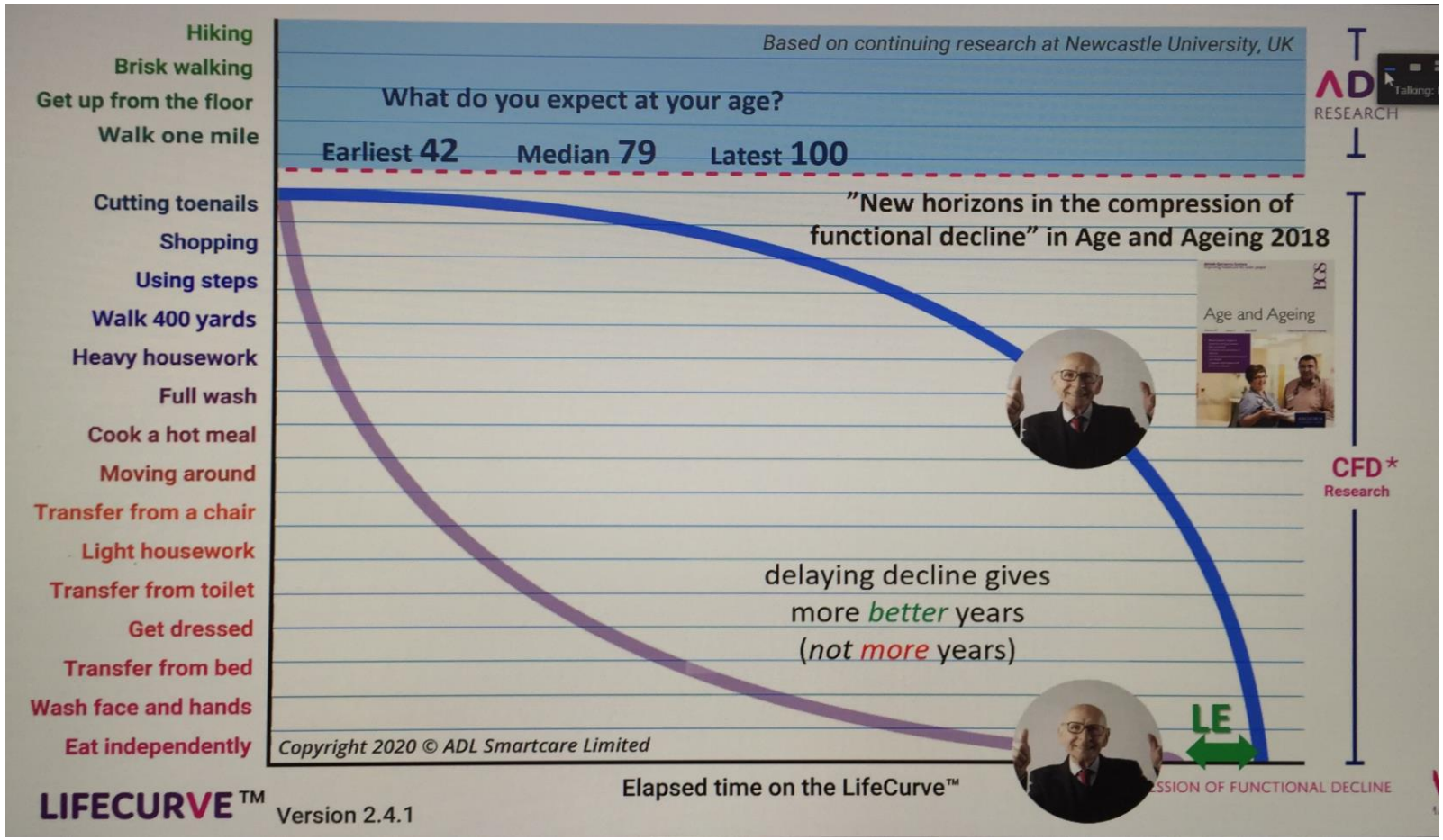
- ↑ prevalence of chronic disease
- ↑ rates of CVD
- ↑ rates of fracture (hip)
- ↑ rates of disability
- for patients, family/whanau
- for the state

Impact of an ageing population

Action:

the system must prepare for the future by building self-management and wellness approaches into everyday conversations

Lifecurve findings



Key Priorities

- Establish responsive equitable services
- Listen to and include disabled people
- Engage early to reduce age-related disability impacts
- Enable choice and control in all interactions
- Equity of access for all
- Develop cross sector relationships to reduce gaps and duplication, not just a health response

Future direction

- HDSR decision on disability due September
- Disability System Transformation embedded
- Respond to Wai 2575 recommendations
- Increasing demand for services
  - Matching workforce to demand
  - Delivering services where they are needed and to whom needs them the most

Future direction cont.

- Agency integration and partnering to reduce barriers to access
- Role of Whānau Ora to facilitate and support access to services
- Focus on enablement
  - Habilitation and wellness models of care
  - Promote wellness
  - Accessibility Charter
  - Lifecurve investment

Questions

Directorate with cluster functions reporting

13 July 2021 HDAC

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

For:

	Approval
	Endorsement
X	Noting

To	Health and Disability Advisory Committee
Author	Andrew Nwosu, Te Uru Whakamauora, Healthy Ageing and Rehabilitation Directorate
Endorsed by	Kathryn Cook, Chief Executive
Date	30 June 2021
Subject	**Directorate Dashboard**

Key questions the Committee should consider in reviewing this paper:

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

RECOMMENDATION

It is recommended that the Committee:

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

Strategic Alignment

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

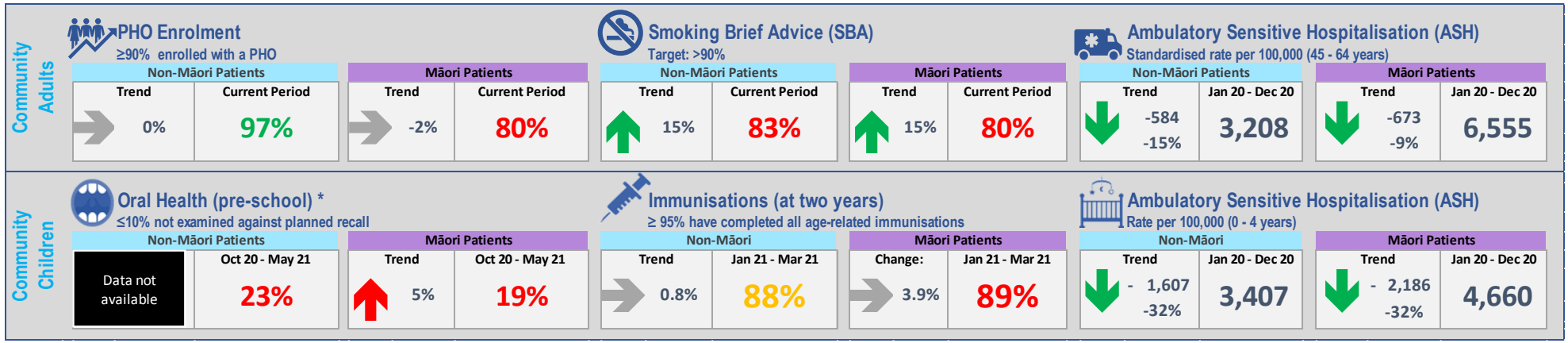
1. PURPOSE

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

2. COMBINED DIRECTORATE VIEW

The metrics follow the same format as outlined in the February 2021 Board Key Performance Indicators (KPI) dashboard and cover the period from 1 July 2020 to 31 May 2021 ('Current Period') unless specified differently within a particular metric. The directorate dashboard is in development and shows placeholders for future performance measures that will be included.

2.1 Primary and Community



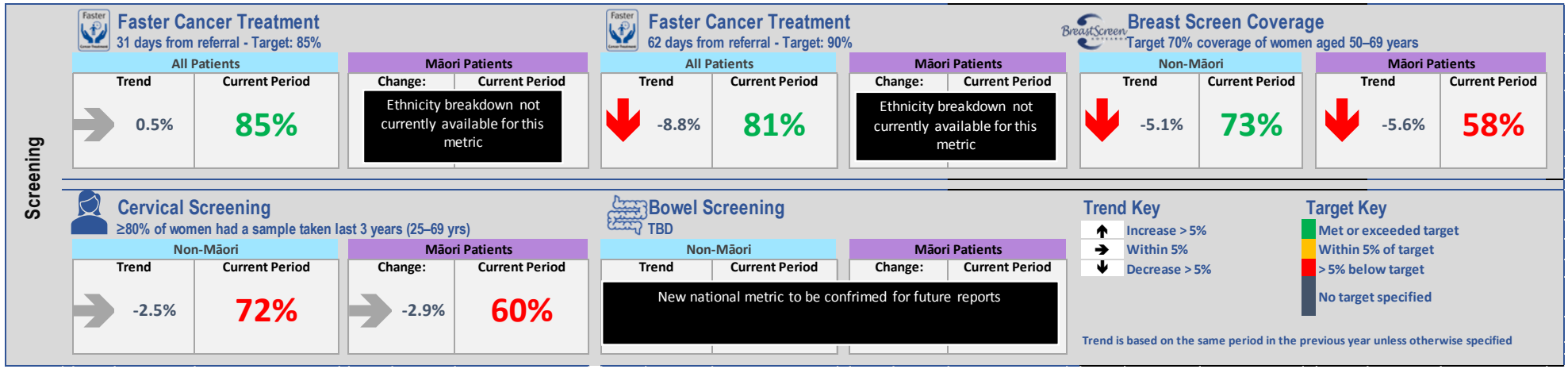
Data not available: Oral Health Preschool data for Non–Māori is requested externally; work is underway to ensure that data gaps are addressed.

Fluctuations in the figures for the Child and Adolescent Oral Health (CAOH) Service are normal given schools being attended at any given time. Over this six-month period, the arrears have increased by five percent for Māori 0-4 year olds. Some success in reducing inequity has been achieved in keeping these arrears lower that the overall 0-4 year old population (19 percent versus 23 percent). For 2021, the CAOH Service has seen significant issues with injuries, elective surgery and retirements causing a 20 percent reduction in the therapist workforce. Arrears for the whole service (<18 years old, >31,000 enrolled tamariki) stay relatively steady. The post COVID-19 lockdown recovery has been hindered by staffing levels. MDHB is only now at the anniversary of getting all our staff and vehicles back from the lockdown, which is when a more noticeable downward trend was expected. Funding approval has been granted to enable the driveable mobile dental clinic to become independent with its own

generator and water system. This will create greater access to places where power and water have been an issue, such as a Kōhanga Reo who have approached us to deliver a service on site.

There has been a significant improvement in Ambulatory Sensitive Hospitalisation (ASH) rates for children aged zero to four years. This should be viewed with caution as the reduced presentations and admissions during the COVID-19 pandemic are included in this reporting period.

2.2 Screening



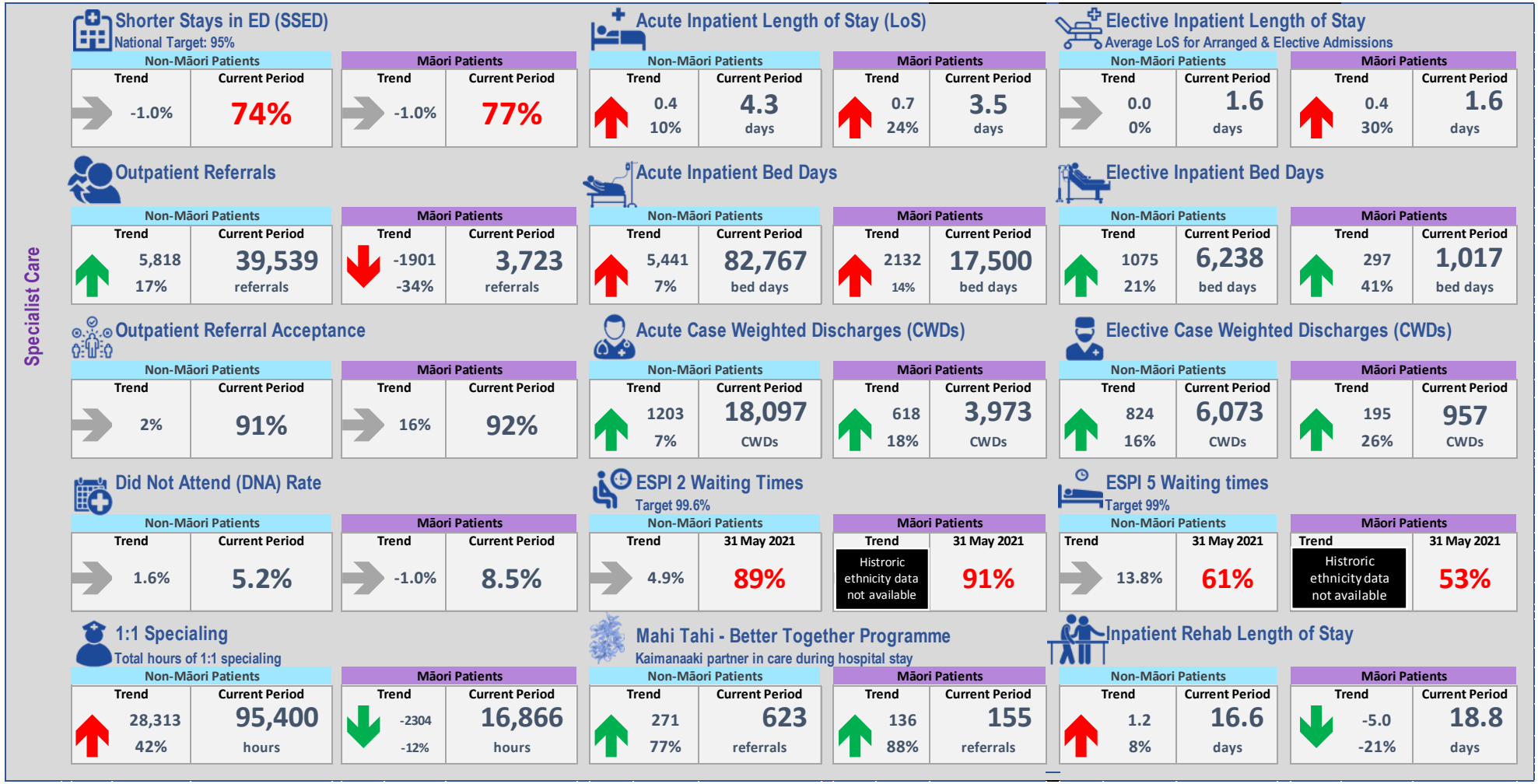
Ethnicity Breakdown: Ethnocentric data is requested externally and followed up regularly however there is no timeline for when this will be available.

National Metric: The National Metric for bowel screening is yet to be confirmed.

The Faster Cancer Treatment (FCT) performance measures are reported nationally. MDHB continues to meet the 31-day target, however there has been a breach in the 62-day target for this reporting period. There was a 55 percent reduction in the number of high suspicions of cancer cases identified in this reporting period, in comparison with the previous reporting period. The small numbers evidence a large percentage reduction in performance. The Tumour Stream Governance meetings undertake a review of timelines from referral to treatment for all patients who breach the FCT targets.

BreastScreen Coast to Coast continues to meet screening volume target requirements. However, the target for priority wāhine Māori remains low, despite incentive programmes. The mobile unit is currently completing its visit to the Tararua area and recruitment activities for priority women remains the primary focus in this area.

2.3 *Specialist Care*



Elective Services Patient Flow Indicators – there has been a system change to enable future data capture.

The Shorter Stays in Emergency Departments (SSIED) remains below target. High acuity and complexity of patient presentations is noted, with road trauma presentations continuing above the average of 33; with 54 in March and 38 in April.

The hospital experienced peaks of high demand throughout April and May, with occupancy rates some days at over 100 percent. The Transitory Care Unit (TCU) is flexible in function in response to demand. Transferring surgical patients direct from the Emergency Department (ED) to the Day of Surgery Admissions unit occurs when the hospital is at capacity.

The Directorates are progressing work across the system to improve the acute flow of patients from front of house to discharge.

- Interface geriatricians work with ED to actively identify patients for direct admission to the Older People's Acute Assessment and Liaison Unit (OPAL). To support this, ED nursing staff screen for frailty which can expedite the admission process.

- Te Uru Arotau met with the Clinical Council in May to discuss acute demand and some of the plans in place. The Clinical Council were very supportive of the approach and acknowledged that all DHBs are under significant acute pressure.

- Te Uru Pā Harakeke is progressing the relocation and extension of hours for the Gynaecology Assessment Unit later in 2021. This will allow for implementation of gynaecology holding orders and improved flow from the ED. A suitable location for the antenatal clinic is required to enable the relocation to occur.

There has been good improvement Elective Services Performance Indicator (ESPI) 2 at the end of May 2021. There has been no change to ESPI 5 at the end of May 2021. Deferment of planned care surgery due to acute demand continues to impact the recovery of ESPI 5. All DHBs have submitted revised ESPI 2 and ESPI 5 waiting list improvement trajectories for 2021/2022 to the Ministry of Health.

The Services Not Engaged (SNE) rate for whānau Māori continues to be higher at nine percent when compared with non-Māori at 3.2 percent. There are several initiatives in place or underway to support services to better engage with whānau Māori. These include patient focused bookings, text reminders, utilising non-contact advice for general practitioners and individuals, clinics in the community.

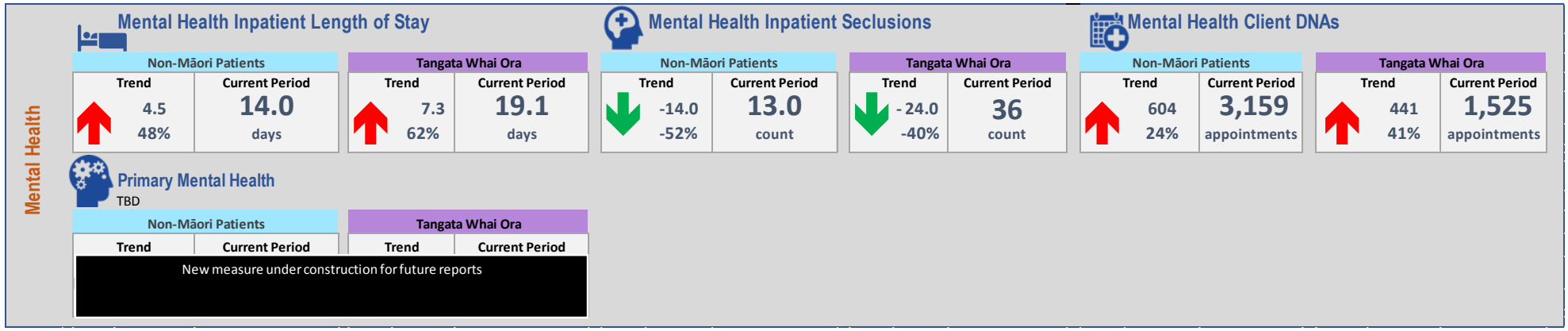
The Whānau Equity Facilitator has commenced working in partnership with Diabetes and Endocrinology and Maternity Services. The initial focus is on early engagement and communication with services and hapu wāhine Māori who attend the diabetic antenatal clinic.

The Telehealth Working Group has partnered with the Rheumatology Team to test and pilot new processes. The first telehealth appointment between the Clinical Nurse Specialist and a consumer occurred in June 2021. The feedback received from the consumer and staff has been positive and has identified areas for refinement. The consumer would normally be required to travel from Ōtaki to Palmerston North Hospital for their appointment, using a shuttle service. The consumer has provided feedback that they would be happy to switch any regular or routine face-to-face appointments to be undertaken by telehealth.

Specialing across Te Uru Whakamauora is above agreed target for April and May. There is a gradual decline in the need for specialing for Older Adult Mental Health inpatients as patients become more stable. The need for specialing within the rehabilitation unit fluctuates and is dependent on the number of patients with acute delirium/dementia. In the OPAL Unit increased demand was attributable to complex patients requiring additional input. A proportion of these hours have been recharged.

In reference to Inpatient Rehabilitation Length of Stay, Non-Māori length of stay was impacted by an increase in acuity across all diagnoses with a higher than normal number of younger people with dense strokes and functional neurological disorders.

2.4 Mental Health



The Mental Health inpatient length of stay is 14.0 days for non-Māori and 19.1 days for Tangata Whai Ora. The length of stay is being impacted by six service users who have a length of stay greater than 50 days (four of whom are Māori). Te Uru Rauhī is currently working with an existing provider to develop a sub-acute/extended care service for this cohort of service users who are no longer acutely unwell but require an extended pathway of rehabilitation and recovery.

Ward 21 bed day usage decreased slightly to 127 percent in May 2021. This trend of high bed usage is placing a substantial strain on existing resources and is impacting on staff wellbeing (such as the use of double overtime shifts). Given that underlying demand will remain above current resourcing, a safe staffing proposal has been submitted to ensure the ward is able to safely provide resources up to 28 beds. This proposal has been accepted and is included in the 2021/2022 budget.

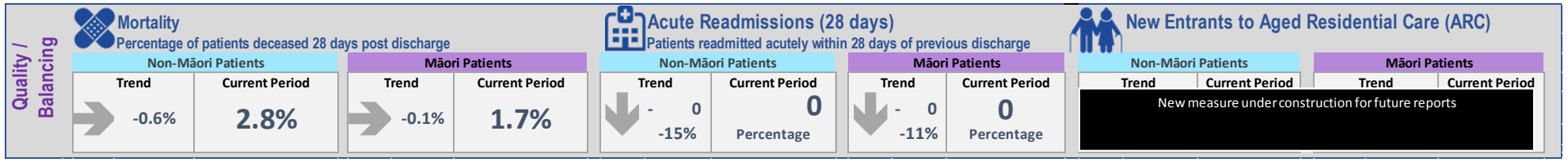
The number of inpatient seclusions for the year to date is 13 for non-Māori and 36 for Tangata Whai Ora. This is a reduction between 40 and 50 percent compared with this time last year. The reduction is the result of the high levels of accountability and ownership from the ward staff, underpinned by a robust programme of continuous review and improvement.

The number of activities recorded against Did Not Attend (DNA) have remained steady in the month. DNAs will be followed up by each team manager to better understand the barriers to keeping appointments. As part of the proposed model of care changes, Te Uru Ruahī will be exploring options to increasing appointments in the weekend and evenings.

The number of people accessing Primary Mental Health (Te Ara Rau) service who identify as Māori sits above the target of 20 percent. The programme was developed and implemented in partnership with the DHB, THINK Hauora and the WAIORA Roopu.

Included are eleven Kaiwhakapuaki Waiora (Health Coaches) roles located within iwi to ensure an overt focus on increasing access for tāngata whaiora and whānau.

2.5 Quality/Balancing



The readmission rate for Māori YTD is 9.4 percent and non-Māori YTD is 9.6 percent, which is a reduction compared to the previous report period ending February 2021. Readmissions continue to be monitored monthly to review potential trends or opportunities for improvement. Where possible, patients are assigned to the previous admissions team. This assists in ensuring consistency for review and highlights any significant issues with the readmission for the patient.

2.6 Workforce

Sick leave rates are stable, with continued emphasis on staff not coming to work if they have any cold or flu symptoms, even if mild.

Annual leave balances greater than two years have increased year to date above the target of nine percent. Individual leave plans are actively managed. Vacancies and shortages across directorates will impact on their ability to reduce the overall annual leave balance for greater than two years.

APPENDIX A: SUMMARY OF THE SIX HEALTH AND DISABILITY SERVICE DIRECTORATES

A SUMMARY OF THE SIX HEALTH AND DISABILITY SERVICE DIRECTORATES		
Te Uru Arotau **Acute and Elective Specialist Services**	**Te Uru Kiriora** **Primary, Public and Community Health**	**Te Uru Mātai Matengau** **Cancer Screening, Treatment & Support**
Te Uru Arotau is responsible for the planning, funding, commissioning and provision of secondary care (hospital level) services: • Medical services and subspecialties • Surgical services and subspecialties • Anaesthetics and Intensive Care Unit • Medical/Surgical inpatient wards • Medical Imaging and Hospital Pharmacy • Emergency services.	Te Uru Kiriora is responsible for the planning, funding, commissioning, and provision of: • Primary and community-based services via a range of contracted partners • Public health services spanning health promotion, protection, regulation, and clinical care delivery • Specialist Sexual Health services • Child and adolescent dental services • Community based nursing services including District and Primary Health Care nursing.	Te Uru Mātai Matengau is responsible for the planning, funding, commissioning, and provision of: • Prevention and early detection (screening) programmes • Cancer diagnostic and treatment services • Cancer support services • Palliative care services • Non-malignant haematology services • Regional services for treatment and screening.
Te Uru Pā Harakeke **Healthy Women Children and Youth**	**Te Uru Rauhī** **Mental Health and Addictions**	**Te Uru Whakamauora** **Healthy Ageing and Rehabilitation**
Te Uru Pā Harakeke is responsible for the planning, funding, commissioning and provision of: • Primary and secondary maternity care • Secondary Obstetrics and Gynaecology services including antenatal day unit, inpatients, outpatient clinics, community midwifery services and lactation services • Family centred inpatient, outpatient and community care for neonates (including neonatal intensive care), children (including high dependency care) and young people – up to their 16th birthday as inpatients and until end of school for ongoing ambulatory care • The commissioning of appropriate services to help improve the local population's health needs with a particular focus on the first 1,000 days and youth oriented care.	Te Uru Rauhī is responsible for the planning, funding, commissioning and provision of: • General adult mental health in community • Primary Mental Health and Addictions • Mental Health Acute Inpatient services • Eating disorders • Maternal Mental Health • Community Rehabilitation • Child Adolescent and Family • Alcohol and Other Drug Specialist Services • Māori Mental Health • Older Adult Mental Health Services • 24 hour Mental Health Acute Care Team.	Te Uru Whakamauora is responsible for the planning, funding, commissioning and provision of specialist services for people over the age of 65 years (55 years for Māori) and those between the ages of 16 and 64 with a physical disability, with a focus on assessment, treatment and rehabilitation. Services are structured into: • ElderHealth • Rehabilitation • Therapy Services • Supportlinks.

APPENDIX B: DIRECTORATE VIEW METRIC DEFINITIONS

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

Shorter Stays in ED (SSIED)	MoH definition – patients discharged from the ED within six hours of arrival in the department.	Excluding Mental Health
Acute Inpatient Length of Stay (ALOS)	The ALOS for acutely admitted patients discharged during the reporting period with an admission type of (AC).	Excluding Mental Health
Elective Inpatient Length of Stay	The ALOS for elective admitted patients discharged during the reporting period with an admission type of (WN).	
Outpatient Referrals	Number of outpatient referrals received.	Excluding where MoH reported = Not required/null/blank
Acute Inpatient Bed Days	Total number of acute inpatient bed days.	
Elective Inpatient Bed Days	Total number of elective inpatient bed days.	
Outpatient Referral Acceptance Rate	Number of outpatient referrals received that were accepted.	Excluding where MoH reported = Not required/null/blank
Acute Case Weighted Discharges (CWDs)	The case weight derived from eligible coded planned care acute inpatient discharges.	
Elective Case Weighted Discharges (CWDs)	The case weight derived from eligible coded planned care elective inpatient discharges.	
Did Not Attend (DNA) Rate	Patients who did not attend their booked outpatient appointment.	Last YTD under the Non-Māori column is actually all patients as ethnicity was not pulled back with snapshots at that point
ESPI 2 Waiting Times	As per the MoH definition used in the non-financial metrics.	Last YTD under the Non-Māori column is actually all patients as ethnicity was not pulled back with snapshots at that point
ESPI 5 Waiting times	As per the MoH definition used in the non-financial metrics.	
1:1 Specialing		
Mahi Tahi – Better Together Programme	Count of referrals to Mahi Tahi programme.	
Inpatient Rehab Length of Stay	The average length of stay for elective admitted patients discharged during the reporting period with all admission types and Specialities D01 & D41.	
Mental Health Inpatient Length of Stay	The ALOS for mental health admitted patients discharged during the reporting period.	
Mental Health Inpatient Seclusion rate	The number of seclusion events in the reporting.	
Mental Health Client DNAs	The number of unattended booked appointments.	
Primary Mental Health		

Mortality	Number of patients deceased 28 days post discharge.	
Acute Readmissions (28 days)	Percentage of patients who were acute readmissions within 28 days of previous discharge.	Acute Readmission Rate KPI – one-month lag due to late coding.
Staff Sick Leave Rate	Staff sick Leave hours as a percentage of staff paid hours.	
Staff Annual Leave >2 Years	Percentage of employees with an Annual Leave balance in excess of two years' worth of their current annual entitlement.	
Staff Turnover Rate	A rate-based measure of staff turnover within the DHB.	

SERVICE	Te Uru Mātai Matengau – Cancer Screening, Treatment and Support
FOR PERIOD	April/May 2021
PREPARED BY	Sarah Fenwick, Operations Executive Dr Claire Hardie, Clinical Executive

1. PERFORMANCE OVERVIEW

The following table provides a summary of the progress to date against the equity outcome, sustainability and other actions in the 2020/21 Annual Plan. Te Uru Mātai Matengau is generally on track, with those actions behind plan discussed in the section below.

	Initiative	**Rating & Trend**	
A-E	Establish and embed an Equity Governance framework	G	•
A-E	Implemented whānau centred care guidelines within tumour streams	G	•
A-E	Establish a Māori Cancer research strategy	A	•
A-E	Achieve equity for screening programmes	A	•
A-E	Review pathways for populations at high risk of cancer	G	•
A-E	Increase referrals to Iwi Cancer Co-ordinators	G	•
A-E	Implement Cancer Prevention / Early Detection Governance framework	G	•
A-S	Accelerate Telehealth for Outpatient Consulting	G	•
A-S	Deliver year two initiatives of the Blood Stewardship programme	G	•
A	Refresh Health and Wellbeing Plan in line with National Cancer Action Plan	G	•
A	Develop a cancer workforce strategy	A	•
A	Deliver to tumour stream work plans	G	•

A	Commission Linac replacements in Palmerston North	G	•
A	Continue projects for Outreach Radiation Treatment	A	•
A	Minimise breaches of the 31-day and 62-day Faster Cancer Treatment waiting times	A	•
A	Commission outreach chemotherapy at Whanganui Hospital	G	•
A	Complete detailed design for a new Cancer Centre by June 2021	A	•
A	Refresh Te Korowai O Rongo, the district Palliative Care Strategic Plan	A	•
A	Deliver year one of the Regional Cancer Treatment Service Plan 2020-2025	G	•

Rating & Trend Legend

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

Plan Legend	A	Annual Plan	S	Sustainability Plan	E	Equity Indicator	

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

A Māori Cancer Research Strategy has been developed that focuses on equity, early detection, prevention and those not engaged in primary care. The document is currently in draft with Pae Ora Paiaka Whaiora Hauora Māori, who are providing guidance and oversight in the approvals process.

Achieving equity continues to be a significant priority for Te Uru Matai Mātengau, with a strong focus in all screening programmes on increasing uptake of screening in priority populations. A health promotion role for bowel screening is in development to support an improvement in Māori participation rates. For breast screening, data is now available to enable the identification of unenrolled wāhine Māori in each primary care practice. A strategy to invite these wāhine to participate has been undertaken with the regional equity coordinator fully engaged.

The Radiation Oncology Workforce Strategy was completed in 2020 as part of the planning for regional linear accelerators. A Regional Cancer Nursing Strategy has been initiated through Te Uru Mātai Matengau's Regional Alliance Group. An initial meeting of the Associate Directors of Nursing for Cancer in Taranaki, Hawke's Bay and MidCentral DHBs occurred in May 2021, at which time a vision and structure for this piece of work was established. The group met again on 24 June 2021.

MidCentral District Health Board (MDHB) continues to work with both Taranaki and Hawke's Bay DHBs in preparing and supporting their business cases for the required facilities builds as part of the regional linear accelerator project.

The project to develop a detailed design for a Cancer Centre remains on hold and is awaiting instruction to proceed. Work to refresh Te Korowai O Rongo, the District Palliative Care Strategic Plan, was put on hold due to staff absence. This has now recommenced.

2. SIGNIFICANT MATTERS

2.1. Linear Accelerator Breakdown

One of the linear accelerators within the Regional Cancer Treatment Service (RCTS) experienced a major failure on 28 May 2021. The RCTS business continuity plan for linear accelerator breakdowns was activated, including patient and staff welfare, contingency and communications planning.

It was identified that an urgent replacement of the linear accelerator was required. The Ministry of Health (the Ministry) were in support of progressing with replacement and drafted a briefing to the Minister of Health recommending that previously agreed Government funding for the linear accelerators for the Hawke's Bay or Taranaki DHBs be brought forward to replace MDHB's linear accelerator under urgency. A paper recommending replacement was provided to the conjoint Board and Finance, Risk and Audit Committee meeting on Tuesday 15 June 2021. Approval was agreed and the linear accelerator has now been ordered.

The lead time for a new linear accelerator is a minimum of 14 weeks from the order date and therefore it is likely that patients will be treated on the new machine in October 2021. The machine is expected to arrive on site in August 2021.

Extended hours on the existing linear accelerators are being utilised to ensure patients get required treatment in a timely manner.

2.2. Radiation Oncology

The current Senior Medical Officer workforce is working at reduced capacity due to delays in arrival dates of new radiation oncologists who were recruited earlier this year. This is being managed proactively and is not currently impacting on wait times for patients.

2.3. Outpatient Clinic Amalgamation

The amalgamation of the outpatient clinics for Radiation Oncology, Medical Oncology and Clinical Haematology is nearing completion. All nine clinics are now in operation and minor building work is expected to be completed by 30 June 2021.

2.4. BreastScreen Coast to Coast

Following the retirement of the Clinical Director for BreastScreen Coast to Coast, the radiology provision for the programme is currently reduced. A mitigation plan is in place and an outsourced workforce is supporting the current radiologists to ensure patients are still seen within required timeframes.

The DAA Group, on behalf of the National Screening Unit, completed an audit of BreastScreen Coast to Coast in the week commencing 21 June 2021. Feedback was positive and a full report is expected within a few weeks.

2.5. Oncology Outpatients

Following the resignation of the Oncology Day Ward Nurse Coordinator, a decision was made to reconfigure the oversight of the RCTS Outpatient Clinics and Day Ward from the current separate entities to an Oncology Ambulatory Care Charge Nurse. Work will be undertaken to move to a contemporary model of ambulatory cancer care that meets patient's needs and enables clinicians to work at top of their scope.

2.6. Te Aho O Te Kahu Visit

Professor Diana Sarfati, Chief Executive and National Director of Cancer Control, and a team from Te Aho o Te Kahu, visited the Palmerston North Hospital on 14 June 2021. After meeting with MDHB's Chief Executive, Professor Sarfati was taken on a tour of the RCTS and met with key staff members involved in the delivery of cancer care. Te Aho o Te Kahu will remain an independent agency in the new health sector reforms. Its vision is to lead and unite efforts to deliver better cancer outcomes for Aotearoa, through fewer cancers, better survival and equity for all.

2.7. Regional Work

Taranaki DHB has successfully rolled out Mosaiq scheduling and chemotherapy e-prescribing, following go-live on 14 June 2021. They join Hawke's Bay DHB and MDHB in the use of this functionality, which increases the visibility of patient care across the region.

2.8 Mosaiq

A business case is being undertaken to request that Mosaiq move from the current IT servers to a cloud-based solution. This will improve speed and capacity of the system. The risk posed by continued use of the current system has been logged on RiskMan to ensure the issues are clearly documented.

SERVICE	Te Uru Pā Harakeke – Healthy Women Children and Youth
FOR PERIOD	April/May 2021
PREPARED BY	Sarah Fenwick, Operations Executive Dr Jeff Brown, Clinical Executive

1. PERFORMANCE OVERVIEW

The following table provides a summary of the progress to date against the equity outcome, sustainability and other actions in the 2020/21 Annual Plan. Te Uru Pā Harakeke is generally on track, with those actions behind plan discussed in the section below.

	Initiative	**Rating & Trend**	
A-E	Reduce equity gap between Māori and non-Māori babies who are exclusively or fully breastfeeding at three months of age.	**A**	•
A-E	Babies who live in smoke free household at Well Child Tamariki Ora (WCTO) first core contact.	**A**	•
A-E	All women screened for family violence three times during babies first year of life.	**A**	•
A-E	Reduce the number Ambulatory Sensitive Hospitalisation (ASH) events for Māori children by at least five percent	**G**	•
A-E	Support whānau who do not engage with services	**G**	•
A-S	Explore and pilot opportunities for telemedicine across paediatrics	**G**	•
A	Increase engagement with family harm training	**G**	•
A	Paediatric to adult (P2A) programme to be evaluated and enhanced to include those with disability	**G**	•
A	Support a sustainable midwifery workforce	**R**	•
A	All families are provided Sudden Unexpected death of Infant (SUDI) prevention information at a WCTO contact before 50 days of age.	**G**	•
A	Complete Ambulatory Sensitive Hospitalisation (ASH) project correlating data across primary and secondary care	**G**	•
A	Deliver district wide breast-feeding strategic plan	**G**	•
A	Increase clinical procedures in the outpatient setting and explore opportunities alongside primary care for services closer to home.	**G**	•

A	Implement the Planned Care Waiting List Improvement Plan - Elective Services Performance Indicator 2 (ESPI 2)	**A**	•
A	Implement the Planned Care Waiting List Improvement Plan - Elective Services Performance Indicator 5 (ESPI 5)	**A**	•
A	Improve shorter stays in the Emergency Department	**A**	•
A	Complete Child Development Service (CDS) strategic review and implement recommendations as appropriate	**G**	•

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

Plan Legend	A	Annual Plan	S	Sustainability Plan	E	Equity Indicator

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

The Ministry of Health (the Ministry) has provided feedback through the quarterly reporting process acknowledging the impact the COVID-19 pandemic has had on community-based health services, including breastfeeding support services. MidCentral DHB (MDHB) breastfeeding rates are expected to improve in the next quarterly reporting period. The MDHB Breastfeeding Steering Group is focusing on key actions that will have maximum impact on closing the breastfeeding equity gap across the region.

Significant efforts have been made to improve the number of babies who live in smokefree households; however, improvement is not being seen. An interdisciplinary meeting including smoke quit services, maternity inpatient services, Lead Maternity Carers (LMCs), MDHB Community Midwifery Team, Maternity Quality and Safety Coordinators and others is planned in July 2021. The group will review current initiatives and develop a fresh approach informed by other successful initiatives nationally.

No updated data is available for the measure regarding family violence. This will be reported to the next Committee meeting.

A team of senior child health practitioners undertook a retrospective audit of 309 Ambulatory Sensitive Hospitalisations (ASH) to Palmerston North Hospital's Emergency Department (ED), for children from birth to four years of age across a six-month period. The resulting data has been evaluated for themes and incorporates an equity focus. A series of recommendations will be shared across services to improve the overall health and wellbeing of the children across the region. The full ASH report is available for Board members on the Stellar platform *(HDAC/HDAC Reports and Documents/ASH project report 2021-v5)*. Housing, child protection, equity facilitator and linkages with primary care are noted as key areas of work.

As highlighted in previous papers, the national shortage of midwives, increasing acuity and handover of care are impacting on the ability to recruit and retain midwives at MDHB. A robust action plan is in place to mitigate the workforce risk, however, the ability to staff all three MDHB-operated birthing facilities has become increasingly challenging. To ensure safety of women, babies and staff, MDHB announced changes to the staffed hours at Te Papaioea Birthing Centre from 10 May 2021. LMC midwives are still able

to use the facility, however the unit is only staffed by MDHB between 8am and 4pm Monday to Friday. MDHB remains fully committed to resuming 24-hour staffing at the Birthing Centre as soon as safely possible.

A change proposal to strengthen midwifery leadership received significant and positive feedback. The decision document released on 24 June 2021 confirmed a reduction to one Charge Midwife within the secondary setting, with an increase of Associate Charge Midwife positions to provide 24-hour cover. In addition, coordinator positions will strengthen midwifery leadership on the Maternity Ward. Union partners and the New Zealand College of Midwives (NZCOM) have been briefed on the decision paper. Recruitment for the permanent Director of Midwifery role is underway, with interviews expected to take place in July 2021.

*1.1 **Performance Indicators***

The increased caesarean section rate is being continually monitored. Caesarean rates for first time nulliparous women remain very low, with repeat elective caesarean sections increasing the rate overall.

Outpatient and Colposcopy 'Did not attend' (DNA) results were 6.4 percent and 6.1 percent respectively in May. This shows the successful influence the Whānau Equity Facilitator role is having on engagement.

2. SIGNIFICANT MATTERS

2.1 Midwifery Review

In March 2021, Emma Farmer (Director of Midwifery, Waitemata DHB) undertook a commissioned site visit to MDHB to help understand the local stressors caused by a chronic shortage of midwives and make recommendations to assist MDHB Maternity Service. The final report was received in May 2021 and an action plan developed to address the findings. Maternity staff, Lead Maternity Carers, NZCOM and Union partners have all have received the report and associated action plan.

2.2 Maternity/Neonatal Clinical Information System (MCIS/NCIS) Global

The launch of the Maternity and Neonatal Global Clinical Information System took place on 16 June 2021 without incident. Prior to go live, 98 percent of staff were trained, with standard operating guidance and champions available to ensure adequate support for the new system. Support from Digital Services was outstanding, working closely with the cluster team.

2.3 MDHB Child Development Service (CDS) Referral Integration Project

Phase two of this project has commenced with both working party and steering groups formed. The scope of the project is being finalised and linkages made with key stakeholders.

2.4 Tūngia te Ururua

Community engagement across the communities of Tararua, Ōtaki and Horowhenua regarding service provision across the first 1000 days has progressed well. Approximately 180 consumer surveys have been received to date, along with 25 provider surveys. Initial analysis of the data has indicated there is only 15 percent feedback from whānau Māori. An extension until 31 August 2021 has been agreed, which will allow the Community Engagement Lead to link with communities to gain further feedback, as it is essential that a true representation of the communities' voice is heard. An independent person will complete the analysis.

2.5 Milk Bank

The formal opening of Whāngai Ora Milk Bank was held on 19 May 2021. Pasteurised donor breastmilk is now being provided to the community, including babies in the Neonatal Unit. This arrangement is directly between the Provider (Whāngai Ora) and parents. Whāngai Ora continue to investigate possibilities of laboratories to conduct post pasteurisation testing. Donors are already serology screened prior to donating milk.

2.6 Family Violence Intervention Programme

A change paper to strengthen the Family Violence Intervention Programme to include the Gateway and Pāruru Mōwai programmes across the district was released on 9 March 2021. Following significant feedback, the decision to progress with the change was announced on 7 May 2021. Recruitment to the Team Leader and Coordinator positions is in progress.

2.7 Nursing Strike

NZNO strike action took place on 9 June 2021, from 11am to 7pm. Robust contingency planning was undertaken. Services successfully managed during the strike period, with the assistance of non-striking staff and life preserving NZNO nurses.

2.8 Child Development Service (CDS) Psychology

A change paper was released on 24 March 2021 proposing a move to a fully outsourced arrangement for neuropsychological assessments, currently performed by psychologists in the CDS. The change is designed to improve the current wait times for tamariki and whānau. The final change decision has been delayed and is now expected by late June 2021.

2.9 Ultrasound

The introduction of surcharges for obstetric ultrasound by local private providers is likely to impact on women accessing scans, cause significant pressure on the Medical Imaging Department and presents a risk for the Obstetric Service. Consideration of options to ensure women get timely and cost-effective access to ultrasound scans is progressing.

2.10 **Colposcopy Audit**

The National Cervical Screening Programme run by the Ministry will be undertaking their national audit of colposcopy screening and treatment processes on 17 and 18 August 2021. The audit process will evaluate cervical screening and management across both primary and secondary services, identifying where improvements can be made against the required national standards.

SERVICE	Te Uru Whakamauora – Healthy Ageing and Rehabilitation
FOR PERIOD	April/May 2021
PREPARED BY	Andrew Nwosu, Operations Executive Syed Zaman, Clinical Executive

1. PERFORMANCE OVERVIEW

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

	Initiative	**Rating & Trend**	
A-E	Improve Māori Health gains in line with the Regional Dementia Action Plan	**G**	•
A-E	Increase access and equity of care for Māori kaumātua and whānau	**G**	•
A-E	Enhance partnerships with Iwi for Māori health gain across the district	**G**	•
A-E	Short Term Loan Equipment Management	**A**	•
A-E	Increase uptake of integrated falls and fracture liaison service	**G**	•
A-E	Develop a more responsive and effective rehabilitation model	**G**	•
A-S	Improve consistency, quality and efficiency of Home and Community Support	**G**	•
A	Increase support for older people managing their long-term conditions	**G**	•
A	Improve models of care for the older person with frailty	**G**	•
A	Support regional improvements for people and whānau living with dementia	**G**	•
A	Promote wellness and age friendly environments for older people	**G**	•
A	Improve patient flow throughout the hospital, reducing barriers and delays	**G**	•
A	Refine models of care for Older People's Acute Assessment and Liaison. (OPAL)	**G**	•
A	Enhance orthogeriatric and general surgical models of care	**G**	•

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

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

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

- Short Term Equipment project – Memorandum of understanding is in the process of being finalised with a start date of 1 July 2021. Slippage from previously intended start date of 1 June 2021 due to cost finalisation issues.

2. SIGNIFICANT MATTERS

2.1. Ombudsman's Report Update

Following on from the Chief Ombudsman's inspection on 29 September 2020, Te Uru Whakamauora provided an update in relation to the Implementation of National Preventive Mechanisms (NPM) under the Optional Protocol to the Convention against Torture (OPCAT). Te Uru Whakamauora is pleased to highlight that all recommendations have now been actioned.

2.2. Care in the Community

Accident Compensation Corporation (ACC) has approved Te Uru Whakamauora to utilise the Non-Acute Rehabilitation (NAR) community code. The contract with Healthcare NZ to partner with Allied Health Therapists to provide rehabilitation in the home has been ratified with services expected to commence June 2021.

A pilot commenced on 31 May 2021 for the provision of community stroke rehabilitation to clients who have been discharged from hospital. Services include access to rehabilitation in the outpatient setting and the client's home and are being provided by Allied Health Therapists (Physiotherapy, Occupational Therapy, Speech Language Therapy). The pilot duration is for 12 weeks and will be evaluated at the end of this period to inform ongoing service delivery.

2.3 Community Capacity

For this period all areas have remained within the Ministry of Health's guidance, with no waits exceeding four months for urgent assessment.

For Physiotherapy, the Community and Musculoskeletal outpatient waitlists are increasing in numbers with a percentage increase of 50 percent. Therapists are prioritising waitlisted clients when there are cancellations. There is a 30 percent increase in community referrals requesting strength and balance interventions which are being monitored and prioritised, but further engagement is required with referrers to review appropriate options.

A fully staffed Community Occupational Therapy team has seen the current waitlist numbers remain the same due to particularly high numbers of referrals in the month of May. (April 80 referrals, May 180 referrals). The longest waiting times are just over 12

months for Palmerston North, Horowhenua and Tararua which is a reduction from 15 and 18 months respectively in Horowhenua and Tararua. Urgent referrals continue to be seen within two days. Occupational therapists are seeing an increase in the complexity of cases in the community, and consequently the need for complex and expensive equipment and environmental solutions. The service continues to liaise with Enable New Zealand and other agencies to highlight the needs for clients and reduce wait times.

There are currently 415 clients on the Supportlinks, Needs Assessment and Service Coordination waitlist, which is a reduction of 167 compared to the last report for non-urgent assessment. Supportlinks is currently recruiting to a number of vacancies which may impact on timely assessment. To mitigate client risks the service has put in place actions such as: Packages of Temporary Care (POTS), providing respite and carer relief packages prior to assessment if required, applying a proactive assessment approach based on risk and urgency for vulnerable client groups and assessment by phone.

Social Work Community capacity has been impacted on by significant staff attrition. Vacancies have been recruited to, with two FTE vacancies outstanding. Prioritisation protocols continue to minimise the impact on vulnerable populations and hospital discharges with resolution anticipated by July 2021.

2.4. Equity

The Speech Language Therapy Service has noted a trend in referrals for people who identify as transgender. Te Uru Whakamauora has confirmed the training schedule for gender and sexual diversity to improve staff awareness and patient experience.

STAR 4 has identified a gap in access to tikanga Māori facilitators and is establishing links with Muaūpoko and Raukawa.

2.5. COVID-19 Vaccination Planning

All Aged Residential Care (ARC) Providers have a nominated provider to deliver vaccinations to residents and staff. The vaccination programme commenced in May for all consenting participants and should be concluded by the end of June 2021.

SERVICE	Te Uru Rauhī – Mental Health and Addictions Service
FOR PERIOD	April/May 2021
PREPARED BY	Scott Ambridge, Operations Executive Dr Vanessa Caldwell, Clinical Executive

PERFORMANCE OVERVIEW

The following table provides a summary of the progress to date against the equity outcomes, sustainability, and other actions in the 2020/21 Annual Plan. Te Uru Rauhī is generally on track, with those actions behind plan discussed in the section below.

Delivering on Equity Outcome Actions	**Status**	**Change**
Increase access and equity of care for Māori whānau engaging with Mental Health and Addiction Services.	G	•
Partner with THINK Hauora to implement the Access and Choice initiative within Primary Care.	G	•
Increase the participation of Iwi, people and whānau in the development and design of services.	G	•
Develop initiatives to increase the diversity and cultural competency of the workforce.	G	•
Develop a responsive, innovative and flexible workforce that supports people and whānau across the continuum of care.	G	•
Delivering on the Sustainability Plan		
Implement mental health service changes aligned to enhanced models of care.	G	•
Delivering on Annual Plan Actions		
Expand capability and capacity in suicide prevention, develop high profile campaigns and training focused on prevention.	G	•
Develop and pilot community-based services that expand access in the Horowhenua and Tararua areas.	A	↓
Work with the THINK Hauora to improve physical health outcomes for whānau with mental health and addiction conditions.	A	•
Deliver clinically safe and effective health care in a less restrictive environment.	G	•
Improve equity of access to alcohol and drug addiction services across the district.	G	•
Progress key capital work (i.e. new inpatient redevelopment).	G	•
Progress digital enhancements to support integrated models of care and improve workforce effectiveness and mobility.	A	↓
Work in conjunction with Te Uru Pā Harakeke to develop and improve access for hapu mama.	G	•
Work with Te Uru Arotau, support the Emergency Department for people presenting with mental health needs.	G	•

Rating & Trend Legend							
G	On track	**A**	Behind plan – remedial action plan in place	**R**	Behind plan – major risks, exception report required	**D**	Not completed as planned
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Request for Proposal (RFP) – Horowhenua Community based step up service

The plan to release this to market is on hold subject to wider DHB budgetary considerations.

Shared Care Programme

A transition project to support implementation of the new model of care is now in place. A current priority is to support workforce wellbeing through the transition process and beyond. A survey is being developed to identify staff preferences, strengths, and areas in need of training and development.

Digital Enhancements

It has taken longer than expected to gain the necessary procurement approvals after conclusion of the RFP process. These have now been obtained and the next step is to conclude due diligence and contract negotiations with the preferred vendor. We hope to commence the first discovery phase in six weeks.

1. SIGNIFICANT MATTERS

1.1 Inpatient Bed Occupancy

Ward 21 continues to experience high occupancy (127 percent year to date). This equates to 28 beds regularly occupied against the current resourcing of 24 beds. A proposal has been approved to increase staffing on the ward to account for the higher occupancy levels. The proposal also aims to reduce the use of double shifts, which is an unsafe practice and impacts on the wellbeing of nursing staff.

1.2 Transition of Care

The working group continues to identify challenges and solutions to quality post-discharge care in the community within seven days. Several new systems are in place to improve communication between the ward and community teams, as well as improve the timeliness of community team responses to clients who have been discharged. Several system errors have been corrected through communication with the Ministry of Health (the Ministry). Further improvement continues to be hampered by theses errors, particularly 'Out of area discharges' remaining on the MDHB system after a person has been transferred to another DHB. Post-discharge contact with Māori clients was at 81 percent for April and 82 percent for May and is out of the Ministry's 'alert zone'. This is better than for non-Māori clients at 79 percent for April and 67 percent for May. Performance will be tracked to determine whether this is a trend and to identify possible reasons.

1.3 Inpatient Facility Rebuild

Mental Health and Addiction Service leadership paused engagement with the professional team for an eight-week period from mid-April to provide time to refine the model of care driving the new build. Re-engagement has begun on the new design and discussions will continue until mid-August when the professional team will submit an updated preliminary design. An updated timeline for construction will be provided as soon as it is available.

1.4 Status of Funding Proposals

The RFP for the new kaupapa Māori Primary Mental Health and Addiction Service is now in its final stage. The proposal has been largely successful as outlined below.

Overall proposed Funding is based on FTE only

2.0 FTE cultural expertise

1.0 FTE clinical, and

4.7 FTE non-clinical.

Total value circa $720,000

Negotiation is ongoing between WAIORA and the Ministry regarding the non-clinical FTE numbers. WAIORA is seeking to increase this to 5.0 FTE. Discussion includes suggested amendments to the draft service specification, FTE distribution and the Ministry's exclusion of the Rongoā component which underpins the approach. Contracts will be finalised by the Ministry once these discussions have concluded.

1.5 Integrated Adult Model of Care

The consultation process on the integrated model of care concluded on 14 May. Sixty-two submissions on the proposed model of care were received and whilst there were some areas of contention, there was a high level of support for the proposed integrated model of care.

The final decision was released to all staff on 17 June and confirms the integrated model of care as proposed.

The next phase is to confirm the management of change process with the unions and commence implementation which sets out a staged/iterative approach over a nine to 12-month timeframe.

1.6 Unannounced Ombudsman visit to Ward 21

This inspection was carried out between 18 and 21 May as part of the Ombudsman's role in examining and monitoring general conditions of treatment of detainees in New Zealand mental health facilities. Preliminary observations have been provided to MDHB by the Senior Inspector.

Observations acknowledge successes with Zero Seclusion in achieving a 47 percent reduction in seclusions in recent years and evidence of focus on seclusion reduction throughout the ward. The open side was noted to be clean and neat and the quantity and quality of food available was good. Availability of cultural and spiritual support was noted with tāngata whai ora participating in waiata and contact details for the chaplain advertised on the walls.

As anticipated, many of the concerns raised relate to the physical environment including the 'stark and prison-like' High Needs Unit (HNU) setting, limited outdoor access, inhospitable whānau visiting area and privacy of patients in the HNU. Issues such as patient access to phones in HNU and need for more extensive use of de-escalation techniques and sensory modulation were highlighted.

The report notes that tāngata whai ora who spoke to inspectors were positive about their care on the ward and that whānau were involved in ward meetings and treated with respect by staff. Further evidence has been requested by the inspectors before findings will be drafted and provided to MDHB. In the meantime, corrective measures possible to implement in advance of the new build are being identified and prioritised for implementation.

1.7 Escalation in Did not Attends (DNAs)

Recent data analysis shows an increase in DNAs from 7 percent to 24 percent across the Mental Health and Addiction Service from July 2019 to March 2020 and the same period in 2020/21. Further investigation was carried out by the Service Improvement Team to determine possible reasons for this. The team showing the highest increase is DNAs is the Opioid Substitution Treatment (OST) team in Alcohol and Other Drug (AOD), with an increase from 8 percent of clients with a DNAs in 2019/20 to 60 percent of clients in 2020/21. Similar increases are evident across a range of teams including Oranga Hinengaro Adult (from 18 percent to 57 percent); Oranga Hinengaro Child (from 3 percent to 54 percent); Palmerston North Community Mental Health Team (from 9 percent to 53 percent); and Early Intervention Team (up to 52 percent, no data for the first period).

Of concern is that MDHB's data is showing a higher level of Māori DNAs than non-Māori. In 2020/21, 27.5 percent of Māori clients recorded a DNA, while 22 percent of non-Māori clients did. This may reflect a higher level of disengagement with the service among Māori tangata whai ora and whānau due to insufficient options for culturally appropriate care. In a recent staff survey, participants noted that improved use of kaupapa Māori based methods was needed in the mainstream mental health and addiction services as well as in Oranga Hinengaro. Improvements in this regard are central to the new integrated model of care now finalised for roll-out soon.

Engagement with clinical managers regarding reasons for the overall increase in DNAs provided a range of different views. All agreed there is much greater emphasis on improving KPIs and entering data and that the notable increase in in DNAs is a more accurate reflection of what has always been happening in the services. The Clinical Manager for AOD carried out a review of DNAs in the OST team and concluded that, over and above improved data entry:

- Many more inappropriate referrals and related appointments are being made frequently by other teams who are not aware of services and thresholds; and by primary mental health services who have new Health Improvement Practitioners (HIPs) referring into OST. Unnecessary appointments are also being made for patients in the process of transferring out of the area to meet KPI expectations, for example post-discharge contact within seven days. Clients have sometimes moved on by the time the appointment arises.
- Reminders are not being sent out before appointments as regularly as they were before, due to changes in administrative staff.
- Post-COVID-19 there has been a preference for phone consultations which offer clients the ability to avoid travel and parking costs. While OST is no longer offering this option, some community organisations are resulting in DNAs in the OST service.
- Coding errors whereby cancellations by patient or clinicians due to inappropriate referral are not entered into the system or entered incorrectly.

Next steps decided on by the OST clinical manager include arranging interviews with a sample of clients to determine consumer perspectives on reasons for DNAs; making phone calls on all initial appointments to clarify that the referral is appropriate; and noting possible coding errors to administrative staff responsible for data. Adult DNAs have now been included in our Project for the Integration of Mental Health Data (PRIMHD) monthly report as well as breakdown by ethnicity, to enable ongoing monitoring of trends.

2. OTHER MATTERS

2.1 Opioid Substitution Treatment (OST) three-yearly Ministry of Health audit

As previously reported, the Ministry conducted an onsite audit of our OST service on 12 March. This team supports 368 OST clients; 84 clients are in GP care and 68 clients are Māori. The preliminary report highlighted the strengths of the team as being knowledgeable, skilled and all seem to enjoy their work. It was also noted that the documentation was very well ordered, easy to follow and current. Consumers interviewed reported they like the staff, receive a positive experience and commented how well their physical health is addressed.

The auditors identified one area that was considered to be high risk. This related to the systems/policies in place for documenting and responding to instances of dispensing errors in a community pharmacy. This was raised as a high risk concern following reports from two clients attending a client focus group with the Consumer Auditor in Levin who reported two pharmacy dispensing errors –

one being given another client's methadone doses and the other given the incorrect methadone dose. These errors are not always reported to the service and clearly showed a system deficit by the prescriber regarding the response to any pharmacy dispensing error. Consequently, a protocol for management of pharmacy dispensing errors has been completed and forwarded to the pharmacies for review and comment. This has now been accepted by the Ministry and we have met the required recommendations made by the auditors. The protocol has been completed by the OST Clinical Lead and aligns with other OST programmes nationally.

2.2 **Criteria based discharge (CBD)**

An initiative is underway on Ward 21 to improve patient, whānau and staff experience of the discharge process and improve patient flow through the ward. This approach has been rolled out on two other wards in the hospital and lessons are being drawn from them on how this may be applied in an acute mental health ward. A multi-disciplinary workshop is planned for mid-July to introduce ward and community staff to the approach.

SERVICE	Te Uru Arotau – Acute and Elective Specialist Services
FOR PERIOD	April/May 2021
PREPARED BY	Lyn Horgan, Operations Executive

1. PERFORMANCE OVERVIEW

The following table provides a summary of the progress to date against the equity outcome, sustainability and other actions in the 2020/21 Annual Plan. Te Uru Arotau is generally on track, with those actions behind plan discussed in the section below.

Delivering on Equity Outcome Actions	**Status**	**Change**
Improve medicines management for Māori and Pasifika people who present with co-morbidities for the treatment of gout	**G**	↑
Advance the role of the Whānau Equity Facilitator to engage early with Māori whānau for Planned Care	**G**	•
Delivering on the Sustainability Plan		
Improve clinical documentation and coding to capture appropriate data and revenue	**A**	↑
Progress development of Hospital Health Pathways	**G**	↑
Delivering on Annual Plan Actions		
Progress the Surgical Procedural Intervention Recovery Expansion (SPIRE) programme	**G**	↑
Progress the acute assessment expansion (ED/MAPU)	**G**	↑
Expand the community-based early intervention non-surgical programme for musculoskeletal conditions	**G**	↑
Integrate National Acuity Index Tool to ensure a standardised approach to meet health needs and timely access	**G**	•
Implement Rationalising Acute Demand programme to improve patient flow throughout the hospital	**A**	↑
Implement the Planned Care Waiting List Improvement Plan – Elective Services Performance Indicator 2 (ESPI 2)	**G**	↓
Implement the Planned Care Waiting List Improvement Plan – Elective Services Performance Indicator 5 (ESPI 5)	**G**	↑

Rating & Trend Legend

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

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

The medicines management for Māori and Pasifika people who present for the treatment of gout initiative is well established. The process will be transitioned to be provided by the primary care support pharmacists' team for ongoing delivery.

There have been delays with the delivery of the Performance Indicators for Coding Quality (PICQ) audit tool. Deployment is expected in July 2021. The coding quality tool objectively assesses all records in a data set according to clinical coding standards and coding conventions. The audit information will identify targeted areas for improvement.

Unplanned Care – Shorter Stays in Emergency Department

Shorter Stays in Emergency Departments (SSIED) remains below target. High acuity and complexity of patient presentations is noted with road trauma presentations continuing above the average of 33; with 54 in March and 38 in April.

The hospital continues to experience peaks of high demand throughout April and May, with occupancy rates some days at over 100 percent. The Transitory Care Unit (TCU) is flexible in function in response to demand at the time. Transferring surgical patients direct from the Emergency Department (ED) to the Day of Surgery Admissions unit occurs when the hospital is at capacity.

The Directorate is progressing work across the system to improve the acute flow of patients from front of house to discharge which includes the following:

- A review of both process and data collection to ensure validity and reliability. A benchmarking exercise of several ED presentations and 'Did not waits' was completed. All District Health Boards (DHBs) now submit data to the Ministry of Health (the Ministry) every Monday with a follow up telephone call on Tuesday for progress. Over the coming weeks the Ministry will work with DHBs regarding the data definitions and indicators.
- The model for acute medical inpatient flow has been designed to ensure consistency which applies home warding principles. The model commenced early May 2021. This actively encourages patients to be placed into the appropriate inpatient ward. For example, the Medical Assessment and Planning Unit (MAPU) for patients with expected length of stay less than 48 hours. Due to bed availability at times of significant presentations, bed block can hinder this. The Directorate met with the Clinical Council in May to discuss acute demand and some of the plans in place. The Clinical Council were very supportive of the approach. The Clinical Council acknowledged that all DHBs are under significant acute pressure.
- Te Uru Arotau continues to work in partnership with Te Uru Whakamauora with a focus on integrated and streamlined processes. Medical wards, with the addition of MAPU, continue piloting direct referrals to the Needs Assessment and Service Co-ordination (NASC). The pilot aims to reduce double handling and bottlenecks to ensure effective and efficient referrals using electronic rather than paper-based systems.

- From 1 June 2021, the ED/COPD (Chronic Obstructive Pulmonary Disease) pathway criteria has been extended for patients discharged from MAPU. This pathway links the patient with general practice teams to provide follow up care. This follow up care includes review and assessment of patient, medication reconciliation and action planning. The general practice teams can link with the Respiratory Physiotherapy service. The aim of this pathway is to enable improved patient self-management following an inpatient stay.
- The pilot with Ward 26 for electronic Allied Health referrals was successful. Allied Health has extended the electronic referral process for whole of hospital, except for Dietitian referrals. This has ensured effective and efficient use of the therapy workforce.
- The medium-term programme includes the flexible function of TCU and additional acute assessment capacity. Additional information for the major facility upgrades can be found in the Te Uru Arotau Directorate report.

Planned Care and ESPIs

There has been good improvement in Elective Services Performance Indicator (ESPI) 2 at the end of May 2021. There has been no change to ESPI 5 at the end of May 2021. Deferment of planned care surgery due to acute demand continues to impact the recovery of ESPI 5.

All DHBs have submitted revised ESPI 2 and ESPI 5 waiting list improvement trajectories for 2021/22 to the Ministry.

At the Board meeting on 15 June 2021, the Board asked whether the DHB was exploring outsourcing to private hospitals outside of the region. Contact has been made with other private hospitals regarding capacity and opportunities for further outsourcing. There is very limited capacity for additional planned care surgeries to be undertaken.

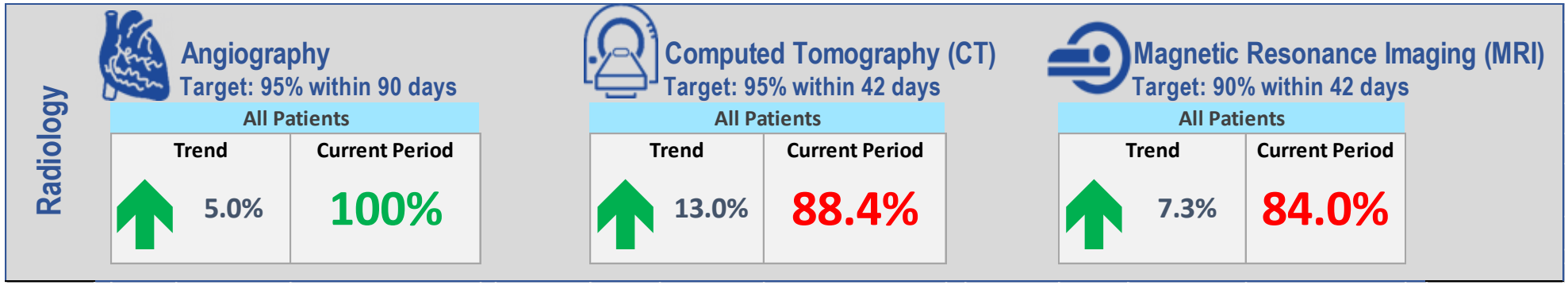
Services Not Engaged (SNE)

The SNE rate for whānau Māori continues to be higher at nine percent when compared with non-Māori at 3.2 percent. There are several initiatives in place or underway to support services to better engage with whānau Māori. These include, patient focused bookings, text reminders, utilising non-contact advice for general practitioners and individuals, and clinics in the community.

The Whānau Equity Facilitator has commenced working in partnership with Diabetes and Endocrinology and Maternity Services. The initial focus is for early engagement and communication with services and hapu wāhine Māori who attend the diabetic antenatal clinic.

The Telehealth Working Group has partnered with Rheumatology to test and pilot new processes. The first telehealth appointment between the Clinical Nurse Specialist and a consumer occurred in June 2021. The feedback received from the consumer and staff has been positive and has identified areas for refinement. The consumer would normally be required to travel from Ōtaki to Palmerston North Hospital for their appointment using a shuttle service. The consumer has provided feedback that they would be happy to switch any regular or routine face to face appointments to be undertaken by telehealth.

1.1 Performance Indicators – May 2021



Computed Tomography (CT) performance continues to improve to 88.4 percent in May, from 82 percent in April. Demands for service continues to increase and acute demand is impacted on planned CTs.

Magnetic Resonance Imaging (MRI) performance exceeded target in April at 92 percent. This reduced to 84 percent in May. The decline in May relates to inability to utilise some additional weekend lists due to booked leave and electrical maintenance work.

The ultrasound machine purchased from the Ministry's planned funding has been installed and is operational.

2. SIGNIFICANT MATTERS

2.1. Major Facility Projects

Progress continues for the Surgical Procedural Intervention Recovery Expansion (SPIRE) facility upgrade. The fit-out and reconfiguration of the former Clinical Records department is progressing, with completion expected in June. This will be the last of the decanting. This area will accommodate the Clinical Lecture Theatre, Clinical Library, surgical offices, Resident Medical Officer (RMO) Unit and the Medical Administration Unit.

Major construction work is scheduled to begin in October/November and the current focus is on finalising the planning process to enable this to start on time. The construction will be done in two stages, with the aim to complete the developed design for Stage One in early June and the detailed design by mid-July. Stage One involves creating the new Day of Surgery Unit, Recovery Unit, Gastroenterology suite and a staff area. This is to be located in the area currently occupied by the Clinical Lecture Theatre, Clinical Library, Medical Administration Unit, RMO Unit, surgical offices and the former Renal Unit. Stage One also includes revamping the theatre changing rooms and creating the shell of Procedure Room Four within the theatre suite.

Stage Two involves the creation of two new theatres, reconfiguration of a further theatre, the Cath Lab and the fit-out of Procedure Room Four will follow. The detailed design for this stage will be completed by November.

A new facility to provide space for an expanded Emergency Department Observation and Assessment (EDOA) area and MAPU continues to be progressed. A workshop with key stakeholders and architects was held in May as part of the detailed design phase. A further workshop is scheduled for June.

2.2. **Wairarapa/MDHB Hub and Spoke Model**

Collaboration has continued between MDHB and Wairarapa DHB to deliver sustainable health services for our respective communities. Highlights include clinical endorsement of the proposed Urology integration service model, establishment of critical factors for successful integration identified as timely recruitment of Senior Medical Officers (SMO), IT enablement (access, standardised information), physical space and proactive change management. Other specialties, including Ear, Nose and Throat (ENT), Gastroenterology and Paediatrics are engaging in discussions of potential integrated service models, based on learnings from Urology.

2.3. **Acute Orthopaedic Service for Wairarapa DHB**

Sudden, unplanned service challenges required Wairarapa DHB to close its acute Orthopaedic service and plans are in place with neighbouring DHBs to support Wairarapa patients. From 10 June 2021, acute Orthopaedic services at Wairarapa DHB will be managed by the Orthopaedic departments at Hutt Valley DHB, Capital and Coast DHB and MDHB. There is a three-way roster between these three DHBs and all patients requiring surgery will need to be transferred to the on-call hospital for treatment. This plan will be reviewed in six months.

2.4. **Pharmacy Support for COVID-10 Vaccination Programme**

Pharmacy have been providing considerable support for the COVID-19 vaccination programme. This includes delivery of vaccines to vaccination clinics as well as with assistance in drawing up doses.

2.5. **NZNO Strike**

Strike action was held on Wednesday, 9 June 2021 by Nurses, Midwives and Healthcare Assistants who are members of the New Zealand Nurses Organisation (NZNO). Despite the challenges presented by the action, MDHB was able to continue to provide a safe environment for patients and staff. An evaluation of planning and preparedness will be completed.

2.6. **Medical Imaging International Accreditation New Zealand (IANZ)**

MDHB's Medical Imaging Department was notified by International Accreditation New Zealand (IANZ) that its accreditation would be suspended from 9 June 2021. This is due to Radiologist vacancies that are being recruited to. IANZ are working with MDHB to ensure accreditation can be regained as soon as possible. IANZ have emphasised that this suspension is not related to poor quality of services. IANZ also commented there is a resilience and determination by the department to ensure the high quality of services to patients is not compromised.

Two additional Radiologists have been recruited and will commence in August 2021.

SERVICE	Te Uru Kiriora – Primary, Public and Community Health
FOR PERIOD	April/May 2021
PREPARED BY	Deborah Davies, Operations Executive Kelvin Billinghurst, Clinical Executive

1. PERFORMANCE OVERVIEW

The following table provides a summary of the progress to date against the equity outcome, sustainability and other actions in the 2020/21 Annual Plan. Te Uru Kiriora's leadership team continue to respond to the Ministry of Health's (the Ministry) direction for community surveillance testing and the ongoing COVID-19 Vaccination Programme. COVID-19 continues to impact on some initiatives, with those actions behind plan discussed in the section below.

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

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

Plan Legend	A	Annual Plan	S	Sustainability Plan	E	Equity Indicator

1.1. Key Progress Commentary

1.1.1 Improve Management of Long Term Conditions (LTCs)

To further understand the experiences of adult Māori and Pasifika whānau in the Horowhenua living with complex LTCs, an analysis has been undertaken via a service scope, data interrogation and in-depth case reviews for a small number of whānau. The emphasis was on understanding whether whānau were enrolled with a General Practice Team (GPT), how they were being supported to engage in essential health services, and any specialist services support in place. This information now provides the foundation for co-designing a pilot model in partnership with key stakeholders, with a focus on improved experience and outcomes.

Community based health care support for people living with Congestive Heart Failure (CHF) continues to increase with delivery set to commence in Horowhenua from mid-June 2021. This joint care pathway is delivered by Clinical Nurse Specialists (CNS) and Nurse Practitioners (NP) in cardiology, in collaboration with Primary Health Care (PHC) Teams, utilising the Primary Options for Acute Care (POAC) programme.

Significant progress has also been realised to improve the post inpatient discharge management of people with Chronic Obstructive Pulmonary Disease (COPD) in partnership with primary care, again utilising a POAC approach. A trial involving General Medicine, and Medical Assessment and Planning Unit (MAPU) patients will link whānau discharged with aligned PHC LTC team members to provide focused post discharge support. This will involve a number of funded visits with the extended GPT to support effective care planning and monitor improvement in partnership with the whānau. MidCentral District Health Board (MDHB) physiotherapy expertise continues to support patients through this transition from hospital to their homes.

2. SIGNIFICANT MATTERS

2.1 COVID-19 Vaccination Programme

The COVID-19 immunisation programme continues to undergo considerable development nationally and regionally, with the plan to vaccinate all of the eligible population (aged 16 years and over) by the end of this year with the two dose Pfizer BioNTech vaccine. Some of the logistical challenges have recently been partially resolved with the ability to store the vaccine locally for a longer period (up to 31 days after removal from ultralow temperature storage in Auckland).

In this region, a distributed model has been developed and implemented, with MDHB working with multiple vaccination providers to ensure efficient and timely access, including consumer choice. This model has been further developed during the immunisation of Group 1b, household contacts of Managed Isolation and Quarantine (MIQ) workers, and Group 2 – frontline health care workers and people living in settings that put them at risk, such as Aged Residential Care facilities (ARC), with a number of providers involved.

The Palmerston North Central Vaccination Hub has been established (for booked appointments) and mobile teams from different providers are visiting iwi, rural and residential sites.

An administration hub is well established at 575 Main Street, Palmerston North with work underway to develop a call centre for booking appointments for Group 3 (those pregnant, or aged 65 and over, and those with long term health conditions) and Group 4 (the rest of the population). This call centre needs to be connected with the National Booking System (NBS) when that is rolled out locally, as well as the multiple providers offering the vaccination.

Staff recruitment and training remains an important component of the work to meet the predicted numbers for vaccination later in the year and to also be able to mass vaccinate if necessary, in the case of a local outbreak.

MDHB has been consistently delivering above its forecast. This is actively monitored at a local and national level.

Key challenges relate to national messaging, public perceptions of vaccine availability and demands on the service to over-deliver based on personal circumstances, for example the desire to travel overseas.

2.2 Update on Contact Tracing and MIQ support

The National Contact Tracing Solution (NCTS) is undergoing a major update, with go-live timed for 20 July 2021. Three staff (superusers) will be sent to Wellington during the week of 14 June 2021 for training. They will then deliver the training to the remainder of the workforce during the period leading up to go-live.

MDHB has been provided an additional contract for a 1.0 FTE position to support COVID-19 Community Managed Isolation and Quarantine. The concept is around providing wrap-around services to support community cases and close contacts to appropriately self-isolate in their home environment, or to establish local managed isolation/quarantine facilities for cases and close contacts who are unable or unwilling to isolate in their own home. The appointee to the role will be responsible for developing MDHB's Operational Plan, which will include a description and feasibility assessment of local MIQ facility options able to be stood up within 48 hours, should this be required, together with an outline of the wrap-around services and how these will be accessed and provided.

2.3 Update on Human Papillomavirus (HPV) Self Testing

On 9 May 2021 the Government announced that it will spend $53 million on developing and rolling out a new HPV self-testing kit to commence in 2023. This funding will support the completed design and implementation of a new human HPV test. HPV is the cause of 99 percent of cervical cancer. It is envisioned that the test, which women can do themselves, will replace the current smear test.

Once more is known about process, a pathway will be developed and included into Health Pathways. The Cervical Screening Action Group will be working on some communication out to encourage not to wait until this new process comes into play as cervical changes can occur quickly.

2.4 Nutrition and Physical Activity

In November 2020 the Board approved the revised Nutrition and Physical Activity Policy. The policy's aim is to encourage and support all people to make healthy lifestyle choices by presenting healthy options within the District Health Board environment.

The Policy applies to all onsite MDHB facilities and off site MDHB functions involving staff, visitors, and the general public. It covers all food and drink provided or able to be purchased on MDHB premises, and at MDHB functions, but specifically excludes:

- Food and drink brought to work by staff for their own consumption
- Staff shared meal or events on and off site
- Gifts from families/whānau to staff
- Inpatient meal services and Meals on Wheels (subject to different regulatory standards)
- Food and drink provided by clients/patients and their families and visitors for their own use.

Given the nature and extent of some of the changes that this policy would bring about, and acknowledging the changes in food service provider, a lead-in period of six months was provided.

Compass Group New Zealand has now taken over as the food service provider and has been working with the Public Health Service to align their provision to the new policy. There have been a number of innovations that provide healthy choices for staff and visitors, including the recently introduced salad bar.

Public Health has planned training around implementation of the policy to staff who are regularly arranging catering, including Executive Assistants and Personal Assistants. Engagement with staff and unions continues as progress is made toward full implementation of the policy. This will see drinks with artificial sweeteners phased out, with water and unflavoured milk becoming the predominant cold drink options. Public Health will also be working with other services to provide an environment that encourages physical activity.

2.5 Primary Care Access and affordability Update

2.5.1 Health Care Home (HCH) Change Programme

The HCH programme aims to improve consumers experience of health and wellbeing care services and to achieve better management of prevention and routine care services to reduce acute services. GPT participants are now required to consider service delivery through an equity lens.

During the first two quarters of this calendar year, Cook Street Medical, Ōtaki Medical, Horowhenua Community Practice and Te Waiora Integrated Community Centre have joined the programme and are at different stages of engagement with iwi, implementation of General Practitioner/Nurse Practitioner triage services and promotion of the patient portal to improve access options. This brings the total engaged practices to eight.

Of the four existing HCH practices, Feilding and Kauri have applied for and been granted recertification of the programme. They have an equity-based triage process; are developing relationships with local iwi; have a particular focus on increasing patient portal utilisation (Feilding has 48 percent of its enrolled population registered on the portal); offer extended hours as business as usual; offer children's clinics; offer a wider range of services than are typical in many smaller general practices – and are able to extend these services to other practice enrolees, such as skin (eczema) and sleep clinics, older person (seniors) clinics.

The progress of The Palms and Tararua Health Group is slower. The Palms has recently re- engaged in the programme and is making rapid progress in adopting triage services to improve access for Māori and young families. Tararua Health Group has four international locum GPs commencing at the practice in July 2021 and will recommence the programme. The Palms is leading the way in the district for delivering telehealth services which has improved access and offers a cost-effective option for their consumers.

Three further practices, Masonic Medical and Queens Street Medical in Horowhenua and Victoria Medical in Palmerston North have indicated their intention to start the HCH programme post winter.

Third Next Available Appointment (TNAA) data is a HCH Collaborative measure that is currently being reviewed. The Collaborative is working to define what data should be captured, such as who the provider is. Previously this was a GP or in some cases it would include NP's. The HCH programme focuses on a broad clinical team delivering services and as a result it could be argued that TNAA should capture consultations available with any provider-types. Other considerations include whether a telehealth consult can be included in this data capture, and if so when does a telehealth interaction become a consultation. As a result, the TNAA data captured by HCH practices nationally varies markedly, and many practices do not capture the data until the topic has been clarified.

In the MidCentral DHB district, Feilding Health Care collects the data manually and reports that the average TNAA for its range of providers is 4.7 days (data collected May 2020 to April 2021). The THINK Hauora Knowledge and Insights and Health Care Home teams are expected to finalise a TNAA template for the district so that the data collected is consistent. While this data may differ to

that collected elsewhere, it will provide an agreed base measure that can be monitored. This data will be captured from 1 July 2021 and will be available on Te Kete Kōrero during that quarter.

2.5.2 Telehealth

THINK Hauora has indicated its interest in participating in a telehealth service that looks like it is a service being delivered by the person's GPT. Patients have the choice of making an appointment with their regular clinical team member (which may include a wait time) or by selecting a same day/week telehealth consult that would be provided by a clinician working remotely. Two PHOs will form a limited liability company, employ the telehealth clinicians and provide the necessary clinical guidelines and digital health infrastructure. The telehealth clinicians would work remotely under an operating agreement between the participating PHOs and could be from anywhere in New Zealand, and potentially from overseas if they have a New Zealand registration. The cost of a consult can be set by the practice, but the minimum charge is $50 irrespective of the age of the person, that is no allowance for equity adjusters, Community Services Card (CSC) holders or children.

The anticipated benefit of this initiative is the ability to add much needed clinical capacity into the district. Over time, it may help reduce acute demand pressures on GPTs, enabling them to spend more time with people who need their attention the most. The initiative would commence with afterhours services and would build to provide day-time consults. Participating PHOs are required to provide a first-year infrastructure contribution and a contribution fee for a minimum of three years based on enrolled service user numbers. The THINK Hauora Board/ALT has agreed to the Ministry's Telehealth funding for primary care being used to offset these costs and a contract with MDHB is expected soon.

2.5.3 Patient Portal

Nineteen of the 28 GPTs offer patient portal. Of the seven practices not offering the portal, two are on Patient Management Systems (PMS) that do not support this capability; two will no longer be operating as a practice by the end of this year; and the remaining practices remain unwilling to offer this service.

As at the end of December 2020 (the last report from the Ministry), 26 percent of patients enrolled at a GPT in the district, approximately 46,500 people over the age of 16, have registered to use a portal. Since December 2020 a further 2200 people have registered to use a portal with patient portal registrations in mid-June 2021 up to 48,710.

Approximately 7500 people have adopted the portal this year which equates to an eight percent increase over the year, that is registrations in June 2020 were 18 percent and now are 26 percent. This increase is largely due to THINK Hauora funding a summer campaign to increase patient portal registrations. One GPT was also funded to prepare material that helps engage with and encourage older people to adopt and use a portal.

Feilding Health Care, HealthHub Project and Sydney Street Medical all have over 40 percent of their patients over the age of 16 registered for a portal. Kauri Health Care and The Palms Medical are almost at 40 percent of their eligible patients registered. Many practices have enabled email consultations via the portal. While the actual number of consultations this equates to is not available from all GPTs, three GPTs using the Indici PMS report that incoming emails via the portal for the January to April 2021 quarter were 11,282 and corresponding email responses were 7,062. (Note: this is a requirement within the first three months of adoption of the THINK Hauora HCH programme.)

2.5.4 General Practice Sustainable Workforce

The workforce recruitment issues in provincial New Zealand and rural general practices in particular, are well known and documented in the media. The MidCentral DHB district is no exception, despite concerted efforts by THINK Hauora, MDHB and GPTs. The cost of locums is a significant financial burden for general practices, and this is further exacerbated by visa constraints due to COVID-19. Again, this has been well documented both in the media and as part of the Health System Reforms. Pressure in hospital services delays referrals and other services and places an additional load on GPTs, and the rise in anxiety and other mental health related services is also impacting the primary care system.

Late 2020, THINK Hauora and GPTs developed a roadmap of activities that aim to improve workforce retention and recruitment, amongst other things. Following the same partnering approach, THINK Hauora and the MidCentral Community Pharmacy Group (MCPG) have worked with community pharmacy teams to develop a similar roadmap of activities that focuses on workforce, digital health collaboration, and ways of working as part of a transdisciplinary team.

Following is an update on progress for both roadmaps.

General practice roadmap update:

THINK Hauora is investigating how to develop the GPEP Programme. Currently Manawatu/Whanganui have seven GPEP1 Registrars, which is one of the lowest ratios per 100,000 population in the country. THINK Hauora and GPEP1 registrars engaged in a discussion planning forum in May 2021 to understand how to improve GPEP registrar numbers. The summary of discussion and advice to improve recruitment generally and GPEP participation was as follows:

- destigmatise – there is a negative perception, especially in online immigration forums, that the Manawatū is not a good place to work and live
- try and get people to the district (either physically or virtually) before they make their decision where they want their placement to be
- develop a flexible placement methodology that tailors the Registrar experience to meet their needs, for example study/training flexibility, cultural awareness training etc.

Some GPEPs are willing to provide ongoing feedback and help explore the value of incentive options.

THINK Hauora worked with MDHB to adopt the MDHB's international recruitment agency Working-In health. Subject to funding, an initial international recruitment campaign will be launched in July 2021 using the recruitment agency. This campaign will include targeted social media marketing, online webinar and tailored migration and registration support for prospective candidates. The focus of the initial campaign will be GP recruitment. THINK Hauora is developing a series of short videos to support this campaign.

Some initial engagement has also occurred with a Māori health provider from outside the district who is exploring options to be based in Horowhenua. Information about operating in the district was sent to the provider. The provider's plans have been affected by COVID-19 and some health issues. While we remain in contact, we are now not confident that this opportunity will be realised in the short term.

A Nurse Practitioner-led clinic will be established in Horowhenua commencing July 2021. This will be an extension of Horowhenua Community Practice and will be in a new locality close to the centre of Levin.

THINK Hauora recently collaborated with other PHOs to club-fund a Rural Network Clinical Director for two years on behalf of rural practices. The Clinical Director has a range of responsibilities that broadly will encompass:

- coordinating a national strategic advocacy programme for rural general practices
- developing ideas put forward from the rural network
- providing clinical oversight on submissions to Government policy that could impact rural health outcomes and the wellness of rural communities, etc.

All three rural general practice teams in the district (Ōtaki Medical Centre, Tararua Health Group and Dr Short's Surgery) support this mahi and look forward to the added value of this appointment.

Discussion has commenced with UCOL regarding offering nursing and health care assistant tertiary courses in Horowhenua and has also with the Secondary School Principals' Association seeking ways to engage with students through careers advisors or careers expos.

Engagement has also occurred with Kia Ora Hauora about offering Māori students the opportunity to experience community-based health and wellbeing career options available in the district. Kia Ora Hauora is a Māori health workforce development programme that seeks to increase the number of Māori working in the health and disability sector by recruiting Māori into health career pathways.

Community pharmacy roadmap update:

The roadmap activities aim to support community pharmacy teams to participate in broader health and wellbeing service delivery as part of a multidisciplinary team. Prioritised activity for this year includes:

- enhancements to services available from community pharmacy
  - a conjunctivitis pilot that enables tamariki with gunky eyes to have a free consultation at a pharmacy. The pilot has been launched in Tararua, Ōtaki, Horowhenua and the south-western suburbs of Palmerston North (as part of the Ora Konnect initiative)
  - minor ailment type services that can be provided by pharmacy for acute, low complexity and long-term condition management are being worked up to be delivered in the coming months.
- unifying equity-based triage processes so GPT's can quickly direct people to the pharmacy of their choice and providing people with easier access
- workforce development activities (largely described above)
- develop digital health innovations and digital literacy to enable working as a multidisciplinary team
- developing the MCPG network to grab opportunities and to enhance workforce development opportunities.

2.5.5 Enrolment and access

Currently there are four practices enrolling patients, including Ōtaki Medical, Tararua Health Group (Dannevirke and Pahiatua sites), The Palms Medical Centre and The Health Hub Project.

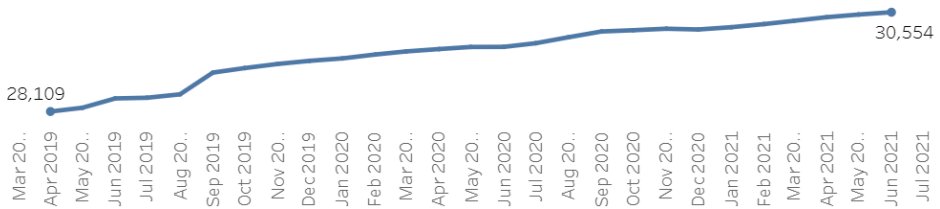
THINK Hauora is recruiting for a full time enrolment coordinator. Currently people seeking enrolment with a general practice who make contact with THINK Hauora, either through the website, an immunisation clinic, or a Whānau Ora Service are supported to enrol with a GPT. Most GPTs will enrol people who are not enrolled if they are Māori or if they have a serious health condition.

Enrolment status

Enrolment in general practice has increased in the last 12 months for the general population and Māori.

Q2 2020			**Q3 2020**			**Q4 2020**			**Q1 2021**		
Apr-20	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**	**Jan-21**	**Feb-21**	**Mar-21**
165,256	165,369	165,288	165,558	165,929	166,241	166,388	166,440	166,379	166,452	166,560	166,633

Māori enrolled with a general practice team has increased slightly over the last two years.



Consultation rates

Most GPTs noticed a quieter period during late November 2020 through to the beginning of February 2021. This is traditionally the catch-up time where practices commence change programmes and review processes and performance. The GPT network has consistently reported this year that there has been no discernible ebb and flow of presentations since the beginning of Quarter Two 2020 and through GPNZ channels, this appears to be consistent across New Zealand. Consultation data is not available at the time of the report due to a change of consultation methodology implementation. This data will be available for the end of quarter MDHB's PHC Consultation Utilisation Report.

Emergency Department (ED) rates

ED presentations remain consistently high, which is also reflected in the increasing number of ED-Redirect services provided in PHC.

Enrolled presentations by Triage Score (1 Most Urgent – 5 Not Urgent)

	Unk	1	2	3	4	5	Total
Jun-21	2	7	177	580	319	24	1,065
May-21	0	11	459	1,225	611	71	2,230
Apr-21	0	19	428	1,195	616	76	2,190
Mar-21	0	13	423	1,317	668	69	2,340
Feb-21	0	9	386	1,089	618	73	2,058
Jan-21	0	7	373	1,152	706	108	2,207

Note: June 2021 data incomplete at time of report

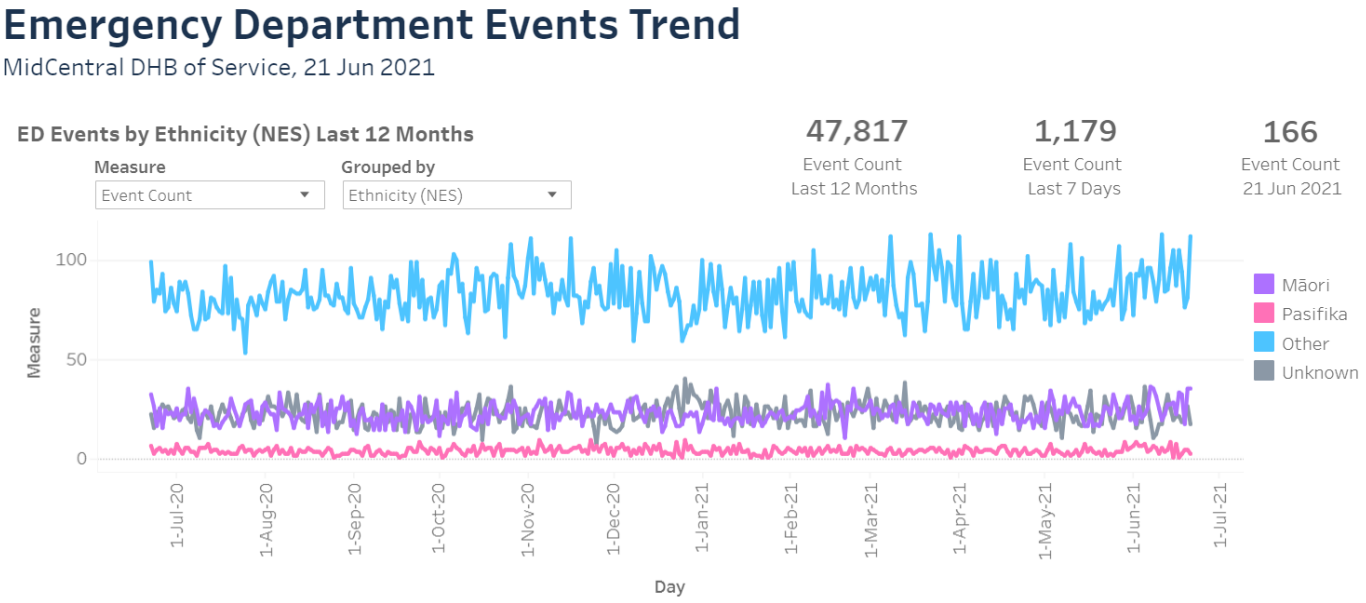
Non-enrolled presentations by Triage Score (1 Most Urgent – 5 Not Urgent)

	1	2	3	4	5	Total
Jun-21	4	28	71	58	6	162
May-21	1	63	168	161	19	390
Apr-21	1	65	183	143	31	402
Mar-21	4	56	187	149	33	409
Feb-21	4	65	162	156	29	398
Jan-21	3	52	173	168	38	405

Note: June data incomplete at time of report

The top three diagnoses for presentation to ED in this group are 'No pathologic diagnosis', 'Did not wait for treatment' and 'Unknown'.

ED events for Māori, non-Māori and Pasifika people has remained relatively consistent during the year.



2.5.6 Acute Demand

Following are some highlights of the primary care acute demand POAC and ED-redirection mahi that occurred in Quarter Three (January to March 2021). Note: Quarter Four is not yet complete.

Quarter	POAC	ED Redirect	Total
Q3 Jan – March 2021	217 Packages of Care (POC)	615 events	832 events delivered in primary care

2.5.7 POAC

217 Packages of Care were delivered in the first quarter of this year, with the most utilised pathways continuing to be cellulitis, iron infusions and Deep Vein Thrombosis (DVT). POAC services in Palmerston North are now delivered by number of smaller GPTs who have agreed to deliver specified POAC services such as cellulitis with oral antibiotics and DVT, and refer to their POAC referral centre for services outside of their scope.

2.5.8 ED Redirect to General Practice

The number of ED Redirects has increased steadily since June 2020, and markedly so since December 2020. In Quarter Three, between 200 and 230 redirections occurred each month. ED Redirection patients were most likely to be Quintile 8+ 9, European young adults (18-28 years), domiciled in the suburbs closest to Palmerston North Hospital, and having a peak presentation time of late morning. The most common ED–Redirect presenting complaints were Limb Pain, 'Unwell' and Limb injury. After a period of not providing ED Redirect services, The Palms will reinstate weekday hours redirection services from 14 June 2021.

2.5.9 Afterhours Service Update

There is no change to afterhours services from that reported in November 2020, except for the Telehealth approach reported above.

2.5.10 Health literacy update

THINK Hauora has been delivering a region-wide awareness campaign about the range of immunisations, designed to be accessible and understandable for whānau. Key messaging focuses on protecting loved ones and the wider community through immunisations, and that they are safe. A visual matrix was developed for whānau to determine who needs which immunisation and when and where they can access. Pop-up and regular community clinics have helped reach more of our priority populations. Messaging was amplified by partnering with the Central Pulse Netball team, who reinforced the importance of vaccination among our communities.

The RIMA (Former Refugee, Internally Displaced, Migrant and Asylum Seeker) Wellbeing Programme has focused on delivering information for these communities in a variety of accessible ways. A regular podcast has been recorded and published which covers a

range of health issues and topics, with one being produced in Dari. Specific events have also been organised aimed at taking information directly to the populations and enabling health conversations and increased access to services.

A pilot project has recently been launched in response to a request for unmanned information stalls at events. An Augmented Reality (AR) experience opens up on a user's phone when a specific QR code is scanned. A video of a clinical kaimahi talking about a specific health topic launches, and users can then choose from a range of links to follow to find more information and support. The pilot has begun with mental health and obesity, two top health concerns for men in our rōhe, and the project will be further developed to incorporate other health subjects over the next few months. This approach provides an additional way for us to engage our communities in a way that suits them.

THINK Hauora and MDHB collaboratively delivered a Seasonal Warrant of Fitness campaign at the beginning of winter, reminding people of top tips on how to stay well and where to go for care if they become unwell. The messaging was shared through a variety of channels, including print media, websites, social media, radio, GP network and digital advertising.

The Community Health Pathways developed for the district reached a milestone of 105 being localised for use in the district, which is pleasing as the work programme target was to publish 70.

The promotion of Health Navigator https://www.healthnavigator.org.nz/ and HealthPoint https://www.healthpoint.co.nz/ for both public and health care providers remain a challenge in an environment of prolific sources of health information, however this has improved as the MoH has regularly referred to both tools as a source of information during COVID-19. THINK Hauora continues to encourage GPTs to have Health Navigator listed first on the resources page on their patient portals and link to both Health Navigator and HealthPoint on their own websites. THINK Hauora has entered into a contract with HealthPoint on behalf of the district to ensure local health and wellbeing providers can be easily searched. This includes being able to list more about the services they offer, referral criteria and pricing. THINK Hauora have facilitated engagement with Pharmacies in our rōhe. There has been a 100 percent uptake of engagement and there are now comprehensive service profiles live on HealthPoint including Child Gastro pathways and the new Conjunctivitis pilot. Invitations for GPT's to update their information was sent out in mid-June 2021 and already two GPT's have booked time to set up their profiles. The team will commence engaging with Māori Health providers next. HealthPoint has also enabled the ability to reflect those sites that are providing COVID-19 vaccinations in their services and Karawhiua (HPA's Māori COVID-19 vaccination campaign) will be streaming Healthpoint's COVID-19 vaccination information into their website.
activity.

Performance reporting

13 July 2021 HDAC

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

HEALTH AND DISABILITY ADVISORY COMMITTEE

For:

	Approval
X	Endorsement
	Noting

Key questions the Committee should consider in reviewing this paper:

- Are there any specific areas of performance the Committee would be interested in hearing more about?
- Is the Committee aware of any additional opportunities for Enable New Zealand to grow and extend its service offering?

To	Health and Disability Advisory Committee
Author	Michelle Riwai, General Manager, Enable New Zealand
Endorsed by	Kathryn Cook, Chief Executive
Date	28 June 2021
Subject	**Enable New Zealand Report**

RECOMMENDATION

It is recommended that the Committee:

- **endorse** the Enable New Zealand Report to 31 May 2021.

Strategic Alignment

This report is aligned with MidCentral District Health Board's (MDHB's) strategy, specifically to achieve equity of outcomes, and sets out performance results for Enable New Zealand. The report also aligns to all three of the strategic goals embedded in Enable New Zealand's Operational Plan.

1. PURPOSE

To provide an update on Enable New Zealand's performance against its Operational Plan and advise of any current and emerging matters.

2. PERFORMANCE OVERVIEW

Overall, performance across Enable New Zealand continues to track well with most performance measures being met. Over the previous two months, attention has been focused on consolidating good performance as well as securing a range of contracts and funding. Enable New Zealand continues to be recognised for its performance with securing new, and the renewal of existing contracts with the Ministry of Health (the Ministry). Growth in the hire and loan equipment service also continues, with overall reach to customers who purchase services also increasing.

	Initiative	**Rating**
	Strengthen and enhance existing services to provide a quality customer experience	
O	Develop a quality driven practice model to drive service excellence	G
O	Deliver responsive and accessible customer services across all areas of the organisation aligned to the customer's requirements	G
O	Partner with key stakeholders to deliver long term sustainable outcomes for the customer	G
	Employ efficient delivery practices and maintain a culture of effectiveness and responsiveness in all areas of work	
O	Develop a responsive, innovative, and flexible workforce that supports people and whānau across the continuum of care.	G
O	Our infrastructure is healthy, and our technology drives enhanced performance in the delivery of services to our customers	G
O	We nurture a positive and diverse workforce culture and a healthy workplace that reflects our values and respects the dignity and privacy of all stakeholders	G
O	We cultivate competency and capability in our workforce that is flexible and responsive to the current and future needs of the business and service requirements	G
	We aggressively pursue opportunities to grow and develop sustainable services	
O	Meet a broader range of customer needs to remain competitive in the changing market	G
O	Increase the total number of customers that purchase services directly from Enable New Zealand	G
O	Increase the number of primary customer contracts	G

O	Grow diversified revenue streams	G
O	Ownership and Governance	G

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

2.1. Performance Indicators

A high-level breakdown of Enable New Zealand's performance indicators is shown in Appendix One: Performance Indicators. Performance across all measures are being achieved and/or is within acceptable levels of tolerance. No significant changes have occurred other than expected seasonal variances.

3. SIGNIFICANT MATTERS

3.1. New Contracts

Hearing and Spectacle Contracts

After a competitive tender process, Enable New Zealand has been selected as the preferred provider for the Ministry's Hearing Contract and Spectacle Contract. Both contracts are for three years with a two-year extension. Negotiations are currently underway.

ACC Contract

Enable New Zealand has been successful in meeting the pre-condition requirements for the Managed Rehabilitation Equipment Services (MRES) contract with ACC and now must present to an evaluation panel in early July. This is a high-value contract which has an expected 10-year tenure (five + three + two years).

MDHB Hire

Enable New Zealand and MDHB have finalised an agreement to implement a hire service model. This model will allow MDHB to hire specific equipment (bariatrics and paediatric). The service has some built in flexibility so any out-of-stock rehabilitation items can be supplied, ensuring patients can be discharged from hospital at the earliest opportunity. Enable New Zealand will deliver equipment to MDHB sites or to client homes, with installation provided if required.

3.2. **Community Update**

EASIE Living Retail and Demonstration Centre continues to engage with the community through a talk series held onsite at the EASIE Living Store. Held monthly whilst being established, the series is focusing on tips and tricks to help the aged and disability community.

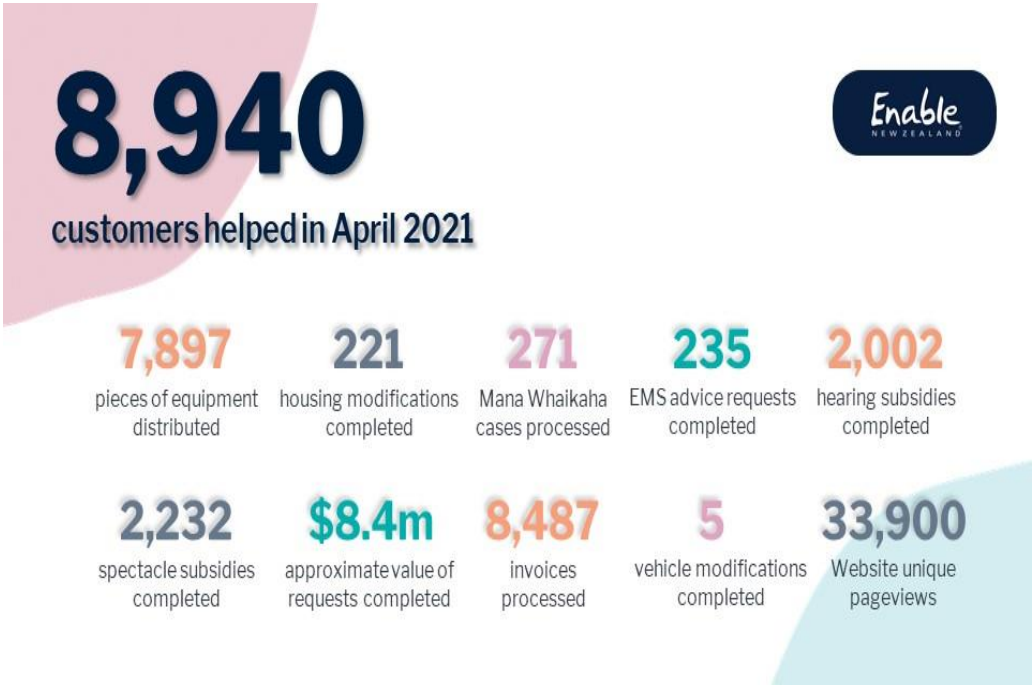
Recent speakers have included Palmerston North City Council's Emergency Officer on how to prepare for an emergency (what to have in your grab and go bag, where to find information etc) and how to keep yourself safe in an emergency. The New Zealand Police spoke around keeping yourself safe at home and online. This week, to celebrate National Volunteers week, a talk is being held around how to volunteer in your community and what organisations are looking for volunteers.

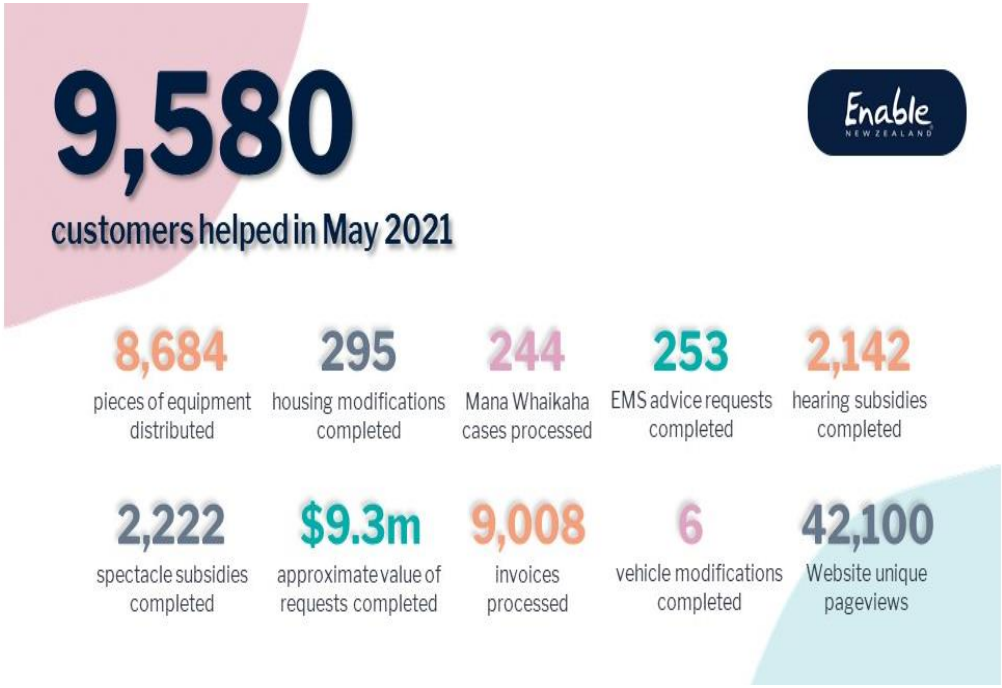
Appendix One: Performance Indicators

This report relates to the reporting period from 1 April to 31 May 2021.

National volumes

The following chart is a high-level snapshot of the volume of work Enable New Zealand has achieved throughout April and May 2021.





Regional results

Equipment requests in the MidCentral DHB region have seen continued growth over the past five months. From January 2021 through to May 2021, there has been a 50 percent increase in requests. The April increase was due to MDHB having their full complement of staff. The 334 requests consisted of 274 Band 1 (low cost) items and 60 Band 2 or Band 3 items, which include equipment such as bed combinations, hoists, lift-out chairs and wheelchairs.

There were 21 housing requests in April, 10 more than in previous months. Of these requests, 13 were determined as complex such as modular ramps, door widenings and wet area shower. Eight were of a more basic nature, such as handrails.

Table 1: Volume/demand of customers accessing Enable New Zealand within MDHB region for April 2021 and May 2021

Client volumes by Service	MDHB Region April	MDHB Region May
Equipment	275	334
Hearing	107	110
Housing	21	9
Spectacles	142	130

All measures across the Mana Whaikaha Prototype have increased. Enable New Zealand continues to support the Ministry of Health to embed its new model of service delivery.

Table 2: Volume/Demand for Mana Whaikaha Services

Mana Whaikaha Regional Results	Launch of Prototype to June 2021
Total disabled people active in the database	2409
People allocated to a Ministry of Health connector (and are still allocated to a Ministry of Health Connector)	1942
People allocated to their own/Independent Connector	178
People in queue (awaiting allocation to a connector)	289
Total number of individuals under the age of 21 years	951

Performance indicators against contractual agreements

Performance against all contracts is within tolerance, with performance remaining relatively stable for both April and May 2021. There was some variance experienced due to severe weather conditions in the South Island in the month of May, which impacted delivery timeframes for Band 1 equipment.

As with previous months, the volume of grabrails is very small. Therefore the variance in this KPI from a percentage viewpoint is considerable. Over both months, three grabrails were not installed within the required timeframe. There were unpreventable and valid reasons for the delays.

The refurbishment of equipment in the warehouses continues to be a priority. Recently the Ministry acknowledged Enable New Zealand for its contribution and significant improvements in this area. The Ministry has approved additional funding to increase staff resourcing to leverage further gains. In May, 2872 items were refurbished, totalling $96k in Ministry savings. Refurbishment and recycling of equipment also significantly reduces the use of landfill.

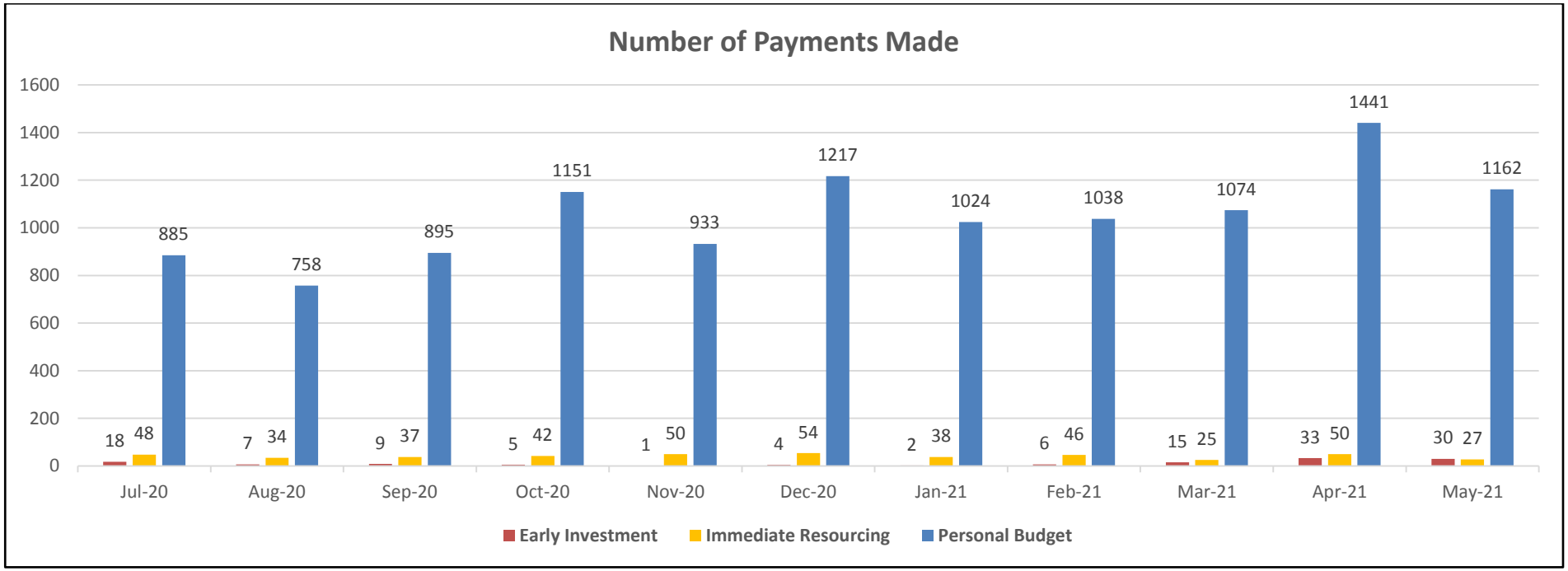
Table 3: Performance against contractual measures

Key Performance Indicator (KPI)/Measure	Target	Achieved April	Achieved May
Percentage of Band 1 Equipment delivered within five working days	90%	98%	89%
Percentage of Complex Housing Modifications completed within 120 working days (Ministry of Health)	60%	80%	85%
Percentage of Equipment provided to Service Users supplied from refurbished stock (Ministry of Health)	35%	29%	33%
Grabrails Installation Non-Urgent (ACC) installed within five days	95%	88%	92%

Mana Whaikaha

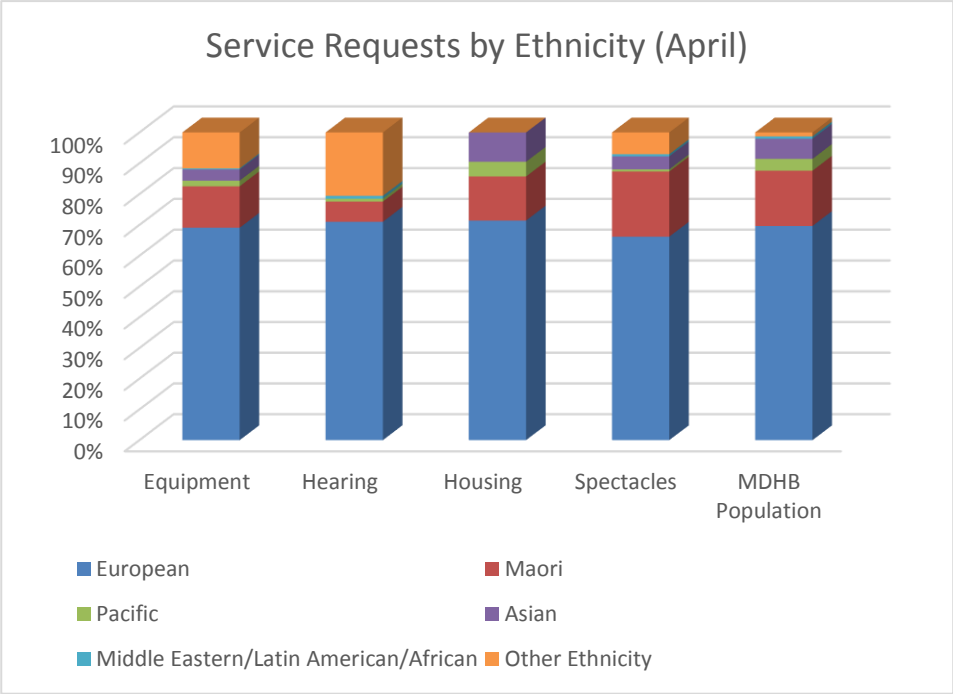
The new Mana Whaikaha model has been implemented, with 632 clients transferred to Enable New Zealand to manage.

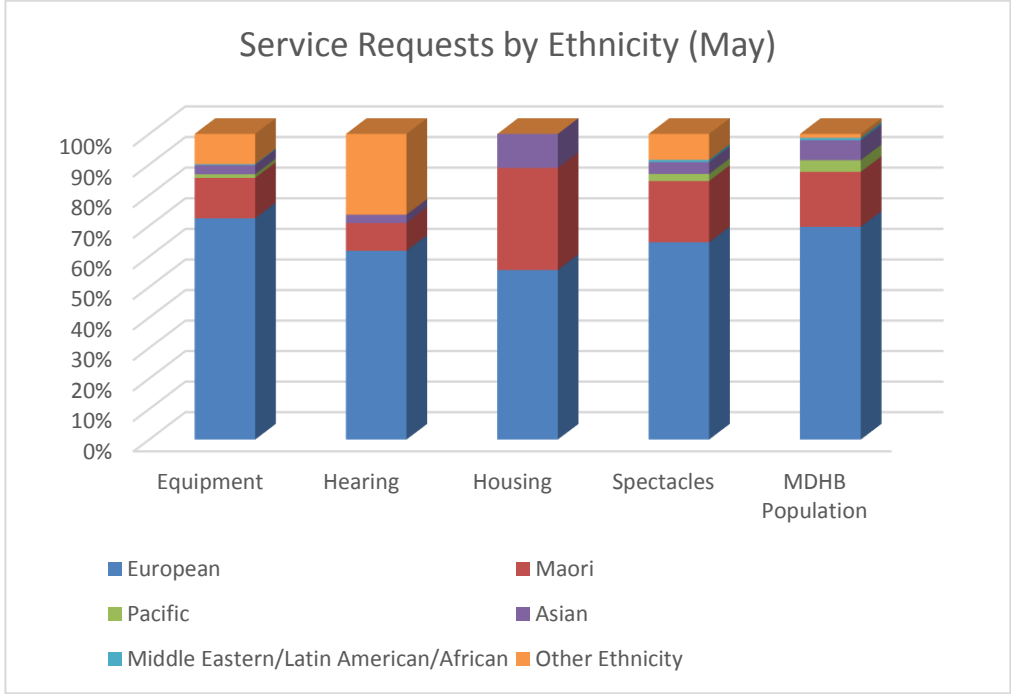
These clients are known in the 'old' system as Needs Assessment Service Coordination (NASC) continuations, either living in the community or living in residential care. Enable New Zealand will start community visits in the coming weeks to review each of the funding arrangements for these clients. Enable New Zealand continues to support Mana Whaikaha by processing payments to clients on their behalf. Approximately 1500 payments are made each month and volumes are increasing.



Ethnicity data

The following chart represents the ethnicity data for the MidCentral District Health Board region.





HEALTH AND DISABILITY ADVISORY COMMITTEE

For:

	Approval
	Endorsement
X	Noting

Key questions the Committee should consider in reviewing this paper:

- Is the current work focus for Pae Ora meeting the Committee's expectations?
- Are the Annual Plan actions in the dashboard performing to the Committee's expectations?

To	Health and Disability Advisory Committee
Authors	Tracee Te Huia, General Manager, Māori Health
Endorsed by	Kathryn Cook, Chief Executive
Date	24 June 2021
Subject	**Pae Ora Paiaka Whaiora Report – Māori Health Directorate**

RECOMMENDATION

It is recommended that the Committee:

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

Strategic Alignment

This report is aligned to the MidCentral DHB's strategy, the Ka Ao, Ka Awatea Māori Health Strategy 2020-2022 and the DHB's strategic imperatives, particularly Achieving Equity of Outcomes Across Communities.

1. OVERVIEW

	Pae Ora Paiaka Whaiora Hauora Māori Directorate	RATING	
	Engagement and obligations as a Treaty partner		
AP	1. Build and review the training and induction process delivered for the newly constituted MDHB Board, to further their understanding and knowledge of Te Tiriti o Waitangi, WAI 2575 developments, and local Iwi and Māori health aspirations EOA	G	↑
AP	2. Provide support to Manawhenua Hauora to identify priorities and aspirations for Māori health across the organisation EOA	G	↑
AP	3. Provide Māori specific reporting on progress to achieve health equity to Manawhenua Hauora EOA	G	↑
	Māori Health Action Plan – Accelerate the spread and delivery of Kaupapa Māori services		
AP	4. Consolidate Kaupapa Māori Service provision within MDHB including the amalgamation of Oranga Hinengaro – Specialist Kaupapa Māori Mental Health Service and Pae Ora Paiaka Whaiora Hauora Māori Directorate EOA	G	↑
AP	5. Develop an Outcomes Commissioning Framework that leads to an outcomes approach across the district and ensure it aligns with Kaupapa Māori measures of success and performance. EOA	G	↑
AP	6. Prioritise new investment into Kaupapa Māori services across clusters EOA	G	↑
	Māori Health Action Plan – Reducing health inequities- the burden of disease for Māori		
O	7. Identify the opportunity to establish other Whānau Ora Link Nurses to focus on key high utilisation areas in secondary care for Māori EOA	G	↑
	Sustainability Plan Actions		
AP	8. Resource and implement the next phase of Kaimahi Ora Whānau Ora – Māori Workforce Development Implementation Plan 2017 – 2022 to advance the pipeline of Māori recruitment EOA	A	↑
AP	9. Partner People and Culture to prioritise the recruitment of Māori to key areas of high utilisation by Māori EOA	A	•
	Working with sector partners to support sustainable system improvements		
AP	10. Pae Ora will continue to actively contribute and participate in the Kainga Whānau Ora Collective Impact Initiative to support Māori into warmer drier homes EOA	G	↑
AP	11. Investigate the establishment of a centralised hub across government agencies to empower families/whānau toward better health and wellbeing EOA	G	•
O	12. Ensure Iwi aspirations are included in planning documentation and investment commissioning at MDHB EOA	G	•
	Delivery of Whānau Ora		
AP	13. Align the investment and commissioning framework to Whānau Ora outcomes and intermediary measures to actively support and compliment the successes of Whānau Ora across the district EOA	G	•
O	14. Embed the MDHB Whānau Ora Position Statement and Implementation Framework into the planning and prioritisation material for FY 21/22	G	↑
O	15. Actively support Cluster Areas and Enablers to participate in Te Ara Whānau Ora training as part of the integrated workforce development approach across MDHB	G	•

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

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

2. PURPOSE

To provide the Health and Disability Advisory Committee (HDAC) with an update on progress of the work programme for Pae Ora Paiaka Whaiora – Māori Health Directorate from April to June 2021.

3. SUMMARY

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

- Māori workforce development implementation
- Working across sectors
- Combined Board to Board work plan
- Māori Data Sovereignty
- Tiriti o Waitangi and cultural competency
- Internal Audit – Equity for Māori.

4. MĀORI WORKFORCE DEVELOPMENT IMPLEMENTATION

The July HDAC meeting will receive the first 'Te Ara Angitū, Equity Report for Workforce'. The report seeks to identify actions to improve focus areas including increasing the number of Māori employed in MDHB. At present, there are 252 staff across the MDHB, with 11 medical staff. MDHB's workforce development strategy Kaimahi Ora Whānau Ora 2017-2022 will be reviewed once the Senior Workforce Manager is appointed to Pae Ora. Interviews were held in June and we hope to make an appointment following two previous unsuccessful recruitment processes.

5. WORKING ACROSS SECTORS

The Regional Partnership Services Leadership (RPSL) Group for the Manawatu and Whanganui regions is discussing its work plan for the next 12 to 24 months. This group sits above the Regional Interagency Network which has a current focus on mental health and addictions, youth/rangatahi and housing. RPSL has an added priority of employment and aims streamline their work and resources without impacting on current work. This includes Whānau Ora Strategic, Innovation and Development Group (WOSIDG), Ora Konnect which focuses primarily on Highbury and the Safety Advisory Board for the Palmerston North City Council (PNCC). Sharon Shea has been contracted by PNCC to provide training in Palmerston North on results-based accountability. This will support the development of an outcomes reporting framework for Palmerston North. This is intended to drive one reporting dashboard across the district after the RPSL work plan is underway.

6. COMBINED BOARD TO BOARD WORK PLAN

The combined Board to Board draft work plan was endorsed at the joint meeting held in May. The plan has now been finalised and is being tabled for approval at the Manawhenua Hauora and MDHB Board meetings in July. This plan ensures the done at both a governance and operational level will continue during the health sector reforms. Implementation against the plan will be monitored and reported to both Manawhenua Hauora and the MDHB Board.

7. MĀORI DATA SOVEREIGNTY

The policy and guideline for data sovereignty has been developed by the 3 DHBs Capital and Coast, Hutt Valley and Wairarapa for endorsement by the central region Chief Information Officers. The documents will then be submitted for endorsement by the central region Chief Executives. Iwi Partnership Boards will then be consulted before the documents are approved. The intention is for the policy and guideline to be used nationally by all DHBs.

8. TIRITI O WAITANGI AND CULTURAL COMPETENCY

Tiriti o Waitangi training sessions are now arranged for the organisation for the next 12 months and for the Board on 5 October 2021. As agreed by the Board, Wall Walk training for Board and executives will be held after the October training is complete. Directorates are concerned there is a waiting period for people to engage in training. We have booked 10 training sessions for the new year to ensure we have a suitable number for staff. It is wonderful to see the level of interest in the training within the organisation.

9. INTERNAL AUDIT – EQUITY FOR MĀORI

The final report for the Māori Health Equity System review was presented to the Finance, Risk and Audit Committee (FRAC) in June which resulted in a strong discussion on the issues of racism and discrimination within the health system. The scope of the review covered the following areas:

- Make health equity a strategic priority
- Build infrastructure to support health equity
- Address the multiple determinants of health
- Eliminate racism and other forms of oppression
- Partner with the community to improve health equity.

The audit identified very good progress by MDHB on areas for addressing the issue of Māori health equity. Leadership of the health system were described as having a pro equity focus. However, there is still a lot of work to be completed to ensure improved outcomes for Māori populations and whānau. A total of eight recommendations were made. These recommendations will form a programme of work which will be led by Lisa Te Paiho, Pae Ora from July. All areas of the work programme are scheduled to be completed within the next 12. Progress reports will be provided to FRAC in six and 12 months' time.

10. WAYNE BLISSETT'S RESIGNATION

After five years, Wayne Blissett will be leaving MDHB to take up a role with Rangitāne o Manawatū, focusing on their Treaty pathway for Oranga Tamariki. Wayne will continue to provide support to iwi in the health field which will be hugely beneficial to both iwi and MDHB as we transition in the reforms. Wayne's contribution to Māori health in the MidCentral DHB district has been outstanding with evidenced outcomes across the system. His leadership is evident in the Pae Ora team and across the directorates within DHB. Wayne also chairs the Kotahitanga Working Group that was recently funded again by MSD for another year to deliver to whānau Māori across the MidCentral and Whanganui DHB districts. We are going to miss Wayne hugely although we know that his next mission is one that will assist this district into the new system ensuring iwi and Māori populations are prioritised.

Discussion/Decision papers

13 July 2021 HDAC

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

For:

	Approval
X	Endorsement
	Noting

To	Health and Disability Advisory Committee
Author	Judith Catherwood, General Manager, Quality and Innovation
Endorsed by	Kathryn Cook, Chief Executive
Date	6 July 2021
Subject	**Clinical Governance and Quality Improvement Framework**

Key questions the Committee should consider in reviewing this paper:

- Is the Committee assured by progress in the development of clinical governance and quality improvement in the MDHB district?
- Is the Committee confident in the frameworks to support clinical governance?
- Is the Committee satisfied with the proposed future approach to reporting?

RECOMMENDATION

It is recommended that the Committee:

- **note** the development and implementation of The Quality Agenda (Clinical Governance Framework) to date
- **note** the development of the accompanying frameworks to support quality improvement and innovation
- **note** the achievements in improving quality, safety and clinical governance arrangements
- **endorse** the proposal that future reporting on quality and safety programmes and improvement will be provided in the quarterly Quality Accounts, the Quality and Safety Dashboard and Directorate reports.

Strategic Alignment

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

1. PURPOSE

To provide information on progress with the implementation of The Quality Agenda (Clinical Governance Framework) over the last three years. This framework sets the vision for quality and safety and has a district-wide focus. It is proposed this is the last report on this specific topic, with future reporting to the Health and Disability Advisory Committee (HDAC) being provided via quarterly Quality Accounts, the Quality and Safety Dashboard and Directorate reports.

2. SUMMARY

Over the last three years the patient quality, safety and clinical risk approach at MDHB has been refreshed to create internal arrangements that support a contemporary clinical governance system. New clinical governance arrangements and several new frameworks have been put in place. Progress in developing these has been reported to HDAC on a quarterly basis.

The Quality Agenda is MDHB's overarching clinical governance framework. Implementation of this framework has resulted in a series of new support systems, educational programmes and toolkits to support improved quality, safety and clinical governance arrangements.

In future, it is proposed reporting on the approach to continuous quality improvement is included in quarterly organisation-wide Quality Accounts. These focus on quality improvement projects, adverse event outcomes and learning, and organisational improvement efforts. Measurement of MDHB's quality and safety system will be provided through the Quality and Safety Dashboard and Directorate reports. These will continue to include the Directorate reports which contain progress on quality initiatives as part of the existing work programme.

3. BACKGROUND

All healthcare organisations are encouraged to develop, support and uphold a strong clinical governance system. This supports the quality and safety of care and enables clinicians to be directly involved in organisational decision making.

The Health Quality and Safety Commission (HQSC) has adopted the international definition of clinical governance in their guidance document published in 2017. HQSC defined clinical governance as "an organisational wide approach to the continuous quality improvement of clinical services"

HQSC also outlined an overarching framework to support healthcare organisations in New Zealand to further strengthen and develop their clinical governance system. It is well documented that healthcare organisations that work to develop, uphold and cherish a strong clinical governance system, will achieve higher levels of organisational performance and success in all domains or facets of healthcare delivery, for example clinical, workforce, financial and corporate governance.

In 2016, two internal audits identified opportunities for improvement in the clinical governance system within MDHB and specifically in the management of serious adverse events.

MDHB implemented a new organisational structure in 2017/18 called the Integrated Service Model (ISM). This included the creation of a new role of General Manager Quality and Innovation which would take a lead in supporting changes and improvements to quality and clinical governance arrangements. It also created the role of Clinical Executive in each of the six Directorates to strengthen clinical governance. In 2018, MDHB developed and published a Clinical Governance Framework (The Quality Agenda) which set the framework through which quality, safety and clinical risk is managed, embracing a shared governance model. This framework was developed to enable the new clinical governance arrangements to come to life across the organisation and district, and support the Integrated Service Model (ISM), Te Wao Nui a Tane.

The Quality Agenda was implemented during 2019/20. To support its implementation, several new supporting frameworks were developed and a number of toolkits, training programmes and policies and procedures have been developed.

All actions to address the recommendations from the two internal audits in 2016 have been completed.

4. PROGRESS IN THE LAST THREE YEARS

The Quality Agenda is now fully embedded. The approach has matured to embed clinical and consumer engagement across MDHB and move toward a model of continuous quality improvement. Progress on the implementation of The Quality Agenda has been reported to HDAC over the last three years. This report summarises the achievements and deliverables over the last three years.

The implementation plan to support The Quality Agenda was completed in 2020. A number of linked activities have been completed over the course of the last three years.

Several new frameworks have been developed to support the transition to a model of continuous quality improvement, including a:

- clinical audit framework which is being implemented at present
- innovations framework which will be implemented in 2021
- quality improvement framework which is in the process of being implemented
- consumer engagement framework which is being implemented

- policy governance framework which is in the process of being implemented
- complaints/feedback framework which is in place and has improved our responses to consumer feedback
- clinical governance committee structure and accountability framework which is being implemented.

Several toolkits have been developed and implemented to support our staff, including a:

- serious adverse events toolkit update to support process improvement
- toolkit to support Quality and Safety walk-rounds has been embedded, involving Board members and Executive leaders
- toolkit to support consumer stories. A process to develop the use of consumer stories and increase the power of storytelling to support continuous improvement is in progress.

Education and training programmes have been developed to support staff to take a greater leadership role in quality and safety in their services or Directorates. These include:

- an educational pathway to support continuous quality improvement.
- in-service training sessions that support staff to feel enabled and empowered when dealing with consumer feedback or concerns. This is being delivered in collaboration with Nationwide Advocacy Services to staff in a number of patient areas across the organisation.
- an education programme to support The Quality Agenda which has been created and implemented. This includes education for the wider clinical workforce in:
    - Serious adverse event reviews
    - Quality improvement methods
    - Change management in clinical pathways and models of care
    - Use of data for improvement.

The following actions, tools and systems have been put in place:

- A clinical governance dashboard on Qlik. This is being continually developed and embellished as required by Directorates and clinical teams.
- The consumer engagement quality and safety marker which is being used to measure and improve consumer engagement systems across MDHB.

- Each Directorate has a quality plan which is refreshed annually by the clinical leadership team for the Directorate, in partnership with the Quality and Innovation Team.
- The Clinical Governance Committee structure has been refreshed and consolidated. This has created eight new enterprise Clinical Governance Committees in addition to the Consumer and Clinical Council Advisory Groups.
- Ngā Pou o te Oranga has been developed and is in the process of being implemented. This is an audit framework to support measurement and improvement in the delivery of the fundamentals of health by encompassing the principles of Te Whare Tapa Wha.

Several quality improvement programmes, projects and initiatives have also been delivered in the Directorates with the support of the Quality and Innovation Team. These include implementation of national programmes in partnership with HQSC or local activities. Some of these are highlighted in Appendix One.

A selection of the frameworks and toolkits are available for HDAC members to review on the Stellar platform.

5. NEXT STEPS

Two areas which required further work to enable the vision of The Quality Agenda to mature within the ISM have been identified. These include:

- improvements to the use and availability of improvement analytics
- support to enable clinical audit.

These two areas remain vital to the clinical governance system and require a strong and robust data and analytics support system. MDHB clinicians have indicated the importance of strengthening these areas.

The Quality and Innovation Team is planning two roles within the team to address these requirements. These roles can be accommodated within the existing establishment. An improvement analyst role will support clinicians and the Quality and Innovation Team to develop the use of data for improvement. This will also increase capacity to support clinically-led improvement teams to measure the impact of their improvement activities.

To support the delivery of the new clinical audit framework, a Quality and Clinical Effectiveness Advisor will be recruited. This role will support the development of an organisational clinical audit system. This will enable our clinical teams to develop audit plans and expand clinical effectiveness initiatives.

During the last quarter of 2020, a broad range of clinicians and representatives from the Clinical Council collaborated to review the Clinical Governance Committee structure. This new structure has been shared with all Directorates, has been finalised and is being implemented. The process identified three overarching goals for the refreshed clinical governance committees and six associated work streams to further progress the enabler work of the Quality and Innovation Team.

Part of the role of the new committees will be to set the working priorities for each quarter aligned to the group's Terms of Reference. This will include key performance indicators and measures of improvement. As this develops, the shared governance model will be further embedded, and continuous quality improvement will continue to be enhanced.

The following three focused goals were agreed upon during the recent refresh of the Clinical Governance Committee structure:

These goals will be achieved through the following work streams.

1. Building consumer and community engagement across the MDHB district.
2. Developing a safety culture across the district.
3. Developing quality improvement capability across the district through:
    - developing Quality tools
    - building Innovation resources
    - building the Enabler team.
4. Driving the use of clinical governance and quality improvement measures.
5. Empowering clinical leadership, collaboration and clinical governance.
6. Enabling research, clinical effectiveness and audit.

Achievements against each of these work streams is provided in Appendix One. This summarises progress over the last six months. It also reflects on and summarises achievements and deliverables over the previous three years.

MDHB was audited by the Designated Audit Agency on behalf of the Ministry of Health in October 2020. One of the focus areas for the audit was organisational clinical governance and quality and safety systems. All quality and safety organisational management standards and criteria were assessed and MDHB received 'Fully attained' status against each of the standards. This indicates the quality systems and approach is strong. There were no corrective actions in this area.

The Quality and Innovation Team plans to support MDHB to achieve continuous improvement ratings in the next certification audit in 2022.

6. FUTURE REPORTING

The Quality and Innovation Team has engaged with the Clinical and Consumer Councils on its proposal to move to quarterly Quality Accounts. It is proposed these will be available for HDAC to review and published on the MDHB website. The Quality and Innovation Team will work with the Communications Team to ensure these reports are used creatively on social media and in other forms of regular communication with the community. This has been supported by both Councils.

Measurement of MDHB's quality and safety performance will be via the Quality and Safety Dashboard report which is provided quarterly to HDAC. All Directorates with Cluster functions already provide regular reports to HDAC inclusive of quality improvements and this will continue.

Appendix One – Achievements with the work streams

Appendix One - Achievements with the Work Streams

Work Stream One – Building Consumer and Community Engagement across the District

Achievements in 2021

The training plan, in collaboration with HQSC, for the Consumer Council and wider consumer network across the district, has been developed. The organisational ratings and supporting evidence for the Consumer Engagement Quality and Safety Marker (QSM) was submitted.

The Consumer Engagement QSM group has developed a work plan that incorporates the key pieces of work that will be prioritised to support the engagement with, responsiveness to and experience of our consumers. The Volunteering Framework continues to be implemented across the organisation.

The Bereavement Group work has progressed work on support and guidance materials for people and whānau, staff and contractors. Addressing the challenges with facilities is being progressed with short and long-term plans considering the care of our tūpāpaku as well as those outside of MDHB needing regional coronial services.

What we have achieved over the past three years

- Consumer and community engagement across the district has been significantly strengthened through the work of the Health and Wellbeing Locality Groups, Consumer Council and Panel.
- A robust consumer network and framework has been developed and implemented in collaboration with the Consumer Council.
- The Consumer Council and Panel are active co-design partners and the delivery of consumer training in partnership with Health Quality and Safety Commission (HQSC) will further develop this approach.
- The Consumer Council was supported in the development of their ambitions and goals of facilitating consumer representation to ensure that person and whānau centred practice and leadership is at the core of all planning, resourcing and health services delivery
- The Consumer Council Engagement quality and safety marker (QSM) is in the process of being implemented across the district.
- The complaints framework has been strengthened to support consumer engagement and the timely review of all feedback. This includes the development of a conflict resolution approach led by Pae Ora Paiaka Whaiora.
- Consumer storytelling has been developed into mainstream feedback systems and continues to be embedded into practice and further strengthened.

Work Stream Two – Developing the Safety Culture Across the District

Achievements in 2021

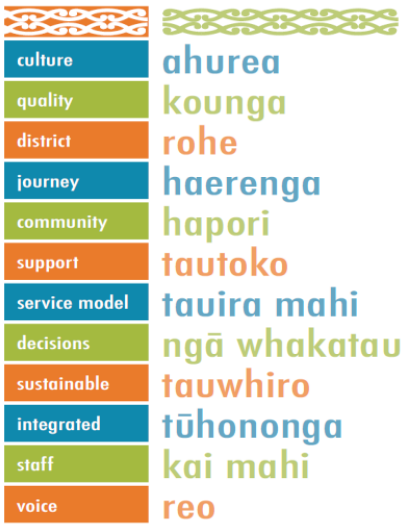
To further strengthen the commitment to patient and staff safety, workshops were held on the principles of a Safety II Culture and how they can be embedded across the organisation. Some existing frameworks are already in place such as the Clinical Governance structure refresh which incorporates a Safety Culture across MDHB systems supporting this approach.

The "Please ID Me" campaign has been completed with ongoing training modules being developed through the Ko Awatea learning platform.

What we have achieved over the past three years

- Mahi Tahi has been established in the inpatient wards. This initiative partners with the patient's whānau as kaimanaaki to become a member of the clinical team and assist in the care and advocacy of the patient. It also forms MDHB's approach to Korero Mai, the second work stream in the Health Quality Safety Commission's Deteriorating Patient Programme.
- The development of He kura te Tangata, A Plan for our People 2019–2023, which is a refresh of the Organisational Development Plan. He kura te Tangata focuses on innovation, people, partners, stewardship and information.
- Cluster Health and Wellbeing Plans led by each Directorate with Cluster functions, focus on wellness, an integrated approach with shared decision making and community-based care.
- Quality and Safety Walk-rounds for Board members have been implemented, evaluated and strengthened to engage more with staff on the ground, as well as giving opportunities for feedback to Board members. Directorates with Enabler functions will be included in these walk-rounds.
- Partnering with HQSC to utilise restorative approaches to heal and learn from serious incidents and events that further enhance organisational processes to enhance a safety culture.
- Collaboration and local workshops, with subject matter experts, on Safety II as applied in NZ health systems to further enhance a Safety II Culture.
- Staff engagement surveys to provide feedback from across the organisation help better understand areas for improvement.

Work Stream Three – Developing Quality Improvement (QI) Capability Across the District



Achievements in 2021

Improvements to the Ngā Pou o te Oranga questionnaire tools and data collection process has been progressed to support the prototype implementation of this work across MDHB. Quality Improvement, Change Management and Data Management training has been delivered. Regular scheduled training will be provided to the district on an ongoing basis. Mentoring for staff undertaking external QI qualifications has been provided. Quality and Innovation frameworks have progressed and been finalised. The Quality Account format and approach was reviewed by both the Consumer and Clinical Councils and agreement for quarterly reporting in short and concise stories of improvement was encouraged to be available across the district.

What we have achieved over the past three years

- A Quality Improvement Training Pathway has been developed, established and is currently being utilised by staff across the workforce.
- A quality network has been established to support development of QI champions.
- A service credentialing model has been developed to incorporate a QI strategic process. This is being led in partnership with the Chief Medical Officer.
- A collaborative partnership between Quality and Innovation and Pae Ora Paiaka Whaiora has been fostered with regular joint hui being held to progress shared purposes and prioritise opportunities for collaborative work.
- Quality and Innovation Frameworks have been developed to reflect a Māori world view and a commitment to Te Tiriti o Waitangi. Current work includes the development of quality improvement training embedded with an equity focus in partnership with Pae Ora Paiaka Whaiora.
- Quality improvement expertise has grown within the Quality and Innovation Team, as well as across the organisation. This has been achieved through partnering with external training organisations including the HQSC.
- Automated data platforms such as Qlik and the HQSC's Quality Safety Measure reporting platforms has reduced some manual reporting, providing opportunities for the team to focus on critical enabler functions.
- Quality and Innovation staff are part of ongoing Directorate planning to support quality and safety as part of MDHB's business partnership model.

Work Stream Four – Driving the use of Clinical Governance and Quality Improvement Measures

Achievements in 2021

The Health Roundtable (HRT) has presented MDHB's latest data. This has assisted staff to understand the data, shared innovations in practice and demonstrated tools for specific projects or areas of improvement.

The Qlik dashboard continues to be expanded to include more quality and safety measures.

Engagement continues with Directorates to improve performance on the quality and safety markers with some significant improvements have been made. These include Patient Deterioration, Pressure Injuries and Safer Surgeries.

What we have achieved over the past three years

- MDHB is one of the few DHBs to have implemented all three work streams in the HQSC's Deteriorating Patient Programme. MDHB was a pilot site for the Shared Goals of Care programme and has been supporting other DHBs in their project planning to implement this work stream.
- Health Quality Safety Commission programmes such as reducing opioid related harm, Safer Surgery, Mental Health and Addictions Quality Improvement projects.
- MDHB has implemented the Red2Green programme to monitor and address issues that may delay progressing a patient care journey.
- Master class attendance by staff with HRT. This involved understanding, navigating and being able to use data for a specific review or improvement purposes such as by ethnicity or diagnosis.
- Expanding the use and application of HRT and other quality benchmarking tools across clinical teams.
- The development of and ongoing improvement to Directorate quality plans.

Work Stream Five – Empowering Clinical Leadership, Collaboration and Clinical Governance

Achievements in 2021

The refreshed Clinical Governance Structure to support the Quality Agenda has been agreed and changes are being implemented. The innovation framework has been finalised and an implementation plan is being developed for both the innovation and quality improvement frameworks across the organisation. A commissioning framework is being developed that will be supported by these frameworks.

What we have achieved over the past three years

- Refreshed the Clinical Governance Committee structures across the organisation.
- Shared governance models have been developed within teams and services in clusters.
- A clinical leadership development programme has been developed to support existing and new staff being appointed to clinical leadership roles within the organisation. This includes elements of learning linked to quality improvement.
- Quality Improvement, Innovation and Commissioning frameworks are being finalised to support staff to deliver quality and excellence in all we do across the district.

Work Stream Six – Enabling Research, Clinical Effectiveness and Audit

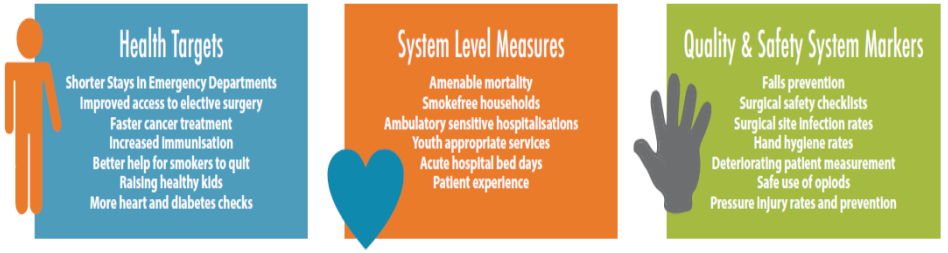
Achievements in 2021

In the last reporting period, the clinical audit framework has been developed and shared across the organisation. An implementation plan is being progressed across all Directorates with Cluster functions.

Since the beginning of the year, 20 new clinical audits have been registered within the Quality Module. Specific audits underway include a consumer experience audit, respiratory care plan, patient survey audit and a child health ambulatory sensitive hospitalisation (ASH) audit for 0-4 year olds.

Technical Advisory Service (TAS) has completed an internal audit on Clinical Audit Activity and Support as part of the Board's internal audit programme. Six areas were reviewed as part of this process. The overall assessment of MDHB's processes and controls relating to Clinical Audit Activity and Support were considered effective, with some significant improvement required and several opportunities to strengthen existing processes. There are 10 recommendations from the audit. An action plan has been developed and staff identified to lead and ensure these recommendations are completed. The development of a research strategy for 2021-2026 is currently underway through the CMO office.

What we have achieved over the past three to five years



- Development of the clinical audit framework to support coordinated organisational and Directorate specific clinical audit plans.
- Development of an implementation plan to support the framework, to support Directorates to develop, undertake, evaluate and improve on clinical audit activities.
- Co-designing clinical audit programmes within Directorates.
- Support to the Directorates to integrate clinical effectiveness and improvement cycles into business as usual.
- Building research partnerships with tertiary facilities in partnership with the Chief Medical Officer.
- Growing of research capacity and publications across the organisation.
- Clinicians are able to share their clinical audits at the annual clinical audit and research week.

For:

	Approval
X	Endorsement
	Noting

Key questions the Committee should consider in reviewing this paper:

- Is there any key equity information which is required for governance that should be included in the report?
- Do the next steps adequately reflect the expectations of the Committee?
- Are there any changes suggested for future reports?

To	Health and Disability Advisory Committee
Author	Scott Ambridge, Operations Executive, Te Uru Rauhī Vanessa Caldwell, Clinical Executive, Te Uru Rauhī Keyur Anjaria, General Manager, People and Culture
Endorsed by	Tracee Te Huia, General Manager, Māori Health Kathryn Cook, Chief Executive
Date	16 June 2021
Subject	**Māori Health Equity Dashboard – Te Ara Angitū Report - Mental Health and Addiction Services Adult Indicators**

RECOMMENDATION

It is recommended that the Committee:

- **note** the equity position for each of the indicators
- **note** the analysis, discussion and proposed next steps to improve Māori health equity and further strengthen MidCentral District Health Board's (MDHB) commitment to Te Tiriti o Waitangi
- **endorse** the Te Ara Angitū report, Mental Health and Addiction Services Adult Indicators.

Strategic Alignment

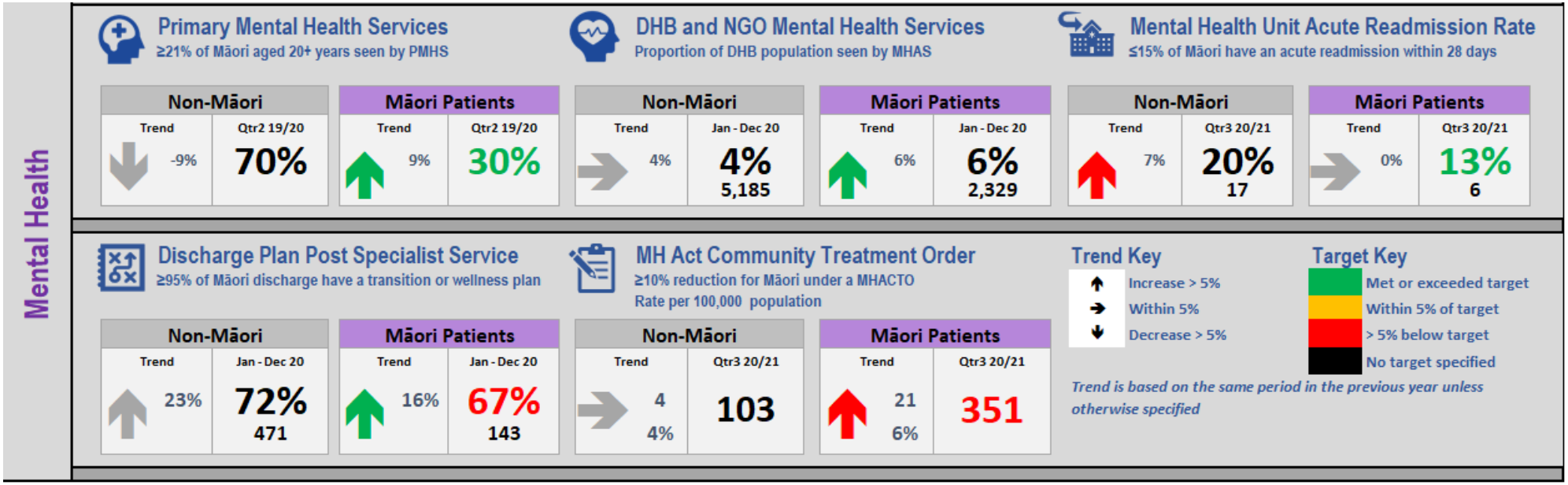
This report is aligned to the DHB's Strategic Plan and Ka Ao, Ka Awatea, the Māori Health Strategic Framework.

1. PURPOSE

To provides analysis of equity indicators across adult mental health. The priority indicators were agreed by MDHB and Manawhenua Hauora at their respective meetings in June and July 2020. They are consistent with the MDHB's health outcomes framework, Whānau Ora, MDHB's commitment to Te Tiriti o Waitangi and deployment of the MDHB Strategy. These detailed reports can be found on the Stellar platform *(MDHB/HDAC/HDAC Reports and Documents/HDAC Report Māori Health Equity Dashboard Report – Adult Health Te Ara Angitu Appendices FINAL).*

The data and information in this report covers different time periods depending on the specific indicator, and ranges from seasonal, through to the past calendar year intervals. The data covers access rates to the newly implemented Te Ara Rau (access and choice) primary mental health service which was funded specifically from the wellbeing budget. We have agreement from the Ministry of Health (the Ministry) to continue to support the rollout of this funding phased over the next two years to support additional clinical and non-clinical roles. The data set provides a strong baseline to test key areas for improvement in Māori health expected because of the implementation of the model of care change programme we are embarking on from July 2021.

2. INDICATOR OVERVIEW



3. WHAT THIS TELLS US

3.1. Primary Mental Health and Addiction Services

The number of people accessing the primary mental health (Te Ara Rau) service who identify as Māori sits above the target of 20 percent. The programme was developed and implemented in partnership with the DHB, THINK Hauora and the WAIORA Roopu. The programme included the appointment of 11 Kaiwhakapuaki Waiora (Health Coaches) roles located within iwi to ensure an overt focus on increasing access for tāngata whaiora and whānau.

Kaiwhakapuaki Waiora are the non-clinical kaimahi within the Te Ara Rau programme. These kaimahi are the rohe connectors, based in iwi and Māori providers, who walk alongside tāngata whaiora and whānau in navigating their own healthcare journey. Kaiwhakapuaki Waiora have lived experience of their own health condition so they are in a prime position to tautoko and awhi others. These kaimahi work alongside Mātanga Whai Ora (clinical staff) and other programme partners and are the rich central cog in connecting our communities for wellbeing.

Cultural Workforce Development Programme

An exciting variation to the original contract has been signed off, allowing for a cultural workforce development programme. This programme adds immense richness and works toward increasing the cultural competency of all our kaimahi across the rohe. Te Ara Rau Access and Choice worked in partnership with the WAIORA Roopu in developing and implementing a Cultural/Māori Advancement Plan. The Takarangi Cultural Competency Training is the model that will be implemented, and this provides potential for increasing understanding of Te Ao Māori using presentations, webinars, guest speakers and cultural supervision over an initial 12-month period.

Positive feedback from service users

An online survey has been developed and Mātanga Whai Ora have posters on site and cards and website link and QR codes to give to tāngata whaiora. Initial responses are limited in number; however it is envisaged that responses and feedback will increase as Mātanga Whai Ora promote the survey with tāngata whaiora and whānau. Initial feedback indicates 100 percent felt valued and appreciated, 75 percent felt the session was helpful, 95 percent found the brief therapy approach helpful. Overall, 95 percent of respondents reported the Mātanga Whai Ora appointment was the right approach for them.

3.2. Service Access

Māori accessing secondary mental health and addiction services month by month is relatively stable and is slightly more (26 percent) than the population (21 percent). Māori accessing services is proportionally higher in Horowhenua and Tararua when compared to the overall population.

Probably the most substantial reflection from the data is that the percent of Māori being supported by the dedicated secondary kaupapa service is five percent of the total Māori within secondary mental health and addiction services. This highlights the significant and historical underinvestment in kaupapa services.

3.3. **Acute Readmission Rate**

Whilst the data shows that readmission rate is lower for Māori, it only shows part of the picture. The length of stay (LOS) for Māori on the ward is longer than for non-Māori. This shows some correlation between LOS and readmission rate, in this case a long length of stay will reduce readmission rate.

	Number	Number/10k population
Māori >= 30 days Length of Stay (LOS)	22	8.9
Non-Māori >= 30 days LOS	28	2.3
Total >= 30 days LOS	50	3.5

3.4. **Seven-dDay Follow up Post Discharge**

Due to the evidence of vulnerability of tāngata whaiora after discharge from an inpatient stay on Ward 21, this indicator has been prioritised as a key improvement initiative within Te Uru Ruahī. This result for the quarter was 72 percent, up from 49 percent since the last report. While still below target, this represents a strong improvement.

Further system strengthening measures have now been put in place to improve compliance with seven-day post discharge follow ups. These include:

- increasing awareness at all levels of the evidence behind the seven-day follow up requirement and impact on the lives of individual people
- increasing community team involvement in the ward discharge process
- daily distribution of the Ward 21 discharge list to all community teams highlighting patients in need of follow up
- updates on seven-day follow ups in daily community team huddles
- reminders sent out to clinicians if contact has not been made with a client by Day 5 post discharge.

3.5. Community Treatment Orders

The use of community treatment orders (CTOs) has both benefits and drawbacks for tāngata whaiora. They are considered helpful in increasing patient safety and are generally favoured over inpatient care. However, the drawbacks include a loss of control and a feeling of being 'imposed on'.

The number of Māori on CTOs are three times higher than non-Māori (Rate/100,000 pop: Māori 351 versus non-Māori 103). This fact highlights the need for a different approach to how the use of CTOs for Māori versus Non-Māori is applied and is a key objective for improvement to address in the new model of care and provision of genuine kaupapa Māori responses.

There is also anecdotal evidence that CTOs are used to improve access to prescription (under a CTO the prescription is funded by the DHB). However, this has become less of a barrier as the number of pharmacies offering free prescriptions has increased.

4. DISCUSSION

The Integrated Primary Mental Health and Addiction service (IPMHA) programme's aim is to improve health and equity of access for a tāngata whaiora and whānau within the rohe by reducing stigma, removing and reducing barriers to engagement. The aim to increase access, equity of access, increase choice in a holistic manner, reduce wait times and improve population health and equity outcomes is embedded in all areas of the programme. The work progressing within the IPMHA programme shows that when services are designed, developed and implemented by Māori for Māori this results in improved access. While the service is still new, the qualitative feedback shows strong alignment with cultural practice and strengthening of access for Māori.

The indicators within secondary mental health and addiction services show a clear equity gap between Māori and non-Māori. This confirms that the current traditional 'medicate and manage' approach is not working for Māori and that this population is being disadvantaged by the lack of culturally appropriate options available to them.

While overall service access for Māori is consistent with the population, it is concerning that the percentage of Māori accessing kaupapa service is very low (five percent of the total). Whilst not all Māori want to be supported by the kaupapa services, the analysis highlights the lack of options that have been developed by Māori for Māori and the undervaluing of kaupapa based services in relation to mainstream services. Consolidating kaupapa Māori health with the amalgamation of Oranga Hinengaro and Pae Ora Paiaka Whaiora on July 2020 was an important first step in addressing equity of access for Māori.

It is pleasing to see improvement in the seven-day post discharge follow up for Māori. There are still a range of barriers evident for Māori. A survey of service users (some of whom are Māori) cited concerns about the stigma associated with using the mental health and addiction services, limited choices available for follow-up and a lack of other options (such as meeting over 'Zoom'). The Quality Action Group continues to focus on this KPI as a key improvement initiative.

A commitment to Māori health equity has been brought to life through the partnership model developed by Pae Ora Paiaka Whaiora and Te Uru Rauhī to develop an Integrated Model of Clinical and Kaupapa Māori Service Delivery for Adult Secondary Mental Health and Addiction Services. The approach takes the best from both and builds on the significant strengths through combining as partners. This partnership gives effect to the findings and aspirations to improve access and outcomes for Māori across the continuum grounded in Te Whare Tapa Whā.

5. NEXT STEPS

Individual indicator analysis notes the current range of improvements that are focused on improving Māori health equity. However, taking a wider system view and fulfilling MDHB's Te Tiriti o Waitangi obligations, the following steps are proposed for discussion with the Committee.

5.1. Primary Care

- Continue to support the ongoing implementation and growth of Te Ara Rau, Access and Choice programme including continued investment in Kaiwhakapuaki Waiora.
- Work with key partners to continue to develop data collection requirements with a specific focus on equity outcomes.

5.2. Service Access

- Implement the integrated model of care that sees the expansion of kaupapa Māori mental health and addiction services with the inclusion of an additional kauapapa team based in Horowhenua. This will increase service offerings and choice that will provide access to rongoa, mirimiri and kaupapa service options in the community.
- The proposal is inclusive of additional cultural advisor roles and peer support roles.

5.3. Seven-day post discharge follow up

- Continue to improve compliance with post discharge seven-day follow up with an overt focus on Māori.
- Continue monthly analysis of individual cases of non-compliance to determine the exact reason contact was not made within seven days and develop remedial actions to address.

5.4. **Community Treatment Orders/28-day readmission rate**

- These indicators will be used to measure the effectiveness of the implementation of the new proposed model of care for adult services. For example, through increasing the capacity of kaupapa services that are being delivered from a te Ao Māori perspective, the use of CTO as a tool to enforce compliance will decrease over time.
- Cultural competency training of a staff is an important intervention to improve the way in which clinicians respond to Māori. Core training will be provided to all staff as part of the proposed Integrated Model of Care.

For:

	Approval
X	Endorsement
	Noting

To	Health and Disability Advisory Committee
Authors	Keyur Anjaria, General Manager, People and Culture
Endorsed by	Kathryn Cook, Chief Executive Organisational Leadership Team
Date	28 June 2021
Subject	**Māori Health Equity Dashboard Report – Workforce Indicators**

Key questions the Committee should consider in reviewing this paper:

- Does the report provide sufficient and detailed information on identified workforce measures?
- Are there any key risks which the Committee would like oversight of?
- Does the commentary and 'next steps' within this report provide assurance on meeting workforce targets for the 2021/22 year?
- Are any changes or amendments suggested by the Committee for future reports?

RECOMMENDATION

It is recommended that the Committee:

- **note** the progress made on workforce indicators identified for the 2020/21 year
- **note** the analysis, discussion and proposed next steps to improve the current workforce indicators, and strengthen MidCentral District Health Board's commitment to Te Tiriti o Waitangi
- **endorse** the Workforce Indicators report.

Strategic Alignment

This report is aligned to MidCentral District Health Board's Strategic Plan and Ka Ao, Ka Awatea, the Māori Health Strategic Framework. The report also draws on the People Plan, '*He kura te Tāngata, A plan for our people'*, especially the action plan for the 2020/21 performance year.

1. PURPOSE

To provide the Committee with an update on key workforce measures identified within the People Plan, *He kura te Tāngata, A plan for our people*, as identified for the 2020/21 performance year. The indicators have been agreed by both MidCentral District Health Board (MDHB) and Manawhenua Hauora at their respective meetings. They are consistent with the MDHB health outcomes framework, Whānau Ora, MDHB's commitment to Te Tiriti o Waitangi and deployment of the MDHB Strategy.

The data and information in this report is as at 30 May 2021. Data, insights and commentary for each indicator have been provided.

The report has been endorsed by the Organisational Leadership team (OLT).

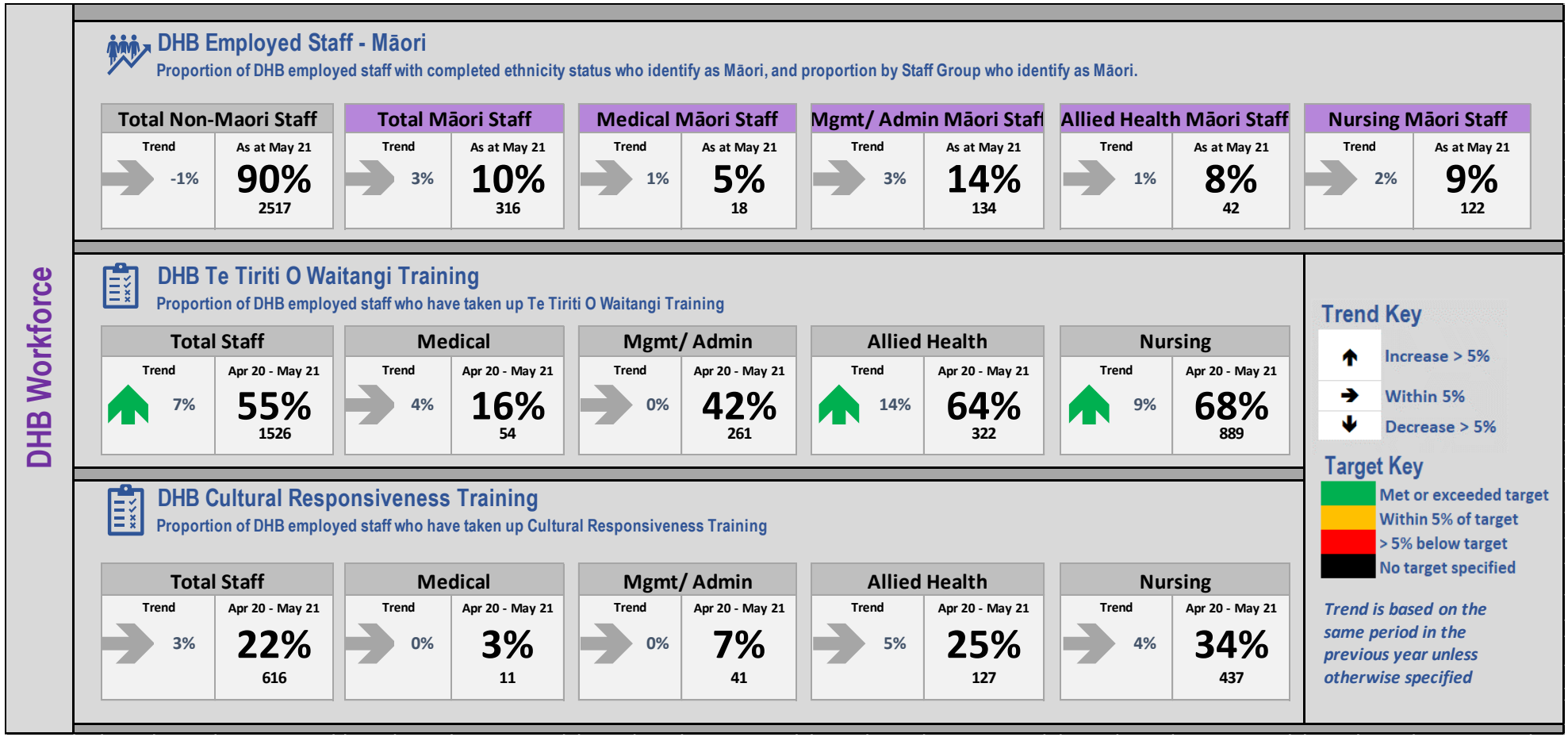
2. BACKGROUND

He Kura te Tāngata, A plan for our people was developed in 2019, following a refresh of the previous Organisational Development Plan of 2017. The plan was developed following consultation with staff and input from the staff engagement survey conducted in 2018. Five strategic areas of focus were identified within the plan:

- Our Commitment to Te Tiriti o Waitangi – Inspire our people towards enhanced cultural responsiveness
- Our Culture – Support a healthy and productive workplace culture which enables excellence
- Our Capability – Empower an increased capability of our people
- Our ways of working – Encourage our people to be agile, innovative and respond effectively to our patients, whānau and community
- Our Environment – Design a work environment which delivers an exceptional employee experience.

The People Plan is supported by an action plan identifying KPIs and markers across the strategic areas of focus for four years. This report provides an update on the actions identified for the strategic area – 'Our Commitment to Te Tiriti o Waitangi for the 2020/21 year'. The relevant section of the action plan for the 2020/21 year is attached as Appendix One.

Information is provided in the dashboard below, followed by commentary against these measures.



3. INSIGHTS

3.1. A pro-equity approach is applied to the Māori workforce

One of the key workforce measures for MDHB is to have a workforce which is reflective of the ethnicities within the community. As at 30 May 2021, about ten percent of staff (316 staff) identified as Māori. This number includes employed and contracted staff. While this number continues to increase, it is acknowledged that more work needs to be undertaken to accelerate the number of Māori staff within our workforce.

To encourage Māori applicants to apply for roles within the DHB, advertisements for vacancies within MDHB (except medical roles) have a statement which says, *"MidCentral District Health Board actively seeks Māori into our workforce to reflect the community we serve".* In accordance with the Te Tumu Whakarai framework which has been approved by DHB Chief Executives, MDHB also shortlists applicants who identify as Māori when they meet the criteria required for the role. Recruitment is underway for a dedicated Māori workforce officer. The person appointed to this role will be expected to work with recruiting managers to support and encourage Māori applicants.

3.2. Our employment processes are inclusive of Te Tiriti knowledge and Tikanga Māori

The following key activities have been undertaken to support this initiative:

- The Pae Ora Paiaka Whaiora Directorate is working closely with cluster leads in incorporating principles of Te Tiriti in all routine reporting and operational activities. The Directorate is also developing a Te Tiriti o Waitangi framework to actively support staff to understand and appreciate how Te Tiriti relates to health and wellbeing for Māori communities. This framework will provide links to practice and behaviour which align with the articles of Te Tiriti in context with the Ministry of Health (the Ministry) Whakamaua Māori Health Framework.
- Tauira mahi ngaio – the professional practice model for nursing has been developed and depicts how nurses practice, collaborate, communicate and develop professionally to provide the best and culturally responsive care.
- The DHB also refreshed Ka Ao, Ka Awatea, a strategy which adopts a cohesive and comprehensive approach across THINK Hauora and MDHB to improve health outcomes for Māori.
- Applicants who identify as Māori are provided with an opportunity to bring a support person with them to their interviews, in line with tikanga.
- Performance plans for members of the OLT include performance objectives related to a commitment to equity and Te Tiriti o Waitangi.
- All new staff are welcomed through a new staff day (held monthly) by way of a powhiri and are educated about Te Tiriti commitments and iwi in the region.

3.3. Our employees demonstrate cultural competence

The DHB continues to deliver training to enhance cultural competency requirements for its staff through focused Te Tiriti o Waitangi and Cultural Competency programmes. As at 30 May 2021, 55 percent of the DHB's staff had completed the Te Tiriti o Waitangi training programme.

About 22 percent of staff have also completed the Cultural Competency programme and this number continues to grow. Further detail of the professional groups who have completed this training is provided in the dashboard.

The OLT undertook a 10-week programme from August to November 2020 to learn Te Reo. The programme was delivered by Massey University. The objective of this programme was to familiarise the Executive Team with basic Te Reo so it could be used appropriately in regular conversations between executive leaders at MDHB.

Tauira mahi ngaio – the professional practice model for nursing has been developed and depicts how nurses practice, collaborate, communicate and develop professionally to provide the best and culturally responsive, care.

The DHB also refreshed Ka Ao, Ka Awatea, a strategy which adopts a cohesive and comprehensive approach across THINK Hauora and MDHB to improve health outcomes for Māori.

4. NEXT STEPS

Reports in the dashboard indicate continued progress across the workforce initiatives which have been identified. Over the next six months, in order to accelerate the workforce performance indicators, the following key activities are planned:

- Continue to deliver Te Tiriti o Waitangi training programmes to meet targets identified within Year Three of the People Plan, including one scheduled for the Board later in 2021.
- Continue to deliver the Cultural Competency training programmes as scheduled.
- Develop and deliver a training programme to manage 'unconscious bias'.
- Recruitment of a dedicated Māori Workforce Development Officer. This is expected to return greater benefits to support the initiatives outlined within the Plan.
- Greater engagement with Kia Ora Hauora, bringing in school leavers and under-graduate students to get a 'feel' for the health system, with a view to seeking employment within the sector.

Appendix One: Year Three activities of the People Plan, *He kura te Tāngata*

Year 2 | 2020/2021

Enable our People

Our Commitment to Te Tiriti o Waitangi Kia ū ki te tika
Our systems and practices ensure that Māori needs are met. • Implement and assess an action plan which ensures that Karakia, waiata, whakawhanaungatanga, pōwhiri, and Te Reo Māori are embedded. **A pro-equity approach is applied to Māori workforce.** • Report on progress made for attracting and retaining Māori workforce. **We drive and measure the progress of Māori health gains.** • Increase recruitment and retention of Māori employees. **Our employment processes are inclusive of Te Tiriti knowledge and tikanga Māori** • Ensure organisational processes are inclusive of Te Tiriti and tikanga Māori **Our employees demonstrate cultural confidence.** • 50 percent of the workforce has completed at least one cultural competence training programme.

For:

	Approval
	Endorsement
X	Noting

Key questions the Committee should consider in reviewing this paper:

- Does this paper provide the Committee with sufficient information and line of sight on progress with delivering the annual planning priorities for the central region?

To	Health and Disability Advisory Committee
Author	Kelly Isles, Director of Strategy, Planning and Accountability
Endorsed by	Chiquita Hansen, Interim General Manager, Strategy, Planning and Performance
Date	21 June 2021
Subject	**Regional Services Plan Implementation, Quarter 3 – 2020/21**

RECOMMENDATION

It is recommended that the Committee:

- **note** the final draft of the Regional Services Plan for 2020/21 was submitted to the Ministry of Health in December 2020 and has been formally approved by the Minister of Health
- **note** there is no requirement to have a Regional Services Plan presented to the Minister for the 2021/22 year
- **note** the progress made on implementing the central region's national and regional priority programmes for the third quarter of 2020/21.

Strategic Alignment

This report concerns the collaborative programme of work undertaken as a region and is consistent with the five enablers of the District Health Board's Strategy and central region's strategic objectives.

1. PURPOSE

To provide an update on delivering the Central Region 2020/21 Regional Services Plan (RSP) for Quarter Three (covering the period from 1 January to 31 March 2021). It is for the Committee's information only and no decision is required.

2. OVERVIEW

- The Ministry of Health (the Ministry) has reviewed the region's progress on implementing the deliverables and milestones for Quarter Three, based on the report provided by Technical Advisory Services (TAS) and provided an overall assessment rating of 'achieved'.
- No significant issues or risks to delivering the priority programmes were identified in the report for Quarter Three.
- Highlights for Quarter Three are provided in the tables below.
- There is a focus on aligning areas of work with the Health and Disability System Review.
- While an RSP is not required by the Minister next year, DHBs within the region will continue to work collaboratively on regional priorities to address issues as they emerge and address requirements of the transition. The Board will be kept updated on progress of the regional priorities.

3. BACKGROUND

The RSP articulates the central region's strategic direction and provides a high-level overview of the priority programmes with actions to be undertaken by the six District Health Boards (DHBs) over the planning year. These actions are aimed at advancing the region's three strategic objectives:

1. Equitable access and outcomes across the region
2. Financial sustainability for all services in the region
3. Clinical sustainability to ensure patient safety and quality of care.

To achieve the region's three strategic objectives, the six central region DHBs have identified the following strategic initiatives.

1. Building regional partnerships with Māori
2. Implementing a networked approach to specialist service delivery
3. Enabling the system.

These are linked to five agreed priority areas to be progressed in the 2020/21 year:

1. Developing regional single systems of care by prototyping orthopaedics.
2. Planning for sustainable complex care.
3. Developing a plan for regional specialist mental health and addiction services.
4. Implementing the regional cardiology plan.
5. Developing a frailty model of care.

These are all underpinned by the commitment to equitable access and outcomes across the region, Te Tiriti o Waitangi and implementation of the regional equity framework, with particular focus on Māori health and wellbeing.

Together with the regional priority programmes for the year, the RSP includes the following national regional requirements.

- Healthy ageing – implementation of the New Zealand Framework for Dementia Care
- Hepatitis C
- Data and digital – regional ICT investment portfolio
- Regional workforce
- Cardiac and stroke services.

A copy of the final draft RSP was provided to the Board in December 2020.

As part of the Non-financial Monitoring Framework and Performance Measures for DHBs, a quarterly progress report on delivering the national regional requirements outlined in the RSP is required to be submitted to the Ministry. TAS prepares and submits these reports on behalf of the six DHBs.

The Ministry provides feedback and an assessment of progress in the delivery of each Government priority area and regional performance results each quarter using the following criteria.

Definitions of ratings of Government Priorities

All health targets/deliverables/milestones have been tracking to plan.	Achieved
Health targets have been achieved; some indicators/deliverables/milestones are not tracking to plan but an adequate resolution plan is in place, more clarification required.	Partially achieved
One or more health targets/indicators/deliverables/milestones have not been achieved; no adequate resolution plan is in place; there are delays in the implementation of the plan.	Not achieved

The Committee receives updates on progress with implementation of the RSP together with the performance assessment provided by the Ministry following their review of the report submitted by TAS.

4. DELIVERY OF THE 2020/21 REGIONAL SERVICES PLAN – QUARTER THREE UPDATE

Implementation of the priority programmes has progressed during Quarter Three. An update on progress of the national regional requirements, regional priority programmes and clinical networks are provided in the following tables.

4.1. National Regional Requirements (National Priorities)

Overall, the report on the RSP deliverables for the quarter received an 'achieved' rating, with all national regional requirements tracking to plan for the most part. It's important to note that TAS prepares and submits these reports on behalf of the six DHBs and the following table summarises the progress of these reports for the quarter. The table also provides the rating for each national regional requirement following the final review by the Ministry.

National Regional Requirements	Comment/Summary of progress	Q1	Q2	Q3
Data and digital	Planning for the next phase is well underway with agreement made within the region on how TAS can align more recommendations from the Tenzing report with the health system review. Next steps: • Implement new structure to align with recommendation (currently in consultation phase) • Review of all governance groups within the region • Move key decisions back to the DHBs to ensure they are clinically led and provide value • Start to build new regional capabilities that support the sector (CISO Role).			
Workforce	The Central Region (CR) regional workforce programme has continued to be been challenged over the last quarter. This was due to several factors including: a heavy human resource work programme of MECAs, Pay Equity and the Holidays Act Remediation. Some additional regional workforce support has been provided to assist GMs make good use of their time. Over the last quarter the Regional Director of Workforce Development has been on sick leave and on reduced hours due to a head injury which has impacted on delivery. The work in the CR Allied Health Scientific and Technical (AHST) has continued to make good progress.			

Hepatitis C	With the support from the Central Region PHOs, education sessions have been organised for Wellington/Wairarapa (CCDHB, HVDHB, Wairarapa DHB), MidCentral DHB and Whanganui DHB. The Wellington and Palmerston North sessions will be provided face-to-face in May with the option for attendees to Zoom in. Work is underway to organise an education/testing session for Manawatū Prison staff. Manawatū Prison have expressed interest on testing for all the current inmates.	●	●	●
Cardiac services	Key progress over this quarter has been in relation to: • Primary Care– Work is currently underway to develop a newsletter for primary care. • Key Performance Indicator Report – The revised KPI report was reviewed by the Cardiac Network at the March meeting. This report will be updated as new datasets become available such as primary care data and time of referral for door to cath. • Medical Imaging – The Network endorses the adoption and progression to a regional medical imaging platform, Synapse. Additionally, the Network supports MidCentral and Hawke's Bay DHBs delivering Cardiac CT and Cardiac MRI. • Sustainable Services – Data modelling that includes the repatriation of angiography and PCI volumes to Hawke's Bay and MidCentral DHBs from Capital and Coast DHB has been updated by TAS.	●	●	●
Stroke services	The regional stroke programme is tracking to plan with 24/7 regional telestroke service launched on 1 March which is progressing well. The region is prioritising a focus on progressing work in the rehabilitation space and is planning regional roadshows to support DHBs. Several FAST initiatives are underway, and equity and Treaty of Waitangi training is being arranged for Stroke Network members.	●	●	●
Dementia care	The region continues to support the work of the National Dementia Framework Collaborative with the contribution of a Geriatrician with a special interest in dementia and a Planning and Improvement Manager (TAS). A focus over this quarter has been to provide 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)	●	●	●

4.2. **Regional Priority Programmes**

An update on progress for the regional priority programmes is summarised below. These programmes are not subject to an assessment and rating by the Ministry.

Regional priority programmes	**Comment/Summary of progress**	**Q1**	**Q2**	**Q3**
Regional complex sustainability	Programme is currently on hold.	🟠	🟠	🟠
Single system of care	Synergia have carried out four out of six of the regional DHB workshops with orthopaedic stakeholders, with remaining sessions scheduled for Hawkes Bay and Whanganui in June. The next clinical network session (late June) will be used to discuss outputs and to test recommended solutions. The Single System of Care final report is expected in early July.	🟠	🟢	🟢
Frail elderly / Health of older people	The health of older persons programme is on track with planning underway to align and integrate the regional programme to meet the CE priority programme on frailty. The aim is to have a regional system of integrated care for frail older people ensuring access and equity for Māori as a priority.	🟢	🟢	🟢
Mental health and addiction	Francis Health have delivered a draft final report. This was presented to the Regional Partnership Group on 31 May. The next steps include: • Francis Health to incorporate feedback from the Regional Partnership Group and finalise the report. • TAS to form a Regional Group to develop a work plan and determine next steps	🟠	🟢	🟢
Clinical Networks				
Radiology	The specific change since last quarter includes: • Paediatrics Radiology Model of Delivery – A Paediatric Radiology stakeholder survey has been completed and the results collated. • Regional RMO training –Work is still progressing to get this finalised with Capital & Coast DHB. Participating DHBs have agreed to proposed changes to the number of RMOs being trained over the next two years. • Allied Health Workforce - An Allied Health workforce training paper has been presented to GMs P&F. GMs P&F have asked for a further paper that contains demand data and weighting around the proposed funding model. • Radiology IT - The radiology digital strategy is in its final draft.	🟢	🟢	🟢
Regional trauma	The Central Region is establishing a Major Trauma Strategic Network whose purpose will be to bring together those who use, provide and commission major trauma services in the Central Region to make improvements in the outcomes for our population taking an integrated, whole of system approach.	🟢	🟢	🟢

	The Central Region Trauma Network has reviewed their benchmarked performance against other regions in the recently published NZ Trauma Registry & National Trauma Network Report 2019/2020. Key trends and messages from this report will be highlighted to regional clinical and executive groups to inform local and regional improvement discussions.			

5. REGIONAL SERVICES PLAN 2021/2022

While there is no requirement to present a Regional Services Plan to the Minister for the 2021/22 year, DHBs in the central region will continue to work and collaborate on a regional plan. The focus will be on priorities for the DHBs, with the flexibility to address emerging issues and aspects of the transition requirements as needed. The Board will be updated on progress of the regional work.

Information papers

13 July 2021 HDAC

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

HEALTH AND DISABILITY ADVISORY COMMITTEE

For:

	Approval
	Endorsement
X	Noting

Key questions the Committee should consider in reviewing this paper:

- Does the report provide a useful update on progress in Ōtaki?
- Is the Committee satisfied with current progress?
- Are there any additional matters that should be included in future locality updates?

To	Health and Disability Advisory Committee
Author	Angela Rainham, Locality and Intersectoral Development Manager
Endorsed by	Chiquita Hansen, Interim General Manager, Strategy, Planning and Performance Vanessa Caldwell, Clinical Executive, Mental Health and Addictions
Date	22 June 2021
Subject	**Locality Plan Progress Report – Ōtaki**

RECOMMENDATION

It is recommended that the Committee:

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

Strategic Alignment

This report is aligned to the DHB's strategy and the strategic imperatives within it. It is particularly aligned with 'Partner with people, whānau and communities to support health and wellbeing'.

1. PURPOSE

To provide an update on progress with MidCentral District Health Board's (MDHB) locality approach in Ōtaki and Te Horo. No decision is required.

2. SUMMARY

The paper provides a summary of:

- progress made in the last 12 months
- current key issues affecting the health and wellbeing of residents
- upcoming locality work in Ōtaki.

3. BACKGROUND

The Ōtaki Locality Plan was completed in 2018 and was one of five plans created for the different localities (Territorial Local Authority areas) across the MDHB rohe. The current plan provides information about the community, including a demographic profile, community priority areas and focus areas within these as identified by the community. There is also a plan of actions that MDHB and partner organisations committed to undertaking to make progress in the identified priority areas.

The current plan (along with the other four plans for Horowhenua, Manawatū, Tararua and Palmerston North) can be found at: http://www.midcentraldhb.govt.nz/Planning/localPlan/Pages/LocalityPlanning.aspx.

The three focus areas within each of the four community priority areas are shown in the table on the following page.

Access to Health Care	Mental Health and Addiction	Better Communication and Connections	Healthy Living
People are able to get help when they need it (improving access to primary care)	People are able to find help when they need it locally	Improving communication	Wider determinants of health
Improving people's access to hospital and specialist care	Locally designed and operated services	Raising awareness of what is available in Ōtaki and how to access it	Supporting whānau to make good lifestyle choices
Health working together as one team (improving people's experience)	Youth-friendly services	Increasing engagement and visibility	Quality living for older adults

4. PROGRESS IN RELATION TO THE CURRENT PLAN

The current plan has 51 actions in total and the reporting template has had seven further actions added to it. Most actions are progressing well or have been completed. Appendix One summarises the action plan progress in each focus area.

4.1. Examples of progress being made in the community priority focus areas

Access to healthcare

Students at all three secondary schools in Ōtaki are receiving school-based health services on site at their schools. Kāpiti Youth Service delivers a school-based health service at Ōtaki College that includes both nurse-led clinics and an onsite general practitioner clinic. Te Kura-a-iwi o Whakatupuranga Rua Mano and Te Kura Kaupapa Māori o Te Rito have school-based health services delivered by Public Health Nurses in nurse-led clinics.

Mental Health and Addictions

The Te Ara Rau 'Access and Choice' service delivery model, which has a focus on holistic wellbeing and early intervention, is now fully operational in Ōtaki. A Matanga Whai Ora (registered primary mental health clinician) is based in the building adjacent to Ōtaki Medical Centre and the medical centre team appreciate the ability to send people through to the free service, which has walk-in slots available each day. A Kaiwhakapūaki Waiora (health coach) is also based in the Ōtaki community.

MDHB also funds Kāpiti Youth Service to provide counselling services for 10 to 24-year olds in the Ōtaki community.

Better communication and connections

The Ōtaki Health and Wellbeing Advisory Group continues to be very active. Representatives from Kāpiti Coast District Council, Ministry of Social Development and the local Citizens Advice Bureau have been added to the group in the last year.

Community engagement in the last 12 months has included regular Health and Wellbeing Advisory Group meetings, a forum aimed at getting feedback from older adults, an annual Public Forum and an annual presentation to the Ōtaki Community Board. Regular e-newsletters continue to be sent out quarterly to a database of groups, organisations and individuals.

Intersectoral relationships have continued to be developed and the Locality Manager has regular meetings with the Senior Advisor Local Outcomes at Kāpiti Coast District Council to look for opportunities to work together to support the health and wellbeing of Ōtaki residents.

Healthy Living

Promotion of individualised funding packages for individuals who have long term care needs is empowering Ōtaki residents to be in control of how, when and who delivers their support at home and in the community. Māori are prioritised for assessment for these packages and 38 percent of those who have chosen this option to date are Māori.

5. CURRENT HEALTH AND WELLBEING ISSUES IN ŌTAKI

Engagement in the last 12 months has highlighted the following common themes as the main challenges affecting the health and wellbeing of people and whānau in Ōtaki.

- Housing affordability and availability. Some whānau are being pushed north (out of the community they know) by the lack of affordable housing.

- There are very few Ōtaki based services – highlighted during COVID-19.
- Drug use and addictions are a big problem for some people/whānau.
- Many whānau are facing financial pressures and stress – not having enough money to pay bills or afford health services.
- The lack of boundary alignment across agencies still causes issues.
- The most acute and desperate in the community are also the most isolated.

Access to a local general practice team is also becoming an issue again, with an Ōtaki Medical Centre general practitioner (GP) recently returning to his country of origin due to ongoing challenges gaining residency in New Zealand. Ōtaki Medical Centre has exhausted all avenues available in its attempt to resolve the residency issues on behalf of this GP. This is not an isolated incident at present in New Zealand and is an example of the challenges that rural and provincial areas are having in recruiting and retaining clinical staff. For clinical safety reasons, Ōtaki Medical Centre has closed enrolments, although the practice has an arrangement with THINK Hauora to enrol babies and Māori who are not enrolled and have an immediate need for healthcare services.

Ōtaki Medical is actively recruiting for a new GP and supports the steps the general practice network and THINK Hauora is taking to attract international clinicians to enter New Zealand to replenish the constrained current resources. These steps include a social media campaign in the United Kingdom starting in late July through Working-In-Health, an international recruitment consultant used by MDHB with some success.

6. COVID-19 VACCINATION ROLLOUT IN ŌTAKI

Covid-19 vaccinations are well underway within the Ōtaki community, with 500 doses having been delivered locally as at the end of the third week of June. The vaccination team are working to increase the capacity of future clinics in Ōtaki to ensure people who want to be vaccinated locally have the opportunity to do so.

The Māori mobile team has delivered clinics at Te Wānanga O Raukawa and Nga Purapura and the vaccination team are planning to add further clinics into their cycle schedule. A local pharmacy will be added as an additional vaccination site within the community.

7. UPCOMING WORK IN NEXT SIX MONTHS

- Extend the current Memorandum of Understanding between MDHB and Capital and Coast DHB regarding health service provision for the people of Ōtaki and Te Horo.
- Distribution of communications regarding the COVID-19 vaccination rollout for Ōtaki and Te Horo residents.
- Continue community engagement and feedback to DHB executive members, including annual forum and annual engagement with Ōtaki Community Board.
- Refresh the demographic profile information for Ōtaki and Te Horo (alongside the other localities) to provide more population information about the community that can be utilised by services. 'Assessing individual, whānau, community aspirations and health needs' is a key step in the commissioning for outcomes framework that is currently being developed and the refreshed locality profiles will provide key information.
- Community engagement to be undertaken to ensure the new model of care for Mental Health and Addiction specialist services, which includes increased resources, are better positioned to be responsive to the needs of Ōtaki residents with significant mental health concerns.

Appendix One: Progress in each community priority focus area

Access to Health Care	Mental Health and Addiction	Better Communication and Connections	Healthy Living
People are able to get help when they need it (improving access to primary care) = six actions. 100 percent complete or progressing well	People are able to get help when they need it = seven actions. 100 percent complete or progressing well	Improving communication = five actions. 100 percent progressing well	Wider determinants of health = four actions. 100 percent complete or progressing well
Improving people's access to hospital and specialist care = seven actions. 86 percent complete or progressing well, 14 percent behind/challenges	Locally designed and operated services = two actions. 100 percent progressing well	Raising awareness of what is available in Ōtaki and how to access it = five actions 100 percent progressing well	Local initiatives to help people make good lifestyle choices = six actions. 100 percent complete or progressing well
Health working together as one team = five actions. 80 percent complete or progressing well, 20 percent behind/challenges	Youth-friendly services = two actions. 100 percent progressing well	Increasing engagement and visibility = five actions. 100 percent complete or progressing well	Quality living for older adults = four actions. 100 percent complete or progressing well

Just two of the 58 actions are classed as 'Behind/challenges':

Focus area	Action	Comment
Access to health care - Improving people's access to hospital and specialist care	People's circumstances (such as locality and family/ whānau responsibilities) will be taken into consideration by more flexible hospital booking systems.	This project has been deferred. The focus remains on seeing patients at a facility closer to home where possible. The use of Telehealth is being encouraged, where appropriate, making it easier for patients to access a secondary care assessment. A number of electronic initiatives are underway to streamline the flow of referrals into the organisation.
Access to health care – Health working together as one team	People will be better supported by health providers who can access the notes they need via improved IT systems.	The indici system that Ōtaki Medical Centre will be adopting will enable better mobility and remote working and improve access to information for the broader multidisciplinary team. The transfer to indici was due to happen in June but has been delayed.

For:

	Approval
	Endorsement
X	Noting

Key questions the Committee should consider in reviewing this paper:

- Does the work programme include the topics needed to confidently govern?

To	Health and Disability Advisory Committee
Author	Margaret Bell, Board Secretary
Endorsed by	Rory Matthews, Interim Director of the Office of the Chief Executive
Date	24 June 2021
Subject	**Committee's Work Programme**

RECOMMENDATION

It is recommended that the Committee:

- **note** the update on the Health and Disability Advisory Committee's work programme.

Strategic Alignment

This report is aligned to the DHB's strategy and key enabler 'Stewardship'. It discusses an aspect of effective governance.

1. PURPOSE

To provide an update on the Health and Disability Advisory Committee's (HDAC) work programme. This is for information only and no decision is required.

2. HDAC WORK PROGRAMME

The HDAC work programme was approved by the Committee in November 2020.

As noted in a separate paper to this meeting, the Clinical Governance recommendations and Quality Improvement Framework systems have been fully implemented. Therefore, reporting on these to future HDAC meetings has been removed from the work programme.

Reporting is occurring in line with the work programme.

Health and Disability Advisory Committee | Work Programme	Fqncy	Feb	Apr	Jul	Sep	Nov	Resp
Strategy/Planning							
Health Needs Assessment and Equity Snapshot to consider the health needs assessment of the district and sub-region	Triennial Nov-21					X	GMSPP & GMP&P
Ka Ao, Ka Awatea – Māori Health Strategic Framework on a three-yearly basis, review/refresh the strategy to ensure it remains relevant and reflects the DHB's Strategy	Triennial Oct-23						GMM
Disability Roadmap to determine a disability strategy and roadmap for the district, and thereafter how it has been advanced, changes, and priorities/investments for the future (3-5 years).	Triennial Aug-22						GMENZ EDAH
Locality Health and Wellbeing Plans to determine how the locality plans have been advanced, what's changed and priority initiatives/investments for the future (3-5 years), and to receive community feedback	Triennial Apr-21		X				OEs & CEs & SPP
Cluster Health and Wellbeing Plans to determine each cluster's planned outcomes, priorities and targets for the next three years, and the roadmap for achieving these, including required investment and resources	Triennial TBC						OEs & CEs
Quality Improvement							
Clinical governance and quality improvement framework – progress and trends to monitor the quality and safety of health care services in the district, including trends, performance against dashboard and markers, and confirm the adequacy of the programme planned or established to advance or address issues. to monitor serious and sentinel events, and HDC complaints	4 / year	X		X			GMQ&I
Consumer Stories (workshop) to hear direct from consumers of health and disability services about their experience	3 / year		X	X		X	GMQ&I
Quality and Safety Dashboard/Online Quality Report quarterly online quality report which includes information from the quality plans developed by clusters with system wide improvement activities that align with The Quality Agenda	4 / year	X	X		X	X	GMQ&I
Performance							
Cluster Reports, including Health and Wellbeing Plans to monitor each Cluster's performance, including the implementation of their Health and Wellbeing Plans, including progress against key targets, initiatives and outcomes.	5 / year	X	X	X	X	X	OE & CEs
Cluster Deep Dive reports (presented under Strategic Focus – rotated between Clusters) to monitor current and emerging matters, including quality and safety, opportunities and challenges, and the adequacy of any mitigations	5 / year	X	X	X	X	X	OE & CEs

	Fqncy	Feb	Apr	July	Sep	Nov	Resp
Locality Health and Wellbeing Plans to determine how the locality plans have been advanced, what has changed, and priority initiatives/investments for the future (3-5 years), and to receive community feedback	Annual	Man	PN	Otaki	Horo	Tar	OE & CEs & SPP GMSPP
Regional Services Plan (implementation) to monitor the implementation of the Plan and achievement of stated outcomes	4 / year	**X (Q1)**	**X (Q2)**	**X (Q3)**	**X (Q4)**		GMSPP
Equity							
Ka Ao, Ka Awatea – Māori Health Strategic Framework to monitor progress being made in achieving the Framework, including the appropriateness of initiatives and investment planned/established.	Annual		**X**				GM
Equity Dashboard – Māori Health Indicators ('Deep Dive' reports) to monitor progress being made in achieving the national Māori health targets, including the appropriateness of initiatives planned/established	Six-monthly each group						
Child and Youth indicators					**X**		OEs and CEs
Adult indicators			**X**			**X**	OEs and CEs
Mental Health indicators				**X**		**X**	OEs and CEs
Workforce indicators				**X**		**X**	OEs and CEs
Disability							
Disability Strategy to monitor progress in implementing the Disability Strategy, including opportunities and challenges, and confirming the priorities and initiatives/investment for years ahead	Annual			**X**			GMENZ EDAH
Governance							
Policies to determine governance and significant quality and improvement policies	As required						

Glossary of terms

13 July 2021 HDAC

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Glossary of Terms

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

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

CMO	**Chief Medical Officer**
CN	**Charge Nurse(s)**
CNM	**Clinical Nurse Manager**
CNS	**Clinical Nurse Specialist**
COI	**Committee of Inquiry**
ComM	**Communications Manager**
COPD	**Chronic Obstructive Pulmonary Disease** A common lung disease which makes breathing difficult. There are two main forms, Chronic bronchitis - a long term cough with mucus. Emphysema - which involves damage to the lungs over time.
COVID-19	**Novel Coronavirus**
CPB	**Combined Pharmaceutical Budget**
CPHO	**Central Primary Health Organisation**
CPI	**Consumer Price Index**
CPOE	**Computer Physician Order Entry**
CRM	**Cyber Risk Monitoring**
CSB	**Clinical Services Block**
CT	**Computed Tomography** A CT scan combines a series of X-ray images taken from different angles around your body and uses computer processing to create cross-sectional images of the bones, blood vessels and soft tissues inside your body.
CTAS	**Central Technical Advisory Services** (also TAS)
CTCA	**Computed Tomography Coronary Angiography** A CT scan that looks at the arteries that supply blood to the heart. Can be used to diagnose the cause of chest pain or other symptoms.
CVAD	**Central Venous Access Device**

CWDs	**Case Weighted Discharges** Case weights measure the relative complexity of the treatment given to each patient. For example, a cataract operation will receive a case weight of approximately 0.5, while a hip replacement will receive 4 case weights. This difference reflects the resources needed for each operation, in terms of theatre time, number of days in hospital, etc.
DCFO	**Deputy Chief Financial Officer**
DDIGG	**Digital and Data Informatics Governance Group**
DHB	**District Health Board**
DIVA	**Difficult Intravenous Access**
DNA	**Did Not Attend**
DNW	**Did Not Wait**
DoN	**Director of Nursing**
DS	**Digital Services**
DSA	**Detailed Seismic Assessment**
DSA	**Digital Subtraction Angiography**
DWP	**Digital Workplace Programme**
DX	**Data Exchange** A data exchange software mechanism developed with the Social Investment Agency (SIA) to support encrypted data sharing between public services.
EAP	**Employee Assistance Programme**
EBITA	**Earnings Before Interest, Taxes and Amortisation**
ECM	**Enterprise Content Management**
ED	**Emergency Department**
EDAH	**Executive Director Allied Health**
EDG-VPSR	**Electrocadiograph – Visual Positioning System Rhythm**
EDN&M	**Executive Director, Nursing & Midwifery**

EDOA	**Emergency Department Observation Area**
EDON	**Executive Director of Nursing**
EECA	**Energy and Efficiency Conservation Authority**
ELT	**Executive Leadership Team**
EMERGO	**Emergo Train System**
EMR	**Electronic Medical Record**
EN	**Enrolled Nurse**
ENT	**Ear Nose and Throat**
ENZ	**Enable New Zealand**
EOC	**Emergency Operations Centre**
EP	**Efficiency Priority**
EPA	**Electronic Prescribing and Administration**
EPMO	**Enterprise Project Management Office**
ERCP	**Endoscopic Retrograde Cholangio Pancreatography**
ERM	**Enterprise Risk Management**
ESPI	**Elective Services Patient Flow Indicator** Performance measures that provide information on how well the District Health Board is managing key steps in the electives patient journey.
EV	**Electric Vehicle**
EWS	**Early Warning System**
EY	**Ernst & Young**
FACT	**Flexible Assertive Community Assessment Team**
FHC	**Feilding Health Care**
FHIR	**Fast Healthcare Interoperability Resources**
FIT	**Faecal Immunochemical Test**

FM	**Facilities Management**
FM Services	**Facilities maintenance and hotel services required by the DHBs**
FPIM	**Finance and Procurement Information Management System**
FPM	**Financial Planning Manager**
FRAC	**Finance, Risk and Audit Committee**
FSA	**First Specialist Appointment**
FSL	**Fire Service Levies**
FTE	**Full Time Equivalent** The hours worked by one employee on a full-time basis.
FU	**Follow Up**
Gap	**Analysis used to examine current performance with desired, expected performance**
GETS	**Government Electronic Tenders Service**
GHG	**Greenhouse Gases**
GM	**General Manager**
GMFCS	**General Manager, Finance and Corporate Services**
GMM	**General Manager, Māori Health**
GMPC	**General Manager, People and Culture**
GMQI	**General Manager, Quality and Innovation**
GMSPP	**General Manager, Strategy, Planning and Performance**
GP	**General Practitioner**
GST	**Goods and Services Tax**
H&S	**Health and Safety**
HaaG	**Hospital at a Glance**
HAI	**Healthcare Associated Infection**
HAR	**Te Uru Whakamauora, Healthy Ageing and Rehabilitation**

HBDHB	**Hawke's Bay District Health Board**
HCA(s)	**Health Care Assistant(s)**
HCSS	**Home and Community Support Services**
HDAC	**Health and Disability Advisory Committee**
HDU	**High Dependency Unit**
HEAT	**Health Equity Assessment Tool**
HEEADSSS	**Home, education/employment, eating, activities, drugs, sexuality, suicide and depression, safety (wellness assessment)**
HIP	**Health Infrastructure Programme**
HISO	**Heath Information Security Framework**
HQSC	**Health, Quality and Safety Commission**
HR	**Human Resources**
HRC	**Health Research Council**
HRIS	**Human Resources Information System**
HROD	**Human Resources and Organisational Development**
HSWA	**Health and Safety at Work Act**
Hui	**Formal meeting**
HV	**High Voltage**
HVAC	**Heating, Ventilation and Air Conditioning**
HVDHB	**Hutt Valley District Health Board**
HWIP	**Health Workforce Information Programme**
HWNZ	**Health Workforce New Zealand**
IA	**Internal Audit**
IAAS	**Infrastructure as a Service**
IAP	**Incident Action Plans**

ICNet	**Infection Control Surveillance**
ICPSA	**Integrated Community Pharmacy Services Agreement**
ICT	**Information and Communications Technology**
ICU	**Intensive Care Unit**
IDF	**Inter-district Flow** The default way that funding follows a patient around the health system irrespective of where the are treated.
IEA	**Individual Employment Agreement**
IFHC	**Integrated Family Health Centre** General practice teams with the patient at the centre, providing quality health care when, where and how patients need it.
IFM / IFM20	**Integrated Facilities Management**
IL	**Importance Level** Seismic assessment rating
IMAC	**Immunisation Advisory Centre**
IMT	**Incident Management Team**
Insourced	**Delivered directly by the DHBs via its staff**
IOC	**Integrated Operations Centre**
IOL	**Intraocular Lens**
IOT	**Internet of Things**
IPSAS	**International Public Sector Accounting Standards**
IS	**Information Systems**
ISM	**Integrated Service Model**
ISP	**Internet Service Provider**
IT	**Information Technology/Digital Services**
ITSM	**Integrated Service Module**

IV	**Intravenous**
IVP	**Improving Value Programme**
JDE	**JD Edwards** Name of software package
Ka Ao Ka Awatea	**Māori Health Strategy for the MDHB District**
KPI(s)	**Key Performance Indicator(s)** A measurable value that demonstrates how effectively an objective is being achieved.
LAN	**Local Area Network**
LDC	**Local Data Council**
LEO	**Leading an Empowered Organisation**
LMC	**Lead Maternity Carer**
LOS	**Length of Stay**
LSP	**Leadership Success Profile**
LTC	**Long Term Condition(s)**
LV	**Low Voltage**
MALT	**Māori Alliance Leadership Team**
MAPU	**Medical Assessment and Planning Unit**
MBIE	**Ministry of Business, Innovation and Employment**
MCH	**MidCentral Health**
MCIS	**Maternity Clinical Information Service**
MDBI	**Material Damage and Business Interruption**
MDHB	**MidCentral District Health Board**
MDM	**Master Data Management**
MDT	**Multi-disciplinary Team**
MECAs	**Multi Employer Collective Agreements**

MEED	**Midwifery External Education and Development Committee**
MERAS	**Midwifery Employee Representation and Advisory Service**
MFA	**Multi-Factor Authentication**
MIT	**Medical Imaging Technologist** A radiographer who works with technology to produce X-rays, CT scans, MRI scans and other medical images.
MIYA	**MIYA Precision Platform**
MoH	**Ministry of Health**
MOU	**Memorandum of Understanding**
MRI	**Magnetic Resonance Imaging** A medical imaging technique used in radiology to form pictures of the anatomy using strong magnetic fields and radio waves.
MRSO	**Medical Radiation Officer**
MRT	**Medical Radiation Therapist(s)**
MSD	**Ministry of Social Development**
MWH	**Manawhenua Hauora**
MYFP	**Midwifery First Year of Practice Programme**
NAMD	**Neovascular Age-Related Macular Degeneration**
NARP	**Non-Acute Rehabilitation Programme**
NBSP	**National Bowel Screening Programme**
NCAMP19	**National Collections Annual Maintenance Programme 2019**
NCEA	**National Certificate of Educational Achievement**
NCNZ	**Nursing Council of New Zealand**
NEAC	**National Ethics Advisory Committee**
NEED	**Nursing External Education and Development Committee**
NESP	**Nurse Entry to Specialty Practice Programme (Mental Health)**

NETP	**Nurse Entry to Practice**
NFSA	**National Food Services Agreement**
NGO	**Non Government Organisation**
NHAWG	**National Holidays Act Working Group**
NNU	**Neo Natal Unit**
NOS	**National Oracle Solution**
NP	**Nurse Practitioner**
NPC	**Nurse Practitioner Candidate**
NPTP	**Nurse Practitioner Training Programme**
NZ	**New Zealand**
NZCOM	**New Zealand College of Midwives**
NZCPHCN	**New Zealand College of Primary Health Care Nurses**
NZCRMP	**New Zealand Code of Radiology Management Practice**
NZD	**New Zealand Dollar**
NZHP	**New Zealand Health Partnerships**
NZHRS	**New Zealand Health Research Strategy**
NZNO	**New Zealand Nurses Organisation**
NZPHD Act	**New Zealand Public Health and Disability Act**
O&G	**Obstetrics and Gynaecology**
OAG	**Office of the Auditor-General**
OD	**Organisational Development**
ODP	**Organisational Development Plan**
OE	**Operations Executive** (of a service)
OHS	**Occupational Health and Safety**

OLT	**Organisational Leadership Team** OLT comprises all General Managers, Chief Medical Officer, Executive Directors - Nursing & Midwifery and Allied Health, General Manager of Enable NZ, all Operations Executives and Clinical Executives.
OPAL	**Older People's Acute Assessment and Liaison Unit**
OPERA	**Older People's Rapid Assessment**
OPF	**Operational Policy Framework**
Outsourced	**Contracted to a third-party provider to deliver**
Pae Ora Paiaka Whaiora	**(Base/Platform of health) Healthy Futures (DHB Māori Directorate)**
PACS	**Picture Archiving Communication System**
PANE	**Proactive, Advocacy, Navigation and Education Team**
PAS	**Patient Administration System**
PBE	**Public Sector Benefit Entity**
PCBU	**Person Conducting a Business or Undertaking**
PCT	**Pharmacy Cancer Treatment**
PDRP	**Professional Development and Recognition Programme**
PDSA	**Plan Do Study Act**
PEDAL	**Post Emergency Department Assessment Liaison**
PET	**Positron Emission Tomography**
PHC	**Primary Health Care**
PHO	**Primary Health Organisation (THINK Hauora)**
PHU	**Public Health Unit**
PICC	**Peripherally Inserted Central Catheter**
PICU	**Paediatric Intensive Care Unit**

PIP	**Performance Improvement Plan** This plan is designed to support the OLT in the prioritisation and optimisation of system wide efforts to achieve our vision. The plan was presented to the MoH as part of MDHB's 2019/20 strategic discussion.
PNCC	**Palmerston North City Council**
POAC	**Primary Options for Acute Care**
PPE	**Personal Protective Equipment**
Powhiri	**Formal Māori Welcome**
PPA	**Promoting Professional Accountability**
PPC	**Public, Primary and Community**
PP&CH	**Public, Primary and Community Health**
PPPR	**Protection of Personal and Property Rights**
PR&RO	**Principal Risk and Resilience Officer**
PSA	**Public Service Association**
PSe	**PS Enterprise**
PSR	**Protective Security Requirements**
PVC	**Poly Vinyl Chloride**
QEAC	**Quality & Excellence Advisory Committee**
QHP	**Qualified Health Plan**
Qlik	**Qlik Sense Data Visualisation Software (Dashboard Analytics)**
Q&SM	**Quality and Safety Markers**
RACMA	**Royal Australasian College of Medical Administrators**
RDHS	**Regional Digital Health Services**
RFP	**Request for Proposal**
RHIP	**Regional Health Infometrics Programme** Provides a centralised platform to improve access to patient data in the central region.

Risk ID	**Risk Identifer**
RM	**Registered Midwife**
RMO	**Resident Medical Officer**
RN	**Registered Nurse(s)**
RP	**Risk Priority**
RSI	**Relative Stay Index**
RSO	**Research Support Officer**
RSP	**Regional Service Plan**
RTL	**Round Trip Logistics** A technology platform.
Rules	**Government Procurement Rules (4th Edition 2019)**
SaaS	**Software as a Service**
SAC	**Severity Assessment Code**
SAN	**Storage Area Network**
SBA	**Smoking Brief Advice (Smoking Cessation)**
SFIA	**Skills Framework for the Information Age**
SGOC	**Shared Goals of Care**
SIEM	**Security Information Event Monitoring**
SLA	**Service Level Agreement**
SLMs	**System Level Measures**
SME	**Subject Matter Expert(s)**
SMO	**Senior Medical Officer**
SNE	**Services Not Engaged**
SOI	**Statement of Intent**

SOR	**Standard Operating Responses**
SPE	**Statement of Performance Expectations**
SPIRE	**Surgical Procedural Interventional Recovery Expansion** A project to establish additional procedural, interventional and surgical resources within MDHB.
Spotless	**Spotless Services (NZ) Limited**
SRG	**Shareholder's Review Group**
SSC	**State Services Commission** (from 2020 - Te Kawa Mataaho Public Service Commission)
SSHW	**Safe Staffing, Healthy Workplaces**
SSIED	**Shorter Stays in Emergency Department**
SSP	**Statement of Service Performance**
SSU	**Sterile Supply Unit**
SUDI	**Sudden Unexpected Death in Infancy**
SUG	**Space Utilisation Group**
STAR	**Services for Treatment, Assessment and Rehabiliation**
TAS	**Technical Advisory Services** (also CTAS)
TCO	**Total Cost of Ownership**
tC02e	**tons of carbon dioxide equivalent**
TCU	**Transitional Care Unit**
THG	**Tararua Health Group Limited**
TKMPSC	**Te Kawa Maataho Public Service Commission** (formerly State Services Commission)
TLP	**Transformational Leadership Programme**
Trendly	A national database capture tool and dashboard that focuses on the measurement of DHBs to the National Māori Health Measures
TTOR	**Te Tihi o Ruahine Whānau Ora Alliance**

UCOL	**Universal College of Learning**
VBS	**Voluntary Bonding Scheme**
VRM	**Variance Response Management**
WDHB	**Whanganui District Health Board**
WebPAS	**Web Based Patient Administration System**
WebPASaas	**Web Based Patient Administration System as a Service**
WHEI	**Whole Hospital Escalation Indicators**
Y	**Yes**
YD	**Yes and delegable**
YTD	**Year To Date**

Late items

13 July 2021 HDAC

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Late items

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

Date of next meeting

13 July 2021 HDAC

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Date of next meeting

Tuesday, 14 September 2021

Exclusion of the public

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Exclusion of public

Resolution:

That the public be excluded from this meeting in accordance with the Official Information Act 1992, section 9 for the items and reasons outlined in the agenda.