MidCentral District Health Board
Health & Disability Advisory Committee Meeting

Venue: Zoom – a public recording of the meeting will be available from http://www.midcentraldhb.govt.nz/AboutMDHB/BoardandCommittees/Pages/Meeting-Dates within 24 hours of the meeting.

When: Tuesday 26 May 2020, 09.00

PART 1

Members:
John Waldon (HDAC Chair), Brendan Duffy (Board Chair), Oriana Paewai, Norman Gray, Materoa Mar, Karen Naylor, Muriel Hancock, Jenny Warren, Lew Findlay, Vaughan Dennison, Heather Browning.

In Attendance:
Kathryn Cook - Chief Executive, Judith Catherwood – General Manager, Quality & Innovation, Gabrielle Scott – Executive Director, Allied Health, Tracee Te Huia – General Manager, Māori Health, Craig Johnston – General Manager, Strategy, Planning & Performance, Jennifer Free - Committee Secretary.

In Attendance (part meeting):

Item 3.1	Andrew Nwosu, Syed Zaman, Debbie Davies, Scott Ambridge, Vanessa Caldwell, Sarah Fenwick, Dr Jeff Brown, Cushla Lucas, Claire Hardie, Lyn Horgan
Item 3.2	Wayne Blisset – Operations Executive Pae Ora Paiaka Whaiora Hauora Māori Directorate
Item 3.3	Michelle Riwai – General Manager, Enable New Zealand

AGENDA – Part 1

1. KARAKIA 09.00

He Karakia Timata

Kia hora te marino
Kia whakapapa pounamu te moana
Hei huarahi ma tatou I te rangi nei
Aroha atu, aroha mai
Tatou I a tatou I nga wa katoa
Hui e taiki e

May peace be widespread
May the sea be smooth like greenstone
A pathway for us all this day
Give love, receive love
Let us show respect for each other

Next Meeting: 21 July 2020
Deadline for Agenda Items: 8 July 2020

Copies to:
Chair
Committee Secretary
Corporate Records

2.	**ADMINISTRATIVE MATTERS**	**PAGES**	09.05
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3.	**PERFORMANCE REPORTING**		09.15
3.1	Cluster Update for February/March 2020	11-56	
3.2	Pae Ora Paiaka Whaiora Hauora Māori Directorate Progress Update Against the Manawhenua Hauora Work Programme	57-65	
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4.	**INFORMATION PAPERS** *Information papers for the Committee to note*		
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5. LATE ITEMS

6. DATE OF NEXT MEETING

21 July 2020, Boardroom MidCentral District Health Board, Gate 2 Heretaunga Street, Palmerston North

7. EXCLUSION OF 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***	***Ref***
"In committee" minutes of the previous meeting	For reasons set out in the order paper of 17.03.20 with the public present.	

MIDCENTRAL DISTRICT HEALTH BOARD

Minutes of the Health & Disability Advisory Committee meeting held on 17 March 2020 at 9.00am at MidCentral District Heath Board, Board Room, Gate 2, Heretaunga Street, Palmerston North

PART 1

PRESENT:

John Waldon (Chair)
Brendan Duffy
Heather Browning
Vaughan Dennison
Lew Findlay
Muriel Hancock
Karen Naylor
Oriana Paewai
Jenny Warren

ATTENDEES:
Kathryn Cook, Chief Executive
Tracee Te Huia, General Manager, Māori Health
Gabrielle Scott, Executive Director, Allied Health
Judith Catherwood, General Manager, Quality & Innovation
Nicki Williamson, Committee Secretary

IN ATTENDANCE – PART MEETING:
Lyn Horgan, Operations Executive, Acute and Elective Services
Sarah Fenwick, Operations Executive, Women, Children & Youth
Dr Jeff Brown, Acting Chief Medical Officer/Clinical Executive, Women, Children & Youth
Dr Claire Hardie, Clinical Executive, Cancer Screening Treatment & Support
Debbie Davies, OE, Primary, Public, Community Health
Scott Ambridge, Acting Operations Executive, Mental Health & Addictions
Dr Vanessa Caldwell, Clinical Executive Mental Health & Addictions
Andrew Nwosu, Operations Executive, Healthy Ageing & Rehabilitation
Dr Syed Zaman, Clinical Executive Healthy Ageing & Rehabilitation
Susan Murphy – Manager, Quality Improvement and Assurance
Vivienne Ayres – Manager, DHB Planning and Accountability
Barbara Ruby – Planning & Integration Lead Acute and Elective Services
Dr Janine Stevens – Public Health Physician & Māori Health Practice Leader
Mariette Classen – Consumer Experience Manager

Public: 2
Comms: 2
Media: 1

1. KARAKIA

The meeting opened with the Organisational Karakia.

2. ADMINISTRATIVE MATTERS

2.1 Apologies

Apologies were received from members Materoa Mar and Norman Gray.
Apologies were also received from Craig Johnston, General Manager, Strategy, Planning & Performance.

2.2 Late Items

There were no late items.

2.3 Conflicts and/or Register of Interests Update

No conflicts were declared.

2.4 Minutes of the Previous Meeting

It was resolved:

> *that the minutes of the previous meeting be approved as a true and correct record. (Moved John Waldon; seconded Muriel Hancock)*

2.5 Matters Arising from the Previous Minutes

There were no matters arising.

3. PERFORMANCE REPORTING

3.1 Cluster Update for January 2020

The individual cluster reports were considered and the following points were discussed:

Te Uru Whakamauora, Healthy Ageing & Rehabilitation: OPAL was going well, the average length of stay which had reduced to 6.8 days. The wait time to be transferred from ED to OPAL was being worked on. The current wait time was nine hours with a target of four hours. A number of measures were been worked on to ensure the right patients were being transferred to the unit and improve patient flow.

Te Uru Kiriora, Public, Primary & Community Health: The annual leave target for staff with greater than two years leave accrued had been set at zero percent across all the clusters. This was to get the Clusters on an equivalent footing and have consistency of targets. The actual target should show at nine percent.

The cluster was looking at the potential to change the oral health service schedule, which in January had a limited service, but this was proving challenging due to lack of access to children during the summer holidays.

MDHB had the second highest polypharmacy rates in New Zealand and management were investigating reasons for this and reviewing with similar sized DHBs.

Te Uru Rauhī, Mental Health & Addictions: Management clarified that the data reporting covered mental health and addictions combined, not as separate reporting lines. This was a generic national measure. It was clarified that a number of people admitted to Star 1 have Dementia and Alzheimers as these conditions are typically assessed by mental health and treated as long term conditions.

KPI-19 was discussed. A major reason that this KPI was significantly behind target was due to clients rescheduling their appointments. Management were investigating ways to engage more and find appointment times that suited clients including having some evening appointments. A business case was underway to improve technology contact with clients eg text reminders.

Staff turnover appeared high this month at seven percent. The exit interviews had not been received to see if there were any recurring issues.

The new inpatient unit was discussed including how engaged or involved with the design the community were and what the older adult model of care would look like in the new unit. There had been many forums for the community and whānau to engage in both the design and the model of care elements and representations on the steering group.

Regarding the new contracts for Māori providers, management agreed to report on the actions specific to this as it developed.

Te Uru Pā-Harakeke, Health Women Children & Youth: The report was taken as read.

Debbie Davies, Sarah Fenwick, Andrew Nwosu and Syed Zaman left the meeting.

Te Uru Mātai Matengau, Cancer Screening, Treatment and Support: The report was taken as read.

Te Uru Arotau, Acute & Elective Services: The pods project was progressing well. A model of care had been developed and that would determine the layout of the pods. There was a weekly project meeting to keep up momentum on the project.

For those who did not wait to be treated in the ED, the re-presentation data had been reviewed to see if there was an opportunity for phone call follow ups with advice to help prevent people re-presenting to the ED.

It was resolved that the Committee

> *endorse the progress made by the Services for January 2020*
> *note the OPAL (Older People's Acute Assessment and Liaison) unit continues to deliver positive patient outcomes*
> *note planning at the local level is well established to prepare for the likelihood of Covid-19 being present in our community*
> *note Te Uru Rauhī have been experiencing higher than anticipated demand through the Acute Care team which has had a flow on effect to the acute inpatient ward*
> *note Te Uru Pā Harakeke maternity services will commence operational management of Te Papaioea Birthing Centre from 1 April 2020. (Moved John Waldon; Seconded Karen Naylor)*

3.2 Te Uru Arotau, Acute & Elective Services Presentation

The Operations Executive Te Uru Arotau, Acute & Elective Services presented an in-depth overview of the service.

3.3 Pae Ora Paiaka Whaiora Hauora Māori Directorate Progress Update Against the Manawhenua Hauora Work Programme

The General Manager, Māori Health presented this report. The report was taken as read. In April there would be a two day regional meeting regarding the Māori Action Plan with the Ministry of Health, Māori Directorate. The General Manager had met with all four Iwi Boards who had been supportive of the direction for iwi to develop health and wellbeing plans. The Māori Health Equity dashboard was due for completion in time for the HDAC and Manawhenua Hauora April meeting. There were 23 identified indicators identified currently. These would be endorsed by governance in April.

The OLT Te Reo learning had been postponed to June due to the COVID-19 situation. A Board member requested the course be open to Board members.

The amount that was invested in smoking cessation across the DHB was being reviewed to ensure that we were getting the best value for money or what could be done better. The budget would not be cut, this was about ensuring maximum dollar efficiency.

It was resolved that the Committee

endorses the Pae Ora Paiaka Whaiora progress report against the Manawhenua Hauora Board Work Programme 2019/2020. (Moved John Waldon; Seconded Jenny Warren)

3.4 Enable New Zealand Report to 31 January 2020

The previous General Manager, Enable New Zealand presented this report. The report was taken as read. The pōwhiri for the new General Manager had been deferred due to the COVID-19 situation.

Under 5.1 of the report the statement "that Mana Whaikaha would be better served if the disabled community-owned and lead the future of the organisation" the Committee would be provided with a further update at the April meeting if there had been a decision from the Minister.

It was resolved that the Committee

- *endorses the Enable New Zealand Report to 31 January 2020. (Moved John Waldon; Seconded Karen Naylor)*

3.5 Ka Ao Ka Awatea – Māori Strategic Framework 2017-2022: Implementation Progress Annual Update

The General Manager, Hauora Māori presented this report. This was an exciting strategy that was developed in collaboration with Te Tihi, THINK Hauora and the DHB to improve equity of health outcomes and Māori health across the district.

It was resolved that the Committee

note the Annual progress update on Ka Ao Ka Awatea – Māori Strategic Framework 2017 - 2022. (Moved John Waldon; Seconded Vaughan Dennison)

3.6 Health Equity Work Programme Update Monitoring Health Equity

Dr Janine Stevens presented this report. The Committee acknowledged the report but advised that they needed to see focus and actions in subsequent reporting recommendations.

Using the Trendly data, the quarter two measures showed very few positive results for Māori and in areas where the overall results had declined, the decline was faster for Māori than the total population. Current data did not allow for complete ethnicity reporting and total population reporting masked the inequity for Māori populations. There were at least 13 indicators that did not report by ethnicity.

All cluster plans had an equity focus and the Board and Committee should continue to challenge MDHB on equity outcomes.

There had been a concerted effort across primary, public and general health to improve the targets.

The Trendly dashboard had been developed in 2014 and launched in June 2015, whilst this data would continue in the background, MDHB was working on a Māori Health Equity dashboard to better support its Māori Health priorities. Where poor performance had been identified actions had been included in the Annual Plan to ensure ongoing focus. In addition quarterly reporting detail would provide the Board with key initiatives and action plans to improve the inequity gaps between Māori and others.

There was a significant project of work being undertaken at a national level on the Oral Health statistics.

In the past two to three years there had been significant advancement in five recommendation areas of the Equity Think Piece document. These were:

1 Equity of culture – this had happened and was top of mind for everyone
2 People first – there was now a focus on Māori and others in all plans
3 Clinical considerations – this was starting to happen
4 Partnering across other sectors – this was starting to happen
5 Take action in our sphere of influence – this was happening but it took time to reflect the results in the dashboard.

It was resolved that the Committee

note the progress update on the Equity Work Programme
note the changes in health equity performance based on Trendly indicators to inform the Annual Plan. (Moved John Waldon; Seconded Muriel Hancock)

3.7 Clinical Governance and Quality Improvement Report

The Manager, Quality Improvement and Assurance and Consumer Experience Manager presented this report. The reports now took an organisational wide and dashboard focused view to ensure consistency. Equity data would be included in the future.

Future patient experience surveys would include ethnicity reporting. The survey would also include cultural questions to ensure patients had been treated appropriately. The team would strongly advocate for the survey to be multi-lingual to HQSC who were co-ordinating the survey at a national level.

The complaints process was discussed. Each cluster individually reported their own complaints and all had a mechanism to review feedback and complaints and adjust processes accordingly if necessary.

It was resolved that the Committee

note the content of the clinical governance and quality improvement report
endorse the creation of a refreshed approach to the ongoing implementation of The Quality Agenda (Clinical Governance Framework) across the organisation
endorse progress in delivering improvements in Clinical Governance and Quality Improvement. (Moved John Waldon; Seconded Lew Findlay)

3.8 Potential and Actual Serious Adverse Events for January 2019 to January 2020

The Manager, Quality Improvement and Assurance presented this report. The results were at a similar level to the previous reporting period. There was a robust review

process of all serious adverse events which included following up and reporting back to family, whānau and how the family and staff were supported through an adverse event.

Management would consider how to include more key recommendations and trend based analysis of actions completed in the report in future.

It was resolved that

The potential and actual serious adverse events report for January 2019 to January 2020 be noted. (Moved John Waldon; Seconded Karen Naylor)

4 DISCUSSION / DECISION PAPERS

4.1 Status Update Report – Implementation of the 2019/20 Regional Service Plan, Quarter 2

The Manager, DHB Planning and Accountability presented this report. The report was taken as read. Of note, the cancer programme of work would be impacted by the national Cancer Action Plan, National Agency and National Cancer Network as they progressed. There had been two ophthalmologists resign from Whanganui DHB and work was underway as to how to support a service coverage solution until recruitment had concluded. The regional WebPAS upgrade was going ahead this week (18/19 March).

It was resolved that the Committee

note the update on progress with implementing the 2019/20 Regional Services Plan. (Moved John Waldon; Seconded Jenny Warren)

5 INFORMATION PAPERS

5.1 Committee's Work Programme 2019/20

The General Manager, Quality & Innovation presented this report. The report was taken as read.

It was resolved that the Committee

endorses the update on the 2019/20 work programme. (Moved John Waldon; Seconded Karen Naylor)

6 LATE ITEMS

There were no late items.

7. DATE OF NEXT MEETING

28 April 2020, Boardroom MidCentral District Health Board, Gate 2 Heretaunga Street, Palmerston North.

8. 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 Health and Disability Committee previous meeting	*For reasons set out in the order paper of 04.02.20*	
Health and Disability Commissioner (HDC) Complaints for January 2019 to January 2020	*To protect personal privacy*	*9(2)(a)*

(Moved John Waldon; seconded Vaughan Dennison)

Confirmed this 28th day of April 2020.

…….
Chairperson

Health & Disability Advisory Committee

- Schedule of Matters Arising, 2019/20 as at 12 May 2020

Matter	Raised	Scheduled	Responsibility	Form	Status
Update re Treaty of Waitangi Policy review process	Bd July 19	6-weekly	T Te Huia	Inc in HP report	Ongoing
Consumer feedback re Choices, particularly intensive wrap-around services	Oct 19	Apr 20	G Brogden	Inc in ENZ report	Scheduled
Mental health business case	Nov 19	~~March 20~~ ~~April 20~~	V Caldwell S Ambridge N Wanden	Separate report	Scheduled *Now with Board papers during HDAC / Board combined meeting 26/5/20*
Consider if an annual report on the disability strategy is enough focus in this area when preparing the next Committee Work Programme	Feb 20	April 20	B Duffy	Not a report, for Chair consideration.	To be considered
Provide trend analysis on holiday levels above two years	Feb 20	July 20	K Anjaria	Report	Scheduled
Investigate why MDHB has second highest polypharmacy rates in NZ and review with similar sized DHBs	Mar 20	Sept 20	D Davies	Inc in Cluster report	Scheduled
KPI-19 – business case on improving technology contact with clients	Mar 20	Sept 20	S Ambridge	Separate report	Scheduled
Consider how to include more key recommendations and trend based analysis of actions completed in future 'Potential and Actual Serious Adverse Event' Reports	May 20		J Catherwood	Include in Potential and Actual Serious Adverse Event report	Scheduled
Completed					
Declined referrals: further information	Nov 19	Feb 20	L Horgan	Inc in Cluster report	Completed Feb
Risk 805 - Follow-up process and procedures: explanation	FRAC Nov 19	Feb 20	L Horgan	Inc in Cluster report	Completed Feb

	**For:** **X** Decision Endorsement Noting

To	Health and Disability Advisory Committee
Author	Cluster Leadership Group
Endorsed by	Dr Jeff Brown, Acting Chief Executive
Date	7 May 2020
Subject	**Update for February/March 2020**

RECOMMENDATION

It is recommended that the Committee:

- **endorse** the progress made by the Services in February/March 2020
- **note** the COVID-19 response and commencement of transition planning for each service area
- **note** the impact to operational plans and performance due to the COVID-19 response
- **note** the innovations in service delivery which are subject to evaluation in the Recovery Planning process.

Strategic Alignment

This report aligns to MidCentral DHB's Strategy and the implementation of its Annual and Operational Plans, Locality Health and Wellbeing Plans and Cluster Health and Wellbeing Plans.

1. PURPOSE

The purpose of this report is provide the Health and Disability Advisory Committee with a summary of the performance against plans, budget and targets and to advise any current and emerging matters in:

- Te Uru Whakamauora - Healthy Ageing and Rehabilitation
- Te Uru Kiriora - Primary Public and Community
- Te Uru Rauhi - Mental Health and Addictions
- Te Uru Pā Harakeke - Healthy Women Children and Youth
- Te Uru Mātai Matengau - Cancer Screening, Treatment and Support
- Te Uru Arotau - Acute and Elective Specialist Services

The data provided in the appended reports relate to the period to end of March 2020, however where relevant and appropriate, comments and data relating to

April 2020 and the COVID 19 response have been included. Due to COVID-19, the planned presentations have been deferred.

A SUMMARY OF THE SIX HEALTH AND DISABILITY SERVICE CLUSTERS	
Te Uru Arotau – Acute and Elective Specialist Services	**Te Uru Kiriora** – Primary, Public and Community Health
Te Uru Arotau is responsible for the planning, funding 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 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 for 0-18 year olds across the district • Community based nursing services including District Nursing and Primary Health Care nursing in partnership with Primary Care and the Central Primary Health Organisation
Te Uru Pā Harakeke – Healthy Women Children and Youth	**Te Uru Rauhī** – Mental Health and Addictions
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 1000 days and youth oriented care.	Te Uru Rauhī is responsible for the planning, funding and provision of: • General adult mental health in community (moderate to severe and inclusive of co-existing problems) • Primary Mental Health & Addictions • Mental Health Acute Inpatient services • Eating disorders • Maternal Mental Health • Community Rehabilitation • Child Adolescent and Family • Alcohol & other Drug Specialist Services • Maori Mental Health • Older Adult Mental Health Services (Community and Inpatient) • 24 hour Mental Health Acute Care Team
Te Uru Mātai Matengau – Cancer Screening, Treatment & Support	**Te Uru Whakamauora** – Healthy Ageing and Rehabilitation
Te Uru Mātai Matengau is responsible for the planning, funding 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 Whakamauora is responsible for the planning, funding and provision of specialist services for people over the age of 65 years (55 years for Maori) and those between the ages of 16-64 with a physical disability, with a focus on assessment, treatment and rehabilitation. Services are structured into: • ElderHealth • Rehabilitation • Therapy Services • Supportlinks

SERVICE:	Te Uru Whakamauora Healthy Ageing and Rehabilitation
FOR PERIOD:	March 2020
PREPARED BY:	Andrew Nwosu, Operations Executive Syed Zaman, Clinical Executive Pauline Holland, Planning & Integration Lead

1. PERFORMANCE OVERVIEW

Te Uru Whakamauora is generally on track with all initiatives under the Annual Operational and Performance Improvement Plans. Whilst there are no emerging risks or areas of concern some of the trends for our initiatives were impacted on by our response to COVID-19. Items of note are discussed under Significant Matters.

Plan	Initiative	Rating & Trend	
A	Increase uptake of integrated falls and fracture liaison service	D	•
A	Improve consistency, quality and efficiency of Home and Community Support	G	•
A	Improve process for the management of PPPR applications	D	•
A	Increase support for older people managing their long term conditions	G	•
P	Implementation of "Red to Green" on wards	G	•
P	Develop Complex patient pathway Plans for improved Discharge Planning	G	•
P	Develop Escalation Plans to manage surge	G	•
P	Timely transfers of care: Improving Acute to Rehab pathways	D	•
O	Improve patient flow throughout the hospital, reducing barriers and delays	D	•
O	Improve models of care for the older person with frailty	G	•
O	Refine models of care for Older Persons (acute) Assessment and Liaison	G	•
O	Support regional improvements for people and whānau living with dementia	G	•
O	Enhance orthogeriatric and general surgical models of care	D	•
O	Promote wellness and age friendly environments for older people	G	•
O	Develop a more responsive and effective rehabilitation model	G	•

Rating & Trend 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/deferred
↑	Improved from last report.	↓	Regressed from last report.	•	No change from last report.		
Plan Legend							
A	Annual Plan	**P**	Performance Improvement Plan	**O**	Operational Plan		

1.1 Performance Indicators – March 2020

KPI Description	Previous Month	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	KPI Trend (13 month)
Customer Patient								
Acute readmissions within 28 days	0.0%	0.0%	7.5%	(7.5%)	1.7%	7.5%	(5.8%)	
Occurrence Rate of Medication Incidents	1.0	3.9	3.5	0.4	3.1	3.5	(0.4)	
Patient Falls Rate	6.0	7.9	5.0	2.9	6.8	5.0	1.8	
Hospital acquired UTI rate	1.52%	0.00%	0.50%	(0.50%)	1.23%	0.50%	0.73%	
Inpatients developing Pressure Ulcers	0.30%	0.00%	0.50%	(0.50%)	0.28%	0.50%	(0.22%)	
Complaints resolved within 15 days	33.3%	100.0%	95.0%	5.0%	57.1%	95.0%	(37.9%)	
Internal Process and Operations								
ED - Shorter Stays	0.0%	100.0%	95.0%	5.0%	50.0%	95.0%	(45.0%)	
ALOS - Acute	17.1	18.2	4.0	14.2	17.5	4.0	13.5	
Bed Day Usage	65.4%	53.8%	85.0%	(31.2%)	63.7%	85.0%	(21.3%)	
DNA - Outpatient	7.3%	2.8%	6.0%	(3.2%)	4.4%	6.0%	(1.6%)	
DNA - Outpatient, 17-64 years	15.7%	11.1%	6.0%	5.1%	8.9%	6.0%	2.9%	
DNA - Outpatient, 65+ years	4.0%	0.9%	6.0%	(5.1%)	3.0%	6.0%	(3.0%)	
DNA - Outpatient, Maori	20.0%	22.2%	6.0%	16.2%	11.4%	6.0%	5.4%	
Smoking Cessation - Hospital	100.0%	100.0%	95.0%	5.0%	93.2%	95.0%	(1.8%)	
One to One Hours	1,059	1,103	0	1,103	10,220	0	10,220	
Organisational Health and Learning								
Staff Stability	99.5%	99.5%	99.0%	0.5%	98.1%	99.0%	(0.9%)	
Staff Turnover	0.97%	0.49%	1.00%	(0.51%)	0.86%	1.00%	(0.14%)	
Sick Leave Rate	3.27%	2.90%	3.20%	(0.30%)	3.54%	3.20%	0.34%	
Staff Annual Leave balance > two years	11.6%	10.7%	0.0%	10.7%	10.7%	0.0%	10.7%	

Te Uru Whakamauora continues to focus on improved compliance and monitoring of key performance indicators.

Length of stay for inpatients was off track for the month of March. The reasons for this were multifactorial; increased patient complexity, difficulty discharging to facilities of choice and delays in court processing. These metrics are expected to improve as business resumes as usual over the following months.

Medication errors related to three cases, two of which were omission errors and one patient related. All ward charge nurses are commited to reducing the risk of errors by implementing a range of initiatives such as double checking, near bed side administration and monitoring rate of errors to ensure patients remain safe.

Te Uru Whakamauora is focused on reducing rate of falls. Root cause analyses show correlations between high dependency patients, the focus on rehabilitation and mobility and occasionally patient non compliance issues. A range of known initiatives are being used for falls mitigation and encourage supervised mobility for higher risk patients.

There is ongoing work with the business intelligence teams to ensure bed day usage by speciality is accurate and reflective of cluster activity as currently a significant proportion of the data is attributable to non-Healthy Ageing and Rehabilitation patient admissions.

Outpatients who did not attend were off track for the month of March, this was attributable to the cancellation of Outpatient Clinics as a response to COVID-19 restrictions.

For March staff annual leave balances over two years exceeded target, this continues to be a work in progress. A number of staff utilised these balances over the months of March, consequently this metric will improve over the coming months.

Year to date variances under customer patient, internal process, organisational health and learning are mostly cumulative.

2. SIGNIFICANT MATTERS

2.1 OPAL Inpatient Unit

Ward 25 which housed the Older People's Acute Assessment and Liaison (OPAL) unit was temporarily stood down as part of a hospital wide response to managing suspected and confirmed cases of COVID-19. Currently frailty patients have decanted to Services for Treatment, Assessment and Rehabilitation (STAR) 2 and STAR 4. Te Uru Whakamauora continues to monitor the situation and intends to return to business as usual when safe to do so.

2.2 STAR 2 and 4

The Red to Green system for identifying and minimising potential delays and wasted days in hospital continues to be business as usual, though timely discharge has been impacted upon by the insistence of some residential facilities for swabbing asymptomatic "new" and returning residents for the presence of COVID-19.

The partnership between Te Uru Arotau and Te Uru Whakamauora in relation to the management of hip fractures, specifically the fast-tracking of uncomplicated hip fractures from Ward 24 to STAR 2 was impacted by temporary reductions in elective surgery.

Work has begun with Te Uru Rauhī to develop an improved model of care that looks to embed parity of esteem for older people with physical and mental health needs. The model proposed looks at a collaborative holistic approach to managing older people with both physical and mental health needs.

2.3 Creating Hospital Capacity

Te Uru Whakamauora's draft OPAL Community Service business case that looks to implement a locality based and partnership focused approach to the management of older people with frailty was re-presented in March 2020, and agreed in principle by the Organisational Leadership Team. Work continues with the finance team to articulate return on investment. It is expected that this will progress in the new financial year.

Under COVID-19 alert Levels 3 and 4, Te Uru Whakamauora has continued to provide essential services across the hospital, including orthogeriatric liaison, ward consultations, interface geriatrics and rehabilitation on STAR Wards 2 and 4.

Our new Elder Health Clinical Nurse Specialist (CNS), Team Leader, commenced on 9 March 2020.

Te Uru Whakamauora is currently focusing on the recruitment of two additional consultant geriatrician positions to enable an enhanced specialist geriatric presence in the Emergency Department. This would be to further support the management of older people with frailty who are unable to be accommodated on the OPAL unit At least one of these geriatricians will be in place by July 2020.

2.4 Care in the Community

In response to Ministry of Health's (MoH) guidelines for alert Levels 3 and 4, Te Uru Whakamauora cancelled all outpatient and community activities, redeploying a number of staff into alternative or extended roles. CNS and Senior Medical Officers have been undertaking telephone consultations with all new and follow-up patients.

A novel Older People's Rapid Assessment (OPERA) team was stood up at short notice to support General Practitioner teams and Age Residential Care (ARC) facilities. CNS proactively communicate with ARC facilities on a locality basis offering advice and support. The OPERA team has enabled the District Health Board to comply with MoH recommendations that any request for hospital admission from an ARC facility be discussed with specialist geriatric services. A number of hospital transfers have been avoided as a result.

The provision of a number of non critical community services were stood down over March in response to MoH guidance under alert Level 3 and 4 restrictions, these services cut across a range of the Te Uru Whakamauora portfolio:

- Home and Community Support Services (HCSS) - housework only visits
- Community daycare
- Falls services such as In Home Strength and Balance
- Equipment provision and non-critical adaptations
- Non-priority Allied Health Community visits
- Non-essential respite

To mitigate the risks of suboptimal user outcomes Te Uru Whakamauora increased its use of Telehealth options, the OPERA team and the Needs Assessment and Services Coordinator mediated check-ins.

In response to MoH's directives Te Uru Whakamauora increased collaborative surveillance of ARC facilities and HCSS agencies providing assurance on a number of critical areas:

- Infection Control
- Workforce
- Personal Protective Equipment provision

It is expected that this will continue until alert levels are substantially reduced.

There has been increase in Protection of Personal and Property Right application/hearing waiting times impacting on patient flow within the system. This is partly due to delays in the court system and some external challenges in transferring new non COVID-19 patients into ARC facilties without swab results.

Intentions are to explore the possibility of telehealth orders with the court using the experience of Te Uru Rauhī.

2.5 Innovations

As a response to the COVID-19 pandemic, Te Uru Whakamauora has seen an increase in the use of telehealth options by geriatricians, CNS and Allied Health to improve the efficiency of health care delivery and maintenance of population health. Users have appreciated the ability to extend timely and convenient consultation.

SERVICE:	Te Uru Kiriora Primary, Public and Community Health
FOR PERIOD:	February/March 2020
PREPARED BY:	Deborah Davies - Operations Executive, Alison Russell - Planning and Integration Lead

1. PERFORMANCE OVERVIEW

Te Uru Kiriora was generally on track with all initiatives under the Annual, Operational and Performance Improvement Plans at March end. The significant impact of the COVID-19 pandemic on both our Public Health and Primary Health Care teams, along with other items of note, is discussed under Significant Matters.

The collective teams across Uru Kiriora – the leadership teams and clinical teams of primary and public health have been outstanding in their collective efforts to mobilise multiple teams. In doing this they have rapidly revised working arrangements, responded to multiple planning prioirities and continued delivering a high volume of clinical and infrastructural support with commitment and courage.

Plan	Initiative	Rating & Trend	
	Better Population Health Outcomes Supported by Primary Health Care		
A	Increase enrolment numbers across the MidCentral District with a focus on Māori	G	↑
O	Drive effective integrated Locality based care delivery through locality team prototype development and workforce planning	G	•
P	Pharmacy Improvement Programme	G	•
P	Improve management of Long Term Conditions with a focus on Chronic Pain, Diabetes and Respiratory Care	G	•
	Improving Child Wellbeing		
A	Improve access to youth friendly and appropriate primary health care services to improve health outcomes	G	•
O	Achieve equity in immunisation coverage rates across priority groups of infants and children	A	↓
	Improving Wellbeing Through Prevention		
A	Increase Cervical Screening coverage rates for Māori, Asian and Pacific women to achieve and sustain equity	A	•
A	Reduce the prevalence of smoking, particularly for Māori and increase uptake of smoking cessation support services	A	↓
A	Promote and enable wellbeing in communities through health policy initiatives	G	•
	Better Population Health Outcomes Supported by a Strong and Equitable Public Health and Disability Strategy		
P	Strengthen community based Acute and Urgent Demand model of care and delivery	G	↑
O	Improve patient health care outcomes and experience in primary care and community settings through scaling of Health Care Home	G	•
A	Strengthen delivery of Whānau Ora "closer to home" increasing number of whānau who benefit from collective impact participation	G	•

Rating & Trend 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.
↑	Improved from last report.	↓	Regressed from last report.	•	No change from last report.		

Plan Legend						
A	Annual Plan	**P**	Performance Improvement Plan	**O**	Operational Plan	

1.1 Performance Indicators

KPI Description	Previous Month	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	KPI Trend (13 month)
Customer Patient								
Child & Adolescent Oral Health Total Arrears	16.6%	17.1%	10.0%	7.1%	1.7%	1.1%	0.6%	
Child & Adolescent Oral Health Total Enrolments	74.2%	73.1%	95.0%	(21.9%)	78.6%	95.0%	(16.4%)	
Complaints resolved within 15 days	0.0%	100.0%	95.0%	5.0%	100%	95.0%	5.0%	
Maori 0 to 4 years Oral Health Arrears	13.2%	11.4%	10.0%	1.4%	10.3%	10.0%	0.3%	
Maori 0 to 4 Years Oral Health Enrolments	54.0%	55.8%	95.0%	(39.2%)	55.0%	95.0%	(40.0%)	
Maori Child & Adolescent Oral Health Arrears	18.8%	19.2%	10.0%	9.2%	18.2%	10.0%	8.2%	
Maori Child & Adolescent Oral Health Enrolments	45.9%	47.4%	95.0%	(47.6%)	48.5%	95.0%	(46.5%)	
PHO Cervical Screening	77.6%	77.6%	80.0%	(2.4%)	77.6%	80.0%	(2.4%)	
PHO Enrolment Maori	83.5%	83.5%	90.0%	(6.5%)	82.8%	90.0%	(7.2%)	
PHO Enrolment Total	94.3%	94.3%	93.0%	1.3%	94.2%	93.0%	1.2%	
PHO Infant Primary Immunisation	88.8%	88.8%	95.0%	(6.2%)	89.2%	95.0%	(5.8%)	
PHO Quit Smoking Advice	74.0%	74.0%	90.0%	(16.0%)	76.7%	90.0%	(13.3%)	
Organisational Health and Learning								
Staff Stability	100.0%	100.0%	99.0%	1.0%	99.2%	99.0%	0.2%	
Staff Turnover	2.17%	0.00%	1.00%	(1.00%)	0.71%	1.00%	(0.29%)	
Sick Leave Rate	4.26%	2.90%	3.20%	(0.30%)	3.86%	3.20%	0.66%	
Staff Annual Leave balance > two years	4.9%	5.9%	0.0%	5.9%	5.9%	0.0%	5.9%	

- Child and Adolescent Oral Health arrears are 7.1 percent adverse, with an improvement in Māori preschool arrear rates. This remains a focus area.
- THINK Hauora Cervical Screening Leads current focus is on supporting practices to identify and target priority women from within their own practice management systems. All General Practice Teams (GPT) and community routine smear clinics were cancelled in the final week of March in response to the COVID-19 lockdown, but are expected to be reinstated at the commencement of Level 2.
- Enrolment has increased with a total increase of 863 enrolments (0.5 percent) compared to the previous quarter, and an increase of 270 Māori enrolments

(0.9 percent) compared to the previous quarter. Key focus areas previously described continue. The direct enrolment initiative planned for the Pae Ora/Ora Konnect community day late March 2020 did not progress as the event was cancelled.

- Childhood immunisation completion rates for both eight months and five years did show a decline at the end of Quarter 3, particularly for Māori. With a large client base of Māori and Pasifika, an unexpected resignation in the Outreach Immunisation Service (OIS) at the end of January 2020 has negatively impacted immunisation timeliness for whānau that rely on a mobile service for childhood vaccinations. Focus continues to work closely with practices to encourage affected whānau to engage with their practice.

- The Smoking Brief Advice (SBA) result was 74 percent. The absence of THINK Hauora providing recall lists to practices over the past two quarters has had a negative impact on the overall achievement of this target. With the THINK Hauora data warehouse transition completed, reinstatement of regular lists for practices to use for managing SBA recalls will be available in the fourth quarter and this is expected to re-energise practice effort in this area.

- Annual leave over two years has increased marginally to 5.9 percent of staff in this category. All have plans in place, however the ability to provide extra leave is challenging given the significant work managing COVID-19.

2. SIGNIFICANT MATTERS

2.1 Set up and delivery of Designated Testing and Community Based Assessment Centres across the rohe

MidCentral District Health Board (MDHB) and THINK Hauora have been working closely together since mid-January 2020 supporting the Public Health Unit who are the lead agency for the current COVID-19 event. An updated District Pandemic Plan was renewed in March 2019 and is current until 2022. The primary purpose of the plan is to establish a framework and define the relationships needed to respond to a pandemic affecting communities within the MDHB boundaries. The guiding principles and objectives of the plan are similar to those identified in the New Zealand Influenza Pandemic Action Plan (NZIPAP-Version 14).

MidCentral DHB and THINK Hauora also have a supporting Community Based Assessment Centre Plan & Procedure Manual. This outlines a model of community based care to provide optimal care during a pandemic to serve local communities and to protect the primary and secondary health care sectors to ensure continued 'business as usual' health service provision during a pandemic.

This work continues to deliver effective COVID-19 responses. These efforts are focused on looking after our communities by supporting primary care, principally general practice and community pharmacy. Primary care and other community services have been under additional pressure to provide increased services such as COVID-19 testing. Focusing on the development of Designated General Practices and Community Based Assessment Centres (CBACs) addresses the following aims:

- continue to meet the demand of testing for COVID-19
- assist Primary Health Care teams to provide safe management of patients presenting with acute respiratory conditions

- reassure our enrolled population that they can safely access all care including for respiratory and other long term conditions at practices across our network.

Six designated testing sites were established alongside a mobile facility:
- 3 are fulfilling CBAC functions, able to both triage/swab AND assess and provide treatment/care plan for potential COVID-19 patients
- 2 additional sites; in Palmerston North (Main Street) and Horowhenua (Horowhenua Health Centre) are positioned to become formal CBAC sites if required to increase assessment and treatment capacity
- One site is providing triage/assessment/swab, and referral for treatment if required.

Currently referrals are managed through a centralised 021 referral number and are accepted from:
- Healthline
- General Practices
- The Emergency Department
- The Public Health Unit

Recently Community Pharmacies have been advised to encourage people with any respiratory symptoms to phone an 0800 number (directed to the same referral line above) to arrange an appointment for a swab.

Key plans have also been completed to ensure safe and responsive testing is available in Aged Residential Care, the Youth Justice Facility and Arohanui Hospice.

2.2 Primary Care Service Delivery

General practices continue to operate as essential services and have transformed their model of care in response to threat of COVID 19. Most patients (up to 70-80 percent) are now assessed and treated using 'virtual' or 'non-contact' means ie phone, email, video consultations, and the use of patient portals. Patients requiring a face to face consultation will still be seen utilising strict infection control procedures which minimises the risk to both their enrolled community and staff. This successful transition was underpinned by the Primary Health Care (PHC) led digital focus over the past three years to implement a cloud-based Patient Management System (PMS), develop strategies for virtual health and the drive for Shared Electronic Health Records and Patient Portals.

Over the period of the Level 4 COVID-19 lockdown presentations to General Practice have significantly declined, including for routine childhood immunisations. This has also adversely affected completion rates of childhood immunisations into the current quarter. During this time there was also a diversion of vaccinating staff to urgently target vulnerable populations and essential workforce for seasonal influenza vaccinations. In response to this, the THINK Hauora Immunisation Co-ordinator has been working with Te Tihi O Ruahine Whānau Ora to provide mobile vaccination clinics to vulnerable populations in the outer localities of the district. Transitioning into Level 3, this focus will return to Childhood vaccinations, with a particular focus on finding alternative solutions to OIS for Māori and Pasifika.

On March 23 all THINK Hauora clinical services were transitioned to providing virtual consultations. Most of the Long Term Conditions (LTC) clinical team were deployed to stand up the local assessment and swab sites and mobile flu vaccination clinics and continue to staff these services into Level 3. Whilst

planning for Level 2 is still dependent on official guidance from the MoH, it is likely that LTC clinical staff will be redeployed to Integrated Family Health Centres (IFHC's) to provide LTC consultations for a cluster of locality practice's. This complements the MidCentral Respiratory Plan for the winter period. This plan identifies each practices capacity and infrastructure to safely deliver COVID-19 testing and respiratory assessment and care. For those practices unable to provide this, patients will be aligned to practices that can safely deliver this care.

All practices have renewed access to a risk stratification report of their enrolled population to assist with targeting patients with co-morbidities, age, recent Emergency Department (ED)/acute admissions and socio-economic risk factors. THINK Hauora LTC, CNS Diabetes PHC and Allied Health clinicians will mentor and support practices to use these lists for LTC preventative and acute management planning (ie Action Plans and medical reviews).

THINK Hauora has also provided General Practice teams with a comprehensive list of activities that can be undertaken during this time, including welfare checks, updating patient recalls and completion of routine screening activities that do not require an in-person consult. This has seen a positive increase in SBA and Cardiovascular Disease Risk Assessment (CVRA) completions. This should improve target achievements this quarter.

2.3 Child Adolescent Oral Health

Service delivery was stable across February 2020, and on announcement of the move into alert Level 4 the Service withdrew routine services. Available staff capacity has been redeployed to work primarily in the designated testing sites, assisting in COVID-19 testing. Our Manager Dental is scheduled to commence late June 2020, with his appointment being affected by the COVID-19 pandemic.

2.4 Managing acute and urgent demand

District Nursing (DN) care moved to 100 percent home based from 23 March 2020. Alongside this the District Nursing Service (DNS) has also provided the mobile response to COVID-19 testing, testing seven days per week in people's homes, and initially in Aged Residential Care (ARC). Caseloads remain significant.

Work has been completed with THINK Hauora to co-design the pathway to support the effective care and treatment of people affected by respiratory conditions over the upcoming months, given the novel situation that COVID-19 presents. This is to be aligned to the Health Pathway and provides for proactive home based care when appropriate, with or without DN team support.

ED redirection for a range of conditions continues with 1375 patients having been deemed suitable for redirection and 1286 have accepted the service at March end. Ethnicity breakdown is at 60 percent European, 24 percent Māori, and six percent Pacific Island. The top three reasons for attending ED are described as: cost, out of GP hours, and unable to get an appointment with GPT.

The ED/Chronic Obstructive Pulmonary Disease (COPD) programme commenced 10 February 2020, with nine patients through this programme up until 23 March 2020. The programme has been on hold due to the impact of COVID-19 on the limited support capacity from the GPTs and THINK Hauora Community Clinical Nurse – Long Term Conditions capacity. Prior to 23 March 2020, it was thought that the

low numbers reflected normal seasonal variation. This is being reviewed as we move back through the alert levels.

Active work is in place with ED to ensure a seamless process for people presenting who are low acuity, meet the Minstry of Health COVID-19 criteria for swabbing, and who could be managed safely at a Designated Testing Centre in the community. The main purpose is to relieve pressure on ED and provide another community option for patients. This option is open to patients who meet the following criteria:

- Low acuity (triage four or five)
- Early Warning Score less than three
- Clinically safe and appropriate to self-care at home
- Consents and chooses option to go to the testing centre

ED redirection options for other patients continues to be in place with three Primary Options for Acute Care (POAC) referral centres available during the COVID-19 Level 4 and 3 lockdown periods. Total numbers have been lower during this time due to a range of factors e.g. lower overall ED volumes.

2.5 Pharmacy Improvement Programme

The Pharmacy Improvement Programme continued into level four lock down, with the Primary Care Support Pharmacists (PCSP) mobilising swiftly to support Community Pharmacy teams with business continuity planning and processes to manage front-line services. Alongside this they have remained focussed on aligned GPTs in the three key areas; reduction in medicine related harm, reduction in unwarranted variation and reduction in medication waste.

The PCSP team have been working with patients virtually since 23 March 2020 and will continue this through Level 3. Due to the impact of the pandemic, the quarterly report is not available.

2.6 Public Health Nursing and School Based Health Service

While initial preparations to expand School Based Health Services (SBHS) were completed, including successful recruitment of further Registered Nurses, transition to the additional decile five schools was placed on hold. Public Health Nurses have been fulfilling a number of core functions to include COVID-19 testing, contact tracing and follow up of cases and contacts. Public Health nurses remain available to provide virtual care and support in areas such as contraception. As the immunisation programme was halted, this will impact on how we deliver planned school vaccinations across the remainder of the year when we are able to resume. This is contingent on national direction as we move out of the alert levels.

2.7 Public Health Response to Covid-19

As at 8 May 2020 the total number of people with COVID-19 across MDHB stands at 31, comprising 26 confirmed and five probable cases. Of these:

- 13 have been associated with overseas travel
- 18 have been associated with another known case
- There are no cases in which the source is still under investigation
- Only one person has been admitted to hospital
- None of our patients have been admitted to Intensive Care Unit
- 31 of the 31 people diagnosed with COVID-19 have recovered

- Most of the cases have been from Palmerston North and Horowhenua. There have been no cases of COVID-19 in Ōtaki at this point
- While most people with COVID-19 have been in the 20-39 year age group, there have been six cases in people over 60 years of age
- The most recent cases (two) were notified on Friday 17 April 2020.

Timely case investigation and contact tracing/management are critical to maintaining control over the disease, and this remains the core focus for the Public Health Service. While there have been relatively few cases of the disease in this region to date, the risk of spread increases as the lockdown provisions are lifted. Work is underway to improve our surge capacity around both case investigation and contact management so that we are able to respond should this be required. A strong focus to date has been testing of people with respiratory symptoms, and the local capacity to do so has increased markedly. This focus will continue over coming weeks and months.

Community testing of asymptomatic people has also commenced. This is part of a nation-wide effort to identify undetected cases of COVID-19, particularly in sectors where there has been high exposure to people with respiratory symptoms. The first tranche involved 315 staff in health care settings across key areas of the hospital (ED, Child Health, Women's Health); and primary care (including staff working at our community testing sites and in general practice). Planning continues around extending this testing to other community settings including ARC, and other groups deemed at risk eg Police.

2.8 Future opportunities

Two key activities in the Te Uru Kiriora 19/20 plan were to explore telehealth and agree virtual access strategies with primary care. With the rapid move into Level 4 lockdown and virtual health being implemented into all general practices, the continuation of these care delivery changes are now being actively explored across the system.

The clear direction to locate as much planned care in primary and community as possible provides the immediate opportunity to co design future care delivery. The provision of Hospital Health pathways to the specialist services free of charge during COVID-19 further supports system alignment and is being actively explored with Te Uru Arotau.

2.9 Recovery planning

As we move through the alert levels, each requires a specific response to enable effective service delivery. Primary Care has received advice that under Level 3 the general principles remain the same, continuing to provide first contact services via virtual means. At the time of writing advice regarding Level 2 is pending.

Primary care is undertaking significant planning both to manage the implications of the winter ahead within an ongoing COVID-19 situation, and to consider primary cares approach to everyday care delivery.

We are awaiting confirmation from the Dental Council and the MoH regarding the plan to recommence child and adolescent dental delivery. We will be unable to

meet our projected delivery targets this year, with a potential impact of altered school holidays.

For our Public Health Service the pandemic response is expected to be required for a significant period of time and recruitment is underway to increase our contact tracing capacity. For the DNS the focus will be on planning to return to some clinic based care aligned within our Teams, and to support increased acute care at home as required.

SERVICE:	Te Uru Rauhī Mental Health & Addictions Service
FOR PERIOD:	February / March 2020
PREPARED BY:	Scott Ambridge, Operations Executive Dr Vanessa Caldwell, Clinical Executive Richard Hodgson, Planning & Integration Lead

1. PERFORMANCE OVERVIEW

Te Uru Rauhī is on track with all initiatives under the Annual, Operational and Performance Improvement Plans. Items of note are discussed under Significant Matters and current/emerging risks.

Plan	Initiative	Rating & Trend	
	Inquiry into Mental Health & Addiction – He Ara Oranga (also read in conjunction with sections below)		
A	Work with the Service Alliance Group to implement a district wide plan that supports increased access and capacity to adopt early intervention models of care and recovery	**G**	•
A	Work with the Primary Health Organisation (PHO), Non-Government Organisations (NGOs), Iwi and Kaupapa Māori services on establishing a range of low threshold community based services that support resilience, connection and wellbeing	**G**	↑
A	Partner with the public health service and the sector to expand capability and capacity in suicide prevention and develop high profile campaigns focused on prevention	**G**	•
A	Develop the acute model of care and progress initiatives to address the critical gaps for those experiencing psychiatric distress (ie home based treatment teams, multi-function planned respite)	**G**	↓
	Population Mental Health		
A	Develop Iwi and community partnerships that support a purposeful focus on addressing the inequities for Māori and prioritise investment towards improving Maori outcomes	**G**	↑
A	Work in partnership with the community to develop and pilot community-based services that expand access in the Horowhenua and Tararua areas	**A**	•
A	Work with the PHO to improve the overall physical health outcomes for people with mental health and addictions conditions	**A**	↓
A	Develop initiatives to increase the diversity of the workforce and work in partnership with Pae Ora to improve the cultural competency	**G**	•
	Mental Health & Addictions Improvement Activities		
A	Drive whole of system improvement across the six domains of quality and against the Health Safety Quality Commission (HSQC) quality improvement programmes (incl. zero seclusion)	**A**	•
A	Commence transitioning to a person centered model of practice and explore ways to use data and technology to increase workforce effectiveness and mobility	**A**	↓
A	Complete business case to Government to secure funding for progressing redevelopment of acute mental health inpatient (Ward 21) facility	**G**	•
	Maternal Mental Health & Addictions		
A	Improve equity of access and reduce waiting times for young people and pregnant Māori women and their whānau	**G**	•

Rating & Trend 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.
↑	Improved from last report.	↓	Regressed from last report.	•	No change from last report.		
Plan Legend							
A	Annual Plan	**P**	Performance Improvement Plan	**O**	Operational Plan		

Overall a number of initiatives have not progressed as hoped caused primarily through the COVID-19 pandemic. This is covered in more detail under significant matters.

Notes

- A review will be undertaken on the shared care programme[1] by the Clinical Programme lead. The work has been delayed due to the COVID-19 pandemic. This review will commence in the first quarter of the 20/21 year.
- A proposal for a sub-acute facility in Horowhenua has been developed. This will be progressed in the next four months.
- The learning from serious adverse events projects by the Health Safety Quality Commission (HSQC) has not substantially progressed. The project has been reset with a new Project Lead established.
- Workforce mobility has been severely challenged as a result of the COVID-19 pandemic. This is covered in more detail below.

[1] Developed in 2015 the aim of the program was to support people with co-existing conditions to be supported in general practice. The goal was to reduce dependency on secondary mental health services by improving integration and providing other options for people

1.1 Performance Indicators – March 2020

Uru Rauhī HDAC Scorecard

For the period ending March 2020. Cluster: C25 - Mental Health & Addictions; Service: (All); RC: (All).

KPI Description	Previous Month	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	KPI Trend (13 month)
Customer Patient								
Acute readmissions within 28 days (NB KPI 2)	30.8%	12.7%	5.0%	7.7%	2.1%	0.6%	1.6%	
Complaints resolved within 15 days	40.0%	42.9%	95.0%	(52.1%)	65.8%	95.0%	(29.2%)	
Internal Process and Operations								
Bed Day Usage	67.3%	62.0%	85.0%	(23.0%)	58.5%	85.0%	(26.5%)	
Community service-user-related time (NB KPI 34)	18.2%	16.8%	35.0%	(18.2%)	2.1%	3.9%	(1.8%)	
Contact time with client participation (NB KPI 33)	85.5%	85.0%	80.0%	5.0%	9.5%	8.9%	0.6%	
ED - Shorter Stays	75.0%	75.0%	95.0%	(20.0%)	82.9%	95.0%	(12.1%)	
ED Presentations	4	4	0	4	41	0	41	
ED Presentations, Maori	1	1	0	1	7	0	7	
In service for more than 90 days with no diagnosis	26.6%	26.3%	0.0%	26.3%	2.8%	0.0%	2.8%	
MH HoNOS/CA/65+ - Community Teams	72.6%	72.1%	80.0%	(7.9%)	8.0%	8.9%	(0.9%)	
MH HoNOS/CA/65+ - Inpatient Team	91.9%	93.2%	80.0%	13.2%	10.7%	8.9%	1.8%	
One to One Hours	2,882	2,402	0	2,402	33,620	0	33,620	
Post-admission community care (NB KPI 19)	54.5%	60.9%	90.0%	(29.1%)	6.3%	10.0%	(3.7%)	
Pre-admission community care (NB KPI 18)	44.7%	51.9%	75.0%	(23.1%)	4.9%	8.3%	(3.4%)	
Smoking Cessation - Hospital	66.7%	83.3%	95.0%	(11.7%)	74.8%	95.0%	(20.2%)	
Organisational Health and Learning								
Sick Leave Rate	3.65%	3.84%	3.20%	0.64%	3.98%	3.20%	0.78%	
Staff Annual Leave balance > two years	4.8%	4.8%	0.0%	4.8%	4.8%	0.0%	4.8%	
Staff Stability	100.0%	100.0%	99.0%	1.0%	99.2%	99.0%	0.2%	
Staff Turnover	1.78%	0.00%	1.00%	(1.00%)	0.67%	1.00%	(0.33%)	

The comments below are relating to specified Key Performance Indicators:

KPI 2: A new approach to safety planning and proactive discharge is currently being trialled. It is a multi-disciplinary team approach that is integrated across inpatient and community services that is person centred and focuses on safety

rather than risk. The aim is to provide shared support and decision making to ensure a more coordinated and responsive approach to discharge planning that will reduce readmission rates.

KPI 18: A project to develop new integrated "shared care" partnership model that addresses the barriers faced by people and their whānau when accessing secondary mental health services will commence in April. The initial focus is on developing a model where the community worker and the inpatient nurse work in partnership to coordinate care that is person/whānau centred and enables improved transition for people through community and inpatient services.

KPI 19: This KPI remains a key focus for the Palmerston North Community Mental Health team. The most common reason for not being able to see a client within the seven-day period is that the client has rescheduled the appointment.

KPI 34: A small project team will be set up to check the accuracy and reliability of this KPI which will also include benchmarking with other District Health Board's (DHB).

Complaints resolved within 15 days: Work to establish the COVID-19 response has meant some responses were not completed within the 15 days. This will be remedied in the next month.

Sick leave continues to be managed within District Health Board protocols. Leave in excess of two years relates to 16 staff, plans are in place to reduce leave balances in excess of two years. These plans will be disrupted by the COVID-19 response.

1.2 Ethnicity Data

Of the 1478 people currently being supported by secondary Community Mental health teams, below is the breakdown by ethnicity:

Ethnicity	Count	Percentage
Asian	24	1.6%
European	989	66.9%
Maori	433	29.3%
Not Stated	2	0.1%
Other	10	0.7%
Pacific Is.	20	1.4%
Grand Total	**1478**	

The number of people admitted to Ward 21 (January – March) is below:

Ethnicity	Count	%
Asian	11	2.5%
European	241	55.8%
Maori	160	37.0%
Not Stated	2	0.5%
Pacific Is.	18	4.2%
Grand Total	432	

2. SIGNIFICANT MATTERS

2.1 Request for Proposals (RFP) – Ministry of Health

Three proposals have been submitted to access new funding:

- Access and Choice Primary Mental Health and Addictions Services – the signed contract has been received from the Ministry and the contract with THINK Hauora is currently being finalised.
- Expansion and/or Replication of Existing Māori and Pacific Primary Mental Health and Addiction Services – still awaiting a response.
- Youth Primary Mental Health – still awaiting a response.

2.2 Older Adult Model of Care

Te Uru Rauhī has been considering for some months the future model of care, direction and location of the Older Adult Mental Health Service. The COVID-19 pandemic and the DHB response to this brought about the need to accelerate this work, specifically to find an alternative inpatient location for psychogeriatric services.

In parallel with the above the model of care is still progressing, a key tenet of the approach is consideration for an integrated model of care between Te Uru Rauhī and Te Uru Whakamauora that considers both the physical and mental health needs of the over 65 population. A plan to have this work completed is in place and consultation has commenced with staff. It is expected to be completed by June 2020.

2.3 Inpatient Facility Redevelopment

The steering group has met via videoconference during this period to finalise the business case. An external review of the demand modelling which informs proposed bed numbers was undertaken and confirmed the plan to open with 24 beds with the ability to flex up to 28 when needed. This is in the context of additional resource in the community to support acute alternatives and a change in the model of care, both of which we are working toward in 2020.

2.4 Te Uru Rauhī Response to COVID-19

On 27 March Te Uru Rauhī implemented its COVID-19 response plan. Whilst this report is to the end of March, additional information using emerging data has been presented below to ensure the committee is briefed on emerging matters over this period. The key facets of the plan are summarised below:

- Services need to operate in a way that limits the risk of the spread and transmission of COVID-19.
- National guidance from the Ministry of Health required Mental Health and Addictions Services to identify and implement an alternative location from the Emergency Department for crisis assessment and treatment.
- Enhancing crisis response services in preparation for a potential increase in mental illness presentations and social distress.
- Ensuring existing clients and their whānau feel supported and are able to connect with MH&A services should they require it.

- Services need to ensure that staff interactions are minimised (utilising physical distancing, virtual meetings and working from home).
- That resources are consolidated to avoid services and staff working in isolation and to prevent whole services being impacted by COVID-19.
- The development of red and green zones within the hospital through the inpatient pathway that includes Ward 21 and Services for Treatment, Assessment and Rehabilitation (STAR 1).
- Ensuring staff working from home remain connected and their skills and abilities are utilised across the service.

Underpinning the plan is that the safety of staff and our clients and their whānau was paramount.

Te Uru Rauhī needed to relocate staff from community village buildings, support people working from home and establish an alternative location for crisis assessment which was the Ruahine building. Current services were consolidated into three programmes that form the pillars for the COVID-19 plan as described below:

Emergency Response Programme (ERP) • 24 hours, 7 days a week multidisciplinary crisis response service • Inpatient mental health unit • Crisis respite (step up and step down from inpatient services, in partnership with Dalcam and MASH Trust) • Consultation liaison services for DHB outside of the Emergency Department (ED) • Alternative venue to ED for assessment, formulation and treatment (Ruahine House)
HUBS non urgent programme and nurse led services (HUBS) • Responsive and timely assessment and treatment services (7-14 days) for all new non-crisis referrals • Nurse led clinics providing administration, monitoring and evaluation of depot antipsychotics and Clozapine • Multi-disciplinary (MDT) care for 18-65 year olds inclusive of alcohol and other drug specialisation • Maori Mental Health consultation and cultural advice to MDT • Located at PN, Tararua, Levin, Child Adolescent and Family
Continuing Care Programme remote services (CCP) • Multi-disciplinary proactive continuing care for current service users aged 18-65 provided remotely via telephone or video conferencing • Care co-ordination for service users who may require nurse led services in the HUBS programme or access to the ERP • Wellness and welfare services for service users • Wellness and welfare services for Te Uru Rauhī staff • Includes coordination and support to specialised support services, for example Opioid Substitution Treatment (OST), Suicide Outreach, remote/virtual group therapy, older people's services

Workforce response

Significant effort has been put into the welfare of our staff during this time. The workforce is feeling anxious, not only about COVID-19 but also the disruption to services that this has caused. Te Uru Rauhī leadership teams have been keeping staff and unions regularly updated with frequent communications and have engaged with staff across a number of forums, face to face and virtual. The service has appreciated the work of the Digital Services team to support services to be able to equip our staff to work from home as quickly as possible. COVID-19 has highlighted our systems and equipment are not mobile ready so this 'upgrade' will continue through the recovery phase.

Managing acute demand

Given the rapid response to COVID-19 the staff working from home did not have access to the usual systems of activity reporting. Manual processes had to be put in place which has impacted on the accuracy of the data for April 2020.

Initial data during the COVID-19 response indicates a reduction in total client contacts of thirty four percent. However within this number there has been a significant increase in tele health and telephonic consultations with a corresponding reduction in person to person consultations in the ward or in the patient's own home.

Readmission rates have substantially reduced since February 2020 and average length of stay has remained stable.

Non-Government Organisation Sector

The NGO and Primary Health team seamlessly transitioned to working from home. Data from Te Ara Rau Primary Mental Health Service averaged 172 consultations virtually during the four weeks of Level 4.

Suicides

During the Level 4 lockdown period we were notified of two suicides in the MidCentral area, one of whom was resident of another DHB and neither of whom were clients of Mental Health Services. There has been no increase in suicide over this period. The rates continue to be monitored. In anticipation of increased anxiety and distress being experienced in the community which may lead to crisis presentations, we increased staffing in our crisis team and this will remain at least until June. Staff working from home have been actively contacting service users with regular check-ins aimed at supporting and identifying early warning signs of distress or crisis.

2.5 Future Opportunities

The implementation of Te Uru Rauhī COVID-19 plan has created opportunities to explore new ways of working that more closely align with its strategic direction.

There are early indications that a more flexible, integrated approach is preferred over the current model of siloed service delivery that requires services to operate within rigid boundaries. This will be fully evaluated during the recovery planning process.

A couple of new initiatives implemented during Level 4 are summarised below:

Remote access Mental Health Court

Court sessions have been held largely via zoom and this has been received very positively by our staff, staff at Ministry of Justice and service users. It has been particularly successful for those in our outlying areas; Tararua and Horowhenua. One of the teams saved an estimated 16 hours of clinical staff travel time in one morning alone.

Relprevv clinics at Rongopai street

Have commenced and are proving to be a great initiative as patients are able to productively utilise the time and space available and a nice environment for staff to work. Service users have commented that they prefer the community setting as it does not have the "stigma" attached to coming to the hospital.

This period has also highlighted the challenges with the current model of siloed service delivery and inability for staff to be mobile due to technology limitations as noted above.

2.6 Recovery planning

Evaluation

A district wide recovery approach that is based on a structured evaluation process to identify what we learned will be progressed. This has been informed by the DHB recovery planning framework and Te Uru Rauhī will continue to participate in the process and engage with all inter-sectional partners.

Staff returning to safe environment

During the lockdown period, 80 staff members from the District Health Board's MHAS teams have been working from home. In order to ensure consistent coordination of this cohort with the common purpose to support our existing clients with severe mental health and addiction issues, they have been operating as 'one team' under the continuing care programme described above.

One of the key drivers in supporting most of this team to remain working from home was to ensure they were able to maintain social distance which we could not provide in their usual work environment at the community village including Ruahine House.

In considering how we manage to bring people back to work while continuing to maintain a level of social distancing for a further period, we have been investigating alternative sites for temporary accommodation of our staff. We have looked at a couple of options in the community including the previous Primary Health Organisation site but none are considered suitable at this time. In addition the DHB will be furthering plans to support the workforce to continue to work flexibly from home and will develop support materials and protocols to manage this approach.

SERVICE:	Te Uru Pā Harakeke Healthy Women Children and Youth
FOR PERIOD:	February/March 2020
PREPARED BY:	Sarah Fenwick, Operations Executive Dr Jeff Brown, Clinical Executive

1. PERFORMANCE OVERVIEW

Te Uru Pā Harakake is on track with the majority of initiatives under the Annual Operational and Performance Improvement Plans. Risks remain in Midwifery and Medical Workforce; these are discussed under Emerging/Current Risks. Items of note are discussed under Significant Matters.

	Initiative	**Rating & Trend**	
A	Increase number of Māori women registered with a Lead Maternity Carer within the first trimester of pregnancy	**G**	•
A	Reduce equity gap between Māori and non-Māori babies who are exclusively or fully breastfeeding	**G**	•
A	Reduce rate of Māori sudden unexpected death in infancy	**G**	•
A	Promote the "5 things to do in the first 10 weeks of pregnancy" initiative	**G**	•
A	Increase support to first time parents requiring education, advice and guidance as they transition to parenthood following the birth of their baby	**G**	•
A	Deliver district wide breast feeding strategic plan	**A**	↑
A	Identification of infants with an unhealthy weight enabling access to appropriate interventions through referrals	**G**	•
A	Increase engagement with family harm training	**G**	•
A	Cross cluster development of Child Health Nurse Practitioners	**G**	•
A	Support Housing NZ client families to access and engage with health and social services through one point of contact	**G**	•
A	Support a sustainable midwifery workforce	**G**	•
A	Strengthen the P2A transition programme - complete evaluation of programme	**G**	•
A	Improve understanding around service options for transgender young people	**G**	•
A	Scope opportunities to develop a connected early intervention approach for learning and behaviour with Ministry of Education and CAFMHS	**G**	•
A	Implement findings of Massey research into childhood obesity engagement	**G**	•
O	Develop strong relationships with Iwi across the district	**G**	•
O	In partnership with Pae Ora new names are gifted to ward areas	**G**	•
O	Develop a cross cluster collaborative approach with Te Uru Arotau and Paiaka Whaiora to better support whānau who do not engage with services	**G**	•
O	Identify and evaluate opportunities for RNs to increase scope in Gynaecology	**G**	•
O	Increase clinical procedures in the outpatient setting	**G**	•
O	Investigate POAC opportunities to provide care closer to home	**G**	•
O	Improve experience for women experiencing miscarriage	**A**	↑
O	Increase access to SUDI prevention activities, education and parenting support to rangatahi and their whānau	**G**	•
O	Cross cluster collaboration with Te Uru Rauhī to improve maternal mental health	**G**	↑
O	Increase the number of midwifery students on clinical placement and quality of the practicum experience	**G**	•
O	Sustain appointment of midwives to established positions employed by DHB	**A**	↑
O	Increase participation in formal training in leadership positions	**G**	•
P	Planned Care ESPI 2 compliance	**A**	↑
P	Planned Care ESPI 5 compliance	**A**	↓
P	Reduce shorter stays in the Emergency Department	**A**	↑

Rating & Trend 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	N	Action not commenced yet
	Improved from last report.	↓	Regressed from last report.	•	No change from last report.				
Plan Legend									
A	Annual Plan	**P**	Performance Improvement Plan	**O**	Operational Plan				

1.1 Performance Indicators – March 2020

KPI Description	Previous Month	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	KPI Trend (13 month)
Customer Patient								
Acute readmissions within 28 days	10.4%	7.9%	7.5%	0.4%	10.9%	7.5%	3.4%	
Complaints resolved within 15 days	0.0%	100.0%	95.0%	5.0%	100.0%	95.0%	5.0%	
ESPI 2 - waiting < 4 months for FSA	97.1%	96.9%	99.0%	(2.1%)	96.8%	99.0%	(2.2%)	
ESPI 5 - waiting < 4 months for treatment	81.0%	67.5%	99.0%	(31.5%)	86.8%	99.0%	(12.2%)	
LSCS rate	20.5%	22.4%	25.0%	2.6%	22.3%	25.0%	2.7%	
Internal Process and Operations								
Bed Day Usage	52.1%	45.2%	85.0%	(39.8%)	59.3%	85.0%	(25.7%)	
DNA - Colposcopy	20.3%	10.5%	15.0%	(4.5%)	15.8%	15.0%	0.8%	
DNA - Outpatient	8.7%	9.2%	6.0%	3.2%	8.9%	6.0%	2.9%	
DNA - Outpatient, Maori	14.1%	13.6%	6.0%	7.6%	16.3%	6.0%	10.3%	
ED - Shorter Stays	79.2%	85.0%	95.0%	(10.0%)	81.9%	95.0%	(13.1%)	
ED Presentations	106	80	0	80	1,120	0	1,120	
ED Presentations, Maori	33	18	0	18	340	0	340	
Smoking Cessation - Hospital	89.5%	85.7%	95.0%	(9.3%)	83.8%	95.0%	(11.2%)	
Organisational Health and Learning								
Sick Leave Rate	3.67%	3.29%	3.20%	0.09%	3.56%	3.20%	0.36%	
Staff Annual Leave balance	13.6%	12.4%	0.0%	12.4%	12.4%	0.0%	12.4%	
Staff Stability	99.5%	99.5%	99.0%	0.5%	98.8%	99.0%	(0.2%)	
Staff Turnover	0.46%	0.93%	1.00%	(0.07%)	0.57%	1.00%	(0.44%)	

Acute readmissions within 28 days – This indicator has improved for March 2020. All readmissions have all been reviewed and were appropriately readmitted.

ESPI 2 and 5 - Reported in Significant Matters

Bed day usage – This is below the expected usage and reflects the beginning of the lockdown for COVID-19. Women have opted to discharge home rather than stay in hospital during this time.

Did Not Attend (DNA - Colposcopy, Outpatient/Māori) - breached in all areas in March 2020 but improved from the January reporting periods. The Colposcopy rate remains variable month to month, this is being closely monitored. The outpatient Māori DNA rate has reduced by 0.5 percent. The Whānau Equity Facilitator is working across the cluster to improve attendance at appointments.

Emergency Department (ED) shorter stays - improved by 5.8 percent by the end of March. Each breach is assessed to identify if any remediable actions and responses are required.

Smoking cessation – Staff have been reminded of the requirement to ensure patients are asked the smoking cessation assessment questions on admission to the maternity facilities.

Staff annual leave balance - slow progress continues to be made with annual leave balances over two years with leave plans in place for all staff with high balances, actual numbers continue to reduce. This metric may be impacted due to the impact of COVID-19.

2. SIGNIFICANT MATTERS

2.1 COVID-19

Significant planning has been undertaken across the hospital to ensure readiness for COVID-19 in line with the National Hospital Response Framework. Te Uru Pā Harakeke has worked with Te Uru Arotau to ensure seamless pathways across the hospital system which ensure patient and staff safety.

Business continuity plans have been enacted within Te Uru Pā Harakeke with essential services prioritised and staff redeployed to support critical services as the country moved to Level 4. Te Uru Arotau report contains further information about the overall hospital planning and impact on service during this time.

Clinical teams have engaged to prioritise workload during this time. Appointments are being offered virtually and work was deferred during Level 4 that is not noted to be an urgent clinical priority. This will impact on the planned care performance.

Recovery planning will be undertaken in line with the National Hospital Response Framework and will be implemented in line with the Government response as we move through the COVID-19 levels.

2.2 COVID-19 Horowhenua Maternity

In response to ensuring COVID-19 readiness across the hospital, it was agreed that the Maternity facility at Horowhenua Health Centre would close from 6 April 2020. This was to ensure the sustainability of the Midwifery workforce throughout the pandemic and to ensure enough elder health beds across the system.

A room in the outpatient's area has been equipped with the necessary equipment for an emergency delivery should a women present in late stage labour.

The unit is expected to reopen when the country moves back to Level 2.

2.3 Breast Feeding Strategic Plan

MidCentral District Health Board (MDHB) Breast Feeding Strategic Plan is now complete and awaiting sign off. This has been delayed due to meetings being cancelled during the COVID-19 pandemic and will be signed off at the first Womens Quality and Safety Group Meeting. The document will be available on the website once it has been signed off.

2.4 Planned Care ESPI 2

Gynaecology was on track to be compliant with achieving the First Specialist Appointment (ESPI 2) target at the end of March 2020; unfortunately compliance was not reached due to two people not attending their appointment. Whilst close monitoring is in place to ensure compliance, the position is not likely to improve in the short term due to the COVID-19 situation.

Paediatrics was non-compliant with the ESPI 2 target at end of March 2020 with eleven patients waiting over four months. This was expected, due to the four Full Time Equivalent (FTE) gap in the Resident Medical Officer roster reported in previous Health and Disability Services Advisory Committee (HDAC) reports. This position was expected to improve as these positions were filled at the end of February 2020; however COVID-19 has impacted on this recovery.

Both Gynaecology and Paediatrics are working hard to ensure they are offering virtual appointments during the COVID-19 pandemic with face to face appointments being used for urgent cases only.

2.5 Planned Care ESPI 5

Gynaecology was not compliant with the Planned Care ESPI 5 treatment target at end of March 2020, with fifty-one patients waiting longer than four months for surgery. This number has increased since the last reporting period due to COVID-19 and the reduced availability of theatre sessions in March 2020.

Cases for surgery are being prioritised by clinicians. Long-wait patients are being reviewed by Senior Medical Officers (SMO) to determine any changes and further care required while waiting for surgery. Elective caesarean sections bookings continue.

2.6 Shorter Stays in ED (SSIED)

Both Paediatrics and Gynaecology breached the six hour Emergency Department stay target in March 2020. However, both teams showed improvement from the February result with Paediatrics achieving 87.7 percent compliance and Gynaecology at 73.3 percent.

Investigations are undertaken by Charge Nurses for each breach. Results demonstrate that for Paediatrics during this two month period all breaches were self-presentation or ambulance transfers to ED. All but one of these presented in the late evening or overnight.

The Gynaecology team are working on improving their response time with a formalised process for documenting findings and the creation of a corrective action plan. Expectations regarding response times have been clearly articulated to Registered Medical Officer (RMO).

2.7 Te Papaioea Primary Birthing Unit

Te Uru Pā Harakeke commenced operational management of Te Papaioea Birthing Centre on 1 April 2020. A handover of services ceremony scheduled for 26 March 2020 did not occur due to the COVID-19 Level 4 restrictions.

It was agreed that while the country was in Level 4 no post-natal transfers would take place to ensure the upmost safety of all women and babies within the facility. This has been reviewed now the country has moved to Level 3, and transfers are now possible.

Tracking against budget for the unit will be reported to Finance, Risk and Audit Committee (FRAC).

2.8 Child Development Service Request for Proposal (RFP) Update

Budget 2019 allocated additional funding to Child Development Services (CDS) to improve the health and social outcomes of children who are not meeting their developmental milestones and have additional needs.

This funding is being administered through Shared Support Agencies who are acting as fund holders. MDHB has invoiced for their allocation which will be utilised as soon as the country moves into the recovery phase of COVID-19.

The proposal to improve point of entry co-ordination and integration of early intervention services for children aged zero to eight years will be project managed by an external provider who is waiting to commence.

It is anticipated that some of the funding allocation will be utilised to reduce the Psychology wait list and options are currently being explored.

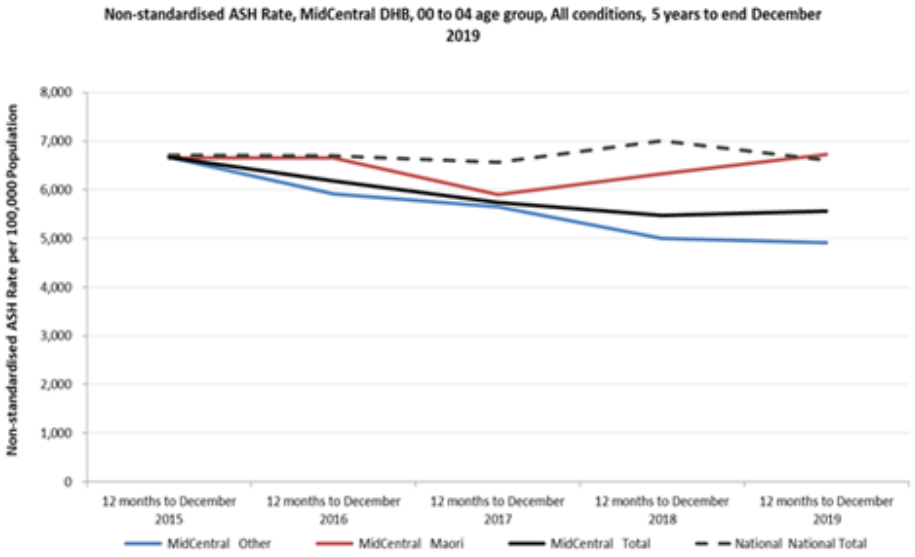
2.9 Women's Assessment and Surgical Unit (WASU)

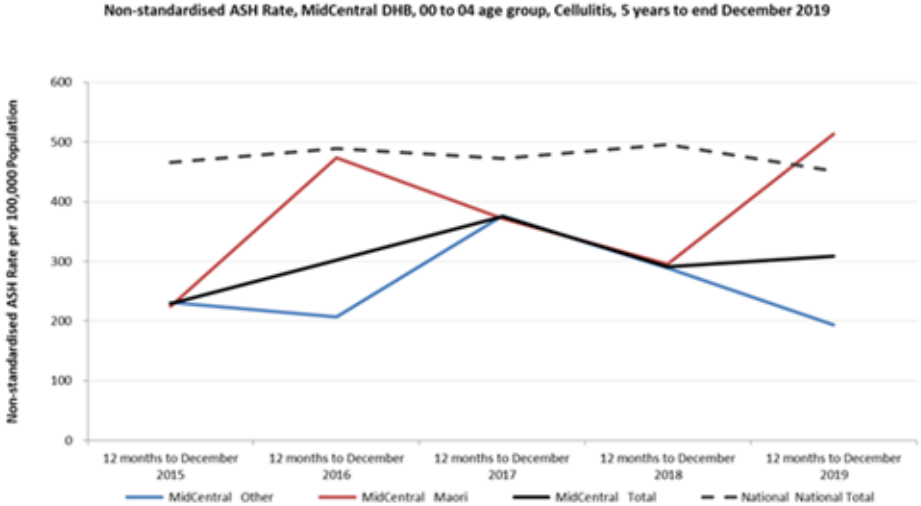
The eight bed Women's Surgical Unit, adjacent to the maternity ward on Level 2, Block C, Palmerston North Hospital will reopen in June 2020. The physical space can cater for eight inpatients with three two bedded rooms and two single rooms, with ensuites. The two single rooms with ensuites can be used as isolation rooms in the unit if infection control precautions are required.

This plan includes the co-location of the Gynaecology Assessment Unit, formerly known as the Gynaecology Day Unit (GDU) into a twenty four hour service. Two further single rooms in the space will be used to accommodate the GDU currently situated on the ground floor of the Women's Health Outpatient area. This will not occur however until an alternative place is located for antenatal clinic. Another clinic location has not yet been established for antenatal and therefore it is required to remain in the rooms that are required for the relocation of GDU. Work is being undertaken to resolve this as quickly as possible.

Recruitment of nursing staff for the Women's Assessment and Surgical unit is underway. It is expected that the opening of the unit will help improve the care of women who are experiencing miscarriage.

2.10 Ambulatory Sensitive Hospitalisations (ASH) (0-4 Years).





MidCentral District Health Board (MDHB) notes a steady increase in the non-standardised ASH rates for the 0-4 year age band for Māori. Of particular note is the increase for 0-4 years Māori admissions with cellulitis. This has occurred despite the suite of Nurse-led skin and respiratory clinics across all of our communities.

The Community Child Health Team will lead a project to analyse the data for the district and localities to understand possible causative factors and possible corrective actions. They will work alongside General Practice teams comparing their data and supporting General Practice teams to work with families/whānau to reduce unnecessary admissions. Further analysis will be presented to HDAC when the project is complete and a plan proposed.

3. EMERGING/CURRENT RISKS

3.1 Medical Workforce

As previously reported the Paediatric RMO roster had four FTE vacancies that could not be recruited to from December 2019 for two quarters. RMOs managed to be sourced and commenced in late February, mitigating the risk the Department were managing.

Staffing issues remain in Obstetrics and Gynaecology, with one Senior Medical Officer (SMO) vacancy. This post has been recruited to, however there has been a delay to the start date due to COVID-19 travel restrictions and a delay in obtaining Medical Registration.

Three gaps in the House Officer roster in quarter three remain unchanged and create additional risk if not filled. Locum cover is being used; this may be impacted by the ability to travel within the COVID-19 pandemic.

3.2 Midwifery

Midwifery workforce risks remain, with robust action plans in place to mitigate the national and local shortfall of midwives. As highlighted in previous reports, clinical risk due to acuity, has determined that additional midwifery FTE resource was essential and six additional FTE agreed to be recruited.

Local, national and international recruitment efforts by MDHB are now starting to pay off, however not all posts have been filled. Some of the additional FTE has been used in alternate ways (as recruitment of midwives was initially slow). The Department is starting to see increased applications to midwifery which is encouraging. Engagement with the unions continues including monthly union partnership meetings specifically for maternity.

3.3 Maternity Clinical Information System (MCIS) Global

The Ministry of Health have advised that the MCIS Global upgrade expected to be implemented in September 2020 will be delayed until the end of 2020 at the earliest due to the COVID-19 situation.

CLUSTER:	Te Uru Mātai Matengau Cancer Screening, Treatment and Support
FOR PERIOD:	February/March 2020
PREPARED BY:	Cushla Lucas, Operations Executive Dr Claire Hardie, Clinical Executive Denise Mallon, Planning & Integration Lead

1. PERFORMANCE OVERVIEW

Te Uru Mātai Matengau is generally on track with all initiatives under the Annual, Operational and Performance Improvement Plans. There are no emerging risks or areas of concern. The focus of this report is the COVID-19 response which is discussed under Significant Matters.

	Initiative	**Rating & Trend**	
A	Work with Ministry of Health to implement the Cancer Action Plan	**G**	•
A	Work with Central Cancer Network to implement Regional Services Plan	**G**	•
A	Implement the pro-equity plan for Breast and Bowel Screening	**G**	•
A	Implement Bowel Screening / Bowel Cancer Improvement Programme	**G**	•
A	Minimise breaches of the 62 day FCT waiting times	**G**	•
A	Increase support for women to live well beyond breast cancer	**G**	•
A	Replace linacs, including implementation of regional outreach programme	**G**	•
P	Improve stewardship of blood and blood products	**G**	•
O	Meet 14 day wait time for Category B radiation treatment	**G**	•
O	Develop and implement a cancer prevention strategy	**G**	•
O	Implement a tumour stream framework	**G**	•
O	Develop a strategic plan for the Regional Cancer Treatment Service	**G**	•
O	Implement an Advisory Oncology in Primary Care service	**G**	•
O	Agree and implement a supportive care work programme	**G**	•
O	Implement systems to capture patient reported outcome measures	**G**	•
O	Launch Cancer Society volunteer programme	**G**	•

Rating & Trend Legend

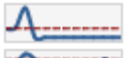
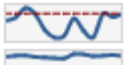
G	On track, progressing as planned.	**A**	Behind plan – remedial action plan in place.	**R**	Behind plan – major risks and exception report required.	**D**	Not completed as planned.
↑	Improved from last report.	↓	Regressed from last report.	•	No change from last report.		

Plan Legend

A	Annual Plan	**P**	Performance Improvement Plan	**O**	Operational Plan

1.1 Performance Indicators – March 2020

Te Uru Mātai Matengau is generally on track with all indicators. Exceptions and plans for improvement are noted below.

KPI Description	Previous Month	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	KPI Trend (13 month)
Customer Patient								
Acute readmissions within 28 days	13.2%	8.2%	7.5%	0.7%	11.1%	7.5%	3.6%	
Cancer treatment within 31 days of referral (FCT)	85.8%	85.1%	85.0%	0.1%	86.4%	85.0%	1.4%	
Cancer treatment within 62 days of referral (FCT)	88.4%	89.7%	85.0%	4.7%	90.3%	85.0%	5.3%	
Complaints resolved within 15 days	100.0%	0.0%	95.0%	(95.0%)	100.0%	95.0%	5.0%	
ESPI 2 - waiting < 4 months for FSA	99.2%	100.0%	99.0%	1.0%	99.8%	99.0%	0.8%	
Hospital acquired UTI rate	2.67%	0.00%	0.50%	(0.50%)	0.73%	0.50%	0.23%	
Inpatients developing Pressure Ulcers	0.24%	0.00%	0.50%	(0.50%)	0.14%	0.50%	(0.36%)	
Occurrence Rate of Medication Incidents	0.0	2.1	3.5	(1.4)	3.3	3.5	(0.2)	
Patient Falls Rate	2.4	2.1	5.0	(2.9)	3.3	5.0	(1.7)	
Internal Process and Operations								
ALOS - Acute	5.9	6.0	4.0	2.0	5.9	4.0	1.9	
ALOS - Elective	0.0	0.0	4.0	(4.0)	0.0	4.0	(4.0)	
Bed Day Usage	81.4%	85.1%	85.0%	0.1%	72.3%	85.0%	(12.7%)	
BreastScreen Coverage	77.3%	77.0%	70.0%	7.0%	77.0%	70.0%	7.0%	
BreastScreen Coverage (Maori)	64.0%	63.8%	70.0%	(6.2%)	64.1%	70.0%	(5.9%)	
DNA - Outpatient	1.4%	1.3%	6.0%	(4.7%)	1.4%	6.0%	(4.6%)	
DNA - Outpatient, Maori	2.2%	2.7%	6.0%	(3.3%)	3.3%	6.0%	(2.7%)	
ED - Shorter Stays	77.8%	73.3%	95.0%	(21.7%)	65.2%	95.0%	(29.8%)	
ED Presentations	27	15	0	15	227	0	227	
ED Presentations, Maori	3	2	0	2	29	0	29	
One to One Hours	105	0	0	0	791	0	791	
Smoking Cessation - Hospital	93.3%	100.0%	95.0%	5.0%	91.8%	95.0%	(3.2%)	
Organisational Health and Learning								
Sick Leave Rate	3.15%	3.08%	3.20%	(0.12%)	3.34%	3.20%	0.14%	
Staff Annual Leave balance > two years	13.3%	14.1%	0.0%	14.1%	14.1%	0.0%	14.1%	
Staff Stability	100.0%	100.0%	99.0%	1.0%	100.0%	99.0%	1.0%	
Staff Turnover	1.10%	0.00%	1.00%	(1.00%)	0.55%	1.00%	(0.45%)	

Acute readmissions within 28 days – all individual cases have been reviewed and there are no issues or trends of note.

Average Length of Stay (ALOS) Acute - all individual cases have been reviewed and there are no issues or trends of note. Potentially the target of four days is not reflective of contemporary practice in oncology care, especially inpatient radiation treatment. The target will be reviewed against national benchmarks.

BreastScreen Coverage (Māori wāhine) - The Independent Service Provider is personally contacting Māori women to discuss if there have been changes in their personal circumstances and to arrange appointments. A koha is being considered as part of the mobile unit visit to Horowhenua this year to acknowledge the current circumstances and encourage women to prioritise their own health. The team is working in partnership with Māori and Iwi providers in Horowhenua and Ōtaki. Planning continues for a marketing campaign to engage Māori women 45-55 years.

Complaints resolved within 15 days – this is a new measure monitoring the time taken to close a complaint, previously the time to acknowledge receipt of the complaint was reported. There were no complaints this month.

Emergency Department (ED) Shorter Stays – four of 15 patients waited longer than six hours in March; each of these was admitted to a medical assessment ward prior to subsequently being transferred to the Regional Cancer Treatment Service (RCTS). All individual cases have been reviewed and there are no trends of note. Strategies to reduce and/or streamline emergency presentations continue, including a direct admission process introduced as part of the RCTS COIVD-19 response.

Staff Annual Leave balance greater than two years – annual leave reviews are regularly undertaken and individual leave plans are in place.

2. SIGNFICANT MATTERS

2.1 COVID-19 Response

Te Uru Mātai Matengau has managed well during the COVID-19 response period. The screening programmes were temporarily suspended but are now returning to service. The RCTS has continued to treat all local and regional patients as planned and within national timeframes.

Planning

Activation of the Business Continuity Plan occurred on the 23 March 2020. The focus was on preserving the health of staff (to ensure continuance of treatment), contingency planning for the outreach units and maintaining a safe environment.

Separation of teams was introduced immediately and continues for high risk workforces. Chemotherapy nurses were particularly critical given the potential that the RCTS would be required to provide contingency capacity regionally. Radiation Therapists were separated into pods, with patients allocated to the same staff and treatment session each day.

A number of staff and clinics successfully and quickly transitioned to working from home. This enabled physical separation onsite. Regional visiting was suspended, this will continue through to June 2020.

Impact on Services - The Regional Cancer Treatment Service

Non-surgical cancer treatment continued as planned and there has been no change in access to treatment services. Outpatient consulting, when not associated with attending for treatment, has been largely managed via telephone or zoom clinics. This has worked well and there is a significant opportunity to continue to develop these virtual modes of consultation permanently.

Patients continue to be screened for COVID-19 symptoms. The RCTS has robust plans to manage treatment for COVID-19 positive patients, but fortunately has not needed to action these.

Due to the linac replacement extended days were already in place for Radiation Treatment. No patients have been delayed or deferred during this time.

Cancer patients presenting to ED, once medically stable, are now transferred directly to the inpatient unit for assessment, reducing waiting times and limiting this vulnerable group's exposure to the general population.

A four bedded room on the inpatient unit has been repurposed for outpatient haemodialysis. This move ensured renal services could quickly improve physical distancing without compromising access. The amalgamation of the patient groups has worked well and the RCTS Inpatient Unit is planning to provide home warding for inpatient renal services in the future.

The outpatient Systemic Therapy Unit extended its hours till 8pm each evening, separating the chemotherapy nurses into two teams and ensuring adequate physical distancing without compromising capacity. No more than six patients and three nurses are in the unit at any one time, compared with up to 25 people normally. No patients have been deferred or delayed for systemic treatment.

Recruitment to clinical trials was suspended during Alert Level 4 but has since re-opened at Level 3. For those patients participating in a trial prior to lockdown there have been minor protocol deviations, mainly related to virtual rather than face-to-face consultations. These are not significant and will be reported to the sponsors as per normal process. The restricted access during Level 4 has excluded ten potential applicants from participation and two international trials within the start-up phase have since withdrawn from New Zealand.

The Cancer Society, despite significant reductions in their volunteer workforce, has sustained a driving service throughout the period. Ozanam House also responded quickly and continues to manage the logistics of ensuring every patient is housed in a separate facility, whether at Ozanam House or in local motels.

Regional patients have been required to remain in Palmerston North when normally they could return home for weekends; this has caused anxiety for many people and Massey Psychology and the Cancer Society has provided ongoing support.

The Radiation Therapists were also concerned for patients returning to their own bubbles after treatment, especially for those living alone, and implemented follow up phone calls, above and beyond the usual follow up processes, to provide support and pastoral care.

Visiting restrictions have been difficult for the majority of patients. A range of technology solutions have been deployed and lower numbers of inpatients enabled staff to spend more time with each individual during their time in hospital.

Impact on Services – BreastScreen and Breast Imaging

BreastScreen Aotearoa suspended screening on 23 March 2020; 1,661 women have been rescheduled for the Palmerston North site and mobile unit visits to Ōtaki and Levin as a consequence.

All screening mammograms up until 23 March have been read and the results sent to women. Anyone requiring further assessment, where the mammogram was highly indicative of a cancer, had this diagnostic procedure during the lockdown. A few women made an informed decision not to be assessed and these appointments are now occurring. Routine breast screening recommences in Palmerston North on the 25 May 2020.

The mobile unit returned from Waipukurau on Wednesday 25 March 2020 affecting 369 women who were yet to be screened. The biannual visit to Ōtaki was to occur from the 20 April 2020, moving on to Levin in mid-May. Due to the lockdown the Unit schedule has been carefully reconstructed, in partnership with local communities, to accommodate all sites before the end of the year, including a return to Waipukurau.

Non screening breast imaging referrals continued to be received and those identified with a high suspicion of cancer were seen in Palmerston North during lockdown. The non-screening imaging service has now fully recommenced. There are no significant concerns regarding wait times.

Impact on Services – Bowel Screening

The National Bowel Screening Programme suspended new invitations from 24 March 2020 and all scheduled screening colonoscopies were cancelled. Invitations will recommence on 11 June 2020, 62 people, with a positive screening test, are waiting for colonoscopy. These participants have been clinically assessed by telephone and those with significant symptoms have been prioritised for urgent colonoscopy. The outstanding colonoscopies will occur over the next two to three months.

Transition

Clinical Governance meetings this month are focusing on transition planning. The screening programmes also have individualised plans, consistent with the national direction and a full recovery will be made by the end of July 2020.

Monitoring and Evaluation

The Cancer Control Agency is monitoring the impact of the COVID-19 response across the cancer continuum. All cancer centers, offering systemic and radiation therapy, are now submitting volume and activity data weekly. The agency plans to expand the data collection to include surgical and referral to specialist services data in the coming weeks. This is work in progress.

The screening programmes have extensive data sets. BreastScreen routinely monitors rescreen profiles, which measure the percentage of women returning for a subsequent mammogram within a 25 to 27 month timeframe. The rescreening profile is currently 81 percent against a target of 75 percent. This measure will be closely monitored, given the suspension of screening, to ensure all repeat screening occurs as planned. Due to the relatively recent adoption of bowel screening there is insufficient data to draw conclusions at this stage.

Emerging Risks

The Equity and Health Promotion groups have continued to meet. There is concern that the ongoing impact of COVID-19 on financial and social wellbeing will disproportionately impact Māori and Pasifika whānau, in turn meaning that activities such as screening will take a low priority. In response the teams are developing tailored initiatives to engage with whānau pro-actively, acknowledge the difficult time being faced and to open kōrero about the signs and symptoms of cancer and the importance of continuing to access health providers. The kōrero will encourage and reinforce key messages that hospital is a safe place to visit for treatment and diagnostics procedures if these are indicated, as well as sharing prevention messages using social media and radio.

2.2 Linear Accelerator Replacements

The commissioning of the first linear accelerator continues as planned. Due to travel restrictions staff did not attend training in the United States in March; an alternate training is now to be delivered locally and there is no risk to the planned go-live at the end of May 2020.

Travel restrictions may impact the installation of the second linear accelerator planned for July/August 2020, as the installation teams are Australian based. This is currently work in progress and mitigations are being considered to remain on schedule. There has been no impact on the manufacture and shipping of the second machine from the United States.

The Ministry of Health capital injection for the first machine has been received.

Work continues on the regional programme. There has been some reduction in the cadence due to COVID-19; however, Zoom meetings continue with both districts and the Cancer Agency, allowing the work programme to move forward. It is expected that confirmation of funding and timelines will be known by the end of the May 2020.

SERVICE:	Te Uru Arotau Acute & Elective Specialist Services
FOR PERIOD:	February/March 2020
PREPARED BY:	Lyn Horgan, Operations Executive Barbara Ruby, Planning & Integration Lead

1. PERFORMANCE OVERVIEW

Te Uru Arotau is generally on track with all initiatives under the Annual, Operational and Performance Improvement Plans. There are three emerging risks or areas of concern. Items of note are discussed under Significant Matters.

Plan	Initiative	Rating & Trend	
A	Improve delivery of Planned Care interventions to meet prioritised population health needs and timely access – utilising outsourcing and outplacing options to maximise capacity for planned surgical interventions	G	•
A	Reduce variation and improve access to cardiac care services – access to echocardiography and local Interventional Cardiology service	G	•
A	Improve planned care services across the system through an agreed system wide three year improvement plan for planned care	G	↑
A	Sustain achievement of the minimum requirements for colonoscopy wait times	G	↑
A	Zero patients waiting longer than four months for a first specialist assessment – streamline referral management and triaging processes	R	↓
O	Develop and pilot a community-based model of care for musculoskeletal services	R	↓
O	Refurbish current building footprint to enable extra theatre capacity	G	↑
O	Partner with Pae Ora and Healthy Women Children and Youth to pilot an engagement conduit for proactive engagement with Māori Whānau to support attendances for planned assessment	G	↑
O	Minimise avoidable repeat hospital admissions for people with COPD through triaged follow up and intervention	G	•
O	Establish Clinical Pharmacist support service to patients presenting to ED who have long term health conditions where medicines management may have, or did, contribute to hospital presentation	G	•
O	Improve patient flow throughout the hospital, reducing barriers and delays to assessment, treatment and discharge.	A	↑
P	Planned Care Improvement, ESPI 5 compliance	R	↑
P	Outpatient ESPI 2 compliance	A	↑
P	Takatu, Emergency Department Performance	R	↑
P	Medimorph (General Medicine)	G	•
P	Surgical Acute Care Improvement	A	↑
P	Uru Arotau Quality Improvement Plan	G	•
P	Pharmacy Improvement Programme	G	•

Rating & Trend 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.
↑	Improved from last report.	↓	Regressed from last report.	•	No change from last report.		

Plan Legend

A	Annual Plan	**P**	Performance Improvement Plan	**O**	Operational Plan		

1.1 Performance Indicators – March 2020

KPI Description	Previous Month	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	KPI Trend (13 month)
Customer Patient								
Acute readmissions within 28 days	9.8%	8.4%	7.5%	0.9%	11.2%	7.5%	3.7%	
Complaints resolved within 15 days	60.9%	47.6%	95.0%	(47.4%)	68.0%	95.0%	(27.0%)	
Diagnostic Angiography < 90 Days	100.0%	100.0%	90.0%	10.0%	100.0%	90.0%	10.0%	
Diagnostic CT< 42 Days	60.7%	72.3%	90.0%	(17.7%)	80.3%	90.0%	(9.7%)	
Diagnostic MRI < 42 Days	83.0%	84.0%	90.0%	(6.0%)	79.3%	90.0%	(10.7%)	
ESPI 2 - waiting < 4 months for FSA	94.7%	94.1%	99.0%	(4.9%)	95.3%	99.0%	(3.7%)	
ESPI 5 - waiting < 4 months for treatment	60.9%	60.3%	99.0%	(38.7%)	66.8%	99.0%	(32.2%)	
Hospital acquired UTI rate	0.45%	0.17%	0.50%	(0.33%)	0.23%	0.50%	(0.27%)	
Inpatients developing Pressure Ulcers	0.20%	0.13%	0.50%	(0.37%)	0.20%	0.50%	(0.30%)	
Occurrence Rate of Medication Incidents	3.6	2.3	3.5	(1.2)	3.0	3.5	(0.5)	
Patient Falls Rate	3.0	4.3	5.0	(0.7)	3.4	5.0	(1.6)	
Internal Process and Operations								
ALOS - Acute	4.8	4.8	4.0	0.8	4.6	4.0	0.6	
ALOS - Elective	2.7	3.3	4.0	(0.7)	2.9	4.0	(1.1)	
Bed Day Usage	113.5%	111.6%	85.0%	26.6%	120.6%	85.0%	35.6%	
DNA - Outpatient	6.3%	6.7%	6.0%	0.7%	6.5%	6.0%	0.5%	
DNA - Outpatient, Maori	12.0%	13.1%	6.0%	7.1%	12.3%	6.0%	6.3%	
ED - Shorter Stays	79.9%	80.9%	95.0%	(14.1%)	75.4%	95.0%	(19.6%)	
ED Presentations	3,628	3,296	0	3,296	33,504	0	33,504	
ED Presentations, Maori	710	644	0	644	6,337	0	6,337	
One to One Hours	2,235	2,325	0	2,325	22,290	0	22,290	
Smoking Cessation - Hospital	84.5%	83.8%	95.0%	(11.2%)	83.9%	95.0%	(11.1%)	
Organisational Health and Learning								
Sick Leave Rate	2.92%	2.68%	3.20%	(0.52%)	3.24%	3.20%	0.04%	
Staff Annual Leave balance > two years	12.6%	12.8%	0.0%	12.8%	12.8%	0.0%	12.8%	
Staff Stability	99.2%	99.9%	99.0%	0.9%	98.6%	99.0%	(0.4%)	
Staff Turnover	0.57%	1.60%	1.00%	0.60%	0.97%	1.00%	(0.03%)	

Acute readmission rates within 28 days: this indicator has improved in March 2020. All individual cases have been reviewed and there are no issues or trends to note.

Complaints resolved within 15 days: this is a new measure monitoring the time taken to close a complaint. Previously the time to acknowledge receipt of the complaint was reported. While swift resolution is mostly acceptable for patients and whānau, some cases are better suited to a longer engagement period which is determined on a case by case basis. All complaints open beyond 15 days have been individually reviewed and are being actively managed.

Diagnostic CT < 42 Days: there are minor data quality issues with this measure in the scorecard. An update is provided under Significant Matters.

ESPI 2 – waiting < 4 months for FSA: an update is provided under Significant Matters.

ESPI 5 – waiting < 4 months for treatment: an update is provided under Significant Matters.

ALOS – Acute: actions continue with the patient flow programme which will improve the Shorter Stays in Emergency Department (ED) (SSIED) and average length of stay results. An update is provided under Significant Matters.

Bed Day Usage: this measure reflects that inpatient volumes have remained consistently high for the past 12 months.

DNA – Outpatient, Māori: Te Uru Arotau, Te Uru Pā Harakeke and Pae Ora Paiaka Whaiora have partnered for the introduction of a Whānau Equity Facilitator role. This role will support a direct focus on Māori equity and system engagement to support attendances for planned assessments.

ED – Shorter Stays: an update is provided under Significant Matters.

Smoking Cessation – Hospital: has decreased in March from February 2020. Action plans are in place for all areas to increase the provision of brief cessation advice to smokers.

Staff Annual Leave balance > two years: all staff with leave have plans in place. These plans may be affected by the impact of COVID-19.

Staff Turnover: there are no issues or trends of note.

2. SIGNIFICANT MATTERS

2.1 COVID-19

The data provided in this report relates to the period to the end of March 2020. However, where relevant and appropriate, comments and data relating to April 2020 and the COVID-19 response have been included.

Te Uru Arotau has responded and managed well during the COVID-19 response period.

Planning

Te Uru Arotau Business Continuity Plan and Hospital Response Framework were activated to ensure a proactive and safe response at each agreed COVID-19 alert level across the hospital.

The hospital was decompressed ensuring essential services remained in place, such as acute assessments and surgery, urgent and non-deferrable assessments and surgery, whilst non-urgent planned care and ambulatory care services were reduced in preparedness. The clinical teams reviewed all patients on all waiting lists by urgency level.

As part of the response the hospital undertook necessary operational reconfiguration.

A pod was moved into place at the front entrance to the ED to screen patients as they presented and ED was divided into Red and Green zones to separate potentially infectious patients. This required changes to the physical layout and rosters and increasing the number of staff to support the separated streams.

Additional negative pressure systems have been installed across Ward 24, Operating Theatre, Intensive Care Unit (ICU) and Coronary Care Unit (CCU)/High Dependency Unit (HDU) to increase the capacity to manage patients who require isolation.

A dedicated COVID-19 ward, Operating Theatre, ICU and HDU capacity were established alongside Red and Green entrances and pathways within the hospital to support separate flow of patients and staff.

Staff were rostered into separate teams across all specialties to ensure safe and appropriate staffing.

Training in Personal Protection Equipment (PPE) for COVID-19 care in ED, wards, theatres, ICU, HDU, outpatients and other relevant settings continues.

Impact on Services

Daily presentations to the ED reduced to 2,696 in April, down from 3,719 in April 2019. The COVID-19 response and zoning of ED impacted on any ongoing improvement in the SSIED target.

There was a reduction of Planned Care activity from 24 March until 4 May 2020, with 307 fewer elective procedures carried out than in the same period last year.

Six thousand and fifty six outpatient attendances, both new patients and follow up appointments, were delivered across all services and departments (excluding Radiation Oncology) during COVID-19. Of these outpatient attendances, 70 percent were delivered either by telephone or video conference or were virtual (non-contact).

Initial delays with receiving COVID-19 test results impacted existing negative pressure rooms which delayed patient flow and extended length of stay.

Staffing was and continues to be impacted due to the application of the national risk assessment tool to ensure safety for those staff determined vulnerable.

Transition

Whilst the risk of COVID-19 will continue to impact on delivery for some time, the increase in Planned Care activity commenced 28 April 2020 and outsourced/outplaced surgery commenced 4 May 2020.

The transition planning includes the incorporation of four key principles to ensure a continued safe environment for patients and staff: Screening and logging of patients/visitors at the front entrance, enabling physical distancing, clinical prioritisation of patients, and being agile to respond to any situation that arises.

These principles will impact on the physical numbers through both MidCentral District Health Board and private peri-operative facilities. This is to limit the risk of COVID-19 infection.

The delivery of virtual outpatient clinics where appropriate will continue. Patients who require face to face assessment will continue to be seen within the hospital facility.

All Planned Care waiting lists are being actively reviewed to identify where priority or treatment may have changed since the patient was accepted and services are being delivered according to clinical priority. Equity with a focus for Māori is part of the Planned Care recovery process.

The ED has reduced the size of the Red zone. However, the screening pod will remain for the foreseeable future.

Monitoring and Evaluation

The post COVID-19 transformation phase opens discovery for determining what we want to capture from the past and current, what should be amplified and how we embed the new.

The short term changes, such as telehealth, have created opportunities for the clinical teams and patients to embrace telehealth as a long term, post-COVID-19 approach to ensure success.

The COVID-19 response and recovery phases have and will continue to impact on how hospital services are managed. Te Uru Arotau Clinical Governance meeting this month will focus on the opportunities realised during this time which will align with the 2020/21 Operational Plan and the three year improvement plan for Planned Care.

2.2 Planned Care

Preparatory work continues on the SPIRE (Surgical Procedural Interventional Recovery Expansion) programme of work with the Board approving the business case in April 2020. The business case is now with Government's Capital Investment Committee.

2.2.1 Planned Care Performance

The delivery of virtual outpatient clinics throughout the COVID-19 response has resulted in Elective Services Performance Indicator 2 showing a more positive result than forecast.

The impact on non-urgent planned care has seen a large increase in Planned Care procedures waiting greater than four months. Strategies to manage waiting lists are outlined in Te Uru Arotau's transition plan.

Three Year Planned Care Improvement Plan

As part of the new Ministry of Health Planned (MoH) Care Strategy, it is a requirement for all District Health Boards to formulate a three year improvement plan for Planned Care. The draft plan is well progressed to send to the MoH as rescheduled for July 2020.

Referrals Accepted or Declined by Specialty

There are a number of categories for which a referral is declined including available capacity, insufficient information on referral, not eligible or advice is provided to referrer negating the need for an appointment. The majority of declined referrals are attributed to capacity. This information can be seen in Appendix 1.

2.3 SSIED and Patient Flow

The organisational SSIED result for April 2020 was 82 percent. This has improved steadily from 72 percent in December 2019. Daily presentations to the ED reduced to 2,696 in April 2020, down from 3,719 April 2019. The COVID-19 response and zoning of ED impacted on any further improvements to the target.

During the COVID-19 response, patient flow initiatives set out below have continued:

- opening all available inpatient beds
- home-based rounding for General Medicine teams
- focusing on proactively identifying two patients before 10 a.m. who can be appropriately discharged from the medical wards
- utilisation of the patient journey boards.

There was a reduction in the number of ED patients re-directed under the Primary Options for Acute Care (POAC) programme and the ED/Chronic Obstructive Pulmonary Disease POAC pathway was paused as part of COVID-19 planning. POAC ED Redirection supported 90 patients in March 2020 and nine patients in April 2020.

As reported, there been a decrease in ED presentations in March and April 2020 and the number of patients who did not wait reduced. This is outlined in the table below with March 2020 data.

Month/Year	Did Not Wait (DNW)	Number of Presentations	Percentage (DNW)
01/05/2019	354	3,945	9%
01/06/2019	392	4,002	10%
01/07/2019	334	4,065	8%
01/08/2019	411	4,142	9%
01/09/2019	440	3,929	11%
01/10/2019	359	3,891	9%
01/11/2019	361	3,773	10%
01/12/2019	459	3,946	12%
01/01/2020	430	3,998	11%
01/02/2020	385	3,759	10%
01/03/2020	280	3,410	8%
01/04/2020	100	2,696	4%

Additional ED and Assessment Capacity

The business case and detailed design for increasing emergency and acute care capacity is nearing completion and will be presented to the Board in June 2020.

2.4 Diagnostic Wait Times

Modality	Target			
		February 2020	March 2020	April 2020
CT	95% within 6 weeks	60.7%	72.3%	75.5%
MRI	90% within 6 weeks	83%	84%	81.3%
Angiography (elective)	>95% within 3 months	100%	100%	100%

Medical Imaging

Computed Tomography (CT) performance improved for March and April 2020 with initiatives to increase hours of operation and throughput having a positive impact.

The Magnetic Resonance Imaging (MRI) result decreased slightly for April 2020 which was expected with statutory holidays and reduced staff during planning for COVID-19. A recovery plan is in place for MRI.

During the COVID-19 Level 4 response, both CT and MRI continued to image acute, non-deferrable and Oncology patients undergoing surgery or requiring follow up.

Cardiology – Cardiac Angiography

Despite the impact of COVID-19, cardiac angiography maintains 100 percent compliance.

2.5 Relocation of Renal to STAR 1

Work is progressing well with the relocation of the Renal Dialysis Unit to STAR (Services for Treatment, Assessment and Rehabilitation) 1. Changes to STAR 1 will accommodate the in-centre Renal Unit as well as the self-care and training facility in the one area.

This work is on track to open the new dialysis unit in STAR 1 at the end of July 2020.

2.6 Emerging Risks

Staffing and recruitment is likely to be challenging given the restrictions for movement of individuals and delays for completion of training programmes as a result of COVID-19 both nationally and internationally.

A combination of COVID-19 response and recovery alongside winter demand will put additional pressure across services, with planning continuing across all specialties and departments.

The medicine supply chain is under pressure globally and specifically for critical care medicines. The hospital pharmacy is working closely with our wholesaler and PHARMAC to mitigate medicine supply chain problems.

APPENDIX 1

Table 1: Referrals Accepted and Declined

Specialty	February 2020				March 2020			
	Total Received	Accepted	Declined Due to Capacity	Percentage Declined	Total Received	Accepted	Declined Due to Capacity	Percentage Declined
Cardiology	201	58	39	20%	190	44	19	10%
Dental	227	143	37	17%	135	53	23	17%
Diabetes	16	13	0	0%	13	7	0	0%
Ear Nose Throat	289	270	5	2%	293	234	2	1%
Endocrinology	44	19	0	0%	50	12	1	2%
Gastroenterology	149	119	3	2%	219	118	1	1%
General Medicine	97	79	1	1%	111	69	0	0%
Endoscopy	326	321	0	0%	247	244	2	1%
General Surgery	489	305	96	20%	506	225	71	14%
Gynaecology	159	147	6	4%	191	169	11	6%
Haematology	48	39	0	0%	76	51	0	0%
Maxillo-Facial	5	5	0	0%	8	8	0	0%
Dermatology	67	53	9	14%	65	46	10	16%
Infectious Diseases	10	9	0	0%	11	8	0	0%
Neurology	114	66	30	27%	102	61	16	16%
Ophthalmology	258	197	0	0%	231	169	7	3%
Orthopaedics	490	321	1	1%	457	271	3	1%
Paediatric Medicine	105	81	0	0%	92	70	0	0%
Respiratory	108	89	6	6%	114	53	9	8%
Renal	33	19	0	0%	29	29	0	0%
Urology	221	177	19	9%	288	155	23	8%
Rheumatology	27	22	3	12%	49	7	17	35%
Total	**3,483**	**2,252**	**255**	**8%**	**3,477**	**2,074**	**215**	**7%**

NB: The process to review and triage referrals is a continous one across rolling months. For example; a referral may be received at the end of one month and processed early in the following month.

Total referrals received includes all referrals currently registered within the WebPAS system for the respective month. It includes referrals not yet triaged, returned and accepted referrals.

	**For:** Approval **X** Endorsement Noting
To	Health and Disability Advisory Committee
Authors	Wayne Blissett, Operations Executive, Pae Ora Paiaka Whaiora Hauora Māori Directorate
Endorsed by	Tracee Te Huia, General Manager, Māori Health
Date	4 May 2020
Subject	**Pae Ora Paiaka Whaiora Hauora Māori Directorate Progress Update against the Manawhenua Hauora Work Programme**

RECOMMENDATION

It is recommended that the Committee:

- **endorses** the Pae Ora Paiaka Whaiora Hauora Māori progress report against the joint District Health Board and Manawhenua Hauora Annual Plan 2019/2020.

Strategic Alignment

This report aligns to the MidCentral District Health Board's (MDHB's) Māori Health Strategic Framework Ka Ao Ka Awatea and the joint MDHB and Manawhenua Hauora (MWH) Annual Plan for 2019/20.

1. PURPOSE

The purpose of this report is to provide the Health and Disability Advisory Committee (HDAC) with an update on activity against the joint annual programme agreed between MDHB and Manawhenua Hauora. In addition, we have provided HDAC with a short brief on Māori health activity in response to COVID-19.

OVERVIEW

	MANAWHENUA HAUORA BOARD WORK PROGRAMME 2019/20 (Appendix 1)	**RATING**	
	THOUGHT LEADERSHIP		
MW	1. To provide clear and cohesive governance leadership for Māori health across the DHB region	**A**	↑
MW	2. To provide direction, investment priorities and focus areas to MDHB on Māori health needs and priorities to support equity of outcomes for Māori	**G**	↑
MW	3. To provide strategic advice on the priorities and focus areas to MDHB across all strategic planning processes	**G**	•
	MONITORING AND REPORTING		
MW	4. To provide a clear direction and purposeful strategies for Māori health gains across the district	**G**	•
MW	5. To monitor Māori health gains in the district through impacts of MDHB's health service delivery and investment	**G**	•
	STEWARDSHIP		
MW	6. Provide expert advice, direction and counsel on important issues that impact on Māori at a governance level	**G**	↑

Rating & Trend 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.
↑	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	**MW**	Manawhenua Hauora

2. REPORT AGAINST THE JOINT WORK PROGRAMME FOR MDHB AND MWH

2.1 Thought Leadership

National Māori Health Response for COVID-19

Tumu Whakarae, the National General Managers (GMs) Māori Health Group, has developed a COVID-19 priorities framework with recommendations to DHB Chief Executive Officers (CEOs) and the Ministry of Health (MoH). These recommendations have been endorsed by Kathryn Cook, Lead National CEO for Māori Health, and Dr Dale Bramley, Lead National CEO for the COVID-19 response. GMs Māori were asked to write an implementation paper which is due 6 May 2020 to national CEOs. The expected outcome of this work is to incorporate the learnings at a national level for Māori Health.

2.2 National Funding for Māori Health for COVID-19

The MoH allocated $13 million to DHBs to support a Māori response to COVID-19. Of the $13 million, $5 million was directly contracted to Iwi and Māori providers nationally with the remaining $8 million to be allocated using Population Based Funding to DHBs.

Ten MidCentral district providers received direct funding from the MoH in April to the value of $25,888 for each provider for the following purposes:

- pakeke, kuia and koroua as they often will have other health conditions that make them more vulnerable to COVID-19
- whānau members with underlying medical conditions such as respiratory issues, heart conditions, high blood pressure, diabetes and other long-term conditions
- whānau members undergoing treatment for cancer and blood conditions, as treatments impact their immune systems, making them more vulnerable to COVID-19
- whānau members caring for tamāriki and rangatahi Māori during the COVID-19 outbreak
- hapū māmā; whilst it is uncertain how COVID-19 impacts pregnant women, during pregnancy women experience changes that may increase their risk from some infections
- whānau without easy access to healthcare, including mental health and addiction services, primary care and disability support services.

Reports are expected by the MoH in June/September on additional services delivered. Pae Ora is currently submitting proposals for newly allocated funding to support flu vaccinations for +65 year olds and those medically compromised. This proposal was endorsed by Te Uru Kiriora, Primary, Public and Community Health. A further proposal was submitted to resource community Māori communications. It is a minuscule amount should we be successful, however will assist our Māori community response.

3. MONITORING AND REPORTING

3.1 Equity Monitored Across the System

The Māori equity dashboard of indicators has been provided to the Board as a separate paper for endorsement. Please be advised that the dashboard has not been consulted on with the Manawhenua Hauora at this point due to COVID-19 restrictions on meeting face to face. This report is included into the Board papers for discussion.

3.2 Equity of Funding for Māori Providers

As the MoH's Māori Health Directorate develops its next five year Māori Health Action Plan for DHBs' implementation, each DHB has been provided with its funding movements for years 2014/15 to 2018/19 for Kaupapa Māori Service delivery. There is clear evidence that 'By Māori for Māori' services are effective particularly if high trust contracts are established and relationships are good between provider and DHB. The finance team is checking its baseline information against the MoH's

report and will be reported in May. This work has been delayed due to COVID-19. Once any changes are submitted to the MoH, DHBs will be sent the final version. The results of this analysis will help inform future investment by MDHB.

4. STEWARDSHIP

4.1 Commissioning for Māori Health Services

You will note by the joint work programme of MDHB and MWH that this project is behind the project timelines and was due in June 2019. This was delayed due to the developing of the Pae Ora Paiaka Whaiora Directorate and the appointment of the GM Māori Health which was completed in November 2019.

A separate paper has been included in this month's Board agenda explaining the findings of the review on Māori health provider contracts as identified in Craig Johnston's Board paper in 2019.

Following discussions with key executive cluster leads, agreement has been reached for the transitioning of the service contracts as listed in the report, for your information. A plan for transition is now being developed by Pae Ora's Planning and Integration Lead. This will be endorsed by relevant cluster leads. To support the transition, partnership agreements between clusters and Pae Ora will be developed with core principles and protocols (kawa and tikanga) to guide the partnership into future joint commissioning.

5. COVID-19 RESPONSE MĀORI HEALTH

In response to the Government's approach to the elimination of COVID-19, Pae Ora Paiaka Whaiora has been proactive in partnering with the Māori Community Response Team that is made up of THINK Hauora, Iwi and Māori Providers, key Government agencies and Councils. This has ensured a joined up approach between MDHB and the Māori community. Pae Ora has actively participated as part of the Incident Management Team with the GM Māori Health actively supporting the internal MDHB approach in partnership with the Māori community response. This has enabled a joined up approach across the DHB and community in an effective and transparent way. A proactive clinical and support management framework across the Pae Ora Paiaka Whaiora team has allowed us to continue to advocate and support whānau across hospital services.

Pae Ora has had to be creative in its approaches to supporting whānau including organising whānau Zoom meetings, linking whānau to spiritual support services and supporting whānau to navigate the death and dying pathway at Alert Level 4. Pae Ora Paiaka Whaiora identified four Kaiwhakarite – Police Whānau Liaison contacts – to work in partnership with the Police and whānau who experience the loss of a loved one. These roles have been particularly busy and most appreciated by the community during these times. These roles also connected directly with hapū kaiwhakarite to create linkages back to Iwi for whānau during these difficult times.

The active partnership with the Māori Community Response Team has seen the strengthening and consolidation of relationships and the efficient use of resources across the Māori sector to reach whānau in need. The Māori Response Team has

been working in partnership with the Whānau Ora Commissioning Agency, Civil Defence and Emergency Management and the Iwi and Māori Provider network. This has seen over 4,900 whānau sanitation and food packs being distributed around the district to whānau in need.

This has been a significant logistics exercise for all concerned. We acknowledge Te Tihi o Ruahine Whānau Ora Alliance for their co-ordination of all Iwi and provider efforts in the provider network to mobilise these services.

6. FLU VACCINATIONS 65+ YEAR OLDS

In addition, a key focus has been the targeted Flu Vaccination Initiative (FVI) that has stood up multiple clinics held around the district in partnership between THINK Hauora, Te Tihi o Ruahine Whānau Ora Alliance and the Iwi and Māori Provider Network. The intention is to actively target Māori 65 years and over and those with underlying medical conditions to get vaccinated. As at 17 April 2020, we have completed 837 vaccinations with 39 percent being Māori and 22 percent Pasifika. The overall completed vaccinations for Māori in the district is 1,004 or 41.7 percent, with a remaining 1,406 to offer services to. Te Tihi o Ruahine Whānau Ora Alliance has a rolling plan to respond to the remaining numbers. The MoH has allocated national funding for Māori immunisations. The FVI team is developing a proposal to the MoH to further its current initiative. The additional resource will achieve greater reach and breadth across the district. *Ka mau te wehi team!!! Kara whiua!*

Communication material has been developed using the COVID-19 official guidance and messaging. These Māori centred resources are used as an active support for whānau to get the best information possible to keep them safe. The messages are being used across social media platforms for Iwi and Māori Providers. This work will continue throughout the recovery stage and in transition back to Level 1, to maintain and support correct messaging for whānau during the changes.

Moving into the recovery stage, the Māori response team has established a framework using Te Pae Mahutonga, developed by Professor Sir Mason Durie, for reviewing the overall response to Māori in the MidCentral district. The intent is that Māori have leadership over their review and, on completion, will feed the findings back into the DHB's review. DHB is now considering how it incorporates Te Pae Mahutonga into its overall recovery framework with the support of Wayne Blissett, Pae Ora's Operations Executive.

Appendix One:

MANAWHENUA HAUORA & MIDCENTRAL DISTRICT HEALTH BOARD: 2019/2020 WORK PROGRAMME

Manawhenua Hauora and MidCentral DHB: 2019/20 Shared Work Programme					
	Objective	**Focus Area**	**Measures**	**Responsibility**	
				MidCentral DHB	**Manawhenua Hauora**
THOUGHT LEADERSHIP	To provide clear and **cohesive governance leadership for Māori health** across the DHB region	Identification of local Māori health priorities to direct investment and focus from the DHB	Paiaka Whaiora – Hauora Māori Cluster is established in synchronicity with other Clusters All Kaupapa Māori contracts sit with Paiaka Whaiora by June 19 Relevant Māori health priorities are identified across all Clusters and Enablers as part of the 5 year planning process.	Incorporate local Māori health priorities into AP, budget planning and portfolio work-plans as advised by Manawhenua Hauora Agree a framework for service specification review and redevelopment in of Iwi/Māori provider contracts by June 30 2019.	Consider and Endorse all MDHB Cluster and Enabler 5 year Plans prior to MDHB Board Approval Support the Establishment of Paiaka Whaiora in accordance with the recommendations provided by Manawhenua Hauora in September 2018
	To provide **direction, investment priorities and focus areas** to MDHB on **Māori health needs and priorities to support equity of outcomes for Māori**	Equity assessment Cluster and Enabler Plan Reporting	How equity is being applied in MCDHB is reported quarterly to Manawhenua Hauora Equity results in respect of Māori Health, including trends and emerging trends, reported to Manawhenua Hauora and MidCentral DHB's Board six monthly Equity of funding for Māori Providers is addressed moving from the 17/18 baseline of 1% of total revenue to 3% by 19/20	Provide Cluster and Enabler specific measures of success in addressing Māori Health Equity actions as identified in the 5 Year Plan	Provide advice on Equity needs from Māori perspectives, identifying key issues for consideration in determining local Māori health priorities and strategies in context with the Locality Plans

					Actively support the development of the Paiaka Whaiora Alliance Group
	To provide strategic advice on the priorities and focus areas to MDHB across all strategic planning processes.	Strategic Imperatives Cluster development Community integration and cohesion	Strategic imperatives will deliver on Manawhenua Hauora aspirations	Consistently obtain Manawhenua Hauora input across strategic imperative development. Ensure the monitoring and reporting of progress against the strategic imperatives is provided to Manawhenua Hauora.	Work in partnership with the MDHB Board to ensure the Treaty Partnership is enacted at Governance level to provide clear leadership and direction for the organisation to give effect to the Treaty of Waitangi
MONITORING AND REPORTING	To provide a clear direction and purposeful **strategies for Māori health gains across the district**	Development of a Māori health strategy	Monitoring and reporting against Ka Ao Ka Awatea, clearly identifies the performance of Clusters and Enablers in meeting the health and wellbeing aspirations of the Māori communities across the district. Position Statement of Whānau Ora is adopted to provide a clear governance expectation of MDHB's commitment and delivery methodology for health's contribution to Whānau Ora across the District	Quarterly reporting against Ka Ao Ka Awatea is provided to Manawhenua Hauora from Clusters Clusters and Enablers identify key actions quarterly that can address the health inequities currently experienced by Māori across the district Receive quarterly report from MCDHB as to how whanau ora is being implemented by the DHB.	Monitor and review performance as governance Iwi partner

	To **monitor Māori health gains** in the district through impacts of MDHB's health service delivery and investment	Equity and Health Needs Assessment (as above)	Monitor trends in Māori Health via the Locality Plans (as above) and health equity tools All Clusters and Enablers to report against their identified equity actions quarterly to Manawhenua Hauora	Provide quarterly report as to how Locality Plans are addressing Māori Health	As above
		Local, regional and national priority measures (as attached)	Quarterly review of results against local, regional and national Māori Health measures reported to Manawhenua Hauora and MidCentral DHB's Board (NB: this includes Whānau Ora.) Manawhenua Hauora will monitor implementation of Māori workforce development against the MDHB Kaimahi Ora Whānau Ora – Workforce Development Strategy and Implementation Plan 2017 - 2022	Provide quarterly reports Accurate and meaningful data profiles are provided as part of the reporting process to Manawhenua Hauora	Provide direction and advice on reports Manawhenua Hauora will monitor Whānau Ora position paper and assist to hold the organisation to account. Monitor investment in Iwi/Māori providers workforce development and Whānau Ora
			Annual Report of results against Ka Ao Ka Awatea is reported to Manawhenua Hauora and MidCentral DHB's Board as part of MDHBs Annual Report	Provide annual reporting of performance against Ka Ao Ka Awatea	Provide advice on report and assist to identify priorities for the following year
			Support and monitor the Regional Māori Health Priorities identified via Te Whiti Ki Te Uru and Board's Annual Forum, i.e.: • Use of the national Māori indicator report to drive improvements in the health outcomes of Māori in our region.	Provide quarterly reports	Provide advice on reports

STEWARDSHIP	**Provide expert advice, direction and counsel** on **important issues** that impact on Māori at a governance level	Major service changes	Any potential Major service change proposals are actively considered by Manawhenua Hauora during the design phase to ensure any likely impact on Māori Health and Equity Issues considered at the earliest possible point	Provide report on any potential or major service proposals prior to a final position	Provide critique, direction and considerations on any major proposal for change with a specific focus on health gains for Māori and any potential impacts
		Significant service plans, e.g. site redevelopment and central Alliance	Manawhenua Hauora views are sought regarding the Long Term Investment Plan being developed for MidCentral DHB as a Treaty Partner,	All significant investment plans are submitted to Manawhenua Hauora for consideration at the earliest possible time	Provide direction. Advice, guidance and critique across all aspects of design, development and implementation of the Long Term Investment Plan.
			Manawhenua Hauora views sought on the Central Alliance Strategy being developed by MidCentral and Whanganui DHBs	Develop Strategic Plan for Central Alliance that actively considers both Iwi Relationship Boards perspectives as part of the Alliance	Provide advice and direction on Central Alliance Strategic Plan in partnership with Hauora A Iwi.

Supporting Arrangements

To support this work programme, the following hui arrangements have been put in place:

- Two Board to Board hui between Manawhenua Hauora and MDHB's boards per annum
- Six-monthly review meetings between Manawhenua Hauora's Chair & Deputy Chair and MDHB's Chair and CEO
- Six-weekly meetings of Manawhenua Hauora, with MDHB management in attendance
- Participation (through Chair) in Te Whiti Ki te Uru – the Central Region's Māori Relationship Forum
- Participation (through Chair and Deputy Chair) in annual planning workshops and other appropriate workshops, forums as necessary
- Ongoing engagement and consultation by Manawhenua Hauora with the Governors of the 4 Iwi Boards regarding Māori Health priorities and outcomes

	**For:** **X** Approval Endorsement Noting

To	Health and Disability Advisory Committee
Author	Michelle Riwai, General Manager, Enable New Zealand
Endorsed by	Jeff Brown, Acting Chief Executive
Date	6 May 2020
Subject	**Enable New Zealand Report to 31 March 2020**

RECOMMENDATION

It is recommended that the Committee:

- **endorses** the Enable New Zealand Report to 31 March 2020

Strategic Alignment

This report is aligned with the District Health Board's (DHB's) strategy, specifically to achieve equity of outcomes, and sets out performance results for Enable New Zealand. It also identifies activity that will further develop Enable New Zealand's capability and capacity across a number of the DHB's enablers.

The report aligns to all three of the Strategic Goals embedded in Enable New Zealand's Operational Plan.

1. PURPOSE

The purpose of this report is to set out Enable New Zealand's performance against its Operational Plan and advise of any current and emerging matters.

2. SERVICE OVERVIEW

Enable New Zealand is a semi-autonomous business unit of MidCentral District Health Board (MDHB).

It provides local, regional and national disability support services to over 75,000 disabled people and whānau across New Zealand through a range of contracts managed on behalf of the Ministry of Health (MoH), Accident Compensation Corporation (ACC) and DHBs.

3. AIM AND PRIORITIES

The aim of Enable New Zealand is encapsulated within its shared purpose:

"To support disabled people and whānau to live everyday lives in their communities"

This statement embodies why Enable New Zealand exists and guides the decisions it makes and the priorities it sets.

4. PERFORMANCE OVERVIEW

	Initiative	**Rating & Trend**	
	Strengthen and enhance existing services to provide a quality customer experience		
O	Actively seek feedback, measure, monitor and interpret our performance	**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 quality driven practice model to drive service excellence	**G**	•
O	Our infrastructure is healthy, and our technology drives enhanced performance in the delivery of services to our customers	**A**	•
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 & Trend 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.
↑	Improved from last report.	↓	Regressed from last report.	•	No change from last report.		
Plan Legend							
A	Annual Plan	**P**	Performance Improvement Plan	**O**	Operational Plan		

4.1 Performance Indicators

The data provided in this report relates to the period ending March 2020, however where relevant, comments relating to April 2020 have also been included.

Regional

Mana Whaikaha Regional Results	Launch of Prototype to 31 March 2020	Total number March 2020
Total Disabled People active in the database	2272	46
People allocated to a MoH connector (and are still allocated to a MoH Connector)	843	48
People allocated to their own / Independent Connector	140	14
People in queue (awaiting allocation to a connector)	271	43
Total, completed, allocated to connector or in queue	1254	105

National

Key Performance Indicator/Measure (YTD 31 March)	Target	Achieved
Percentage of Band 1 Equipment delivered within 5 working days.	90%	97%
Percentage of Complex Housing Modifications completed within 120 working days (MoH).	60%	78%
Percentage of Equipment provided to Service Users supplied from refurbished stock (MoH).	35%	31%
Grabrails Installation Non-Urgent (ACC)	95%	58%
Enablement Programme – Exiting RTL platform	100%	100%

Recent Key Performance Indicator data for refurbishment of equipment showed the highest KPI result for over 18 months, this trend however will not continue over the coming months due to COVID-19 restrictions resulting in no collections occurring during Level 4 and limited collections occurring during Level 3. Grabrail installation saw a drop in the KPI results. This was due to the low number of requests being received coupled with several installations missing timeframes by two days leading to an adverse percentage outcome result for March.

The table below sets out the number of customers accessing Enable New Zealand's contracted services, for the financial year to date at 31 March 2020.

Client volumes by Service	MDHB Region	All Service Regions
Housing Service	136	1539
Equipment Service	2481	30820
Hearing Aids Service	869	19535
Spectacle Service	1151	17904

MDHB referral numbers for equipment over the last quarter has seen an average of 250 requests being received per month, compared to an average of 280 per month in the previous quarter. Hearing and Spectacle requests remain consistent with no significant increase or decrease in requests.

However, Enable New Zealand has seen a significant reduction in service requests in April due to COVID-19 restrictions. This has largely been driven by the requirement for Optometrists and Audiologists to be closed under Alert Level 3 and 4 restrictions and not being able to complete assessments and send requests through.

5. SIGNIFICANT MATTERS

5.1 Mana Whaikaha Prototype

The Prototype

In April 2020 the Mana Whaikaha Governance Group had planned to submit a report and recommendations to the relevant Ministers regarding the structure of the prototype moving forward. Much of the internal work around this was put on hold whilst Enable New Zealand focused on its COVID-19 response. In the interim the MoH have advised that the current Mana Whaikaha contract will be extended until 30 September 2020. This will allow time for the May 2020 Government budget process to confirm ongoing funding and for a change proposal to be agreed. Overall there is consensus that the prototype is owned and lead by disabled people.

Intensive Support Services

In August 2019 Mana Whaikaha/Enable New Zealand entered a contract with Choices NZ (subsidiary of IHC) to deliver an intensive support service for disabled people in the Mid Central region. The service was designed to give a structured 6 week coordinated response from multiple services across the region. To date 19 referrals have been made with 6 people successfully being discharged. Success stories have included people moving into independent living, gaining paid employment, better relationships with families and the wider community, less Police involvement and reduced presentations to the MDHB emergency department. The current contract runs alongside the Mana Whaikaha prototype.

Technology

Mana Whaikaha implemented Phase 2 of Dynamics365 (Customer Relationship Management system) on March 31, 2020. The project was completed within timeframe and under budget. Due to the Covid-19 lockdown, training was delivered remotely. The design has been a result of staff input from all facets of the business. The outcome of this approach has shown staff are keen to learn and engage in the use of the system.

A major component of the upgrade was the implementation of the Case Management data collection point. This enhancement has enabled greater visibility and tracking of the number of people engaged at the different stages of the service and greater oversight of goals and outcomes of the service users.

The upgrade has also provided transparency, ease of use and greater reporting functionality providing opportunities for research and business improvements. While the technology has been improved, the use of technology will not drive the service, it is there to support the process not to dictate a process that must be followed.

5.2 Enablement Programme

Enable New Zealand has been progressing activities related to the Enablement Programme, however since the beginning of the COVID-19 pandemic activity has slowed as the focus shifted to supporting customers and staff during this challenging period.

The activity related to Tranche 1 will continue to focus on replacing the current end of life technology solutions, while beginning to enhance recently implemented systems in a continual improvement cycle based on feedback.

5.3 Contract Matters

Enable New Zealand has received the new EMS contract which was signed by the Chief Executive on 16 April 2020. This contract is for three years with a two year extension clause. Further discussions and negotiations will continue in the coming months regarding some minor contract variation.

Enable New Zealand is currently in discussions with the MoH regarding the Disability Information Advisory Service contract, due to expire 30 June 2020. The Ministry has advised that all expiring contracts will be extended. This is a significant contract for the organisation.

The current Mana Whaikaha contract expires on 30 June 2020. Enable New Zealand has agreed with the MoH, in principle, that the current contract will be extended until 30 September 2020. In the interim, discussions between the key stakeholders to determine the future of the contract are ongoing.

5.4 Response to COVID-19

Utilising technology, all Enable New Zealand's Main Street staff have been fully operational from their homes. Staff meetings, work allocation, and collaboration is occurring using tools such as Microsoft Teams and Zoom video conference applications, supporting the staff in their psychosocial outcomes as well as allowing work activity to continue seamlessly. The Warehouse teams in Hamilton, and Palmerston North are operating 'split shifts'. This is a separated two-team approach to reduce the impact on service delivery if a staff member is suspected, or confirmed, with COVID-19.

Enable New Zealand continued to provide all essential services during Alert Level 4. Essential services, with agreement of contracted funders such as the MoH, are focused on the following:

- Ensuring people can be discharged from Hospital with essential equipment
- Remain safely in their homes, be prevented from serious harm or needing Hospital treatment.
- The continued provision of funding for local community-based support provided via Mana Whaikaha.

Non-essential services were scaled back, such as provision of hearing or spectacle subsidy as those services were closed under Alert Level 4.

Enable New Zealand also contacted DHB's and offered additional rehabilitation equipment for them to hold locally onsite to assist with prompt discharging of patients. This was supported by the MoH.

The EASIE living retail service is also operating on reduced hours, and via courier delivery (not a face to face in-store service). This is in line with Ministry of Business Innovation and Employment's definition of essential services. The main service being requested is the supply of incontinence products. These items have been in higher demand following the closure of the store at the Hospital.

A number of services were able to be extended under Alert Level 3. These included additional building and modification services and equipment collection. Prior to accessing any personal home a risk assessment is completed, and where possible, contactless interactions are occurring (eg collecting equipment from outside homes or asking clients not to enter rooms where builders are working). Contracted service providers (such as builders and freight providers) are also adhering to their own industry requirements for Alert Level 3.

Enable New Zealand has also provided a very limited number of full personal protective equipment (PPE) to repair subcontractors, and the Mana Whaikaha service is working with the DHB to ensure local community-based providers have access to masks and gloves.

Enable New Zealand is also supporting the DHB's wider response at this time and is undertaking administrative work and supporting the communications team at the Hospital.

Planning for moving to Alert level 2 is currently underway. As Enable New Zealand provides services across New Zealand, any regional variations at different alert levels will need to be considered.

MidCentral District Health Board | Te Pae Hauora o Ruahine o Tararua	**For:** X Approval Endorsement Noting

To	Health & Disability Advisory Committee
Author	Judith Catherwood, General Manager, Quality & Innovation
Endorsed by	Jeff Brown, Acting Chief Executive
Date	6 May 2020
Subject	**Committee's Work Programme, 2019/20**

RECOMMENDATION

It is recommended that the Committee:

- **endorses** the update on the 2019/20 work programme.

Strategic Alignment

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

COPY TO:

Quality and Innovation
MidCentral DHB
Heretaunga Street
PO Box 2056
Palmerston North 4440
Phone +64 (6) 350 8030

1. PURPOSE

This report updates the Committee on the 2019/20 work programme.

The report is for the Committee's consideration and no decision is required.

2. BACKGROUND

The Board established the 2019/20 governance reporting framework in June 2019, to ensure the Board and its Committees will receive appropriate information at the right time to enable members to carry out their duties.

Work programmes for all Committees, including the Health & Disability Advisory Committee (HDAC), have been developed from the framework and approved by the Board.

3. 2019/20 WORK PROGRAMME

3.1 General

A copy of the Committee's work programme for 2019/20 is attached. It focuses on the planning, delivery, quality and performance of health and disability services across the district and continuum of care.

A schedule of matters arising from committee meetings is maintained for the Committee and this is reported separately.

3.2 Progress

Due to the COVID 19 response, the committee's work programme and reporting framework has been disrupted. The Board Chair has agreed an interim reporting approach until end of June 2020.

April's HDAC meeting was cancelled and a combined HDAC and Board meeting is to occur on 26 May. Each Cluster and Enable NZ, have provided a performance summary report. Pae Ora Paiaka Whaiora (Maori Health Directorate) have provided their work programme report. There will be no deep dive presentation at this meeting.

A review of progress against the Cluster Health and Wellbeing Plans has been delayed until later in 2020 as approval of these plans only occurred in late 2019. It is appropriate the annual review of progress is delayed to the end of 2020. The Pae Ora Paiaka Whaiora (Maori Health Directorate) will not produce a Health and Wellbeing Plan but will report against the Manawhenua Board work programme and a revised equity dashboard. The equity dashboard is included in the Board reports for May 2020. Iwi Health and Wellbeing Plans are in progress to support the next annual planning cycle and our revised strategy.

A number of other reports have been postponed until later in the calendar year including the clinical governance and quality improvement, medical workforce, and research report.

Some reports due to HDAC in June will also be postponed including the regional service plan and the Palmerston North Health and Wellbeing Plan update report. These will be rescheduled from July 2020.

The Mental Health Unit Business Case is being presented to the Board on the same day as the HDAC meeting.

The work programme for Board and Committees is currently under review, under the leadership of the Board Chair, and further work to update this is anticipated.

Health & Disability Advisory Committee | 2019-20 Work Programme											
Report	**Fqncy**	**Aug**	**Sep**	**Oct**	**Nov**	**Feb**	**Mar**	**Apr**	**Jun**	**Jul**	**Resp**
Strategy/Planning											
Health Needs Assessment & Equity Snapshot • to consider the health needs assessment of the district and sub-region	Triennial Nov 21										GMSPP & GMP&P
Ka Ao Ka Awatea – Maori 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 20										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).	One-off (Aug 19) then triennial	**X**									GMENZ EDAH
Locality Health & Wellbeing Plans • to determine how the locality plans have been advanced, what's changed & priority initiatives/investments for the future (3-5 years), and to receive community feedback	Triennial Apr 21										OEs & CEs
Cluster Health & Wellbeing Plans • to determine each cluster's planned outcomes, priorities & targets for the next three years, and the roadmap for achieving these, including required investment & resources	Triennial		**X**			**X** (Pae Ora)			**X**		OEs & CEs
Quality Improvement											
Clinical governance & quality improvement framework – progress & 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	Qtrly		**X**		**X**		**X**		**X**		GMQ&I
Clinical Professions • to monitor the quality and standard of care and processes from a professional perspective • to monitor the implementation of workforce strategies from a professional perspective, and the health of the professional workforce group across the district	Annual		**X** AH			**X** N&M		**X** Med			EDAH, CMO & EDN&M
Consumer Stories • to hear direct from consumers of health and disability services about their experience	3/year Wkshop			**X**		**X**			**X**		GMQ&I
Quality account • to determine the Quality Account for the financial year	Annual			**X**							GMQ&I
Research • to receive details of research activity underway within MidCentral DHB	Annual							**X**			CMO
Performance											
Cluster Reports & Health & Wellbeing Plans • to monitor each Cluster's performance, including the implementation of their Health & Wellbeing Plans, including progress against key targets, initiatives and outcomes. • to monitor current and emerging matters, including quality & safety, opportunities and challenges, and the adequacy of any mitigations	6-wkly 6-mthly deep dive	**X** MHA PPCH	**X** HWCY	**X** CSTS	**X** HAR	**X** ENZ	**X** AESS	**X** PW	**X** MHA	**X** PPCH	OE & CEs
Locality Health & 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	Otaki	Horo		Tara	Man			PN		OE & CEs & GMSPP
Ward 21 Business Case • to determine the most appropriate means of ensuring an effective mental health inpatient facility is provided.	One-off	**X**									OEMH&A GMF&CS
2018/19 Regional Service plan (implementation)	One-off	**X**									GMSPP

Health & Disability Advisory Committee | 2019-20 Work Programme Report	Fqncy	Aug	Sep	Oct	Nov	Feb	Mar	Apr	Jun	Jul	Resp
• to monitor the implementation of the Plan and achievement of stated outcomes. (NB: detailed report to be provided from Governance SharedNet site.) 1/4 to 6/12 Nov18											
2019/20 Regional Service plan (implementation) • to monitor the implementation of the Plan and achievement of stated outcomes.	Quarterly				X		X		X		GMSPP
Equity											
Ka Ao Ka Awatea – Maori 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 Targets – Progress • to monitor progress being made in achieving the national Maori health targets, including the appropriateness of initiatives planned/established	6-mthly		X				X				GM
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 & improvement policies	Triennial										
• Serious & Sentinel Event Reporting Policy					X						GMQ&I

Key:

AESS	Acute & Elective Specialist Services	EDN&M	Executive Director, Nursing & Midwifery	GMQ&I	General Manager, Quality & Innovation
CE	Clinical Executive	EHR	Elder Health & Rehabilitation	GMSPP	General Manager, Strategy, Planning & Performance
CEO	Chief Executive Officer	GMENZ	General Manager, Enable New Zealand	MHA	Mental Health & Addictions
CMO	Chief Medical Officer	GMF&CS	General Manager, Finance & Corporate Services	OE	Operations Executive
CPHO	Central Primary Health Organisation	GMM	General Manager, Māori	PPCH	Primary Public & Community Health
CSTS	Cancer Screening, Treatment & Support	GMP&C	General Manager, People & Culture	W&CS	Women and Children's Health
EDAH	Executive Director, Allied Health				

Board Members		Register of Interests: Summary, April 2020 (Full Register of Interests available on Governance SharedNet Site)
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
Duffy, Brendan	3.8.17 8.9.19	Chair & Commissioner - Local Government Commission Trustee - Electra Trust Member - Environmental Legal Assistance Fund, Ministry for the Environment Chairperson - Business Kapiti Horowhenua Inc (BKH) Member - Representation Commission
Dennison, Vaughan	4.2.20	Councillor – Palmerston North City Council
Findlay, Lew	1.11.19	President, Manawatu Branch and Director Central District - Grey Power Councillor - Palmerston North City Council Treasurer - Abbeyfield
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
Mar, Materoa	16.12.19 11.2.20	Upolo Whakarae Te Tihi O Ruahine Whānau Ora Alliance Chair - EMERGE Aotearoa Matanga Mauri Ora MoH Mental Health and Addiction Etipu Rea Science Challenge Board Member – WDHB Member of Cluster Member of local Child & Youth Mortality Review Group (CYMRG)
Naylor, Karen	6.12.10 9.10.16	Employee - MidCentral DHB Member & Workplace Delegate - NZ Nurses' Organisation Councillor - Palmerston North City Council
Paewai, Oriana	1.5.10 13.6.17 30.8.18	CEO - Rangitane o Tamaki nui a Rua Member - Te Runanga o Raukawa Governance Group Chair - Manawhenua Hauora Member - Child Health Tamariki Ora District Group Co-ordinating Chair - Te Whiti ki te Uru Trustee - Tararua Hauora Services Charitable Trust Member Alliance Leadership Team (Central PHO Board) - Central Primary Health Organisation Member Clinical Governance Group - Feilding Health Care Member Nga Manu Taiko, a standing committee of the Council - Manawatu District Council Member Governance Board - Te Ohu Auahi Mutunga (TOAM) Member - Before School Checks (B4SC) Collective Committee Member - Nga Kaitiaki o Ngati Kauwhata Inc Member - Te Tihi o Ruahine Whanau Ora Alliance Board Member - Cancer Society Manawatu
Waldon, John	22.11.18	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 Member Clinical Board - MidCentral DHB

Board Members **Continued**		**Register of Interests: Summary, April 2020** (Full Register of Interests available on Governance SharedNet Site)
Warren, Jenny	6.11.19	Team Leader Bumps to Babies - Barnardos New Zealand Consumer Representatives National Executive Committee - National On Track Network Pregnancy & Parenting Education Contractor - Palmerston North Parents' Centre
Committee Members		
Hartevelt, Tony	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)
Management		
Cook, Kathryn	1.7.16	Director - Central Region's Technical Advisory Services
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 & Service Co-ordination Service – MDHB
Ayres, Vivienne	26.8.10	Nil
Bradnock, Barb	26.8.10	Nil
Brogden, Greg	16.2.16	Nil
Brown, Jeff		
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
Hansen, Chiquita	9.2.16	Employed by MDHB and seconded to Central PHO 8/10ths - MidCentral DHB CEO - Central PHO
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
Lucas, Cushla	1.5.18	Nil
Johnston, Craig	19.2.16 19.4.16	Member, Alliance Leadership Team - Central PHO Son is an employee and works within hospital services - MidCentral DHB
Matthews, Jill	1.3.16	Nil
Miller, Steve	18.4.17 26.2.19 6.3.19 1.10.19	Director. Farming business - Puriri Trust & 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
Nwosu, Andrew	10.8.18	Director UK health consulting company - AB Therapy Services
Ratana, Darryl	29.5.19	Nil
Russell, Greig	3.10.16	Minority shareholder - City Doctors Member, Education Committee - NZ Medical Council
Sapsford, David	18.5.18	Nil

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
Walker, Barbara Marie	Feb 20	Partner is a permanent MDHB employee and works in finance
Zaman, Syed	1.5.18	Nil

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 Uro Arotau Acute & Elective Services**
ALOS	**Average Length of Stay**
Anti- VEGF	**Anti-Vascular Endothelial Growth Factor**
AP	**Annual Plan** The organisation's plan for the year.
ARC	**Aged Residential Care**
AS/NZS ISO 31000	**2018 Risk Management Principles and Guidelines**
B Block	Wards, Laboratory, Admin, Out-Patients and Clinical Records
BAG	**Bipartite Action Group**
BAU	**Business as Usual**
BN	**Bachelor of Nursing**
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)
CEO	**Chief Executive Officer**
CIO	**Chief Information Officer**
CLAB	**Central Line Associated Bacteraemia**
CME	**Continuing Medical Education**
CN	**Charge Nurse(s)**
CNM	**Clinical Nurse Manager**
CNS	**Clinical Nurse Specialist**
COI	**Committee on Inquiry**
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	
CPHO	**Central Primary Health Organisation**
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	**Cost 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.
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 Siesmic Assessment**

DX	**Data Exchange** A data exchange software mechanism developed with the Social Investment Agency (SIA) to support encrypted data sharing between public services.
ED	**Emergency Department**
EDG-VPSR	**Electrocadiograph – Visual Positioning System Rhythm**
EDOA	**Emergency Department Observation Area**
EDON	**Executive Director of Nursing**
EECA	**Energy and Efficiency Conservation Authority**
ELT	**Executive Leadership Team**
EMERGO	**Emergo Train System**
EN	**Enrolled Nurse**
ENT	**Ear Nose and Throat**
ENZ	**Enable New Zealand**
EOC	**Emergency Operations Centre**
EP	**Efficiency Priority**
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.
EWS	**Early Warning System**
FHC	**Feilding Health Care**
FPIM	**Finance and Procurement Information Management System**
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**
GM	**General Manager**
GMFCS	**General Manager, Finance & Corporate Services**
GMPC	**General Manager, People & Culture**
GMQI	**General Manager, Quality & Innovation**
GMSPP	**General Manager, Strategy, Planning & Performance**
GP	**General Practitioner**
HaaG	**Hospital at a Glance**

HAR	**Te Uru Whakamauora, Healthy Ageing & Rehabilitation**
HBDHB	**Hawkes Bay District Health Board**
HCA	**Health Care Assistant**
HCSS	**Home and Community Support Services**
HDAC	**Health & Disability Advisory Committee**
HDU	**High Dependency Unit**
HVDHB	**Hutt Valley District Health Board**
HQSC	**Health Quality & Safety Commission**
HR	**Human Resources**
HSWA	**Health and Safety at Work Act**
Hui	**Formal meeting**
HV	**High Voltage**
HVAC	**Heating, Ventilation and Air Conditioning**
HWNZ	**Health Workforce New Zealand**
IA	**Internal Audit**
ICT	**Information & 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.
IL	**Importance Level** Seismic assessment rating
IOC	**Integrated Operations Centre**
IOL	**Intraocular Lens**
IS	**Information Systems**
ISM	**Integrated Service Model**
IT	**Information Technology / Digital Services**
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.
LDC	**Local Data Council**
LEO	**Leading an Empowered Organisation**
LOS	**Length of Stay**
LTC	**Long Term Condition(s)**
LV	**Low Voltage**
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**
MECAs	**Multi Employer Collective Agreements**
MEED	**Midwifery External Education and Development Committee**
MERAS	**Midwifery Employee Representation and Advisory Service**
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 Platford**
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**
MSD	**Ministry of Social Development**
MWH	**Manawhenua Hauora**
MYFP	**Midwifery First Year of Practice Programme**
NAMD	**Neovascular Age-Related Macular Degeneration**
NBSP	**National Bowel Screening Programme**
NCAMP19	**National Collections Annual Maintenance Programme 2019**
NCEA	**National Certificate of Educational Achievement**
NCNZ	**Nursing Council of New Zealand**
NEED	**Nursing External Education and Development Committee**
NESP	**Nurse Entry to Specialty Practice Programme (Mental Health)**

NETP	**Nurse Entry to Practice**
NGO	**Non Government Organisation**
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**
NZHP	**New Zealand Health Partnerships**
NZNO	**New Zealand Nurses Organisation**
O&G	**Obstetrics & Gynaecology**
OD	**Organisational Development**
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 Peoples Acute Assessment and Liaison Unit**
OPERA	**Older People's Rapid Assessment**
Pae Ora Paiaka Whaiora	(Base /Platform of health) Healthy Futures (DHB Māori Directorate)
PACS	**Picture Archiving Communication 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**
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 MDHBs 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 & Community**
PP&CH	**Public, Primary & Community Health**
PPPR	**Protection of Personal and Property Rights**
PSA	**Public Service Association**
QHP	**Qualified Health Plan**
Qlik	**Qlik Sense Data Visualisation Software (Dashboard Analytics)**
RDHS	**Regional Digital Health Services**
RHIP	**Regional Health Infometrics Programme** Provides a centralised platform to improve access to patient data in the Central Region.
Risk ID	**Risk Identifier**
RM	**Registered Midwife**
RMO	**Resident Medical Officer**
RN	**Registered Nurse(s)**
RP	**Risk Priority**
RSI	**Relative Stay Index**
RSP	**Regional Service Plan**
RTL	**Round Trip Logistics** A technology platform.
SAC	**Severity Assessment Code**
SGOC	**Shared Goals of Care**
SIEM	**Security Information Event Monitoring**
SLA	**Service Level Agreement**
SLMs	**System Level Measures**
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.
SRG	**Shareholder's Review Group**
SSHW	**Safe Staffing, Healthy Workplaces**
SSIED	**Shorter Stays in Emergency Department**
SSU	**Sterile Supply Unit**
SUDI	**Sudden Unexpected Death in Infantcy**
SUG	**Space Utilisation Group**
STAR	**Services for Treatment, Assessment and Rehabiliation**
TAS	**Technical Advisory Services** (also CTAS)
TCU	**Transitional Care Unit**
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**
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**
YTD	**Year To Date**