31 July 2020

Whanganui District Health Board

31 July 2020 09:30 AM - 02:30 PM

Agenda Topic			Presenter	Time	Page
PUBLIC SESSION					
1.	PROCEDURAL				4
	1.1	Apologies	K Whelan	09:30 AM-09:35 AM	
	1.2	Continuous Declaration of Interest			4
		1.2.1 Interest Register	K Whelan	09:35 AM-09:40 AM	4
		1.2.2 Declaration of conflict of interest	K Whelan	09:40 AM-09:45 AM	
	1.3	Minutes previous meeting	Ken Whelan	09:45 AM-09:50 AM	5
	1.4	Matters Arising	K Whelan	09:50 AM-09:55 AM	
	1.5	Chair Update	K Whelan	09:55 AM-10:00 AM	
	1.6	Combined Statutory Committee Update	A Main	10:00 AM-10:05 AM	12
		1.6.1 Draft Minutes - Information Only			12
2.	Chief Executive report		R Simpson	10:05 AM-10:15 AM	19
3.	DECISION PAPER				21
	3.1	National Public Health Advisory Team	R Simpson	10:15 AM-10:25 AM	21
4.	DISCUSSION PAPER				25
	4.1	Paediatric Update – Summary of evaluation of intervention to improve support for families of children with behaviour issues	P Malan and I Murphy	10:25 AM-10:40 AM	25

4.2	COVID-19 Integrated Recovery Team Update	L Allsopp	10:40 AM-10:50 AM	33
4.2.1	Appendix 1			36
4.2.2	Appendix 2			57
5.	INFORMATION PAPER			90
5.1	Financial Update	A McKinnon	10:50 AM-11:00 AM	90
5.2	Hospital and Provider Service Update	I Murphy	11:00 AM-11:10 AM	105
5.3	Health & Safety Update	L Allsopp	11:10 AM-11:20 AM	110
6.	RESOLUTION TO EXCLUDE THE PUBLIC			117
7.	NEXT MEETING DATE - 25 September 2020			
PUBLIC EXCLUDED				
8.	PROCEDURAL			119
8.1	Declaration of conflict of interest	K Whelan	11:20 AM-11:25 AM	
8.2	Minutes of previous meeting	K Whelan	11:25 AM-11:30 AM	119
8.3	Chair update	K Whelan	11:30 AM-11:35 AM	
8.4	Combined Statutory Advisory Committee Chair Update	A Main	11:35 AM-11:40 AM	124
8.4.1	Draft Minutes of Meeting - information only	A Main		124
8.5	Finance Risk and Audit Chair Update	T Anderson-Town	11:40 AM-11:45 AM	126
8.5.1	Draft Minutes of Meeting - for Information Only	T Anderson-Town		126
9.	Chief Executive Report	R Simpson	11:45 AM-11:55 AM	133
10.	DECISION PAPER			135
10.1	Lambie Ground Floor Refurbishment	A McKinnon	11:55 AM-12:05 PM	135
10.1.1	Appendix 1			136
10.1.2	Appendix 2			137
10.2	Annual Plan and Statement of Exepctation	P Malan	12:05 PM-12:20 PM	139

	10.3	Whanganui DHB Strategic Document	R Simpson	12:20 PM-12:30 PM	141
		10.3.1 Appendix 1			143
11.	DISCUSSION PAPER				175
	11.1	National Bowel Screening - Verbal Update	R Simpson	12:30 PM-12:45 PM	175
		11.1.1 Appendix 2 - MoH Response			175
		11.1.2 Appendix 3 - Whanganui DHB Acknowledgement Ltr of MoH Response			177
	11.2	Maintaining National Intervention Rates	P Malan	12:45 PM-12:55 PM	178
12.	INFORMATION PAPER				185
	12.1	Facilities Maintenance and Hotel Services RFP	A McKinnon	12:55 PM-01:05 PM	185
	12.2	Health and Disability Complaint Report	L Allsopp	01:05 PM-01:15 PM	204
13.	MEETING CLOSURE				232
	13.1	Confidentiality of public excluded minutes	K Whelan	01:15 PM-01:25 PM	232

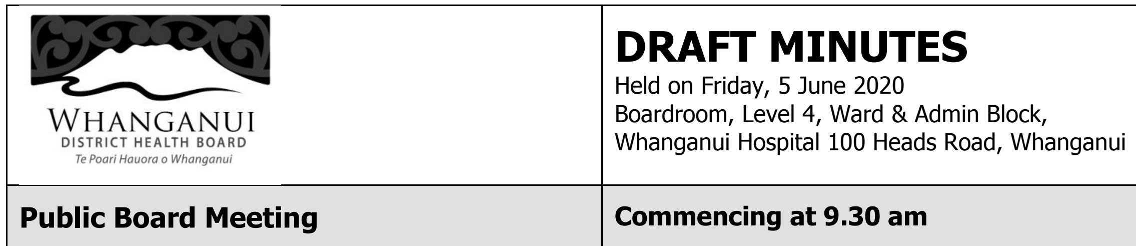
The board to confirm that all papers discussed in this section should remain in public excluded.

Interest Register

5 June 2020

Name	Date	Interest
Ken **Whelan** *Chair*	13 December 2019	Crown monitor for Waikato DHB Crown monitor for Counties DHB Board member RDNZ (NZ) Chair Eastern Bay of Plenty PHO Contractor General Electric Healthcare Australasia
Annette **Main** *Deputy Chair* *Chair CSAC*	18 May 2019	Nil
Anderson-Town Talia *Chair FRAC*	2 June 2020	▪ A board member of Ratana Orakeinui Trust Incorporated ▪ A board member of Te Manu Atatu Whanganui Maori Business Network.
Adams Graham	16 December 2016	▪ A member of the executive of Grey Power Wanganui Inc. ▪ A board member of Age Concern Wanganui Inc. ▪ A trustee of Akoranga Education Trust, which has associations with UCOL.
Anderson Charlie	16 December 2016	An elected councillor on Whanganui District Council.
	3 November 2017	A board member of Summerville Disability Support Services.
Baker-Hogan Philippa	10 March 2006	An elected councillor on Whanganui District Council.
	8 June 2007	A partner in Hogan Osteo Plus Partnership.
	24 April 2008	Her husband is an osteopath who works with some of the hospital surgeons, on a non paid basis, on occasions hospital patients can attend the private practice, Hogan Osteo Plus, which she is a Partner at.
	29 November 2013	Chair of the Future Champions Trust, supporting promising young athletes.
	7 November 2014	A member of the Whanganui District Council District Licensing Committee.
	3 March 2017	A trustee of Four Regions Trust.
Chandulal-Mackay Josh	10 December 2020	An elected councillor on Whanganui District Council
	21 February 2020	A council member of UCOL A member of Aged Concern Deputy Chair for Whanganui Youth Services Trust
Hylton Stuart	4 July 2014	▪ Executive member of the Wanganui Rangitikei Waimarino Centre of the Cancer Society of New Zealand. ▪ The Whanganui District Licensing Commissioner, which is a judicial role and in that role he receives reports from the Medical Officer of Health and others.
	13 November 2015	An executive member of the Central Districts Cancer Society.
	2 May 2018	▪ The chairman of Whanganui Education Trust ▪ A trustee of George Bolten Trust
	2 November 2018	The District Licensing Commissioner for the Whanganui, Rangitikei and Ruapehu districts.
MacDonald Judith	22 September 2006	The chief executive of Whanganui Regional Primary Health Organisation
	11 April 2008	A director of Gonville Health Centre
	4 February 2011	A director of Taihape Health Limited, a wholly owned subsidiary of Whanganui Regional Primary Health Organisation, delivering health services in Taihape
	21 September 2018	A director of Ruapehu Health Ltd
	23 July 2020	A Board member of Aged Concern, Whanganui
Peke-Mason Soraya	21 February 2020	▪ Chair, Te Totarahoe o Paerangi – Ngāti Rangi (Ohakune-Raetihi) ▪ Director, Ruapehu Health Limited ▪ Trustee, Whanganui Community Foundation ▪ Iwi Rep, Rangitikei District Council Standing Committee ▪ Labour Candidate for Rangitikei District Council

5 June 2020 **Public**



WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**DRAFT MINUTES** Held on Friday, 5 June 2020 Boardroom, Level 4, Ward & Admin Block, Whanganui Hospital 100 Heads Road, Whanganui
Public Board Meeting	**Commencing at 9.30 am**

Present
Mr Ken Whelan, Board Chair
Ms Annette Main, Deputy Board Chair, Chair Combined Statutory Advisory Committee
Mrs Talia Anderson-Town, Finance Risk and Audit Chair
Mr Graham Adams, Member
Mr Charlie Anderson, Member
Mrs Philippa Baker-Hogan, Member
Mr Josh Chandulal-Mackay
Mr Stuart Hylton, Member (via zoom)
Mrs Judith MacDonald, Member
Mrs Soraya Peke-Mason

In attendance
Mr Russell Simpson, Chief Executive
Mrs Nadine Mackintosh, Board Secretary
Mr Lucy Adams, Director of Nursing/COO
Mrs Louise Allsopp, General Manager Patient Safety, Quality and Innovation
Mr Mark Dawson, Communications Manager
Mrs Rowena Kui, General Manager Māori Health and Equity
Mr Paul Malan, General Manager Strategy Commissioning and Population Health
Mr Andrew McKinnon, General Manager Corporate

Members of public
Nil

1. Procedural

1.1 Karakia/reflection
The meeting was opened with a karakia by Soraya Peke-Mason.

1.2 Apologies
Nil.

1.3 Continuous Disclosure
1.3.1 Amendments to the Interest Register

The board **accepted** the amendments from members as follows:

1.3.2 Declaration of conflicts in relation to business at this meeting
Nil

DRAFT

5 June 2020 **Public**

1.4 Confirmation of minutes

1.4.1 20 March 2020

Amendment: Ms A Main chaired the meeting and zoom facilities were available for virtual attendance.

The minutes of the meeting held on 20 March 2020 were **approved** as a true and accurate record of the meeting subject to the amendment above.

Moved G Adams **Seconded** J Chandulal-Mackay **CARRIED**

1.5 Matters Arising

Nil

1.6 Board and Committee Chair Reports

1.6.1 Chair verbal report

The chair thanked the team for their efforts during COVID-19 with a request we maintain vigilant. The following key items were raised:

- Foster and enhance our partnership and community relationships
- Keep our community well by allowing other organisations to lead
- Hospital flow improvements during COVID-19 to be enhanced to become business as usual
- The Heather Simpson report will be released in the next few weeks and some recommendations will require a response
- IDF pressure continues to impact our DHB and we will collaborate further with both MidCentral and Capital and Coast DHBs to better manage our patient flows
- MidCentral discussion for CentralAlliance meetings was discussed with agreement for an initial meeting at the chair level, prior to the next board meeting with a focus on the Heather Simpson report and priorities for areas of collaboration.
- Board only sessions will be held when members request to discuss a particular issue.

The Whanganui District Health Board members **supported** holding a governance level meeting to address equity and investment in our community and debt reduction.

Action: Arrange a session for the board to discuss debt reduction. Management will provide some scenarios on management of the debt reduction.

2. Chief Executive Report

The paper was taken as read with the chief executive outlining the social governance leadership and support model.

The chief executive acknowledged the leadership from S Hylton and J MacDonald with their contribution and participation in the community lead emergency operations centre. Complacency is a risk and we need to maintain vigilance.

Our success was attributable to the collaborative effort between primary care and public health on our achievement for immunisation, particularly WRHN leadership to programme.

A new vodafone 1GB connection into the hospital campus went live on 3 June 2020, this provides an upgrade from a 100Mb connection.

Bowel Screening Rates

Whanganui DHB have achieved above the 60% target for the first five months for both our total and Māori population, with the equity gap being between 0-2% in any given month. Our results have fallen slightly in the last month reported (March), however this would have been impacted by COVID-19 and it is expected these will increase now that our outreach services are starting their work again (post shut-down).

5 June 2020 **Public**

The bowel screening equity group met recently and commended all those involved for the achievements, the results clearly indicate that our approach of working in partnership with our Māori Health Providers is a tribute to our strong relationships in our communities.

Primary Mental Health and Addiction Services – Revenue Contract
On 30 March 2020 the Board Chair provided email approval for the Chief Executive to sign the $1.2m primary mental health and addiction services revenue contract and the board were requested to ratify of the approval.

The $1.2m revenue contract is held with the Ministry of Health for the provision of primary mental health and addiction services. We provided a local agreement with standard terms and conditions to Whanganui Regional Health Network to deliver the services through the general practice.

The Covid-19 testing strategy is to maintain the contact tracing policy, we are testing those with coughs and colds but no longer proactive on asymptotic cases.

The Whanganui District Health Board members:

a. **Received** the paper titled chief executive report.

b. **Noted** the new legislation passed on 30 April 2020 allowing Ministers to extend the time for meeting planning requirements under the Crown Entities Act 2004 by up to three months

c. **Noted** the Minister of Health has agreed to expand the timeline for finalising and publishing the 2020/21 statement of performance expectation (SPE) to 15 August 2020, this also applies to the statement of intent (SOI) for those DHB choosing to produce one

d. **Noted** the reason the extension has been granted is to reflect the revised timelines agreed for finalising 2020/21 DHB annual plans due to COVID-19 impacts, and to ensure quality SPE/SOI documents are produced that align with DHB annual plans and appropriately reflect COVID-19 recovery.

e. **Acknowledged** the collaborative work provided by a number of community providers to address the management of COVID-19. The agile approach provided by our primary care providers to address immunisation an excellent example of how we should aim to work in the future.

f. **Ratified** the **approval** provided by the Board Chair for the Chief Executive to sign the Primary Mental Health and Addiction Services revenue contract of $1.2m.

Moved K Whelan **Seconded** A Main **CARRIED**

3. Decision Paper

3.1 Whanganui DHB Communication Procedure

The paper was taken as read. The procedure is sensible with acknowledgement of media releases during the COVID-19.

Members views were discussed in relation to informing the board chair on what individual members would release to the media to prepare the board and board chair for follow up questioning by media.

The Whanganui District Health Board members:

a. **Received** the report titled 'Whanganui DHB Communication Procedure'

b. **Noted** the suggested tracked changes to the procedure

c. **Approved** the WDHB Communication Procedure for a further three-year term Management confirmed that evacuation trials are undertaken regularly.

Moved K Whelan **Seconded** A Main **CARRIED**

Against P Baker-Hogan

5 June 2020 **Public**

4. Discussion paper

4.1 COVID-19 Recovery – Reset and Redesign

The paper was taken as read. There appears to be an absence of funding for mental health and request that the identification of the gaps in services for mental health and funding requirements was requested to be enhanced.

This is an integrated approach to recovery and working in this manner has proved beneficial for our communities. We need strong leadership across this district and willing to be agile and nibble. The governors need to have this appetite for change and would like to see some examples provided by management for the board to support.

Recommended that when we report was ensure that the reporting on iwi is in an inclusive manner rather than an add on – "in the waka".

Te Ranga Tupua is a confederation of chairs of the iwi for this rohe, their mobilisation was swift and fast with support from Te Oranganui. The group met twice per week during level 2 and continue to met once per week to ensure resilience for our communities and integrate with the community recovery team.

The mobilisation of the community based assessment centres led by primary care provided the hospital with the opportunity to look at models of care within the hospital, particularly length of stay and flow within the hospital.

Action: How does the clinical board fit into this process, particularly with models of care changes that we should be considering.

The Whanganui District Health Board:

a. **Received** the paper titled COVID-19 Recovery – Reset and Redesign
b. **Noted** the principles and structure of the Whanganui Regional Recovery Team
c. **Noted** the role of the Whanganui DHB Recovery Health-taskforce
d. **Discussed** the direction and degree of change Whanganui DHB board wishes to see for our rohe.

Moved J Chandulal-Mackay **Seconded** S Peke-Mason **CARRIED**

5. Information papers

5.1 April 2020 Financial Update

The month was extremely busy with a number of areas to address as we mobilised for the COVID-19 pandemic. Direct and in-direct costs increased over this period some of these costs will be recovered.

Our leave liability is slightly higher than we had budgeted as planned leave over this period was not taken, management will encourage annual leave when we have lower occupancy levels and deploy staff in other areas.

The board discussed rationale around unforeseen increases in IDFs. The chair highlighted that as the population ages the requirements for cardiac treatments increases, and the better way to manage this is through better relationships with our community providers to manage communities health at home and have a good relationship with secondary when they come to hospital to be able to better management the care.

The Whanganui District Health Board members:

a. **Received** the report 'Detailed financial report – April 2020'.
b. **Noted** the April 2020 monthly result of a $926k deficit is favourable to budget by $183k.
c. **Noted** the year-to-date result of $10,404k deficit is unfavourable to budget by $113k.

Moved A Main **Seconded** C Andersen **CARRIED**

DRAFT

5 June 2020 **Public**

5.2 Remuneration and Restraint

The paper was taken as read.

Whanganui District Health Board members:

a. **Received** the paper

b. **Noted** that all executive leaders will forego remuneration reviews until June 2021

c. **Noted** that DHB GM Human Resources have requested further guidance on pay restraint from State Services Commission to ensure our alignment

d. **Notes** that staff employed on an individual employment agreement (IEA) will comply with the guidance and principles for pay restraint

Moved S Hylton **Seconded** J Chandulal-Mackay **CARRIED**

5.3 Health and Safety Update – for information only.

The paper was taken as read.

The Whanganui District Health Board members:

a. **Received** the report entitled 'Health and safety update'.

b. **Noted** there were no notifiable events reported to WorkSafe New Zealand in the 2017/18, 2018/19 financial years or 2019/20 year-to-date.

c. **Noted** the overall trend for the top five injury/incident categories indicates a slight decline over the three year period.

d. **Noted** the following trends for each of the five categories:

- Aggression injuries/incidents decreased over the three year period.
- Manual handling injuries/incidents decreased over the three year period.
- Infection control injuries/incidents decreased over the three year period.
- Slip, trip, falls injuries/incidents increased over the three year period.
- Struck by, bumped injuries/incidents decreased over the three year period.

Moved J MacDonald **Seconded** Phil **CARRIED**

5.4 Suicide Prevention Strategy – for information only

The DHB sponsored a position employed by Te Oranganui to develop a process for community engagement on suicide prevention strategy. This has been an outstanding piece of work, with a good framework process.

Phase one is completed with an action plan for the next two years to be made available in the next few months.

Emerging priorities areas

- An inter-connecting health-system highlights the integrated and collaborative approach that we continue to take for our communities.

The board acknowledged that there is a time-lag between an event and reporting due to the investigations that are required.

It was recommended that we continue to focus on the impacts of Covid-19, particularly when the financial benefits stop.

The Whanganui District Health Board members:

a. **Receives** the paper

DRAFT

b. **Notes** that the programme has moved to the second phase
c. **Notes** that the membership will be decided by both the Whanganui Alliance Leadership Team and Hauroa A Iwi Board.

Moved S Hylton **Seconded** S Peke-Mason **CARRIED**

Action: Management will release the Suicide Prevention Strategy in the resource centre.

5.5 Provider Arm services (excludes financials)

The paper was taken as read.

Elective procedures were reduced during Covid-19 with 130 cases deferred under alert level two of those cases 81% seen and treated. 910 outpatient appointments were scheduled to be addressed and virtual consultations were undertaken were possible. Management have not received any negative feedback on theatre cancellations, noting that all urgent procedures continued.

Integrated daily operations centre that was developed during the pandemic recovery phase has continued and we are continuing our reporting to MoH.

Our occupancy dropped to 50-60% and staffing numbers were maintained to address system reviews and model of care improvements. Staff were able to undertake other duties during this period.

Medical staff are at 2.5 FTE vacancies, ED SMOs are fully, Nursing FTE has been reduced to budgeted FTE, the r

The TAS rostering review will be received at FRAC, although management have commenced addressing the recommendations in the report.

Management were proactive with communication and strategies to maintain a safe environment with restrictions on visitor policies.

Delayed access to diagnostics are also being address.

The key areas highlighted to the board were:

- Xxx – use above

The Whanganui District Health Board members:

a. **Received** the paper entitled Provider Arm Services
b. **Noted** comments around operational performance
c. **Noted** that the hospitals across the country are the quietest we have seen and would like to know what we maintain this.

6. General business

Nil

7. Resolution to exclude the public

The Whanganui District Health Board members:

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

DRAFT

5 June 2020 **Public**

Whanganui District Health Board minutes of meeting held on 21 March 2020	For reasons set out in the board's agenda of 20 March 2020	As per the board agenda of 20 March 2020
Chief executive's report Board & committee chair reports Smokefree Policy Submission	To enable the district health board to carry out, without prejudice or disadvantage, commercial activities or negotiations (including commercial and industrial negotiations) To protect the privacy of natural persons, including that of deceased natural persons To avoid prejudice to measures protecting the health or safety of members of the public To protect information which is subject to an obligation of confidence or which any person has been or could be compelled to provide under the authority of any enactment, where the making available of the information would be likely to prejudice the supply of similar information, or information from the same source, and it is in the public interest that such information should continue to be supplied; or would be likely otherwise to damage the public interest.	Section 9(2)(i) and 9(2)(j) Section 9(2)(a) Section 9(2)(c) Section 9(2)(ba)
Integrated Facilities Update Pathology and Laboratory Services	To enable the district health board to carry out, without prejudice or disadvantage, commercial activities or negotiations (including commercial and industrial negotiations	Section 9(2)(i) and 9(2)(j)
Draft Annual Plan Covid-19 Opportunities Consumer Engagement	To maintain the effective conduct of public affairs through the free and frank expression of opinions by or between or to Ministers of the Crown or members of an organisation or officers and employees of any department or organisation in the course of their duty	Section 9 (2) (g) (i)

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

Person(s)	Knowledge possessed	Relevance to discussion
Chief executive, senior managers and clinicians present	Management and operational information about Whanganui District Health Board	Management and operational reporting and advice to the board
Board secretariat or board's executive assistant	Minute taking, procedural and legal advice and information	Recording minutes of board meetings, advice and information as requested by the board

Moved Josh **Seconded** Talia **CARRIED**

The public section of the meeting concluded at 11.23am

Signed K Whelan
Board Chair
Whanganui District Health Board

DRAFT

Minutes
Public session

Meeting of the Combined Statutory Advisory Committee

held in the Board Room, Fourth Floor, Ward/Administration Building
Whanganui Hospital, 100 Heads Road, Whanganui
on Friday 15 May 2020, commencing at 9:45am

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

In attendance for Whanganui District Health Board (WDHB)
Mr Russell Simpson, Chief Executive Officer, WDHB
Mr Paul Malan, General Manager, Strategy Commissioning & Population Health
Ms L Allsopp, General Manager, Patient Safety Quality & Innovation
I Murphy, Chief Medical Officer, WDHB
Ms Deanne Holden, Secretariat

1. Procedural

1.1 Karakia & Welcome

A Main opened the virtual meeting at 9:30am, thanking staff for their mahi, commitment and support to the community during the COVID-19 pandemic.

It was noted the meeting was being held virtually due to COVID-19 restrictions. A recording of the meeting will be available on request.

1.2 Apologies

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

K Whelan, S Peke-Mason and P Baker Hogan (for lateness).

1.3 Conflict and register of interests update

2.1 Amendments to the register of interests
- A Main advised she is no longer a member of UCOL
- F Bristol advised there is a formatting error merging two committee member's information for his entry.

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- M Bellamy to be added to register as per information provided by email in March 2020.

Action: F Bristol to email secretariat confirmation of his register of interests

2.2 Declaration of conflicts in relation to business at this meeting

There were no declarations of conflicts in relation to business at this meeting

1.4 Minutes of the previous committee meeting

That the minutes of the public session of the meeting of the Combined Statutory Advisory Committee held on 13 March 2019 be accepted as a true and correct record.

An amendment to the attendance register was noted: M Bellamy recorded as attending and T A McDonnell as not attending. Alter to record M Bellamy as not attending and T A McDonnell as attending.

1.5 Matters Arising

The following updates to the Matters Arising were accepted:

10/18-01	Draft Commissioning Cycle Framework: Confirmation paper presented to Hauora A Iwi who confirmed they are comfortable the framework aligns with the values under which we operate and had no suggested changes. Item complete.
11/22-01	Faster Cancer Treatment: BSS11 to include ethnicity breakdown. To be carried forward with FCT status update, including ethnicity breakdown, to be provided at next meeting.
03/13-01	Access to "Diligent Board Books" for committee members: Updated 05/15-01: Roll out not implemented due to cost implications. Committee members without access were provided meeting papers via email. If this method was not satisfactory, committee members to advise Chair directly to enable alternative distribution options to be explored.

1.6 Committee Chair's Report

The Chair provided a brief verbal report to committee, advising she has been in regular contact with the WDHB Chair, K Whelan over the recent COVID-19 period and associated matters.

2. Chief Executive / Whanganui Alliance Leadership Team (WALT) update

R Simpson, Chief Executive Officer, Whanganui District Health Board

A paper titled "Chief executive report" was tabled by R Simpson with a verbal summary of the key points provided and shown below:

External research company Sapere have now produced a report, as commissioned by WALT, into a review of the current business model which provides both urgent primary and emergency care at the front door. The review put forward a number of options which WALT are now in the final stages of evaluating.

Further updates will be provided to both CSAC and Board once the detail has been considered by WALT and engaged parties.

It was resolved that the committee:

a. **Receive** the paper titled Chief executive update

b. **Note** the progress of the review for emergency and urgent care services being managed by the Whanganui Alliance Leadership Team

DRAFT

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

3 Presentation

3.1 COVID-19 update
L Allsopp, General Manager, Patient Safety Quality & Innovation

Louise Allsopp joined the meeting via virtual network from the Emergency Operations Centre (EOC) and provided a verbal update to committee on the recent COVID-19 response.

Background

During the COVID-19 pandemic, an (EOC) was opened initially onsite at the District Health Board office and subsequently re-housed to the Whanganui District Council buildings. New Zealand is now at Alert Level 2, with the State of Emergency officially ended.

The team is now working through a transition plan as the focus shifts from response to recovery. Readiness to respond needs to be maintained as COVID-19 cases and subsequent alert levels may change at short notice. The recovery model, as per the initial response, follows an integrated approach which is focused on social determinates of health.

Framework for recovery has been drafted with three main pillars; Economic, Social and Health. Interviews with strategic leaders are ongoing as part of a wider stakeholder engagement plan which includes liaison with Whanganui, Ruapehu and Rangitiki district councils.

Welfare support for whanau and patients onsite was discussed. The Haumoana team provided welfare support, when made aware whanau were at times waiting in cars for extended periods due to COVID-19 restrictions. This included providing refreshments and food packs as required. The welfare team, via EOC, also worked closely with community organisations to support the regions homeless, providing temporary accommodation and food packs.

R Simpson confirmed the WDHB would continue to promote key messages at Level 2. Reinforcing the need to follow guidelines relating to social distancing and hand hygiene.

The appendix titled "Please press pause" was noted by the Chair. Members were encouraged to review the document and provide feedback directly to A Main who will collate to inform the WDHB Board at their next scheduled meeting on 5th June.

It was resolved that the committee:

a. **Receive** the paper titled "COVID-19: Recovery and beyond for Whanganui District Health Board

b. **Note** the intended framework, partnerships and processes that are planned

c. **Note** the appendix "Please press pause"

d. **Support** the proposal for the recovery framework

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

DRAFT

4 Discussion Paper

4.1 Non-financial quarterly performance reporting & progress reporting against the current annual plan (2019-20)
P Malan, GM Strategy Commissioning and Population Health

A paper titled "Non-financial quarterly performance reporting & progress reporting against the current annual plan (2019-20)" was tabled by P Malan with a verbal summary of the key points provided and shown below:

Due to COVID-19, the MOH reduced reporting requirements for Quarter 3. Results, as received from the MOH against the reduced reports, were tabled and discussed.

It was noted that the measure indicated relates to achievement against a target identified in the annual plan for the relevant quarter, and not overall achievement, or otherwise. Non applicable is recorded if there was no requirement to report.

Although progress has been slow in addressing oral health concerns for children, a highlight this quarter is the achieved overall of caries free result for children at 5 years of age. Inequity still remains a concern, however significant improvement is in this area was noted with thanks to local kaupapa providers for their active engagement in this area.

H Gifford advised, research has recently been undertaken into how data drives the change and outcomes for improvements in the oral health of under 5 year olds (U5). Feedback of results was delayed due to COVID-19 and is now due to take place in the coming weeks. Although challenging, the findings will allow an opportunity to further explore Maori involvement in the decision making process.

Following discussion on the way data and information can be presented, the Chair advised, on receipt of meeting papers, members are welcome to email her directly with suggestions or concerns relating to the readability of data. This will enable an opportunity to ensure other options for presentation can be made available at the meeting.

ACTION: "Oral Health update – U5" to be added as an item for the next agenda.

It was resolved that the committee:

a. **Receive** the paper titled "Non-financial quarterly performance reporting & progress reporting against the current annual plan (2019-20)"

b. **Note** the reduced Q3 reporting requirements from the Ministry of Health

4.2 Annual Plan 2020-21 Update
P Malan, GM Strategy Commissioning and Population Health

A paper titled "Annual Plan 2020-21 Update" was tabled by P Malan with a verbal summary of the key points provided and shown below:

The Minister's Letter of Expectation and first draft of the Annual Plan 2020-2021 was submitted in March 2020, however, due to COVID-19 subsequent amended guidance around expectation and timelines has been received.

Feedback on the first draft of the Annual Plan 2020-21 due mid May with the final Draft Annual Plan (AP), System Level Measures (SLM) and Regional Service Plans (RSP) not expected until end June. Statement of Performance Expectations (SPE) are required to be published at the start of the financial year to which it pertains, and tabled in Parliament within a set number days after that.

Final confirmation of all dates will be dependent on national lockdown status, change to the state of emergency, and any subsequent legislative modifications that may occur.

It was noted no feedback had been received from committee in relation to the first draft of the plan provided to committee on 13 March. P Malan reconfirmed feedback on the draft plan is welcomed and may be sent to him directly.

It was resolved that the committee:

a. **Receive** the paper titled "Annual Plan 2020-21 Update"

b. **Note** that there has been no feedback from CSAC members on the Draft Plan provided at the last meeting

c. **Note** the updated advice and timeline

4.3 Aged Residential Care Readiness Assessments
P Malan, GM Strategy Commissioning and Population Health

A paper titled "Aged Residential Care Readiness Assessments" was tabled by P Malan with a verbal summary of the key points provided and shown below:

During the recent COVID-19 state of emergency all DHBs were asked to assess, with urgency, the preparedness of their local residential services including Aged Residential Care (ARC), Disability Support Services (DSS) and Mental Health & Addictions (MH&A) residential services.

The WDHB team, led by infection prevention and control (IPC) staff were mobilised. Staff either visited or remotely assessed each facility using a prescribed framework to identify areas such as capability to isolate, staff illness and visitor policies. Following the assessment each facility was rated to indicate a level of support that could be required if a case of COVID-19 occurred within the facility.

As alert levels change plans are being made to ensure a response to any outbreak can be mobilised quickly and appropriately to continue to support our community.

It was resolved that the committee:

a. **Receive** the paper titled "Aged Residential Care Readiness Assessments"

b. **Note** the assessment results for aged residential care, disability support services and mental health and addictions facilities

4.4 Influenza immunisation
Paul Malan, GM, Strategy Commissioning and Population Health

A paper titled "Influenza immunisation" was tabled by P Malan with a verbal summary of the key points provided and shown below:

The influenza immunisation programme has been ongoing during the COVID-19 response. A proactive approach has been taken to ensure wide uptake and targeting of hard to reach groups. This approach has resulted in excellent results which are a reflection of the strong community leadership of the WDHB, Iwi, the Whanganui Regional Health Networks (WRHN) outreach team and Primary Health Organisation (PHO) staff.

It was noted that Whanganui DHB is the highest performing DHB for influenza immunisation in the over 65 age group for Māori and non Māori.

DRAFT

It was resolved that the committee:

a. **Receive** the paper titled "Influenza immunisation"

b. **Note** that Whanganui DHB is the highest performing DHB for influenza immunisation in the over 65 age group for Maori and non Maori.

4.5 Special funding for community response due to COVID-19
Paul Malan, GM, Strategy Commissioning and Population Health

A paper titled "Special funding for community response due to COVID-19" was tabled by P Malan with a verbal summary of the key points provided and shown below:

Significant changes to funding and contracting were made during the COVID-19 response which has enabled the system to respond appropriately. These included, but were not limited to:

- Home and Community Support Services (HCSS). Traditionally providers are funded on a fee for services basis. This was changed for a period of time to bulk funding, based on recent averages, to recognise the need to alter individual care requirements.

- Special funding was also made available for primary care, pharmacy and public health, including direct funding to every general practice (GP), based on enrolled service users (ESU). Fee-for-service to GP to deliver COVID-19 assessments and the configuration of Community Bases Assessment Centres (CBAC's).

- Special funding for Maori health support initiatives.

- Urgent dental services for community card holders including WDHB specific initiative that extended the scope of the Combined Dental Agreement to temporarily include urgent care for community services card holders.

- A Government support package totalling $26 million for Aged Residential Care (ARC)

- Locally enabling ARC facilities to complete and use interRAI assessments which would have previously required DHB assessment or approval.

It was resolved that the committee:

a. **Receive** the paper titled "Special funding for community response due to COVID-19"

b. **Note** additional and rearranged funding that has been made available

c. **Note** there are other special funding arrangements anticipated and in progress.

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

DRAFT

5. Date of next meeting

Friday 14 August 2020 from 9:30am in the Board Room, Whanganui District Health Board, 100 Heads Road, Whanganui

6 Reasons to exclude public

It was resolved that:

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

Agenda item	Reason	OIA reference
Combined Statutory Advisory Committee minutes of the meeting held on 13 March 2020 (Public – excluded session)	For the reasons set out in the committee's agenda of 13 March 2020	As per the committee's agenda of 13 March 2020
April Financial Update	To enable the combined Statutory advisory Committee of the Whanganui District Health Board to carry out	

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

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

Moved: G Adams **Seconded**: C Anderson

The public session of the meeting ended at 10:50am

Adopted this day of 2020

……………………………………………………

Chair

DRAFT

July 2020 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Chief Executive Paper**
	Item 2
Author	Russell Simpson, Chief Executive
Subject	**Chief Executive Report**

Recommendations

Management recommend that Whanganui District Health Board members:

a. **Receives** the paper titled chief executive report.

b. **Note** this Crown Funding Agreement variation funding value has been identified as sufficient by the General Manager Strategy, Commissioning and Population Health and the General Manager of Corporate.

c. **Approve** the board chair sign the Crown Funding Agreement Variation to support COVID-19 Surveillance Plan and Testing Strategy.

d. **Note** the Māori Crown Relations Team plan to undertake governance training and networking needs assessment of DHB Board Māori Members and Iwi/ Māori governance partners.

e. **Note** that DHB Māori health teams have confirmed the names of Māori board members and relationship board membership and representation for the governance training.

1. Schedule I-9: COVID-19 Surveillance Plan and Testing Strategy

The Ministry of Health (MoH) has presented the Whanganui District Health Board with a Crown Funding Agreement (CFA) for COVID-19 Surveillance Plan and Testing Strategy funding. It totals $525,363.00 and is to cover the following expectations:

- Each DHB will be responsible for the delivery and planning of ongoing, sustainable and flexible health services to deliver the Testing Strategy at a local level and across its DHB geographical area (as defined in the New Zealand Public Health and Disability Act 2000).
- As part of planning and preparedness, it is expected that each DHB will maintain an up to date, clear plan for enabling higher volumes of assessment and investigation of individuals with clinical symptoms consistent with COVID-19 in the event of further outbreaks/transmission, and in response to Ministry requests.
- DHBs will be required to take specific actions to increase access to testing in population groups if there is significant variation to the national average in a DHB geographical area or within population groups. DHBs must manage this within the funding provided under this agreement under the funding clauses below. DHBs will be given sufficient notice of any changes that impact on the services.
- The approaches for community testing required in each geographical area will vary depending on geographical location (urban, rural), characteristics of COVID-19 cases/spread locally (if applicable), and the needs of the population and local communities.
- There are a number of possible modalities including Community Based Assessment Centres (CBACs), designated general practices, mobile services, and supported general practice. It is likely that DHBs will need to use a combination of these modalities to best meet the needs of their populations under the new testing strategy. However, the Ministry will require DHBs to ensure that operational models are sustainable within the available funding.

- CBACs, designated general practices, mobile services and supported general practice will be available across all DHB geographical areas, with good access to seven day a week swabbing. The DHB will make information on local testing capacity easy to access
- Access to testing facilities over the weekend and public holidays will be clearly communicated to the public.
- DHBs are asked to work with their Primary Health Organisations, Public Health Units and general practices to implement and adjust/monitor services in their geographical area.
- Testing (that is either a clinical assessment, swabbing and laboratory analysis) will remain free of charge to the public for those scenarios covered by the Testing Strategy.
- This funding is inclusive of the cost of Personal Protection Equipment required to deliver the services.
- The DHB agrees that it will only use the Funding for the purposes of performing the Services.

The CFA has been checked by the Commissioning Manager, the General Manager Strategy, Commissioning and Population Health and the General Manager of Corporate for accuracy and to ensure that the funding levels are sufficient to undertake the required expectations.

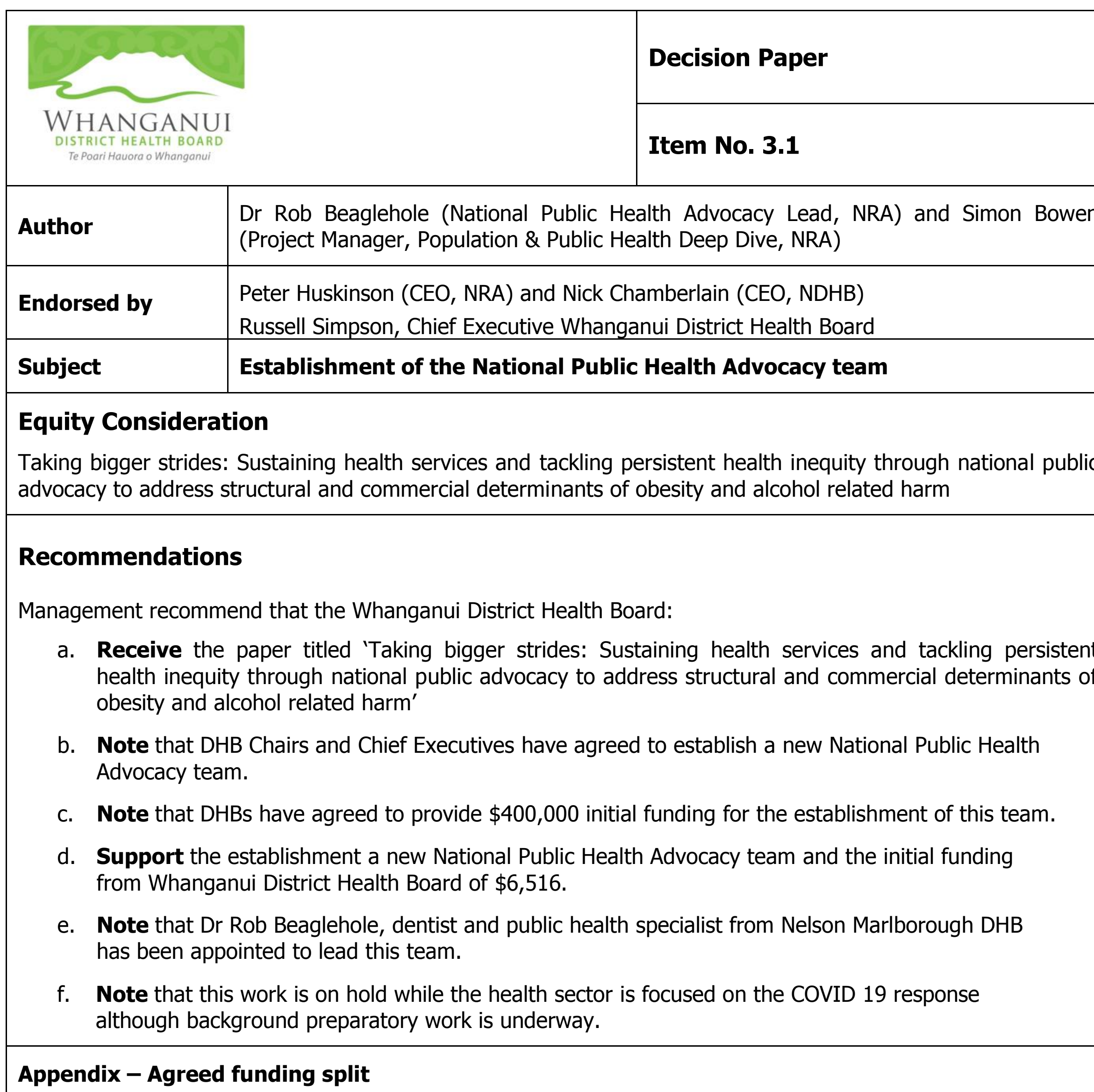
2. Ministry of Health Investment in Strengthening Māori Health leadership and Governance

Whakamaua: MoH Māori health action plan (draft) signals investment in strengthening Māori Health Leadership, DHB and Iwi/ Māori governance arrangements. The Māori Crown Relations Team plan to undertake a governance training and networking needs assessment of District Health Board Māori Members and Iwi/ Māori governance partners. This is connected to the next phase of DHB governance training (in development), following on from the regional DHB Induction Programme delivered by the DDG Māori Health at the start of this year. Dates are yet to be confirmed for the needs assessment and the proposed training.

The team is working with the DHB Performance Directorate to ensure DHB Māori members and Iwi Māori governance members' needs are being met. Additionally this feeds into the mahi of developing guidance and principles for DHB and Iwi partnerships which build on exemplars and responds to the Health and Disability System Review recommendations 2020.

In preparation DHB Māori health teams have confirmed the names of Māori board members and relationship board membership and representation.

July 2020 **Public**



	Decision Paper
WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Item No. 3.1**

Author	Dr Rob Beaglehole (National Public Health Advocacy Lead, NRA) and Simon Bowen (Project Manager, Population & Public Health Deep Dive, NRA)
Endorsed by	Peter Huskinson (CEO, NRA) and Nick Chamberlain (CEO, NDHB) Russell Simpson, Chief Executive Whanganui District Health Board
Subject	**Establishment of the National Public Health Advocacy team**

Equity Consideration

Taking bigger strides: Sustaining health services and tackling persistent health inequity through national public advocacy to address structural and commercial determinants of obesity and alcohol related harm

Recommendations

Management recommend that the Whanganui District Health Board:

a. **Receive** the paper titled 'Taking bigger strides: Sustaining health services and tackling persistent health inequity through national public advocacy to address structural and commercial determinants of obesity and alcohol related harm'

b. **Note** that DHB Chairs and Chief Executives have agreed to establish a new National Public Health Advocacy team.

c. **Note** that DHBs have agreed to provide $400,000 initial funding for the establishment of this team.

d. **Support** the establishment a new National Public Health Advocacy team and the initial funding from Whanganui District Health Board of $6,516.

e. **Note** that Dr Rob Beaglehole, dentist and public health specialist from Nelson Marlborough DHB has been appointed to lead this team.

f. **Note** that this work is on hold while the health sector is focused on the COVID 19 response although background preparatory work is underway.

Appendix – Agreed funding split

1 Overview

DHB Chairs and Chief Executives have agreed to establish a new National Public Health Advocacy team to address the structural and commercial determinants of obesity and alcohol related harm. This paper provides a briefing for DHB boards about the new Public Health Advocacy team. For further information about this work or to provide feedback please contact Dr Rob Beaglehole at: Rob.Beaglehole@nra.health.nz

2 Context

Obesity and alcohol related harm are major public health challenges in NZ. Every year there are almost 10,000 premature deaths from unhealthy diet and unhealthy weight, and New Zealand ranks as the third most obese population of the 36 countries in the OECD. Both alcohol and obesity are major drivers of inequity for Māori, Pacific, and communities with high deprivation.

Risk Factor	Premature Deaths p.a	Years Lived with Disability p.a	Comment
Unhealthy Diet and High BMI	9,600	47,000	Third highest obesity prevalence among OECD countries. Significantly higher rates for Maori and Pacific
Alcohol Use	1,260	13,600	Estimated to be a factor in half of serious violent crimes in NZ

Effective public health legislation and policy initiatives are the most financially affordable and cost-effective interventions available to New Zealand to improve health status & health equity. These levers have the largest potential impact but require a sustained and smart strategic multi-year approach to secure implementation.

Research shows that the public and policy makers can often focus on supporting individuals to make health choices but neglect the structural factors that currently make it easier for people to choose, (or default to) less healthy options, which can be particularly acute in communities facing high deprivation.

There can also be commercial factors in play, sometimes putting individual firms in an invidious position that they feel they would be at a competitive disadvantage to be the first to act on a health related issue if their rivals do not. Smart public policy can ensure all firms act, and the most responsible firms feel confident to show early leadership.

The current coalition government has wellbeing policy objectives which are potentially congruent with this agenda but is starting from a food environment and regulatory position that benchmarks poorly against international comparators.

A hui and national workshop on these issues last year with DHB Chairs, Chief Executives and Ministry of Health representatives suggested that DHBs would be well placed to take forward advocacy and noted the importance of building cross party support to create the right climate for robust public health national policy that can be maintained across electoral cycles and changes in government.

COVID-19 and New Zealand's response to it also provide opportunities to progress this work. COVID-19 has highlighted the importance of public health. There is an increasing recognition and valuing of public health services and approaches. The response to the pandemic has also demonstrated New Zealanders willingness to make changes to our lifestyles and behavior in order to protect the most vulnerable.

The establishment of a National Public Health Service will strengthen the leadership of public health in NZ. The size and scope of this service is not yet clear and it is expected that at least initially it will have a focus on health protection. The National Public Health advocacy team will link and work with the new National Public Health Service as it develops.

3 Establishment of the Public Health Advocacy team

Following this hui DHB Chairs and CEOs agreed in late 2019 to establish a new national Public Health Advocacy team. The overarching aims for this work is:

To improve the sustainability of the health system and help eliminate health inequities.

To establish & deploy strategic communications and advocacy capability, using DHB assets, partners and connections to secure public and cross-party support for a more assertive national policy, smart regulation and legislation to make greater impact on structural and commercial determinants of health.

The Northern Regional Alliance is hosting the new team under the leadership of Dr Nick Chamberlain, CEO of Northland District Health Board and national lead DHB Chief Executive for Public Health. Mark Gosche, Board Chair of Counties Manukau District Health Board has been appointed by the national DHB Chairs to act as the Chair sponsor for the work that the team will be undertaking. DHBs have agreed to provide $400,000 initial funding for the establishment of this team in its first year.

A steering group with expert support drawn from across New Zealand is being established to help guide and advise on the priorities and work programme. Membership will include representatives from a range of DHBs and public health units as well as strong Maori and Pacific representation.

Doctor Rob Beaglehole has been appointed to lead the new team's establishment and development. Rob is a dentist and public health specialist. He currently works as the public health advocate in Nelson Marlborough District Health Board. Rob previously served as a senior political advisor to the Minister of Health and has worked internationally for the World Health Organisation and World Dental Federation. Due to the Covid-19 crisis Rob will initially be seconded into this role at 02.FTE until October 2020.

The team will complement the work of the Health Promotion Agency nationally, and the good practice that exists within District Health Boards, regional Public Health Units, and partner agencies, and provide a valuable supportive resource for policy makers and leaders. The work will include co-ordination with DHB public health leaders to ensure the relevant DHB policies are strengthened, consistent, and reflective of best practice (e.g. healthy food and drink policies).

4 Next Steps

Preparatory work is underway and opportunistic support is being provided while DHBs and the health sector are focused on the COVID 19 response. Key next steps include the following:

i. Building relationships with key stakeholders

ii. Establish the expert steering group to help guide and advise on the team's priorities and work programme. (The group will be convened as New Zealand moves beyond the pandemic response and into recovery)

iii. Recruit a Strategic Communications lead

iv. Develop and agree initial priorities and work plan. Potential focus areas include:

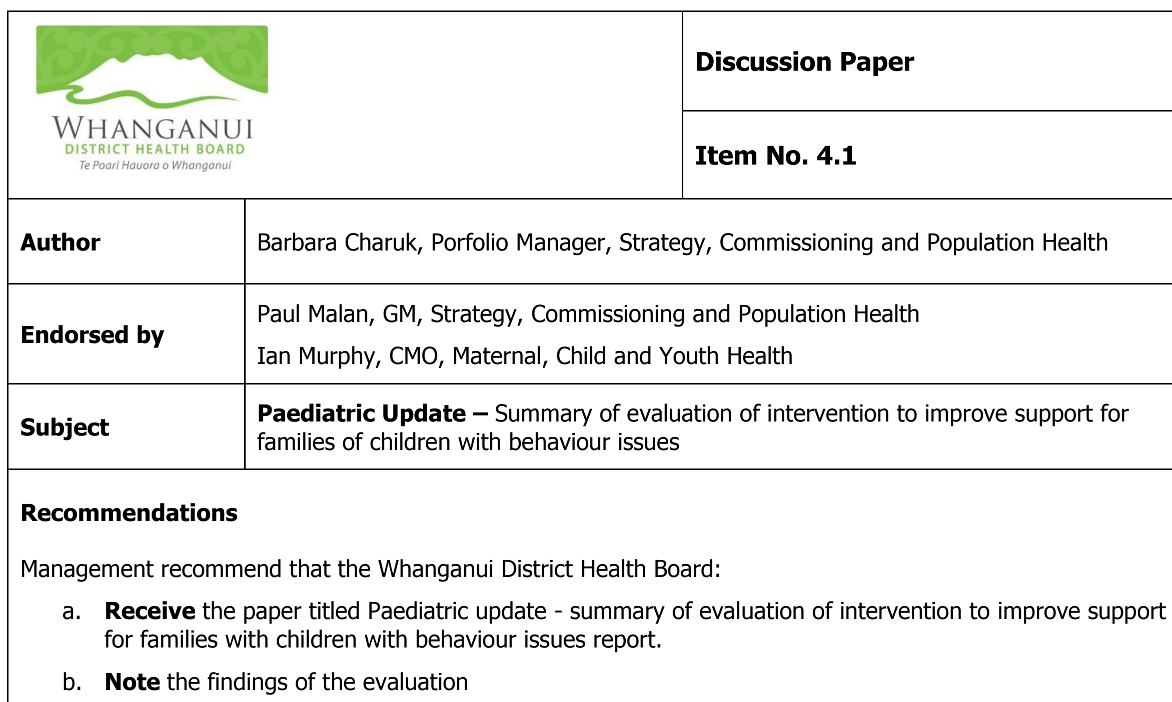
- Reviewing existing DHB Healthy Food and Beverage policies and implementation plans
- Formulating a plan to support schools to adopt best practice Food and Beverage policies
- Investigating where the reformulation of food process is up to with a focus on sugar and salt reduction
- Identifying opportunities to address structural factors to reduce alcohol related harm

Regular updates will be provided once DHBs return to business as usual.

Appendix 1: Agreed Public Health Advocacy funding split by PBFF Shares as used in the 2019/20 PBFF model

DHB	Overall PBFF Share	$ Value
Auckland	9.51%	$38,031
Bay of Plenty	5.61%	$22,443
Canterbury	10.84%	$43,347
Capital & Coast	5.70%	$22,792
Counties Manukau	11.00%	$44,015
Hawkes Bay	3.84%	$15,361
Hutt	2.97%	$11,875
Lakes	2.50%	$10,013
Mid Central	4.00%	$16,018
Nelson Marlborough	3.39%	$13,579
Northland	4.64%	$18,561
South Canterbury	1.40%	$5,611
Southern	6.75%	$27,001
Tairawhiti	1.27%	$5,070
Taranaki	2.61%	$10,426
Waikato	8.98%	$35,921
Wairarapa	1.10%	$4,387
Waitemata	11.39%	$45,574
West Coast	0.86%	$3,456
Whanganui	1.63%	$6,516
Total	**100.00%**	**$400,000**

July 2020 **Public**



WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Discussion Paper**
	Item No. 4.1
Author	Barbara Charuk, Porfolio Manager, Strategy, Commissioning and Population Health
Endorsed by	Paul Malan, GM, Strategy, Commissioning and Population Health Ian Murphy, CMO, Maternal, Child and Youth Health
Subject	**Paediatric Update –** Summary of evaluation of intervention to improve support for families of children with behaviour issues

Recommendations

Management recommend that the Whanganui District Health Board:

a. **Receive** the paper titled Paediatric update - summary of evaluation of intervention to improve support for families with children with behaviour issues report.

b. **Note** the findings of the evaluation

1 Purpose

This paper provides a summary of the evaluation completed by the WDHB's Centre for Patient Safety, Quality and Innovation on the intervention to improve support for families with children with behaviour issues.

1.1 Introduction

There are a number of children being referred to the Paediatric department who have difficulties with behavioural issues.

The causes of behavioural disturbances in children are diverse. Some children have Attention Deficit Hyperactivity Disorder (ADHD), but often there are multiple factors which cause the behavioural difficulties. For example, exposure to family harm, attachment difficulties, parental mental health and addiction, intrauterine alcohol and drug exposure, genetic factors, childhood grief and trauma, anxiety, depression, Autism Spectrum Disorder, ineffective parenting techniques, and genetic factors, all play a role in these behaviours.

Significant disruptive behaviour which adversely impacts the child's functioning in the school and home settings affects at least 10% of children. This means that at least 1,500 children in our community could be affected by significant behaviour and development problems.

The Maternal, Infant, Child and Adolescent Mental Health and Addition Services (MICAMHAS) can only support the most severe 2-3% of children, and only those for whom the primary diagnosis is a mental health concern. This means that most referrals for children with behaviour problems are directed to Paediatric medicine. Prior to the establishment of the Development and Behaviour coordinator position, the conventional approach for the medical assessment of these children was slow and cumbersome.

1.2 Background

The traditional medical model of outpatient assessments requires a GP referral followed by one or more outpatient appointments for the child and caregiver, with multiple appointments separated by weeks or months being common. This means the process is slow.

Previous process:

- Family/School identify behavioural issues
- School may attempt to put supports in place but may not be adequate /appropriate or maybe a delay in accessing funding for same
- Referral sent to Paediatrics but frequently incomplete, so request may be sent to GP asking for further information
- Referral triaged and appointment sent usually within 8 weeks
- Seen by paediatrician and generally attended only by child and family
- Further information and assessment requested and booked for follow-up appointment in 3 months
- Assessment forms given to families and sent to schools, once returned need to be reviewed and scored by paediatrician.

Chart one below indicates the time from referral being received by the WDHB to the first appointment with the paediatrician, with 89% waiting between 2 and 3 months.

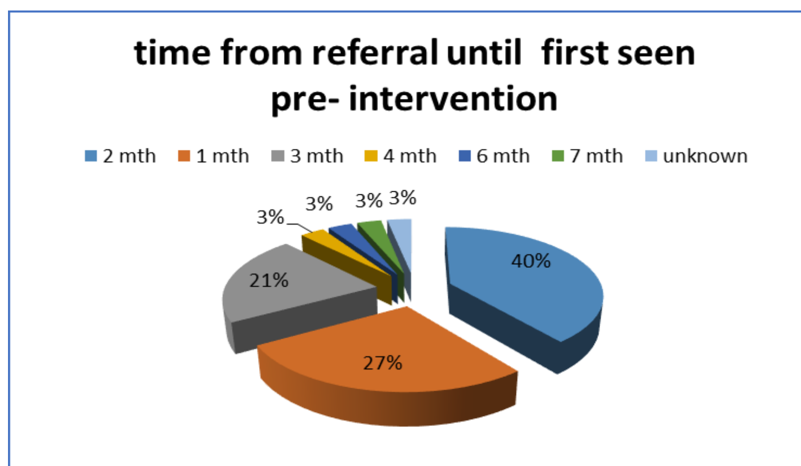


Chart one

After the first appointment with the paediatrician, there is a further delay for a follow up appointment as demonstrated in chart two. Though 37% of wait is unknown, there are still significant delays in securing that follow up appointment, and is still in the pre-intervention stage, awaiting a diagnosis and intervention plan. This process can therefore take at best 3-6 months and sometimes over a year in this time the stress on the family and education setting can be immense

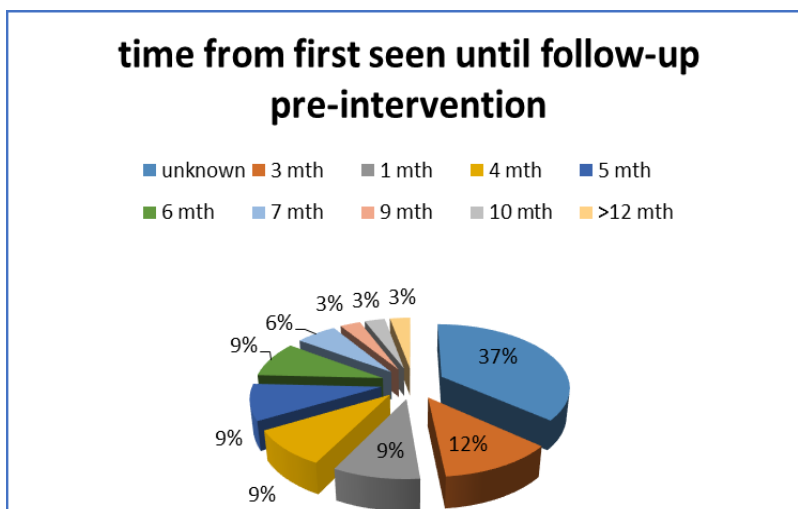


Chart two

This model is hospital or clinic-centred, and fails to adequately integrate with schools, NGOs, Primary Health providers, and extended whanau. Considering the diverse causes of these disturbances, a holistic response is required, but difficult to deliver with the conventional medical model.

The outcomes from such medical assessments lack sufficient depth and quality of information from these multiple sources, and the therapeutic recommendations from such assessments do not adequately harness the supports available from these agencies in the community.

Repeated hospital or clinic-based appointments increase the likelihood of DNAs (non-attendances) at these appointments, and vulnerable families including those affected by poverty, parental mental health and addiction, single parent families, and Maori and Pasifika families, are particularly susceptible to DNAs, which often result in further delays or even discharges from the service, further increasing the inequality of outcome for these families.

1.3 Implementation of Child Development and Behaviour Coordinator position

A child development and behaviour coordinator was employed to manage the journey for children and families who are referred to WDHB paediatric service with behavioural issues. The role is to act as the point of contact for families, schools and other professionals and to assess and collect all the relevant information needed for a comprehensive assessment to be done by the paediatrician. This process aims to ensure relevant information is gathered and relevant referrals completed in a timely manner. It also reduces the number of appointments a family needs to attend ensuring care is delivered within a more appropriate timeframe.

1.4 Improved pathway

The development of the Child Development and Behaviour Coordinator role has transformed the assessments of children with behavioural disturbances.

The Coordinator is outwardly focussed by:

- contacting families directly in the community,
- meeting them face-to-face,
- gathering extensive information, including a full profile of risk factors for behavioural disturbance.

With consent, the Coordinator speaks directly to the child's teacher and school principal and performs an in-school observation. The information gathered in this way is invaluable, and greatly enhances the quality of the final assessment of the child.

The Coordinator also ensures that special assessment tools, for example the Conners Rating Scales, are completed by the Parent and the Teacher, and then analyses the questionnaires using proprietary software.

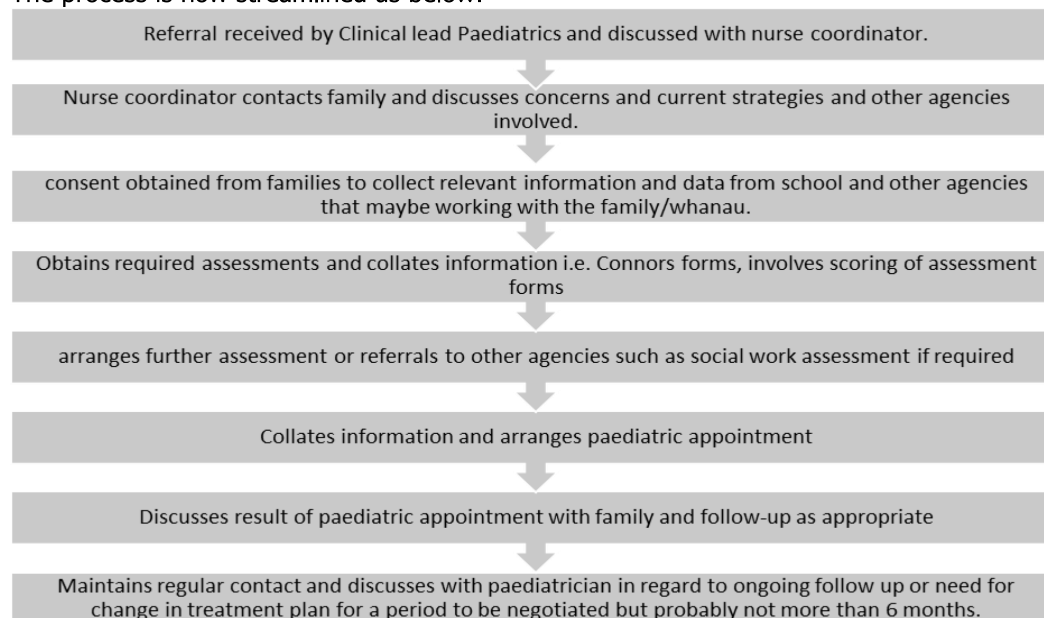
The Coordinator also prepares the child's caregivers for the coming paediatric appointment, by performing education about causes of behaviour problems, including ADHD, and the Pros and Cons of various treatments, such as medications. This allows parents to have time to make informed choices about the possible use of medications, so that they are equipped to participate fully in the discussion about treatment if that is recommended at the subsequent appointment with a Paediatrician.

Once this extensive evaluation has been completed, the child and family can be assessed in a joint clinic appointment with the Coordinator and the Consultant Paediatrician. At this appointment, all the information necessary for a diagnosis is available, and if treatment is necessary and has been agreed to by the parents, it can be started immediately.

The Coordinator, who by now has a strong working relationship with the child, their family, and the school, then follows up with the family and the school over the coming weeks to monitor the success of the treatment, liaises with the paediatrician if required, and helps navigate the child and family into ongoing follow-up with primary care.

The Paediatrician writes a detailed report including all relevant information gathered over the entire assessment process, and in most cases the child can be handed back to the GP/primary provider for ongoing management and follow-up, but with a direct link back to the paediatrician by phone, email or teleconference for trouble-shooting and dosage adjustment. Referrals to other services can also be made as required.

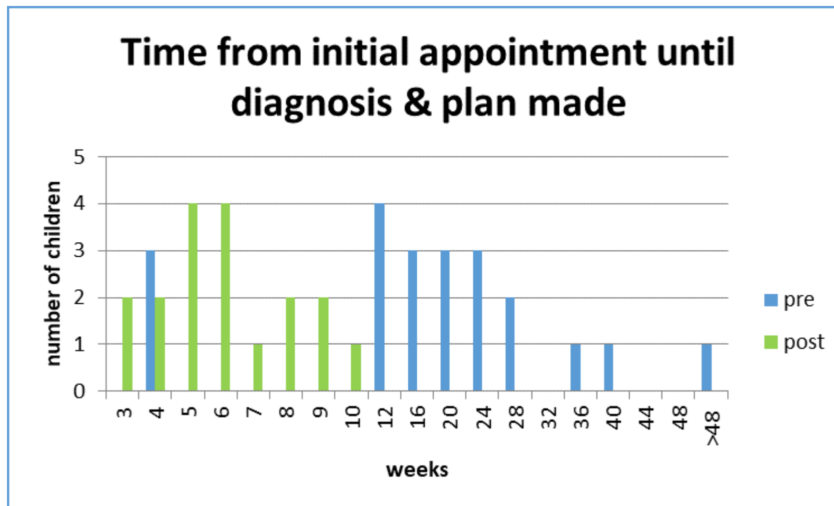
The process is now streamlined as below:



1.5 Evaluation six months post implementation of position:

WDHB Centre for Patient Safety, Quality and Innovation conducted an evaluation six months post implementation of the position. In terms of wait times, it showed that 78% of children referred are now being seen within eight weeks of referral. Prior to the change in process only 27% of children were being seen within eight weeks of the time of referral.

The evaluation reported that overall turnaround for assessment to plan having been completed within a 10 week timeframe. This timeframe had been impacted by the Christmas holiday period. Prior to August 2019 when the process change was introduced, children and their families would wait three months or more to have a diagnosis made and plan put in place.



Other advantages:

- The time taken from referral to diagnosis and treatment is now measured in weeks, whereas before it was several months, or in some cases even years
- The quality and accuracy of the assessments has improved
- We are able to accept more referrals than before, because the use of the paediatrician's time is much more efficient, and because we no longer decline referrals where the referral information is inadequate
- No DNAs. The Coordinator ensures that the family are engaged in the process and can see that they are on a fast track to diagnosis, treatment and support for their child. This is especially crucial for those families who are more susceptible to DNAs than some other families. There are many examples from the old system of families whose children have needed treatment for ADHD and other disorders but have not been able to access it early enough, and in some cases not at all, because they have been discharged after multiple DNAs.
- The schools are involved in the process and can give direct input into the assessment, and then are engaged in the follow-up. Better quality information from the schools is now obtained than ever before, because they are partners in the assessment
- Primary care providers/GPs are an integral part of the ongoing management of these children. The "Medical Home" for children with ADHD and other neurodevelopmental/behavioural disorders is with their primary care provider in their community, not with a paediatrician at the hospital. The GP has direct access to the paediatrician for immediate advice on trouble-shooting and dosage adjustments, so that further outpatient referrals are not required, and the GP can make immediate changes to the child's treatment without the delay and the communication difficulties which would arise with an outpatient referral.

1.6 Future developments

A project is being planned to co-develop a Clinical Pathway for the Integrated Care Management of ADHD.

It is envisioned that most of these assessments could be started in the Primary Care setting, including use of formalised assessment tools, and wherever possible for specialist input to be given in the primary care practice setting.

Guidelines and resources for ongoing management in primary care, with enhanced processes for obtaining prompt specialist support and advice, will be developed, and implemented.

There is also provision for workforce development with a nurse practitioner specialising in child health assessments. A nurse practitioner could perform many of the tasks usually performed by paediatricians in these assessments.

2 Patient stories

A nine year old, Pacific Island girl presented with major behavioural problems at school and home and some mental health concerns. The school were planning to stand her down as her behaviours were becoming unmanageable. Mum had tried to get help for 7 years at another DHB and felt nobody had listened to her. The coordinator met with the mother and completed the initial assessment. Mum was very emotional during the assessment process saying that at last she was being heard.

With Mums permission, the coordinator met with the Principal and teachers at school and did a school observation. Both school and Mum filled out Conners 3 forms as part of the ADHD assessment.

The coordinator attended the Paediatric Clinic Appointment and supported Mum with the process ensuring that there was a consistent message and approach by both clinicians. Following the appointment the girl was prescribed medication for ADHD. I kept in regular contact with Mum for 4 weeks following the paediatric appointment to ensure that she was happy with the use of medication.

The outcomes have been that the child has remained at school, she is learning, she has made friends and can now tolerate a class environment. She is settled on the prescribed medication There are no current mental health concerns reported. Other supports were put in place for both.

The seven year old, male, NZ European, living with parents and 2 older siblings. He presented with unmanageable behaviours both at school and home. Unable to learn, focus, concentrate at school. He had no friends and was reported to scream for 45 mins in the classroom when overwhelmed and unable to tolerate the learning environment.

The coordinator met with mum to complete the initial assessment and take a history. Mum was overwhelmed by school constantly ringing her daily around her son's behaviour. She was feeling unheard and expressed that she must be a "bad parent."

The coordinator observed him at school for an observation and to talk to the teachers. Conners 3 forms, school information forms were completed and scored.

During the assessment process and school observation, it became evident that he had significant behaviours indicating both ASD and ADHD.

The coordinator attended the Paediatric appointment with Mum. He was prescribed medication and given a diagnosis at first paediatric appointment.

The outcomes have been that the child only required to see a Paediatrician once for a dual diagnosis as the assessment clearly had obtained sufficient information from school and family.

There have been no further concerns raised about his behaviour at school. He is settled and learning. There have been no episodes of screaming in the classroom.

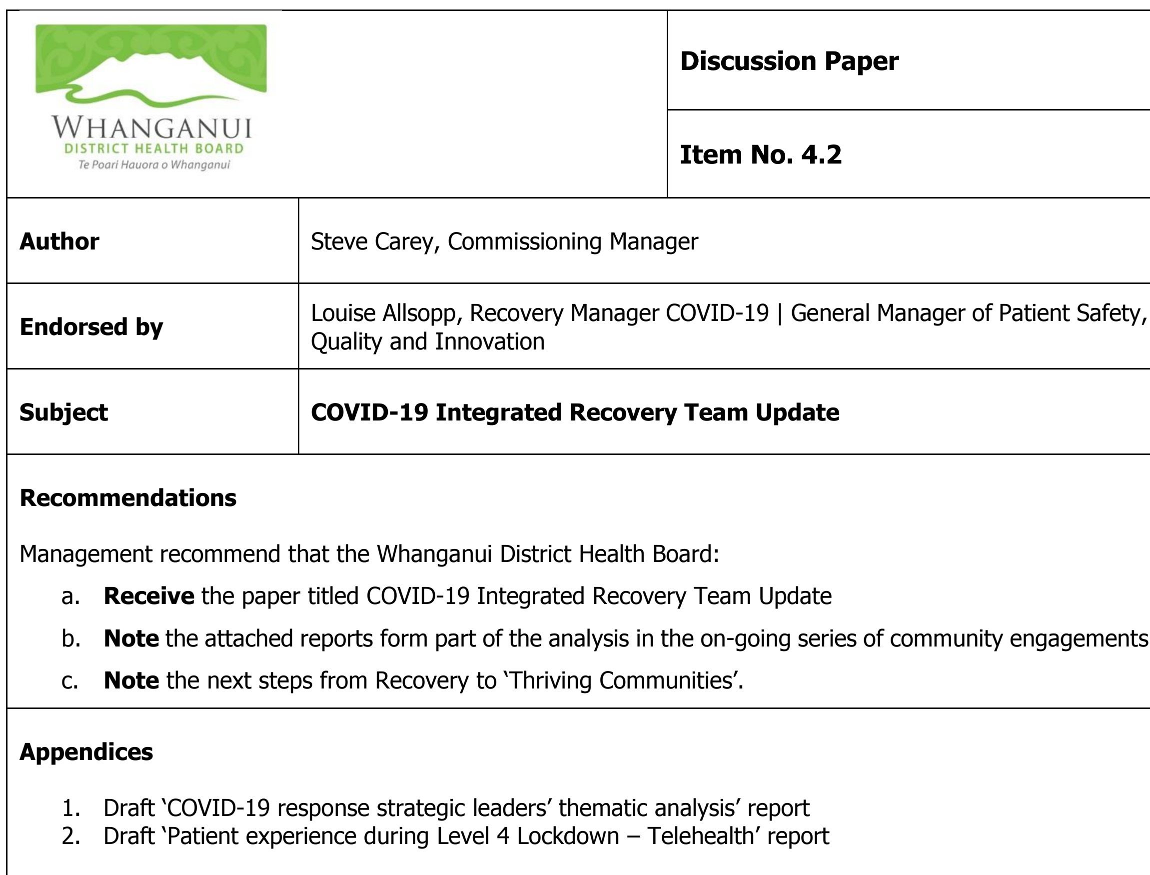
In addition, supports to be put into place for the both child and parents.

At 6 weeks observation, he was learning and engaging alongside his peers, interested in the teacher and the tasks. He was engaged, happy and settled. There had been no episodes of screaming. He had a friend.

A nine year old Māori boy, unable to concentrate, focus, stay in the classroom and learn. Teachers were at the point of excluding him as they had tried ways to manage him but with little success.

Parents were not concerned about his behaviour at home and had strategies to manage him. They lived an outdoor life style which used up his energy levels. He is an only child. They were reluctant to use medication.

A full assessment was completed alongside the Connors 3 forms, school information and information from family and a school observation. The boy was running around the classroom, shouting out at the teacher, interfering with other children's learning and unable to concentrate or focus on his own learning. The boy was able to be seen that week and a diagnosis and treatment plan started. It had an immediate effect on the child's behaviour and he is now able to stay in the classroom, learn and be around other children. Without this intervention, he wold have likely been excluded from school.



WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Discussion Paper**
	Item No. 4.2
Author	Steve Carey, Commissioning Manager
Endorsed by	Louise Allsopp, Recovery Manager COVID-19 | General Manager of Patient Safety, Quality and Innovation
Subject	**COVID-19 Integrated Recovery Team Update**

Recommendations

Management recommend that the Whanganui District Health Board:

a. **Receive** the paper titled COVID-19 Integrated Recovery Team Update
b. **Note** the attached reports form part of the analysis in the on-going series of community engagements
c. **Note** the next steps from Recovery to 'Thriving Communities'.

Appendices

1. Draft 'COVID-19 response strategic leaders' thematic analysis' report
2. Draft 'Patient experience during Level 4 Lockdown – Telehealth' report

1 Purpose

The purpose of this paper is to provide the board an update from the Integrated Recovery Team. It presents two reports that have been produced by the team as a result of patient and strategic leader engagement. These reports form part of the wider engagement and will support the design and development of community-led, Community Impact Plans. These plans will outline how, through working with our communities, we will achieve 'thriving communities'.

2 Summary

The impact of COVID-19 on New Zealand has been far-reaching and profound. As at the 17th of July 2020, about 1,548 people have contracted the virus and 22 people have died. Across the globe, over 13.7 million people have contracted the virus and over 586,000 people have died. Health systems have been overwhelmed in many countries and the economic impact is huge and unfolding. The global pandemic and the measures taken to control it have disrupted the lives of all New Zealanders. This has created the need to support the health and wellbeing of the whole population and also ensure we support and address the needs of those most severely impacted, whether that be health and wellness, socially or economically.

The COVID-19 pandemic has tested all aspects of New Zealand society, but with every emergency new opportunities are created. A Whanganui integrated emergency operations centre was opened on the 16th of March 2020 in response to the pandemic. As this response moved towards recovery, an Integrated Recovery Team was been established to lead the recovery phase of the COVID-19 pandemic. The intention was to plan for recovery from COVID-19 by thinking strategically about 'reset and re-design'. This is best achieved through collaboratively working together and planning for the 'next normal'. Integrated planning, redesign and ultimately provision of services will provide our communities with the best opportunity to increase its economic growth, social connection and health and wellbeing.

Engagement to date:

The Integrated Recovery Team has embarked on engaging with the community in as many forms as possible to ensure that people have the opportunity to be heard. As at the 17th of July 2020, the team have received 372 individual responses to the community engagement survey, 87 responses to the organisational engagement survey, undertaken an engagement day at the River Traders and Farmers Market, conducted 24 strategic leadership 1-1 interviews and have been travelling across the rohe to complete 41 focus group sessions (which includes representation from more than 60 community groups and organisations).

'Quick-win' actions taken:

Throughout the engagement process, the Integrated Recovery Team has identified 'quick win' opportunities to rapidly support our communities in practical ways, which they have identified will make positive impacts for their communities, organisations or whanau. Some of these 'quick wins' include:

- Provision of a defibrillator for Upokongaro.
- Tamaupoko Community Led Developments members and Department of Internal Affairs regional liaison meeting with Russell Simpson.
- Enable a Pasifika liaison to Civil Defence in future events.
- Ministry of Primary Industries Kai packs for Pasifika community.
- Pasifika churches Provisional Growth Fund funding applications with Whanganui & Partners.
- Establishment of Kai Collective with oversight of local food rescue systems and supporting initiatives.
- Preparing for next emergency so we can respond even better, for example kai pack coordination.

Analysis to date:

The two reports which form appendixes to this paper form parts of the analysis to date. On-going analysis is being completed for the community and organisational surveys, the River Market feedback, and the focus group sessions that have been completed to date. As the community engagement is an on-going process, the analysis will be evolutionary and ensure that once the thematic analysis has been completed, that the engagement with the community becomes a way of critically evaluating the findings, and utilising it as a platform to support the development of the Community Impact Plans.

3 The Integrated Social Governance Leadership

The Integrated Social Governance Leadership Team (ISGLT) is a group of local and regional chief executives who are collectively providing the strategic leadership to enable community led impact planning. Membership comprises of Hauora ā Iwi, Whanganui District Health Board, Whanganui District Council, Rangitikei District Council, Ruapehu District Council, Ministry of Social Development, Department of Internal Affairs, New Zealand Police and Te Ranga Tupua. The formation of the leadership team is underway, having conducted a couple of meetings to date, with a terms of reference and framework currently being drafted.

Extending on from the work of the Integrated Recovery Team, through community and sector engagement, the community will identify what services and supplies they require in order to live a more meaningful and healthy life in our thriving communities. As this work transitions from the Integrated Recovery Team, through to the integrated 'Thriving Communities Team', the ISGLT will support the communities and organisations that already have impact plans (such as the regional economic recovery taskforce, Caring for the Community, Build Back Better and the Ruapehu whanau transformation), and partner with communities who do not have existing plans to develop them. To date, the ISGLT have committed to supporting the resourcing the 'Thriving Communities Team' to ensure that collectively they can work with the community to support them to meet their needs and aspirations.

Identified community needs will be presented to the ISGLT and operationalised through the integrated Thriving Communities Teams joint vision and mahi. The ISGLT has identified that it is important that we begin to work 'on' the system, rather than 'in' the system, for collectively we can achieve more for our communities than through individual organisational responses – ***he waka eke noa – we are all in this together.***

4 Next steps

As we transition from the CDEM recovery phase into operating as a 'Thriving Communities Team', the Integrated Recovery Team will continue to engage with our communities and undertake the analysis of the completed focus group sessions, community and organisational surveys, and the River Market feedback. The outcomes of this analysis will be presented to the board.

The Integrated Social Governance Leadership Team will support the transition from Recovery to Thriving Communities to ensure that the gains that have resulted from COVID-19 are continued into the future, becoming the rule than the exception.

Integrated Recovery Team

COVID-19

From Response to Recovery – the next normal.

A Thematic Analysis of 24 identified Whanganui strategic leaders in the COVID-19 response and understanding the 'next normal'.

Draft

Report Author
Steve Carey

Abstract

This report seeks to provide some clarity to the Reset, Redesign – Recovery team in terms of understanding what the 'next normal' looks like to the people of the Whanganui DHB rohe. This foundational document merges and provides interpretation to 24 COVID-19 Response Strategic Leader interviews through thematic analysis. Thematic Analysis allows us to determine precisely the relationships between individual interviewee's concepts and compare them with the wider interview data. By using thematic analysis, there is the possibility to link the various concepts of the strategic leaders and compare these with the data that is being gathered through the focus groups and wider community engagement.

Draft

Background

The impact of COVID-19 on New Zealand has been far-reaching and profound. As at the 10th of July 2020, about 1,540 people have contracted the virus and 22 people have died. Across the globe, over 12.2 million people have contracted the virus and over 552,000 people have died. Health systems have been overwhelmed in many countries and the economic impact is huge and unfolding. The global pandemic and the measures taken to control it have disrupted the lives of all New Zealanders. This has created the need to support the health and wellbeing of the whole population and also ensure we support and address the needs of those most severely impacted, whether that be health and wellness, socially or economically.

The COVID-19 pandemic has tested all aspects of New Zealand society, but with every emergency new opportunities are created. A Whanganui integrated emergency operations centre was opened on the 16th of March 2020 in response to the pandemic. As this response moved towards recovery, an Integrated Recovery Team was been established to lead the recovery phase of the COVID-19 pandemic. The intention was to plan for recovery from COVID-19 by thinking strategically about 'reset and re-design'. This is best achieved through key strategic leaders working collaboratively and planning together for the 'next normal'. Integrated planning, redesign and ultimately provision of services will provide our communities with the best opportunity to increase its economic growth, social connection and health and wellbeing.

The Integrated Recovery Team understand that collectively we are required to enable and support our communities to live their healthiest lives possible in thriving communities. The arrangements for recovery, which we called Reset, Redesign - Recovery, involved the coordinated efforts and processes used to bring about the immediate, medium-term and long-term holistic regeneration and enhancement of our communities following the COVID-19 pandemic. To start this journey, we first needed to understand the learnings that our community strategic leaders; who were part of the Emergency Operations Centre Response, took from their experiences during the pandemic response. We set about interviewing these strategic leaders and sort to understand the themes of their experiences and whether or not these themes had the potential to create impactful change in our communities.

Draft

Method

In our analysis, 24 Whanganui Strategic Leaders, all of whom had been involved in the Emergency Operations Centre Response, were interviewed using the interview questions displayed in Table 1. Interviews were semi-structured in that conversations with each leader were guided by the questions listed in Table 1. Although each interview began with Q1 and ended with Q3 conversations were not constrained by the interview guide so as to allow new questions or discussion points as a result of each participant's discourse. Both clarification ("What do you mean by…?") and elaboration probes ("Can you give me an example of…?") were used throughout each interview to both prompt the leaders in such circumstances and encourage clarity and richness of data. The Strategic Leaders were sent a copy of the interview questions along with their invites to the meeting at least three days prior to their interview and were asked to reflect on these questions. As can be seen in Table 1, we did not ask the leaders to reflect on the negative aspects of their experiences with the response phase to COVID19, these negative experiences are more readily available and recalled by the leaders (through our predisposition to the psychological negativity bias).

Table 1: *Reflection pre-interview questions for the Strategic Leaders*

Each of the strategic leaders were asked the following questions:

1. Have there been unexpected positive outcomes of this crisis?
2. Have there been unexpected positive outcomes of this crisis *for you*?
3. What changes have been made that you would like to keep once the crisis has ended?

Draft

During the interview, often directly following question 2, we asked the leaders if "there were any negatives that came about as a result of the COVID19 pandemic response"? This enabled the leaders to work through areas for improvement in the health sector in the future, should such an event such as the COVID19 pandemic occur again.

Unfortunately, at the stage that these interviews were conducted, we did not record the interviews and are therefore unable to provide verbatim analysis. Notes were taken during all interviews; in real time by a dedicated note taker, in a manner which provided the clearest account of discussions had within the interviews. The notes were reviewed by both the interviewer and the note taker to ensure the accuracy of the interview notes.

Participants – Strategic Leaders

We undertook face-to-face interviews with key strategic leaders involved in the COVID-19 response. Those interviewed were representatives from welfare, economic and health (DHB, primary and community health leads), the Emergency Operations Centre (EOC), and community leaders.

Table 2: Strategic leaders interviewed

Name	Area/role
Ian Murphy	Whanganui DHB Executive Leadership Team
Lucy Adams	Whanganui DHB Executive Leadership Team
Alex Forsyth	Whanganui DHB Executive Leadership Team
Rowena Kui	Whanganui DHB Executive Leadership Team
Paul Malan	Whanganui DHB Executive Leadership Team
Andrew McKinnon	Whanganui DHB Executive Leadership Team
Louise Allsopp	Whanganui DHB Executive Leadership Team, EOC Controller

Kath Fraser-Chapple	Whanganui DHB business development manager
Catherine Marshall	Whanganui DHB business development manager
Russell Simpson	Chief Executive Whanganui DHB
Wheturangi Walsh-Tapiata	Chief Executive Te Oranganui
Jonathan Murray	National Hauora coalition (NHC)
Dr Rawiri McKree Jansen	National Hauora coalition (NHC)
Stuart Hylton	EOC Controller
Lauren Tamehana	EOC Welfare response/recovery
Rhonda Morris	EOC Economic response/recovery
Leighton Toy	Whanganui District Council, Economic response/recovery
Daryn Te Uamairangi	EOC Iwi liaison response/recovery
Frank Bristol	Whanganui DHB consumer advocate
Patrick O'Connor	Medical Officer of Health
Steve Yanko	St John Ambulance
Rebecca Davis	Director and Impact Strategist at The Change & Innovation
Erena Mikare	Ruapehu Whanau Transformation
Nigel Allen	Whanganui Police

Draft

Data Analysis

The depth and richness of the interviews is best reflected through the use of both qualitative and quantitative methodologies. In order to objectively analyse the interviews, first these were both through a text analyser to provide the exact number of times that a phrase or word was mentioned throughout the interviews. We then conducted a qualitative analysis of the interviews by way of thematic analysis. This was to ensure that the stories, experiences and concepts provided insights by way of themes, into the areas of importance for the strategic leaders.

Text Analysis

Text Analysis, sometimes called text mining, is a type of quantitative analysis. Text mining is the process of exploring and analysing large amounts of unstructured text data aided by software that can identify concepts, patterns, topics, keywords and other attributes in the data. For the purposes of this report, we have structured this analysis as a complete word analysis (number of times mentioned) and an artificial intelligence (AI) key theme identification based on the text analysis. The key theme analysis is reported in terms of identified themes and percentages. These percentages can total greater than 100, due to the text analysis enabling sentences to be applied against multiple themes where appropriate. These themes were then collated into larger theme groupings where the same topics were mentioned.

Thematic Analysis

Thematic Analysis is a type of qualitative analysis. It is used to analyse and present themes (patterns) that relate to the interviews. It illustrates the data in detail among diverse subjects via interpretations. Thematic Analysis is considered most appropriate for studies that seek to discover using interpretations - providing a systematic element to data analysis. It allows us to associate an analysis of the frequency of a theme with one of the whole contents. Thematic Analysis gives an opportunity to understand the possibility of other issues more widely. Namey et al. (2008) stated, "*Thematic [analysis] moves beyond counting explicit words or phrases and focuses on identifying and describing both implicit and explicit ideas.*"

Thematic Analysis allows us to determine subjectively the relationships between concepts and compare them with the replicated data. By using thematic analysis, there is the possibility to link the various concepts and opinions of the leaders and compare these with the data that has been gathered in focus groups and wider community engagement.

The process for thematic analysis will follow a method of coding and verifying triangulation thematic mapping. Guest et al. (2012) describe four basic steps in undertaking thematic analysis:

1. Familiarisation with, and organisation of, transcripts.
2. Identification of possible themes (coding)
3. Review and analysis of themes to identify structures (coding and thematic analysis)
4. Construction of themes, constantly checking against new data (thematic analysis and triangulation)

The process of coding and thematic analysis is outlined in the following sections.

Coding

The data consisted of the notations taken throughout the 24 structured interviews. Drawing on principles and techniques from grounded theory, the data were read and reread several times and open coding was used to initially mark parts of the interviews that suggested a theme. The constant comparison method was used to determine whether a chunk of text would be placed in an existing theme or a new one. During this phase, we reviewed the coded data extracts for each theme to consider whether they appear to form a coherent pattern. The validity of individual themes was considered to determine whether the themes accurately reflect the meanings evident in the data set as a whole (Braun & Clarke, 2006). In the course of this phase, inadequacies in the initial coding and themes were revealed and required various changes (King, 2004). When we identified a relevant issue in the text not covered by an existing code, a new code was inserted. Through this process, if we found no need to use a code or if it substantially overlapped with other codes, it was deleted.

During this phase, it also became evident that some themes did not have enough data to support them or the data was too diverse. Some themes collapsed into each other while other themes needed to be broken down into separate themes. Selected themes needed to be refined into themes that were specific enough to be discrete and broad enough to capture a set of the ideas contained in numerous text segments.

Draft

Verifying triangulation thematic mapping

This process consisted of having two other people within the team read and then re-read the interview notes and undertake a thematic mapping process. These were then matched against the initial thematic analysis to ensure that the themes were consistent across the verifiers and the initial reported themes. If they matched, the theme was identified as a core theme, if they did not match these were moderated to either form part of a larger theme or became a subtheme within this report.

Results

Text Analysis

Have there been unexpected positive outcomes of this crisis?

The text analysis for this question had 3695 words analysed. The breakdown of the top five words mentioned were:

1. Community
2. Collaboration
3. Working
4. Iwi
5. Leadership

Collectively they attributed 7 percent of the total word count.

Key theme identification based on text analysis:

Main Topics:

- Working together/collaboration [*42.56%*]
- Focus on Community [*38.29%*]
- New ways of working (enablers such as technology) [*19.86%*]
- Social Leadership (governance) [*18.8%*]

Draft

Have there been unexpected positive outcomes of this crisis for you?

The text analysis for this question had 716 words analysed. The breakdown of the top five words mentioned were:

1. People
2. Family
3. Working
4. Home
5. Quieter

Collectively they attributed 6 percent of the total word count.

Key theme identification based on text analysis:

Main Topics:

- Working from home [*44.79%*]
- Need to be agile [*37.33%*]
- Focus on people and family (on what is important) [*31.36%*]
- Quiet time, slower pace of living [*25.4%*]

Have there been challenges or negative outcomes of this crisis?

The text analysis for this question had 759 words analysed. The breakdown of the top five words mentioned were:

1. Communication
2. Media
3. Working

4. Top-down
5. Lockdown

Collectively they attributed 5.5 percent of the total word count.

Key theme identification based on text analysis:

Main Topics:

- Concerns around returning to a top-down model for services and funding [*56.25%*]
- Concerns with how we communicated with the public [*34.38%*]
- Anxiety around the level four lockdown [*31.25%*]
- Problems with IT at home [*21.87%*]

What changes have been made that you would like to keep once the crisis has ended?

The text analysis for this question had 1597 words analysed. The breakdown of the top five words mentioned were:

1. Care
2. Communities
3. Collaboration
4. Change
5. Leadership

Collectively they attributed 5 percent of the total word count.

Key theme identification based on text analysis:

Main Topics:

- Care for the community in the community [*45.10%*]
- Changing the funding models [*41.36%*]
- Focus on the social determinants of Health [*25.57%*]
- Shared accountability and responsibility [*20.31%*]

Thematic Analysis

The coding of the interview data resulted in a total of 368 coded units. Through this coded data, four core themes and eleven subthemes were developed. The themes combined both the positive and negative experiential elements for the leaders during the COVID19 pandemic.

Core themes

- Collaboration between partners in care
- A focus on the community
- Technology as an enabler
- The ways we are working

Draft

Subthemes

- *Collaboration between partners in care*
    - Social Governance Leadership (shared responsibility and accountability to the community)
    - Changes to the funding models and service delivery
    - Focus on the social determinants of Health
- *A focus on the community*
    - Focus on people, whānau and communities
    - Care for people in the community
    - Strength of leaders
- *Technology as an enabler*
    - How we communicate with the community
    - Suite of services
- *The ways we are working*
    - Working from home
    - Taking time for ourselves and our whānau
    - The need to be agile in how we work

Collaboration between partners in care

Most leaders interviewed acknowledged the important role that the intersectoral partners, iwi and our partners in care had in working together to achieve thriving communities. The ability for rapid decision making to occur, the breaking down of organisational barriers and the capacity to work for the benefit of the community were all effective in our response to COVID-19.

Social Governance Leadership

The way that we, collectively, operate in an integrated manner across boundaries, across organisations and across the social determinants of health will directly impact on the health and wellness of the community. The leaders outlined that iwi worked together to support their whanau in a very responsive and agile manner. Furthermore, that the integrated response emergency operations centre provided the clarity to the strategic vision of social governance and how it could operate in a functioning setting.

"Social Governance model and the ability to further it, trial it and enact it early on. Shown that we had existing structures in place and are well placed to respond on an even bigger scale if needed in future."

"We were one of the only areas to operate as an integrated response and it worked well."

"Iwi have always supported, but from a distance. Now more of a vested interest, ensuring an iwi voice and solutions are informed from an iwi position."

"Biggest strength for us was a community-led EOC. Health has not dominated. Synergies in EOC which we should continue post-COVID. Opportunity to kick-start social governance space."

"Integrated response model at EOC – unique and great. Keep for recovery. Connectivity is key."

Draft

> *"System response (health, Government, formal). Whanganui has regional cross-sectoral working. Have gained understanding and trust to be able to go straight into response mode. Effective collaboration and collective thinking."*

Changes to the funding models and service delivery

The importance of, the way in which and the variation in the delivery of funding and services was outlined by many leaders as both an opportunity and concern going forward post COVID-19. A significant shift in the focus of funding and services from a 'top-down model' and 'widget counting' to a more sustainable, community and prevention focus based on outcomes was identified as important.

> *"Concerns about the end of funding and our ability to keep changes. Especially for those we have been supporting through welfare."*

> *"Funding and governance are key factors in any decision change for it to be sustainable."*

> *"Understand systems thinking more. Opportunity to embed these now. Continuously improve the way we work rather than going back to what the system knew."*

> *"The funding model has to be turned on its head - Primary care should be free and find ways to fund this that incentivises primary care/prevention."*

> *"Health and wellness focus where Whanau ora plans are made more available."*

> "Bo*ttom-up vs top-down operations were confusing at times. Sometimes the top-down directives gave no regard to local circumstances. Having to work through the national dictates slows things down."*

> *"Showed we can change at a local level. And once we have proven we can do it; we can do it again. Can't lose this traction. Strike while the iron is hot."*

> *"Integrated EOC model strengthened relationships and ensured the best outcomes for communities. The better connected we are the better we can utilise funding and resources."*

> *"Practice viability under current funding scheme is a significant concern."*

> *"The crisis has enabled rapid funding changes. Were able to quickly put money behind things and allow work to occur as needed (without funding worries). Financial barriers which previously existed were removed in order to support people/providers quickly."*

> "General decision making in a crisis much faster - really good. Replicate this after."

Focus on the social determinants of Health

The social determinants of health, also known as the contributory factors to poor health outcomes, was identified as a key topic. Not only the actions that we are undertaking to address these, but moreover our inactions. It was identified that health 'compensates' for the greater social determinants in-as-far-as that it operates as the 'ambulance at the bottom of the cliff' – leaders identified that through a collaborative approach with social governance partners that we can better utilise the communities strengths and a preventative approach to set up the barriers at the top of the cliff.

Draft

"We need to be active in our communities – asking what they want and keeping connected (health/business/social) – health has traditional not been at the table."

"Changes to the whole health system – a re-focus. COVID, health and disability system review are timely."

"Want a re-focus on better health for our communities rather than on deficits."

"Social determinants of health thinking – considering social, education, justice etc. (not just health) - housing strategy (essential for health)."

"Became aware that community didn't know what protective factors are (family harm, chronic disease, suicide etc.). Knowledge in health is in the system or with subject matter experts and requires a change in power dynamic – shifting the knowledge and information over to community. How do we build community wellness? Quote: "Well individuals belong to well whanau who live and participant in well communities." (Barry Taylor - Taylormade)"

"Healthy Families and Suicide Prevention work with community and intervention (and through this prevention). People are collaborating around prevention, mid-intervention and reflecting on how to deal with crisis."

"Huge willingness to collaborate on difficult issues. Prevention alongside crisis management is phenomenal. Shows willingness for transformational shift towards community-led."

"Talking about pai ora in non-health forums now too (heathy lifestyle approach), rather than deficit/unwell approach."

"Need to bring people together under a shared vision (rather than patch protection)."

Draft

A Focus on the community

The importance of the communities in determining and delivering upon what makes them healthy and well has been recognised as a key strategic driver in the way that we operate in the future. The strength in the response phase was that we worked closely with our communities and the community providers to support individuals and whānau to meet their own needs – this moved away from a traditionally organisational centric focus for the DHB and the councils alike. Moving forward, we must take the opportunity to engage with our communities to support them build resiliency and capability to ensure that they are able to achieve communities that are healthy and are economically and socially thriving. This cannot be about 'us doing it to them', but about partnering with our communities to achieve great things.

Focus on people, whānau and communities

He aha te mea nui o te ao? He tangata, he tangata, he tangata.

All of the strategic leaders emphasised the importance on focusing on our people. It was outlined that the biggest impact as a result of COVID-19 was on the people first, then the organisations. Through this focus, the impacts on our whanau and communities become evident, and the response that evolved was community owned – be that iwi looking after iwi, 'rouge' community groups supporting the vulnerable, or the simplicity of being kind to one

another. This people, whanau and community focus enabled the response team to get resources rapidly to where they were required – be that hygiene packages, food parcels, mobile pop -up clinics and CBACs or Personal Protective Equipment.

> *"Locally, Maori providers have been able to drive some community initiatives in direct response to need in their communities."*

> *"We naturally work well together as a community and work closely across sectors."*

> *"Been able to support the community in a different way through welfare. Communal vision for the betterment of the community."*

> *"We want resilient, self-determining communities. – Maori communities have gone after this and supported others to do so too. Build on this. Hasn't only occurred in Maori communities, but this is what I see from my position."*

> *"Different expectations from political, community and organisational levels made it difficult. It was easier to focus on our communities and support solutions to their needs."*

> *"Need commitment on both sides and good relationships. COVID has been the measure of this, and we have done well. The gradual process led by pro-equity gave us a strong platform."*

> *"Russ clearly articulated genuine need for relationship with community. COVID has created this in a meaningful manner."*

> *"The ability to deconstruct, reconstruct and mobilise the health system. Showed we can do this, and in a way that meets a need rather than in a systems approach."*

Care for people in the community

The COVID-19 pandemic necessitated a new way of working with our communities. No longer could we attend hui in person, hold appointments face-to-face (unless urgent and clinically relevant), or engage with our communities in traditional manners. Not all experiences in this transition worked as planned, and we have some learning opportunities as a system to undertake to ensure that in the future we are better prepared. However, despite some learnings, overall the providers and the community relished the opportunity to spend more time in their immediate communities. GP and hospital services moved to technological methods of interaction, welfare teams deployed staff to conduct food deliveries and many local groups undertook grocery runs for vulnerable members of their communities.

> *"Delay in patients seeking care. Know there is a huge clinical demand being built up in the community. Not yet seen this come into play."*

> *"Lots of changes: presentation numbers have reduced, change in demand, and moved to a virtual care environment."*

> *"The community and staff were not consulted about patients not coming into Te Awhina."*

> *"Important to differentiate between what clinicians want to do (e.g. care for dying person clinically best way/in hospital), and what whanau want (e.g. take on the challenge of caring for dying family member at home)."*

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"One solution we are looking into is pop-up clinics providing holistic care for whole communities (not just GP/clinic populations)."

"Community response - Consistently scanning social media and networks to see how community was responding. Powerful. Black-market response of generosity. Sharing food, caring for each other."

"Watching the natural generosity. People/businesses have been generous with food, time, money, assets to help this community and this has helped us to have a gentler ride through COVID here and mitigated a lot of hurt."

"The community can learn new ways of doing things. We already have rural communities doing things differently."

"Allowed better working with communities, building trust."

"Validated that the hospital demand is intertwined with social systems."

"Huge importance of tipping ourselves upside down and putting patients and whānau first. Hospital is important when needed, however focus needs to be in the community, and this is becoming more apparent. The Hospital did what any hospital would do – prepare for COVID. But biggest the action space was in the community."

"*Critical that community is the centre-piece."*

"Willingness of local suppliers to work with us. Very good people locally who we should maintain relationships with."

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Strength of Leadership

The fortune 100 leadership consultant and author Jay Richards penned as a result of COVID-19, that in a crisis "where some see doom and gloom, great leaders take the reins and make stuff happen" (May 8, 2020). Of the leaders interviewed, most outlined the importance of strong leadership during the crisis and more-so in our response to what 'the next normal' looks like. During the COVID-19 response, we saw the strength in leadership from individuals, iwi and communities – this enable agile decision making in sometimes rapid evolving situations (i.e. standing up of the CBACs). However, what this also highlighted for some, was the way that we have traditionally led may not be successful in the future post COVID-19.

"The crisis has shown who our leaders are, who can step up to the challenge, who can adjust well."

"Heartened by the level of trust across a range of leaders to the ways we look proactively at solutions - all informed by a Social Governance approach."

"Sowing the seed for Iwi leaders as to their importance in the heath space. From a national perspective the national directive has stepped up, which has resulted in a strengthened collective Maori leadership across DHB's."

"There is strength in the leadership working together, regularly connecting."

"In a time of crisis, iwi leaders activate themselves. COVID has brought leaders together to the point they are talking about establishing an iwi alliance, looking at what can they

do collaboratively across the motu to ensure they have a voice and are showing leadership in spaces (Te Ranga Tupua)."

"Clear that our leadership has been more focused on the hospital than on the system. Leader cohesion and communication can always be worked on."

"Horizontal integration – leaders from different sectors all working well together in EOC."

"'Shared leadership,' resulted from respect and equality."

"Firm leadership needed to maintain the gains. Group of leaders on same page with consistent messages."

"Leadership - Recovery will show a new way of doing things, it will help us to understand what is needed and who is best to do it."

"During COVID, at times we have had to make very quickly decisions, while other times we have had to wait for accurate info before moving forward. The principle is good, but long-term this is exhausting – we need to ensure we look after our leaders."

"We have community ground-swell. Movers and shakers ready for this. How to we nudge this and keep fueling this to keep momentum of change."

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Technology as an enabler

Technology has the ability to hold such promise in the age of iPhones, surface books and over the internet video calling - but often we find technology holds us back instead of enabling our organisations. Some of this is due to the way it is implemented, some is due to the upgrades or advancements not being prioritised, and some is how it is communicated/how we communicate. During the COVID-19 response, we saw rapid roll outs of new innovations and new technologies as a result of necessitation in the way we are expected to operate. However, with some of these rapid roll outs, we did not engage in sound change management processes to bring all our teams and the community on the journey.

How we communicate with the community

The strategic leaders mentioned the way that we communicate with the community as being enabled through technology. Although this is not a perfect fit in terms of technology as a theme, it does indicate how they, and the community engaged in the dialogue resulting from COVID-19. The analysis does outline that we can do better in terms of how we communicate, the speed and the frequency often being the areas for consideration. This is further emphasised in the way that we communicated with patients about '*how*' the changes to appointments etc affected them personally, or what it meant to use new technologies.

"Some patients believed that the telephone call was a 'pre-appointment' call, not realising it was the appointment itself."

"We need to communicate in a way that is understandable. Health jargon is not helpful."

"Will need to communicate with the community better in how it works and gain acceptance of new way of having an appointment."

"Always things to improve, e.g. Communication with people."

"Ensure messaging remains positive to support consumer confidence, e.g. Aroha local."

"Communication from the MoH to NZ public and the DHB's around a common purpose (fighting COVID) has shown strength and instilled solidarity."

"Telling members of the public to 'stay home' caused confusion. Some people have reported not going to the hospital even if they were sick due to them being told to 'stay home'. The communication needs to be worked on and localised."

Suite of Services

The COVID-19 pandemic enabled businesses and organisations to evaluate, redesign and develop new ways of interacting with members of the community – whether it was a shift to online shopping, online payments or online appointments. It additionally gave teams the ability to interact with one another through the use of teams, zoom conferences (also known as a 'zui'), and virtual desktops. In terms of Health, Telehealth advancements and utilization as a new way of interacting with patients was seen as a strategic leap forward. The leaders acknowledged that although most of the technological roll outs went well, some caused concerns around the lack of change management rather than the technology itself.

"Microsoft Teams worked well. Although additional support in the beginning about how it works would have been helpful"

"Remote access working. Worked well in a pandemic scenario too."

"When you have a burning platform you can suddenly get things done fast. E.g. IT space with Microsoft 365. Previously had only 100 staff able to work remotely, within one week we had whole DHB working remotely. Otherwise would have taken months to do this."

"Technology uptake by business community. Some have been forced to get on board and now have online services, new distribution routes etc."

"Enablement of technology and quick roll-out. Virtual desktop."

"Technology has been humorous at times."

"More succinct meetings via zoom, however we need to learn how to run good meetings using technology."

"Significant increase in DHB Zoom (25% of the increase is patient-related zoom)."

Video telehealth. But not everyone has webcam, zoom. Needs to be part of a suite of services rather than the only option."

"Zoom meetings e.g. with SMO's, GP's have been a great forum for discussing ideas."

"Telehealth, especially for allied and primary health is a game changer. What was traditionally 'too difficult' to implement occurred within a few days."

The ways we are working

The COVID-19 pandemic provided an opportunity to change the way we work and post COVID-19 it appears that flexibility and remote working is here to stay. When faced with the prospect of allowing employees to work from home or have no revenue coming in, many businesses suddenly adapted. When the DHB and councils faced an inability to operate in a face-to-face environment they enabled their staff to work from home, with connectivity back into their teams through the utilisation of

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technology. The leaders indicated that now's the time to build on those changes and how they'll apply long-term - however, there will always be a need for physical spaces for people to come together. We are still social beings and human contact is important for creativity, thought generation, mental health and wellbeing. There's no substitute for face-to-face contact.

Working from home

Many of the leaders acknowledged that due to some team members being considered 'vulnerable' that working from home was one way to continue to keep them engaged in the team environment whilst not physically being in the office. It enabled work to continue and for some staff, the environment enabled them to work more productively due to less distractions. For others, it provided flexibility and a sense of security that they did not need to work in the office and potentially be exposed to the virus. As previously mentioned in terms of technology, it was sometimes 'humorous' when working with it from home, but most of the staff made the best of it.

"Still felt connected to people when working from home."

"Felt more relaxed about working from home going forward into BAU work. Allows flexibility/ balance in work."

"Staff relaxed about working from home and are still able to work with sick children."

"Working from home, certainly is a nice home office."

"Staff flexibility working from home was greatly appreciated."

"Initial IT challenges but has improved."

"Focus on wellness in occupational health. Understanding staff vulnerabilities, helping get back to work."

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Taking time for ourselves and our whānau

COVID-19 brought the frantic pace of everyday life to a screeching halt in the matter of hours following Jacinda Ardern's Level 4 lockdown announcement. No longer could we rush to work, to a gym class, to a restaurant and then to the movies – and that was just a normal Monday. We were confined to our bubbles advised to 'stay home' and reconnect with those family/friends within our bubbles. The leaders advised how they saw families out walking and exercising together, parents were role modelling 'being kind', that neighbourhoods seemed safer and that life seemed all round quieter. Families came back together and reported enjoying this time together – infact, many leaders indicated that it would be nice to have more time to continue this post COVID-19.

"For whanau, while there may have been some increase in family violence etc., the majority have quite enjoyed the opportunity to be together. Some sad things around tangi, but also many positives around being a cohesive whanau. Many have moved to be with family during COVID. Allowed role-modelling within whanau."

"Many whanau moved home and many will stay home."

"Community reached out and focused on wellbeing/connectivity. E.g. hundreds turning up to karakia to connect with each other."

“Focus on wellbeing continues. E.g. young people reaching out, teaching karakia with Maori form of karate. How to prepare food.”

“Town feels safer, more relaxed neighbourhoods.”

“More people using walkways and a sense of a level of connection, cohesion, cooperation across communities”

“Communities taking responsibility for themselves. Meant the conversation was around ‘working together against COVID’ rather than ‘enforcement’ or ‘us vs them.’”

“Mokai Patea and Taihape did great work connecting with families. In fact, Iwi, NGOs and whānau all stepped up.”

“The pace was slower; the streets were quieter. I did not realise how tired I was until I could take time to slow down. The pace pre-COVID was unsustainable for many of us and would eventually lead to burn outs. In a strange way, COVID was a chance to reset – as individuals, whanau, environmentally and as communities. It would be a real shame to lose this again.”

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The need to be agile in how we work

When the ground shifts, it pays to be agile

As the COVID-19 pandemic has rippled across and impacted the world, challenges that once existed in the background are being brought into the spotlight. One of those is the critical value of an agile operation that identifies and adapts to rapid change. We define “agility” as the ability to reconfigure strategy, structure, processes, people, and technology quickly toward impact-creating and impact-protecting opportunities. The uncertainty brought on by COVID-19 requires organisations to recognise leadership, employee and communities sentiments and explore new ways of working towards ‘thriving communities’. In the not-so-distant past, local government and crown agencies were viewed as slow moving, bureaucratic beasts who did not easily change in an environment that requires it (akin to turning the titanic). However, throughout the response phase and into recovery, the leaders identified that the old play book needed to be reworked and a new, more agile focus was required.

“COVID has highlighted governance policy, procedural issues, which need to be brought up to speed with the modern-day.”

“We proved that we could remove barriers to getting things done quickly - especially for logistics, payments. This should not be lost.”

“The inability to see our patients in person has forced us to look at how to do things in the community.”

“Ensuring the pace we are moving is manageable, sustainable long-term and thorough planning still exists.”

“Huge potential going forward working collaboratively.”

“We have to remain agile in the way we work together for our communities. Through COVID our communities have come to expect this, and we cannot go back.”

"Within regional spaces there is room for more agile arrangements."

"Should be a continuous learning system and embedding learnings, therefore we need quality improvement. DHB could have been more agile, used more co-design."

"Initiatives have led to thinking about an alternative future, e.g. hubs doing lots of activities, staying in touch with patients, whanau-looking, MDT meetings, etc."

"Don't go back to old ways. Understand what didn't go well in our changes e.g. telehealth, and address it. – don't use it as a reason not to keep changes."

"Changes to the whole health system – a re-focus. COVID, health and disability system review are timely. We want a re-focus on better health for our communities rather than on deficits."

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Insights into the next normal

The COVID-19 pandemic has enabled a systemic rethink about how we deliver services to our communities and our customers. As we step into the post-coronavirus future, we will need to find a balance between what worked before and what needs to happen to succeed in the next normal. Collaboration, flexibility, inclusion, and accountability are things organisations have been thinking about for years, with some progress. But the massive change associated with the coronavirus could and should accelerate changes that foster these values.

The strategic leaders interviewed collectively agree that the future post COVID-19 has changed as a result of the crisis. Many indicated that the integrated approach to the pandemic response was a way of working that needed to continue to address the wider social determinants of health, it needed to become 'the way' of working – the next normal. As a result, the formation the strategic Integrated Social Governance Leadership Team (ISGLT) will continue to provide a platform for collaboration as we move into the next normal.

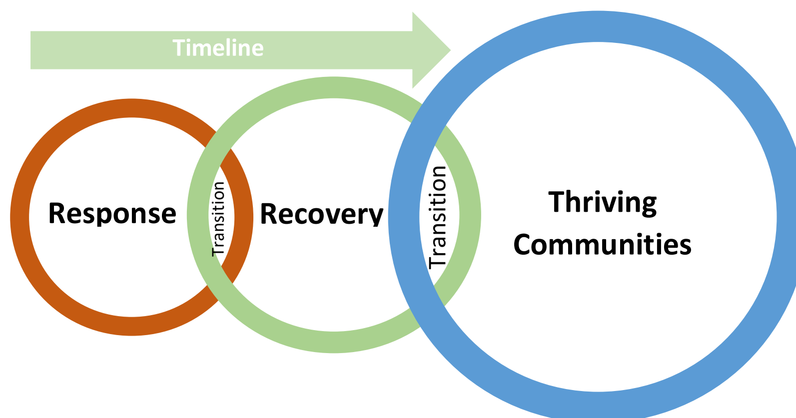
The next normal – the need to engage with the community

The direction indicated from central government is a move towards a more community centric model. We will be required to engage more, and enable community led services based on individual community needs. These services will be required to be impactful in terms of how they support the health and wellness of our communities – to enable thriving communities. The integrated recovery team is currently undertaking widespread community engagement to better inform the next normal. However, the community engagement does not stop following the official recovery phase – it is iterative and will ensure a continuous feedback loop is created between our organisations and the communities to whom we support.

The next normal – the transition from Recovery to Thriving Communities

The direct effects of COVID-19 in terms of health, social and economic wellbeing will be with us for generations to come. The Recovery Phase under the National Civil Defence Emergency Management (NCDEM) protocols involves the co-ordinated efforts and processes used to bring about the short, medium and long-term holistic re-generation and enhancement of a community following an emergency. As with the response phase of the COVID-19 pandemic with its extended periods of waiting for a potential viral wave, the recovery requires a new way of operating which operates with the future community impacts in mind. Figure 1 represents the transition phases between response (4 weeks), NCDEM recovery (12 weeks – based on regional CDEM determination) and Thriving Communities (the next normal).

Figure 1 – transition phasing



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As a result, within the Whanganui rohe, the transition from the NCDEM recovery phase into the next normal is being supported by the Integrated Recovery Team and the Integrated Social Governance Team as we move towards an integrated 'Thriving Communities' team. This team will be focused on short, medium and long term positive, sustainable community impacts and whose membership is representative and supported by the organisations who are committed to the ISGLT and framework.

The Integrated Recovery Team have been able to identify 'quick wins' within the community and action these, as well as begin the wider community engagement about what keeps them healthy and well. This report as a result of the Strategic Leader Interviews, along with the analysis of the community engagement will support the transition into the future as we identify the key health, social and economic contributories that are preventing us from achieving communities that are vibrant and sustainable. The 'Thriving Communities' team will work in partnership to identify existing plans, support networks and advisory committees to reduce duplication, uncover 'blind spots' and strengthen community relationships. The result will be a set of truly collaborative, community led, impact focused plans to address the needs of our communities.

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Integrated Recovery Team

COVID-19

From Response to Recovery – the next normal.

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Patient experience survey of face-to-face and telehealth appointments during the Level 4 COVID-19 Lockdown.

Report Team

Jessica McGregor - Patient Safety, Quality and Innovation (Interviewer and Author)
Steve Carey - Strategy, Commissioning and Population Health (Design and Methodology)

Purpose

The purpose of this report is to advise the Whanganui District Health Board (WDHB) of the effectiveness from the patient perspective, of the face-to-face and telehealth appointment services, provided to patients during the COVID-19 lockdown period.

During the COVID-19 lockdown period most patients of the WDHB were unable to attend the Whanganui Hospital for planned assessments and consultations. These patients were given the opportunity to complete their appointments with WDHB staff using a telehealth stream – using either a telephone or video format.

The COVID-19 lockdown period has given the 20 DHBs an opportunity to utilise technology as never done before within the New Zealand health system. Now that the health system is progressing to a post-COVID-19 format it is important to formulate a record indicating the effectiveness of these appointments.

There is no readily available record of how many consultations occurred during this time period. This means the most effective form of research that can be completed is a descriptive study

Materials and Methods

The study used a descriptive design.

A sample population of 50 WDHB patients who had face to face, telephone or video consultations during the lockdown period completed a telehealth questionnaire. The participants were selected based on their ethnicity and their cognitive ability to answer a telehealth questionnaire. Inclusion criteria included the ability to communicate and those who were contactable within general working hours.

Participant identification details were provided by the hospital Outpatient Department to a registered nurse in the Patient Safety, Quality and Innovation team. Chosen participants were called by the registered nurse and asked to provide feedback of their experience of a telehealth or face-to-face appointment that they had with WDHB staff during the COVID-19 lockdown period. The purpose of the study and demands on the participants was explained prior to receiving their verbal consent. Patients were advised that identifying details would remain confidential.

The telehealth surveys were conducted between 12 and 15 weeks after the consultation.

Collated feedback focused on strengths and weaknesses of both the telehealth and face-to-face service offered by the WDHB during the COVID-19 lockdown period. Patients were also questioned on areas of improvement and encouraged to advise of challenges and barriers that occurred around their appointment. Information on this feedback is described in the next section.

Please see Appendix A to view the Telehealth Questionnaire.

Patient contact during lockdown occurred via telephone, video or face-to-face consultation. Please see Appendix B to see the breakdown of information gathered from the feedback questionnaire.

A similar report by the 'Consumer Leadership Team: Auckland DHB Mental Health and Addictions Directorate' collated feedback from their service users, as regards their experience of telehealth during the lockdown period. Please see Appendix C to view this report.

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Results

General information

Participant socio-demographic data was obtained during the questionnaire. This information can be found below, under the headings of gender, age, ethnicity and home location. Consultations and appointments occurred via face-to-face, telephone and video formatting. One respondent cancelled her appointment and has been included as other. Percentage of the cohort who fit into each category has also been included.

GENDER PROFILE		
Gender	Count	Percentage
Female	31	62
Male	19	38

AGE PROFILE		
Age	Count	Percentage
0-14	1	2
15-24	5	10
25-34	4	8
35-44	2	4
45-54	5	10
55-64	15	30
65+	18	36

ETHNICITY PROFILE		
Ethnicity	Count	Percentage
NZ European/Pakeha	23	46
NZ Maori	23	46
Other	4	8

LOCATION PROFILE		
Location	Count	Percentage
Rangitikei	12	24
Ruapehu	2	4
Rural Whanganui	2	4
South Taranaki	3	6
Whanganui City	31	62

CONSULATION/ APPOINTMENT PROFILE		
Medium	Count	Percentage
Face to face	4	8
Telephone	32	64
Video	13	26
Other	1	2

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Qualitative Variable Results

Overall, appointment experiences during the COVID-19 lockdown period were reported as positive. Participants utilised a 5-point Likert Scale to inform their appointment satisfaction level. A scoring of one corresponded to being 'very dissatisfied' while those who stated five were 'very satisfied' with their appointment. More than 83% of participants reported feeling 'satisfied' or 'very satisfied.' 10% of respondents reported feeling 'neither satisfied nor dissatisfied' with their experience. Two participants (4% of respondents) reported feeling 'dissatisfied.' One respondent (2%) reported feeling 'very dissatisfied' with their appointment.

One patient cancelled her appointment as the reason for the assessment was no longer applicable. She had been contacted as the cancellation was not included in the provided Outpatient Department data. She has been included in the study. Her information has not been entered in the below chart due to limitations of the telehealth questionnaire: The registered nurse was unable to continue using the questionnaire programme once it was indicated the patient did not attend an appointment. The patient verbalised during the questionnaire that she was very satisfied with her experience pre-appointment cancellation.

SATISFACTION RATING: TELEHEALTH vs FACE TO FACE						
	Very Dissatisfied	Dissatisfied	Neither	Satisfied	Very Satisfied	Number of appt.
Telehealth	1	-	5	7	31	44
Face to face	-	2	-	-	3	5
Total	1	2	5	7	34	49

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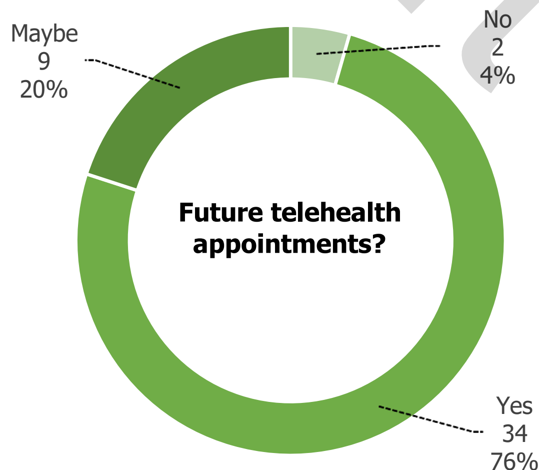
Of the participants who had telehealth appointments, 34 stated that if given the option, they would like to have a telehealth appointment in the future. Nine participants responded 'maybe' to the option of having another telehealth appointment. Two participants stated that they would not like to have another telehealth appointment.



Descriptive results

The data collected gave rise to two main themes and six sub-themes. These themes centre on participant experience, as remembered after the fact.

Theme 1: *Effective consultation*

Most participants reported being satisfied with the health appointments provided during the COVID-19 lockdown period. The ease of access and convenience of being able to speak from the comfort of their own home, and the benefit of being able to communicate their medical concerns with medical personnel was mentioned repeatedly during the feedback conversations.

Sub-theme 1: *Ease of access and convenience*

Most respondents reported that gaining access to appropriate technology for the consultations and assessments was easy.

> "*Everything worked well. There was a problem at one point with the audio but it was fixed easily and we were able to have a laugh about it. Got the information I needed and it helped"*

> *"You have a phone in your pocket all the time and no matter what you are doing you can pick it up and talk – you don't have to shower and get changed and come to the hospital. It is more convenient… it saves time and money and it works great"*

Some said that they would prefer to continue video and telephone conferencing unless face-to-face was required. One individual noted that due to her immunosuppression, social distancing was especially important. She stated that it was: "*good [if telehealth is] offered in the future because waiting rooms in hospital would not be full.*"

Due to the breadth of the Whanganui district, some patients are required to travel long distances to attend the hospital. Participants reported their appreciation of not having to make this trip. Others appreciated not having to organise work around their appointment.

> *"It was nice to not have to drive from Ohakune for the appointment"*

> *"I would definitely consider a Zoom call again due to convenience. I don't have to travel and can get dressed and go to the next room for the appointment. I didn't want to leave the house so soon after my surgery so it was perfect"*

> *"I have to rely on my kids to get to my appointment because I can not drive anymore. The telephone appointment means that I do not have to rely on them"*

> *"I am happy to be able to have the consultation from home or work"*

> *"It is a 30-35 minute drive over to the hospital which I don't mind, but at the end of the day it is easier for me to do the consultation on the phone"*

> *"I use a wheelchair and telehealth is a great option because it eliminates issues around accessibility"*

Patients who were unable to attend the hospital due to physical limitation, childcare availability, financial concern or work constraints reported a preference for the telehealth medium over the traditional face-to-face option.

Sub-theme 2: *Benefit of communication with medical staff*

Psychological wellbeing was a large concern during the COVID-19 lockdown, where people were unable to complete heretofore activities of daily living. Some participants expressed their surprise and happiness that they would have post-procedure follow-up-care, stating that they had believed that with the lockdown, this would not be happening. Some participants expressed their concern of attending the hospital during COVID-19 lockdown.

> *"The fact that the appointment wasn't cancelled because of COVID-19 was brilliant"*

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"It was good having a close connection with the doctor and being able to talk to them"

"I was happy... Because of COVID-19 I did not want to go to the hospital"

"I was happy to do the phone call, especially during the COVID time"

"Especially during COVID-19 I did not want to attend the hospital"

"It was great that I could still have my appointment even though we were in lockdown. I was not able to attend the hospital and staff were not able to come to my house. If this happened again it is good to know that I can still have my appointment"

Theme-2: *Ineffective consultation*

Issues raised by participants around telehealth appointments included but was not limited to; appointments that felt hastened, the feeling of being brushed off by medical personnel, the ineffectiveness of medical assessments without the physical aspect, limited access to technology, poor reception in rural areas and lack of whānau involvement.

Sub-theme 1: *Lack of technology and connectivity*

Inefficient technology and poor connectivity were themes that were repeatedly mentioned during feedback sessions. Some respondents reported that family members had to set up video conferencing for them. Others, particularly those living rurally, mentioned poor connectivity.

"There was a problem with the internet speed where voice and mouth movement were happening at different times. [I] could hear the feedback of her voice about 15 seconds after they were actually spoken"

"[The] computer is a wee bit old and a couple of appointments we had I found it hard to get the sound going - although I could see a picture I couldn't hear. So we spoke on the phone and used the internet to see each other"

"[I am]... not great with technology and without [my] wife to set the programme up would have struggled"

"I'm a face-to-face person and don't like talking to a machine because to me at my age it is unnatural"

Sub-theme 2: *Whānau involvement*

14% of respondents stated that whānau presence would have been preferred for their consultation. These respondents included a patient who attended the hospital for their obstetric appointment:

"It is my first pregnancy and I have twins – would have been nice to have a support person"

One feedback participant was the mother of a pre-teen patient. The telephone consultation occurred between the physician and the patient's mother only. The patient asked to speak to the physician and was disappointed because she didn't get the opportunity to talk.

"I didn't really understand the terminology of the doctor. I was answering a lot of questions about my daughters' well-being. Because he [the surgeon] couldn't assess her himself we couldn't ask questions regarding how long it would take for my daughter to be able to walk properly again [fractured leg]… She has been asking lots of questions since surgery and really wanted to talk to the doctor - there wasn't the opportunity during the brief 1-minute conversation that I had with him over the phone… My daughter wanted to ask questions and felt that she wasn't able to over the phone - she wasn't given the opportunity."

Sub-theme 3: *Breaks in communication*

There was feedback that reported breaks in communication where respondents were not contacted when they were told they would be or where they were not given sufficient information to be able to complete their appointment.

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"I was advised the appointment would be at 11am and it was not until 4pm. When I questioned this I was advised by the obstetric team that it was presumed that due to COVID-19 I would be at home anyway so calling late was not problem. It was a problem for me, especially with 3 kids at home and having to have them occupied and out of the way"

"I was sent instructions to set up the consult. This was very useful. There was an issue with break in communication where I was told that I would receive the information a week prior to the consultation. By the day before the consult I still had not received the information. I contacted the clinic and was sent the appropriate details straight away"

"I have hearing problems and people when they talk need to talk louder. So it would be good to advise me beforehand so that I am home for the call – the home phone has a speaker"

Others were concerned that they had not been offered the use of a video conference which meant that a physical concern was not able to be visualised by the medical professional during the consultation.

"If it was video there would be no barriers. I would just use Apple or Zoom or whatever"

"There was no physical examination and I feel that this was needed"

"I am very much a face to face person and while the physician was very good at reading my voice and my comments I felt the requirement to connect emotionally by being face to face. I was not offered to use Skype which would have been preferable to telephone consultation"

"I would have liked to have been given the option of Skype which did not happen"

"I was not given the option of having a video consultation. I would have preferred to do that"

Sub-theme 4: *Disconnect with ownership of rehabilitation pathway*

Some participants who had teleconferencing reported a disconnect with the health professional which then lead to an unsatisfactory treatment pathway.

"I much prefer face to face because then I feel like I am taking part in my health"

"I had no idea what was going to happen… I didn't get an answer to my question – which was the whole point of the consultation"

"I was not happy with what he said to me. I would have liked to have seen him face to face. I felt like I was being brushed off. I have lost my job because of this and am unable to work until this is fixed. I felt like I had no say in the matter – it was what he said and now it's done and dusted. There was no physical examination and I feel that this was needed"

"It was really fast – like 5 minutes and I was glad it was by phone because my husband and I would have been really annoyed if we'd taken time off work and with the travel involved for a 5-minute conversation"

Discussion and Recommendations

The findings of this study showed that most participants were satisfied with their consultations and appointments with WDHB staff during the COVID-19 lockdown period.

As the number of patients who had assessments and consultations with WDHB staff during lockdown is an unknown variable, it is not possible to know what a statistically significant sample size would be. It can be assumed however, that 50 people would not be enough to represent the target population.

All patients who took part in the questionnaire stated that no cultural barriers were noted in the conduction of their WDHB appointments and consultations during COVID-19.

Most of the respondents for this study were aged older than 56 years. Another large group of respondents were obstetric patients who are currently at home. The reason for this high number in responses is likely to be a correlation with those who are contactable from 8am until 430pm; the hours during which the telehealth questionnaire was conducted.

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The time period between health appointment and telephone questionnaire is a concern. As this time increases, so too does the potential for patient recall error (Dalziel et al., 2018). For this study, there was a 12 to 15 week time lapse between consultation and questionnaire phone call. For future studies it is advisable that this gap in time be decreased.

A drawback of the consultations was that respondents stated they were not given the option of an appointment medium. Some declared that they would have preferred a video format rather than the telephone. The video consultations were offered by the physiotherapists and the occupational physician only.

The registered nurse who made the phone calls for the telehealth questionnaire counselled two respondents who were dissatisfied with their telephone consultations, as follows

- An older male patient was laid off from his workplace last year for an operable condition. He reported that he has been advised by other companies that he is viewed unemployable until he has had the operation. He has financial concerns and stated that he had been looking forward to seeing the surgeon to 'get the ball rolling'. Sight unseen, the surgeon advised him over the phone that he would not be having any procedures until the issue was 'a problem'. The patient was concerned as he is the main source of income in his household. During the questionnaire, the patient described his issue to the Registered Nurse who then advised him to see his general practitioner (GP) and ask for a second opinion, which would include a physical examination.
- Similarly, a middle-aged woman described to the registered nurse a physical malformation that sounded concerning enough that she was advised get a second opinion via the GP. This patient described the fantastic 'bed manner' of the surgeon on the phone but said that her questions regarding the malformation were not answered. Sight unseen, the surgeon advised her that she should wait until the symptoms worsened. The symptoms as described during the questionnaire phone-call sounded potentially neoplastic.

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Both respondents stated that they would have liked to have been offered a video consultation with the surgeon so that their conditions could be visualised. It is a concern that these two potential 'misses' were caught by chance and raises the following questions: how many 'misses' occurred during the lockdown; and should telehealth video consultations or face-to-face contact be a requirement for initial consultations and telephone consultations be limited to follow-up only.

When patients are in a waiting room, they can speak with a receptionist or telephonist when prior appointments run overtime. It was reported by two respondents that their Telehealth consultations were late – one of these by five hours. Both respondents reported that they thought they had been 'lost in the system'. If the option of telehealth consultations and appointments continues, a clear communication platform indicating appointment time and date will be required. This platform should allow for further communications with change to appointment time.

Some respondents did not have the internet or phone reception, or the technology appropriate for a video consultation. It will be important to consider the equitable availability of technology should telehealth be considered in the future.

Due to the wide dispersal of patients and the breadth of the Whanganui DHB area, telehealth should be considered as an optional medium for health consultations in the future. Telehealth consultations and appointments enable patients from rural areas to have near-equitable care to those who are more readily able to attend the Whanganui hospital.

Appendix A
Telehealth Questionnaire:

1. Gender?
2. Age Range?
3. Ethnicity?
4. Location (by TLA)
5. Did you attend an appointment with DHB staff?
6. Was your appointment:
   - in person (at hospital)
   - in person (at your location)
   - via telephone
   - via videolink (teams, zoom etc)
7. What was the reason that you could not attend your appointment?
8. Were you given the opportunity to attend this appointment by telephone or videolink?
9. Were there particular reasons for you wishing to attend a face-to-face meeting?
10. If you had been given the option to attend by videolink or telephone, would you have taken this option?
11. What are some of the reasons why you would not attend by videolink or telephone?
12. What are some of the reasons why you would like to have attended by telephone or videolink?
13. What telehealth service did you receive?
14. What was the service that you received telehealth for (physio, general practice etc)
15. Prior to your telehealth appointment were you given any material to help prepare for your appointment/consultation?
16. Was this useful?
17. How could it have been improved?
18. In the future, how would you like to receive information prior to your appointment?
19. Would you have liked to receive information prior to your appointment?
20. In the future, how would you like to receive information prior to your appointment?
21. What information should we have included?
22. Can you tell us more about how this appointment was for you? What worked well for you? What didn't?
23. Would you have liked someone with you?
24. Did you have any concerns or difficulties getting started with the barriers in relation to your online telehealth appointment?
25. What were these concerns?
26. Would you consider having another telehealth appointment in the future?
27. Can you please tell us more about why you feel that way?
28. If the option of telehealth appointments continued, how could things be improved?
29. How would you rate your experience of your telehealth appointment/ consultation? On a scale from 1 = very dissatisfied, to 5 = very satisfied
30. Do you have any other feedback to offer about these types of appointments in general?
31. What was the service that you received your face to face appointment for (physio, general practice etc)
32. Prior to your face-to-face appointment, were you given any material to help prepare for your appointment/ consultation?
33. Was this useful?
34. How could it have been improved?
35. In the future, how would you like to receive information prior to your appointment?
36. Would you have liked to receive information prior to your appointment?
37. In the future, how would you like to receive information prior to your appointment?
38. What information should we have included?
39. Can you tell us more about what your appointment was like for you? What worked well for you? What didn't?
40. Would you have liked someone with you?
41. How would you rate your experience of your face-to-face appointment/consultation? On a scale from 1=very dissatisfied, to 5=very satisfied
42. Do you have any other feedback to offer about these types of appointments in general?

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Appendix B
Breakdown of respondent answers:

AGE	LOCATION	ETHNICITY	GENDER	COMMUNICATION MEDIUM	SATISFACTION LEVEL	TELEHEALTH AGAIN?
0-14	Whanganui City	NZ Maori	Female	Telephone	3	Maybe
15-44	Rangitikei	NZ Maori	Female	Telephone	3	Yes
	Ruapehu	NZ Maori	Female	Telephone	5	Yes
	Whanganui City	NZ Maori	Female	In person (at hospital)	5	N/A
	Whanganui City	NZ Maori	Female	Telephone	5	Yes
	Whanganui City	NZ Maori	Female	Video	4	Yes
25-34	Rangitikei	NZ European	Female	Telephone	5	Yes
	Rangitikei	Samoa (other)	Female	Telephone	5	Yes
	South Taranaki	NZ European	Female	Telephone	5	Yes
	Whanganui City	NZ Maori	Male	In person	5	N/A
35-44	Whanganui City	NZ European	Female	Telephone	4	Yes
	Whanganui City	NZ Maori	Female	Telephone	5	Yes
45-54	Rangitikei	NZ Maori	Female	In person (at hospital)	2	N/A
	Rangitikei	NZ Maori	Female	Telephone	3	Maybe
	Rural Whanganui	NZ European	Female	Video	5	Yes
	Whanganui City	NZ European	Female	Telephone	5	Yes
	Whanganui City	NZ Maori	Female	Reason for appointment no longer present		
55-64	Rangitikei	NZ European	Female	Video	5	Yes
	Rangitikei	NZ European	Female	Video	5	Yes
	Rangitikei	NZ European	Male	Telephone	5	Yes
	Rangitikei	NZ European	Male	Telephone	5	Yes
	Rangitikei	NZ European	Male	Video	5	Yes
	Rangitikei	NZ Maori	Female	Telephone	5	Yes
	Rural Whanganui	NZ European	Female	Video	5	No
	South Taranaki	NZ Maori	Female	Telephone	5	Yes
	Whanganui City	NZ European	Female	In person	5	N/A
	Whanganui City	NZ European	Female	Telephone	5	Yes
	Whanganui City	NZ European	Female	Video	5	Yes

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	Whanganui City	NZ European	Female	Video	4	Yes
	Whanganui City	NZ European	Male	Telephone	1	No
	Whanganui City	NZ Maori	Female	Video	5	Yes
	Whanganui City	NZ Maori	Male	Telephone	4	Maybe
	Whanganui City	NZ Maori	Male	Telephone	5	Yes
65+	Rangitikei	Welsh (other)	Male	Video	4	Yes
	Ruapehu	NZ Maori	Female	Telephone	5	Yes
	South Taranaki	NZ European	Male	Telephone	3	Maybe
	Whanganui City	Ireland (other)	Male	Telephone	5	Yes
	Whanganui City	NZ European	Female	Telephone	5	Yes
	Whanganui City	NZ European	Female	Telephone	5	Yes
	Whanganui City	NZ European	Female	Video	4	Maybe
	Whanganui City	NZ European	Male	Telephone	3	Maybe
	Whanganui City	NZ European	Male	Telephone	5	Yes
	Whanganui City	NZ European	Male	Video	5	Maybe
	Whanganui City	NZ Maori	Female	Telephone	5	Maybe
	Whanganui City	NZ Maori	Male	Telephone	2	Maybe
	Whanganui City	NZ Maori	Male	Telephone	5	Yes
	Whanganui City	NZ Maori	Male	Telephone	5	Yes
	Whanganui City	NZ Maori	Male	Telephone	5	Yes
	Whanganui City	NZ Maori	Male	Telephone	5	Yes
	Whanganui City	USA (other)	Male	Video	4	Yes

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Appendix C
Auckland DHB Initial Telehealth Service User Report (2020)

Consumer Leadership Team: Auckland DHB Mental Health & Addictions Directorate

Telehealth QIP Report: Service User Feedback

May 2020

1

CONTENTS

He Mihi 2
Introduction 3
Executive Summary 4
Methodology and Analysis 5
Methodology 5
Data Analysis 7
What's Working Well? 9
Ease of Access and Convenience 9
Psychological Benefit 9
Staff Attitudes and Qualities 10
Challenges and Barriers 11
Technology and Logistics 11
Communication Barriers 12
Limitations with Group Activities 13
Other Key Points 14
Sampling Limitations 15
Equity 16
Summary 18
Discussion and Recommendations 18
Appendix A: Questionnaire 20

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He Mihi

Anei tātou nā ko te pō, anā tātou nā he rā ki tua, tihei wā mauri ora!

E mihi ana ahau ki a koutou e hoa mā, e whānau mā, e ngā tangata mātau ā-wheako, e ngā tangata whai i te ora katoa.

Anei ā koutou whakaaro, anei ā koutou kupu, anei ā koutou kōrero.

Mei kore ake mā koutou, mā wai tēnei mahi? E hoa mā, ko koutou te ngākau o te toka tumai.

Mā koutou tēnei pūrongo.

The COVID-19 pandemic has changed the national landscape over the past couple of months. For many New Zealanders, it has impacted our mental wellbeing and how we access services and support. Telehealth has become a new normal for service engagement, and it is imperative that the voices of those who use it, are central to future development of mental health best practice. Above all else, respect for choice and self-determination must be upheld in the pursuit of improving accessibility.

I want to mihi to those who participated in this quality improvement project. These are your thoughts, your words and your stories. If it were not for you then this project would not have been possible. This is your report. Many thanks also to the *NAMHSCA* whānau who shared their processes and findings that ended up assisting the ADHB MH&A directorate to undertake similar co-design approaches. To the *Consumer Leadership Team* (transitioning into the *Recovery Consultants*), you have risen to the occasion during this quality improvement project. You have shown your passion, professionalism and poise in a tight-turnaround situation. Tēnā rawa atu koutou.

Turou Hawaiki,

Aaryn Hulme-Niuapu

Service Manager – Consumer Leadership Team

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Introduction

3

Service Engagement During Lockdown

The COVID-19 Pandemic has had a substantial effect on service engagement throughout all twenty DHBs and their MH&A directorates. Throughout the country, consumer advisors/leaders have been working collaboratively with MH&A services to make sure the voice & experiences of service users are pivotal in analyzing the present (and future) use of telehealth.

Three-Month Action Plan

This report details the process, findings and recommendations of a telehealth *quality improvement project* (QIP), that focused on an initial scoping of ADHB MH&A service user experience. It is part of several actions belonging to the *Tele-Mental-Health Workstream* which filters into one of the directorate's key work areas for the next three-months (as well as linking into the ADHB's drive to build upon recent telehealth gains and success). This initial push for getting a snapshot of service user experience is the result of the ADHB ELT wanting to focus in on two key enablers for its 3-month action plan. Equity is one of the key enablers and patient/service user & whānau experience is the other.

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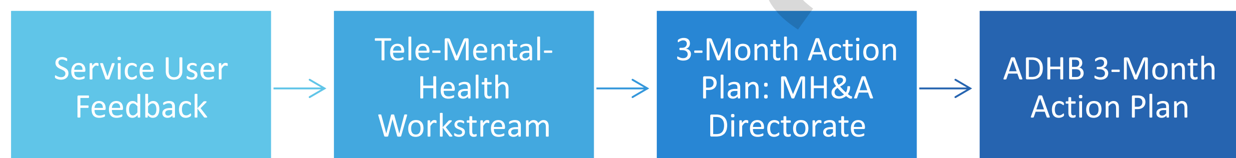

Executive Summary

4

Overall, the participants who provided feedback represented a diverse group of people across genders and ethnic groups. A few limitations with the sample size not representing diverse age groups were identified, however, these were expected due to the quick nature of the initial phase of the project. Most participants reported positive views on their telehealth appointments and would consider continuing with them in the future, post-COVID restrictions, as well.

The positives identified were: ease of access and convenience in having virtual consultations, psychological benefit and the alleviation of anxiety as people were able to stay indoors and be safe, while it ensured that people had a degree of social connection with their clinical teams and through group activities to prevent further social isolation. Positive staff attitudes and qualities were also commended and described as a key factor in facilitating a positive experience of the telehealth appointments.

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Some of the challenges and barriers in accessing telehealth appointments identified were related to utilizing technology and the logistics with setting things up, the financial costs involved and the impact of this on the disadvantaged, barriers to virtual communication, limitations of groups and activities facilitated online, and the difficulties in opening up and being able to read body language and other physical cues.

Equity has been ear marked as a key enabler for the ADHB 3-month action plan. Māori & Pacific communities have been highlighted as populations of focus for ADHB equity work. There were three main equity themes from the feedback data: 1) taonga tuku iho – cultural safety; 2) kia piki ake i ngā raruraru o te kāinga – material accessibility; and 3) tausi le va tapuia – a new way of connecting.

Overall, experiences were largely positive, and we end this report by highlighting a few considerations and recommendations for the District Health Board to consider when moving forward with using telehealth as an option for clinical appointments.

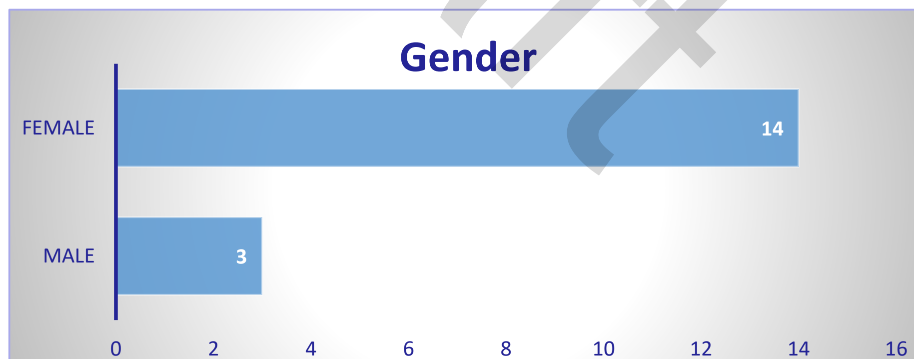
Methodology and Analysis

5

Methodology

The initial target sample size of the Telehealth QIP, was pitched to encompass and include the views of 20 service users. To date, the Consumer Leadership Team (CLT) have been provided consent from 17 service users. Key workers and lead clinicians from these services, provided CLT with the names and phone contact details of these 17 service users and the CLT managed to collate and collect feedback data over the phone, from all 17 consenting service users. Individuals provided verbal feedback over the phone and responses were entered the questionnaire on Qualtrics by the CLT, for ease of sorting through data. Questionnaires were completed on Qualtrics and data was extracted. Please see Appendix A for the full length of the questionnaire used.

The findings of this initial Telehealth QIP report encompass and incorporate the views of these 17 service users. The demographic characteristics, distribution and variations in age, gender and ethnicity, are detailed in the charts below.



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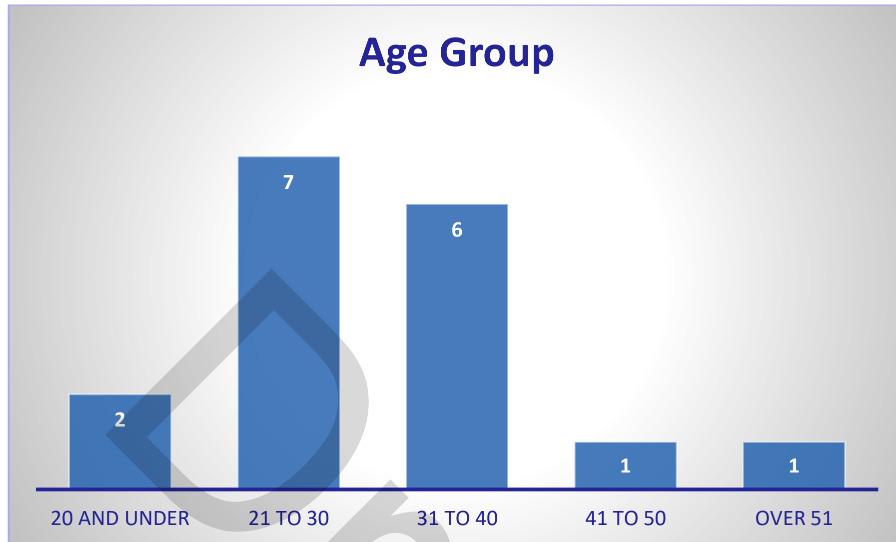

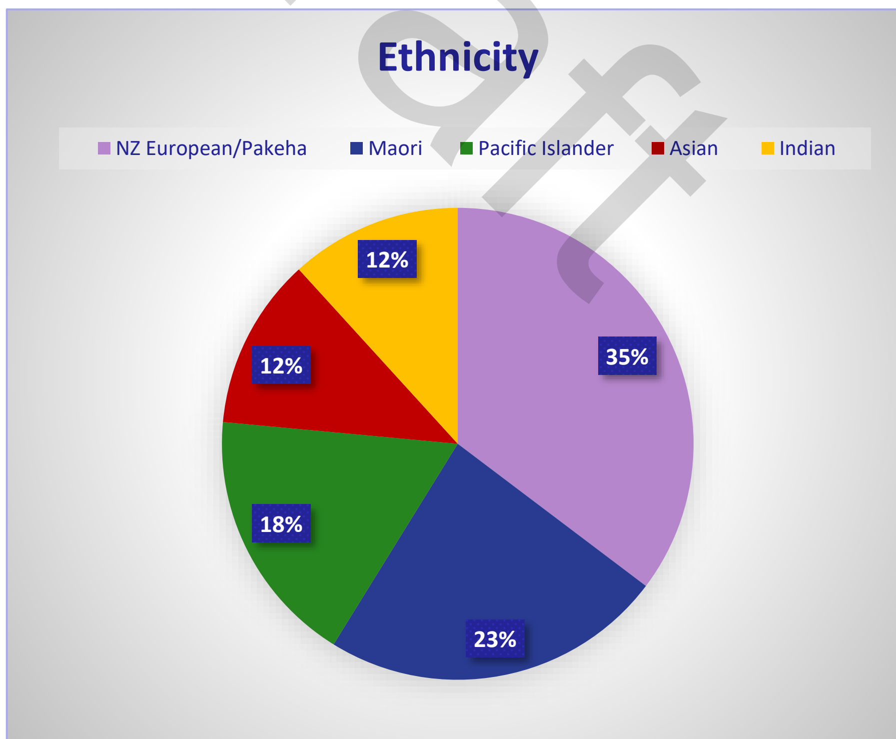

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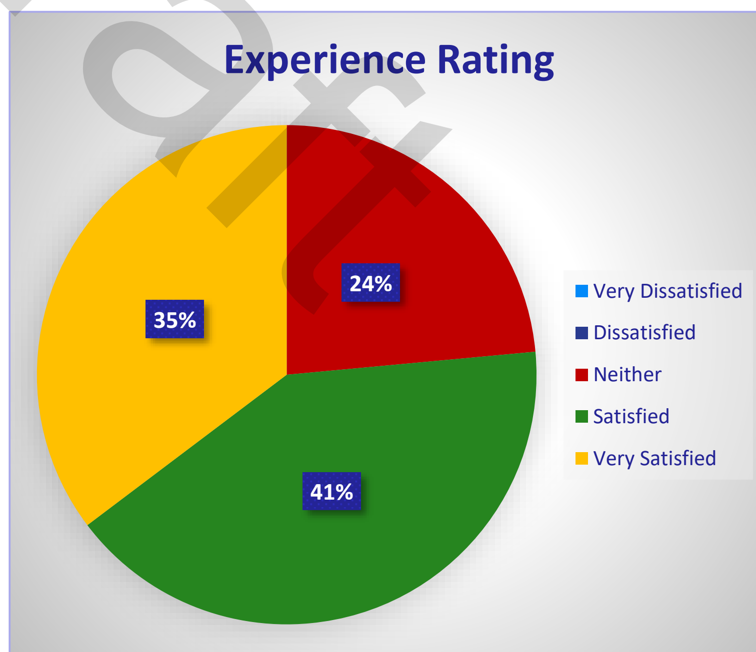
Data Analysis

The individual qualitative feedback collated was analyzed for key themes, focusing on the strengths of telehealth services, while also noting challenges and barriers, or areas for future improvement. Further detail on these key themes and findings is described in the next section. For the question about concerns related to telehealth appointments, participants were probed with concerns such as access to technology, having a safe and secure space to talk, and whānau involvement.

Overall, from the feedback received, the experiences of having online virtual appointments was overwhelmingly positive. The experience rating of service users was recorded on a Likert Scale of 1 to 5, with 1 corresponding to 'Very Dissatisfied' and 5, corresponding to 'Very Satisfied' (*Question 1,* Appendix A).

More than 70% of participants reported being 'Satisfied' or 'Very Satisfied' with their telehealth experience. With a smaller majority reported feeling 'Neither satisfied nor dissatisfied'. Interestingly, none of the participants reported having a dissatisfactory experience of their telehealth appointment.



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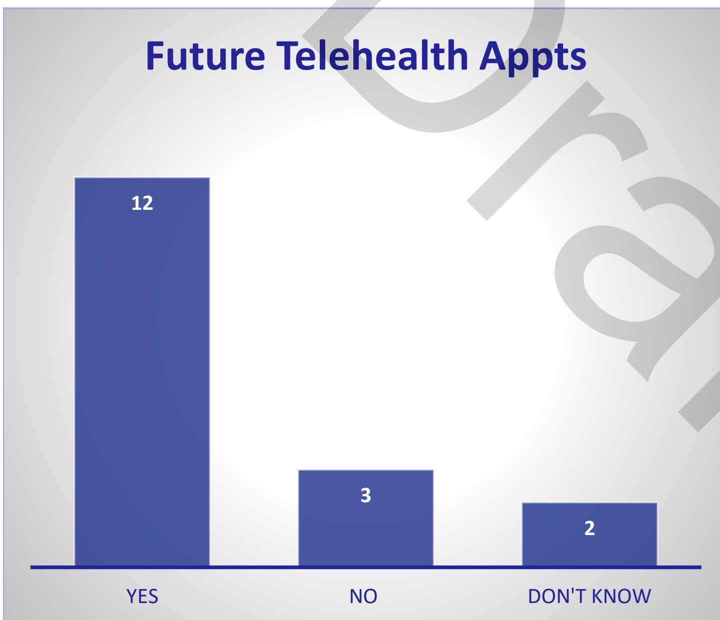
More than 70% of participants also indicated that they would consider having online or virtual appointments in the future. Whereas less than 20% indicated they would not consider telehealth at all.

Some were unsure of whether they would consider future online appointments at all. The qualitative feedback gathered on the proportion that were unsure, suggest, that barriers towards accessing telehealth appointments in the future were in relation to: cultural understanding and comfort.



“I do prefer to be in person, as sometimes feel it would be easier to open up”

"From a cultural perspective, being Māorii I do not prefer Zoom, would prefer face to face consultations instead"

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What's Working Well?

Ease of Access and Convenience

Most participants reported having easy access to available technology (computers & mobile phones), allowing them to participate in virtual consultations with their clinical teams and setting up Zoom was described as relatively easy by some. Overwhelmingly, many reported on telehealth appointments allowing for ease of access in relation to not having to leave the house during a pandemic, saving costs and time in travelling to and from appointments, saving costs in relation to parking or public transport, saving time in relation to travel and finding parking, not needing to take time off work or school, and being able look after children during appointments and not needing to look for childcare options. Overall, the convenience in having virtual consultations was identified as one of the biggest advantages and many reported considering this option in the future in the interest of saving time, money and effort.

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Psychological Benefit

One of the biggest concerns individuals had during the COVID 19 restrictions were related to being isolated and forgotten, and a definite fear that psychological well-being would deteriorate whilst in isolation. Many participants reported feeling 'uneasy' about having to leave the comfort and security of their homes due to the pandemic. One person stated, "I had concerns about my own immunity issues during COVID 19 and was scared to go out. It was a God send to be able to have online sessions." Others described appreciating the option of being able to get back into bed immediately after their meeting if they woke up feeling unwell, which can be a common factor for many who experience psychological distress. This was also true for those who experienced other physical health issues. Overall, participants reported feeling comforted, re-assured and engaged and believe they would have been worse off psychological without the option of virtual consultations.

Staff Attitudes and Qualities

One of the key themes from the feedback collated highlighted positive staff attitudes and qualities that made the experience of telehealth appointments an extremely positive one. Staff were described as extremely respectful, professional and empathetic during clinical appointments. Despite the barriers related to not being able to pick up on physical cues during virtual communication, feedback suggested that clinicians were still attentive and picked up on changes to body language, with one person stating, "she (therapist) noticed physical cues, such as when I got tense in my shoulders or if I looked anxious." One person stated that although she had not had the opportunity to establish a relationship with the clinician she was working with in person (due to a recent involvement with services), she still felt safe, listened to and able to engage via the telehealth appointment, and found this support invaluable.

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Challenges and Barriers

11

Technology and Logistics

The use of technology and other logistics involved with using technology were identified as a key barrier for people. Some identified barriers of access for individuals who were unable to meet the financial costs of investing in a computer. This feedback was particularly identified by the individuals in our sample who identified as Māori, who noted a major disadvantage for Māori populations (Note: more on the barriers to equity will be discussed further in the report). One person in our sample even spoke about how he had to borrow a computer from a friend of his and then go through the hassle of understanding how to set things up.

Some described connectivity issues as a barrier, stating that calls were not always clear, and it was sometimes difficult to understand or hear the clinician on the other side of the call. Although many also identified this barrier as related to their own internet usage at home, it highlights the connectivity issues that may hinder the facilitation of a seamless call, where everyone is being heard and understood. One respondent even stated having to move around their own house in order to find a suitable spot where the connection was not choppy. A few participants reported being concerned about the data usage to make telehealth calls, which may also suggest that those with financial constraints may be disadvantaged when utilizing telehealth. One person identified blurry faces in the call, suggesting that the District Health Board may need to update their computers or cameras due to this.

Logistical issues were also identified by some, with reports of minimal information being provided by the District Health Board to aid setup and operate Zoom. This raises concerns for individuals who may not be as familiar or comfortable with the use of technology (more on this in the 'Sampling Limitations section). Although many described Zoom as relatively easy to operate, the hassle of downloading and app and creating an account was identified as a barrier. One person spoke about having wasted 10 minutes of their clinical appointment to test the microphone, volume and sound. Another individual described having to end the call after 30 minutes and reconnect, which was annoying as it took up time. This

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participant believes that this may have taken place in the initial period of the COVID 19 restrictions while the District Health Board was still operating using a free license of Zoom.

Other challenges that were described were issues related to screen sharing to view therapy worksheets. This was especially true for individuals who were accessing Zoom through their phones and were unable to view screenshares. Concerns related to privacy were identified by one participant, who had experienced a 'Zoom hack' in the middle of a University lecture. She states, "not sure who could be listening or if it could be hacked. Other Zoom meetings I have been on have been hacked." It may be crucial to alleviate these concerns that some individuals may have while utilizing telehealth to discuss private details of their lives. Lastly, a couple participants talked about how it was difficult to keep track of meeting times as they varied on a weekly basis.

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Communication Barriers

Difficulties in communicating via a virtual tool was identified by many as a significant barrier to continuing with telehealth appointments. These included the usual concerns related to non-physical contact, such as understanding other's due to limited visibility of body language and gestures, inability to read other people's responses and reactions, difficulty in explaining self, and difficulties in asking questions and being able to discuss things in detail. One participant stated that "this form of communication doesn't allow people to connect," which summarises a lot of key issues with communication barriers with telehealth. A few also identified the cultural barriers with virtual consultations, reporting that it was sometimes difficult to understand others (accents and without non-verbal cues) when English was a second language.

Many participants reported issues with not being able to open up and be honest through virtual consultation, due to issues with not being able to read other people's body language. One person stated,

“difficult and really hard to engage and open up in an environment where I wasn’t there in person. It was hard to concentrate”.

Limitations with Group Activities

Some spoke about the limitations with using virtual consultations for group activities, as they can get crowded and sometimes be difficult to co-ordinate. The big groups also made it difficult for some people to contribute due to the barriers in reading body language and other physical cues. The big groups also meant that not everyone felt that they had an opportunity to contribute and some stated holding back due to this. On the other hand, some spoke about how social isolation has been quite difficult for some and how they would have appreciated more groups, activities, fun, games and classes to engage in during this difficult period. Lastly, one person commented on how it can get confusing try to follow two different tutors that are based in different locations.

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Other Key Points

14

"People should be provided a choice between physical meetings or online. We should always have a choice."

One key point raised by many was related to being provided with a choice in relation to telehealth consultations. Many spoke about being provided with the option of face-to-face in conjunction with virtual or online consultations; instead of online appointments becoming the only option available. Some points of consideration would be if the benefits of telehealth consultations outweigh the cons for the particular service user or individual, seeking treatment. This would have to be an individualized, tailored and person-centered decision, respectful of the service user's preference and choice. As suitability, ease of access, convenience and cultural factors, do vary across a spectrum, with some service users being more comfortable than others across these dimensions and aspects.

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It is also important to ascertain and consider the perspective of clinicians and key workers in terms of service delivery. Some service users have also noted that it depends on the content of the consultation and meeting. With brief check in's or catch up's potentially lending well to online platforms. However, this would have to be tailored to meet the individual service user's needs, coming back to point around ease of access and most importantly, facilitating choice.

Sampling Limitations

Although most participants reported positive experiences of meeting their clinical teams using telehealth platforms, a sample of 17 is by no means an exhaustive sample and caution must be taken while interpreting these results.

Approximately 70% of participants were between 21 and 40 years of age; an age group that is generally familiar and comfortable with the use of technology. The only person in our sample over the age of 50 stated having to borrow a computer from his friend in order to access Zoom, which presented as a barrier for him in understanding how to set it up.

The older population may not be as well-rehearsed with the use technology and utilizing telehealth may not be as convenient and simple for this age group. Additionally, we only spoke to people who had experienced using telehealth as an option. It would be interesting and wise to seek feedback from individuals who have not utilized this option to explore their views and perspectives.

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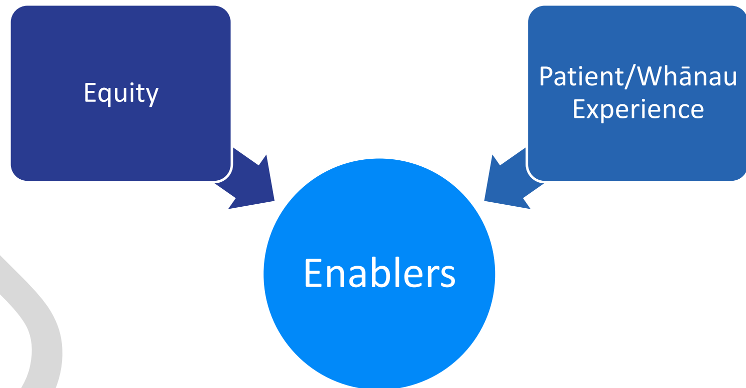
Equity

Key enabler



'Equity,' along with 'patient/whānau experience', has been earmarked as a key enabler for the wider ADHB 3-month action plan as well as that of the MH&A directorate. Māori and Pacific service users have been highlighted as specific populations for equity work, and there were important factors that arose in the feedback data.

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Māori

Taonga tuku iho: Cultural safety

Cultural needs, aspirations and preferences were highlighted in the data as being significant variables for tāngata whai i te ora. Many commented on the cultural preferred norm of meeting 'face-to-face' – *kanohi ki te kanohi* – and how the use of telehealth made some feel like it took away the mana of the whanaungatanga process. Body language and presence were related factors that tāngata whai i te ora spoke on. Namely, that they could not pick up the usual cues and languaging that come from meeting kanohi ki te kanohi. Tāngata whai i te ora also felt like they were less likely to be 'open' about how they are feeling and disclosed that it was hard to engage properly during group activities via Zoom. Tāngata whai i te ora highlighted, though, if given the choice then they would choose a Zoom appointment rather than a phone appointment. Although Māori are not a homogenous group, most participating tāngata whai i te ora indicated that the face-to-face preferance was synomous with being Māori.

Kia piki ake i ngā raruraru o te kāinga: Material accessiblity

Across all participating tāngata whai i te ora, they highlighted the issue of material resources as barriers to telehealth engagement and accessiblity. Concerns situated around the access to and financial support for stable intenet/data usage as well as having access to the necessary technology (computers, tablets).

> ***“Within Māoridom, I feel we feel much more respected in being face to face and in person (mana). I also feel many of our people will be further disadvantaged as they cannot afford such technology and thus the disparity in mental health between Māori and European will be further widened.”***

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Pacific

Tausi le va tapuia: A new way of connecting

Although there are cultural similarities between Māori and Pacific communities, the Pacific service users who participated in this QIP by and large enjoyed the use of telehealth to stay connected to their key workers. Pacific service users detailed how their telehealth appointments meant that less logistical resources (time, energy, travel, petrol, parking) were used, ensuring that they could spend more time on other responsibilities as well as spent more time with family. They felt like their cultural needs were being met and that non-verbal communication (like body language) was not overly impacted via telehealth. Considering this though, there was a strong collective concern for other people in the community who do not have ready access to telehealth and the related resources needed to engage.

> ***“Some people do not have computer so I think these should be made available or financial assistance to purchase one.***
> ***Also, we should always have choice.”***

Summary

Discussion and Recommendations

Overall, feedback suggested that individuals had an overwhelmingly positive experience with their telehealth appointments, specifically in relation to the ease of access and convenience in using virtual consultations, the alleviation of anxiety and other psychological benefit telehealth appointments brought, and the positive staff attitudes and behaviors that made a world of a difference in the experiences of individuals. We noted a few limitations in the sampling size that we sought current feedback from, with the more exhaustive approach to seeking feedback on telehealth in the future, will endeavor to involve a more diverse sample group.

There was room for improvement moving forward and participants identified some key challenges and barriers that the District Health Board must consider, such as barriers of access, non-verbal communication, and involvement in group activities. One of the biggest barriers identified was the financial cost involved in accessing telehealth appointments. With an increase in the availability of telehealth appointments in the future, we assume that the District Health Board will see a decrease in their costs involved in transport (taxi for people to get to and from clinical appointments). From our perspective, it is important that the District Health Board consider allocating some of these costs towards meeting the needs of individuals who may be disadvantaged from the move to telehealth appointments.

When asked about future improvements in the consideration of continuing use of telehealth appointments, participants recommended the following:

- Costs for internet or investing in technology considered, especially for those with financial restraints.
- A regular schedule of weekly meetings, as it can be difficult to keep track.
- Technical aspects tested prior to the session commencing, to avoid eating into clinical section of appointment.

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- Cultural safety and access barriers for certain ethnic populations considered, especially equity for Māori and Pacific communities.
- Flexibility in length of meeting, dependent on individual need.
- Reminders/notifications sent to individuals 10 or 15 minutes before appointment sessions

In summary, the shift to providing telehealth appointments as an option for individuals to meet with their clinical teams appears to be a positive step forward. Although, it goes without saying that this should be provided as an option for people, as opposed to being a clinician made decision that is made in the interests of saving time.

Our final remarks are that sometimes, individuals may be encouraged to make a decision about utilizing telehealth due to their psychological symptoms, such as increased social anxiety or depression (trouble getting out of bed). In our experience, clinical appointments are the only times that some people will leave their house, and it is important that clinician expertise is considered when deciding what may be in the best interests of people.

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Appendix A: Questionnaire

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1. How would you rate your experience of your online appointment/consultation?
   On a scale from 1 = very dissatisfied, to 5 = very satisfied

2. Can you tell us more about your experience? What worked well for you? What didn't?

3. Did you have any concerns or barriers in relation to your online appointment?

4. Would you consider having online appointments in the future?
   (Yes / No / Maybe / Don't know)

5. Can you please tell me more about why you feel that way?

6. If the option of online appointments continued, how could things be improved?

7. Do you have any other feedback to offer about online appointments in general?

Reference:

Dalziel, K., Li, J., Scott, A., Clarke. (2018). Accuracy of patient recall for self-reported doctor visits: Is shorter recall better?. *Health Economics*, 27: 1684-1698.

The Consumer Leadership Team: Auckland DHB Mental Health & Addictions Directorate (May 2020). Telehealth QIP Report: Service User Feedback. Auckland District Health Board.

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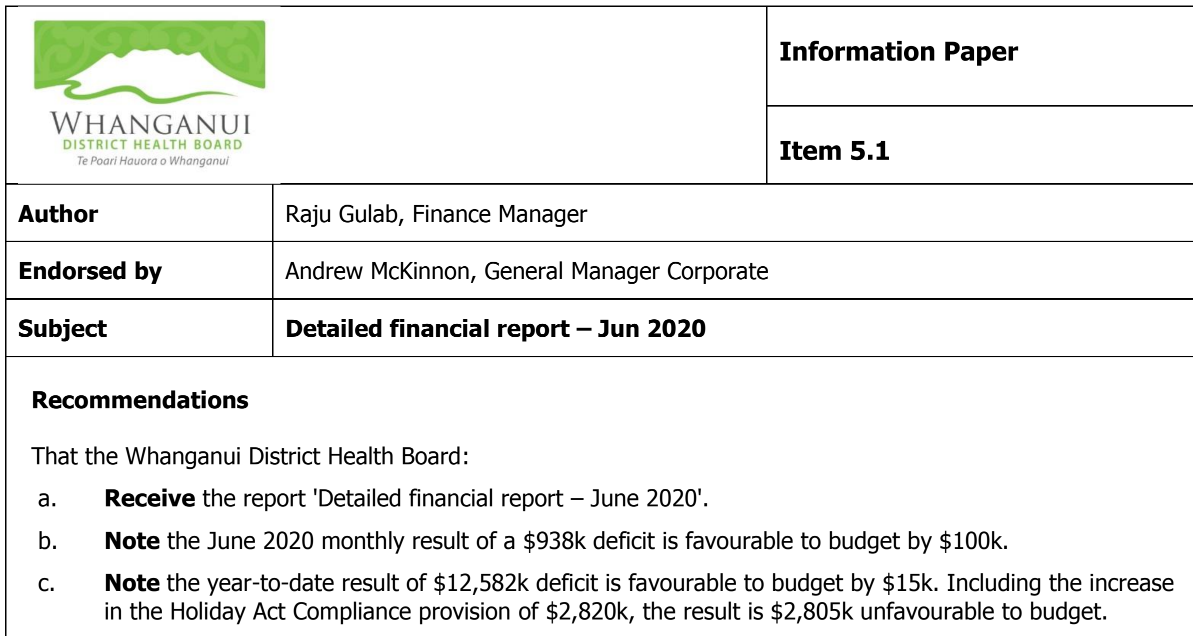


WHANGANUI DISTRICT HEALTH BOARD *Te Poari Hauora o Whanganui*	**Information Paper** **Item 5.1**
Author	Raju Gulab, Finance Manager
Endorsed by	Andrew McKinnon, General Manager Corporate
Subject	**Detailed financial report – Jun 2020**

Recommendations

That the Whanganui District Health Board:

a. **Receive** the report 'Detailed financial report – June 2020'.

b. **Note** the June 2020 monthly result of a $938k deficit is favourable to budget by $100k.

c. **Note** the year-to-date result of $12,582k deficit is favourable to budget by $15k. Including the increase in the Holiday Act Compliance provision of $2,820k, the result is $2,805k unfavourable to budget.

Financial Overview – June 2020

YTD Performance	YTD IDF net Flow	YTD CWDs
$12.6m deficit (excluding Holiday Act Compliance provision)	$37.5m expenditure	4.4% behind
Against budgeted deficit of $12.6m, result includes the impact of COVID19.	Against budgeted expenditure of $35.4m, $2.1m unfavourable due to high inpatient CWS and loss of inflow due to COVID- 19.	531 CWDs below plan (IDF CWDs excluded).

YTD FTE	YTD Capital Expenditure
937	$3.2m spend
Budgeted FTE of 937	Against budgeted expenditure of $7.5m.

Consolidated Statement of Financial Performance for the period ended 30 June 2020

$'000	Month Actual	Month Budget	Month Var		Year to Date Actual	Year to Date Budget	Year to Date Var		Annual Budget 2019-20	Annual Actual 2018-19
Revenue	23,092	22,770	322	F	272,578	271,775	803	F	271,775	262,211
Revenue– COVID-19	90	–	90	F	3,931	–	3,931	F	–	–
Total Revenue	23,182	22,770	412	F	276,509	271,775	4,734	F	271,775	262,211
Less:										
Provider Health Service	(12,362)	(12,146)	(216)	U	(143,996)	(144,785)	789	F	(144,784)	(138,617)
Corporate Service	(787)	(113)	(674)	U	(1,990)	(1,716)	(274)	U	(1,716)	(300)
Governance	73	(78)	151	F	(719)	(960)	241	F	(961)	(718)
DHB Funder Division (exl IDF outflow)	(6,696)	(7,895)	1,199	F	(91,960)	(93,901)	1,941	F	(93,901)	(88,113)
Inter-district Outflow	(4,462)	(3,607)	(855)	U	(45,247)	(43,290)	(1,957)	U	(43,290)	(43,778)
ACC Contract (net)	36	31	5	F	265	280	(15)	U	280	317
COVID-19	78	–	78	F	(5,444)	–	(5,444)	U	–	–
Total expenditure	(24,120)	(23,808)	(312)	U	(289,091)	(284,372)	(4,719)	U	(284,372)	(271,209)
Net Surplus/(Deficit) before HolidayPay	**(938)**	**(1,038)**	**100**	**F**	**(12,582)**	**(12,597)**	**15**	**F**	**(12,597)**	**(8,998)**
NoS Impairment	–	–	–		–	–	–		–	(1,048)
Holiday Pay Provision	–	–	–		(2,820)	–	(2,820)		–	(3,608)
One-off	–	–	–		(2,820)	–	(2,820)		–	(4,656)
Net Surplus / (Deficit)	**(938)**	**(1,038)**	**100**	**F**	**(15,402)**	**(12,597)**	**(2,805)**	**U**	**(12,597)**	**(13,654)**

Note :- F = Favourable variance; U = unfavourable variance

Overview

Result for the month of June 2020 is favourable to budget by $100k.

- ***Revenue***
  Revenue is $322k favourable to budget due inter district inflow revenue.

- ***Revenue- COVID- 19***
  Covid-19 related revenue is $90k favourable.

- ***Provider health service (Appendix 2)***
  Provider division is $216k unfavourable due to increase in radiology outsource service, medical locum cost and nursing cost. These increases were partly offset by lower clinical cost and lower other personnel cost relating to course and conferences.

- ***Corporate service (Appendix 2)***
  Corporate is $674k unfavourable due to provision for facility contract outstanding SECA claim.

- ***Governance***
  Governance is $151k favourable to budget due to lower staff cost, profession fees and other operating expense.

- ***DHB Funder division (exl IDF outflow) (Appendix 3)***
  Funder division is $1.1m favourable due to pharmaceutical rebate as per Pharmac advice $542k, mental health $296k and various other saving in personal health.

- ***Inter-district flows (Appendix 4)***
  Inter-district flows are $855k unfavourable to budget inpatient and PCT wash-up.

- ***COVID -19***
  These Covid-19 costs of $78K mainly clinical supplies and telehealth license cost.

Year-to-date Jun 2020 result is favourable to budget by $15k; including the adjustment to Holiday Act Compliance provision, the result is $2,805k unfavourable to budget

- ***Revenue (Appendix 1)***
  $803k favourable mainly due to additional revenue for funder division side contracts (offset by corresponding expense), MECA settlement, bowel screening, cost recovery from other DHB, interest and patient consumables, partly offset by IDF inflow revenue.

- ***Revenue- COVID- 19 (Appendix 1)***
  $3,931k favourable Ministry of health funding for CBAC establishment, GP sustainability funding, GP based assessments, primary response and virtual consolation and public health unit funding, Maori health and HOP support (offset by corresponding expense).

- ***Provider division (Appendix 2)***
  Provider division is $789k favourable due to savings in clinical supplies in theater, wards, district nursing and dental, and allied health vacancies. These were partly offset higher medical personnel, locums and nursing resource to meet patient demand.

- ***Corporate (Appendix 2)***
  Corporate is $274k unfavourable due to provision for facility contract outstanding SECA claim, there increases partly offset by lower personnel costs (vacancies), increases in other income and a reduction in building insurance costs. These are partially offset by higher reactive building maintenance costs.

- ***Governance***
  Governance is $241k favourable due to lower personnel costs, professional fees and other operating expenses.

- ***DHB Funder division (exl IDF outflow) (Appendix 3)***
  Funder division is $1,941k favourable due to a larger than expected pharmaceutical rebate of $1,007k, as well as lower health of older people, aged residential and home based support costs. This was partly offset by personal health domiciliary and district nursing costs.

- ***Inter-district flows (Appendix 4)***
  Inter-district flows are $1,957k unfavourable to budget mainly due to increase in volume for inpatient $1,341k (257 CWD mainly Capital & Coast DHB relates to high acute demand for cardiothoracic, vascular surgery and respiratory inpatient services and Midcentral DHB relates to acute demand for haematology, maternity inpatient). PCT wash-up $541k mainly Midcentral DHB and various other $75k.

- ***COVID -19 (Appendix 5)***
  These Covid-19 costs of $5,444k are the direct incremental costs the WDHB has incurred in responding to Covid-19. They are reported on to the Ministry of Health. They do not include all the costs of all staff that were involved in responding to Covid-19 (i.e. do not include the hospital staff cost). The costs are made up of:
    - CBAC establishment, GP based easements, Primary care response and virtual consultation, Community pharmaceutical, Public health unit funding $1,225k
    - Maori health support $1,922k
    - HOP support $377k
    - Clinical supplies $667k
    - Non-clinical and infrastructure $563k

    Payroll cost (further validation of these cost required)
    - Incident management team and planning $5k
    - Provider arm service response $685k (includes payroll costs for some staff who were sent home and were not required to work)
    - Payroll, including overtime and additional leave.

- ***Holiday Act provision***
  The WDHB has completed the review of its compliance with the Holiday Act. This review has been audited by an independent auditor and review by MBIE Labour Inspector. Based on the remediation required, the provision has been recalculated and is required to be increased by $2.8 million to cover accumulated annual leave and accumulated effect higher of average daily pay versus relevant daily pay.

1. Revenue- Appendix -1

$'000	Month Actual	Month Budget	Month Var		Year to Date Actual	Year to Date Budget	Year to Date Var		Annual Budget 2019-20	Annual Actual 2018-19
Ministry of Health	21,457	21,676	(219)	U	259,440	258,783	657	F	258,783	248,274
Inter-district inflow	1,120	661	459	F	7,764	7,928	(164)	U	7,928	6,984
Other District Health Board (DHB)	70	36	34	F	612	549	63	F	549	653
Accident Compensation (ACC)	357	286	71	F	3,317	3,332	(15)	U	3,332	4,109
Other Government	20	31	(11)	U	145	147	(2)	U	147	269
Patient consumer sourced	7	25	(18)	U	371	298	73	F	298	359
Other income	61	55	6	F	929	738	191	F	738	1,563
COVID-19	90	–	90	F	3,931	–	3,931	F	–	–
Total revenue	23,182	22,770	412	F	276,509	271,775	4,734	F	271,775	262,211

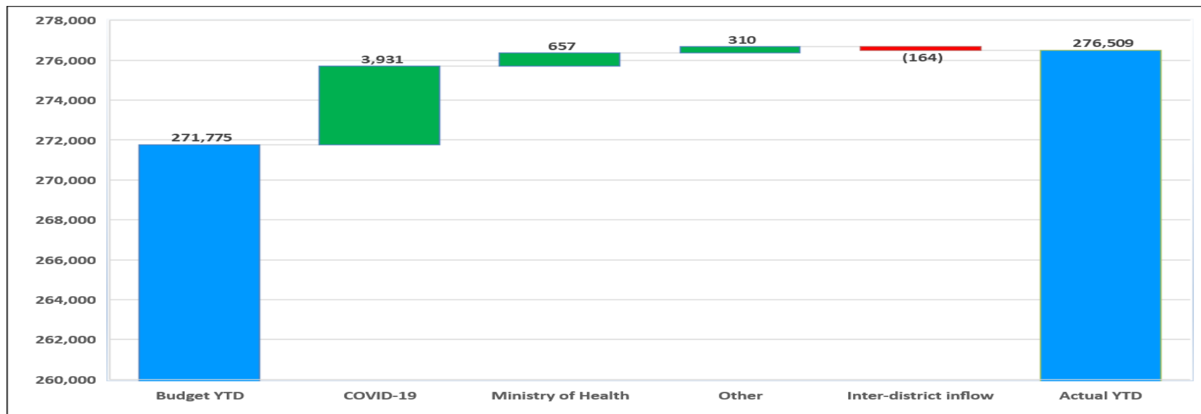
Note :- F = Favourable variance; U = unfavourable variance

Month comments

Ministry of Health
Revenue unfavourable to budget by $219k mainly due to pregnancy and parenting revenue moved to income in advance.

Inter-district inflow
$459k favourable to budget due to favourable wash-up with various DHBs.

Year-to-date comments



COVID- 19

$3,931k favourable due to Ministry of health funding for:

- CBAC establishment $409k
- GP based easements $331k
- Primary care response and virtual consultation $253k
- Community pharmaceutical $232k
- Maori health support $1,922k
- HOP support $377k
- Pharmaceutical Covid-19 $407k

This revenue passes on to various community health providers.

Ministry of Health

Revenue favourable to budget by $657k due to:

- Additional revenue for funder division for a number of side contracts (well child, B4 school, school base health, gateway assessment, pay equity etc.) largely offset by increased cost $141k
- New integrated primary mental health and addiction service, offset by cost $255k
- Youth AOD Exemplar services funding from income in advance $50k.
- Prior year one-off In-between-travel (IBT) favourable wash-up $168k.
- health activity learning, cervical screening, MECA funding, national travel assistance $113k

This is partly offset by:

- Health workforce training revenue decrease of $70k, relating to lower uptake and also non-resident RMOs training not funded.

Inter-district inflow

$164k unfavourable to budget due to under delivery of volume for various DHB.

Patient Consumer sourced

$73k favourable to budget due to revenue from an increase in non-resident patients and also an increase in dental and pharmaceutical co-payment.

Other Income

$191k favourable to budget due to:

- Ophthalmology staff cost recovery from other MidCentral DHB $57k,
- Flight nurses cost recovery for various DHB $52k (usage driven),
- Interest income due to better than plan cash position relates lower capital expenditure $52k,
- Number of various other income $30k.

2. Provider Health and Corporate Services - Appendix 2

	Month				Year to Date				Annual	Annual
	Actual	Budget	Variance		Actual	Budget	Variance		Budget 2019-20	Actual 2018-19
Expenditure										
Medical Personnel	2,013	2,176	163	F	22,696	24,714	2,018	F	24,714	22,080
Nursing Personnel	3,840	3,506	(334)	U	42,778	41,956	(822)	U	41,956	39,994
Allied Personnel	1,064	1,075	11	F	12,346	12,601	255	F	12,601	11,727
Support Personnel	89	82	(7)	U	934	965	31	F	965	852
Management & Admin Perseonnel	1,060	1,043	(17)	U	12,061	12,406	345	F	12,406	11,464
Total Personnel(Exl other & outsourced)	**8,066**	**7,882**	**(184)**	**U**	**90,815**	**92,642**	**1,827**	**F**	**92,642**	**86,117**
Personnel Other	(377)	259	636	F	1,737	2,560	823	F	2,560	2,319
Outsourced Medical Personnel	587	323	(264)	U	6,433	3,904	(2,529)	U	3,904	5,076
Outsourced Allied Personnel	79	50	(29)	U	704	611	(93)	U	611	610
Outsourced Manag & Admin Personnel	(19)	10	29	F	59	100	41	F	100	59
Total Personnel outsourced)	**270**	**642**	**372**	**F**	**8,933**	**7,175**	**(1,758)**	**U**	**7,175**	**8,064**
Total Personnel Expenditure	**8,336**	**8,524**	**188**	**F**	**99,748**	**99,817**	**69**	**F**	**99,817**	**94,181**
Outsourced Clinical Service	649	509	(140)	U	6,015	5,815	(200)	U	5,815	5,810
Clinical Supplies	1,423	1,451	28	F	16,107	17,348	1,241	F	17,348	16,564
Infrastructure & Non Clinical Supplies Costs	2,021	1,059	(962)	U	15,541	14,630	(911)	U	14,629	13,097
Capital Charge	217	217	–	F	2,748	2,749	1	F	2,749	3,521
Depreciation & Interest	543	539	(4)	U	5,563	5,882	319	F	5,882	5,428
Internal Allocation	(40)	(40)	–	F	264	260	(4)	U	260	316
Total Other Expenditure	**4,813**	**3,735**	**(1,078)**	**U**	**46,238**	**46,684**	**446**	**F**	**46,683**	**44,736**
Total Expenditure	**13,149**	**12,259**	**(890)**	**U**	**145,986**	**146,501**	**515**	**F**	**146,500**	**138,917**
Expenditure										
Medical personnel and Locum	2,600	2,499	(101)	U	29,129	28,618	**(511)**	U	28,618	27,156
Nursing Personnel	3,840	3,506	(334)	U	42,778	41,956	**(822)**	U	41,956	39,994
Allied Personnel	1,143	1,125	(18)	U	13,050	13,212	**162**	F	13,212	12,337
Othe Personnel costs	753	1,394	641	F	14,791	16,031	**1,240**	F	16,031	14,694
Clinical Supplies	1,423	1,451	28	F	16,107	17,348	**1,241**	F	17,348	16,564
Outsourced Clinical Service	649	509	(140)	U	6,015	5,815	**(200)**	U	5,815	5,810
Infrastructure & Non Clinical Supplies Costs	2,198	1,236	(962)	U	18,553	17,639	**(914)**	U	23,520	22,362
Depreciation & Interest	543	539	(4)	U	5,563	5,882	**319**	F	8,891	9,265
								F		
Total Expenditure	**13,149**	**12,259**	**(890)**	**U**	**145,986**	**146,501**	**515**	**F**	**155,391**	**148,182**
FTEs										
Medical	105.8	113.3	7.5	F	103.4	112.5	9.1	F	112.5	112.3
Nursing	500.8	460.9	(39.9)	U	478.2	462.2	(15.9)	U	462.2	455.0
Allied	156.4	153.7	(2.7)	U	152.8	153.4	0.7	F	153.4	160.7
Support	18.0	16.8	(1.1)	U	16.2	16.8	0.6	F	16.8	16.0
Management & Admin	180.4	176.9	(3.5)	U	173.2	176.8	3.5	F	177.9	175.9
Total FTEs	**961**	**922**	**(39.7)**	**U**	**924**	**922**	**(2.0)**	**U**	**923**	**920**
Case Weighted Discharges (CWD)										
Unplanned (Acute)	771	724	(47)	U	8,560	8,836	276	F	8,836	2,383
Planed (Elective & Arranged)	254	291	37	F	2,972	3,227	255	F	3,227	594
Total CWD	**1,025**	**1,015**	**(10)**	**U**	**11,533**	**12,063**	**531**	**F**	**12,063**	**2,977**
Further information										
General Medicine	368	285	(83)	U	3,779	3,478	(301)	U	3,478	3,703
General Surgical	228	212	(16)	U	2,571	2,488	(83)	U	2,488	2,595
Orthopaedics	181	207	27	F	1,897	2,390	494	F	2,390	1,915
Gynaecology	29	31	2	F	388	350	(38)	U	350	408
Emergency Medicine	79	110	31	F	1,096	1,342	246	F	–	–
Othter	142	170	29	F	1,801	2,015	214	F	3,357	(5,644)
Total CWD	**1,025**	**1,015**	**(10)**	**U**	**11,533**	**12,063**	**531**	**F**	**32,833**	**14,574**

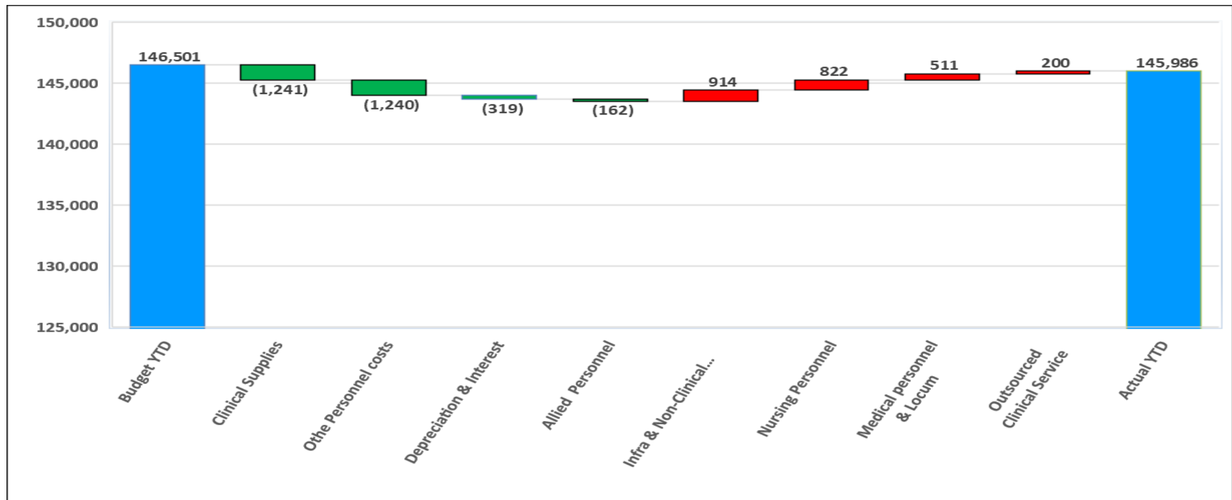
Month comments

Inpatient volumes were 101% to target in June 2020 with unplanned (acute) being 106.4% and planned (elective and arranged) being 87.4% of budget for the month.

The overall expenditure for the month of June was $890k unfavourable to budget

- **Total personnel costs $188k favourable to budget** mainly due to medical personnel payroll cost, course conference and CME related cost, this is partly offset by medical personnel locum cost and nursing personnel payroll cost. This is partly offset by higher overtime of $113k.
- **Outsourced clinical service $140k unfavourable to budgeted** mainly due to prior year radiology outsourced cost.
- **Infrastructure and non-clinical supplies $962k unfavourable** due to accrual provision for disputed facility contract SECA.

Year-to-date comments



Inpatient volumes were 95.6% to target year to date with unplanned (acute) 96.9% and planned (elective and arranged) 92.1% of budget year-to-date.

The overall year-to-date expenditure $515k favourable to budget.

- **Clinical supplies $1,241k favourable to budget due to**:
  - Theatre consumables $830k favourable mainly related to reduced orthopaedics volumes which were 493 CWS lower than planned (overall volume 531 CWD lower than planned, planned volumes 92.1% and unplanned volumes $96.9% lower than target).
  - District nursing consumables $164k favourable mainly related to reduced treatment and disposables costs directly related to volumes (mainly dressings).
  - Ward consumables $103k favourable mainly related to lower pharmaceutical costs as a result of patient mix and COVID-19 impacted on wards activity.
  - Dental costs $56k favourable mainly related to dental consumables mainly due to COVID-19 impacted on activity of dental units.
  - Other operating expenditure includes health promotion $93k.
  - Blood costs $164k favourable (demand and volume driven).

  These favourable variances are partly offset by:
  - Patient travel $126k unfavourable (a higher number of transfers to Starship which are particularly expensive).
  - Orthotics and surgical footwear $34k unfavourable.
- **Other personnel costs $1,240 favourable to budget**
  - Support personnel $31k favourable.
  - Management personnel had a net favourable variance of $386k mainly resulting from vacant positions not being filled.
  - Personnel other costs were $823k favourable to budget mainly due to course and conferences not being attended as a result of COVID 19. These savings were partly offset by RMO recruitment costs, parental leave and gratuities.
- **Depreciation and interest favourable to budget by $319k**, deprecation $287k (mainly related to IT, buildings and clinical equipment, capital spend not occurring as quickly as budgeted) and interest $32k.

- **Allied personnel costs net favourable variance of $162k favourable mainly due to vacancies** in audiology, physiotherapy, Pharmacists, health promotion. Favourable payroll savings of $255k were partly offset by outsourced costs of $93k mainly orthotics and radiology locum.

- **Infrastructure, non-clinical supplies costs $914k unfavourable to budget** due to provision made for outstanding facility contract SECA settlement.

- **Nursing personnel $822k unfavourable** due to high nursing costs in the Medical Ward, CCU, ED, Maternity Ward, ATR community service, community mental health, and patient safety unit. The staffing levels were particularly high at the beginning of the year, but the staff levels have been reviewed and proactive staff management practices have been implemented to better utilize staff.

- **Medical personnel net unfavourable variance of $511k mainly due to use of locums to cover vacancies.** Unfavourable locum costs of $2,529k are partly offset by savings in payroll costs of $2,019k due to vacant positions not filled or parental leave. Locum costs made up of ophthalmology $348k, orthopaedics $30k, RMOs $433k, ED $475k, anaesthetics $338k, mental health $545k, gynaecology $518k and dental $65k. This was partly offset by urology and other $210k.

- **Outsourced clinical and other services $200k unfavourable to budget** with radiology services $446k, ophthalmology $68k (offset by saving in personnel cost), medical and surgical terminations $101k, dental patient treatment $22k ($46k one-off) and laboratory $20k (offset by funder savings), these were partly offset rest home convalescence $339k (paid by funder), CCDHB infectious disease $15k, ECO service $71k and various other $32k.

Case Weighted Discharges

Year to date case weighted discharges (CWD) are 4.4% lower than plan. For the year, there were 531 CWD lower than plan, out of 531 CWD, 441 (79.17%) favourable CWD attribute to March and April due to impact of COVID-19.

General medicine CWD 8.7% and Gynaecology CWD 10.8% were higher than plan.

Note that CWD above includes services provided at Whanganui Hospital, This CWD does not include IDF outflows and means it is not the complete result in relation to the Planned Care Target.

3. DHB Funder Division - Appendix 3

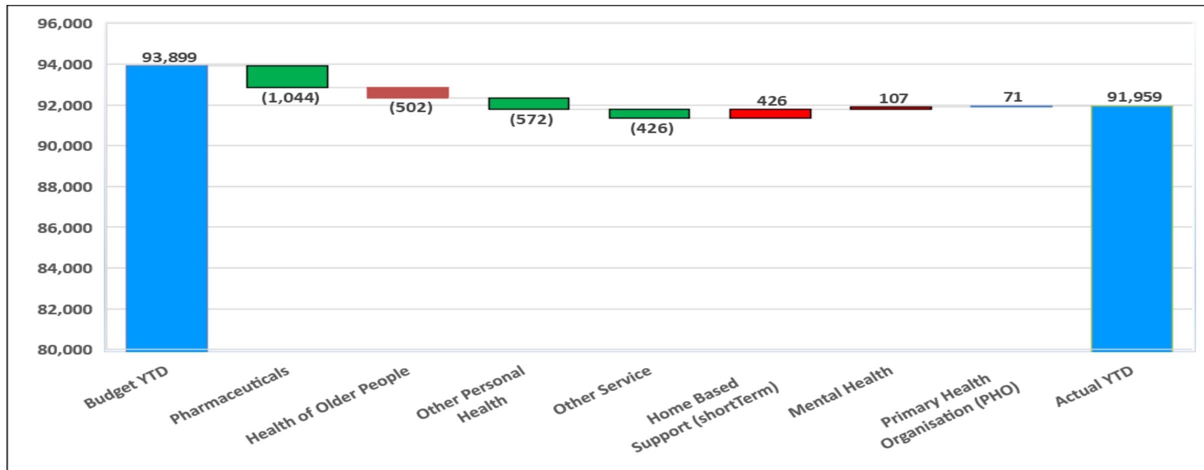
	Month				Year to Date				Annual	Annual
	Actual	Budget	Variance		Actual	Budget	Variance		Budget 2019-20	Actual 2018-19
Expenditure by type										
Pharmaceuticals	883	1,403	520	F	16,096	17,140	**1,044**	F	17,140	15,986
Primary Health Organisation (PHO)	1,287	1,460	173	F	16,941	16,870	**(71)**	U	16,870	15,037
Home Based Support (short Term)	27	112	85	F	1,766	1,340	**(426)**	U	1,340	1,486
Other Personal Health	819	1,091	272	F	12,439	13,011	**572**	F	13,013	12,511
Health of Older People	2,491	2,557	66	F	30,511	31,013	**502**	F	31,013	29,118
Mental Health	455	750	295	F	9,085	8,978	(107)	U	8,978	8,882
Public Health	91	82	(9)	U	976	986	**10**	F	986	855
Maori Services	123	134	11	F	1,602	1,695	**93**	F	1,695	1,595
Total Other provider expenditure	**6,176**	**7,589**	**1,413**	**F**	**89,416**	**91,033**	**1,617**	**F**	**91,035**	**85,470**
Funding Admin	142	306	164	F	2,543	2,866	**323**	F	2,866	2,644
Total funder expenditure	**6,318**	**7,895**	**1,577**	**F**	**91,959**	**93,899**	**1,940**	**F**	**93,901**	**88,114**
Expenditure by service										
Personal Health	3,016	4,066	1,050	F	47,242	48,361	1,119	F	48,363	45,020
Health of Older People	2,491	2,557	66	F	30,511	31,013	502	F	31,013	29,118
Mental Health	455	750	295	F	9,085	8,978	(107)	U	8,978	8,882
Public Health	91	82	(9)	U	976	986	10	F	986	855
Maori Services	123	134	11	F	1,602	1,695	93	F	1,695	1,595
Funding Admin	142	306	164	F	2,545	2,867	322	F	2,866	2,643
Total Expenditure	**6,318**	**7,895**	**1,577**	**F**	**91,961**	**93,900**	**1,939**	**F**	**93,901**	**88,113**

Month comments

The overall expenditure for the month of June is $1,577k favourable to budget

- **Pharmaceuticals favourable to budget** is due to Pharmaceuticals rebate based on Pharmac advice, this is partly offset by discretionary pharmaceutical (DPF).
- **Health of older people favourable to budget** is due to lower demand of home-based support.
- **Mental Health favourable to budget** is due to costs reversing of accrual provision for parenting and pregnancy, offset by equal amount of revenue moved to income in advance.

Year-to-date comments



The overall year-to-date expenditure is $1,842k favourable to budget.

- **Pharmaceuticals $1,044k favourable to budget -** due to receiving a larger pharmaceutical rebate than budgeted and lower than budgeted pharmaceuticals expenditure.
- **Health of Order People $502k favourable to budget -** largely due to residential care service relating to demand, partly offset by short-term, home-based support.
- **Other personal health favourable to budget $572k -** largely due to general medicine subsidy (partly offset by PHO cost), and lower expenditure in surgical outpatient, palliative care and other expenditure.
- **Other service $426k favourable to budget -** largely due lower funding administration costs.
- **Home based support (short term) $426k favourable to budget -** largely due to lower funding increased demand in short term home based and community service support costs, offset by health of older people favourable variance.
- **Mental Health $107k unfavourable to budget -** largely due to two new service contracts, integrated primary mental health and addiction service and, offset by equal amount of funding.
- **Primary Health Organisation (PHO) $71k unfavourable to budget-** largely due to increased capitation first contact service payment which indicates increase in enrollment.

4. Inter-district flows (IDFs) Appendix 4

	Month				Year to Date				Annual	Annual
	Actual $000	Budget $000	Variance $000		Actual $000	Budget $000	Variance $000		Budget 2019–20 $000	Actual 2018–19 $000
Expenditure										
Outflow inpatient	$2,241	$1,871	($ 370)	U	$24,073	$22,450	($ 1,623)	U	$22,450	$22,624
Outflow other	$2,221	$1,736	($ 485)	U	$21,174	$20,840	($ 334)	U	$20,840	$21,154
Total outflow	**4,462**	**3,607**	**(855)**	**U**	**45,247**	**43,290**	**(1,957)**	**U**	**43,290**	**43,778**
Inflow inpatient	($ 596)	($ 288)	$308	F	($ 3,269)	($ 3,461)	($ 192)	U	($ 3,462)	($ 2,926)
Inflow other	($ 524)	($ 373)	$151	F	($ 4,495)	($ 4,467)	$28	F	($ 4,466)	($ 4,058)
Total inflow	**(1,120)**	**(661)**	**459**	**F**	**(7,764)**	**(7,928)**	**(164)**	**U**	**(7,928)**	**(6,984)**
Total IDF net flow	**3,342**	**2,946**	**(396)**	**U**	**37,483**	**35,362**	**(2,121)**	**U**	**35,362**	**36,794**

Note :- F = Favourable variance; U = unfavourable variance

Year-to-date comments

Year-to-date outflow IDF expenditure is $1,957k unfavourable to budget.

IDF-wash-up processes for Personal Health Inpatient, HOP AT&R Inpatient and PH Outpatient IDFs. IDF payments will be made based on actual delivery for the months of Jul 2019 to Feb 2020 with the wash up to be processed against 8/12 of the relevant 2019/20 forecast. There will be no wash up on these specific IDF categories for the months of March 2020 to June 2020.

- **Inpatient IDF outflow unfavourable variance of $1,623k**, majority of variance contributed by Capital & Coast DHB relates to acute demand for cardiothoracic, vascular surgery and respiratory inpatient service $1,410k and MidCentral DHB relates to acute demand for haematology, maternity inpatients and elective demand for urology inpatient services $230k.
- **Other IDF outflow unfavourable variance of $334k**, mainly made off outpatient $27k, HOP AT&R Inpatient $63k, PCT $541k (cancer treatment service provided by Midcentral DHB), pharmaceutical of $206k. These increases were partly offset by mental health sub-acute extended care $122k, various service changes $381k.

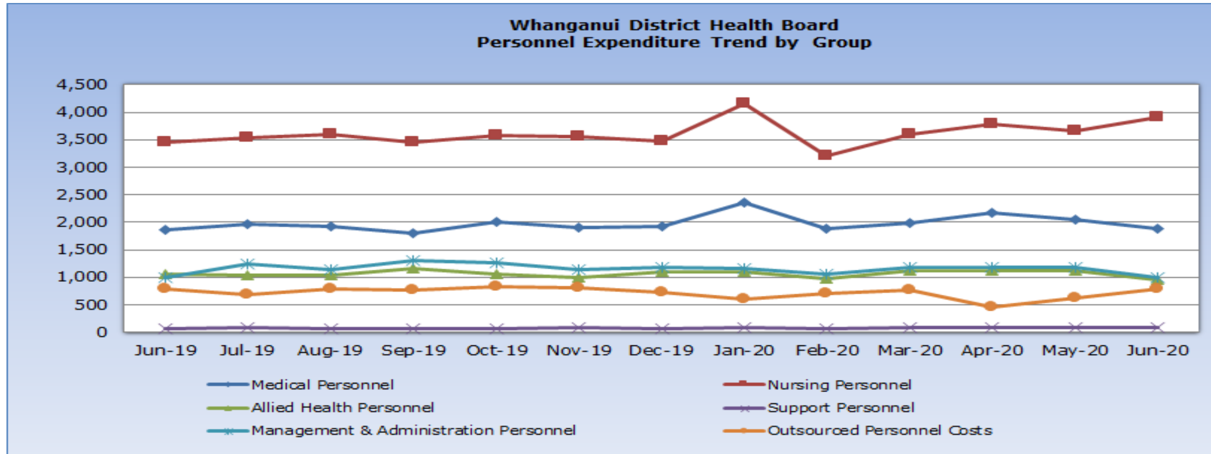
Year-to-date inflow IDF revenue is $164k unfavourable to budget.

- **Inpatient inter-district inflow unfavourable $192k** mainly due to Taranaki DHB personal health inpatient IDF not eventuated as planned.
- **Inter-district other inflow favourable $28K** mainly due to favourable pharmaceutical.

5. Other information Appendix 5

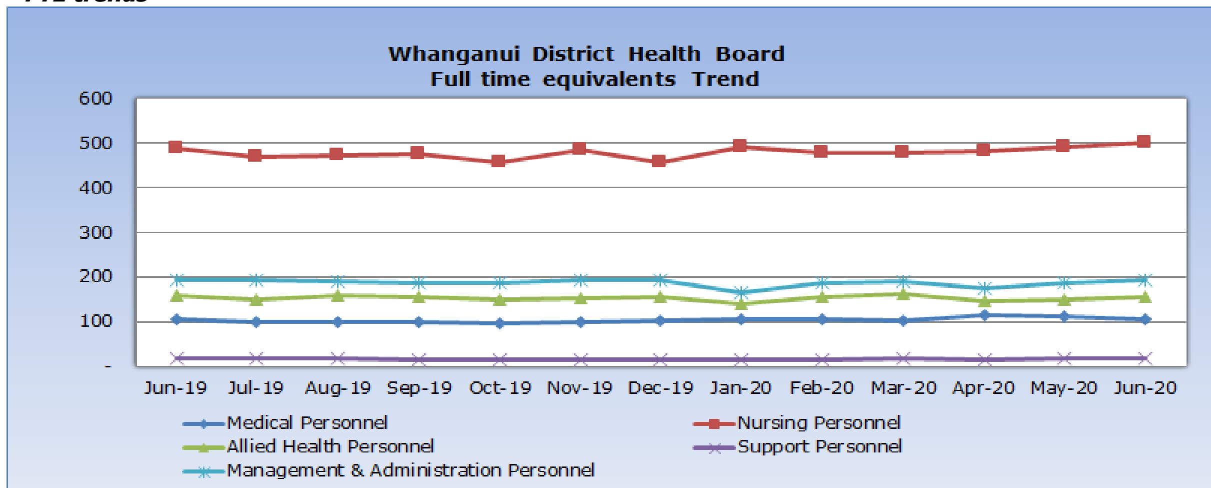
Supplementary information on costs

Personnel cost trends



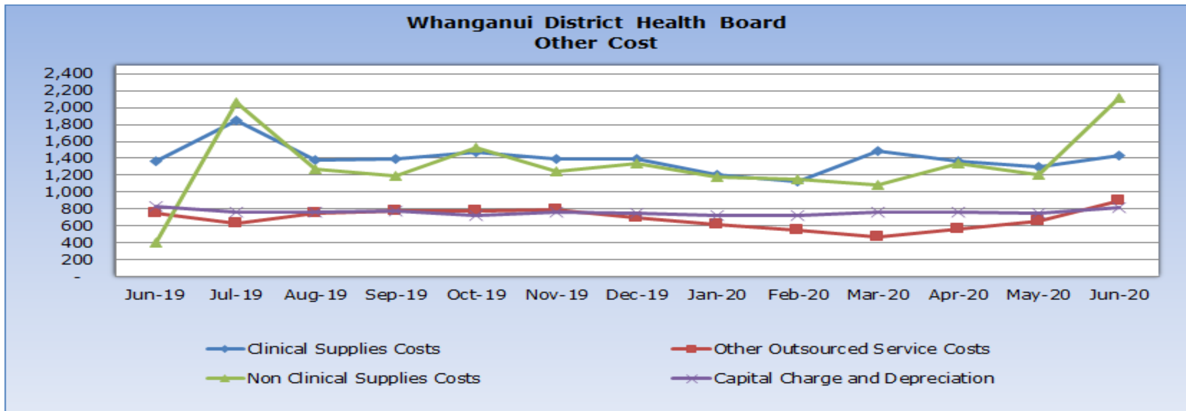
- Nursing personnel costs upward trend in June compared to prior month is due to impact of high acuity volume 106.4% target.
- Overall personnel cost downward trend in June reflects the impact of one less working day in month compared to prior month.
- Outsourced personnel costs upward trend in June compared to prior month is due to mental health locum, RMO locum and ACC contract.

FTE trends



The FTE trend largely reflects the impact of statutory holidays and timing of leave; otherwise the trend is comparable to the prior period.

Other operating costs



- Clinical supplies upward trend in June compared to the prior month is due to increased use of theatre consumables and pharmaceutical drug cost.
- Non-clinical supplies upwards trend in June compared to the prior month is due to facility contract accrual provision.
- Other outsourced service upward trend in June compared to prior month is due to increased radiology service costs.
- Capital charge and depreciation in line with prior month.

6. Statement of financial position- Appendix 6

	Actual 2019 $000	Actual 2020 $000	Budget 2020 $000	Varinace to Budget	Annaul Budget 2019 $000
Assets					
Current assets					
Cash and cash equivalents	3,020	3,813	5	3,808	5
Receivables & Prepayments	6,290	6,594	6,914	(320)	6,914
Investments	–	–	–	–	–
Inventories	1,427	1,617	1,437	180	1,437
Trust /special funds	181	191	180	11	180
Patient and restricted trust funds	4	3	4	(1)	4
Total current assets	**10,922**	**12,218**	**8,540**	**3,678**	**8,540**
Non current assets					
Property, plant and equipment	75,230	72,932	76,138	(3,206)	76,138
Intangible assets	11,777	11,741	12,366	(625)	12,366
Investments in associates	1,146	1,185	1,171	14	1,171
Total non current assets	**88,153**	**85,858**	**89,675**	**(3,817)**	**89,675**
Total assets	**99,075**	**98,076**	**98,215**	**(139)**	**98,215**
Liabilities					
Current liabilities					
Bank Overdraft	–	–	(6,918)	6,918	(6,918)
Payables	(18,234)	(20,852)	(15,904)	(4,948)	(15,904)
Borrowings	(230)	(198)	(198)	–	(198)
Employee entitlements	(16,713)	(21,920)	(18,181)	(3,739)	(18,181)
Provisions	–	–	–	–	–
Total current liabilities	**(35,177)**	**(42,970)**	**(41,201)**	**(1,769)**	**(41,201)**
Non-current liabilities					
Borrowings	(684)	(486)	(486)	–	(486)
Employee entitlements	(873)	(839)	(942)	103	(942)
Total non current liabilities	**(1,557)**	**(1,325)**	**(1,428)**	**103**	**(1,428)**
Total liabilities	**(36,734)**	**(44,295)**	**(42,629)**	**(1,666)**	**(42,629)**
Net assets	**62,341**	**53,781**	**55,586**	**(1,805)**	**55,586**
Equity					
Contributed Capital	(105,567)	(112,409)	(111,409)	(1,000)	(111,409)
Accumulated surplus / (deficit)	67,287	82,696	79,884	2,812	79,884
Property revaluation reserves	(23,881)	(23,881)	(23,881)	–	(23,881)
Hospital special funds	(180)	(187)	(180)	(7)	(180)
Total equity	**(62,341)**	**(53,781)**	**(55,586)**	**1,805**	**(55,586)**

Current asset increased by $3,678k compared to budget- better cash position mainly due to lower capital expenditure.

Non-current asset decreased by $3,817k compared to budget due to Capital expenditure Programme running behind schedule, mainly clinical equipment, facility IT and RHIP.

Current liabilities decreased by $1,769k compared to budget due to Bank over draft better than budget due to Capital expenditure Programme running behind schedule, partly offset by increased in payables relates to IDF wash-up provision and funder demand driven expenditure and employee leave entitlements impact of staff not taking annual leave due to COVID -19 and timing accruals.

Equity increased by $1,805k compared to budget due to receipt of additional $1m deficit support (budgeted $6m and received $7m) and also impact of Holiday Act compliance provision $2.9m

7. Cash Flow – Appendix 7

Consolidated Summary Statement of Cash Flows for the period ended 30 Jun 2020 ($000)

	Actual 2017-18	Actual 2018-19	Actual YTD 2019-20	Budget YTD 2019-20	Variance	
Net surplus / (deficit) for year	(4,179)	(13,654)	(15,402)	(12,597)	(2,805)	U
Add back non-cash items						
Depreciation and assets written off on PPE	4,720	**5,417**	5,565	5,858	(293)	U
Revaluation losses on PPE	–	–	–	–	–	F
Total non cash movements	**4,720**	**5,417**	**5,565**	**5,858**	**(293)**	**U**
Add back items classified as investment Activity						
(loss) / gAmn on sale of PPE	16	15	5	–	5	F
Profit from associates	(129)	(95)	(108)	(95)	(13)	U
GAmn on sale of investments				–	–	F
Write-down on initial recognition of financial asset	83	1,048	–			
Movements in accounts payable attributes to Ca	64	268	(127)	144	(271)	U
Total Items classified as investment Activity	**34**	**1,236**	**(230)**	**49**	**(279)**	**U**
Movements in working capital						
Increase / (decrease) in trade and other payables	**(873)**	**4,312**	**2,618**	(2,330)	4,948	F
Increase / (decrease) employee entitlements	**2,112**	**3,907**	**5,173**	1,537	3,636	F
				–	–	F
(Increase) / decrease in trade and other receivable	(1,091)	2,555	(196)	(529)	333	F
(Increase) / decrease in inventories	(85)	(15)	(190)	(10)	(180)	U
Increase / (decrease) in provision	–	–	–	–	–	F
Net movement in working capital	**63**	**10,759**	**7,405**	**(1,332)**	**8,737**	**F**
Net cash inflow / (outflow) form operating activ	**638**	**3,758**	**(2,662)**	**(8,022)**	**5,360**	**F**
	–	–	–	–		
Net cash flow from Investing (capex)	(6,402)	(4,572)	(3,109)	(7,499)	4,390	F
Net cash flow from Investing (Other)	(7)	(65)	(48)	(24)	(24)	U
Net cash flow from Financing	(351)	(385)	(388)	(388)	–	F
Net cash flow from deficit support	–	–	7,000	6,000		
Net cash flow	(6,122)	(1,264)	793	(9,933)	10,726	F
Net cash (Opening)	10,406	4,284	3,020	3,020	–	F
Cash (Closing)	**4,284**	**3,020**	3,813	**(6,913)**	**10,726**	**F**

Closing cash is better than budget due to the capital expenditure programme running behind schedule and received additional $1m deficit support.

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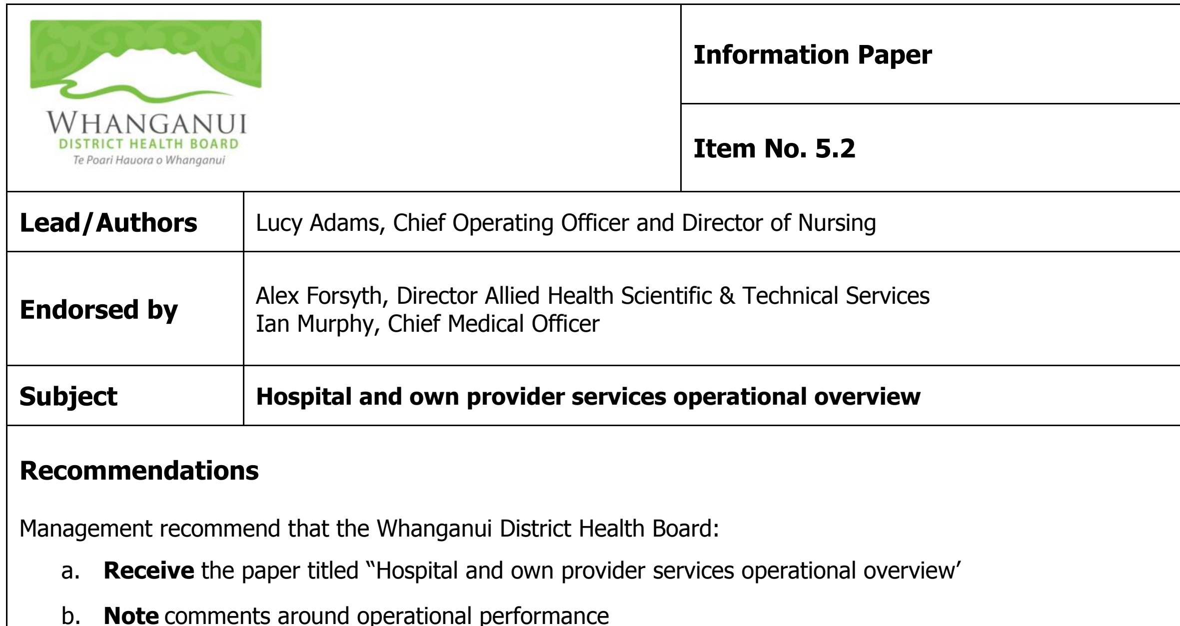


WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	Item No. 5.2
Lead/Authors	Lucy Adams, Chief Operating Officer and Director of Nursing
Endorsed by	Alex Forsyth, Director Allied Health Scientific & Technical Services Ian Murphy, Chief Medical Officer
Subject	**Hospital and own provider services operational overview**

Recommendations

Management recommend that the Whanganui District Health Board:

a. **Receive** the paper titled "Hospital and own provider services operational overview'

b. **Note** comments around operational performance

1 Purpose

To provide the Board with a high-level overview of hospital and own provider operational performance for the month of June 2020.

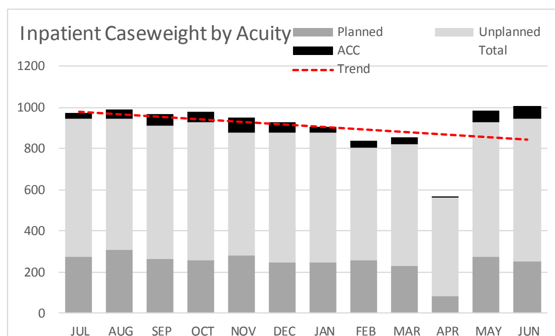
2 Service Delivery Overview

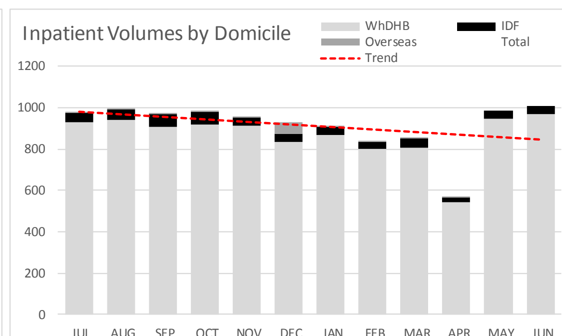
2.1 Discharges and caseweight delivered against contract

Patient throughput for the month of June has returned to pre-COVID levels for inpatient and outpatient services. Planned care services (surgery and minor procedures) are at planned levels and we have had high numbers of patients in the hospital for May and June.

The COVID-19 service interruption has meant that we are non-compliant in Elective Services Productivity Indicator 5 with 73 patients waiting longer than 120 days for treatment as at Friday 17 July. This is an improvement on April (121 non-compliant) and May (137 non-compliant). Whanganui has been consistent in meeting ESPI targets and we have committed to being compliant by 31 December if not sooner.

Inpatient activity by acuity shows that we have had increased planned and unplanned activity in May and June, putting pressure on inpatient services. IDF inflow volumes have stabilised from higher numbers early in the year.





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3 Hospital and Clinical Services

3.1 Inpatient wards

All wards are now fully functioning at normal levels of operation. Medical and surgical wards have permanently swapped floors geographically, giving more isolation rooms in the Medical Ward. July Medical Ward utilisation was 101.5%, Surgical Ward 99% and ATR 94%.

From a staffing utilisation perspective, required inpatient hours matched actual inpatient clinical hours worked. This has required some nursing resource unit staffing to match resource to demand. Redeployment of staff has been pivotal to ensuring safe staffing requirements. This remains a balancing act as we continue to maintain service within financial boundaries. Care Capacity Demand Management (CCDM) programme is in place and is being actively used all the times.

Ward staffing is fully recruited. We are currently recruiting for the clinical nurse manager Medical Ward and a seconded staff member is currently filling the vacancy.

3.2 Emergency Department (ED)

Demand in the Emergency Department has increased in the weeks since moving to alert Level 1. In parallel, elective surgery has also moved back to normal throughput, increasing bed demand. This has created tension between acute and planned capacity requirements, placing pressure on patient flow and bed demand. This has been reflected in the acute assessment unit use which is situated within the ED.

The community-based assessment centre (CBAC) remains open which has been vital in preventing unnecessary respiratory and winter illness presentations.

3.3 Mental health inpatients Te Awhina

The clinical nurse manager (CNM) of Te Awhina has resigned and recruitment is in progress. Staffing in Te Awhina is at budgeted FTE. The unit has been over capacity, with up to 17 patients in the 12-bed unit and has required support by more staff. Acuity is high with excess IPC use. There are also some very acutely unwell patients within the unit requiring significant resource to ensure safety for all within the unit. This has ensured required inpatient hours match actual inpatient clinical hours worked.

Illicit substance use/abuse within Te Awhina is a current concern and a root cause analysis is underway. Smoking policy has been reinforced through the coordinators as this has slipped over the Covid-19 lock-down period. Clinical nurse coordinator (CNC) fortnightly meetings are now occurring to ensure consistency with the mental health key quality indicators, primarily focusing on medication errors, documentation and physical assessments. Regular safety huddles continue during the day to ensure staff are managing/learning and the coordinator has a full knowledge of the department.

Whanganui DHB Mental Health Services remain on the risk register; monitoring and mitigation strategies are in place with regular review by service management.

3.4 Workforce

Medical staff

There are currently 2.5 active vacancies for senior medical staff; psychiatry 1.5 FTEs and obstetrics and gynaecology 1 FTE. We are awaiting that arrival of the new ophthalmologist, which has been delayed due to Covid-19 and lockdowns in the UK and India. A newly recruited anaesthetist is expected to arrive in September dependant on the ability to travel from South Africa.

There are no RMO vacancies for quarter 3 with four vacancies in quarter 4. Quarter 3 staffing includes locums due to several RMOs returning at short notice to the UK due to the Covid-19 situation. There is an opportunity to align the 2021 RMO start dates with the Australasian Colleges which is currently under consideration nationally by the CMOs.
The actions arising from the medical department credentialing are being assigned leads and timeframes. Work has commenced on implementing these actions.

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

The senior nursing management team are working through a strategy to recruit new graduate nurses for 2021. This will include at least 12 new graduates employed over a six month period. These graduates will complete a 12-month programme to support them in their new roles.

Uniforms

Whanganui, MidCentral, Capital and Coast, Wairarapa, Hutt Valley and Hawkes Bay have been working collaboratively to agree a new uniform for nursing and midwifery across the DHBs. The procurement process has been led by MidCentral DHB under the NZHP supply panel arrangement.

The roll out of the uniforms will commence in July/August. All nursing and midwifery staff working in the acute services block will swap from scrubs into the new uniform. The white nursing uniforms will gradually be replaced as the uniforms deteriorate and are no longer fit for purpose. It is expected that the new uniforms will be fully rolled out within two years.

Emergency preparedness task cards

To support the clinical staff in managing a COVID-19 breakout in Whanganui, task cards have been developed. These cards assist staff to quickly mobilise teams and provide clear direction regarding education and processes to follow from isolation process to discharge. These will be in the front of all the WDHB COVID-19 folders.

4 Primary and Community Services

4.1 Service delivery

The vision of 69,000 beds (your own bed is the best bed) is being socialised with the clinical teams and embedded into models of care and service delivery as opportunities for changes in service delivery are identified. Primary & Community Services need to build on progress made to date as new models of care implemented with clinical teams adapting and being more responsive to service user needs.

Overall, there has been an increase in referrals for all services as expected post Covid-19. Clinical teams are actively looking at management of waiting lists to ensure that patients do not experience unnecessary waiting times for access to services. Examples of this include implementation of a combined physiotherapy and occupational therapy community triage process to help identify overlaps in current system and promote a more transdisciplinary approach moving forward. Radiology has obtained additional sonographer resourcing to address waiting lists for ultrasound.

Lone worker in community

District nursing and Community Mental Health and Addiction Services (CMHAS) have been trialling a technology solution for safety in the community called "Stay Safe". The trail is being extended to mid-July to enable enough time for CMHAS rural based teams to trial it.

4.2 Workforce

Two speech language therapists commenced in June which will see a reduction in outsourcing for this service.

Ongoing recruitment challenges in Pharmacy are being reviewed with the development of specialist pharmacy roles, such as a system wide role with a focus on mental health in the community.

The physiotherapy service is looking at different models of care to cover vacancies with increased use of therapy assistants, while ongoing recruitment continues.

The clinical informatics lead role has been appointed and will strengthen the ability of Primary and Community Services to measure value adding interventions across all services and wider community.

4.3 Service change

Difficulty recruiting into specialist services means that services need to continue to manage capacity, considering how services should be delivered differently to meet need such as greater engagement with providers in the community and a cross–sector, whole of system approach.

5 Maternal, Child and Youth Services (MCYS)

5.1 General

Service level alliance

A Terms of Reference is now complete, and membership of the group is being populated now. Aiming for a diverse range of community and expert perspectives to ensure the shaping and delivery of services reflects the needs of the community.

Leadership team

Lucy Pettit has been appointed to the role of director of midwifery. Lucy comes to this role from her present role as clinical midwife manager of the Maternity Unit at WDHB. She joins the Maternal, Child and Youth leadership team.

5.2 Service delivery

Paediatrics

Permanent CNM Paediatrics appointed. Bed occupancy slightly below this period last year but this was expected due to COVID 19 lockdown and increased uptake in flu vaccinations in whole population.

Public health

Staff involved in COVID response now focusing on catching up with school-based programmes such as HEAADSS assessments and immunisations. There is also roll out of the Ministry of Health measles, mumps and rubella (MMR) vaccination programme for 12-29 year olds. Public Health staff continue to assist in staffing of CBAC.

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

Noticeable increase in number of referrals since end of lockdown, referrals up by 28 for month of June. Staff developing strategies to ensure those most at risk are prioritised. Pressure for service also noted by NGO services which is impacting on the referral rate for MICAMHAS.

Oral health

Review of oral health services to commence to ensure hospital-based service is not over delivering to community. Prioritisation of services to those considered to be high risk and focus on community-based provision of services otherwise.

Maternity

Birthing numbers remain static as expected. Identification of need for Primary Service, due to unavailability of local lead maternity carers for the December/January period. Planning for this is underway.

5.3 Future focus

Whanganui District Board has a DNA project in place. MCYS has developed a project team to scope current processes within different areas of service. The goal is to identify the best ways to assist whanau and children to attend appointments particularly those who access multiple services. This project is in line with the desire to provide child and whanau with a more integrated MCYS.

6 Te Hau Ranga Ora Māori Health Service

Following the restructure, Kaitākitāki support is now in place for each hub/waka and services. The Haumoana service of Te Hau Ranga Ora sits within the hospital-clinical hub/waka with the Kaitākitāki Clinical assigned to this hub and responsible for the management of the Haumoana service.

The functions will be reported in this section and will look at including utilisation of qualitative, quantitative information including the functions of Mauri Ora emergency/temporary accommodation and the Whare Whakataumate.

The Haumoana are an essential enabler to high quality care and whānau ora working alongside and supporting patients/tangata whaiora, whānau and staff. The learnings over COVID showed the Haumoana used innovative and supportive approaches during this time with technology to support patients/tangata whaiora to connect to love ones in hospital through reassurance and relaying of messages, regular support and care packages given to families/whānau waiting in the carpark during Lockdown period. During the lockdown period, the Haumoana worked alongside the CBAC and with Iwi health providers, PHO to connect and support our community.

The beginning of March saw full occupancy of Mauri Ora emergency/temporary accommodation with various families/whānau from out of town in residence until closure on 19 March 2020 due to COVID.

The Whare Whakataumate was occupied from 6-9th March 2020 as support to a large whānau who had a loved one in palliative care on the medical ward. The whare was used as an alternative option to take pressure off the ward at this time, which the whānau were appreciative of and aware of the kaupapa/purpose of the whare. The Whare Whakataumate was closed due to COVID on 19 March 2020.

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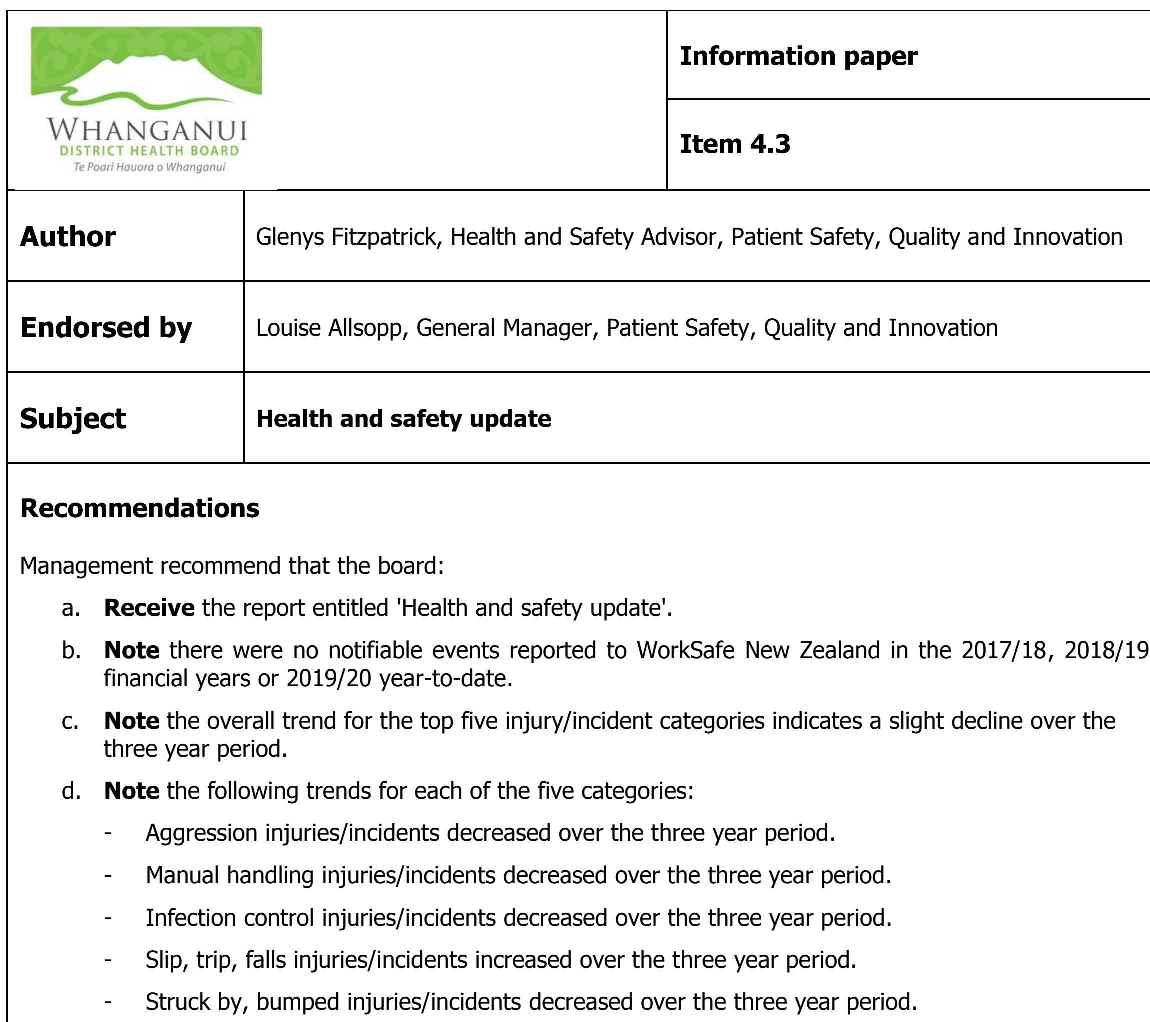	**Information paper** **Item 4.3**
Author	Glenys Fitzpatrick, Health and Safety Advisor, Patient Safety, Quality and Innovation
Endorsed by	Louise Allsopp, General Manager, Patient Safety, Quality and Innovation
Subject	**Health and safety update**

Recommendations

Management recommend that the board:

a. **Receive** the report entitled 'Health and safety update'.

b. **Note** there were no notifiable events reported to WorkSafe New Zealand in the 2017/18, 2018/19 financial years or 2019/20 year-to-date.

c. **Note** the overall trend for the top five injury/incident categories indicates a slight decline over the three year period.

d. **Note** the following trends for each of the five categories:

- Aggression injuries/incidents decreased over the three year period.
- Manual handling injuries/incidents decreased over the three year period.
- Infection control injuries/incidents decreased over the three year period.
- Slip, trip, falls injuries/incidents increased over the three year period.
- Struck by, bumped injuries/incidents decreased over the three year period.

1 Purpose

To enable the board to exercise due diligence on health and safety matters. This report on key health and safety system risks covers:

- incident/injury trends.
- incident/injury details.
- employee participation.
- contractor management.

2 Incident/injury trends

The graph below provides a rolling average, actual summary and trend line of the last three years' top five injury/incident trends.

The trend line (based on the rolling average) indicates a slight decline in the overall number of incidents/injuries (top five) over the three year period.

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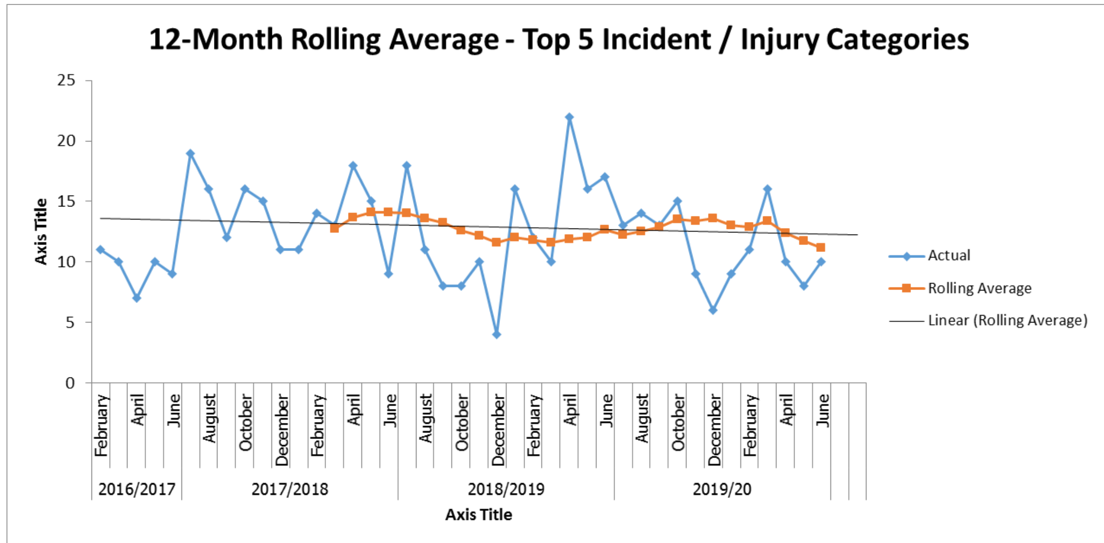
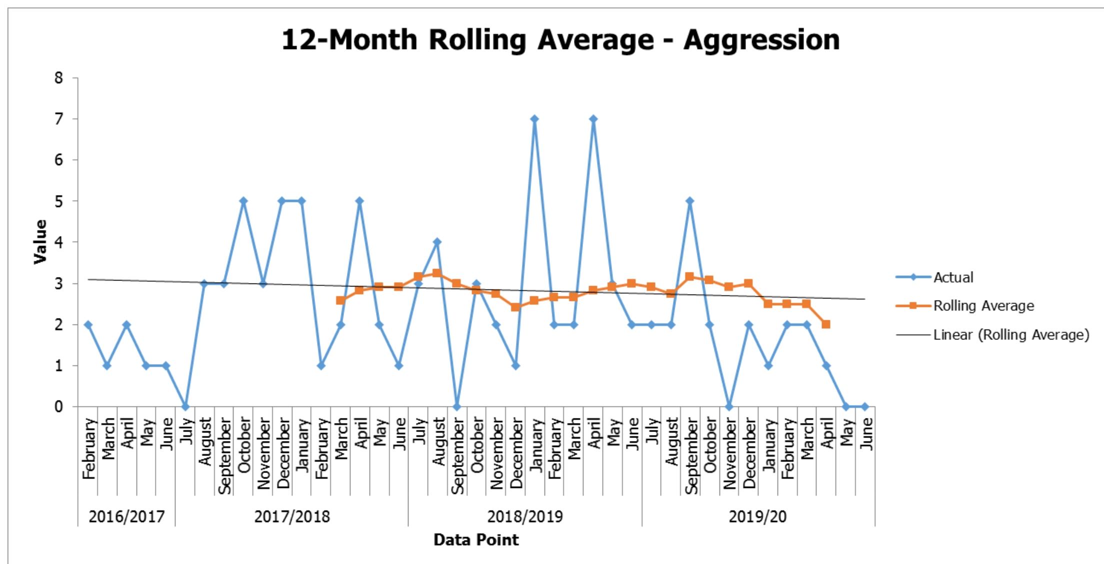


The following graphs provide a rolling average, actual three year breakdown of monthly incidents and trend line for each of the top five incident/injury categories.

Aggression



The trend line (based on the rolling average) shows a slight decrease in the number of incidents/injuries over the three year period.

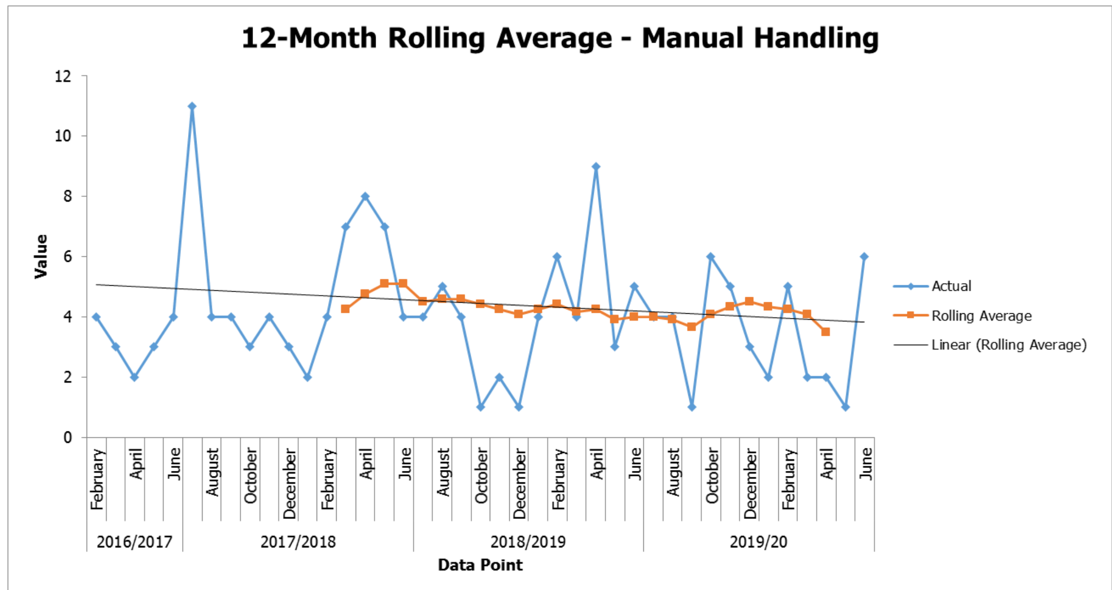
During May and June 2020 there were no aggression injuries/incidents recorded on RiskMan.

Improved risk mitigations continue and include:

- All police staff who come to assist with aggressive patients are informed of the total plan. This ensures that everyone is on the same page.
- Commenced “hub” nursing to ensure the patients in intensive care areas are better covered with a team of staff.

  - Trying to have consistency with the same staff caring for the same person for a few days in a row.
  - This ensures the patient has the appropriate number of staff caring for them and there is cover for breaks
- Huddles continue throughout the day to manage the workload, picking up changes of the patient and to ensure better communication
- Broset scoring continues

Manual handling



The trend line (based on the rolling average) shows a decrease in the number of incidents/injuries over the three year period.

During May and June 2020, there were four patient (ATR (2) and Medical (2)) and three object related manual handling injuries in ATR, Therapies and Theatre.

Issues identified:

- Lack of communication and critical thinking between staff
- Lack of suitable equipment for transfer of bariatric patient
- Same staff transferring bariatric patient

Improved risk mitigations include:

- Q2 roller education (device assists with turns and pressure injury prevention and positioning)
- Reviewing positioning and manual handling techniques
- Ensuring manual staff training is up to date
- Book staff onto manual handling training to refresh knowledge
- Equipment that can be used with ceiling hoists
- Rotating staff working with bariatric patients
- Working on a project to provide ceiling hoists in wards that do have them

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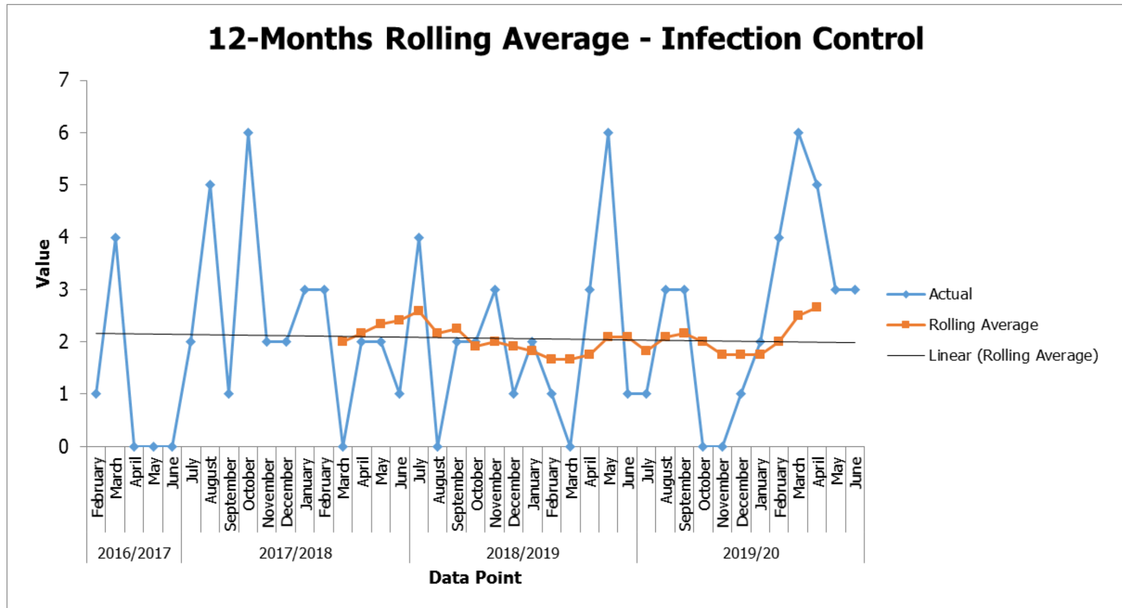
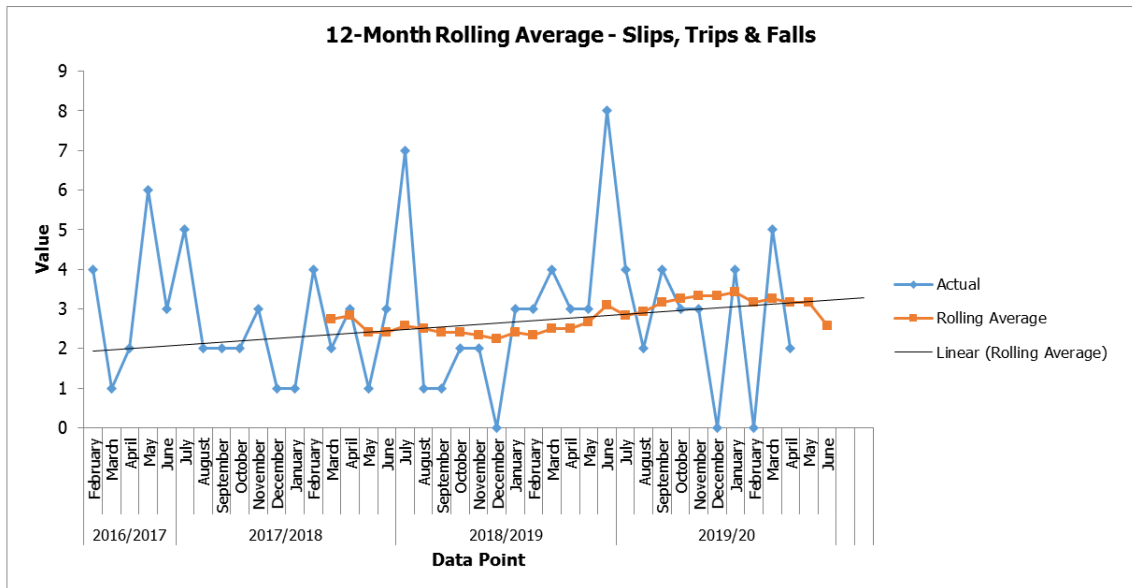
Infection prevention



The trend line (based on the rolling average) shows a decline in the number of infection control incidents/injuries over the three year period.

During May and June 2020 there were six infection control (5 needle-stick and 1 blood body fluid splash) incidents.

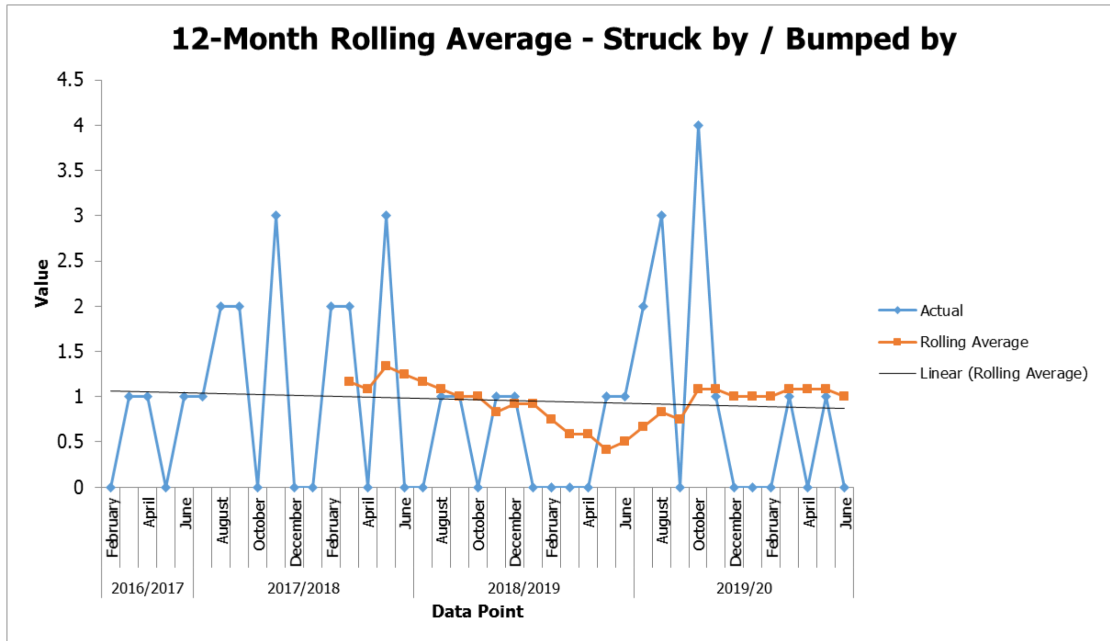
Slips, trips and falls



The trend line (based on the rolling average) shows an increase in the number of slips, trips and falls incidents/injuries over the three year period.

During May and June 2020 four slips, trips and falls incidents/injuries were reported. Injuries/incidents included: tripped and fell going down steps, knee gave out whilst changing position, fell off a chair and missed a step whilst walking.

Struck by or bumped by



The trend line (based on the rolling average) shows a steep decline in the number of struck by or bumped by incidents/injuries over the three year period.

During May and June 2020 one bumped by incident/injuries was reported.

3 Incident/injury details

There were 20 staff incidents (injuries/potential injuries) recorded by staff on RiskMan in May and June 2020.

The graph below provides a cumulative view of outcomes classifications for 2018/19/20.

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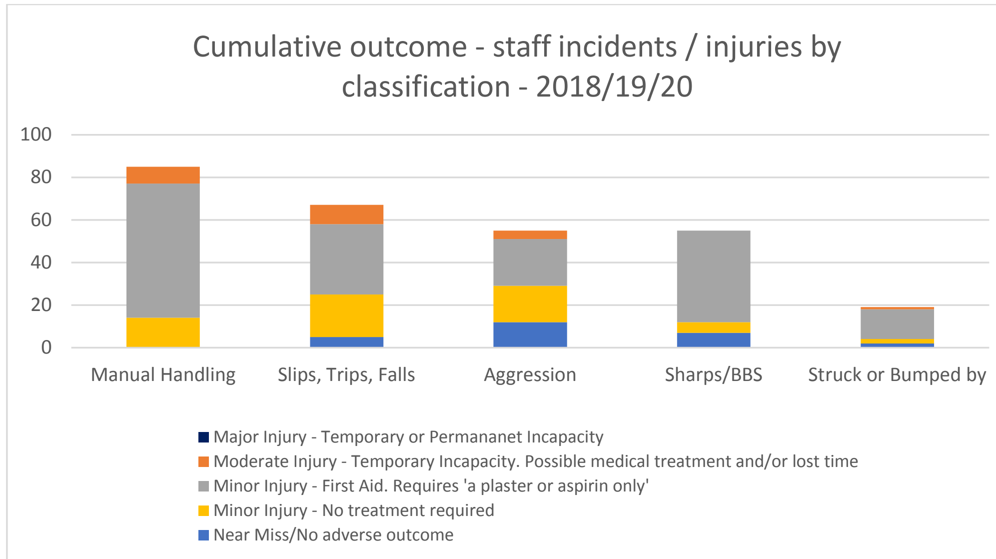
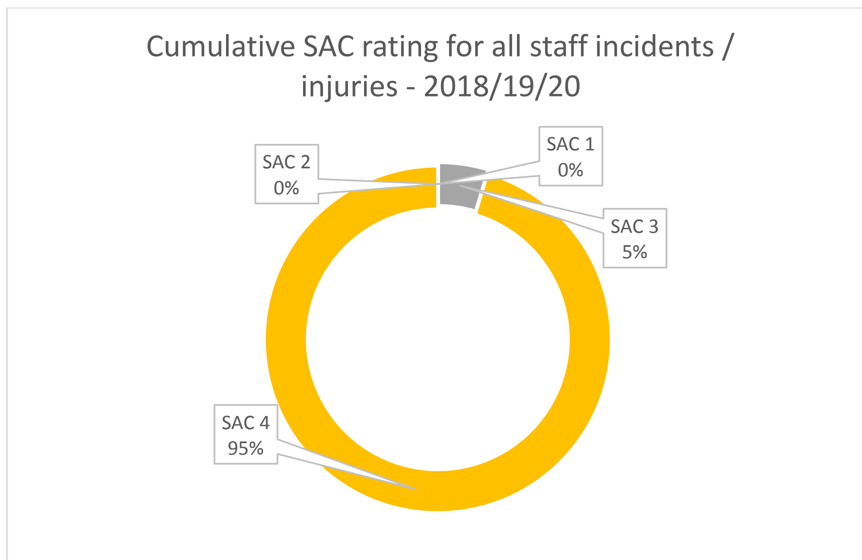


The graph below provides a cumulative SAC rating (Likelihood x Consequence) for all staff incidents/injuries for 2018/19/20.



Definitions used in the graph:

SAC 4 Minor/minimal – no injury
SAC 3 Moderate – permanent moderate or temporary loss of function
SAC 2 Major – permanent major or temporary severe loss of function
SAC 1 Severe – death or permanent severe loss of function.

SAC 1 incidents/injuries (and potentially SAC 2 incidents/injuries) require WorkSafe notification. No notifiable events were reported to WorkSafe New Zealand in the 2017/18 or 2018/19 financial years. For all SAC 1 and 2 incidents/injuries, a Critical Systems Analysis (CSA) is undertaken. All injuries reported to Wellnz (tertiary ACC provider) are investigated.

July 2020 **Public**

4 Employee participation

The WDHB Health and Safety Committee met in June.

The following issues were discussed at the WDHB Health and Safety Committee meeting.

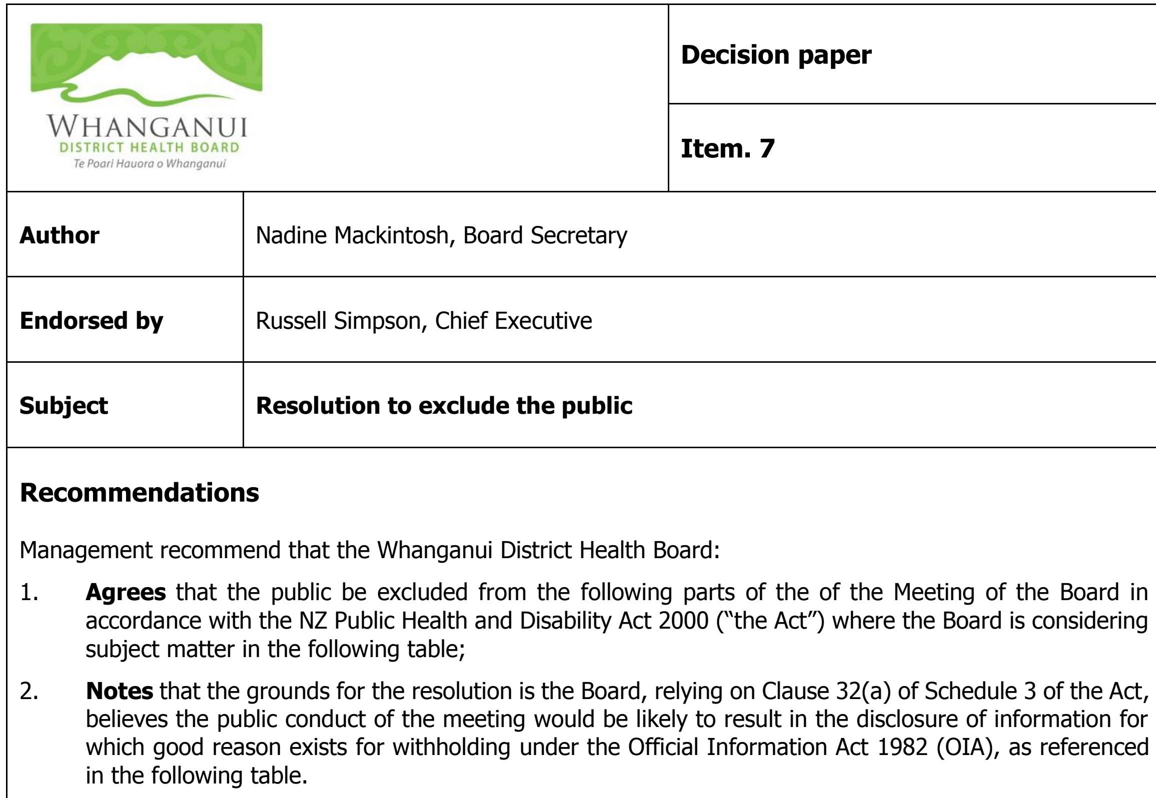
- WorkWell wellness programme
- Review of monthly incident trends
- Rolling average trends and graphs for board report
- Monitor and update of health and safety objectives for 2019/2020
- Aggression workgroup
- Excellence and innovation in health and safety
- Manual handling
- AEP self-assessment
- Generic hazards review
- Health and safety review

5 Contractor management update

Spotless Services, as our key on-site contractor, provided the following health and safety report, which is evidence of having active health and safety systems in place.

Spotless H&S	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec 19	Jan 20	Feb-20	Mar 20	Apr 20
Category A: Fatality / Disabling	0	0	0	0	0	0	0	0	0	0	0	0	0
Category B: Lost Time Injury	0	0	0	0	0	0	0	0	0	0	0	0	0
Category C: Medical Treatment	0	0	0	0	0	0	0	0	0	0	0	0	0
Category D: First Aid / Allied Health	0	0	0	0	0	0	0	0	0	0	0	0	1
Category E: Injury with no treatment	0	0	0	1	0	0	0	0	0	0	0	1	0
Category G: Non-work	0	0	0	0	0	0	0	0	0	0	0	0	0
Near Miss	0	0	0	0	0	1	0	0	0	0	0	0	0
Spotless H&S	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec 19**	**Jan 20**	**Feb 20**	**Mar 20**	**Apr 20**
Hazard	10	9	8	10	12	11	9	10	10	10	8	6	8
Safety Observations	17	11	15	17	17	14	15	15	15	17	14	11	15
Sub-Contracted to Spotless	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec 19**	**Jan 20**	**Feb 20**	**Mar 20**	**Apr 20**
Contractor Safety Interactions	9	12	8	6	4	5	3	0	0	4	2	2	4
Contractor Hazard	0	0	0	0	0	0	0	0	0	0	0	0	0
Contractor Injury	0	0	0	0	0	0	0	0	0	0	0	0	0
Contractor Near Miss	0	0	0	0	0	0	0	0	0	0	0	0	0

July 2020 **Public**



	Decision paper
	Item. 7
Author	Nadine Mackintosh, Board Secretary
Endorsed by	Russell Simpson, Chief Executive
Subject	**Resolution to exclude the public**

Recommendations

Management recommend that the Whanganui District Health Board:

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

Agenda item	Reason	OIA reference
Whanganui District Health Board minutes of meeting held on 5 June 2020	For reasons set out in the board's agenda of 5 June 2020	As per the board agenda of 5 June 2020
Chief executive's report Board & committee chair reports WDHB Strategy Document Risk Report	To enable the district health board to carry out, without prejudice or disadvantage, commercial activities or negotiations (including commercial and industrial negotiations) To protect the privacy of natural persons, including that of deceased natural persons To avoid prejudice to measures protecting the health or safety of members of the public To protect information which is subject to an obligation of confidence or which any person has been or could be compelled to provide under the authority of any enactment, where the making available of the information would be likely to prejudice the supply of similar information, or information from the same source, and it is in the public interest that such information should continue to be supplied; or would be likely otherwise to damage the public interest.	Section 9(2)(i) and 9(2)(j) Section 9(2)(a) Section 9(2)(c) Section 9(2)(ba)
Integrated Facilities Update Lambie Ground Floor Refurbishment	To enable the district health board to carry out, without prejudice or disadvantage, commercial activities or negotiations (including commercial and industrial negotiations	Section 9(2)(i) and 9(2)(j)
Draft Annual Plan Sustainability Initiatives Maintaining National Intervention rates	To maintain the effective conduct of public affairs through the free and frank expression of opinions by or between or to Ministers of the Crown or members of an organisation or officers and employees of any department or organisation in the course of their duty	Section 9 (2) (g) (i)

July 2020 **Public**

Persons permitted to remain during the public excluded session

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

Person(s)	Knowledge possessed	Relevance to discussion
Chief executive, senior managers and clinicians present	Management and operational information about Whanganui District Health Board	Management and operational reporting and advice to the board
Board secretariat or board's executive assistant	Minute taking, procedural and legal advice and information	Recording minutes of board meetings, advice and information as requested by the board