WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

AGENDA

Combined Statutory Advisory Committee

Meeting date	**Friday 1 September 2017**
Start time	9.30am – 1.00pm
Venue	Fourth Floor Ward and Administration Building Whanganui Hospital 100 Heads Road Whanganui

Embargoed until Saturday 2 September 2017

Contact
Phone 06 348 3393
Fax 06 345 9390

Also available on website
www.wdhb.org.nz

Distribution

Board members *(full copy)*

- Ms Dot McKinnon, Board Chair
- Mr Graham Adams
- Mr Charlie Anderson
- Mrs Philippa Baker-Hogan
- Mrs Jenny Duncan
- Ms H Hipango *(public session only until after General Elections)*
- Mr D Hull
- Mr Stuart Hylton, Combined Statutory Advisory Committee Chair
- Mrs Judith MacDonald
- Ms Annette Main
- Hon Dame Tariana Turia

External committee members *(full copy)*

- Mr Frank Bristol
- Mr Matt Rayner
- Ms Maraea Bellamy
- Mr Leslie Gilsenan
- Dr Andrew Brown

Executive Management Team and others *(full copy)*

- Mrs J Patterson, Chief Executive
- Mrs S Blake, Director of Nursing, Patient Safety and Quality
- Mrs S Campion, Communications Manager
- Mr H Cilliers, General Manager, Human Resources and Organisational Development
- Ms K Fry, Director Allied Health
- Mrs R Kui, Director Māori Health
- Mr F Rawlinson, Chief Medical Officer
- Ms T Schiebli, General Manager, Service and Business Planning
- Mr B Walden, General Manager, Corporate Services
- Mr M Power, Funding and Contracts Manager
- Ms K Fraser-Chapple, Business Manager, Medical, Community and Allied Health
- Mrs L Torr, Business Manager, Medical Management Unit
- Mr P Wood-Bodley, Business Manager, Surgical Services
- Mrs A Bunn, Portfolio Manager, Health of Older People
- Ms C Sixtus, Portfolio Manager, Primary Care
- Mrs L Allsopp, Manager Patient Safety and Quality
- Mrs J Haitana, Associate Director of Nursing General
- Mr J Hammond, Associate Director of Nursing Mental Health
- Mrs E O'Leary, Project Manager
- Mr D Rogers, Nurse Manager Surgical Services
- Mrs W Stanbrook-Mason, Nurse Manager Medical Services
- Mrs K Butter, Nurse Manager, Mental Health Services
- Mr J Buchan, Portfolio Manager, Child and Youth
- Ms S Fergusson, Executive Assistant

Others *(public section only)*

- Mrs K Anderson, Chief Executive, Hospice Wanganui
- Dr B Douglas, GP, Jabulani Medical Practice
- Ms C Blomkvist
- Ms A Stewart
- Hauora a Iwi
- Wanganui Public Library
- Wanganui Chronicle

Agendas are available at www.wdhb.org.nz one week prior to the meeting.

Combined Statutory Advisory Committee member attendance schedule – 2017

Name	24 February (Joint AP workshop)	3 March	7 April	26 May	14 July	1 September	13 October	1 December
Graham Adams	✓	×	✓	✓	✓			
Charlie Anderson	✓	×	✓	✓	✓			
Frank Bristol	✓	✓	✓	✓	✓			
Philippa Baker-Hogan	✓	✓	✓	✓	✓			
Andrew Brown	Appointed to committee 7 April		✓	✓	✓			
Darren Hull	✓	✓	✓	✓	✓			
Jenny Duncan	×	✓	✓	✓	✓			
Leslie Gilsenan	Appointed to committee 7 April		✓	×	✓			
Harete Hipango	✓	✓	General election candidate until further notice					
Stuart Hylton (committee chair)	✓	✓	✓	✓	✓			
Judith MacDonald	✓	✓	✓	✓	✓			
Annette Main	✓	✓	✓	×	✓			
Matthew Rayner	✓	✓	✓	✓	✓			
Tariana Turia	×	✓	✓	✓	✓			
Susan Osborne	✓	✓	✓	✓	Left committee 26 May 2017			
Maraea Bellamy	✓	✓	✓	✓	✓			
Dot McKinnon (Board Chair)	✓	✓	×	✓	✓			

Legend

✓ Present
× Apologies given
✦ No apology received
✸ Attended part of the meeting only
☝ Absent on board business
⊙ Leave of absence

WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

Agenda
Public session

Meeting of the Combined Statutory Advisory Committee

to be held in the Board Room, Fourth Floor, Ward/Administration Building
Whanganui Hospital, 100 Heads Road, Whanganui
on Friday 1 September 2017, commencing at 9.30am

Combined Statutory Advisory Committee members

Mr Stuart Hylton, Committee Chair
Ms Dot McKinnon, Board Chair
Mr Graham Adams
Mr Charlie Anderson
Mrs Philippa Baker-Hogan
Ms Maraea Bellamy
Dr Andrew Brown
Mr Frank Bristol
Ms Jenny Duncan
Mr Leslie Gilsenan
Ms Harete Hipango *(on leave until after 2017 general elections)*
Mr Darren Hull
Mrs Judith MacDonald
Ms Annette Main
Mr Matthew Rayner
Hon Dame Tariana Turia

1 Apologies

2 Conflict and register of interests update Page 9

2.1 Amendments to the register of interests
2.2 Declaration of conflicts in relation to business at this meeting

3 Late items

Registration of minor items only. No resolution, decision or recommendation may be made except to refer the item to a future meeting for further discussion.

4 Minutes of the previous committee meetings Page 13

Recommendation
That the minutes of the public session of the meeting of the Combined Statutory Advisory Committee held on 14 July 2017 be approved as a true and correct record.

5 Matters arising

Nil

6 Committee Chair's report

A verbal report may be given at the meeting

7 Delivery against commitments in the 2016/17 WDHB Annual Plan Page 23

7.1 Annual Plan focus area: Equitable access to clinical services - Mental health and addictions Page 25

7.2 Annual Plan Focus Area: Improving equity for priority populations - All of population initiatives, including prevention and management of long term conditions Page 31

7.3 Annual Plan focus area: Improving equity for priority populations - Maternal, child and youth health Page 47

7.4 Annual Plan focus area: Living within our means Page 69

8 Information Section

Attachment	Description	Page 77
1	**Annual Plan focus area:** **Equitable access to clinical services | Mental health and addictions**	
	1.2 Quality improvement and service development update	79
	1.3 Wellbeing model and proposed model of care presentation	87
	1.4 Mental Health Social Investment Fund	97
2	**Annual Plan Focus Area:** **Improving equity for priority populations | All of population initiatives, including prevention and management of long term conditions**	
	2.1 Access to primary care and acute demand	111

Reference and Information attachments – combined committee interest		
3	Glossary	115
4	Committees – Terms of Reference	119

9 Date of next meeting

Friday, 13 October 2017

10 Glossary and Terms of References *(for information only)* **Page 115 & 119**

11 Exclusion of public

Recommendation

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

Agenda item	Reason	OIA reference
Combined Statutory Advisory Committee minutes of the meeting held on 14 July 2017 (public-excluded session)	For the reasons set out in the committee's agenda of 14 July 2017	As per the committee's agenda of 14 July 2017
Service and Business Planning – risk register	To protect the privacy of natural persons, including that of deceased natural persons To protect information where the making available of the information would be likely unreasonably to prejudice the commercial position of the person who supplied or who is the subject of the information 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)(a) Section 9(2)(b)(ii) Section 9(2)(i) and 9(2)(j)

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	Minute taking	Recording minutes of meetings

WHANGANUI DISTRICT HEALTH BOARD

REGISTER OF CURRENT CONFLICTS AND DECLARATIONS OF INTEREST

Up to and including 9 August 2017

BOARD MEMBERS

NAME	DATE NOTIFIED	CONFLICT/DECLARATIONS
Graham Adams	16 December 2016	Advised that he is: ▪ A member of the executive and the treasurer of Grey Power Wanganui Inc. ▪ A board member of Age Concern Wanganui Inc. ▪ Treasurer of NZCE (NZ Council of Elders) ▪ A trustee of Akoranga Education Trust, which has associations with UCOL.
Charlie Anderson	16 December 2016	He is an elected councillor on Whanganui District Council.
Philippa Baker-Hogan	10 March 2006	Advised that she is an elected member of the Whanganui District Council.
	8 June 2007	Partner in Hogan Osteo Plus Partnership.
	24 April 2008	Advised that her husband is an osteopath who works with some surgeons in the hospital on a non paid basis but some of those patients sometimes come to his private practice Hogan Osteo Plus and that she is a partner in that business.
	25 September 2009	Appointed to Whanganui Community Foundation from 1 October 2009
	29 November 2013	Advised that she is Chair of the Future Champions Trust, which supports promising young athletes.
	7 November 2014	Philippa Baker-Hogan declared her interest as: ▪ A member of the Whanganui District Council District Licensing Committee; and ▪ Chairman of The New Zealand Masters Games Limited
	3 March 2017	Philippa Baker-Hogan declared her interest as: ▪ A trustee of Four Regions Trust; and ▪ A trustee of Wanganui Events Trust
Jenny Duncan	18 October 2013	Advised that she: ▪ Is a member of the Whanganui Community Foundation ▪ Is an elected member of the Whanganui District Council
	1 August 2014	Advised that she is an appointed member of the Castlecliff Community Charitable Trust
Harete Hipango	7 March 2014	Advised that she acts as lawyer for clients who may be consumers of services from WDHB.
	31 March 2017	Nomination confirmed as National Party candidate for the general election being held on 23 September 2017. In accordance with State Services Commission's advice, will stand down from Whanganui District Health Board until the election.
Darren Hull	28 March 2014	Advised that he acts for clients who may be consumers of services from WDHB.
	27 May 2014	Advised that he: ▪ is a director & shareholder of Venter & Hull Chartered Accountants Ltd which has clients who have contracts with WDHB ▪ acts for some medical practitioners who are members of the Primary Health Organisation ▪ acts for some clients who own and operate a pharmacy ▪ is a director of Gonville Medical Ltd
	20 June 2014	Advised he is on the Whanganui Regional Health Network Risk & Audit Committee.
	23 May 2016	Advised he is no longer on the Whanganui Regional Health Network Risk & Audit Committee.
Stuart Hylton	4 July 2014	Advised that he is:

		▪ Executive member of the Wanganui Rangitikei Waimarino Centre of the Cancer Society Of New Zealand. ▪ Appointed 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	Advised that he is an executive member of the Central Districts Cancer Society.
	15 March 2017	Advised that he is appointed as Rangitikei District Licensing Commissioner.
Judith MacDonald	22 September 2006	Advised that she is: ▪ Chief Executive Officer, Whanganui Regional Primary Health Organisation ▪ Director, Whanganui Accident and Medical
	11 April 2008	Advised that she is a director of Gonville Health Centre
	4 February 2011	Declared her interest as director of Taihape Health Limited, a wholly owned subsidiary of Whanganui Regional Primary Health Organisation, delivering health services in Taihape.
	27 May 2016	Advised that she has been appointed Chair of the Children's Action Team
Annette Main		
Dot McKinnon	3 December 2013	Advised that she is: ▪ An associate of Moore Law, Lawyers, Whanganui ▪ Chair, Powerco Wanganui Trust ▪ Wife of the Chair of the Wanganui Eye & Medical Care Trust
	4 December 2013	Advised that she is Cousin of Brian Walden
	23 May 2014	Advised that she is a member of the Health Sector Relationship Agreement Committee.
	31 July 2015 and 10 August 2015	Advised that she is appointed to the NZ Health Practitioners Disciplinary Tribunal
	2 March 2016	Advised that she is a member of the Institute of Directors
	16 December 2016	Advised that she is Chair of MidCentral District Health Board
	3 February 2017	Advised that she is on the national executive of health board chairs
Tariana Turia	16 December 2016	Declared her interests as: ▪ Pou to Te Pou Matakana (North Island) ▪ Member of independent assessment panel for South Island Commissioning Agency ▪ Life member CCS Disability Action ▪ Healthier Lives Governance Group ▪ Te Pookai Aronui – Nga Rauru Investment Board ▪ National Hauora Coalition Trustee Chair ▪ Cultural adviser to ACC CEO ▪ Te Amokura of Te Korowai Aroha Trust (National)

BOARD ADVISORS

NAME	DATE NOTIFIED	CONFLICT/DECLARATIONS
Peter Brown		No current declared interests.

COMBINED STATUTORY ADVISORY COMMITTEE MEMBERS

NAME	DATE NOTIFIED	CONFLICT/DECLARATIONS
Maraea Bellamy		No current declared interests.
Frank Bristol	8 June 2017	Advised that he is: ▪ Member of the WDHB Mental Health and Addiction (MH&A) Strategic Planning Group co-leading the adult workstream. ▪ An executive member of the National Early Intervention for Psychosis society. ▪ In a management role with the NGO Balance Aotearoa which holds Whanganui DHB contracts for Mental health & addiction peer support, advocacy and consumer consultancy service provision.

		▪ Working as the MH & A Consumer Advisor to the Whanganui DHB through the Balance Aotearoa as holder of a consumer consultancy service provision contract. ▪ Working as Consumer Advisor to MidCentral DHB MHA Services. Member of MidCentral DHB MHA Executive Management team. ▪ Member of Sponsors and Reference groups of National MH KPI project. ▪ Member of Health Quality and Safety Commission's MH Quality Improvement Stakeholders Group. ▪ Member of Te Pou/Ministry of Health Information and Data reference group ▪ Member of Ministry of Health 'He Tangata" (MH Outcomes Framework) Informatics workstream ▪ Member of Whanganui DHB/WRHN Strategic IT group ▪ Has various roles in Whanganui DHB MHA WD, Quality Improvement programmes and Strategic planning ▪ Member of Whanganui DHB CCDM Council ▪ Steering group partner via Balance Aotearoa with Ministry of Health on Disability Action Plan Action 9d).This is legal and improvement work associated with MH Act, Bill of Rights and UN Convention on Rights of Disabled people. ▪ Balance Aotearoa is a Disabled Persons Organisation (DPO) and a member of the DPO Collective doing work with the Disability Action Plan representing the mental health consumers. ▪ Life member of CCS Disability Action
	14 July 2017	Advised that he is doing consultancy work for Capital and Coast District Health Board
Andrew Brown	13 July 2017	Advised that: ▪ he is an independent general practitioner and clinical director of Jabulani Medical Centre; ▪ he is a member of Whanganui Hospice clinical governance committee; and ▪ most of his patients would be accessing the services of Whanganui District Health Board.
Leslie Gilsenan		No current declared interests.
Susan Osborne	25 February 2014	Advised the following conflicts/interests: ▪ Hauora a Iwi (Whanganui Representative) Governance ▪ Te Oranganui Iwi Health Authority Board of Trustees ▪ Jigsaw Whanganui Board of Trustee Tupoho Runanga Whanganui Health portfolio representative.
	20 June 2014	Advised that she is on the Te Oranganui Iwi Health Authority Risk & Audit Committee.
	31 July 2015	Advised she is a trustee of Nga Tangata Tiaki.
Matt Rayner	11 October 2012	Advised that: ▪ He is an employee of Whanganui Regional PHO – 2006 to present ▪ His fiancée, Karli Kaea-Norman, is an Employee of Gonville Health Limited
	26 October 2012	Advised that he is a member on the Diabetes Governance Group
	31 July 2015	Advised that he is: ▪ employed by the Whanganui Regional Health Network (WRHN) ▪ a trustee of the group "Life to the Max"
	27 May 2016	Advised that he is a member of the Health Solutions Trust
Ailsa Stewart		No current declared interests.

RISK AND AUDIT COMMITTEE MEMBERS

NAME	DATE NOTIFIED	CONFLICT/DECLARATIONS
Kate Joblin	11 May 2007	Confirmed that she is a Trustee of 'Life to the Max Trust'.
	23 May 2008	Declared that she is a director and shareholder of Kate Joblin & Co Limited, which company has a number of clients that have contracts with WDHB.
	17 December 2010	Advised that she is an appointed Director of MidCentral District Health Board.

	17 February 2012	Advised that Kate Joblin & Co Limited acts for some medical practitioners who are members of the Primary Health Organisation.
	12 December 2012	Advised that Kate Joblin & Co Limited acts for a client who owns a pharmacy.
	20 November 2013	Advised Kate Joblin & Co Limited provides accountancy services for Whanganui Youth Services Trust
	11 & 16 April 2014	Advised that her daughter-in-law is about to commence working for WDHB and is a registered nurse on the NETP (Nursing Entry To Practice) programme.
	29 January 2016	Advised that her niece works for Te Awhina Mental Health Unit.

NAME	DATE NOTIFIED	CONFLICT/DECLARATIONS
Anne Kolbe	26 August 2010	▪ Medical Council of NZ – Vocational medical registration – Pays registration fee ▪ Royal Australasian College of Surgeons – Fellow by Examination – Pays subscription fee ▪ Private Paediatric Surgical Practice (Kolbe Medical Services Limited) – Director – Joint owner ▪ Communio, NZ – Senior Consultant - Contractor ▪ Siggins Miller, Australia – Senior Consultant - Contractor ▪ Hospital Advisory Committee ADHB – Member – Receives fee for service ▪ Risk and Audit Committee Whanganui DHB – Member – Receives fee for service ▪ South Island Neurosurgical Services Expert Panel on behalf of the DGH – Chair – Receives fee for service
	18 April 2012	Advised that she is an employee of Auckland University but no longer draws a salary.
	20 June 2012	Advised that she holds an adjunct appointment at Associate Professor level to the University of Auckland and is paid a small retainer (not salary).
	17 April 2013	Advised that her husband John Kolbe is: ▪ Professor of Medicine, FMHS, University of Auckland ▪ Chair, Health Research Council of New Zealand, Clinical Trials Advisory Committee (advisory to the council) ▪ Member Australian Medical Council (AMC) Medical School Advisory Committee (advisory to the board of AMC) ▪ Lead, Australian Medical Council, Medical Specialties Advisory Committee Accreditation Team, Royal Australian College of General Practitioners ▪ Member, Executive Committee, International Society for Internal Medicine ▪ Chair, RACP (Royal Australasian College of Physicians) Re-validation Working Party ▪ Member, RACP (Royal Australasian College of Physicians) Governance Working Party
	12 February 2014	Advised that she is a Member of the Australian Institute of Directors – pays membership fee
	18 February 2016	Joined the inaugural board of EXCITE International, an international joint venture sponsored by the Canadian Government, to consider how to pull useful new technology into the marketplace. No fee for service, although costs would be met by EXCITE International.
	13 April 2016	Advised that she: ▪ is an observer to the Medicare Benefits Schedule Review Taskforce (Australia).
	10 August 2016	Advised that: ▪ Transition of the National Health Committee business functions into the NZ Ministry of Health was completed on 9 May 2016. The Director-General has since disbanded the NHC executive team. ▪ Emma Kolbe, her daughter, has taken up a position at ESR (Institute of Environmental Science and Research), Auckland as a forensic scientist working in the national drugs chemistry team. ▪ She is chair, Advisory Council, EXCITE International. ▪ She is member of MidCentral District Health Board's Finance, Risk and Audit Committee.

WHANGANUI DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

Unconfirmed

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 14 July 2017, commencing at 9.30am

Combined Statutory Advisory Committee members in attendance
Mr Stuart Hylton, Committee Chair
Mr Graham Adams
Mrs Philippa Baker-Hogan *(from 11.10am)*
Mr Frank Bristol
Dr Andrew Brown
Ms Jenny Duncan
Mr Leslie Gilsenan
Mr Darren Hull
Mrs Judith MacDonald
Ms Dot McKinnon, Board Chair
Ms Annette Main
Mr Matthew Rayner

Invited guest
Dr Annette Beautrais, Adjunct Professor at the University of Canterbury and Suicide Prevention Coordinator at the South Canterbury District Health Board.

In attendance
Mrs Louise Allsopp, Manager, Patient Safety and Quality
Mrs Sandy Blake, Director of Nursing, Patient Safety and Quality
Mr Jon Buchan, Portfolio Manager, Maternal, Child and Youth Health
Mrs Andrea Bunn, Senior Portfolio Manager, Mental Health and Health of Older People
Ms Katheryn Butters, Nurse Manager, Mental Health and Addiction Services
Ms Marama Cameron, Health Promotion Manager
Ms Sue Campion, Communications Manager
Ms Katherine Fraser-Chapple, Business Manager, Medical, Community and Allied Health *(part meeting)*
Mrs Jevada Haitana, Associate Director of Nursing
Mr Jeff Hammond, Associate Director of Nursing, Mental Health/DAMHS
Mrs Rowena Kui, Director Māori Health
Mr Gordon Lehany, Medical Director Mental Health
Ms Loren Mooney, Public Health Nurse
Ms Carla O'Keefe, Clinical Nurse Manager, Emergency Department *(part meeting)*
Mrs Julie Patterson, Chief Executive
Dr Frank Rawlinson, Chief Medical Officer
Mr Declan Rogers, Nursing Manager, Surgical Services *(part meeting)*
Ms Candace Sixtus, Portfolio Manager, Primary Care
Ms Amanda Van Elswijk, Clinical Nurse Manager, ATR Ward *(part meeting)*
Mr Peter Wood-Bodley, Business Manager, Surgical Services and Procurement
Ms Margaret Bell, EA and Professional Advisor Administration *(minutes)*

Unconfirmed

Media
One media representative attended the meeting *(from 10.20am)*.

Public
There were three members of the public in attendance.

Karakia / reflection
Mr Matt Rayner offered a karakia.

1 Welcome and apologies

A welcome was extended to Dr Annette Beautrais, Adjunct Professor at the University of Canterbury and Suicide Prevention Coordinator at the South Canterbury District Health Board. Dr Beautrais had been invited to give a presentation to the committee on mental health and suicide prevention.

An apology was received and accepted from Charlie Anderson. It was noted that Maraea Bellamy may not be able to attend due to the impact of bad weather in the central North Island.

Philippa Baker-Hogan had advised she would arrive late due to bad weather affecting her travel plans.

No apology was received from Dame Tariana Turia.

2 Conflict and register of interests update

2.1 Updates to the register of interests

Frank Bristol
- Doing some consultancy work for Capital and Coast District Health Board.

2.2 Declaration of conflicts in relation to business at this meeting

Frank Bristol
- Agenda item 7 – various roles relating to mental health and addiction, as previously declared.

It was agreed that all committee members could take part in the discussion on agenda item 7: Mental health – suicide prevention.

3 Late items

No late items were advised.

4 Minutes of the previous meeting

It was resolved that:

The minutes of the public session of the meeting of the Combined Statutory Advisory Committee held on 26 May 2017 be approved as a true and correct record, noting the following amendments:

Meeting attendances
Dot McKinnon, board chair, was present at the meeting.
Harete Hipango, board member, was not present at the meeting.

Unconfirmed

Item 6 Committee chair's report
First bullet point should read:
- Recognition of community health providers and the need for **pay** parity with DHBs.

5 Matters arising

Item 7.4 Service level agreement between WDHB mental health and addiction services and Whanganui Police
It had been stated that '… there can be up to 6000 hours a week of police time concerned with clients already involved in the WDHB mental health and addictions service.' Clarification of this showed that 6000 hours a week of police time was involved nationally, not locally.

6 Chair's report

At the meeting held on 26 May 2017, the committee resolved to recommend to the board that a summit be held with key stakeholders to discuss suicide prevention for our community. The presentation from Dr Annette Beautrais and discussion at this meeting would give board and committee members a greater understanding of the issues, alongside the services that the WDHB and community provide for mental health. This increased knowledge would enable the committee to determine whether a summit was necessary and if so, what it might look like, who would lead it and what the desired outcomes were. The committee also needed to consider whether the district health board was doing everything possible to prevent suicide.

7 Mental health – suicide prevention

The associate director of nursing, mental health introduced Dr Annette Beautrais, who had worked in our rural communities of Bulls, Marton, Taihape and Raetihi. Dr Beautrais noted her presentation on current suicide issues in New Zealand would cover the following:
- Epidemiology
- Risk factors
- Opportunities for intervention.

Statistics
- The Ministry of Health provided suicide statistics for each calendar year, with the latest data showing there were 504 suicides in 2015.
- The chief coroner provides data up to the end of each financial year. Data showed there were 529 suspected suicides to the end of June 2016, and it was expected there would be more than 600 suspected suicides to the end of June 2017.
- Data on NZ suicides by age group from 2005 to 2014 showed the highest suicide rate in 2014 was people aged between 25 and 44 years, with the youth suicide rate decreasing.
- International data showed the rate of suicide for 'middle aged men' was increasing.
- The number of suicides could be under-estimated by 10-20%, as it was not always possible to determine the cause of death, eg a road accident fatality may have been a suicide.
- The majority (55%) of suicide deaths were men aged between 23 and 65 years, ie working age. Young men aged between 20 and 40 years accounted for 30% of those deaths.
- Death by suicide was more common than workplace fatalities in New Zealand.
- The highest rates of suicide were in the 'trades' – including farming, fishing, freezing works.
- Some workplace suicide prevention programmes are available, eg MIC NZ. These provide early intervention to reach men who may be at risk of suicide.
- Men tend to use a more lethal method of suicide, whereas women tend to choose a method that may not be successful. This means women are more likely to present to emergency departments and utilise health care services.

Unconfirmed

- Need to be aware of high suicide rates for people in the older age group. As people live longer, their quality of life may diminish. Many elderly couples are moving from large cities to provincial areas like Whanganui. When one partner dies, the other may be lonely and present an increased suicide risk.
- While media reports often focus on child and youth suicides, statistics show there have only been four suicides in children aged under 10 years over a 20-year period. In the period from 1993 to 2013, 16.5% of suicides were in the 16 and under age group (ie school-aged), and 75% in youth aged between 18 and 24 years. The risk of suicide increases up to 18-19 years of age and then levels off.
- There is no evidence that suicide education prevents future attempts.
- The most common methods of suicide in NZ (from highest to lowest) are: hanging, strangulation, suffocation; poisoning by solids and liquids; poisoning by gases and vapours; firearms (average 8%, but up to 49% in farming communities where firearms are more accessible); jumping from a high place; sharp object; drowning.
- Deprivation has a huge impact on suicide rates, with quintile 5 neighbourhoods likely to have twice the suicide rate as a quintile 1 neighbourhood.
- The Ministry of Health published suicide rates by DHB, which were misleading and did not provide good comparisons.
- The ecological model of suicide risk factors shows links between society, community, relationship and individual.
- Ministry of Health have introduced a new 'Need to talk' helpline – phone 1737. This was for people to talk about any concerns – not just depression or suicide.

Strategies and approaches to suicide prevention include:

Universal
- Target the general population.
- Strengthen protective factors, enhance resiliency.
- Enhance access to help, care and services.
- Destigmatise help-seeking.
- Enhance knowledge of who is most at risk.

Examples:
- Restricting access to means of suicide.
- Public education programmes.
- Media suicide reporting guidelines.
- Public messaging programmes.
- Reducing harmful use of alcohol – there is a strong link between depression and alcohol use.
- Gatekeeper training programmes.

The Wanganui Chronicle reporter joined the meeting at 10.20am

Selective
- Screening programmes.
- Support for at risk groups.
- Gatekeeper training programmes.
- Training for health care workers, including primary care.

Notes:
- Difficulties for clinicians when carrying out risk assessment – cannot predict what will happen.
- Suicide risk increases exponentially with comorbidities.
- Important to ensure adherence to treatment – follow up and management.

Indicated
- Target individuals with high risk for suicidal behaviour.
- Stay in touch with someone.
- Send supportive text or emails for a year – needs to be long-term and consistent support.
- Transitions in care – a significant number of suicides occur within 72 hours of discharge from a mental health service or emergency department.

Unconfirmed

Systemic

- Impact of suicide prevention from integrating multiple interventions.
- 'Top down' leadership.
- Culture change.
- Well-trained health care staff.
- Informed community.
- Deployment of all relevant evidence-based components of a suicide prevention response.
- Goal is to decrease suicides – it's about quality improvement.

Examples:

- Plan developed by United States Air Force – adopted in other countries.

Canterbury DHB introducing the 'Zero' model, which has seven essential elements:

- *Lead* – create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care.
- *Train* – develop a competent, confident and caring workforce.
- *Identify* – systematically identify and assess suicide risk among people receiving care.
- *Engage* – ensure every individual has a pathway to care that is both timely and adequate to meet their needs; include collaborative safety planning and restriction of lethal means.
- *Treat* – use effective, evidence-based treatments that directly target suicidal behaviours.
- *Transition* – provide continuous contact and support, especially after acute care.
- *Improve* – continual review.

Theoretically valid upstream approaches

- Family start/early start.
- School-based programmes.
- Violence intervention.

Interventions for adolescents – to prevent adolescent suicidal behaviour

- Motivation to change.
- Sobriety.
- Familial or non-familial support.
- Promotion of positive affect.
- Healthy sleep.
- Providing family support – or another adult as a mentor.

Note: None of the above requires the involvement of mental health services.

Dr Beautrais suggested the DHB might consider the following:

- Education about the risks of suicide – staff (include staff from all services, including midwives and therapies), community, patients and families.
- Primary care – integrated programme, screening, suicide risk assessment, SCAN (suicide crisis assessment nurse) model; information dissemination and training; Safe Hands, Safe Plans workshop.
- ED – training for staff; mandatory screening for suicide risk all ED patients; standardise coding; integrated programme; Vaiva model. (Potential risk that a patient may have mental health issues that are not noted by ED staff, who send them home with medicines.)
- Mental health services – training for staff needs to be routine, sustained, updated every two years; conduct root cause analysis (RCA) of any suicide; means restriction; programme such as Zero suicide.
- Everyone needs to recognise depression – your workplace is not safe if one of your workmates is upset.
- While youth suicide seems tragic, focus should be on male suicide prevention programmes as men have children who are affected by their suicide.
- Should not fund programmes that are not supported by evidence of success.

Unconfirmed

General discussion

The following points were noted during general discussion:

- Māori suicide rates were one and a-half times higher than the rates for non- Māori, and mostly in the under 25 years age group. Very few Māori aged over 55 years committed suicide.
- Non-government organisations (NGOs) should partner with a university expert to have programmes evaluated before they are implemented.
- Alcohol use is involved in a range of adverse outcomes that can lead to suicide – eg financial issues, relationship breakdowns, road crashes, failing drug test leading to loss of employment.
- DHBs need to show leadership in the local community as the Ministry of Health has devolved responsibility to the DHBs and alcohol policies are the responsibility of local bodies.
- A recent UNICEF report of 41 developed countries showed New Zealand had the highest rate of teen suicide (15 to 19 years), which could be attributed to the culture of youth binge drinking. Our rate for other age groups ranked relatively low. When compared with Australia, Canada and the United States, New Zealand's rate of suicide is similar.
- While New Zealand's rates of youth suicide ideation and attempt are similar to other countries, completed suicides are higher.
- People at risk of suicide due to bullying are both the perpetrators and victims. The most effective prevention are anti-bullying programmes, such as the 'kindness' campaign and Zippy campaign introduced by some schools.
- Whanganui had initiated a 'restorative city' approach, which could contribute to suicide prevention.
- Although the Ministry of Health was funding some suicide prevention programmes, none of these had been evaluated over the last ten years. There was an opportunity to work with NGOs to evaluate programmes being used, which would ensure the best use of resources and that the programmes were safe and effective.

Philippa Baker-Hogan joined the meeting at 11.10am

- There were guidelines in place about how media should report suicides, but there was not good information about public messaging. The best approach was to be cautious – and to promote consistent messages about getting help, or how to help others to get help.
- There is a risk that binge watching television programmes that 'normalised' suicide could increase suicide attempts. Many young people don't recognise these programmes as fiction, and identify with the situation. They can be morbidly fascinated and don't understand the finality of suicide.

Local issues

The associate director of nursing, mental health acknowledged the work done around suicide prevention by DHB staff and other groups in the local community. A summary of this work, and training that had been provided, was outlined in the written report to the committee.

The following points were noted during discussion:

- WDHB had recently launched a WorkWell programme, which would provide an opportunity to train all staff as gatekeepers. One of the DHB's health promoters had introduced this programme at AFFCO (local freezing works).
- While we are now informed by the coronial service of all suicides that occur in our district, we are not advised of people from our area who have committed suicide in another DHB's area.
- Models of care for mental health services are being reviewed to see how they can be more integrated and supportive to primary care providers. The frustration experienced by GPs when trying to have patients seen urgently were acknowledged and will be addressed by the review. Consideration will be given to developing direct linkages between GPs and a psychiatrist.
- GPs find it difficult to work with separate alcohol and drug service and mental health service, as the issues are often combined for their patients.
- Inter-sectoral leadership approach needed to the alcohol and drug culture in our communities. The issue is not just about health – consider involving other councils, Safer Whanganui, business community and employers. Need to have a long-term view and go beyond health agencies.

Unconfirmed

- Difficult to control and monitor social media influences on suicide due to international law. However, if people Google 'methods of suicide', they are also alerted to help lines to call.
- Employers now have increased responsibilities under the Health and Safety at Work Act (HSWA). A summit could help local employers understand suicide risk and prevention, which would also help target the male of working age group.
- Many professionals, including lawyers and accountants, deal with people who are facing difficult situations and would benefit from gatekeeper training to help their clients.
- Mental health services were already looking at how to integrate primary care, and strengthening the linkages between mental health services and GPs in both directions. It was crucial that GPs had confidence in the support that was available from the DHB. Work was also being done on linking the currently separate mental health and alcohol and other drug services.
- The Rising to the Challenge plan was due to be refreshed and could incorporate points raised at this meeting.

Next steps

- The resolution to hold a summit with key stakeholders to discuss suicide prevention for our community would stand.
- Management would prepare a plan outlining the current state of suicide prevention, the gaps, how we can reach the community to improve support, and encapsulating the opportunities suggested by Dr Beautrais.
- The DHB would take the lead in developing a plan/strategy, and invite key people from external agencies to contribute.
- Progress against these steps would be reported to the next committee meeting.

8 Date of next meeting

Friday 1 September 2017.

9 Glossary and terms of reference

Taken as read.

10 Exclusion of 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
Minutes of meeting held on 26 May 2017 (public excluded session)	For the reasons set out in the committee's agenda of 26 May 2017	As per the committee's agenda of 26 May 2017
Mental health	To protect the privacy of natural persons, including that of deceased natural persons	Section 9(2)(a)
Annual plan for 2017/18	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)

Unconfirmed

Persons permitted to remain during the public excluded session

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 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	Management and operational information about Whanganui District Health Board	Management and operational reporting and advice to the board
Committee secretary	Minute taking	Recording minutes of meeting

The public session of the meeting ended at 12.07pm.

Unconfirmed

5 Matters arising from previous meetings

There are no matters arising from the last meeting.

6 Committee Chair's report

A verbal report may be provided at the meeting.

7. Delivery against commitments in the 2017/18 Annual Plan

The purpose of this report is to inform, and seek advice, from the committees on delivery against priorities from Whanganui DHBs Annual Plan. This also provides an opportunity to 'scan to horizon' to inform future planning priorities.

All our work is underpinned by the following four commitments which drive and inform our annual planning and associated work programme:

1. Advancing Māori health and Whānau Ora
2. Investing to improve health outcomes and living within our means
3. Growing the quality and safety culture
4. Rising to the challenge to build resilient communities

Our annual work programme for 2017/18 is divided into priority areas as follows:

Annual Plan, Focus Area 1 | Improving equity for priority populations

Maternal, child and youth

- Increased immunisation – *Better Public Service and Health Target*
- Supporting vulnerable children – *Better Public Service Target*
- Raising healthy kids – *Health Target*
- Child Health – *details to come*
- Reducing rheumatic fever – *Better Public Service Target*
- Reducing unintended teenage pregnancy – *Better Public Service Target*
- Prime Minister's youth mental health project
- Local DHB priorities – *Oral health improvement project, Maternal health*

Older people

- Healthy Ageing Strategy – *including Regional Priorities*
- Local DHB priorities

People with disabilities

- Disability support services
- Local DHB priorities

Prevention and management of long term conditions

- Mental health – *including Regional Priorities*
- Living well with diabetes
- Bowel screening
- Better help for smokers to quit – *Health Target*
- Pharmacy Action Plan
- Hepatitis C – *Regional Priorities*
- Local DHB priorities – *Renal, Cardiac services improvement projects*

Annual Plan, Focus Area 2 | Equitable access to clinical services

- Shorter stays in emergency department and major trauma – *Health Target and Regional Priorities*
- Improved access to elective surgery – *Health Target and Regional Priorities*
- Faster cancer treatment – *Health Target and Regional Priorities*
- Cardiac and diagnostics – *Regional Priorities*
- Stroke services – *Regional Priorities*
- Local DHB priorities – *Service improvement focus across all specialist services - medical, surgical, allied, mental health & addictions, and community & rural services*

Annual Plan, Focus Area 3 | Enablers

- Improving quality – *including Regional Priorities*
- Information technology – *including Regional Priorities*
- Workforce – *including Regional Priorities*
- Primary care integration – Alliance oversight of system level measures and enablers
- Investing to improve health outcomes and living within our means

7.1 Annual Plan focus area: Equitable access to clinical services | Mental health and addictions

Leads: Jeff Hammond, Associate Director of Nursing
Katheryn Butters, Nurse Manager Mental Health and Addictions Services

The committee will receive a presentation on the wellbeing model and proposed model of care across primary and secondary care.

Background

The purpose of this report is to inform and seek advice from the committee on delivery of specialist mental health and addiction services to our community. This includes reporting on improvement initiatives from the annual plan, workforce development, key service metrics – access and financial performance, and key risks and mitigations.

Quality improvement and service development update Ref page: 79

Whanganui DHB's Mental Health and Addictions Services Strategic Plan (2016-20) outlines the services' values and priorities. Work is currently being undertaken by each of the departments to develop departmental plans under the strategic framework. A copy of the plan is included in the *Information Section.*

It is to be noted that there are three key pieces of development over the next two years:

- Addictions regional model and Substance Addiction (Compulsory Assessment and Treatment) (SACAT) Act 2017
- Fit for the future revising the model of care for Community Mental Health and Addictions Services
- Addressing health outcomes/equally well and suicide prevention.

Wellbeing model and proposed model of care presentation Ref page: 87

This presentation to the combined committee is an update on activity being undertaken in primary and secondary care to improve our response to mental health and addictions. A copy of the background report is included in the *Information Section.*

Suicide Prevention – Barry Taylor

The Mental Health and Addictions Services Workforce Development Group have approached Barry Taylor to hold a symposium on-site on 18 September 2017. It is envisaged that staff from both mental health and addictions services and the general hospital will attend, with invitations also being extended to include the Whanganui Regional Health Network, general practitioners, practice nurses, Iwi and NGO services within the Whanganui community.

Barry has worked in suicide prevention and postvention at local, national and international levels for over 30 years. He led the first national response to youth suicide in New Zealand in the late 1980s.

Known for his lecturing and commentary on the risk and protective factors that impact on wellbeing and suicidal risk, he has led and evaluated a diverse range of community based and national suicide prevention and postvention programmes, written guidelines and policies, and sat on numerous government advisory committees.

Substance Addiction (Compulsory Assessment and Treatment) (SACAT) Act 2017

The Substance Addiction (Compulsory Assessment and Treatment) (SACAT) Act will replace the Alcoholism and Drug Addiction Act 1966 (the ADA Act). The ADA Act was reviewed by the Law Commission in 2010. The review identified that the Act was out-of-date and several practical, clinical and legal issues limited its use. The use of committal procedures under the ADA Act are infrequent and have declined steadily since the 1970s. The review also found that the language, definitions and approach to alcohol and drug treatment did not reflect modern human rights-based approaches to compulsory treatment and were not consistent with changes to the health sector or other relevant legislation. The Law Commission recommended a new compulsory treatment framework be designed and worked with the Ministry of Health (MoH) to develop the proposal for the new legislation. The MoH worked with parliamentary counsel to further refine the SACAT Bill and to ensure that it reflects modern legislative structures and is consistent with other legislation.

The SACAT Bill was developed to protect the health and safety of people with severe substance dependence that have experienced, or are at risk of, serious harm and who do not have the capacity to participate in treatment.

The fundamental principles of the legislation include:
- A high threshold for compulsory treatment
- Limited duration for compulsion
- Protection of patients' rights; and
- Compulsory treatment is considered as part of a 'treatment pathway' for addiction.

There is a need to develop plans, protocols, prepare for new roles and models of care in order to be ready to respond to the Act when it comes into force on 21 February 2018.

A key enabler for the successful implementation of the legislation is an accessible workforce skilled and experienced in alcohol and other drug intervention, treatment and support. The current numbers of staff are considered insufficient for the expected increase in volume of people accessing services. A multi-disciplinary team approach will ensure a strong combination of expertise in clinical and non-clinical support. It is likely that the responsible clinician (RC) role will be undertaken by AOD specific nurse practitioners or AOD medical specialists.

DHBs will need to identify additional workforce needs at the local DHB level. The Ministry is coordinating national wide collaborative workforce education and development programmes, in conjunction with Matua Raki, which will be addressing the SACAT specific knowledge, peer support approaches, skilled assessment and diagnostics including physical health, cultural competency, clinical competency (including capacity testing), family therapy/inclusive engagement/motivational approaches, and coexisting problems.

A summary of the key roles is below:

Role	Role Requirements	Summary of Functions
Director of Addiction Services	Appointed by the director-general of health.	▪ Responsible for the general administration of the Act ▪ Designates directors of area addiction services.
Director of Area Addiction Services (Area Director)	Appointed by the director of addiction services.	▪ Responsible for administration of the Act in a geographical area ▪ Designates other officers and roles ▪ Provides oversight ▪ Receives initial applications ▪ Assigns key roles associated with an individual's care.

Role	Role Requirements	Summary of Functions
District Inspector	Lawyer appointed by the Minister for a term of three years.	▪ Ensures patient rights are upheld; must visit treatment centre for purpose of inspection at least once during patient's period of detention and treatment and report to the area director within 14 days.
Authorised Officer (AO)	Health professional designated by the area director. "The area director must be satisfied that the health professional has undergone appropriate training and has appropriate competence in dealing with persons who have severe substance addictions." (Clause 91). In the Northern Region Model AO's will be practitioners employed by the local CADS or DHB or NGO Addiction Services provider in each DHB. They will be HPCAA, dapaanz or social work registered professionals.	▪ Assists applicants to make the application (if required) including assisting the applicant to have the person medically examined to obtain a medical certificate to support the application. ▪ If medical certificate cannot be obtained, must investigate and if satisfied that there are legal grounds for the application develop a memorandum to explain absence of the medical certificate and support the application. ▪ AO gathers all required documentation and information to support the Assessment process (including information from the family and whānau, other treatment providers and other people involved). ▪ The AO screens and recommends (or not) a person for a more comprehensive assessment.
Approved Specialist	A health professional who has significant experience in the treatment of severe substance addictions and is suitably qualified to conduct specialist assessments and reviews designated by area director. In the northern region model approved specialists will be medically registered professionals with addiction expertise. A regional pool of approved specialists will be maintained; telehealth facilities will be utilised to facilitate assessments as needed.	▪ Assesses the person to ensure criteria and conditions for compulsory treatment are met (See Appendix 4 for criteria). ▪ Multidisciplinary Team (MDT) input will be required to determine suitability of a Compulsory Treatment Certificate. This may require a multi-disciplinary case conference involving professionals already involved in the person's care. ▪ If appropriate, issues a Compulsory Treatment Certificate (CT Cert) effective immediately. ▪ Arranges for the person to be detained (either in Hospital or Regional SACAT Facility or for Northland a local Managed Withdrawal Facility). ▪ Notifies area director of CT Cert.

Role	Role Requirements	Summary of Functions
Responsible Clinician (RC)	A health professional who is assigned to the patient by the area director. Not the AO for the person. Wherever practicable the person should not also be the approved specialist. In the northern region model approved specialists will be medically registered professionals with addiction expertise.	Responsible for developing, and overseeing implementation of treatment planning and care co-ordination in consultation with SACAT co-ordinator and MDT. Within seven days of CT Cert being signed, must: ▪ Develop a treatment plan ▪ Arrange admission to a Treatment Centre (or confirm continuation of care within SACAT regional facility) ▪ Apply to the court for a review of compulsory status. The court issues the Compulsory Treatment Order (as appropriate) or discharges the person. RC is responsible for ongoing review; application for extension of the Act for suspected brain injury and transition to continuing care. RC can delegate functions to managed withdrawal and treatment providers – must be documented in treatment plan.
SACAT Coordinator	A health professional who is support the person through the SACAT pathway. SACAT Coordinators will be registered health professionals with addiction expertise.	Responsible for supporting the RC and MDT in treatment planning and care co-ordination in consultation with the all others involved.
Peer Support Worker	An AOD peer support professional employed by the local DHB or NGO addiction services. Competencies as defined in Te Pou (2014) | *Competencies for the mental health and addiction service user, consumer and peer workforce.*	Provide peer support to the person for the duration of the Pathway including: ▪ Support treatment engagement ▪ Encourage and model recovery and hope ▪ Provide practical support for the treatment plan as defined in conjunction with the MDT ▪ Modelling and supporting mana enhancing approach. Services will be mobile and informed by an assertive approach to service delivery and defined core peer values.
Whānau Support Worker	An AOD whānau support professional.	Provide whānau support to the person's whānau for the duration of the pathway including: ▪ Active engagement of whānau and involvement of whānau in the person's treatment journey ▪ Active engagement of other community

Role	Role Requirements	Summary of Functions
		supports where whānau are unable or unwilling to be engaged ▪ Modelling and supporting mana enhancing approach ▪ Supporting the treatment plan. Services will be mobile and informed by an assertive approach to service delivery and defined core peer values.
Cultural Advisor/Support Worker	A professional matched to the cultural needs of the person. Employed within the local DHB.	Provide cultural support to the person for the duration of the Pathway including: ▪ Supporting engagement ▪ Modelling and supporting mana enhancing approach ▪ Ensuring other professionals are informed and supported to meet the person's cultural needs ▪ Supporting the treatment plan.

Mental Health Social Investment Fund **Ref page: 97**

Details of the recently announced mental health social investment fund are included in the *Information Section.*

Office of the Ombudsman visit

In 2007, the Ombudsmen were designated one of the National Preventive Mechanisms (NPMs) under the Crimes of Torture Act (COTA), with responsibility for examining and monitoring the general conditions and treatment of clients in New Zealand secure hospitals.

Unnanounced visits were made to Stanford House and Te Awhina on 24 - 26 July 2017. These visits were conducted by inspectors designated by the Ombudsmen. Previous visits had occurred in 2011 and 2013.

The inspectors were given access all to areas of the wards, all service users/tangata whaiora, staff, patient records, policies and operating procedures and meeting minutes.

Their investigation methodology is informed by the Association for the Prevention of Torture's Practical Guide to Monitoring Places of Detention (2004) Geneva.

The following areas were examined on this occasion to determine whether there had been anything that could be construed as torture, or cruel, inhuman or degrading treatment or punishment, or any other issues impacting adversely on detainees:
- Treatment
- General living conditions
- Seclusion
- Restraints.

Verbal feedback from the inspectors was positive, Whanganui DHB are awaiting full reports.

7.2 Annual Plan Focus Area: Improving equity for priority populations | All of population initiatives, including prevention and management of long term conditions

7.2.1 System Level Measures: Amenable mortality and acute hospital bed days

Leads: Candace Sixtus, Portfolio Manager Primary Care
Wendy Stanbrook-Mason, Nurse Manager Medical Services

Background

The amenable mortality system level measure is about prevention and early detection to reduce premature death. Amenable mortality is defined as premature deaths (deaths under age 75) that could potentially be avoided, given effective and timely healthcare. That is, early deaths from causes (diseases or injuries) for which effective health care interventions exist and are accessible to New Zealanders in need.

Not all deaths from these causes could be avoided in practice, for example, because of comorbidity, frailty and patient preference. However, a higher than expected rate of such deaths in a DHB may indicate that improvements are needed with access to care, or quality of care. We know that the prevention and management of risk factors is essential in reducing the development of morbidity.

Amenable mortality is grouped into six super-categories:

- Infections
- Maternal and infant conditions
- Injuries
- Cancers
- Cardiovascular diseases and diabetes
- Other chronic diseases.

For acute hospital bed days, this measure is about using our health resources effectively. As a Whanganui health system we want our population to be well in the community, and to be supported to receive appropriate care when they are not well. We want to reduce the amount of time people need to spend in hospital through good upstream primary care, and discharge and transition planning. This requires good communication and cooperation between primary and secondary care. We know that better prevention and management of long term conditions is essential to support improvement against this target in the long term.

How are we performing?

The latest target or accountability measure results for the areas which support improvement in these two system level measures are:

	Target	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
More heart and diabetes checks	90%	91%	91%	91%	91%
Better help for smokers to quit - Primary	90%	85%	85%	84%	86%
Better help for smokers to quit - Maternity	90%	97%	95%	100%	100%
Shorter stays in emergency departments	95%	94%	95%	94%	95%

Cervical Screening *Target is to reach 80% screening coverage for all eligible women*				
Ethnicity	**Jun-17**	**Mar-17**	**Dec-16**	**Sep-16**
Māori	70.3%	71.2%	70.4%	70.5%
Pacific	66.7%	68.0%	66.8%	63.9%
Asian	67.7%	70.4%	70.1%	71.3%
Other	78.8%	80.4%	81.1%	81.6%
Total	76.1%	76.1%	77.9%	78.3%
Breast Screening *Target is to screen 70% of eligible women aged 50-69 years every two years*				
Ethnicity	**Mar-17**	**Dec-16**	**Sep-16**	**Jun-16**
Māori	71.4%	72.1%	71.9%	70.6%
Pacific	70.5%	73.6%	76.2%	78.0%
Other	79.1%	79.1%	79.3%	79.4%
Total	77.7%	77.8%	78.0%	77.9%

Service improvements:

Areas of focus we believe will assist us to improve outcomes which are currently underway include:

Specialist diabetes services

The service has been strengthened with an additional diabetes nurse specialist re-joining the team. This provides an opportunity for the team to enhance support for primary care including collaborative clinics, upskilling and case review with the aim to enable proactive management of patients in primary care.

More heart and diabetes checks

While the more heart and diabetes checks is no longer a health target, it continues to be a district health board accountability measure. For 2017-18, the focus is to achieve a target of 90% for eligible Māori men aged 35-44 years who have had a cardiovascular and diabetes risk assessment undertaken in primary care.

Psychology

Work is nearly complete to establish a psychology support service for people including children with long term conditions. The objective of the service is to support people and their families to adjust to the requirements and impacts of the illness.

Primary Options for Acute Care (POAC)

A primary options for acute care (POAC) programme is being progressed for selected conditions starting with funding deep vein thrombosis (DVT) investigation and management and cellulitis IV therapy. It is intended to consider other modules once these two services are implemented effectively. The aim of POAC is to manage acute illness in the community as an alternative to referring patients to hospital and simplify arrangements through provision of funded care options.

While it is expected that POAC will be offered to all general practices in the Whanganui DHB region, and that where possible services should be offered within the patient's health home, there may be some exceptional circumstances where other settings make sense, for example where access to radiology is required to create a 'one stop shop'.

Effective implementation of POAC has a number of success factors including clinical governance, clinical guidelines, coordination and evaluation and reporting against baseline data, and the DHB will work closely with both primary health organisations (PHOs) to progress this programme.

Access to primary care and acute demand **Ref page: 111**

The district health board has been hearing increasing reports about the difficulty for patients to access timely GP appointments in Whanganui. A conversation has been initiated with both PHOs to inform a joint discussion including gathering data to provide a snapshot of GP waiting times, GP to patient ratios and practice opening hours. It is not clear whether this situation is the result of a particularly bad winter in terms of illness in the community, or a more system issue of the pressure facing our primary care sector. There has been a flow on impact on the hospital emergency department.

A copy of a recent briefing to the Ministry of Health on acute demand pressures at Whanganui DHB is included in the *Information Section.*

Cervical and breast screening

A number of actions have been identified to improve screening rates across the region. These include improving the profile of screening through targeted health promotion and availability of information, provision of cervical screening opportunities after hours and in other settings, and developing a standardised recall process across general practice. Efforts to date have not improved performance or equity for this target.

Targeted approaches for Māori , Pacific and Asian women will include focusing on general practices with the highest number of priority women and linking through appropriate community networks and other settings including workplaces.

Additional resource has been provided to increase the current cervical screening health promotion role in primary care to include breast screening support. This will provide an integrated approach to support women to engage in the national breast screen programme.

Tobacco control

The Tobacco Control Plan has been updated to reflect priorities for 2017-18 to build on work undertaken to date to guide tobacco control across the region to reduce the prevalence of smoking in the lead up to a Smoke free Aotearoa by 2025.

The areas which require particular focus are reducing the uptake of smoking in youth and addressing the high number of pregnant women who smoke. For youth, increasing health promotion and awareness and identifying opportunities to reduce smoking initiation linking in with schools and education providers, health services and the community.

Engagement with Lead Maternity Carers (LMCs) has identified a number of improvements to increase support for pregnant women. These include provision (including training) of smokealyzers in LMC clinics and introducing an incentivised quits project which aims to encourage pregnant mums/hapu mama to quit smoking through incentives ('free stuff') to

attend a structured conversation with a quit coach and support to enrol in the Stop Smoking Service.

The Tobacco Advisory Group supported the Whanganui District Councils Smokefree and Vapefree Outdoor Areas Policy through the submission process including presenting to the Council.

The introduction of smoke and vape free public places has at its core the aim of reducing the amount of smoking young people see around them, therefore reducing the negative role model effect of seeing adult smokers and increasing the positive role-modelling effect of seeing non-smoking adults. This may contribute to making young people less likely to start smoking or remaining smokefree.

The inclusion of vaping into the policy addresses the growing market of vaping in New Zealand. Vaping is seen as the new smoking – it is being marketed to young people as an alternative to smoking. However it has not been around long enough for researchers to study the long term effects.

The Whanganui DHB smokefree coordinator continues to focus on developing smokefree systems including the development of online training modules tailored to the Whanganui region, one on one support for staff to become smokefree and tailored solutions for mental health services.

7.2.2 Promoting men's health in the Whanganui DHB region

Leads: Marama Cameron, Manager Health Promotion
Karney Herewini, Health Promotion Officer

Whanganui DHB health promoter, Karney Herewini, will be in attendance at the committee meeting to provide an overview of activity that has been occurring in our community to promote men's health.

Background

In December 2016, an invite was sent to services and community members to meet and discuss opportunities for promoting men's health in the Whanganui DHB region.

From this meeting there were two main outcomes.

- Men's health month in June 2017 was identified as an opportunity to work together on a collaborative project.
- The Tane Hauora collaborative was created.

The Tane Hauora (TH) Collaborative is made up of nine local stakeholder organisations and services:

- Whanganui District Health Board
- Whanganui Regional Health Network
- Te Oranganui – Healthy Families and Te Kaiwhakakaha
- Ngā Tai O Te Awa
- Cancer Society Wanganui
- Jigsaw Whanganui
- Sport Whanganui
- Whanganui Police
- Family Works Whanganui.

Key areas highlighted by the TH collaborative to promote strength based, health promotion approaches included:

- Mental health
- Nutrition and physical activity
- Alcohol and other drugs
- Smoking and men's cancers
- Relational (positive relationships, role modelling)
- Health education/literacy
- Health care access/stigma/barriers.

In planning for Men's Health Month 2017 the collaborative set out to achieve the following shared outcomes:

- Promote men's health
- Engage 'Men in Men's Health Month'
- Increase Awareness in relation to men's health
- Collaborate.

This was the first time attempting a project in this space and of this colaborative nature, therefore it was key to develop a model that would achieve shared outcomes and help guide future work in this space.

Men's health month was successful in achieving all shared outcomes through the activities and approaches used, a model/framework was developed to guide future work in this space, opportunities for growth were identified and some light was put on real barriers impacting men's health.

Thank you for the opportunity to share these outcomes and learnings on behalf of the Tane Hauora Collaborative.

7.2.3 Whanganui DHB Community Responsiveness Programme

Lead: Eileen O'Leary, Project Manager, Service and Business Planning

Purpose

The purpose of this report is to inform the combined committee on the community responsiveness work programme.

Strategic Context

This work programme links to all four of Whanganui DHB's Strategic Commitments contained in the draft 2017/18 Annual Plan:

- Advancing Māori health and Whanau Ora
- Investing to improve health outcomes
- Growing the quality and safety culture
- Rising to the challenge to build resilient communities.

Background

In April 2017 the combined committee received a report and presentation on a review of missed appointments conducted in 2016. That review of outpatient appointment (Did Not Attends/DNAs) was part of building a deeper understanding of how to meet the needs of the people, whānau and the communities we serve.

The overriding finding of the review was that to improve attendance rates we need both:

- A holistic view of the patient/whānau and their health journey, and of the system; as well as,
- A more granular view of each patient's/whānau needs and strengths, and of the services they need to access.

The review found an inequitable gap between Māori and Pasifika attendance and 'other' ethnicities especially for children and young people.

The resulting community responsiveness work is currently being addressed through four workstreams and these will be reported on separately below:

- Improving attendance at scheduled appointments (did not attends/DNA)
- Health literacy
- Supporting patient navigation
- Patient travel.

Community Responsiveness | Improving attendance at scheduled appointments (did not attends/DNA)

Background

While DNA rates across outpatient appointments are of concern, it was decided to focus on an area where there was a high rate of Māori and Pasifika baby and child missed appointments and conduct an in-depth work programme that could inform a roll out to other areas.

This tight focus was deliberate to be realistic within the DHB's resources at a time when the DHB is introducing major information technology change, with embedding of Clinical Portal and introduction of WebPAS, the new patient information system. Once embedded, WebPAS is expected to be a further tool to improve the organisation's capacity to improve community responsiveness and facilitate administration staff's capacity and information to engage with patients about their appointments.

The choice to focus on audiology and newborn hearing screening clinics was based on the clinics high DNA rates, the focus on babies, children and young people and the use of rural clinics for screening. It also allows us to work closely with a smaller group of whānau and staff and build a richer understanding of the wider more systematic changes that can be scaled-up.

This project was successful in obtaining additional funding of $60,000 through the Ministry of Health's Elective Services-Patient Focused Booking Improvement Initiative, for a 12 month project in this financial year, to implement patient-focused bookings. Northland DHB was also successful in receiving Ministry funding with a similar audiology project. The Northland and Whanganui project teams plan to share learnings during the projects.

Audiology and Newborn Hearing Screening Improvement Initiative

The project aims to improve equity and outcomes for Māori and Pasifika patients and their whānau/families. It aims to develop strategies to help improve equity through improved appointment management and scheduling practices leading to improved engagement with patients and their whānau/families and resulting improved utilization of resource. This project is closely aligned with the oral health project which also seeks to address inequities and improve appointment attendance.

Outcome Measures

- The project aims to have a 50% increase on both the UNHSEIP and audiology clinic attendance among 0 to 14-year old Māori and Pasifika patients by June 2018.

Baseline Data Analysis

DNA rates of 0 to 1 month old babies from NHS clinics for year 2015/16 and 2016/17

Total No. of Patients	Total Māori	Māori Attended	Māori DNA	Total Pasifika	Pasifika Attended	Pasifika DNA	Total Other	Other Attended	Other DNA
998	496	328	168	54	40	14	448	372	76
DNA Rate			**34%**			**26%**			**20%**

DNA rates of 0 to 14 year olds from Audiology clinics for year2015/16 and 2016/17:

Total No. of Patients	Total Māori	Māori Attended	Māori DNA	Total Pasifika	Pasifika Attended	Pasifika DNA	Total Other	Other Attended	Other DNA
1215	547	356	191	61	37	24	607	533	74
DNA Rate			**35%**			**39%**			**12%**

As well as patients missing appointments, the hospital and patient also cancel appointments. The baseline data reviewed on both NHS and audiology shows a higher rate on hospital-driven cancellations for booked appointments especially on the latter.

Hospital and Patient Driven Cancellation Rates in NHS 2015/16 and 2016/17:

Values	2015/16	2016/17	Cancellation Rate 2015/2016	Cancellation Rate 2016/2017
Total Bookings	554	613		
Patient-driven cancellation	25	39	**5%**	**6%**
Hospital-driven cancellation	28	35	**5%**	**6%**

Hospital and Patient Driven Cancellation Rates of 0 to 14 year olds Audiology Clinics 2015/16 and 2016/17:

Values	2015/16	2016/17	Cancellation Rate 2015/2016	Cancellation Rate 2016/2017
Total Bookings	1311	1536		
Patient-driven cancellation	152	200	**12%**	**13%**
Hospital-driven cancellation	162	271	**12%**	**18%**

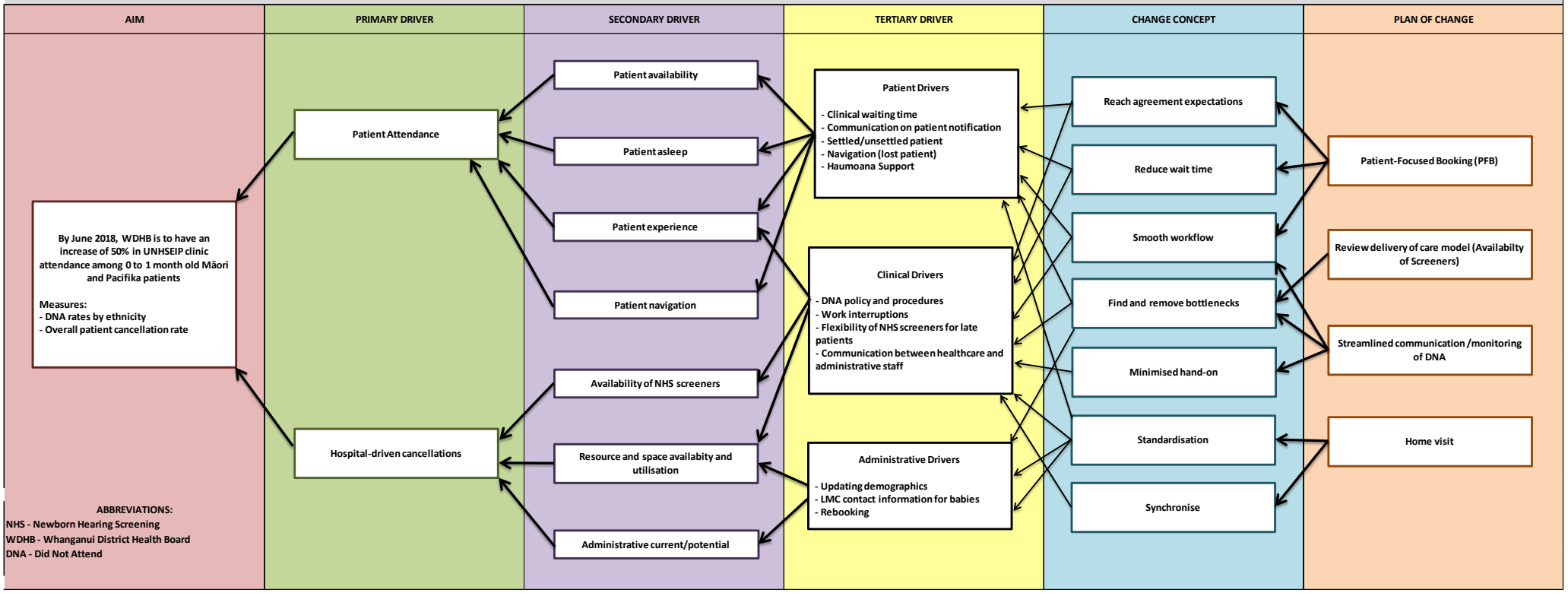
Governance Group

The project is sponsored by Rowena Kui, director Māori healthr and has representation from consumers, primary health care, Ministry of Education hearing advocacy, the children's team, public health, haumoana service and clinical and administration staff.

Progress to Date

Business mapping of every step in the patient journey for both audiology and newborn hearing screening has resulted in the following two driver diagrams which highlight the workstream and activities being undertaken.

WHANGANUI DISTRICT HEALTH BOARD OUTPATIENT AUDIOLOGY IMPROVEMENT INITIATIVE PROJECT
Driver Diagram for Universal Newborn Hearing Screening Early Intervention (UNHSEIP) Clinic



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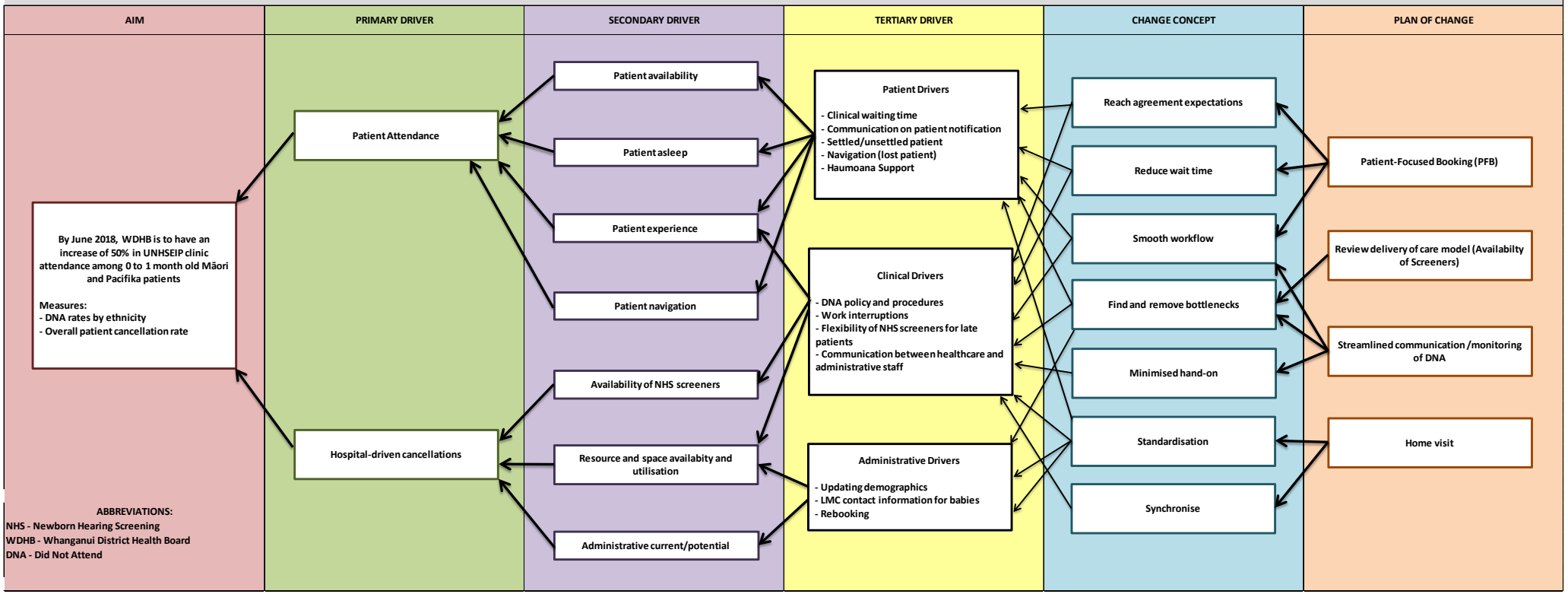


Community Responsiveness | Health Literacy

Background

A lack of capacity for decision making was identified as a barrier to appointment attendance in the 2016 review of missed appointments. Health literacy is the capacity to find, interpret and use information and health services to make effective decisions for health and wellbeing (Ministry of Health, 2010).

Health Literacy New Zealand reports that international research shows a strong link between consumers' level of health literacy and their health status. It also reports 56% of the NZ population have poor health literacy skills. This means they are not able to obtain, understand and use basic health information and services to make informed and appropriate health decisions.

In presenting to the board in July, Health and Disability Commissioner Anthony Hill also referred to poor communications between practitioners and patients leading to a high portion of complaints to the commission.

Actions for improvement

Māori health director Rowena Kui, communications manager Sue Campion and Eileen attended a Health Literacy symposium in Palmerston North in May run by the central PHO.

Learnings from this have been disseminated and the outpatients department and public health staff have had a presentation of the key learnings. Also in this area, the public health team are running two workshops on 'Healthy Conversation Skills.'

The WDHB has invited the speaker who addressed the Palmerston North symposium, Health Literacy NZ director Susan Reid, to Whanganui on 20 September to talk to staff and health practitioners about the importance of communicating clearly and building their patients' knowledge and skills to manage their own health.

The address to staff will take place as a MedScan Lecture from 12.15pm – 1pm. During the afternoon Ms Reid will meet with smaller groups of staff before addressing a public meeting from 5.30pm to 7pm. The evening talk will be free of charge with light refreshments served before the presentation begins.

NZ Health Literacy promotes the use of language that patients understand, while also encouraging doctors, nurses and others to ask their patients what they know about their condition what they have just been told to guage their understanding.

The key points are:

1. Find out what people know.
2. Build people's health literacy (knowledge and skills) to meet their needs.
3. Check you were clear – that they understand what it you told them.

Key messages

- Improving health literacy, that is, the ability to make sound decisions about health as part of everyday life is an important aspect of improving the health of New Zealanders.
- The health workforce can help patients and their whanau improve their health literacy.
- It's everyone responsibility: medical, nursing, allied, administration and volunteers.
- For doctors, nurses and everyone working in health, it's about providing information in a way that is right for each patient and their family/whānau.
- If the health workforce is doing its job then our patients will be better able to make informed decisions and access and navigate appropriate quality and timely health services.
- You can't judge a person's health literacy by looking at them.
- Health literacy is connected to empathy.
- 'Tell me' are powerful words when talking to your patients.

- Health literacy is about:
  - clear communications about health
  - plain easy to understand language
  - using diagrams and other demonstrations to help people understand their health and what's happening to them.

Community Responsiveness |Supporting Patient Navigation

Background

The missed appointment work highlighted the need for improved signage, use of maps and other supports for patients navigating their way round the hospital campus. Patients and their whānau/families reported difficulty in finding where they were supposed to go for appointments. This has been backed up by subsequent qualitative interviews with patients and their whānau/families and reiterated by reception staff and the friends of the hospital, who guide people from the main entrance on Monday to Thursday mornings.

Actions for improvement

An initial audit of hospital signage has been carried out. As well, existing maps have been reviewed.

This work has shown the need for a comprehensive navigation plan. Developing the plan would require involvement from Māori and Pasifika and other consumers. The plan would need to carefully consider the needs of people with disability, the elderly, cognitively impaired and people with reading and other information processing issues. The plan would need to encompass existing work including on the Emergency Department. It would also need to look at 'wayfinding tools' used by other DHBs including: gate numbering, colour coding; coloured floor lines; signage size and placement; language; the style and use of maps; as well as how signage and maps link to other patient communications such as letters and texts.

This work is to be scoped for feasibility and to identify priorities.

Community Responsiveness |Patient Transport

Background

In April the board and combined committee discussed patient transport with the board making a number of recommendations to improve support for patient travel.

Actions for improvement

Currently work is underway to review the demand on the travel office services, roles and responsibilities and what the ideal resourcing, office opening hours and positioning would be for that office.

A new 0800 number is being set up for patients to use to contact the travel office during office hours or to leave a message. A new folded business card has been developed to provide patients with ready access to basic information about eligibility for current support and contact details.

Work has begun with Māori health providers: Te Oranganui, Mokai Patea, Te Puke Karanga Hauora and Ngati Rangi on the best way to provide additional support for their patients transport needs working with and building on existing networks, services and resources.

The DHB is developing criteria for a discretionary fund to be administered by WDHB travel office for targeted support outside the NTA. Initially this fund would be focused on first specialist appointments (FSA) not covered by the NTA, support to return home following specialist treatment at another hospital, and people living in isolated rural areas. The criteria will target high need and vulnerable families.

Further work is looking at the better ways to support patients after discharge both from other DHB hospitals and from Whanganui hospital afterhours.

7.2.4 Cardiac Service Improvement Programme

Leads: Wendy Stanbrook-Mason, Nurse Manager Medical Services
Katherine Fraser-Chapple, Business Manager Medical, Allied and Community Services

Purpose
The purpose of this update is to inform the combined committee of progress against the annual plan service improvement in cardiac services.

Background
The nurse manager, medical services has taken on the clinical lead role for the cardiac planning portfolio, and will work with the service and business planning team on the improvement programme.

A stock take of the service, by way of reviewing what is occurring and what needs to be achieved has been the initial focus. This work will be informed by Whanganui DHBs representation on the Central Region Cardiac Network, and monitoring and working with Capital Coast DHB to improve cardiac surgery intervention rates, for the Whanganui population. The work programme will have a strong focus on addressing the equity issues in this area. We know what Māori often present late with advanced cardiac conditions, bypassing the opportunity for early diagnostics, intervention and management of their conditions. Better identification and management of risk factors in primary care, work on the determinants of health, and health promotion are key actions that underpin improvement in this priority area. Performance against the national targets is monitored by ethnicity to identify where equity issues are occurring. A dashboard is being developed to track progress in this area.

A snap shot of the current targets:

National targets for intervention (per 10,000):
- Cardiac surgery - target 6.5 (performance 4.49 at March 2017)
- Angiography - target 34.7 (performance 26.47 at March 2017)
- Angioplasty/PCI - target 12.5 (performance 11.17 at March 2017)

Breakdown by ethnicity is not currently available for achievement of these targets

ANZAC QI measures:
- 70% of high risk patients receive an angiogram within three days of admission. July 2017 results are 84.6%. For the quarter ending 30 June 2017 performance by ethnicity was 0% for māori and 76% for other, however only 2 patients of a total of 27 in the quarter identified as māori)
- Data collection within 30 days - 95% for patients presenting with ACS who undergo coronary and angiography, and patients undergoing cardiac surgery. July performance was 87.5%. For the quarter ending 30 June 2017 performance by ethnicity was 100% for māori and 96% for other, 3 patients of a total of 24 in the quarter identified as māori).

First specialist assessment – 100% seen within four months

CVD Risk Assessment - eligible population – target 90% risk assessed in last 5 years:

- Māori, Pacific and South Asian males 35–74 years
- Māori, Pacific and South Asian females and all other ethnic group males 45–74 years
- All other ethnic group females 55–74 years
- Blood tests for CVD risk assessment and a blood test (HbA1c) to screen for diabetes
- Current performance hovering around 91%

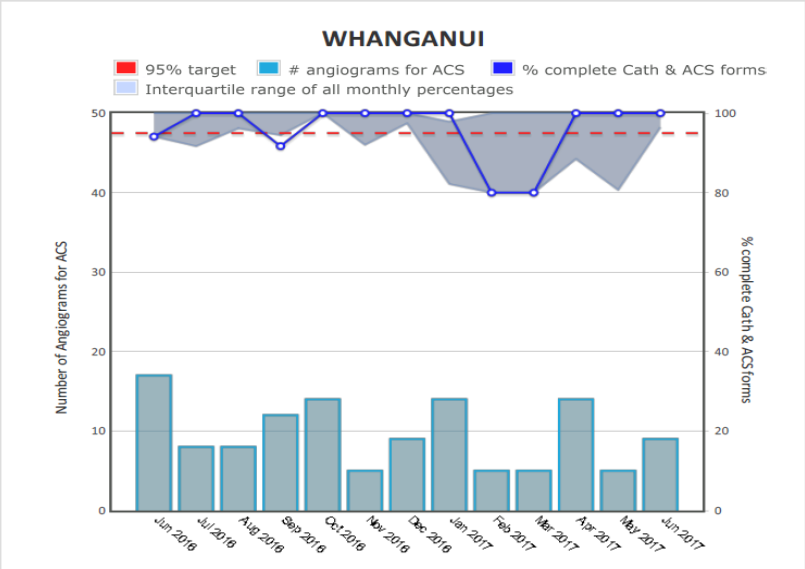
Triple Therapy - 70% of CVD patients prescribed all three medications

- Current performance hovering around 80%. This data is not available from current sources by ethnicity.

Data collection:

Whanganui DHB is reliant on the provision of tertiary intervention for some cardiology conditions and these rates are discussed and reviewed at the central regional cardiac network. The data is provided monthly and compares Whanganui volumes to the central region and nationally. This is collected through a data base known as ANZACS –QI.

The below table provides an update on the registry completion for Whanganui. This data completion is essential for measuring cardiac interventions for Whanganui and to provide data as a central network.



Cardiac Echo:

A snap shot of patients waiting for an echo (ultrasound of the heart) has been collated. There is no "target'" for waiting times therefore this data will form a baseline to monitor triaging of referrals, and wait times and volumes going forward by ethnicity, age and gender. Currently this service is provided by two consultants and a contracted visiting technician.

A Map of Medicine pathway for general practitioners to refer directly to radiology for cardiac echoes has been developed, however due to the wait list volumes this has been postponed. This has been identified as potentially affecting the effectiveness of the Heart Failure Map of Medicine. However while the current waiting list is being reviewed introduction to this pathway will be occurring at a WIPE session and to each GP practice in the next months.

Cardiologist outpatients:

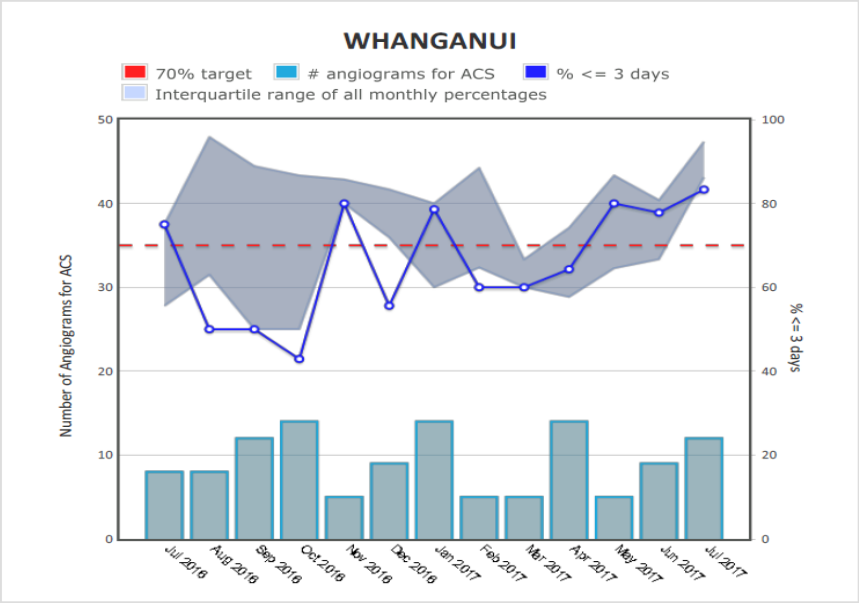
In May 2015 a visiting cardiologist was contracted for one day per month through MidCentral DHB. However, we have received notification in July 2017 that the individual specialist providing this service has resigned. MidCentral DHB have confirmed they are committed to providing the Cardiologist

service to Whanganui DHB on its current basis, and they are currently working though capacity issues to the end of the 2017 calendar year.

Cardiac interventions:

Assessment in the emergency department with treatment (door to needle) through to surgical intervention at a tertiary centre (door to Cath) is monitored and reported monthly through ANZACS – QI data.

The table provides an indication of Whanganui's access to angiography intervention within the recommended three days. There has been an improvement in access in the last three months. This is monitored not only by Whanganui but the regional cardiac network.



Cardiac rehabilitation:

A new national programme for tracking patients referred to cardiac rehabilitation services was launched 1 August 2017, which will be recorded through ANZACS – QI data base.

Attendance at phase 2 cardiac classes (community based) is historically poor both in New Zealand and worldwide, with average attendance been 30-35%. A research review and studies from America and Australia showed uptake for phase 2 cardiac classes to be <22%, 25% and 49% respectively. The above table gives a % figure taken from the maximum attendance over each course.

There is a waiting list for cardiac rehabilitation, but this is not due to oversubscription but based around the frequency of the course. The course at present can accommodate a maximum of twelve patients per course. This enables safe acuity levels and each patient to get the best from the exercise component of the programme. Māori are under-represented in cardiac rehabilitation and this are will be a focus of the improvement programme.

Patient data (June 2016 to May 2017)

Month	Inpatient contacts (phase 1)	Inpatient suitable for/invited to phase 2 community cardiac	Actual attendance phase 2 community cardiac classes	Percentage (%) uptake
June 2016	32	-	-	-
July 2016	28	16	6	38%
August 2016	32	19	7	37%
September	28	-	-	-
October 2016	38	20	9	45%
November	21	-	-	-
December	26	-	-	-
January 2017	29	19	8	42%
February 2017	23	-	-	-
March 2017	27	22	12	55%
April 2017	22	-	-	-
May 2017	28	18	5	28%
TOTALS	**334**	**114**	**47**	**40.5%**

** This data is currently being collected manually, however in future months will become part of the ANZAC QI data set with more detailed reporting available on performance*

Actions for improvement

A work plan is now in development to not only look at the big picture of service provision but to inform the work to create service improvement and improve equity.

1. Map the referral process and patient journey across the system (primary to tertiary) including:
   - The multi cardiac services and link with other processes and services.
   - Define echo wait times
   - Cardiac rehabilitation services, access and outcomes.

2. Work with primary healthcare to improve referral processes and timely access to echo diagnostics.

3. Get a better understanding of activities in primary care to support early identification of cardiovascular risk, management, and rehabilitation, focusing on Māori .

4. Continue to monitor door to needle and door to cath times, identify contributing factors and mitigation strategies.

5. Maintain overview of ANZACS –QI data input and outputs.

6. Continue to work with MidCentral DHB to manage cardiologist services while there are capacity issues.

7.3 Annual Plan focus area: Improving equity for priority populations | Maternal, child and youth health

Lead: Jon Buchan Portfolio Manager: Maternal Child and Youth, Service & Business Planning

Lead: Kim Fry, Director Allied Health (Oral Health Improvement Project) and Felicity Spencer, Project Lead

Purpose

The purpose of this report is to inform the committee of the service improvement activities being undertaken in the maternal, child and youth priority.

Special attention is being given to delivery against the 2017/18 Service Level Measures (SLM) Plan, which is a component of Whanganui DHB's 2017/18 Annual Plan. The DHB is working closely alongside primary and community providers to improve performance and outcomes for this population group.

Strategic Context

This work programme links to all four of Whanganui DHB's Strategic Commitments contained in the 2017/18 Annual Plan:

- Advancing Māori health and Whanau Ora
- Investing to improve health outcomes
- Growing the quality and safety culture
- Rising to the challenge to build resilient communities

Overview

System Level Measures are designed to support whole of system performance improvement. There is a strong focus on children, youth and vulnerable populations, providing an opportunity for DHBs to work with their primary, secondary and community care providers to improve health outcomes of their local population.

The six System Level Measures as of 1 July 2017 are:

- **Ambulatory Sensitive Hospitalisation (ASH) rates for 0–4 year olds (that is, keeping children out of hospital)**
- Acute hospital bed days per capita (that is, using health resources effectively)
- Patient experience of care (that is, person-centred care)
- Amenable mortality rates (that is, prevention and early detection)
- **Proportion of babies who live in a smoke-free household at six weeks post-natal (that is, healthy start)**
- **Youth System Level Measure (that is, youth are healthy, safe and supported).**

Three of these measures (**in bold** above) are maternal, child and youth related and shall be explored in depth to allow a greater understanding of where we are, groups or sub groups that are not meeting expectations and agreed activities to improve performance.

7.3.1 System Level Measure | Ambulatory Sensitive Hospitalisations (ASH)

Background

Ambulatory sensitive hospitalisations (ASH) are mostly acute admissions that are considered potentially reducible through prophylactic or therapeutic interventions deliverable in a primary care setting.

In New Zealand children, ASH accounts for approximately 30 percent of all acute and arranged medical and surgical discharges in that age group each year. However, determining the reasons for high or low ASH rates is complex, as it is in part a whole-of-system measure. It has been suggested that the admission rates can serve as proxy markers for primary care access and quality, with high admission rates indicating difficulty in accessing care in a timely fashion, poor care coordination or care continuity, or structural constraints such as limited supply of primary care workers or services.

Data analysis

Data being utilised for this analysis became available to the Whanganui DHB at the end of July 2017 for the first time.

Demographic and deprivation quintile analysis

The graph below indicates that during the period ending 2013 the number of events between Māori and 'other' was equitable however the population split at this time with Māori was inequitable. Māori represented a small proportion of the population. This demonstrates that Māori were indeed overly represented within the ASH event. Note that although the ASH rate fluctuates each year, by March 2017 the overall number of ASH events had reduced and levelled off with the most significant decline among the 'other' population, especially for females. Māori have achieved a minimal reduction in ASH events over this period. The population's ethnic profile of the 0-4 age group has changed during this period, which does account for the apparent poorer reduction of Māori ASH events. This shall be discussed later in the report.

DHB of Domicile	Whanganui						
Patient Age Group	00 to 04						
Event Facility	(All)						
Count of Patient Deprivation Quintile	**Column Labels**						
	Female		**Female Total**	**Male**		**Male Total**	**Grand Total**
Row Labels	**Maori**	**Other**		**Maori**	**Other**		
12 months to March 2013	**78**	**81**	**159**	**91**	**91**	**182**	**341**
1	1	3	4	1	13	14	18
2		11	11	4	8	12	23
3	5	3	8	3	6	9	17
4	16	20	36	19	35	54	90
5	56	44	100	64	29	93	193
12 months to March 2015	**107**	**82**	**189**	**82**	**88**	**170**	**359**
1	4	10	14		9	9	23
2	5	10	15	5	19	24	39
3	7	3	10	5	2	7	17
4	37	29	66	30	36	66	132
5	54	30	84	42	22	64	148
12 months to March 2017	**71**	**66**	**137**	**88**	**80**	**168**	**305**
1	7	7	14	1	9	10	24
2	9	11	20	9	8	17	37
3	1	7	8	2	5	7	15
4	21	15	36	28	34	62	98
5	33	26	59	48	24	72	131
Grand Total	**256**	**229**	**485**	**261**	**259**	**520**	**1005**

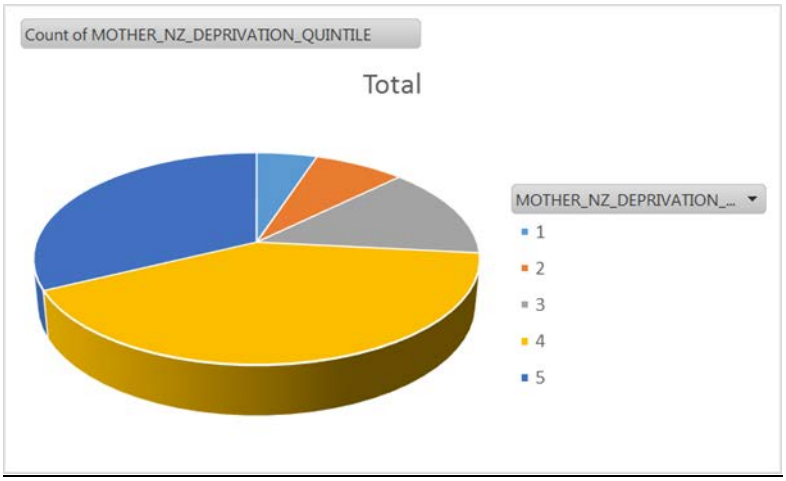
This table demonstrates the profile of ASH event by gender, ethnicity and deprivation quintile. NZ population is divided into quintile based on levels of deprivation, with 1 being the least deprived and 5 the most. This demonstrates that the majority of events are attributed to those living in deprivation quintiles 4 and 5, with Māori being the majority of these (130/99 respectively during the 2017 period).

This data is based on events rather than individuals, and analysis has shown that several unique individuals have a high level of ASH events within our population, spread across all ethnicities. This may be due to known chronic illness such as brittle asthma, where the criteria for attendance and admission are significantly lower than for regular asthmatics. This is a perfectly appropriate ASH attendance and highlights the difficulties of using ASH statistics or individuals and whānau who are in need of additional support.

When dealing with events, it is important to consider the 'pool' you are studying. Graph one below demonstrates that approximately 75% of pregnant women during 2015/16 lived in deprivation 4-5. Clearly with 75% of children being born into a certain group, it can be expected that this group will be over represented in ASH event/s. During the period ending 2017 deprivation, 4-5 children accounted for approximately 76% of ASH events.

Deprivation quintile of pregnant women during 2015/16 as collected by LMC

Impact of ethnicity



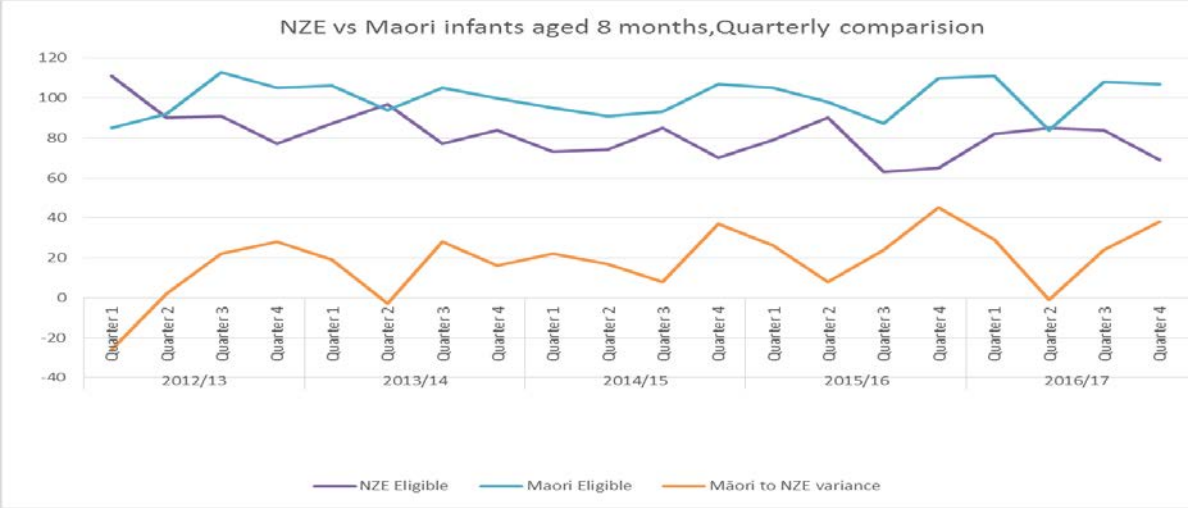
Based on Imms volumes based on 8 month result
0-4 ASH for the period 12 months to March 2017

	ASH Events (0-4)	Number of children passing the 8 month immunisation target in the last four years	Ratio of children to events
Other	146	2202	15.08
Maori	159	1996	12.55
Total	305	4198	13.76

The table above demonstrates the ratio of ASH events to ethnicity. Regardless of deprivation level, Māori children are more likely to have an ASH admission, 1:12.5 vs 1:15.1 for the remainder of the population. Eight month immunisation data has been used as a proxy for census data for these calculations, as a vast majority of this population were not born at the time of the previous census.

This reafirms that Māori need to be the focus of ASH initiatives as we strive to achieve equitable welbeing for our population. With a growing proportion of Māori to 'Other' children the importance of this is again reenforced.

The following graph demonstrates the variance of Māori to NZ European (NZE) of eight month olds within our population over the past five years. The consistently higher Māori variance will be reflected in the increasing proportion of Māori within the wider population, especially the child population.

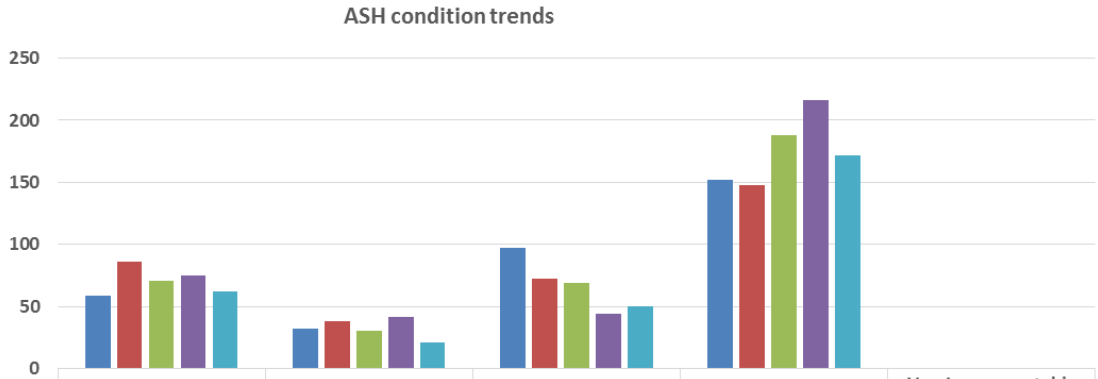


ASH conditions analysis

The reasons for ASH events over the last five years on an annual basis is demonstrated below.

DHB of Domicile | Patient Age Group

Count of ASH Chapter



	Dental	Dermatological	Gastrointestinal	Respiratory	Vaccine preventable disease
12 months to March 2013	59	32	97	152	1
12 months to March 2014	86	38	73	148	
12 months to March 2015	71	31	69	188	
12 months to March 2016	75	42	44	216	
12 months to March 2017	62	21	50	172	

ASH Chapter

Gastrointestinal and respirtory stand out as the main areas of change within this period. Gastro admissions have almost halved since March 2013, this is due to the introduction of the Noravirus vaccine in 2014.

Respiritory admissions continue to be the main contributor to ASH, accounting for over 50% of our ASH rate, and have consistently done so. As previously demonstrated, the bulk of the ASH events occur with children who live in decile 4 and 5 homes. These homes are inevitably the cold and dampest and most likely to trigger respiratory distress in whoever inhabits them.

The dermatological rate has halved during the previous two years but why this has occued is not certain. Possible factors include changes to dermalogical guidelines (around the use of steriod creams) or the atypical weather condition during the 2016/17 summer reducing exposure to the sun and factors that may trigger dermalogical exacerbation.

PHO led initiatives

Whanganui Regional Health Network has developed a follow-up service for children identified by ASH events, that is twofold. Firstly, every practice is sent a copy of all their children who were identified as ASH attendees. To ensure the practice is aware of their attendance, many practices have practice based wrap-around for this group (funded by SIA). Secondly, WRHN child health services team coordinator follows up on all children presenting with asthma and eczema and enures supporting services such as 'Healthy Homes' are in place and work with the families to produce action plan and improve health literacy.

Immunisation coverage for eight month-olds during the quarter four period of 2016/17 has not reflected the work performed by the NIR, IOS, general practice and WCTO providers, all of whom have tried to maximise immunisation for eight month olds. Immunisation coverage for total population fell to 87.3% with Māori dropping slightly further to 85%.

Resourcing has been stretched due to the roll out of influenza vaccinations and introduction of HPV for males. In addition, feedback from parents indicates that renewed mainstream reporting on potential side effects 'put them off' immunising their children so young. Ongoing positive messaging and work within the WCTO workforce around scripted/consistent messaging continues.

Conclusion

ASH monitoring and data analysis will now be much more achievable due to the improved data available to the Whanganui DHB as a mechanism for focused wrap-around support for our 0-4 population. Further analysis is required at an NHI level from the DHB, although the PHO has been using this data to provide information to their practices. The wider DHB services have yet to utilise this information to its maximum effect, due to the limited time this data has been available.

Next steps

- The DHB and partners to utilise the Service Level Measures (SLM) Plan as the lead document for our approach to reducing ASH.
- Actively monitor ASH reduction activities as outlined within our SLM, as per the table below.
- Explore opportunities for the DHB service to align and work in partnership with primary care to maximise wrap around support for children who have ASH admissions.
- Progress data analysis process as a DHB to increase our understanding our area of opportunity and investment in regards to ASH.
- Progress improvement activities within the babies in smoke free home service level measure.

System Level Measure | ASH improvement activities (from Whanganui DHB 2017/18 Annual Plan)

Ambulatory Sensitive Hospitalisations (ASH) 0-4 year olds	
Improvement milestone Reduce ASH rates for Māori age 0-4 years to 8,099 per 100,000 (Māori ASH rate) by June 2018	
Contributory measures	**Improvement activities**
Hospital admissions for children aged 0-4 years with dental caries as primary diagnosis Source - MoH ASH report	▪ Implement onsite Iwi provider mobile dental unit visits to provide treatment for children who would not be seen otherwise. ▪ Engage Iwi provider network to assist with attendance to mobile unit. ▪ Redevelop newborn multi-enrolment form to allow greater information sharing between services. ▪ Analyse data to gain better understanding of the ASH cohort.
Hospital admissions for children aged five years with a primary diagnosis of asthma Source - MoH ASH report	▪ Smokefree homes education supported and promoted by WCTO services, LMC and general practice. ▪ Healthy Homes programme continues to be targeted at high risk groups. ▪ Track repeat presenters back to general practice teams for development of plans to avoid readmission. ▪ Vaccinate all children 0-5 who qualify for the free influenza vaccine. ▪ Promote adding influenza and *Boostrix* vaccines in pregnancy to prevent serious communicable illness in newborn babies.

7.3.2 System Level Measure | Babies in smokefree households

The purpose of this report is to provide the latest data available on 'Babies in smoke free households' and agreed actions to reduce these as a component of our System Level Measures Plan.

Data analysis

'Babies living in smokefree homes' data is collected by the mother's LMC at two to six weeks postpartum and by WCTO providers at core one checks (six – eight weeks). The MoH has recently released NHI level data from LMCs and WCTO providers allowing in depth analysis. Smoking data from older children is collected during the B4SC. Whilst B4SC data is of limited use for the SLM milestone, it does add to the wider smoke free picture of our children.

The Ministry does not routinely audit smoking data. Given this, significant concerns exist about the integrity of the data. Our DHB smoking related data sets contain:

- High numbers of incomplete data fields (i.e. blank or missing information).
- Incorrect and unrecognisable values (i.e. partially completed or transposed information).

The DHB will work with providers to identify pragmatic approaches that will improve the robustness and accuracy of the data that is submitted to the Ministry. These will include initiating improvement activities that focus on assessing:

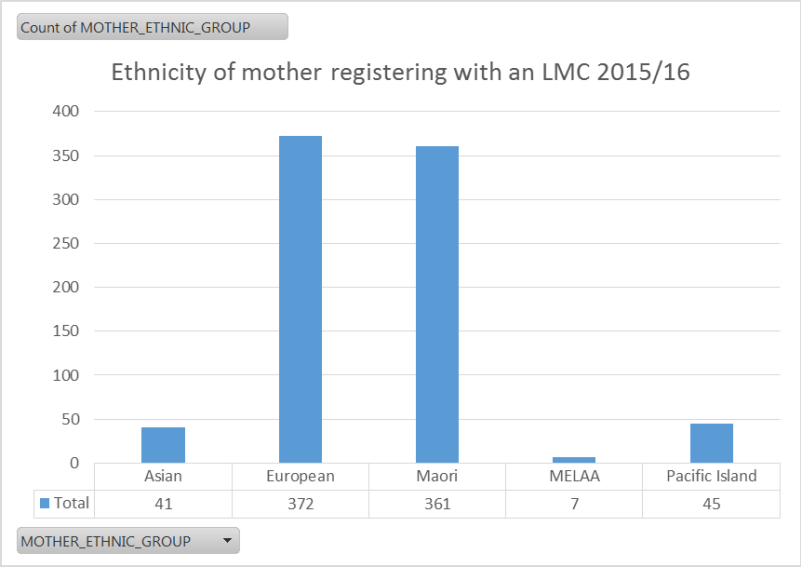
- How smoking information is elicited from patients.
- How smoking information is recorded electronically.
- What data analyses and validation checks are performed.

LMC Smoking Data

LMC data at this point is the most complete data set available. This is principally because the data LMC enter is linked to the funding they receive for the women they care for.

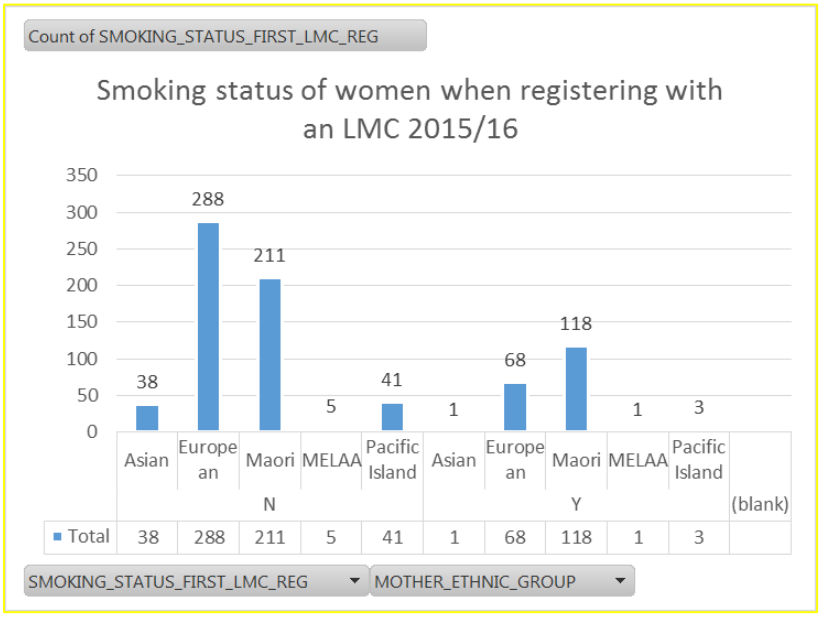
As this chart demonstrates, Māori and European represent the vast majority of ethnicities of mothers within our DHB. The Asian number is almost on par with Pacific Islanders. Increase in Asian has occurred significantly over the last five years. During the 2012/13 period less than 12 Asian babies were born within our DHB. The impact of this to our service providers could be significant - we need to ensure that providers have the ability to provide information that it easily understandable to our whole population, as required under the Health and Disabilities Commission's 'Code of Right', especially rights 5-7. This will need planning, as few resources in asian languages are currently available.

Assistance has been sought from the MoH for Pacifica resources for the Well Child Tamariki Ora service. The increase in Asian mothers does indicate similar needs will exist for Asians.



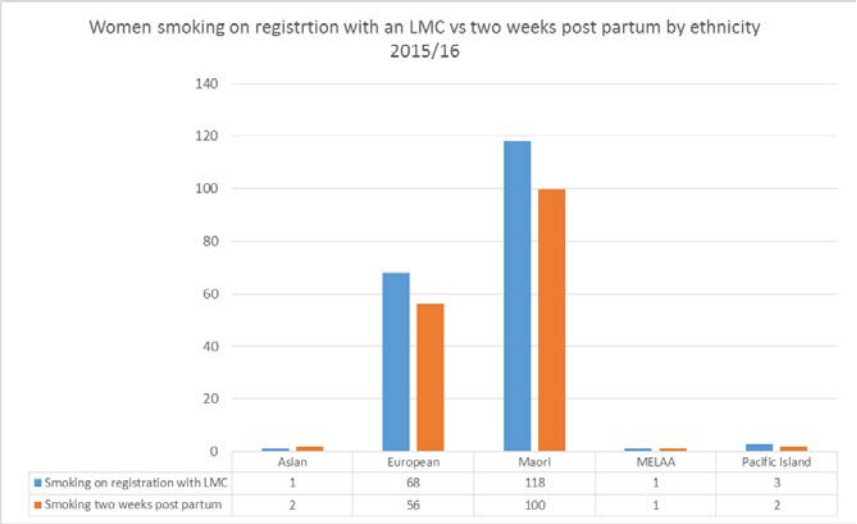
During the 2015/16 period, 583 or 75.3% of women reported that they were not smokers when they registered with their LMC's. Europeans and Māori smoking rates are the highest with 20.66% and 35.86% of mothers smoking respectively. Smoking among other ethnicities while pregnant is minimal.

This indicates that our efforts should continue to be on Māori and Europeans.

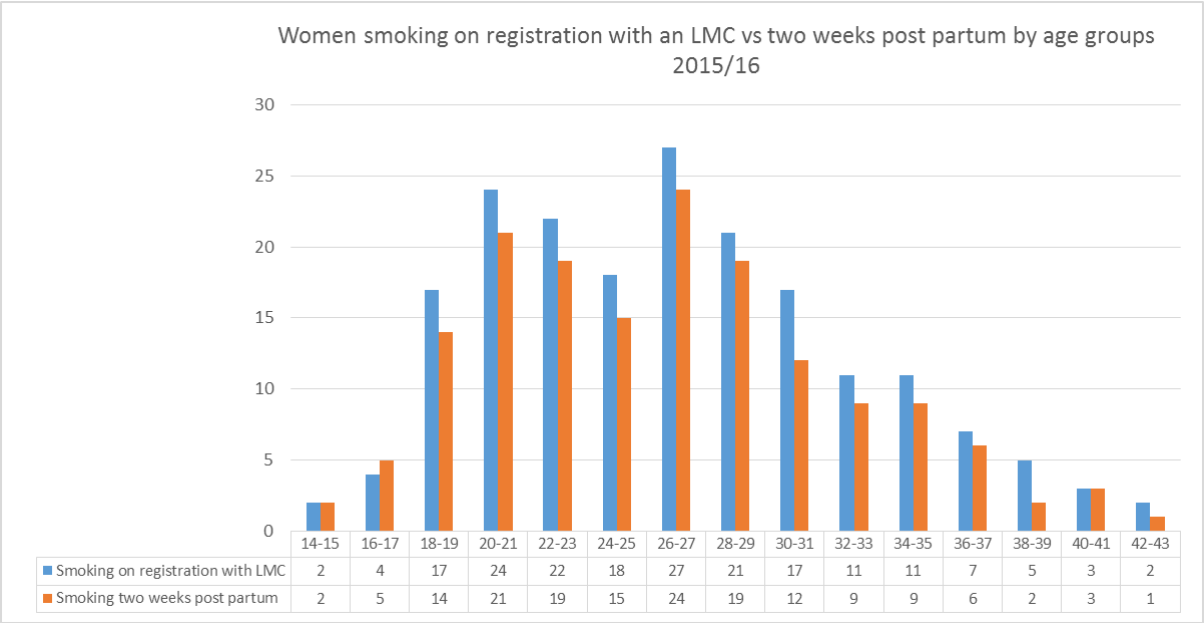


Note: the N indicates women who do not smoke, the Y indicates group which does.

This graph demonstrates the numbers of women smoking on registration with an LMC compared with women smoking two weeks post-partum. While a reduction can be seen, smoking remains unacceptably high in both the main ethnicities.



	Asian	European	Maori	MELAA	Pacific Island
Smoking on registration with LMC	1	68	118	1	3
Smoking two weeks post partum	2	56	100	1	2



	14-15	16-17	18-19	20-21	22-23	24-25	26-27	28-29	30-31	32-33	34-35	36-37	38-39	40-41	42-43
Smoking on registration with LMC	2	4	17	24	22	18	27	21	17	11	11	7	5	3	2
Smoking two weeks post partum	2	5	14	21	19	15	24	19	12	9	9	6	2	3	1

Smoking cessation during pregnancy, when reviewed by age, demonstrates that cessation of smoking is occurring across all age groups.

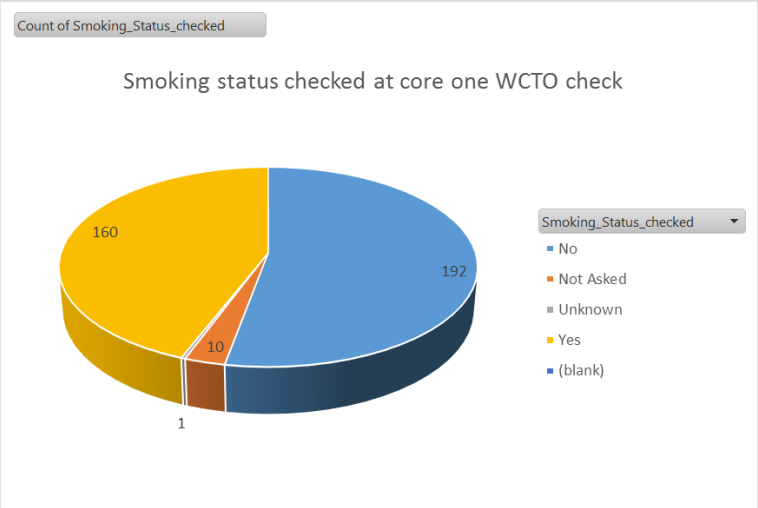
LMC data has allowed us to gain a better understanding of the profile of women who smoke, clearly Māori and European need to continue to be the target groups for cessation activity.

Successful smoking cessation for women who are pregnant is not high, no age group or ethnicity stands out as being an outlier in this, either positively or negatively. This reinforces the view that smoking cessation during pregnancy is exceptionally difficult for our whole population. Reducing uptake or cessation of smoking prior to pregnancy is likely to have a much better result. To reduce smoking in pregnancy we must focus on youth aged 17 years and preconception smoking cessation. By 18 years of age, smoking among youth is almost on a par with the adult population and the number of smokers expands substantially.

WCTO data

Plunket and Tamariki Ora services provided core one checks at six to eight weeks of age. Establishing the smoking status of the household is a component of this.

The pie chart below indicates (based on six months data), smoking status information is not checked in a majority of core one checks. To date the DHB has had no method of recognising this information was not being collected.



The DHB is now working with all WCTO providers to support them in correctly collecting this information and recording it correctly. This will be monitored on an ongoing basis.

Smoking_Status_checked	Yes
Count of Smoking_Status_Smoker_Presence	
Smoking_Status_Smoker_Presence	Total
Yes	30
(blank)	
Grand total	30

As this table demonstrates, of the 160 children's parents asked about smoking at the core one visit, just 30 indicated that a smoker existed in the household.

Of these 30 households with smokers, just 11 indicated that their baby was exposed to smoke. Instinctively these figures seem rather implausible and reinforce the need for data collection improvement.

Smoking_Status_checked	Yes
Count of Smoking_Status_Exposure	
Smoking_Status_Exposure	Total
Yes	11
Grand Total	11

Smoking cessation initiative targeting youth and pregnant women

The Whanganui Tobacco Control Plan priorities for 2017-18, which focussed on youth and pregnant women, include:

- Linking the national Health Promotion Agency (HPA) young adults' campaign within a local context.
- Identify opportunities to support social and physical environments for youth which are smokefree.
- Establish relationship between stop smoking services and schools, youth education, social service and health providers.
- Increase cessation activity for youth through stop smoking services.
- Engage with Youth Services Trust.
- Explore use of social media options for reaching young smokers in primary care.
- Integrate general practice youth smokefree activities with the wider youth and smokefree context.
- Consider recommendations from Maternal Smoking Research Project.
- Implement incentives programme for pregnant women.
- Explore group coach training to engage whole whanau.
- Provide smokefree training to LMCs.
- Explore provision of smokerlyzer use for LMCs.

Next steps

The reduction of smoke exposure in infants requires a holistic approach, whereby complete family/whānau groups stop smoking which allows them to support and encourage each other to stop smoking. To achieve this, focusing on mothers in isolation to create a smokefree environment for children alone will not suffice.

This paper has demonstrated that cessation of smoking is a challenge for all ages and ethnicities especially during pregnancy.

The 2017/18 SLM plan will work in conjunction with the Whanganui Tobacco Plan to identify activities to improve smokefree homes and this is attached below:

System Level Measure: Babies in smokefree households improvement activities (from Whanganui DHB 2017/18 Annual Plan)

Babies in Smokefree Households	
Improvement milestone Proportion of babies who live in a smoke free household at six weeks post-natal ***Note: Target to be confirmed when data becomes available***	
Contributory measures	**Improvement activities**
Pregnant women who identify as smokers upon registration with a DHB employed midwife or Lead Maternity Carer who are offered brief advice and support to stop smoking.	▪ Support use of *smokerlyzers* in maternity settings. ▪ Facilitate early enrolment of pregnant women with LMCs. ▪ Explore LMC/Pregnancy incentives programme. ▪ Work with LMCs and primary care to identify appropriate ways to support increased number of pregnant women active in smoking cessation services. ▪ Ensure primary care, LMCs and secondary care advise every smoker of the harms of smoking and offer support to quit (ABC approach). ▪ Explore opportunities to offer smoking cessation support to whanau of paediatric inpatients/outpatients and paediatric ED attendances. ▪ Improve regional data collection so that referral to SSS for women who are pregnant and are current smokers are identified and can be monitored. ▪ Analyse reasons for low referrals to smoking cessation.
Mothers are smokefree at two weeks post-natal. Maternal Smoking Prevalence data: Rationale: While data are available for maternal smoking at registration and 2 weeks post-partum from the National Maternity Collection, these data are not available quarterly. These data are required to monitor the impact of activities on population maternal smoking prevalence health and inequalities.	▪ Improve regional data reporting such that smoking rates in pregnant women at birth can be calculated in a timely, consistent manner.

Four year old children living in a smokefree home Rationale: Whānau: Smokers who live in the same household as babies and young children may be reached through community, primary care and secondary care. Offering cessation support, NRT or referral to SSS is important to assist whānau members to become smoke-free. The use of other settings to identify and support smokers that live with young children will also be explored. A focus on activities that will increase quit rates for Māori and Pacific is particularly important given the higher prevalence of smoking in these ethnic groups.	Scope processes to identify household members of pregnant women and newborns who are current smokers including data collection processes. Explore opportunities to offer smoking cessation support to whānau of newborn inpatients / outpatients and paediatric ED attendances. Explore additional ways of offering smoking cessation support to whānau of young children e.g. pharmacy initiatives, Well Child providers.

7.3.3 System Level Measure | Youth access to services

Background

The DHB believes that many youth within our community have a level of unmet health need. Youth need services that are accessible, and appealing to the youth mind set. The DHB and supporting health service providers want youth to be engaged with all health services, especially those that support them to maintain wellbeing and mana within their homes and communities.

Preventative services for youth represent a very broad range of service so no one measure will successfully be able to demonstrate an improvement. To monitor improvement, the DHB and its partners have agreed three contributory measures that will be monitored:

- Utilisation of DHB funded primary care health services, including those supporting mental health, these include:
  - Primary mental health initiative
  - SUPP
  - Youth Service Trust
- HPV immunisation rates; female data only at present, males data will be included once it is available.
- Adolescent enrolment and utilisation of dental services.

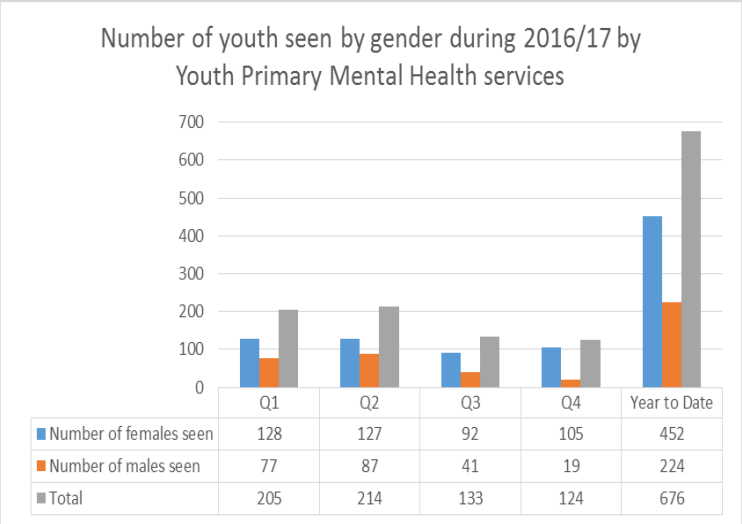
Data analysis

Youth access to preventative services within the Service Level Measures plan has a mandatory milestone, adolescent dental utilisation. This measure is explored in depth within the Oral Health Improvement Project Paper contained in this agenda. The DHB has adopted multiple contributory measures to monitor youth accessing preventative services.

The data presented within this report only represents services funded by health. In reality, services for youth include those funded by other ministries as well as multiple NGOs and other groups working with children and youth. This data only represents the health funded component of all the services available.

Youth primary mental health services are provided by:

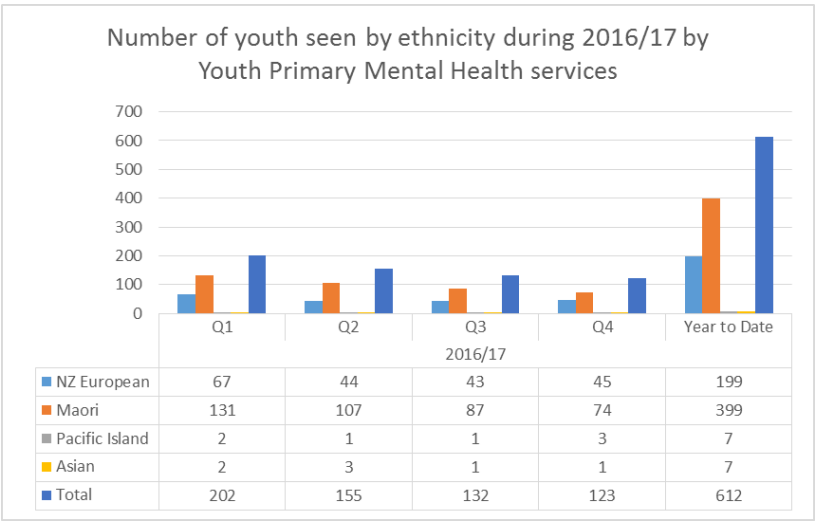
- Te Oranganui
- Whanganui Regional Health Network
- National Hauora Coalition.



	Q1	Q2	Q3	Q4	Year to Date
Number of females seen	128	127	92	105	452
Number of males seen	77	87	41	19	224
Total	205	214	133	124	676

Services provided include youth clinics, brief interventions, extended consultations, packages of care and group work. As with a majority of youth health services, the attendees are heavily weighted towards females. A national review of primary mental health services did identify Whanganui as having a much higher level of male attendees than the national average.

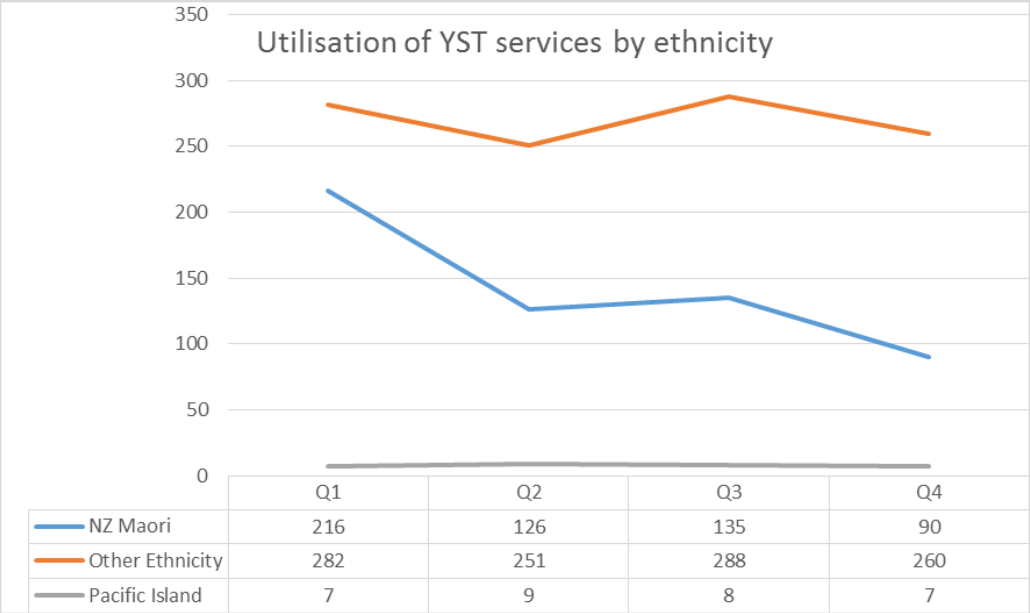
As this graph indicates the ethnicity mix is atypical with all providers seeing an unusually high level of Māori within their services. Volumes have fluctuated over the year. This is not uncommon for these services and is being actively monitored.



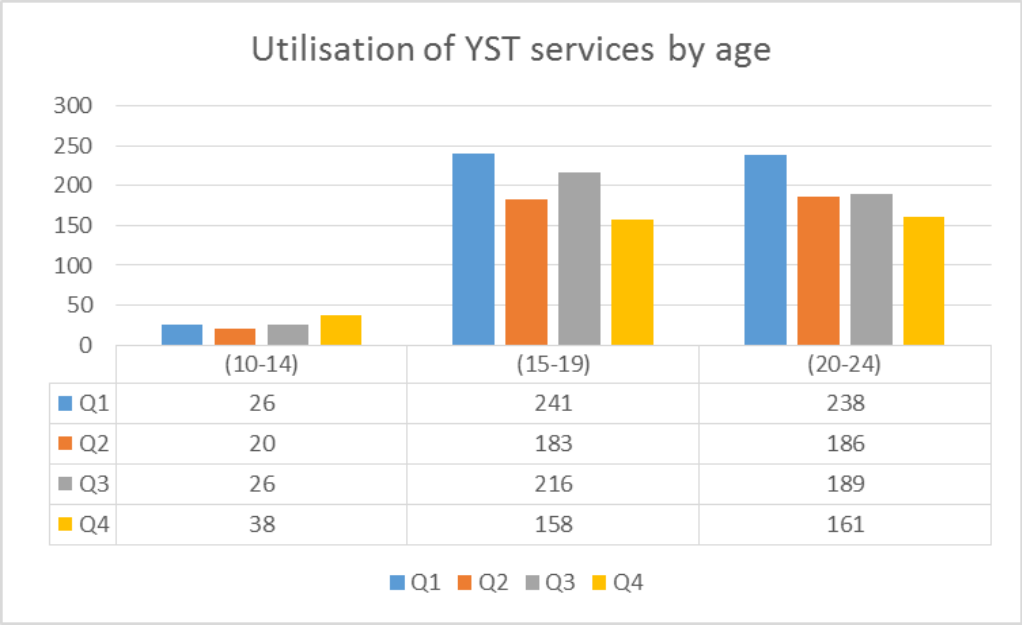
	Q1	Q2	Q3	Q4	Year to Date
2016/17					
NZ European	67	44	43	45	199
Maori	131	107	87	74	399
Pacific Island	2	1	1	3	7
Asian	2	3	1	1	7
Total	202	155	132	123	612

Whanganui's hub for youth health services outside of general practice is the Youth Services Trust (YST). This is a youth one stop shop (YOSS) and provides no cost access to a nurse, counselling, social worker and a limited service by a general practitioner for youth 12-24 years of age. While the service is currently city based, opportunities to develop a mobile 'pop up' service are being looked at. The DHB SUPP youth CEP service is based within YST and this is a good example of shifting specialist services closer to the community.

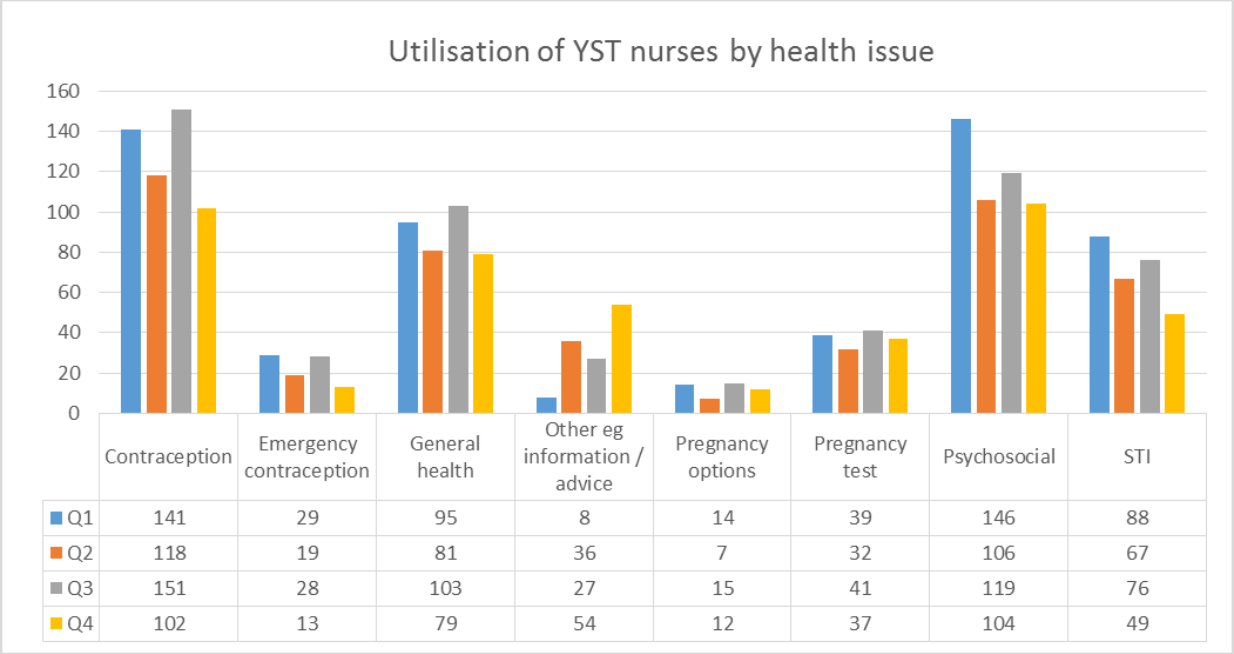
As the information below indicates, Māori represent approximately 34% of the YST clients. This represents equity for this age group based on data available. Youth aged 15 or above represent the majority of services users, the rationale for this is clear when the reasons youth attend YST are seen in the following graphs. Sexual and personal health issues and concerns represent a majority of reasons youth attend the service. These services contribute significantly towards the 'reducing unintended teenage pregnancies' expectation of the government.



	Q1	Q2	Q3	Q4
NZ Maori	216	126	135	90
Other Ethnicity	282	251	288	260
Pacific Island	7	9	8	7



	(10-14)	(15-19)	(20-24)
Q1	26	241	238
Q2	20	183	186
Q3	26	216	189
Q4	38	158	161

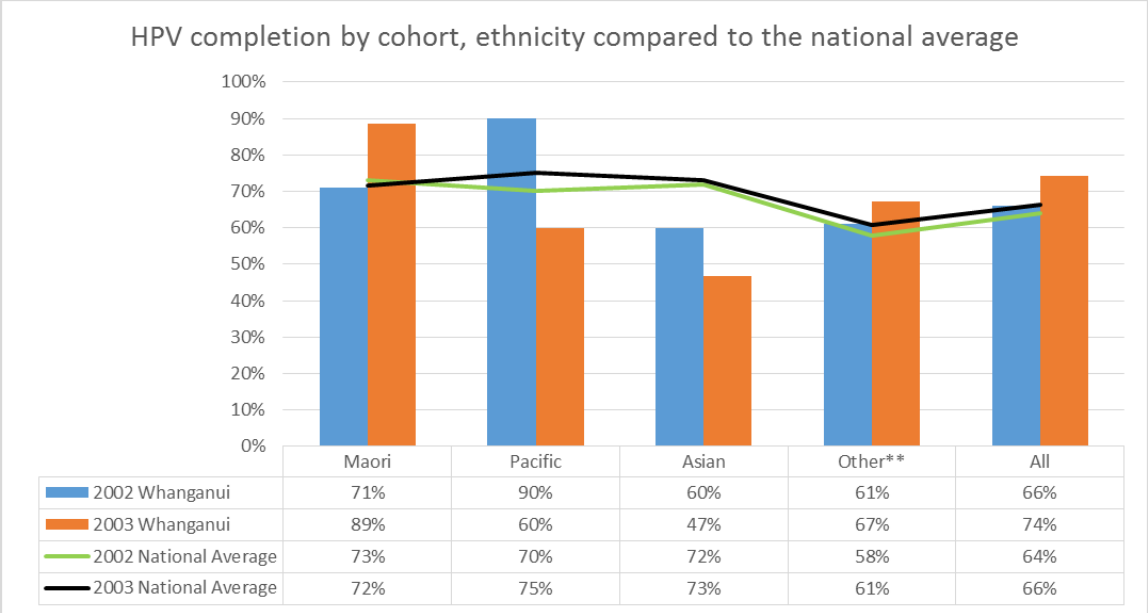


	Contraception	Emergency contraception	General health	Other eg information / advice	Pregnancy options	Pregnancy test	Psychosocial	STI
Q1	141	29	95	8	14	39	146	88
Q2	118	19	81	36	7	32	106	67
Q3	151	28	103	27	15	41	119	76
Q4	102	13	79	54	12	37	104	49

Human Papillomavirus (HPV) is a group of very common viruses that infect about four out of five people at some time in their lives. HPV causes cells to grow abnormally, and over time, these abnormalities can lead to cancer. Within NZ, immunisation is now provided for those aged 9 to 14 years, in two doses spaced at least six months apart. This age group develops a stronger immune response than those vaccinated when they are older, which is why it is recommended for both boys and girls at age 11 to 12.

Data for males is not currently available, as the 2016 calendar year being the first that they have been funded for this vaccination.

To date Whanganui has delivered vaccination for HPV at or above the national average; this still leaves a lot of room to improve performance, especially among 'other' ethnicity cohort represents birth cohort, ie the year they were born.



	Maori	Pacific	Asian	Other**	All
2002 Whanganui	71%	90%	60%	61%	66%
2003 Whanganui	89%	60%	47%	67%	74%
2002 National Average	73%	70%	72%	58%	64%
2003 National Average	72%	75%	73%	61%	66%

Next steps

The SLM focus for youth is increasing access to services and the improvement activities reflect this as below. The challenge for the DHB and partners will be responding to this increased utilisation, and ensuring the services youth need, can meet the demands being placed on them.

Māori have been demonstrated to be accessing preventative services beyond that which may be expected. This may indicate that this group has a higher need for service or, that the targeted planning of services has ensured these options are easily available to this group. Realistically both factors contributing Māori utilisation of services are envisaged.

System Level Measure: Youth access to preventative services (from Whanganui DHB 2017/18 Annual Plan)

Youth access to preventative services	
Improvement milestone During the 2016/17 reporting period, 79.4% of adolescents utilised DHB funded dental services against a national target of 85%. Achieving a milestone of 82.5% for the 2017/18 period will demonstrate more youth are accessing preventative services, this equates to approximately an additional 116 youth receiving services.	
Contributory measures	**Improvement activities**
Increased utilisation of DHB funded primary mental health services including: ▪ Youth Primary Mental Health initiative ▪ SUPP ▪ Youth One Stop Shop	▪ Create data sets to establish consistent reporting/measure of youth access to preventative services ▪ Identify gaps in service from reporting and commission services to fill gaps in service/need ▪ Monitor and feedback equity of service access to the providers to reduce any inequity on a quarterly basis
Immunisation of preventable diseases: ▪ HPV eligibility changes and vaccine entitlement. ▪ Immunisation coverage achieving the target of 75% across all ethnicities.	▪ Monitor HPV implementation coverage inequities to ensure equity of HPV immunisation. ▪ Areas of inequity will receive a focussed service delivery focus. ▪ General practice to receive support and education to ensure staff are aware of new immunisation regime and client entitlements during quarters one & two.
Increased registration of youth with dental services with a target of enrolment and utilisation at or over 82.5% across all ethnicities.	▪ Increase adolescent dental enrolment and participation with a focus on ensuring equity of enrolment. ▪ Monitor decayed/missing/filled teeth (DMFT) rate for year 12 students to identify the most vulnerable groups. ▪ Review DHB dental service caravan utilisation. Re-configure locations and times where practical to maximise reach towards hard to reach and unengaged groups within our population.

7.3.4 Oral Health Improvement Project

Purpose

The purpose of this report is to inform the committee of the most recent data regarding DHB oral services and the condition of our preschool, child and adolescent oral health. The report also presents the current status of the oral health project and the next steps to improving oral health within the DHB for children and youth.

Background

The vision for the oral health improvement project is good oral health for all, for life, by improving the oral health of our youngest and most vulnerable (Māori , Pacific, low socio-economic and rural) populations within our community, *through an equitable whanau centred service*.

It is recognised that the oral health status of our children is not as good as it should be. This is significant as research shows that oral health at age five is a predictor of oral health at age 26, therefore promoting good oral health in the early years will produce benefits that will last a lifetime.

Where we are now

National data shows a worrying trend of inequality in child oral health statistics. Our 2016/17 annual plan targets are:

2016/17 annual plan targets	Target	Our rates
Percentage of children carries free at five years of age	≥56%	52.8%
Year Eight Mean dmft	≤1.12	0.95

As can be seen above, we are under meeting our carries free rate by 3.2% However our high enrolment rate of our pre-schoolers means that more of them are being seen, and treated, which in turn will have an impact on the caries rate.

Our decayed/missing/filled teeth (dmft) rate in year 8 children is 0.95, so we have met and exceeded this. This reflects the health of our children's permanent teeth.

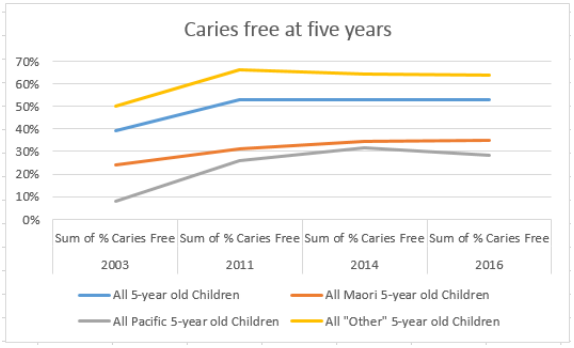
The local data that has recently been received for the 2016/17 period clearly reflects inequalities, with a lower percentage of Māori and Pacific Island children being caries-free at five years of age and year eight, and having a higher mean dmft score at age five and year eight than non-Māori and non-Pacific Island children. Furthermore, dental is the third highest reason for admissions in Māori children aged 0-4 years of age, based on non-standardised ASH data and sits well above the national average, this is explored further within the ASH section of this paper.

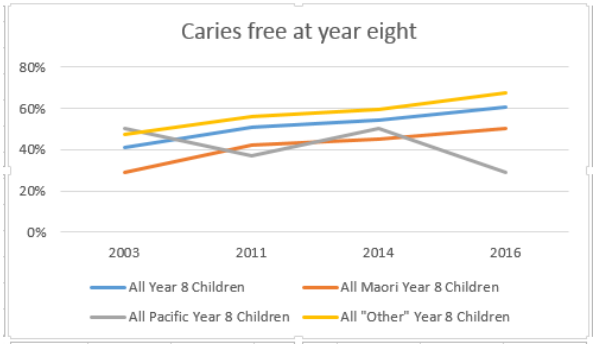
In addition to being a high ASH contributor, the oral health services are also among the highest DNA rates seen, particularly for Māori Tamariki (0-4 years). The 2016/17 Māori Health Plan reports the rate as high as 33% for recalls. Not attending appointments delays preventative measures and treatment therefore affecting the caries rate.

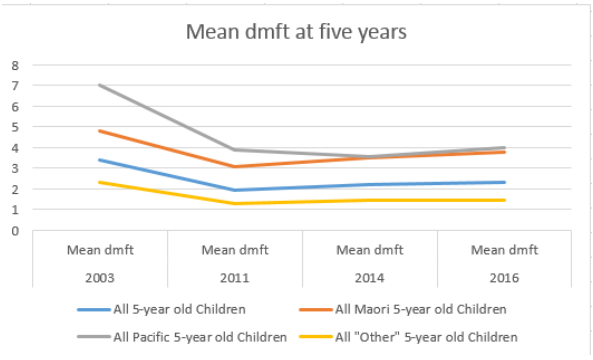
The data set below show a definite improvement over the years, and reflects the hard work of our dental team in both the percentage of children who are carries free at age five and year eight as well as the mean dmft. However, of note, is that there is a flat-lining of the data and this plateau may not shift until other significant issues are addressed - such as water fluoridation.

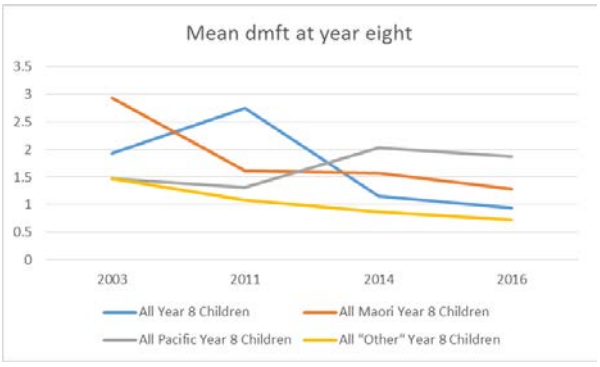
The other point the data below shows is that although we have met the dmft target for year eight as noted above, there is inequity with both Māori and Pacific Island year 8s not meeting the ≤1.12 target and being 1.28 and 1.88 respectively.

Caries free				
	2003	2011	2014	2016
	Sum of % Caries Free	Sum of % Caries Free	Sum of % Caries Free	Sum of % Caries Free
All 5-year old Children	39%	53%	53.1%	52.8%
All Maori 5-year old Children	24%	31%	34.5%	34.9%
All Pacific 5-year old Children	8%	26%	31.7%	28.2%
All "Other" 5-year old Children	50%	66%	64.1%	63.7%
	Sum of % Caries Free	Sum of % Caries Free	Sum of % Caries Free	Sum of % Caries Free
All Year 8 Children	41%	51%	54.1%	60.5%
All Maori Year 8 Children	29%	42%	45.0%	50.0%
All Pacific Year 8 Children	50%	37%	50.0%	29.2%
All "Other" Year 8 Children	47%	56%	59.4%	67.46%
Mean dmft				
	2003	2011	2014	2016
	Mean dmft	Mean dmft	Mean dmft	Mean dmft
All 5-year old Children	3.4	1.96	2.22	2.31
All Maori 5-year old Children	4.8	3.08	3.49	3.77
All Pacific 5-year old Children	7	3.89	3.59	3.97
All "Other" 5-year old Children	2.29	1.29	1.47	1.43
	Mean dmft	Mean dmft	Mean DMFT	Mean DMFT
All Year 8 Children	1.93	2.74	1.15	0.95
All Maori Year 8 Children	2.93	1.62	1.57	1.28
All Pacific Year 8 Children	1.47	1.31	2.03	1.88
All "Other" Year 8 Children	1.47	1.08	0.87	0.73









Enrolment Data:

Data from the Ministry of Health show our enrolment data to be at 104.2% of the population, reflecting that the new born services multi-enrolment process is efficient and effective.

Attendance Data:

The Titanium programme provides data for the number of visits failed during the 2016 calendar year.

The failure to attend appointments rate for the different population groups are:

	Ethnicity	Percentage (based on total population)	Percentage (calculated out per ethnicity)
Pre-School		30%	
	Māori	15%	38.5%
	Pacific Islander	1.7%	34.6%
	Other	13%	23.6%
Primary School		2.5%	
	Māori	1.2%	3.4%
	Pacific Islander	0.1%	3.2%
	Other	1.2%	1.9%
Adolescent		14%	
	Māori	8.8%	19%
	Pacific Islander	0.4%	10.9%
	Other	5%	10%

Examination Arrears:

Although we may have a high rate of failed appointments among the pre-school population, the actual total population who have not been seen meets and exceeds the target of ≥95% (or ≤510 children). Only 3% of our pre-school and primary school population are overdue in regards to their examinations. However our Māori pre-school children sit at 10%.

Measure 2 (PP13b): Number of enrolled pre-school and primary school children overdue for their scheduled examinations, 2016 calendar year

	ALL ETHNICITIES					MĀORI ONLY					PACIFIC ONLY				
	Number of Children Overdue	Total Number Enrolled	Percentage Overdue	Longest waiting time Duration (in months)	Longest waiting time Number Affected	Number of Children Overdue	Total Number Enrolled	Percentage Overdue	Longest waiting time Duration (in months)	Longest waiting time Number Affected	Number of Children Overdue	Total Number Enrolled	Percentage Overdue	Longest waiting time Duration (in months)	Longest waiting time Number Affected
Pre-School Children (age 0 -4)	259	4,450	6%	8	2	185	1,940	10%	7	15	21			8	2
Primary School Children (age 5 - Year 8)	93	7,472	1%	7	1	69	2,695	3%	6	10	11	250	4%	7	1
TOTAL	352	11,922	3%	8	2	254	4,635	5%	7	15	32	250	13%	8	2

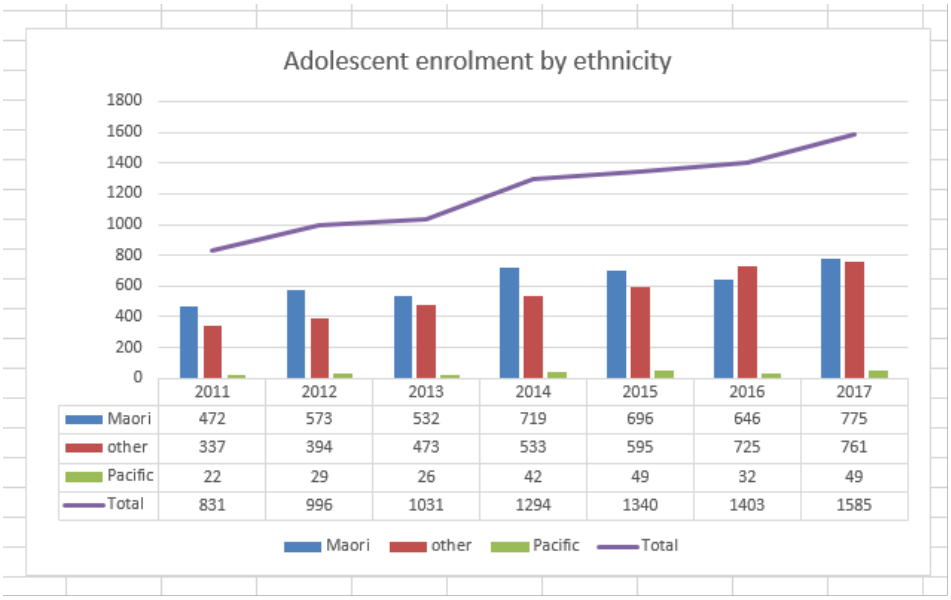
	OTHER				
	Number of Children Overdue	Total Number Enrolled	Percentage Overdue	Longest waiting time Duration (in months)	Longest waiting time Number Affected
Pre-School Children (age 0 -4)	53			5	9
Primary School Children (age 5 - Year 8)	13	4,527	0%	4	3
TOTAL	66	4,527	1%	5	9

Adolescent Services:

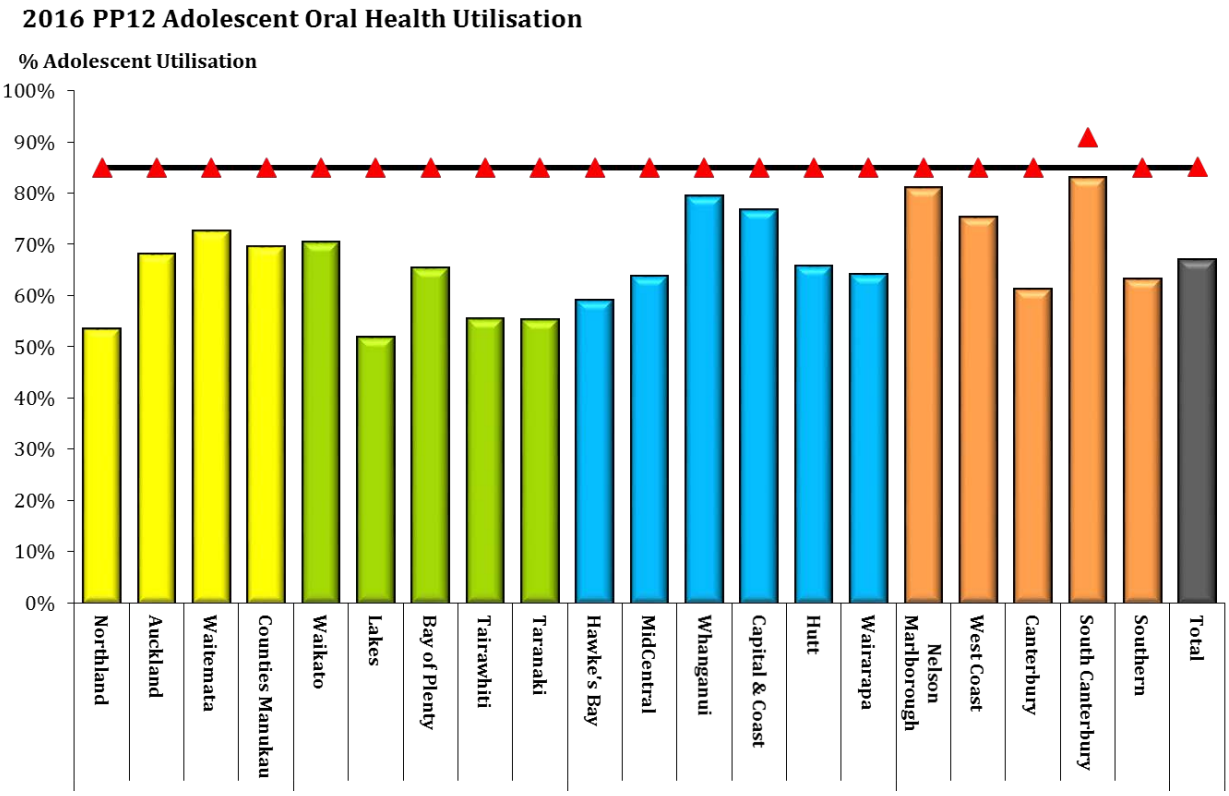
Adolescents now have the option of enrolling with either a private Dentist or with the DHB dental therapy service. Although dental therapists are unable to provide the full menu of option for children and youth, they are able to refer on and are much more convenient for youth to attend. As a result of this the number of adolescents enrolling with the DHB services has grown substantially over the past five years. This has resulted in a consistent increase in the number of adolescents utilising oral health services.

Year	Number of adolescence utilising DHB oral health services
2011	831
2012	996
2013	1031
2014	1292
2015	1340
2016	1403

WDHB Adolescent numbers enrolled - Oral Health by ethnicity				
Year	Maori	other	Pacific	Total
2011	472	337	22	831
2012	573	394	29	996
2013	532	473	26	1031
2014	719	533	42	1294
2015	696	595	49	1340
2016	646	725	32	1403
2017	775	761	49	1585



Ministry of Health data shows us in one of the top three performing DHB's in regards to Adolescents utilisation oral health services.



What we are doing to improve the current situation?

We are conducting a thorough mapping of what is currently happening within our DHB. This has included looking at our hospital, pre-school, primary school, adolescent and public health services. Interviews have been conducted with the Kohanga, Haumoana team, public health staff, dental staff, Plunket, Tamariki Ora nurses and patients.

Data sets have been analysed and all this information has been pulled together into relevant documents. A list of opportunities and gaps in current services have been identified with strengths and weaknesses for each presented.

A mobile unit has visited Te Oranganui during both the April and July school holidays, and quality cycles have been undertaken following these visits to enhance utilisation of the service. Other potential sites outside of schools that this approach could work in are being carried out or considered.

Next steps

The outcome of the mapping exercise will be shared and examined by the key stakeholders, to inform what further actions need to be taken. A district wide governance group will monitor progress.

7.4 Annual Plan focus area: Living within our means

Leads: Matt Power, Funding and Contracts Manager
Kath Fraser-Chapple, Business Manager Medical, Community and Allied Health
Peter Wood-Bodley, Business Manager Surgical Services and Procurement

The purpose of this report is to present the financial results for Whanganui DHB for the period ending July 2017. The report covers service and business planning, and the hospital service divisions.

7.4.1 Service and Business Planning (Funding Division)

The purpose of the report is to update the joint committee on the consolidated financial result for Whanganui DHB for the month ending July 2017, with commentary on the Funder and Provider Divisions.

Consolidated performance for the period ending July 2017

STATEMENT OF FINANCIAL PERFORMANCE for the period ended
CONSOLIDATED

	Month				Annual	Annual	
	Actual	**Budget**	**Var**		**Budget 2017-18**	**Actual 2016-17**	
Provider Division	(340)	(488)	148	F	(2,235)	(3,001)	F
Corporate	12	-	12	F	(584)	839	F
Provider & Corporate	**(328)**	**(488)**	**160**	**F**	**(2,819)**	**(2,162)**	**F**
Funder Division	(286)	(131)	(155)	U	-	1,517	F
Governance	1	(7)	8	F	-	(67)	F
Funder divison & Governance	**(285)**	**(138)**	**(147)**	**U**	**-**	**1,450**	**F**
Net Surplus / (Deficit)	**(613)**	**(626)**	**13**	**F**	**(2,819)**	**(712)**	**F**

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

Funding Division

STATEMENT OF FINANCIAL PERFORMANCE for the period ended 31 Jul 2017($000s) FUNDER DIVISION	Month				Annual	Annual
	Actual	Budget	Variance		Budget 2017-18	Actual 2016-17
REVENUE						
Government and Crown agency	19,360	19,355	5	F	232,465	18,239
Inter-district Inflow	638	742	(104)	U	8,902	638
Other Income Revenue	37	51	(14)	U	600	(120)
Total Revenue	**20,035**	**20,148**	**(113)**	**U**	**241,967**	**18,757**
EXPENDITURE						
Personal Health	7,852	7,898	46	F	95,470	7,807
Disability Support	254	254	-	F	3,049	254
Mental Health	1,491	1,491	-	F	17,897	1,491
Public Health	13	13	-	F	152	13
Maori Services	9	9	-	F	108	9
Total own provider expenditure	**9,619**	**9,665**	**46**	**F**	**116,676**	**9,574**
Personal Health	3,456	3,617	161	F	42,740	2,829
Disability Support	2,448	2,440	(8)	U	28,754	896
Mental Health	679	681	2	F	8,170	(176)
Public Health	72	75	3	F	896	(23)
Maori Services	211	211	-	F	1,649	(62)
Inter-district Outflow	3,512	3,266	(246)	U	39,198	3,491
Total Other provider expenditure	**10,378**	**10,290**	**(88)**	**U**	**121,407**	**6,955**
Governance	324	324	-	F	3,884	324
Total Expenditure	**20,321**	**20,279**	**(42)**	**U**	**241,967**	**16,853**
Net Surplus / (Deficit)	**(286)**	**(131)**	**(155)**	**U**	**-**	**1,904**

Year-to-date July 2017 Funder Division

- $155k unfavourable variance to budget for the Funder Division
- $46k favourable variance to budget with internal provider (Provider arm). Mainly due to $100k electives wash up wash up with own provider (offset by provider division).
- $88k unfavourable variance with external providers (including IDFs) due to savings budgeted in IDFs not being realised.
- Timing differences of external personal health expenditure is producing a favourable variance in this area.

Outlook for 2017/18 year

- Achieving budgeted IDFs demand remains a risk

7.4.2 Mental health and addictions services (Provider Division)

STATEMENT OF FINANCIAL PERFORMANCE for the period ended July 2017 ($000s)
MENTAL HEALTH CLUSTER

	Month				Year to Date				Annual
	Actual	Budget	Variance		Actual	Budget	Variance		Budget
REVENUE									
Government and Crown agency	2	5	(3)	U	2	5	(3)	U	89
Funder to Provider Revenue (internal)	1,491	1,491	-	F	1,491	1,491	-	F	17,897
Other income	15	14	1	F	15	14	1	F	131
Total Revenue	**1,508**	**1,510**	**(2)**	**U**	**1,508**	**1,510**	**(2)**	**U**	**18,117**
EXPENDITURE									
Personnel	1,097	1,150	53	F	1,097	1,150	53	F	14,259
Personnel Other	10	7	(3)	U	10	7	(3)	U	164
Outsourced Personnel	8	-	(8)	U	8	-	(8)	U	-
Total Personnel Expenditure	**1,115**	**1,157**	**42**	**F**	**1,115**	**1,157**	**42**	**F**	**14,423**
Outsourced Clinical Service	-	1	1	F	-	1	1	F	8
Clinical Supplies	25	25	-	F	25	25	-	F	308
Infrastructure & Non Clinical Supplies Costs	117	125	8	F	117	125	8	F	1,344
Depreciation, Interest & Internal Allocation	359	360	1	F	359	360	1	F	3,107
Total Other Expenditure	**501**	**511**	**10**	**F**	**501**	**511**	**10**	**F**	**4,767**
Total Expenditure	**1,616**	**1,668**	**52**	**F**	**1,616**	**1,668**	**52**	**F**	**19,190**
Net Surplus / (Deficit)	**(108)**	**(158)**	**50**	**F**	**(108)**	**(158)**	**50**	**F**	**(1,073)**
FTEs									
Medical	13.4	13.4	0.0	F	13.4	13.4	0.0	F	13.34
Nursing	100.9	94.0	(6.8)	U	100.9	94.0	(6.8)	U	94.32
Allied	31.2	35.2	4.1	F	31.2	35.2	4.1	F	35.31
Support	-	-	-	F	-	-	-	F	-
Management & Admin	14.7	17.5	2.8	F	14.7	17.5	2.8	F	17.58
Total FTEs	**160.1**	**160.2**	**0.0**	**F**	**160.1**	**160.2**	**0.0**	**F**	**160.6**

Month result

A deficit of $108k is reflected for the month. This is $50k favourable to budget. The main contributor to this favourable variance is personnel and outsourced contractor costs. Nursing costs are over budget due to high volumes in Te Awhina. Higher than normal specialing hours has further increased this unfavourable variance. All other job groups are within budget for the month. Outsourced cost are unfavourable to budget but the offset is a favourable variance under personnel cost. This is the last month of the locums' contract and all medical vacancies are now filled. An over accrual for corporate training from last month has seen the infrastructure cost also reflect a favourable variance.

Outlook and mitigations

The continued vacancies in allied staff will see this favourable variance grow monthly until suitable personnel are recruited to fill the vacancies.

Key risks and mitigations

The implementation of required roles under SACAT legislation are receiving no additional national funding, therefore this will be an unbudgeted cost.

7.4.3 Medical Services including ED, Medical Ward, Critical Care Unit, AT&R (Provider Division)

STATEMENT OF FINANCIAL PERFORMANCE ($000s)
MEDICAL CLUSTER

	Month				Year to Date				Annual
	Actual	Budget	Variance		Actual	Budget	Variance		Budget
REVENUE									
Government and Crown agency	79	104	(25)	U	79	104	(25)	U	1,818
Funder to Provider Revenue (internal)	2,458	2,458	-	F	2,458	2,458	-	F	29,502
Other income	13	11	2	F	13	11	2	F	177
Total Revenue	**2,550**	**2,573**	**(23)**	**U**	**2,550**	**2,573**	**(23)**	**U**	**31,497**
EXPENDITURE									
Personnel	1,466	1,565	99	F	1,466	1,565	99	F	19,404
Personnel Other	21	34	13	F	21	34	13	F	613
Outsourced Personnel	23	19	(4)	U	23	19	(4)	U	226
Total Personnel Expenditure	**1,510**	**1,618**	**108**	**F**	**1,510**	**1,618**	**108**	**F**	**20,243**
Outsourced Clinical Service	4	5	1	F	4	5	1	F	61
Clinical Supplies	259	263	4	F	259	263	4	F	3,130
Infrastructure & Non Clinical Supplies Costs	165	166	1	F	165	166	1	F	1,916
Depreciation, Interest & Internal Allocation	418	418	-	F	418	418	-	F	3,554
Total Other Expenditure	**846**	**852**	**6**	**F**	**846**	**852**	**6**	**F**	**8,661**
Total Expenditure	**2,356**	**2,470**	**114**	**F**	**2,356**	**2,470**	**114**	**F**	**28,904**
Net Surplus / (Deficit)	**194**	**103**	**91**	**F**	**194**	**103**	**91**	**F**	**2,593**
FTEs									
Medical	50.5	52.5	2.1	F	50.5	52.5	2.1	F	52.7
Nursing	131.1	126.1	(4.9)	U	131.1	126.1	(4.9)	U	130.0
Allied	-	-	-	F	-	-	-	F	-
Support	-	-	-	F	-	-	-	F	-
Management & Admin	4.1	3.7	(0.4)	U	4.1	3.7	(0.4)	U	3.7
Total FTEs	**185.6**	**182.4**	**(3.3)**	**U**	**185.6**	**182.4**	**(3.3)**	**U**	**186.3**

Month Result

Presentations to ED, Acute Admissions and high occupancy have all had a large impact in the medical cluster form the month of July, with presentations to ED 20% higher than the same month in the past two years and flow on impact into wards and other services, with occupancy of 123% vs. June 113%. High numbers of presentations for flu like illnesses have come earlier than in previous years and are close to the extreme numbers we experienced in the winter of 2015.

Acute volumes delivered for July have exceeded PVS contract volumes (July 123.17% delivery or 79.48 CWD). For the 17-18 year the 17/18 PVS volumes were aligned with historical actuals, however demand has exceeded previous years. The acute budget is phased on a straight line basis and demand should realign with budgeted volumes once we are out of the winter months,. Correspondingly the wards are also showing high occupancy for the month (July 123% vs. June 113%).

Despite this the Medical Cluster is favourable to budget by $91k, due to reduced costs in in personnel and supply costs, offset slightly by reduced revenue from non-acute inpatient rehabilitation in the AT&R ward.

Revenue

Revenue was lower than average for non-acute inpatient rehabilitation in the AT&R ward, however there is potentially further revenue to come through for 3 patients which will improve the position.

Personnel Costs

Personnel savings were in both Medical and Nursing staff. This was due to the staff mix, with 2.1 FTE reduced medical staff was offset by nursing staffing was 4.9 FTE above budget including 1.5 FTE worked as overtime. Some of these favourable variances are timing related and are not expected to continue in later months.

Clinical Supplies

High acuity and occupancy has increased spending in clinical supplies, in particular treatment disposables. This has been offset by significant reductions in cost in patient transport and overall spend on clinical supplies is within budget.

Outlook and mitigations

Nursing FTE budgets have been re-aligned with the proposed CCDM rosters and there is better alignment with actual worked FTE, despite the busy-ness of the hospital in the month. Close monitoring and active management will be vital to ensure they remain within budget, including redeployment of surplus resources across services during quieter months.

Reduced costs in patient travel are continuing into the new financial year and however any sustained benefits will be quickly impacted by Starship transfers. There is work on a proposed national patient transport service underway and this may impact on resourcing and costs.

Community and Public Health Services including District and Specialist Nursing, Faster Cancer Treatment, Public Health Nurses, Health Promotion and Rural Health Centres

STATEMENT OF FINANCIAL PERFORMANCE ($000s)
PUBLIC HEALTH & COMMUNITY CLUSTER

	Month				Year to Date				Annual
	Actual	Budget	Variance		Actual	Budget	Variance		Budget
REVENUE									
Government and Crown agency	277	285	(8)	U	277	285	(8)	U	1,687
Funder to Provider Revenue (internal)	536	536	-	F	536	536	-	F	6,436
Other income	2	1	1	F	2	1	1	F	14
Total Revenue	**815**	**822**	**(7)**	**U**	**815**	**822**	**(7)**	**U**	**8,137**
EXPENDITURE									
Personnel	385	406	21	F	385	406	21	F	5,046
Personnel Other	5	1	(4)	U	5	1	(4)	U	37
Outsourced Personnel	-	2	2	F	-	2	2	F	24
Total Personnel Expenditure	**390**	**409**	**19**	**F**	**390**	**409**	**19**	**F**	**5,107**
Outsourced Clinical Service	-	-	-	F	-	-	-	F	-
Clinical Supplies	105	117	12	F	105	117	12	F	1,429
Infrastructure & Non Clinical Supplies Costs	42	41	(1)	U	42	41	(1)	U	418
Depreciation, Interest & Internal Allocation	155	155	-	F	155	155	-	F	1,334
Total Other Expenditure	**302**	**313**	**11**	**F**	**302**	**313**	**11**	**F**	**3,181**
Total Expenditure	**692**	**722**	**30**	**F**	**692**	**722**	**30**	**F**	**8,288**
Net Surplus / (Deficit)	**123**	**100**	**23**	**F**	**123**	**100**	**23**	**F**	**(151)**
FTEs									
Medical	0.2	0.3	0.1	F	0.2	0.3	0.1	F	0.29
Nursing	41.8	42.4	0.6	F	41.8	42.4	0.6	F	42.67
Allied	9.2	10.1	0.9	F	9.2	10.1	0.9	F	10.07
Support	0.8	0.9	0.1	F	0.8	0.9	0.1	F	0.89
Management & Admin	10.3	9.4	(1.0)	U	10.3	9.4	(1.0)	U	9.39
Total FTEs	**62.3**	**63.0**	**0.7**	**F**	**62.3**	**63.0**	**0.7**	**F**	**63.3**

Month result

For the month of July 2017 the cluster showed an overall favourable variance of $23k, made up of underspend in personnel and clinical supplies.

Revenue

ACC revenue was $8k unfavourable to budget. This follows the increase of the 2017-18 budget to allow for the maximisation of revenue from the Community Nursing contract, with results expected in the area in coming months.

Personnel

Budgets for the 2017-18 year were realigned with actual FTE levels, and this has resulted in the service being closer to budget as a whole. Public health nursing vacancies are currently being recruited and they are expected to remain below budget until this is complete. Administration staff costs are over budget relating to sick leave and project work.

Clinical Supplies

Clinical supply costs were favourable for the month relating to reduced spend in IV antibiotics due to lower demand. This is not expected to continue through future months.

Outlook and mitigations

Ongoing work in the department is being done to identify consumables used with ACC funded patients and on charging should increase the ACC revenue for the service. Results expected in the later in the year. Staff working within the service will ensure ACC claiming is maximised under the contracts.

Nursing FTE budgets have been realigned to match actual staffing levels for the current year and this will reduce variance to budget from "normal" workload and demand. Administration costs are high due to sick leave and project costs, following the completion of the project these are expected to return to within budget levels for August.

Clinical supply budgets were increased to cope with higher demand levels and it is expected that the current favourable variance to budget will continue.

Allied Health Services including Radiology, Pharmacy, Therapy teams, Dental and outsourced Laboratory

STATEMENT OF FINANCIAL PERFORMANCE for the period ended July 2017 ($000s)
ALLIED HEALTH CLUSTER

	Month				Year to Date				Annual
	Actual	Budget	Variance		Actual	Budget	Variance		Budget
REVENUE									
Government and Crown agency	184	180	4	F	184	180	4	F	2,228
Funder to Provider Revenue (internal)	945	889	56	F	945	889	56	F	10,729
Other income	26	22	4	F	26	22	4	F	397
Total Revenue	**1,155**	**1,091**	**64**	**F**	**1,155**	**1,091**	**64**	**F**	**13,354**
EXPENDITURE									
Personnel	759	779	20	F	759	779	20	F	9,796
Personnel Other	9	6	(3)	U	9	6	(3)	U	172
Outsourced Personnel	63	61	(2)	U	63	61	(2)	U	759
Total Personnel Expenditure	**831**	**846**	**15**	**F**	**831**	**846**	**15**	**F**	**10,727**
Outsourced Clinical Service	393	385	(8)	U	393	385	(8)	U	4,466
Clinical Supplies	189	180	(9)	U	189	180	(9)	U	2,379
Infrastructure & Non Clinical Supplies Costs	74	81	7	F	74	81	7	F	871
Depreciation, Interest & Internal Allocation	322	326	4	F	322	326	4	F	2,827
Total Other Expenditure	**978**	**972**	**(6)**	**U**	**978**	**972**	**(6)**	**U**	**10,543**
Total Expenditure	**1,809**	**1,818**	**9**	**F**	**1,809**	**1,818**	**9**	**F**	**21,270**
Net Surplus / (Deficit)	**(654)**	**(727)**	**73**	**F**	**(654)**	**(727)**	**73**	**F**	**(7,916)**
FTEs									
Medical	1.7	2.4	0.7	F	1.7	2.4	0.7	F	2.4
Nursing	6.0	7.5	1.5	F	6.0	7.5	1.5	F	7.5
Allied	97.6	98.5	0.9	F	97.6	98.5	0.9	F	98.5
Support	0.2	0.2	0.0	F	0.2	0.2	0.0	F	0.2
Management & Admin	17.7	15.2	(2.4)	U	17.7	15.2	(2.4)	U	15.3
Total FTEs	**123.2**	**123.9**	**0.7**	**F**	**123.2**	**123.9**	**0.7**	**F**	**123.9**

Month Result

Overall the Allied health service is favourable to budget by $73K for the month of July.

Revenue

Revenue is reflecting a favourable variance mainly due to dental revenue which has been under accrued over the past few months. This will now be invoiced on a monthly basis, so consistent revenue is captured.

Personnel

Personnel costs are favourable to budget due to reduced costs for medical staff. The favourable variance has been partially offset by increased costs for administration staff due to sick leave and back filling in Radiology and Physiotherapy.

Outsourced Services

Outsourced service costs are unfavourable by $8K due to high levels of outsourcing in dental to reduce waiting lists for patients. This will be offset by increased patient revenue as above.

Clinical Supplies

Clinical supply costs are unfavourable to budget by $9K, relating to increased volumes of orthotic and surgical footwear, and dental supplies due to the restocking of mobile dental caravans. Orthotic costs are under review to ensure value for money in this area

Infrastructure and Depreciation

Infrastructure and depreciation costs are favourable to budget due to reduced costs for equipment and lower than budgeted depreciation costs due to delayed asset purchases.

Outlook and mitigations

Additional Radiology FTEs have been approved in principle to meet demand in the emergency department and for CT scanning. This will impact on the personnel cost budget once recruitment has occurred.

Increased costs in clinical supplies will be monitored, in particular that we are getting value for money in the area of Orthotic and surgical footwear supplies.

7.4.4 Surgical Services (Provider Division)

STATEMENT OF FINANCIAL PERFORMANCE ($000s)
SURGICAL CLUSTER

	Month				Year to Date				Annual
	Actual	Budget	Variance		Actual	Budget	Variance		Budget
REVENUE									
Government and Crown agency	413	376	37	F	413	376	37	F	4,142
Funder to Provider Revenue (internal)	3,740	3,841	(101)	U	3,740	3,841	(101)	U	46,733
Other income	11	16	(5)	U	11	16	(5)	U	151
Total Revenue	**4,164**	**4,233**	**(69)**	**U**	**4,164**	**4,233**	**(69)**	**U**	**51,026**
EXPENDITURE									
Personnel	1,662	1,731	69	F	1,662	1,731	69	F	21,409
Personnel Other	15	26	11	F	15	26	11	F	459
Outsourced Personnel	443	393	(50)	U	443	393	(50)	U	4,703
Total Personnel Expenditure	**2,120**	**2,150**	**30**	**F**	**2,120**	**2,150**	**30**	**F**	**26,571**
Outsourced Clinical Service	174	195	21	F	174	195	21	F	2,121
Clinical Supplies	601	643	42	F	601	643	42	F	7,722
Infrastructure & Non Clinical Supplies Costs	198	200	2	F	198	200	2	F	2,250
Depreciation, Interest & Internal Allocation	652	656	4	F	652	656	4	F	6,072
Total Other Expenditure	**1,625**	**1,694**	**69**	**F**	**1,625**	**1,694**	**69**	**F**	**18,165**
Total Expenditure	**3,745**	**3,844**	**99**	**F**	**3,745**	**3,844**	**99**	**F**	**44,736**
Net Surplus / (Deficit)	**419**	**389**	**30**	**F**	**419**	**389**	**30**	**F**	**6,290**
FTEs									
Medical	24.8	30.4	5.6	F	24.8	30.4	5.6	F	29.95
Nursing	132.1	133.5	1.4	F	132.1	133.5	1.4	F	135.63
Allied	3.2	3.6	0.4	F	3.2	3.6	0.4	F	3.60
Support	12.0	12.1	0.1	F	12.0	12.1	0.1	F	12.07
Management & Admin	29.5	26.6	(2.8)	U	29.5	26.6	(2.8)	U	26.67
Total FTEs	**201.5**	**206.2**	**4.7**	**F**	**201.5**	**206.2**	**4.7**	**F**	**207.9**

Monthly result

Elective volumes for July were 18.22 CWD behind of contracted volumes (93% delivery) primarily due to ophthalmology (vacancies), ENT (leave taken during the month) and urology (reduced sessions). Acute volumes dropped slightly, below the PVS by 2.87 CWD or 99% delivery (under delivery primarily acute orthopaedics due to leave).

Surgical Cluster is $30k favourable for the month, which is the result of a combination of; savings in personnel and clinical supply costs, additional other revenue offset by significant shortfalls in internal revenue.

Revenue

- Elective volumes are likely to recover providing an ophthalmologist is sourced. A six month locum is due to commence in October
- ESPI patient flow indicator compliance is important to ensure at risk elective revenue is not compromised. In July ESPIs were non-compliant as ophthalmology had a backlog of FSA's waiting to be seen. It is anticipated that with the locum resource secured in August that ESPI compliance will be achieved in August
- Inter district flow revenue. Waikato contract documents have not been received. Enquiries on progress have been made, awaiting a reply.

Personnel costs

Savings in personnel are due to vacancies (including SMO's), partial implementation of CCDM proposed nursing rosters, lower training, courses and conferences and SMO overtime than budgeted and reduced ACC contractor costs due to an over accrual at 16/17 FY end.

Clinic Supplies

Clinical supply cost savings were mainly in implants and prostheses (less acute Orthopaedic CWD and mix of procedures undertaken). Increased other revenue was derived from ACC assessments and implants delivered on-site. Offsetting against these savings are a high use of locums (especially Obstetrics and Gynaecology, Orthopaedics and Ophthalmology) and a significant shortfall in internal revenue (under delivery of elective volumes against the PVS - all specialties except General Surgical and Orthopaedics).

Year to date

As this is the first month of the new financial year please refer to comments above.

Outlook and mitigations

The focus for the surgical cluster to manage clinical supplies and doctor / locum costs within the budget set will remain key in 17/18. Clinical supplies in theatre will again be a risk area with the 17/18 budget factoring in cost savings of $150k (standardisation improvements through Health Alliance and Pharmac). At present Doctor / locum costs are being contained within budget due to vacancies. As such if these vacancies were to be filled locum costs could put pressure on the budget if they continue at a level similar to current. Clinical supplies have started the year favourable to budget, mainly in implants and prostheses. These will be subject to changes based on volumes going forward. Acute volumes have dropped slightly in July, however have been trending higher. It is expected elective volumes will continue to at risk with the urology service redesign and vacancies in ophthalmology (which are proving difficult to fill). Non-CWD PVS lines were well below target volumes for 16/17 FY, especially Colonoscopy and Cystoscopy. Future resources for colonoscopy is being discussed with the medical resourcing unit. CCDM recommended nursing FTE levels are budgeted in 17/18 (Surgical Ward) which should help mitigate the risk of overruns experienced in 16/17 FY, however closely monitoring and actively managing nursing FTE remains vital to ensure these costs are contained.

8 Information papers

Attachment	Description	Page 77
1	**Annual Plan focus area:** **Equitable access to clinical services | Mental health and addictions** 1.2 Quality improvement and service development update 1.3 Wellbeing model and proposed model of care presentation 1.4 Mental Health Social Investment Fund	 79 87 97
2	**Annual Plan Focus Area:** **Improving equity for priority populations | All of population initiatives, including prevention and management of long term conditions** 2.1 Access to primary care and acute demand	 111
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Attachment 1.2

WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

MENTAL HEALTH & ADDICTIONS SERVICES

STRATEGIC PLAN

2016 - 2020

OUR VISION & PURPOSE

Whanganui District Health Board's objective is to achieve:

'Better health and independence
He hauora pai ake, he rangatiratanga'
through integrity - fairness - looking forward - innovation'.

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

What is the most important thing in the world?
It is the people, it is the people, it is the people.

CONTENTS

4 WHO WE ARE

Mental Health and Addictions Services are available for people of all ages with each of the services focusing on different aspects of assessment, treatment and care for those eligible people and their families/whānau who are most seriously affected by mental illness or addiction.

5 OUR VALUES

- Working together
- Hope & recovery - we believe resiliency and meaningful recovery is possible for everyone
- Openness & transparency
- An outcome focus

5 OUR PRIORITIES

- Improve people's mental health and wellbeing
- Reduce harm caused by alcohol and other drugs
- Improve integration across primary/secondary and social sector agencies
- Improve service delivery

WHO WE ARE

Mental Health and Addictions Services (MH&AS) are available for people of all ages with each of the services focusing on different aspects of the mental health and illness continuum. Specialist Mental Health and Addictions Services are delivered to those eligible people who are most seriously affected by mental illness or addiction.

Specialist services provided include:

- Infant, Child and Adolescent Mental Health and Addictions (SUPP) Services (ICAMHAS)
- Community Mental Health and Addictions Services (urban & rural)
- Mental Health Assessment & Home Treatment (MHAHT)
- Te Awhina (acute adult inpatient unit)
- Stanford House (regional forensic rehabilitation).

The range of services provided by highly skilled multidisciplinary teams include assessment, diagnosis, treatment and care (including a strong therapy, family/whānau system based approach) and rehabilitation, as well as urgent response when needed. The multidisciplinary team include senior medical officers, registrars, resident medical officers, nurses, occupational therapists, psychologists, social workers, alcohol and other drug clinicians, and support/youth workers. The teams are supported by a consumer and family advisor, peer support and Haumoana (cultural advisors). Whanganui DHB MH&AS aim to support recovery and reduce the impact of mental illness and reduce harm caused by drug and alcohol dependency or addiction through a person/family-centred whole of health approach.

Services are based on the hospital grounds or in rural health centres but have a place-based approach so that people can be seen where they are most comfortable. Although the specialist service is funded to provide services to a small percentage of those in the population with high levels of need, the imperative for early intervention and to provide consultation and support to other providers is well understood.

In addition to the provision of specialist assessment and interventions, the Whanganui DHB MH&AS aim to strengthen connections across the mental health sector, primary care and the social sector. Whanganui DHB MH&AS utilise population health approaches acknowledging the importance of social determinants including housing, employment, physical health, social connectedness and participation all have a significant impact on mental health and wellbeing. It is unlikely that any single provider will deliver the full range of services, therefore all services in the mental health and addiction and social sector must work collaboratively and cooperatively to provide a well-integrated and seamless continuum of care.

OUR VALUES

WORKING TOGETHER

- We are committed to working with service users/tangata whaiora, family/whānau, staff and cross-sector partners to co-design and produce the best possible mental health and addictions services for our community.
- We value the views of others and respect diversity of views and culture.

OPENNESS & TRANSPARENCY

- We encourage sharing of information in a just culture so we can identify best practice to learn from our successes and mistakes.

AN OUTCOME FOCUS

- We want the best outcomes for people who use our services, their family/whānau, our staff and our cross-sector partners.
- We value and already seek service user/tangata and family/whānau feedback.
- We measure successes and areas for improvement, respond then share findings.
- We use the best available evidence as the basis of care.

OUR PRIORITIES

PRIORITY AREA ONE:
IMPROVE PEOPLE'S MENTAL HEALTH AND WELLBEING

FOCUS

- A whole-of-person wellness model underpins the service.
- Social determinants approach to health and wellbeing.
- Increase range of therapeutic interventions available to people and their families/whānau accessing services.
- Trauma informed/wellbeing models of care inform service delivery.
- Self care/management tools are readily available to the community.
- Health promotion strengthens wellbeing and resilience.
- Operationalise Supporting Parents Healthy Children Plan.

OUTCOMES

- People have improved access to housing and employment options.
- People receive the physical health care they need and have equity of outcomes.
- Specialist services workforce act at top of scope and have a range of therapeutic modality skills.
- Alternatives to pharmacological interventions are strengthened.
- Technology supports people to access information and support for their mental health.
- Youth navigators are trained to support young people to seek help when needed.
- A family/whānau-centred approach supports people in parenting.
- Key focus on infant attachment.

PRIORITIES continued

PRIORITY AREA TWO:
REDUCE HARM CAUSED BY ALCOHOL & OTHER DRUGS

FOCUS

- Develop CEP capable systems and workforce.
- Early identification and interventions are available; particularly for youth and pregnant women.
- Health promotion and messaging occurs to reduce harmful usage.

OUTCOMES

- People are routinely screened for problematic alcohol and drug usage.
- Shared suite of screening tools across primary/secondary services.
- Screening and access rates increase.
- A range of specialist therapeutic interventions are available to the community.

PRIORITY AREA THREE:
IMPROVE INTEGRATION ACROSS PRIMARY/SECONDARY & SOCIAL SECTOR AGENCIES

FOCUS

- Revise model of care across the whole system.
- Operationalise the health strategy principles.
- Provide place based care.
- Build confidence and capability of primary care/NGO providers.

OUTCOMES

- A services directory is available to the community.
- Map of Medicine pathway guides primary practice to most appropriate referral source.
- Standardised screening tools support triage and referral responses.
- Revised model smooths bumps as people travel through stepped care continuum.
- Primary and NGO practice have established links and relationships with specialist teams.
- Supervision, education and caseload review occurs between primary/NGO/secondary providers.
- Workforce pathways support the development of nurse/allied specialists including a prescribing nurse practitioner.

PRIORITY AREA FOUR:
IMPROVE SERVICE DELIVERY

FOCUS

- Effective suicide prevention and postvention.
- Violence Intervention Programme identifies and intervene for at-risk people.
- Systems are reviewed to support effective, reliable high quality care is provided and outcomes are measured.
- Services are developed and improved based on outcomes and evidence.
- Supporting Parents Healthy Children (formerly COPMIA).
- Reporting is transparent.
- The workforce is supported to work at top of scope.
- Services are developed and improved based on outcomes and evidence.

OUTCOMES

- Sector-wide suicide governance group oversees implementation and reporting on plan.
- Suicide prevention workshops increase community resilience and help-seeking.
- Suicides are reduced in our community.
- People are well supported in postvention and risk of contagion is minimised.
- Clinical, administrative and IT systems support people to do their work at top of scope.
- Capacity and demand are well-matched.
- Workforce development continues in key areas and continues to support high quality specialist therapeutic interventions.
- Releasing Time To Care programme continues.
- Outcomes are measured, reported on and service improvement is based on a range of data which includes people's experiences.
- People are screened and supported to prevent harm from domestic violence.
- Feedback is made available through a number of reporting mechanisms across the organisation and to people using services.

MENTAL HEALTH & ADDICTIONS SERVICES

STRATEGIC PLAN

2016 - 2020

Report to accompany presentation
Whanganui District Health Board (WDHB)
Combined Committee Meeting
1 September 2017

This is a presentation to the combined committee as an update on activity being undertaken in primary and secondary care to improve our response to mental health and addictions.

Nationally there is growing call for action and change. It is hoped that the presentations and discussions today help provide assurance that we are well placed as a region to respond to, and be at the forefront of a shift in approach for Mental Health and Addictions , with Whanganui Rising to the Challenge framing a life course approach.

Abstract from: Toward a Whole of Government/Whole of Nation Approach to Mental Health
May 22 2017

OFFICE OF THE PRIME MINISTER'S CHIEF SCIENCE ADVISOR
Professor Sir Peter Gluckman, ONZ KNZM FRSNZ FMedSci FRS
Chief Science Advisor

At present, the structure in New Zealand for treating mental disorder and supporting mental health is neither optimal nor working well. There are at least six reasons for this:

1. we do not, as a society, grasp the extent and severity of the problem;
2. the context of the way we live our lives as a society has changed and that imposes a greater burden on our mental health resilience
3. although we understand that all parts of the social sector deal with the fallout from this systemic insufficiency, we have not built a whole-of government response;
4. we do not recognize or treat many of those who need it;
5. when we do treat, we do not always use the right approach;
6. we do not pay enough attention to prevention and early intervention and the maintenance of mental health.

However, we have the understanding to design and build a new structure that is enabled by the social investment approach. The new structure will involve all social-sector ministries, because they not only deal with the consequences of the broken system, they are also part of the solution – and some of the needed resources are already in place.

What is needed is:

1. the bringing together of those pieces into a coherent whole;
2. an understanding that mental health is not just a health problem;
3. upgrading skills and building new capacity across the sector;
4. a focus on prevention, early detection, and better treatment;
5. an understanding of the life course and its implications for mental health;
6. active consideration of those contextual levers that can be reached;
7. Time

Background – Whanganui Rising to the Challenge

In late 2014 work began on a project applying the principles framed by 'Whanganui Rising to the Challenge – The Mental Health and Addiction Service Framework 2014'. The framework was developed in 2013 and 2014 as a regional response to 'Rising to the Challenge – The Ministry of Health Mental and Addiction Service Development Plan 2012 -2017'.

The vision proposed by the framework '*That the people of the Whanganui region understand, value and promote mental health and wellbeing, possess the knowledge and resilience to weather adversity and where necessary have access to excellent mental health and addiction services that are recovery focused and provide hope'* is significant in scope and aspiration and extends beyond Mental Health and Addiction services into a range of social, public health and general health services. The framework forms an interconnected improvement and change narrative with eight elements supported by various mechanisms for change. The proposed changes are in line with all national strategy including the NZ Health Strategy, On Track and Fit For the Future.

*"The true lifetime prevalence rates of mental illness are much higher than many people assume: **more than half the population are likely to experience a disorder at least once in their lives**. The 12-month prevalence is approximately 20%; in other words, in any one year, one in five New Zealanders will present with a mental disorder that sufficiently impairs their lives to warrant intervention" MoH 2017*

While the Rising to the Challenge document is currently under review, there are activities underway which continue to aspire to the vision and intent of the original framework.

This large scale change project aims to provide continuity, and an integrated approach across primary and secondary care.

PART 1: WELLBEING APPROACH

Whanganui Regional Health Network (WRHN) and the WDHB

Presenters:
Alex Loggie – Adult Work stream Co-lead (WDHB)
Chloe Mercer – Contracts Manager-Project co-lead (WRHN)

During 2015 the Adult Work Stream of Whanganui Rising to the Challenge (WRTTC) identified a selection of process improvements relating to key drivers of change. There were a number of small improvements trialled, and while there were learnings they were not a complete, integrated solution.

To achieve the infrastructure and culture change, with an initial focus on primary care, it was agreed that full systems approach needed to be taken; and that development should encompass the priority areas and goals which straddle key local and national strategic frameworks these included:

- Person centred approach
- Social determinant inclusive

- Involves community/ co-design
- Health not disease focused
- Applies principles of Self-Management

The platform for change was the development of a collaborative pathway and associated Advanced Forms/decision support tools for general practice teams. Advanced forms are dynamic, Patient Management System (PMS) integrated tools.

A modular format was designed, which aimed to be flexible to practitioner workflow and the multiple entry point of patients, while also ensuring a structured and consistent approach to screening, referral and management.

The tools itself were developed within a care plan, with the completion of modules helping to create the plan which can be printed and provided to the patient.

There are seven other components/modules which interact with each other. The graphic is what is seen by the general practice team and clicking on any one of the modules opens up options siting underneath. The components are:

- **Identification** of at risk population and prompt system for review of activity within the care plan. (Patient Dashboard link)
- **Te Whare Tapa Whā** framework for consideration of context for presentations.
- **Core Screening Module**
- **Live-well assessment** and change module (Generic could be used in all health pathways)
- **Clinical module** which includes integration of existing metabolic screening module and link to pathwat
- **Referral directory** and standardised referral document includes live database and enables electronic referral [second phase of development currently underway]
- **Built-in Patient and clinician evaluation**

Framing the tools is a Collaborative Pathway which provides detailed information for clinicians.

Not just tools, but a change in model

The original development of modular tools is complete, and the team has shifted in to a longer term programme of work to change the model of care and implement all elements of change.

The Wellbeing Approach is a holistic, person centred model underpinned by the stepped-care approach.

It aims to:

- Provide a connected and seamless approach which also considers wider supportive environment (health literacy and health promotion).
- acknowledges the complex interactions between biological, psychological and social factors
- acknowledges that those whom have had a diagnosed mental health disorder face major health inequities and systematic approach is required to improve outcomes

Stepped care involves:

1. Providing different types of interventions and therapies of varying intensity to meet different levels of complexity and severity
2. Processes for matching a person to the step that will best meet their needs
3. Identifying when a person's needs are not being met at their current step, and changing steps up or down accordingly.

The Wellbeing Modules

The Wellbeing Module(s) have been designed to support the implementation of the stepped-care model within the local context, while also providing generic tools which can be used in other pathways including long term conditions with the aim of;

Increase in early identification of problems through consistent and appropriate use of screening tools:

- Providing an assessment and care planning framework
- Increasing access and knowledge of web based support, information and e-therapy
- Increase knowledge and use of MH and Addictions referral pathways.
- Support the development and recording of care plans/ packages of care for primary care patients
- Design of care underpinned by self-management principles

As a care coordination tool the wellbeing modules:

- Provide a central directory to support access to a wide range of services and resources
- Provide a consistent standard of referral
- Supports a decrease in unnecessary, inappropriate or incomplete referrals
- Supports electronic referral to all WRHN services – with the aim of future integration with the WDHB and NGOs.

Use of the wellbeing modules aligns with the Health Promoting Practices framework.

Supporting self-management

Developing self-management skills in our community is a core component of the Wellbeing Approach. 'Self-management' refers to any way in which a person manages their condition/health by themselves. Learning and practising self-management is an ongoing process; it is not achieved in a single step. Self-management is a continuum of learning experiences and opportunities, where a person with a Long Term Condition and their family and whānau work in collaboration with carers and health professionals.'

Self-management is about enabling people ...to 'make informed choices, to adapt new perspectives and generic skills that can be applied to new problems as they arise, to practice new health behaviours, and to maintain or regain emotional stability' (Lorig 1993).,

Supported Self-management can be a clinically effective and a cost effective option for many people and as such is an important treatment tool within a stepped care approach to health including primary mental health and addictions.

Coordination and point of entry

It has been identified that there is a need for ease of access to information about support and service options with supporting smart systems which facilitate electronic referral.

The Wellbeing Approach focuses on ensuring that practices know and understand the criteria for accessing a wide range of services and options, including online and e-therapy.

A 'Wellbeing Facilitator' role provides a central point of access to most counsellors, and can also support general practice with different options available. It is anticipated that this model will improve knowledge of and confidence in accessing alternative appropriate options to best meet the needs of the client.

Change in Funding Model

The model of care was to be implemented within existing funding with the hope that more funding becomes available as obvious need is identified. This will require changes to the funding model and mechanisms.

Historically Primary Care Mental Health Initiative (PCMIHI) funding has been used for counsellor and social worker. A new funding model, particularly increase in access to extended consultations, represents a significant change and sustainability of costs will only occur once general practice teams are able to deliver components of support within practices. There will be cross over costs as we transition from employed staff with a recognised risk of overspend in the transition year.

Workforce development

Workforce development is a pivotal component of embedding the 'Wellbeing Model' and ensuring that the primary care workforce are capable and confident. It is also pivotal in creating effective integration between primary and secondary care which will be discussed in the Network Model. To support workforce development the WDHB have developed and funded a Primary care workforce development role. This does not fully cover cost of workforce development, i.e. release time for nurses, but is positive start.

Focussing on building capacity and capability will also allow us to grow a workforce who are integrated in primary care teams and can provide 'close to home' support in a setting which patients are comfortable in.

In addition to all clinicians being trained in core competencies, the WRHN/WDHB led initiative would support practice development for nurse credentialing utilising the Te Ao Māramatanga New Zealand College of Mental Health Nurses Mental Health and Addictions Credential in Primary Care. This will be be available to practice nurses who would want to have an advanced level of primary care mental health and addictions practice, and education modules will be available to the wider workforce.

The overall nursing objectives are:

- To routinely screen for and recognise signs of depression, anxiety, addiction and harmful substance use in people.
- To feel confident talking to and supporting people with signs of depression, anxiety, addiction and harmful substance use. This includes feeling confident about inquiring about and addressing concerns about risk. To include screening, brief assessment and interventions, ongoing monitoring (psychosocial, physical, and pharmacological), and promoting self-management strategies within daily practice.
- To be familiar with referral pathways within communities that are culturally appropriate, and meet the needs of individuals, families and whānau.
- To understand the concepts of recovery and wellbeing
- To incorporate the principles of a motivational approach within therapeutic relationships.
- To understand societal influences that impact on people's mental health and journeys of recovery including stigma and discrimination

Alignment with this credentialing framework will support the implementation of the Wellbeing Approach and Network Model and is consistent with goals to:

- Increase recognition and screening of mental health and addictions in primary care
- Provide advice and brief interventions
- Develop health and wellbeing care plans
- Provide structured follow up and support
- Enable high quality electronic referral

PART 2: NETWORK MODEL – Community Mental Health and Addictions Services

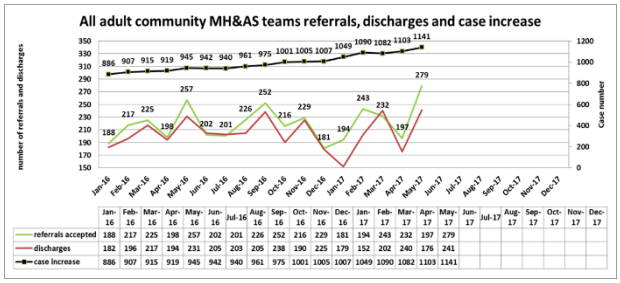
Presenters: Dr Gordon Lehany – Medical Director (WDHB) Kath Butters – Nurse Manager (WDHB)

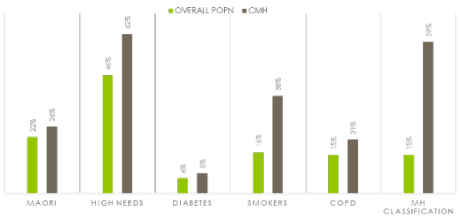
As previously reported to the committee development work on a model to reconfigure the current Specialist Community Mental Health Model of Care (MoC) to an expanded 'one team' network model delivering care 'closer to home' has been underway for some time, and while there has been a delay for a number of reasons there is now a strong focus and commitment to achieving the change.

Background

There has been no significant change in the service structure, and underpinning MoC for the Whanganui Community Mental Health and Addictions Service for some time, and there are some key indicators that a change is necessary to enable a service which can adapt best support the needs of our community.

At a service level these include An over provision of service with CMH and Addictions service filling gaps in community based support for people whom are below the threshold for specialist services. This has contributed to high, and growing caseloads and highly skilled staff not working at top of their scope. There are some core processes which are not as efficient or as effective as they could be, including transition planning between secondary and primary care. There is also no clear strategy between mental health and physical health, but as is evident in national data there is higher exposure to risk factors, and burden of chronic illness in the population accessing specialist services.





Nationally and internationally There is growing conversation and evidence around the need for change to address; increased need and access to mental health and addictions services, poor health outcomes for people whom have long-term mental health and addictions problems, high suicide rates as well as a lack of consistency and quality across services.

Some of the key themes include

Evidence and social determinant based approaches need to be used

- Complex-social problems which cannot be solved by any one entity
- Fragmentation causes frustration, and change needs to be built on strong relationships and ongoing communication
- Physical health needs (including social and spiritual) need to be addressed alongside mental health

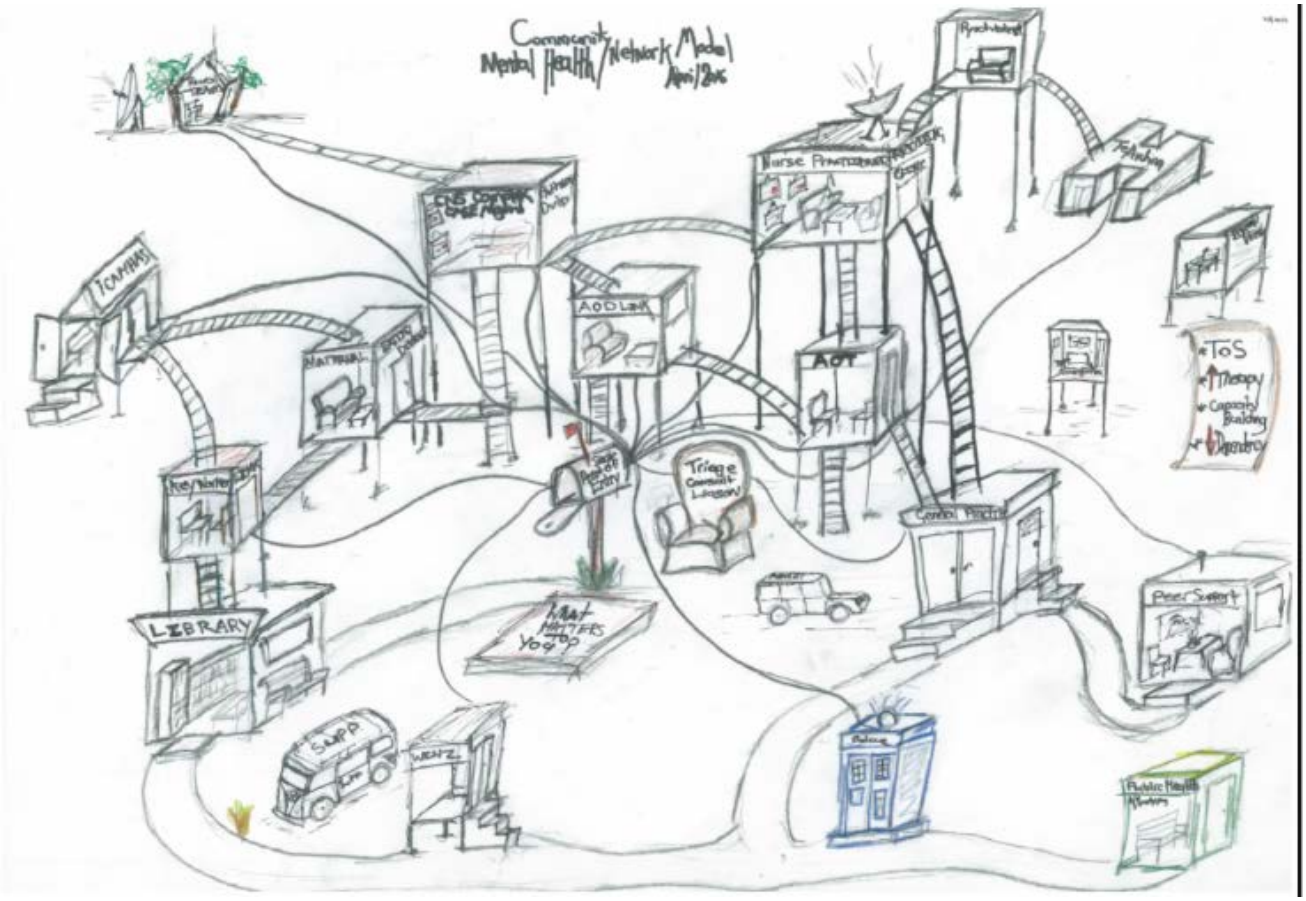
The WDHB is committed to improving and evolving its service and considerable work has been put into developing a quality improvement culture across the system, and within the organisation which steads it well for implementing the changes. However the service is also aware that the change cannot be achieved alone and a partnership approach will need be taken.

The aim of this work is to develop and implement a revised the adult mental health and addictions MoC, and develop an approach which is fit for the future and integrated with primary care and the community. The implementation of the Network Model will create deep and sustainable change for the service and its partners and most importantly will improve outcomes and experience for service users and their whanau/family.

It is proposed under this plan that a Network Model of care will be developed in a phased approach, starting with integration with general practice.

What is the Network Model?

The Network Model will allow for support within the local community and the services that are present, with MH&AS hub team providing linkages to health and social services as well as providing direct care. The model will be designed and adapted to ensure that specialist support services are available either as providers of care or for advice and support to other providers, to increase the capability and capacity of primary care providers to provide care to their patient group. To be successful the model is reliant on the networking and relationship skills of the key points of contact.



It is envisaged that there will be hub teams which will be aligned to general practice populations, and will also be networked to pharmacy, NGO and other resources and support in the community. This will occur across the WDHB region, but it is noted that as a natural result of rurality, rural areas have partial development of this model.

The below is an example of what Network teams could be constructed in terms of general practice groupings. Whanganui Accident and Medical will also be included in a team, and consideration will need to be given to Youth Services Trust and education institutions where there may be a higher number of non-enrolled persons. Administration and coordination functions will expand to deliberate coordination and networking with police, ambulance and social agencies etc.

A model built on relationships

The ability to build collegial and high trust relationships with primary care providers and community services will be key to ensuring that the bumps and barriers inherent in the health system are smoothed as far as possible for tangata whaiora and their families. The links required to achieve this extend beyond health providers to key social and community settings.

The relationship with government agencies such as the police, probation service and Oranga Tamariki will also be critical over time, as are NGO providers and community resources such as pharmacies, schools and libraries. In taking a whole of system approach the intent is to move towards addressing the social determinants of health which are the conditions in which people are born, grow, live, work and age that impact health and wellbeing.

Goals and objectives

To revise the adult mental health model of care, and develop an approach which is fit for the future and integrated with primary care and the community. The objectives are:

Partnership approach taken to developing the model of care through open consultation and communication.

- Service users their family/whanau, General practice, NGO service providers, Social agencies and staff are involved during all phases.
- Primary care teams feel supported and engaged (change occurs with, not to)

The model of care is transparent, and creates consistency and standardisation, reduces variation whilst remaining adaptable to the needs of service users.

- Role's and responsibilities are clear
- Model underpinned by the stepped care approach
- All key components of the service user pathway are reviewed and streamlined where require

Single point of entry functions effectively as a doorway to service(s)

- Clear access criteria
- Coordinates access to other services and does not slow down access to service

Workforce development is aligned to the model and strengthens all elements

- Specialist services are enabled to work top of scope
- Support improvement of capability and capacity in primary care
- Care occurs within a Co Existing Problem (CEP) Framework - cogniscent of social determinants, physical health and co-existing problems

Benefits

There are a broad range of anticipated improvement outcomes from this work but the key expected benefits are:

- Service users and family/whanau experience a connected and easy to navigate mental health and addiction system which is there to support them when they need it ; and which builds personal and community resilience
- There will be improved transitions of care and communication between providers (one plan)
- There will be reduced fragmentation of primary/secondary and physical/mental health and addictions
- There will be Improved relationship sat at an organisational and individual level
- Increased capability and confidence in primary and NGO system
- Sustainable case loads and service
- Focus on supporting primary care to enable identification of risk and early intervention.

Timeframes

Phase	Start	End
Initiation, engagement and development of outcome framework.	August 2017	October 2017
Development of model, processes and business case.	October 2017	February 2018
Implementation	February 2018	May 2018
Sustainability and evaluation	June 18	On going

Mental Health Social Investment Fund

	Proposal	Description	Approx. cost
Distance and e-therapy			**$10 million**
1	**Enhanced e-therapy options for pre-teens, adolescents and young adults**	This investment will support a package of pilots designed to enhance the effectiveness, responsiveness and reach of e-therapy options for pre-teens, adolescents and young adults, in particular Māori and Pacific youth. Science Advisors and others will undertake an assessment of the current service coverage/gaps and the range of e-therapy approaches and products available to inform the design of a complementary package of e-therapy initiatives. <u>Impact:</u> E-therapy and distance therapy offer the potential to transform mental health services through the delivery of effective services in convenient, easy to access formats, using the Internet and telephone services. The electronic delivery of therapy and other programmes focused on improving mental health has a strong evidence base, particularly delivery of Cognitive Behavioural Therapy (CBT)-based therapies for people experiencing anxiety and depressive disorders. A systematic review of computerised anxiety and depression interventions for young people found that 60 per cent of anxiety and 83 per cent of depression programmes improved at least one outcome measure.[1] Evaluations of SPARX concluded that the programme led to a "…clinically significant reduction in depression, anxiety, and hopelessness and an improvement in quality of life"[2], and found that approximately half of users felt SPARX had helped them improve their wellbeing (54 per cent) and their ability to manage their own wellbeing (62 per cent).[3] In addition to these outcomes, enhancing e-therapy options for young people is expected to impact positively on educational achievement and employment outcomes; to reduce future use of health and social services; and to reduce the likelihood of justice sector interactions.	
2	**E-therapy for young prisoners**	This proposal will provide prisoners under the age of 25, and with a diagnosed mild to moderate mental health need, with access to e-therapies in their cells or in prisons' computer suites. This initiative is intended to provide a more tailored response to the mental health needs of young prisoners by overcoming the traditional barriers to treatment imposed by lengthy periods of cell-time.	

[1] Christensen H et al (2010) *Community-based prevention programmes for anxiety and depression in youth: a systematic review*. Journal of Primary Prevention: 31: 139-170. (cited in D'Arcy and Meng, 2014)
[2] Merry S, Stasiak K, Shepherd M, Frampton C, Fleming T, Lucassen M (2012). The effectiveness of SPARX, a computerised self-help intervention for adolescents seeking help for depression: randomised controlled non-inferiority trial, BMJ 2012;344:e2598.
[3] Malatest International (February 2016). *Evaluation of SPARX.* https://www.health.govt.nz/system/files/documents/publications/evaluation-sparx-dec16.pdf.

	Proposal	Description	Approx. cost
		Impact: There is little evidence around the specific use of e-therapy with young prisoners, but we know for youth in prison to effectively engage in rehabilitation, it is important for them to overcome barriers that could undermine the treatment gains. For a number of these young people, mild to moderate mental health needs are a barrier to effective rehabilitation. By increasing access to services that address mild to moderate mental health needs for this population through e-therapy, it is expected to see an increase in mental well-being and better rehabilitation results, which in turn would contribute to reduced re-offending and improved life outcomes.	
3	**Package of tailored telehealth pilots**	It is proposed to design and pilot innovative, tailored telehealth initiatives for adolescents and adults with mild to moderate mental health needs, with a proposed focus on those who face access barriers to traditional support (e.g. rural communities); follow-up following suicide attempts; and addiction support. The design of the package will need to be considered in the context of the broader package of electronic and distance therapy initiatives, to investigate integrating self-directed help through e-therapy with follow-up via tailored telehealth services. Impact: There is a strong international evidence base for the effectiveness of distance therapy, compared to face-to-face therapy. Research shows that distance therapy reduces financial, physical, geographic and psychological barriers[4]; can improve adherence/completion rates[5]; and results in higher self-disclosure and stronger relationships with therapists.[6] It is expected that this will lead to better overall health and wellbeing outcomes for clients, including greater resilience, coping skills and ability for self-management; with flow-on impacts including reduced acute/unplanned care; improved educational, employment (including productivity) and housing outcomes; and reduced future use of health, social and justice services. Further testing is needed to evaluate the potential impacts of integrating self-directed help through e-therapy with follow-up via tailored telehealth services.	

[4] Bouchard S[1], Paquin B, Payeur R, Allard M, Rivard V, Fournier T, Renaud P, Lapierre J. Delivering cognitive-behavior therapy for panic disorder with agoraphobia in videoconference. Telemed J E Health. 2004 Spring;10(1):13-25.
Swinton JJ[1], Robinson WD, Bischoff RJ. Telehealth and rural depression: physician and patient perspectives. Fam Syst Health. 2009 Jun;27(2):172-82.
Taylor TK[1], Webster-Stratton C, Feil EG, Broadbent B, Widdop CS, Severson HH. Computer-based intervention with coaching: an example using the Incredible Years program. Cogn Behav Ther. 2008;37(4):233-46.
Lingley-Pottie P[1], McGrath PJ. Telehealth: a child and family-friendly approach to mental health-care reform. J Telemed Telecare. 2008;14(5):225-6.
Beattie A[1], Shaw A, Kaur S, Kessler D. Primary-care patients' expectations and experiences of online cognitive behavioural therapy for depression: a qualitative study. Health Expect. 2009 Mar;12(1):45-59.
[5] David C. Mohr, PhD, Joyce Ho, PhD, Jenna Duffecy, PhD, Douglas Reifler, MD, Lesile Sokol, PhD, Nichelle Nicole Burns, PhD, Ling Jin, MS, and Juned Siddique, DrPH. Effect of Telephone-Administered vs Face-to-face Cognitive Behavioral Therapy on Adherence to Therapy and Depression Outcomes Among Primary Care Patients: A Randomized Trial. JAMA. 2012 Jun 6; 307(21): 2278–2285.
[6] Lingley-Pottie, P., Ph.D., & McGrath, P. J., Ph.D. (2013). Barriers to mental health care: Perceived delivery system differences. Advances in Nursing Science, 36(1), 51-61.

	Proposal	Description	Approx. cost
4	**Ensuring support and follow-up for those who attempt suicide**	This proposal is to pilot a package of initiatives to ensure support and follow-up for those who have attempted suicide or are at risk of taking their own lives. People who attempt suicide or are at risk of suicide may present to various services or agencies for reasons unrelated to self-harm or suicide attempts, providing opportunities to improve identification of people at risk of suicide in various settings. There is a range of existing services available that people who have attempted suicide or people who are at risk of taking their own life can be referred to; however, there are some people for whom these services are not accessible or appropriate, and for whom other forms of support may need to be explored. The detailed design of the package of initiatives will consider population groups for whom alternative approaches may need to be trialled, e.g. rural communities, Māori and young people. There is also a gap in follow-up for people who have attempted suicide or are at risk of suicide. In the absence of follow-up support, some may have an increased risk of subsequent suicidal behaviour. This package will consider options to: • improve the identification of people at risk of taking their own life in a range of settings, e.g. general practice, Police, ambulance services and emergency departments; • pilot alternative or additional forms of support for people who have attempted suicide or are at risk of suicide, for whom existing services are not appropriate, acceptable or effective; and • pilot of a range of methods of follow-up to provide ongoing support for people who have attempted suicide or are at risk of suicide (e.g. routine referral following suicide attempts to ongoing support, follow-up phone calls/text messages, app-based follow-up and/or phone-based talking therapies including CBT or brief problem-solving therapy), with ongoing support available for at least one year. <u>Impact:</u> There is evidence to support the benefits of screening for suicide risk, particularly in primary care and emergency department settings.[7] However, more work is needed to identify what method of screening is most effective.[8] There is also evidence that follow-up, particularly after discharge can reduce subsequent suicidal behaviour. [9] Further testing is needed to determine whether and what methods of follow-up is beneficial in a New Zealand context. Being able to identify more people who are at risk of taking their own life, and ensuring people who have attempted suicide or are at risk of taking their own life receive support and follow-up, has the potential to improve the wellbeing of those individuals and prevent suicide. This will also likely have beneficial impacts on those around the person, such as their whānau, friends and colleagues.	$5 million

[7] A rapid review of the suicide prevention literature. 2016. *A report produced for the Ministry of Health*. URL: www.health.govt.nz/system/files/documents/pages/rapid-review-suicide-prevention-literature-dec16.docx.
[8] Zalsman G, Hawton K, Wasserman D, et al. 2016. Suicide prevention strategies revisited: 10-year systematic review. *Lancet Psychiatry*, 3(7), 646-59. doi: 10.1016/S2215-0366(16)30030-X.
[9] A rapid review of the suicide prevention literature. 2016. *A report produced for the Ministry of Health*. URL: www.health.govt.nz/system/files/documents/pages/rapid-review-suicide-prevention-literature-dec16.docx.

	Proposal	Description	Approx. cost

5	**Expanding and enhancing primary and community mental health and addiction care**	We know there are capacity constraints and gaps in services for people with mental health needs, particularly those whose needs are not easily managed by GPs but who do not meet the threshold for specialist services. This can result in mental health needs going unidentified and unaddressed, and eventually escalating to a level that does require specialist intervention. This is supported by anecdotal evidence suggesting that people are sometimes left to wait for issues to worsen before they can get help.
		System transformation is needed to shift more focus to early intervention and prevention to stem the flow of future demand for mental health services, but we also need to improve the way we respond to people who have mental health needs now, particularly in primary and community service settings.
		Responding to current challenges requires a strong and capable primary health workforce and an enhanced community workforce to support the focus on prevention, self-care and care closer to home. The mental health and addiction workforce also includes a diverse range of people working in a number of different settings.
		This investment will enhance and expand primary and community mental health services (with an initial focus on children, adolescents and young people) and will trial new service models for primary and community mental health and addiction care. Design of the package will consider a mix of:
		• Building a diverse workforce who can support delivery of CBT, use of e-therapies and services provided closer to communities (e.g. in Youth One-Stop Shops, Communities of Learning and alongside primary and community care). It is estimated investment of approximately $5 million p.a. will enable:
		  ○ The training of approximately 250 youth peer support workers and approximately 125 community care workers with a focus on young people;
		  ○ Approximately 250 health professionals such as nurses, social workers and other allied health; professionals to train in therapies such as CBT and motivating behaviour change, as well as training to act as supervision to team-based care;
		  ○ An additional approximately 13 clinical psychology intern positions; and
		  ○ Support for the workforce to make the best use of e-therapies.
		• Expanding access to mental health services for children, adolescents and young people, e.g. YOSS and other YOSS-like services and Child and Adolescent Mental Health Services
		• Testing components of an integrated primary, community and multi-disciplinary spectrum of services (e.g. supported self-management options, social interventions to support wellbeing, continued referrals for talking therapies and shared care between primary and secondary care services).
			$25 million

Step-up/step-down support for people experiencing acute and emergency mental health needs			
6	**Support service for people in acute mental health crisis to sustain tenancies**	The proposal is for people experiencing or at risk of an acute mental health crisis to be supported to establish and sustain tenancies and access appropriate services, with the aim of providing a stable foundation for mental wellness. The initiative will target people who are: • In the private market or in social housing; and • At risk of experiencing an acute mental health crisis and at risk of losing their tenancy; or • Currently in hospital for mental health and in need of safe and stable housing. This service will provide practical support to sustain, retain and establish tenancies which could include things such as liaising with landlords and mediation with neighbours, as well as help to navigate appropriate social services (such as Work and Income and community mental health services). The proposal aligns with the wider mental health strategic approach, by intervening early to avoid potential further escalation of mental health and housing issues. A community based provider(s) will be contracted to deliver this service. <u>Impact:</u> There is New Zealand evidence that sustaining stable housing significantly improves mental health outcomes and reduces hospitalisation rates. A 2010 study found that hospitalisation rates for mental and behavioural disorders for people placed in Housing New Zealand properties declined by approximately 20 per cent following placement in social housing and reduced rates persisted for at least two years. International evidence suggests that the point of discharge from inpatient units can be an effective intervention point for preventing homelessness and that stable tenancies enhance engagement with mental health services, and can lead to a range of positive outcomes, including better physical health and increased social participation.	$4 million
7	**Wraparound and step-up/step-down care trial**	There is an identified need for alternative support options for people experiencing mental health crisis – to make sure we provide timely responses in the most appropriate settings. There is also a known gap in step-down support for people being discharged from in-patient hospital care to return back into the community. Mechanisms for responding more quickly and appropriately to mental health-related emergencies, and for supporting people to return back to the community following in-patient care, may include increased/more effective use of: • Mental health crisis teams; • Home-based treatment teams; • Community respite units; • In-patient units; • Medium-term secure environments; and	$4 million

		• Wrap-around support (e.g. development of discharge plans or use of ongoing peer support to engage with appropriate support services). The most appropriate configuration of these options will vary between regions and according to population needs. This funding will enable the local design and trial of innovative wraparound/ step-up/step-down care options, tailored to regional needs. This investment will complement the support service for people in acute mental health crisis to sustain tenancies, as well as the multi-agency co-response service for people who ring 111 for Police or Ambulance requiring a mental health response. <u>Impact:</u> It is expected that improved wraparound/ step-up/step-down care options will lead to more sustainable outcomes for individuals who have experienced a mental health-related emergency or who have been treated in in-patient care. This includes improved mental wellbeing and ability to cope with life's stressors, with flow-on positive impacts in other areas of their lives, including their housing and employment situations.	
8	**Multi agency co-response service for people who ring 111 for Police or Ambulance requiring a mental health response**	It is proposed to operate in three locations, a multi-agency co-response service for people who ring 111 for Police or Ambulance requiring a mental health response. The proposed service will have staff from Police, Ambulance, and Mental Health services deploying together, as a priority emergency response, to events requiring mental health intervention, such as attempted suicides. Whenever possible, the person will be assessed on scene or in the community to ensure they receive a timely and holistic response. Responses could include direct transfer to a community mental health facility, reassurance for family members or the person themselves that they are safe to stay at home, advice on managing the situation and referrals to appropriate follow-up services and support. Transportation to emergency departments will be a last resort response. This initiative covers an up to 12 month design and implementation period and three years operational delivery in three sites. The three sites would include two metropolitan locations and one provincial/rural location. There will be continual monitoring of delivery in each of the three sites so that the model can be responsively adapted, enabling agile service delivery in response to local circumstances. This initiative is intended to quickly inform future mainstream service design. <u>Impact:</u> The co-response service is a mechanism for improving the service mentally unwell people receive. It will provide more timely and appropriate specialist assessment and care for people, by intervening earlier in the course of a person's illness with treatment in the community or at home rather than at hospital or a police station. This will reduce the number of people being detained by Police or transported to emergency departments; minimise the need for more intensive and expensive health care options, through delivery of the right services at the right time; reduce repeated calls for service; and assist with capacity in DHB crisis services.	$8 million

		There is strong international evidence that a co-response service will be more cost effective than the current operating model, with a lower average cost per event attended. The service will build strong and effective partnerships between agencies and service providers. This will mean a more responsive service, with improved use of referral pathways to link people to appropriate services such as housing and alcohol and drug treatment. These referrals could also be to other services proposed in this package, i.e. Trauma Focused Cognitive Behavioural Therapy, Electronic and Distance Therapy. Providing a coordinated and comprehensive service from the outset means people are more likely to receive the care they require when they need it, reducing repeat demand, and resulting in fewer emergency service calls to Police and Ambulance.	
9	**Strengthening self-regulatory skills in early childhood**	This initiative would seek a provider to deliver a pilot to deliver and evaluate an intervention focused on developing internal self-regulatory skills for 3 and 4 year olds in home and/or ECE settings. A pilot approach is needed because, while some promising age-appropriate interventions to improve self-control in pre-school age children are developing, further evidence of effectiveness is needed before a rollout is advisable. It is expected that a proposed intervention would not only show the ability to improve self-control in young children, but also at a relatively low cost per child and before the cost of adverse outcomes is incurred. Impact: Low levels of self-control appear to be relatively common in early childhood. The Growing Up in New Zealand Study found that just over 25 per cent of children aged four and a half lacked self-control when assessed using a standard test. Higher levels of self-control have been found to predict many important outcomes that extend into adulthood. After accounting for socioeconomic status and IQ, individual differences in children's self-control can predict physical and mental health, criminal behaviour, and wealth in adulthood, as well as better educational outcomes.	$3 million
Schools package			
10	**Pilot frontline mental health provision in schools**	This proposal is for a pilot the provision of frontline mental health services in selected schools to: • Support the development of a universal screening approach/es, to identify mental health issues or issues that left unchecked could manifest as mental health issues later on; • Where mental health issues are identified, provide on-location access to frontline mental health care so that students have fast, easy access to the support they need to address issues as they occur. The objective of universal provision is to identify emerging issues early to reduce this as a barrier to learning, and to build the capability within the Community of Learning to address mild to moderate needs. Screening is likely to be carried out by existing resources, such as nurses, social workers and counsellors, with the oversight and support of a mental health practitioner. When mental health needs are identified, children will be referred to the specialist mental health service.	$11 million

		Screening will build on existing screening tools, such as HEEADSSS, and administration through Communities of Learning enables this pilot to test whether additional screening points and would support earlier identification of issues, monitor children's development, and evaluate the effectiveness of interventions across school years, and at critical transition points. <u>Impact:</u> The Youth'12 survey indicates that over time, the mental wellbeing of students appears to have deteriorated slightly between 2007 and 2012, with small increases in the proportions of students reporting significant depressive symptoms (12.8 per cent up from 9.5 per cent), deliberate self-harming (24 per cent up from 19.4 per cent), and suicidal ideation (15.7 per cent up from 13.1 per cent) (Youth'12 survey). Evidence shows that where young people have access to well resourced, on-site services, the student population experiences lower depression and suicide statistics, decreased visits to emergency departments, and increased educational achievement and engagement. Evidence also shows that young people 'snack' on services as and when need arises and in order for this to occur, services must be easily accessible. Better educational outcomes are associated with better employment outcomes and reduced justice and welfare costs. By increasing accessibility for children and young people to services and improving continuity of care across their whole education pathway, we are increasing the likelihood that they will seek help and support early in the incidence of their issues or illness, which will in turn increase positive life outcomes.	
11	**Improve learning environments and build resilience**	Specific social and emotional skills, including those related to self-control and resilience, can be taught to all young people through school-based programmes. This proposal is aimed at improving the social and emotional learning environment in schools and developing the resilience of children and young people. The proposal is to develop a more evidence-based, effective universal approach building on the capability already in place through PB4L School Wide. This will enable schools to embed a strong foundation of effective systems and processes for positive behaviour, improve the social and emotional learning environment, and develop skills required for resilience. Current evidence suggests this will mean systems and processes for developing leadership strategies to embed a culture to support a positive social and emotional environment, developing the capability to use data and evidence to make decisions, and implementing effective teaching practices across the curriculum to teach students the skills they need to be resilient. In addition, additional targeted interventions, such as an adaptation of the well-researched and well-evidenced Good Behaviour Game will be developed to supplement the universal approach, to address a specific area of need identified by the school or Community of Learning (e.g. anti-social behaviours). This approach will be made accessible to all schools by 2020.	$8 million

		Impact: Building resilience across the school years is a core preventive strategy and to be able to cope with stressors such as bullying. Effective interventions establish a safe, positive physical and emotional school environment for students' achievement and wellbeing. Strategies to improve wellbeing, and critical areas of development known to increase resilience, such as self-control, are most effective when they are part of a whole-school focus on improving the culture and environment, and provide students with the skills they need to face stressors when they arise. Improved resilience is associated with positive social behaviour, reduced emotional distress and mental health issues, and improved academic performance. Targeted interventions such as the Good Behaviour Game have been shown to have widespread effectiveness. Specific impacts include: lowered verbal and physical aggression and oppositional behaviours; greater compliance; reduced hyperactive behaviours; increased pro-social behaviours; self-control; increased engagement in academic tasks; and perseverance. The London School of Economics estimates a significant return on investment for school-based interventions to improve the skills that contribute to resilience, including social and emotional skills.	
12	**Electronic HEEADSSS assessment and brief intervention for young people**	It is proposed to pilot an electronic HEEADSSS (home, education/employment, eating, activities, drugs, sexuality, suicide and depression, and safety from injury and violence) assessment tool with young people within 12 services, focusing on School Based Health Service secondary schools and Youth One-Stop Shop settings. The pilot would reach an estimated 4,000 young people from age 12-24 years per annum. Assessment of workforce capacity to respond to arising need will be considered, and resourcing to ensure appropriate workforce response will be added if required. Impact: Electronic assessment has been shown to improve disclosure of sensitive information and to enhance screening as a pathway to improved support and outcomes. School Based Health Services have been estimated to reduce depression by 3.4 per cent and to impact positively on suicide risk, sexual health, alcohol misuse and school engagement. It is anticipated that use of electronic assessment and brief intervention in these settings would enhance those outcomes. Evaluation of the pilot is essential and should include an annual school health and well-being survey in participating and comparison schools to enable clear measurement of any additional impact of the pilot on these outcomes. Collated data from the assessment tool and the evaluation surveys will also be of significant benefit at the school level enabling school-wide, specific health promotion initiatives to be implemented, and at the area/national level where data from all services can be used in an aggregated format to inform policy and services on levels and areas of youth psychosocial need.	$1 million

13	**Supportive housing models for youth with a mental health condition**	This proposal would provide accommodation support with wraparound services for young people aged 16-24 who are at risk of developing a mental health disorder or who have one diagnosed already; and are living in insecure housing situations. A community based provider(s) could be contracted to provide the housing and wrap around support services for the young person. Wraparound support will focus on: • Mental health support (diagnosis, medication, counselling, engagement in activities that support wellness); • Housing support (learning rights and responsibilities of tenants and landlords); and • Life skills support (support in cooking and cleaning, house activities and working towards education and/or employment goals). The initiative would support up to 30-40 young people per year, with on average three-four young people per house, in up to ten houses. This would enable a number of locations around the country to test this intervention, with locations to be determined by level of need and provider interest and capability. The initiative would operate as a pilot to test this type of support and its effectiveness in improving mental health and achieving positive outcomes for young people. <u>Impact:</u> We know that there is a significant association between poor mental health and a need for housing support and there is New Zealand evidence that sustaining stable housing significantly improves mental health outcomes and reduces hospitalization rates. We know that young people with mild to moderate mental health issues are three times more likely to be benefit dependent. International supportive housing models that take an integrated approach to housing, education and employment outcomes for young people who are at risk of homelessness suggests that a high proportion of residents move onto stable housing and some form of employment and education upon exiting (an Australian study showed that 81per cent of ex-residents were in recognised and on-going permanent housing and 52 per cent of ex-residents were in education and training a year after leaving).	$5 million
14	**Strongest Families pilot**	This investment will support a pilot based on the Canadian programme ‘Strongest Families’ that delivers Cognitive Behavioural Therapy via telephone conferences for whānau with children experiencing anxiety or moderate mental health or behavioural problems. The programme teaches whānau skills to better manage their child’s behavioural problems, and teaches children how to manage their symptoms of anxiety. It is proposed to test and evaluate the initiative with up to 1,000 children aged between 3-12 and their whānau. <u>Impact:</u> The Canadian programme on which this pilot is based has been evaluated to improve behaviour modification (approximately 25 per cent of participants successfully managed behavioural problems to extent they avoided	$6 million

		diagnosis), educational outcomes and whānau relationships/functioning[10,11]; and to reduce treatment barriers, strengthen therapeutic alliance and result in higher self-disclosure than usual treatment.[12] It is expected that these impacts will lead to improved future outcomes for the children involved (including being better able to cope with their symptoms, reduced acute/unplanned care, reduced likelihood of offending and improved employment outcomes) as well as their whānau (including creating safer and supportive home environments, improved health literacy and improved mental wellbeing, resulting in a reduction of the intergenerational impacts of poor mental health)	
15	**Culturally responsive trauma-focused CBT for children following experiences of family and/or sexual violence**	Trauma-focused Cognitive-Behavioural Therapy (TF-CBT) is a conjoint parent-child treatment that uses cognitive-behavioural principles and exposure techniques to prevent post-traumatic stress disorder, depression and behavioural problems as a result of the trauma. The initiative is to pilot a culturally responsive TF-CBT service for children aged 5-12 years that have experienced or been exposed to family and/or sexual violence in the New Zealand context. The pilot is estimated to reach up to 270 children over two years across three locations. <u>Impact:</u> There is a considerable body of evidence that has documented the relationship between childhood trauma associated with family and/or sexual violence and subsequent aggression and criminality. Child abuse as a result of family and/or sexual violence or witnessing violence is the most common risk factor for post-traumatic stress and associated behavioural problems (including aggression, antisocial behaviour and inappropriate sexual behaviours) as a result of such trauma. In the long-term, across the child's life course, sexual and/or family violence trauma is associated with a wide range of negative outcomes including increased mental health issues, substance abuse and involvement with the criminal justice system. Through early identification, TF-CBT has been proven to decrease and prevent symptoms of post-traumatic stress disorder which are associated with, in the short-term and long-term: • Improved social adjustment; • Improved educational achievement; • Reduced likelihood of offending; • Reduced likelihood of mental health escalation; • Improved ability to recognise and respond to abusive situations; • Improved family communication and connectedness;	$4 million

[10] McGrath, P. J., PH.D., Lingley-Pottie, P., Ph.D., Thurston, C., M.A., MacLean, C., M.D., Cunningham, C., Ph.D., Waschbusch, D. A., Ph.D., . . . Chaplin, W., Ph.D. (2011). Telephone-based mental health interventions for child disruptive behavior or anxiety disorders: Randomized trials and overall analysis. Journal of the American Academy of Child and Adolescent Psychiatry, 50(11), 1162-1172.

[11] Removing the barriers to care. (n.d.). Retrieved from http://strongestfamilies.com/wp-content/uploads/2012/11/Insert_BusinessPortfolio_01June15.pdf

[12] Lingley-Pottie, P., Ph.D., & McGrath, P. J., Ph.D. (2013). Barriers to mental health care: Perceived delivery system differences. Advances in Nursing Science, 36(1), 51-61.

		• Decreased behavioural and conduct problems; • Decreased anxiety and depression; • Decreased substance abuse; and • Reduced likelihood of welfare receipt and therefore increased likelihood of employment opportunities and earnings.	
16	**Enhancing mental health and neurodevelopmental capacity in Gateway assessment teams and associated service pathways**	Within this initiative, Health will enhance the capacity and capability of Gateway assessment teams by including mental health specialists, to improve responses to the mental health and neurodevelopmental needs of children and young people (aged 0 – 18 years) who are engaged with the statutory care system. It is proposed to pilot this initiative in three DHBs alongside MVCOT's Access to Services trial sites, through which MVCOT will direct purchase responses to needs identified through Gateway assessments when those services are not available through the public system i.e. the service doesn't exist or there is a waiting list for an existing service. This Health-led initiative has been designed to align with MVCOT's Access to Services trials, and will share governance arrangements to ensure the systems to strengthen assessment, referral and therapeutic responses are integrated. Collecting the evidence on the impact of this enhancement will help inform how Health and MVCOT can better invest in future services to support the mental health needs of this population coming into statutory care. <u>Impact:</u> Engagement with the sector has informed this proposal – Gateway assessments tend to focus on physical health needs and reports from paediatricians administering assessments that they don't feel they have the skills to properly assess and respond to mental health and neurodevelopmental needs. There is substantial evidence that exposure to Adverse Childhood Experiences (ACEs) has a dose-response relationship to poor outcomes in early adulthood. Prolonged exposure to adversity and trauma (toxic stress) can affect the development of the brain and the foundations for good mental health. If these issues remain unidentified and unaddressed they can increase in severity and contribute to a range of negative outcomes, including poor educational attainment, benefit dependence, offending behaviour, risky sexual behaviour and teen pregnancy, substance misuse, mental health issues, poor parenting behaviours, physical health issues and increased mortality. The risk of negative outcomes can be increased by the introduction of well-intentioned yet uninformed interventions. This initiative targets a population of vulnerable children and young people who have some of the highest exposures to ACE's and toxic stress in New Zealand and who are therefore likely to have a high prevalence of mental health and neurodevelopmental issues - often in combination. At present, these issues are not always identified for a range of systemic reasons, and opportunities to intervene early and effectively are lost. Increasing the mental health and neurodevelopmental capacity of	$4 million

		Gateway teams will support the implementation of effective and child-centred intervention, and increase the capacity of those working with or caring for these children to adapt their approach to best suit their needs. We expect that this will improve outcomes for this cohort and their whānau. This initiative has also been designed to collect data on the incidence and severity of mental health and neurodevelopmental need, and to identify barriers and service gaps for responding to that need effectively. Increasing the health system's responsiveness will also have benefits for a broader population of children and young people.	
17	**Improving the evidence base about New Zealanders' mental health and interventions that work**	Our understanding of mental health and mental disorder (including addiction) in present-day New Zealand is limited. As there are indications that rates of mental disorder are increasing, establishing this with precision is important for understanding who is at risk, for measuring changes since the last research was undertaken, for planning prevention, and for organising services. To build our understanding, this funding will support a programme of extended semi-structured interviews ensuring the inclusion of young people, the hard-to-find, the transient, the homeless, and migrant populations, among others. This would enable us to get a reliable estimate of unmet need and provide an accurate baseline against which to measure progress as we transform our approach to mental health/resilience and the better prevention and management of mental disorder (including addiction). More detailed work, including privacy and ethical considerations, needs to be done. <u>Impact:</u> Data and information is an important enabler that will support the ongoing transformation of mental health and related services in New Zealand. It is vital that we have a clear picture of the nature and prevalence of mental disorders in New Zealand, helping us to understand who is at risk, to develop prevention strategies and to plan and organise services. Collecting and collating data in a way that allows for international comparisons and benchmarking is also important, enriching our understanding of the New Zealand situation. Building the evidence base is a critical element of a social investment approach – we need to understand where to target investment to have the greatest positive impact for New Zealanders.	$5 million

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**MINISTRY OF HEALTH BRIEFING PAPER** **ACUTE DEMAND AND PRESSURES AT WHANGANUI DISTRICT HEALTH BOARD** Date: 3 August 2017 Julie Patterson, Chief Executive Officer

PURPOSE

To provide the Ministry with a high level snapshot of current pressures and how Whanganui District Health Board is managing acute demand and pressures on the Emergency Department.

RESPONSES AND DISCUSSION

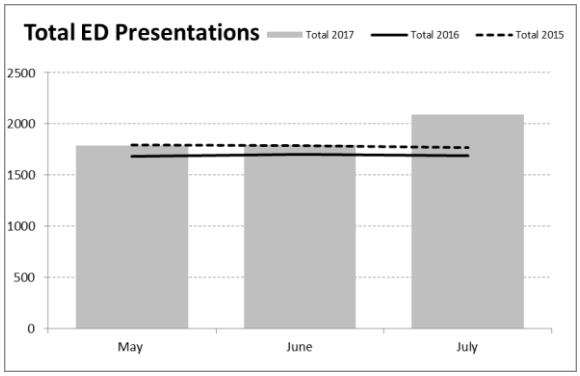
Do you have a particular problem with acute demand - have peaks in demand been more difficult to manage this year than in previous years?

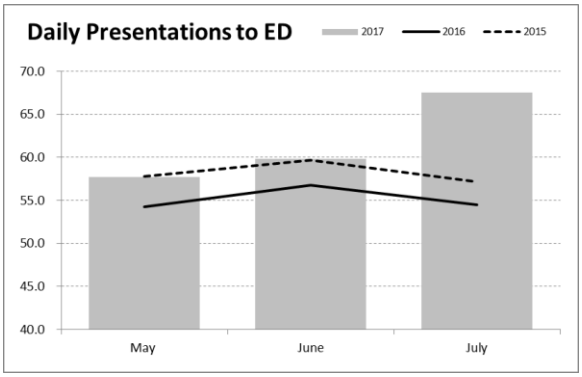
Whanganui District Health Board (WDHB) has seen an increase in acute demand this winter. This has been compounded by sicker patients presenting to the Emergency Department and high numbers of patients presenting to primary care, indicating high levels of illness across the population.

If so what appears to be driving the pressures e.g., patient acuity, shortage of beds or workforce, flow-on from primary care capacity pressures, other factors?

There are a number of factors impacting on high demand in the winter of 2017. These include:

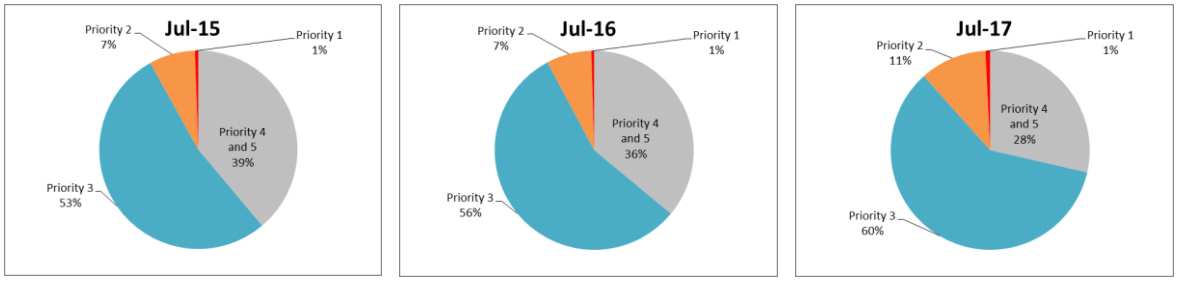
An increase in volumes presenting to the Emergency Department (ED) with daily presentations approximately 25% higher than the same period last year, and the compounding factor of increased acuity in those patients presenting to ED.



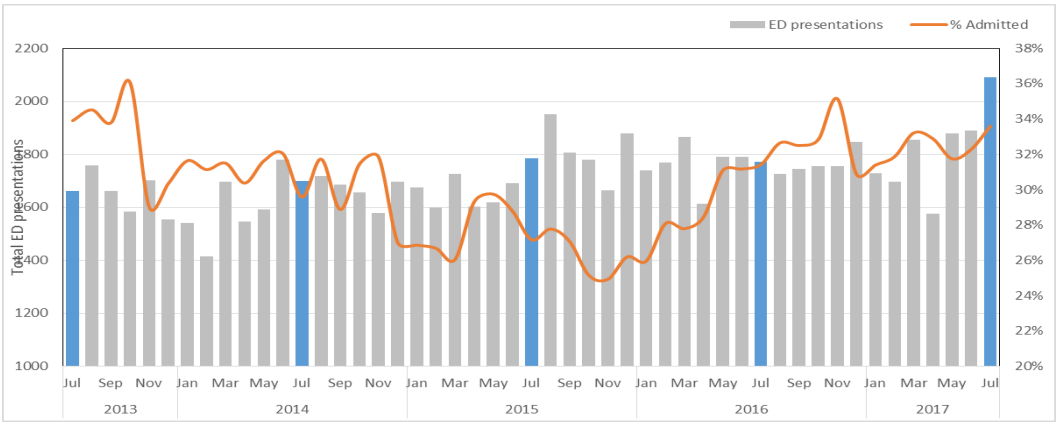


Higher acuity of patients has been measured using the priority at triage, and a comparison of the percentage of total presentations each month. In the two years July 2015 to July 2017, higher priority patients have increased from 61% of total presentations to 72% of total presentations.

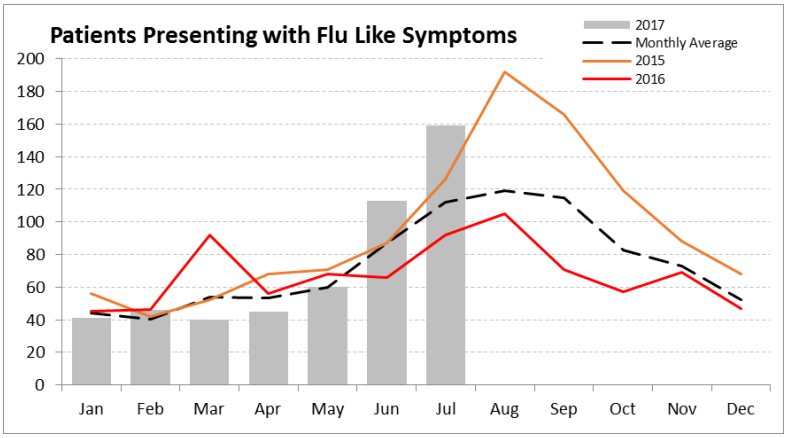
Effectively we are experiencing a larger proportion of sicker patients presenting to ED than in previous years.



Overall higher acuity patients have resulted in higher percentages of patients being acutely admitted to wards – 34% of ED patients were admitted to hospital in July 17, the highest rate over the past four winter seasons. Rates of admission are increasing, and the current rate of 34% far exceeds the usual winter average of 30%.



The number of patients presenting to the Emergency Department with respiratory and flu like symptoms is also peaking earlier than in previous years, and volumes for June and July are significantly higher than the average rate for this time of year, and the two previous years.



The demand experienced in the hospital and emergency department has been mirrored in primary care, and the information below has been supplied by the Whanganui Regional PHO owned Accident and Medical Centre co-located with the ED Department.

Whanganui Accident and Medical

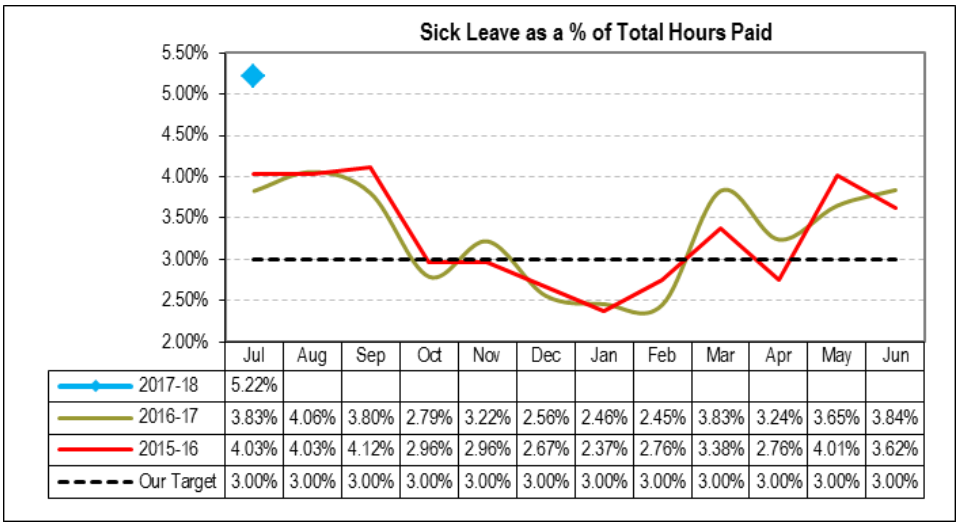
WAM has had an increase in volumes of 1366 in 2017 compared with 2016.

Overall trends reflect a year on year increase for WAM volumes. The increase in recent months has seen an increase in children with respiratory illnesses and adults with flu like symptoms. This has resulted in increased wait times. This is reflected of presentations being seen at general practices as well. Recent communication has occurred to practice teams asking them to open up acute clinics to assist in reducing the number of presentations to WAM. We also have plans in place with all general practices aligned with SIA to meet system measures which includes a focus on reducing preventable admissions, This includes tracking people who are presenting multiple times.

Staffing

High levels of illness in the community, are also apparent in the levels of illness amongst our staff with sick leave as a percentage of total paid hours for July 5.22%. This far outstrips the previous two financial years, with the previous high of 4.12% experienced during the 2015 flu season. Many staff have been ill for long periods of time, with some experiencing flu-like symptoms from a few days to three weeks.

Illness amongst staff has put pressure on resources in acute and non-acute areas across the hospital.



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
2017-18	5.22%											
2016-17	3.83%	4.06%	3.80%	2.79%	3.22%	2.56%	2.46%	2.45%	3.83%	3.24%	3.65%	3.84%
2015-16	4.03%	4.03%	4.12%	2.96%	2.96%	2.67%	2.37%	2.76%	3.38%	2.76%	4.01%	3.62%
Our Target	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%

ED Health Target

There were a number of occasions when ED had to 'hold' patients waiting for a bed as the hospital was full. This has impacted on the ED 6 hour health target, with our July 2016 performance at 94% dropping to 92.3% in July 2017. We continue to monitor this closely and investigate breaches of the 6 hour timeframes on a patient by patient basis.

What are the key measures the DHB is taking to manage demand e.g. key aspects of winter planning?

Hospital

Forecasting and planning for winter:

- Daily bed management meetings with management and leadership involvement to support team when hospital demand increases

- Access to real time hospital capacity and occupancy on all WDHB computer workstations and large screens in bed and resource management department
- Increased resourced beds in winter months (six beds across two wards, with the option to increase occupancy in combined paediatrics and maternity ward by 4 beds)
- Daily multidisciplinary rounding focusing on care and discharge
- Nursing and allied health staff working across the organisation to meet demand at peak times during the year
- Flexible recruitment throughout the year
- Decrease staff training over the winter months
- Flexible employment options and part timers offered additional shifts
- Increased uptake of flu vaccinations amongst staff

Increased communications with the community

- Communications focusing on wellness and accessing care at the right time and right place,
- Publicity around flu vaccination, and availability.

Are these actions having an impact, and how do you see your ability to manage demand over the next six weeks?

This winter we have noted:

- Increased levels of staff sickness with influenza and respiratory infections, particularly among nurses, mirroring rates of infection the community. This has been managed by having a well-staffed casual pool, goodwill of nursing staff and the ability of staff to move from one area to work in another using the Trendcare and CCDM tools;
- An increase in the number of confused elderly patients which can delay discharge timeframes;
- Slightly reduced average length of stay across all wards but a higher than average number of patient discharges. This means that there is high patient throughput which creates resourcing pressures. Coding for July is not yet complete so we do not have an accurate picture acute throughput for inpatients.

Have you implemented new measures to manage demand this year compared with previous years?

We have several pieces of work occurring simultaneously on an ongoing basis to manage demand and to support our health care partners in the community setting. Other initiatives that will or are impacting on community wellness and improved integration between healthcare teams include:

- Community integration project – district nursing, mental health
- Increase specialist and chronic care nursing services
- Increased cancer support
- Map of medicine pathways in primary care

Managing acute demand is not just a winter activity but is an ongoing programme of work across the system including new activities. The impact of the full range of initiatives is reflected in output and outcome measures that are monitored by our Alliance Leadership Team.

Glossary and terms of reference *(for information and reference)*

ACE	Advanced Choice of Employment
AH	Allied Health
AOD	Alcohol and Other Drugs
AoG	All of Government
APEX	Association of Professional and Executive employees
APC	Annual Practising Certificate
ASD	Autism Spectrum Disorder
ASMS	Association of Salaried Medical Specialists
AT&R	Assessment, Treatment & Rehabilitation
Capex	Capital expenditure
CAR	Corrective Action Request
CCU	Critical Care Unit
CMO	Chief Medical Officer
CPHAC/DSAC	Community Public Health Advisory Committee and Disability Support Advisory Committee
CSA	Critical Systems Analysis
CTA	Clinical Training Agency
CWD	Case Weighted Discharge
DNA	Did Not Attend
DSS	Disability Support Services
ED	Emergency Department
EN	Enrolled Nurse
ESPI	Elective Services Performance Indicator
FTE	Full Time Equivalent
GP	General Practitioner
HAC	Hospital Advisory Committee
HAI	Hauora a Iwi
HDC	Health and Disability Commission(er)
HPPPD	Hours Per Patient Per Day
HQPP	Hospital Quality and Productivity Programme
HQSC	Health Quality and Safety Commission
HWNZ	Health Workforce New Zealand
IANZ	International Accreditation New Zealand
InterRAI	International Resident Assessment Instrument
LMC	Lead Maternity Carer
MERAS	Midwifery Employee Representation and Advisory Services
MERT	Medication Error Review Team
MHAHT	Mental Health Assessment Home Treatment
MoH	Ministry of Health
NASC	Needs Assessment Service Coordination Agency
NETP	Nurse Entry To Practice (Nursing)
NHC	National Hauora Coalition
NRT	Nicotine Replacement Therapy
NZHP	New Zealand Health Partnerships
NZNO	New Zealand Nurses Organisation
NZPHDA	New Zealand Public Health and Disability Act, 2000
NZRDA	New Zealand Resident Doctors' Association
OAG	Office of the Auditor-General
Opex	Operational expenditure
PACS	Picture Archive Communication System
PATHS	Providing Access To Health Solutions
PDRP	Professional Development and Recognition Programme (Nursing)

RAC	Risk and Audit Committee
RCA	Root Cause Analysis
RIS	Radiology Information System
RFI	Request for Interest
RFP	Request for Proposal
RMO	Resident Medical Officer
RN	Registered Nurse
RSP	Regional Service Plan
SAR	Severity Assessment Rating
SCBU	Special Care Baby Unit
SLT	Speech Language Therapist
SWIS	Social Workers In Schools
TAS	(Central Region) Technical Advisory Services
TOIHA	Te Oranganui Iwi Health Authority
TOR	Terms Of Reference
VIP	Violence Intervention Prevention
WDHB	Whanganui District Health Board
webPAS	Web-based Patient Administration System
WRHN	Whanganui Regional Health Network

Kupu Māori	**English**
Aotearoa	Land of the long white cloud – New Zealand
Aroha	Love
Hapai te Hoe	Name of WDHB Education Programme
Hapū	Sub-tribe of a large tribe. It also means pregnancy or to be pregnant
Hariru/Hongi	Acknowledge (Pressing noses x2)
Haumoana	Family/whanau navigator
Hinengaro	Psychological realm, mental well-being
Hui	Meeting, gathering
Ipu Whenua	Container for placenta
Iwi	Tribe
Kai	Food
Kaiarahi	Clinical Management - Te Hau Ranga Ora Framework
Kaihoe	Frontline Staff - Te Hau Ranga Ora Framework
Kaikorero	Speaker (on behalf of group)
Kaitakitaki	Operational Management - Te Hau Ranga Ora Framework
Kaitiaki	Protector, caretaker
Kaitiakitanga	Protection, Guardianship
Kaihautu Hauora	CEO - Te Hau Ranga Ora Framework
Kaiuringi	Executive Management Team - Te Hau Ranga Ora Framework
Karakia	Blessings, incantations, prayer
Karakia tuku i te wairua	A prayer/incantation for the safe departure of the spirit from the deceased
Karanga	Calling (done by women)
kāumatua	Elder (usually male)
Kaupapa	Policy, protocol, theme, rule, topic. It also means a fleet (of ships)
Kia ora	Greetings
Kia piki te ora	Get well/May you be well
Koha	Gift

Kupu Māori	English
Koroheke	Elder (male)
Kotahitanga	Unity, cohesion, sharing vision, working together, trust, relationships
Kuia	Elder (female)
Kupu	Words
Mana	Status, standing, power, influence. The spiritual power/authority to enhance and restore tapu
Manakitanga	Ultimate respect and care
Manatangata	Dignity of relationships
Māoridom	Plural of Māori world
Māoritanga	Maori culture and perspective
Marae	Traditional meeting place
Mātua	Parents
Mauri	Life essence
Mauri Ora	Emergency Housing of families on WDHB Campus (Name of building)
Mihi or Mihimihi	Greeting/welcome, acknowledgement
Mihi Whakatau	Informal welcome
Noa	Free from tapu. Tapu and noa are terms used to describe a state or condition affecting both the animate and inanimate. Tapu denotes a state of restriction or sacredness. Noa is free from tapu
Pae Ora	Healthy Futures – Aim of the Ministry of Health Maori Health Strategy – He Korowai Oranga.
Pēpē	Baby infant
Pou tuara	Back bone
Pōwhiri	Formal Māori welcoming ceremony
Rangaimārie	Humility, peace
Rangatahi	Youth
Rongoa	Traditional Māori methods of healing
Take	Subject, topic, purpose
Tamariki	Children
Tāngata Whaiora	Māori mental health service user
Tangata Whenua	Local people Māori
Tangihanga	The mourning process before burial. Funeral
Tāonga	Treasure, valuables. Tāonga is interpreted to mean in its broadest sense an object or resource which is highly valued. Children and future generations are also regarded as tāonga
Tapu	Sacred. Tapu and noa are terms used to describe a state or condition, affecting the animate and inanimate. Tapu denotes a state of restriction or sacredness. Noa is free from tapu
Tapu o te Tinana	Respect for people
Te Hau Ranga Ora	WDHB Māori Health Services
Te Piringa Whanau	Building on WDHB campus under Tikanga of the Whanganui Iwi.
Te Puawai Arahi	Māori Mental Health Cultural Advisor
Te Reo Māori	Māori Language
Te Whare Whakatau Mate	Building on WDHB campus under Tikanga of the Whanganui Iwi – Temporary resting place for the deceased.
Tena koutau/koutou katoa	Greetings/to all
Tikanga	Customs, protocols or policies. Tikanga is used as a guide to moral

Kupu Māori	English
	behaviour and within a health context indicates the way resources, guardianship, responsibilities, obligations and future generations will be protected
Timatanga	Beginning
Tinana	The physical body
Tino Rangatiratanga	Māori chieftainship, self-determination, and absolute sovereignty
Toihau	Board/Chairperson – Te Hau Ranga Ora Framework
Tūpāpaku	Deceased person
Waiata	Song
Waiora	Health
Wairua	Spirit. Wairua refers to the spiritual element, an integral part of tapu and noa
Wairuatanga	Spirituality
Wananga	Place of learning
Whakamutunga	End
Whakanoa	Ceremony to make an area safe to use again
Whakapapa	Genealogy
Whakatauki	Proverb
Whakawhanaungatanga	Family/make connections
Whānau	Family. It also means to be born/give birth. Whānau in this document refers to Māori patients and their families and can include groups regarded as extended family as well as groups outside the traditional family structure
Whanaungatanga	Relationship
Whare	House, Building
Whenua	Placenta. Also means land

*The English definitions for Kupu Māori are reflective of the WDHB context.

Terms of Reference

Combined Statutory Committee	
Applicable To: Whanganui District Health Board	**Authorised By:** Whanganui District Health Board
	Contact Person: Chief Executive

1. Committee of the board

The Combined Community and Public Health, Disability Support and Hospital Advisory Committee is a standing committee of the board, established in accordance with Section 34 of the New Zealand Public Health and Disability Act 2000 (the Act). These Terms of Reference are supplementary to the provisions of the Act and Schedule 4 of the Act.

2. Functions of the committee

- To provide advice to the board on the needs, and any factors that the committee believes may adversely affect the health status of the resident population of the district health board.
- To provide advice to the board on the disability support needs of the resident population of the district health board.
- To provide advice to the board on policy and priorities for use of the health and disability support funding provided.
- To ensure that all service interventions the district health board has provided or funded, or could provide or fund for the population, maximise the overall health and independence of the population whilst contributing to improving equity of outcomes for all people.
- To promote, through its services and policies, the inclusion and participation in society, and maximise the independence of people with disabilities within the district health board's resident population.
- To advocate to external parties and organisations on the means by which their practices may be modified so as to assist those experiencing disability.
- To monitor and advise the board on the financial and operational performance of the hospitals (and related services) of the district health board.
- To assess strategic issues relating to the provision of hospital services by or through the district health board.
- To recommend policies relative to the good governance of hospital services.
- To report regularly to the board on the committee's findings (generally the minutes of each meeting will be placed on the agenda of the next board meeting).

3. Delegated authority

The advisory committee shall not have any powers except as specifically delegated by the board from time to time. The following authorities are delegated to the Combined Statutory Committee.

- To require the chief executive officer and/or delegated staff to attend its meetings, provide advice, provide information and prepare reports upon request.
- To interface with any other committee(s) that may be formed from time to time.

4. Membership and procedure

Membership of the Committee shall be as directed by the board from time to time. All matters of procedure are provided in Schedule 4 of the Act, together with board and committee Standing Orders.

Membership will consist of:

- All board members, one of which will be appointed to chair the committee
- External (non-board member) appointments:
  - Up to two members following nomination from Hauora A Iwi
  - Up to five members able to advise on matters relating to the DHB's functions and objectives.

5. Meetings

The Advisory Committee shall hold meetings as frequently as it considers necessary or upon the instruction of the board. It is anticipated that 8-10 meetings will be held annually, including the annual planning workshop.

Note
For the purposes of this document, the definitions of 'public health and disability support services' is incorporated in the Act, which means the health and disability support of all of the community in the district health board's region.

'Hospital' means all public health services owned by the Crown and previously known as 'Hospital and Health Services'.