Public Agenda

2 MAY 2018

11th Floor Board Room, Grace Neill Block, Wellington Regional Hospital, Riddiford Street, Wellington, 9.30am

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<th>ITEM</th>
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<tbody>
<tr>
<td>1 PROCEDURAL BUSINESS</td>
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<td>1.1 Karakia</td>
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<td>1.2 Apologies</td>
<td>Record</td>
<td>F Wilde</td>
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<tr>
<td>1.3 Continuous Disclosure</td>
<td>Confirm</td>
<td>F Wilde</td>
<td>Accept</td>
<td>F Wilde</td>
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<tr>
<td>- Interest Register</td>
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<td>- Conflicts of Interest</td>
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<td>1.4 Confirmation of Draft Minutes 12 February 2018</td>
<td>Approve</td>
<td>F Wilde</td>
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<tr>
<td>1.5 Matters Arising</td>
<td>Note</td>
<td>F Wilde</td>
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<td>1.6 Action List</td>
<td>Note</td>
<td>F Wilde</td>
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<td>1.7 Terms of Reference</td>
<td>Approve</td>
<td>F Wilde</td>
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<td>1.8 2018 Work Programme</td>
<td>Approve</td>
<td>F Wilde</td>
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2 PRESENTATIONS

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<tbody>
<tr>
<td>2.1 Prioritisation and Investment – Implementing the Health System Plan</td>
<td></td>
<td>R Haggerty</td>
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<tr>
<td>2.2 Even Better Health Care Update</td>
<td></td>
<td>R Haggerty</td>
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3 DECISION

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<tbody>
<tr>
<td>3.1 Investment in and Performance of CCDHB Primary Health Organisations (PHOS)</td>
<td></td>
<td>R Haggerty</td>
<td></td>
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<td>70</td>
</tr>
<tr>
<td>3.2 Investment and Performance – Aged Residential Care, Community Dental Agreement, Community Pharmacy Service Agreement</td>
<td></td>
<td>R Haggerty</td>
<td></td>
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4 DISCUSSION

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<tr>
<td>4.1 Hospital &amp; Healthcare Services (HHS) Bi-Monthly Performance Report</td>
<td></td>
<td>C Lowry</td>
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<td>98</td>
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DATE OF NEXT MEETING 30 MAY – BOARDROOM, LEVEL 11, GRACE NEILL BLOCK WELLINGTON REGIONAL HOSPITAL

APPENDICES

1.6.1 Letter to the Minister re reducing childhood obesity including sugar tax | | | | | 106 |
| 4.1.1 Acute Work Flow Programme | | | | | 108 |
### Conflicts & Declarations of Interest Register

**UPDATED AS AT APRIL 2018**

<table>
<thead>
<tr>
<th>Name</th>
<th>Interest</th>
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</thead>
</table>
| **Dame Fran Wilde** | • Ambassador Cancer Society Hope Fellowship  
| **Chairperson**    | • Chief Crown Negotiator Ngati Mutunga and Moriori Treaty of Waitangi Claims  
|                     | • Chair, Remuneration Authority  
|                     | • Chair Wellington Lifelines Group  
|                     | • Chair National Military Heritage Trust  
|                     | • Deputy Chair, Capital & Coast District Health Board  
|                     | • Deputy Chair NZ Transport Agency  
|                     | • Director Museum of NZ Te Papa Tongarewa  
|                     | • Director Frequency Projects Ltd  
|                     | • Member Whitireia-Weltec Council  |
| **Mr Andrew Blair** | • Chair, Hutt Valley District Health Board (from 5 December 2016)  
| **Member**         | • Advisor to the Board, Forte Health Limited, Christchurch  
|                     | • Owner and Director of Andrew Blair Consulting Limited, a Company which from time to time provides governance and advisory services to various businesses and organisations, include those in the health sector  
|                     | • Former Member of the Hawkes Bay District Health Board (2013-2016)  
|                     | • Former Chair, Cancer Control (2014-2015)  
|                     | • Former CEO Acurity Health Group Limited  |
| **Ms Sue Kedgley** | • Member, Capital & Coast District Health Board  
| **Member**         | • Member, CCDHB CPHAC/DSAC committee  
|                     | • Member, Greater Wellington Regional Council  
|                     | • Member, Consumer New Zealand Board  
|                     | • Deputy Chair, Consumer New Zealand  
|                     | • Environment spokesperson and Chair of Environment committee, Wellington Regional Council  
|                     | • Step son works in middle management of Fletcher Steel  |
| **Dr Roger Blakeley** | • Member of Capital and Coast District Health Board  
| **Member**         | • Deputy Chair, Wellington Regional Strategy Committee  
|                     | • Councillor, Greater Wellington Regional Council  
|                     | • Director, Port Investments Ltd  
|                     | • Director, Greater Wellington Rail Ltd  
|                     | • Economic Development and Infrastructure Portfolio Lead, Greater Wellington Regional Council  
|                     | • Member, Harkness Fellowships Trust Board  
|                     | • Independent Consultant  
<p>|                     | • Brother-in-law is a medical doctor (anaesthetist), and niece is a medical doctor, both working in the health sector in Auckland |</p>
<table>
<thead>
<tr>
<th>Name</th>
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</table>
| Ms ‘Ana Coffey       | • Son is Deputy Chief Executive (insights and Investment) of Ministry of Social Development, Wellington  
                          • Invited to join the Board of the Wesley Community Action Group.                                                                                                                                 |
| Member               |                                                                                                                                                                                                           |
| Ms Eileen Brown      | • Member of Capital & Coast District Health Board  
                          • Councillor, Porirua City Council  
                          • Director, Dunstan Lake District Limited  
                          • Trustee, Whitireia Foundation  
                          • Brother is Team Coach for Pathways and Real Youth Counties Manukau District Health Board  
                          • Father is Acting Director in the Office for Disability Issues, Ministry of Social Development |
| Member               |                                                                                                                                                                                                           |
| Ms Sue Driver        | • Community representative, Australian and NZ College of Anaesthetists  
                          • Board Member of Kaibosh  
                          • Daughter, Policy Advisor, College of Physicians  
                          • Former Chair, Robinson Seismic (Base isolators, Wgtn Hospital)  
                          • Advisor to various NGOs |
| Member               |                                                                                                                                                                                                           |
| Mr Fa’amatuainu Tino Pereira | • Managing Director Niu Vision Group Ltd (NVG)  
                          • Chair 3DHB Sub-Regional Pacific Strategic Health Group (SPSHG)  
                          • Chair Pacific Business Trust  
                          • Chair Pacific Advisory Group (PAG) MSD  
                          • Chair Central Pacific Group (CPC)  
                          • Chair, Pasefika Healthy Home Trust  
                          • Establishment Chair Council of Pacific Collectives  
                          • Chair, Pacific Panel for Vulnerable Children  
                          • Member, 3DHB CPHAC/DSAC |
| Member               |                                                                                                                                                                                                           |
| Dr Tristram Ingham   | • Senior Research Fellow, University of Otago Wellington  
                          • Member, Capital & Coast DHB Māori Partnership Board  
                          • Clinical Scientific Advisor & Chair Scientific Advisory Board – Asthma Foundation of NZ  
                          • Trustee, Wellhealth Trust PHO  
                          • Councillor at Large – National Council of the Muscular Dystrophy Association  
                          • Trustee, Neuromuscular Research Foundation Trust  
                          • Member, Wellington City Council Accessibility Advisory Group  
                          • Member, 3DHB Sub-Regional Disability Advisory Group  
                          • Professional Member – Royal Society of New Zealand  
                          • Member, Institute of Directors  
                          • Member, Health Research Council College of Experts  
                          • Member, European Respiratory Society |
<p>| Member               |                                                                                                                                                                                                           |</p>
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<td></td>
<td>* Member, Te Ohu Rata o Aotearoa (Māori Medical Practitioners Association)</td>
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<td>* Director, Miramar Enterprises Limited (Property Investment Company)</td>
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<td></td>
<td>* Daughter, Employee of Hutt Valley based Māori provider (Tu Kotahi Māori Asthma Trust)</td>
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<td></td>
<td>* Wife, Research Fellow, University of Otago Wellington</td>
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<tr>
<td>Mr Bob Francis</td>
<td>* Chair, Masterton Medical Limited</td>
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<tr>
<td>Member</td>
<td>* Chair, Biomedical Services New Zealand Limited</td>
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<td>* Chair, Sub-Regional Disability Advisory Group</td>
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<td>* Chair, Pukaha Mount Bruce</td>
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<td>* Chair, Wings over Wairarapa</td>
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<td>* Chair, Te Kauru Upper Ruamahanga River Management Plan</td>
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CAPITAL AND COAST DISTRICT HEALTH BOARD
DRAFT Minutes of the Community and Public Health Advisory Committee (CPHAC)
Held on Monday 12 February 2018 at 9.30am
Conference Room, Level 6, Grace Neill Block, Wellington Regional Hospital

PUBLIC SECTION

PRESENT:

BOARD
Dame F Wilde (Chair)
Dr K Adams
Ms E Brown
Dr R Blakeley (left at 11.45am)
Mrs S Driver
Ms S Kedgley
Ms A Coffey
Dr T Ingham

STAFF:
Dr A Bloomfield (Interim Chief Executive)
Ms R Haggerty (Director, Strategy Innovation and Performance) (joined at 9.45am)
Ms C Lowry (General Manager Hospital and Healthcare Services) (joined at 11.40am)
Ms C Khoo (Minute Secretary)

PRESENTERS:
Mr Peter Guthrie, Mr Terry Smith and Mr Sam McLean, item 2.1
Ms Astuti Balram, item 3.1
Ms Sandra Williams and Ms Jan Marment, item 3.3

GENERAL PUBLIC:
No members of the public was present.

1 PROCEDURAL BUSINESS

1.1 PROCEDURAL
The Karakia was led by Tristram Ingham. Committee Chair, Dame Fran Wilde, welcomed members and the DHB staff.

1.2 APOLOGIES
Received from Andrew Blair, Roger Jarrold, Darrin Sykes, Kim Ngarimu, Bob Francis and Fa’amatuainu Tino Pereira

1.3 INTERESTS

1.3.1 REGISTER OF INTERESTS
No changes were registered.
1.4 \textbf{CONFIRMATION OF PREVIOUS MINUTES:}

‘Ana was an apology and Eileen left the meeting around 11.30am via video conference.

\textbf{Item 2.1a. Wairarapa Child Health}

Discussion on fluoridation and amalgam use. Sue Kedgley (Sue K) asked two questions on these issues and was told the team will get back to her with an answer.

\textbf{Action:}

1. Rachel to provide an update to Sue K on amalgam use of fluoridation.

\textbf{Item 1.6 Equity Monitoring Indicators}

Eileen asked to see the framework again (from Action Point 2.3).

\textbf{Action:}

1. Rachel to share the Equity Monitoring Framework.

\textbf{Items 1.6 and 2.2 Regional Public Health (RPH) Update}

Eileen asked if we could expect to receive a population health update from the RPH at every meeting. (Item 1.6, Action Point 2.5). Fran suggested that this topic be moved to item 2.2 (on November’s agenda) for discussion.

A communication is to be drafted to the new government. Eileen asked at what stage the communication is at (Item 2.2).

\textbf{Actions:}

1. Regional health update to be discussed with the work programme in May’s agenda
2. Final letter to the Minister on sugar is ready for the Board Chair’s signature.

\textbf{Item 1.7 Dissolution of 3DHB CPHAC/DSAC.}

Eileen asked when the combined Board discussion would happen.

\textbf{Action:}

1. This is transferred to the Capital and Coast Board

1.5 \textbf{MATTERS ARISING}

\textbf{1.5.1 Implementation of a tax on sugar-sweetened beverages}

The paper was taken as read.

‘Ana had not been at the previous meeting where all the information was discussed. She said that while she is not against the idea of supporting this implementation, she has concerns around conversations with Maori communities around the text and how it may impact on poorer communities. She asked if there is an option to show if someone wants a sugary drink, there could be an alternative. She asked if this should perhaps be part of the equity discussion or work programme in CPHAC.

‘Ana suggested that it would be good to have an empowering discussion with the community rather than telling them that their behaviour is ‘wrong’.

Tristram agreed with the intent of the letter but he felt it would be good to explicitly signal that this may be only one of a number of initiatives about reducing obesity. He suggested that we should indicate that we have considered the issues more broadly rather than imply that this is the one and only initiative we’ve considered.
Eileen thought it would be good to mention other initiatives such as Project Energise and reinstating school clinic guidelines. She said the letter would need to be redrafted to reflect the changes. It should provide evidence to explain why this is such an issue, for example the dental statistics on teeth extractions. The revised letter should also acknowledge the Minister’s recent statements on the topic.

The Committee endorsed the letter but proposed amendments before it is sent.

**1.5.2 National Bowel Screening Programme (NBSP) roll-out**

Paper was taken as read.

**1.5.3 Draft update on Community Water Fluoridation (CWF)**

The paper was taken as read.

**2 PRESENTATIONS**

**2.1 ANALYTICAL INSIGHTS FROM INTEGRATED DATA**

The paper was taken as read. The Committee noted the presentation.

The Committee discussed privacy protection on the data used and operational governance. Fran requested a ‘one pager’ noting that the Committee endorsed the proposed approach to developing a whole-of-system analytics to support strategic planning and investment. The Committee considered this is fundamental to enable CCDHB to deliver on its strategic goals.

**Action:**
1. SIP to provide a one page paper based on the presentation for the Board.

**3 FOR DISCUSSION AND DECISION**

**3.1 HEALTHCARE HOME UPDATE**

The paper was taken as read. The Committee noted update.

Tristram moved a note of caution (supported by Eileen) about proceeding to an additional roll-out. He felt that this should wait until the equity formula is working effectively to address the equity gap before expanding to other areas. Other committee members indicated support for the point through ensuring additional research and design work so that equity is well addressed.

**3.2 SYSTEM LEVEL MEASURES UPDATE**

The paper was taken as read.

**3.2.1 SYSTEM MEASURES REPORT**

The Committee noted the report.

**3.2.2 ICC SLM DASHBOARD – Q2**

The Committee noted the report.
3.3 PERFORMANCE DASHBOARD – COMMUNITY SERVICES FOR OLDER PEOPLE

The paper was taken as read.

Staffing levels to patient ratios
Sue K asked for possible comparison between Aged Residential Care (ARC) facilities. The Committee responded that the only mandated requirement is for there to be a registered nurse on staff but there is no mandated requirement for FTE levels. The performance dashboard will help provide information that will alert to any problems with the provision of care.

3.3.1 PRESENTATION

The Committee noted the presentation.

3.3.2 InterRAI Data Visualisation

The Committee noted the information.

4 FOR INFORMATION

4.1 GENERAL BUSINESS

There was no general business.

4.2 RESOLUTION TO EXCLUDE THE PUBLIC

The Committee noted the paper.

The meeting closed at 12.30.

5 DATE OF NEXT MEETING

2 May 2018, 9.30am, Level 11 Board Room, Grace Neill Block, Wellington Regional Hospital.
### SCHEDULE OF ACTION POINTS – HEALTH SYSTEM COMMITTEE (HSC)

<table>
<thead>
<tr>
<th>AP No:</th>
<th>Topic:</th>
<th>Action:</th>
<th>Responsible:</th>
<th>How Dealt With:</th>
<th>Delivery Date:</th>
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<td><strong>Ex CPHAC Public Meeting 12 February 2018</strong></td>
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<td>2.1a</td>
<td>Child Oral Health</td>
<td>Request to provide an update to Sue Kedgley an update on amalgam use of fluoridation</td>
<td>Director, SIP</td>
<td>Data was given to Sue Kedgley on 14 March.</td>
<td>Closed.</td>
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<tr>
<td>1.4</td>
<td>Confirmation of previous minutes</td>
<td>Request to receive regional health update from the RPH at every meeting.</td>
<td>Director, SIP</td>
<td>To be discussed with the work programme in May’s agenda.</td>
<td>Closed.</td>
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<td>Communication to be drafted to the new government.</td>
<td>Director, SIP</td>
<td>Final letter on the sugar tax was sent to the Minister on 27 April 2018. Please refer to Appendix 1.6.1 in the May HSC Board Books for the letter.</td>
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<td>2.1</td>
<td>Analytical Insights from Integrated Data</td>
<td>Request for a one pager based on the presentation for the Board.</td>
<td>Director, SIP</td>
<td>Completed and submitted as part of the CPHAC Recommendations to the Board in February.</td>
<td>Closed.</td>
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<td><strong>Ex CPHAC-DSAC Public Meeting 5 July 2017</strong></td>
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<td>2.2</td>
<td>Regional Services</td>
<td>Request the 3 Chief Executives advise on a sub-regional approach for implementing the cardiac model and timeframe.</td>
<td>Director, SIP</td>
<td>The approach to implementing the cardiac model is a regional approach. The Plan is being developed with the support of TAS and is one of the four priorities for the central region.</td>
<td>Closed.</td>
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<td><strong>Ex CPHAC-DSAC Public Meeting 20 May 2016</strong></td>
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<td>2.3</td>
<td>Equity Monitoring Indicators</td>
<td>Requested management to bring back to the Committee in the next Equity Report an outline of the specific actions in the Annual Plan and the</td>
<td>Director, SIP</td>
<td>Replaced by development of Equity Approach presented at March 2017 meeting.</td>
<td>Closed.</td>
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Maori Health Plan and advice to the Committee so it could advise the Boards on an equity action plan over a longer time period.

Recommendations to come back to November 2017 meeting. Framework was emailed to Eileen on 27 April 2018.
Capital & Coast District Health Board
Terms of Reference

Health System Committee
Community & Public Health and Hospital Advisory Committee

May 2018

| Compliance | In accordance with sections 35 and 36 of the New Zealand Public Health and Disability Act 2000, the Board of Capital and Coast DHB shall establish a Community & Public Health Committee and Hospital Advisory Committee. Hereinafter these combined committees shall be called “The Health System Committee.” The members and chairperson shall be as determined by the Board from time to time.

The Committee shall comply with the New Zealand Public Health and Disability Act 2000. The terms of reference of the Committee shall be to do the following in a manner not inconsistent with the New Zealand Health Strategy. The Committee shall comply with the Board’s Standing Orders for Statutory Committees.

These Terms of Reference:
- are supplementary to the provisions of the Act and Schedule 4 to the Act;
- are effective from May 2018.

| Functions of the Committee | The functions of this Committee are to give the advice to the Board on:
- the needs, and the factors that may affect the health of the residents of the DHB;
- the priorities for use of health support funding;
- monitoring the financial and operational performance of the provided by CCDHB, and those commissioned by CCDHB; and
- the strategic issues relating to the provision of health and associated services by or through the DHB.

The aim of the Committee’s advice is to ensure that the DHB maximizes the overall health gain for the population and promotes the inclusion and participation in society, and maximize the independence of the resident population within the DHB through:
- the service interventions the DHB has provided or funded or could provide or fund for the population; and
- the policies the DHB has adopted or could adopt for those people.

The Committee’s advice will be consistent with the New Zealand Health Strategy and the CCDHB Health System Plan. The Committee shall present its findings and recommendations to the Board for their consideration.

| Objectives and Accountability | The Committee shall:
- monitor the health status and health support needs of the DHB resident population providing advice to the Board; |
- provide advice to the Board on the implications of health needs to support planning and funding of nation-wide and sector-wide health goals;
- provide advice to the Board on policies, strategies and commissioning (planning and funding) to support improved health outcomes in the district;
- provide advice to the Board on priorities for health improvement and independence as part of the strategic and annual planning process to improve health gain and independence within the district;
- provide advice to the Board on strategies to achieve equity in modifiable health status amongst the population of the DHB including but not limited to Māori, Pacific, people living in high deprivation and people with mental health and addiction conditions;
- report on DHB provider and commissioned services and, as required, summarizing strategic issues for consideration;
- monitor and advise the Board on the impact of health support services being provided for the resident population of the DHB;
- identify the issues and opportunities in relation to the provision of health services that the Committee considers warrant further investigation and advise the Board accordingly;
- identify when ‘expert’ assistance will be required in order for the Committee to fulfill its obligations and achieve its annual work plan by co-opting experience when required;
- collaborate as required with Committees of other district health boards in the interests of providing optimum, economical and efficient services;
- 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); and
- perform any other functions as directed by the Board.

**Authorities and Access**

The following authorities are delegated to the 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.

**Meetings**

The Committee shall hold no less than nine meetings per annum, but may determine to meet often if considered necessary by the Committee or upon that instruction of the Board.

**Quorum**

A quorum is a majority of Committee members, and must include at least one member from the Board and at least one co-opted member from the Sub-Regional Disability Advisory Group, Sub-Regional Pacific Advisory Group or Māori Partnership Board.

**Membership**

Membership of the Committee shall be as directed by the Board. The Committee has the ability to co-opt expert advisors as required.

**Procedure**

Schedule 4 of the New Zealand Public Health and Disability Act will apply to the business and procedure of the Committee.
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<th>CCDHB</th>
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<th>Ratonga Rua o Porirua</th>
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<th>Kenepuru Community Hospital</th>
<th>Kāpiti District Council</th>
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<td>2 May</td>
<td>TBC</td>
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<td>Integrated Performance Monitoring</td>
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<td>30 May</td>
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<td>Healthy Aging System Performance</td>
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<td>Community Health Networks Performance</td>
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<td>27 June</td>
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<td>Integrated Performance Monitoring</td>
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<td>25 July</td>
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<td>Community Health Networks Performance</td>
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<td>26 September</td>
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<td>24 October</td>
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**System Performance Reporting**
- HHS Bi-monthly performance report
- MHAIDS Bi-Monthly performance report
- Regional Public Health Bi-Monthly Report
- EBHC Bi-monthly performance report

**Provider Performance**
- Community Providers Performance report - (ARC, PHO, Dental, Pharmacy)
- Community Providers Performance report - (NGOs, Integrated Care)

**Community Providers Performance report - (ARC, PHO, Dental, Pharmacy)**
- Community Providers Performance report - (ARC, PHO, Dental, Pharmacy)
- Community Providers Performance report - (NGOs, Integrated Care)

**Health System Investment and Prioritisation**
- Investment & Prioritisation - TBC
- Planning Projects and Service Plans – Topics TBC
- Planning Projects and Service Plans – Topics TBC

**System and Service Planning**
- Draft Regional Services Plan
- Draft Annual Plan
- Planning Projects and Service Plans – Topics TBC

**Prioritisation and Investment Update for implementing the Health System Plan**
- Planning Projects and Service Plans – Topics TBC
- Planning Projects and Service Plans – Topics TBC
- Planning Projects and Service Plans – Topics TBC

**Investment Plan - TBC**
- Planning Projects and Service Plans – Topics TBC
- Planning Projects and Service Plans – Topics TBC
- Planning Projects and Service Plans – Topics TBC

**Community Providers Performance report - (ARC, PHO, Dental, Pharmacy)**
- Community Providers Performance report - (ARC, PHO, Dental, Pharmacy)
- Community Providers Performance report - (NGOs, Integrated Care)
Keeping our communities healthy and well

In your home
GIVING PEOPLE BETTER CONTROL OF HEALTH SERVICES WHERE AND WHEN THEY NEED THEM

In your community
COMMUNITY HEALTH NETWORKS HELP PEOPLE ACCESS THE SERVICES THEY NEED

In your hospital
PROVIDING SPECIALIST SERVICES TO THOSE WHO NEED THEM THE MOST

MA TINI, MA MANO, KA RAPA TE WHAI - BY JOINING TOGETHER WE WILL SUCCEED
Investment & Prioritisation

Investment intentionally signals a move to expenditure choices that explicitly deliver health-related benefit for the communities we serve and/or improves the performance of the organisation.
Our purpose

Deliver on health outcomes:

- Promote health and wellbeing
- Prevent onset and development of avoidable illness
- Improve health and wellbeing outcomes
- Support people to live better lives
- Support end of life with dignity

Strengthen our organisation

- Ensure safety and quality of our services
- Create a sustainable and affordable healthcare system
- Deliver on the priorities of government
- Live within our means
- Be a good employer
Making our CCDHB Choices

Safe and quality services

Equity & better outcomes amongst our population

Our sustainable health system

Service resources, systems and results:
- Operational management
- Facilities development
- Organisational performance
- Models of care
- Service reviews, plans and credentialing

Investment & outcomes planning for:
- Urgent and planned health care
- Families and whānau
- People with complex care needs

Reduce Inequities
- Māori
- Pasifika
- Those with disability
- Those with mental illness and addiction

- Models of care supporting community health networks and localities
- A greater Wellington hospital/service network
- Regional Care Arrangements that strengthen complex tertiary services
- Digital technology to expand services in the community
- Technology to share information between all providers/professionals
- Multidisciplinary teams and a sustainable workforce
The Investment Process

• Identify investment opportunities that have potential to improve our health system

These bids

• Complete a feasibility study to determine the scope of the bid and connected investments and/or services

Further develop for 19/20

Develop cases for 18/19

• Develop an options paper across the agreed scope with a focus on meeting the health need and/or system performance.

Options Development

• Final case to invest and/or manage change.

Business Case for Investment/Change

Option Choices

Develop cases for 19/20

Feasibility and scope

Bids Received

Health System Committee (also known as CPHAC-HAC) - 2.1 Prioritisation and Investment Update
This process

**We got started?**
- Proposals developed by services
- Shared information across the organisation
- *It's not perfect!!*

**Who we engaged?**
- Clinical Council
- Integrated Care Collaborative
- Executive Leadership Team

**What we know?**
- Government priorities but not funding allocation
- Detailed budget development still under review
- Estimated sustainability fund of $7 to 8 million
# Our considerations

## Government Priorities

**Responding to critical cost pressures**
- A sustainable system
- Modelling demand and impacts
- Quality, safety and health and safety

**Investing in workforce**
- Organisation culture
- Wage costs for MECA settlements
- Living wage for our employed and contracted workforce

**Investing our capital**
- To maintain health and safety
- To support our key strategies

**Investing in the Health System we want**
- This discussion.
Government Priorities

• Reducing inequities
• Sustainability and safety of our healthcare system
• Mental health and wellbeing
• Primary healthcare
• Wellbeing of children and young people

• The areas identified the coalition agreements include:
  – Mental Health & Alcohol & Drug
  – Inquiry into Aged Care
  – Pharmaceuticals
  – General Practice
  – School Health Teams
  – Screening
  – HIV Prevention
  – Health Eating & Nutrition for Children
  – Cancer treatment
  – Disability
  – Long Term Conditions
## Capital expenditure prioritisation

<table>
<thead>
<tr>
<th>ICT Strategic</th>
<th>Clinical and Service Priorities</th>
<th>Maintenance &amp; Replacement</th>
</tr>
</thead>
</table>
| - Operational performance  
  - Financial resources  
  - Human resources  
  - Asset Management  
  - People and Capability  
  - Specialised Care  
  - Mobile Care by the Bedside  
  - Ward optimisation  
  - Patient flow and performance  
  - Digital Health and Disability  
  - Discharge advice  
  - Community Health Networks  
  - E-Referrals – advice and consult  
  - Shared care records and plans  
| - Clinical equipment to integrate with the electronic bedside  
  - Complex care services and specialised equipment  
  - Integrated data analytics and use of information to manage service performance and outcomes  
| - Quality & Safety and Business Continuity  
  - Facility maintenance & development  
  - ICT maintenance & upgrades  
  - Clinical equipment replacement & upgrades  

Health System Committee (also known as CPHAC-HAC) - 2.1 Prioritisation and Investment Update
Balanced investment

For SIP and MHAID Bids the scoping can be found in the appendix.
Service Development

Life Course Investment

Integrated Responses to Specialist Services

Mental Health & Wellbeing

Specialist Services

Community Health Networks

Locality Development
Life Course Investment

Improving health, mental health and wellbeing across the life course
Life Course Investment

A holistic, life-course, systemic approach to prevention:

- Development
- Environment
- Skills & Knowledge
- Work expertise & experience

Prenatal Infancy Childhood Adolescence Adulthood Old Age

Influences on individuals

- Parental support & early years educations
- Education, employment & professional development
- Services for well-being, health prevention and care
- Secure safe and supportive environment

Areas for action in communities

Important for equity

Developing life skills that build resilience to risk.
Important for equity
Influencing Health Outcomes

Health influences all of life

Individual Health
Family • Whānau
Community
Education • Housing
Social Support • Workplaces
Transport • Recreation
Environment
Economy

Many factors contribute to health

Important for equity
Engaging with Families

• Strengthening our contact points with families and young people
  – Points of vulnerability in people’s lives
  – Significant inequalities for Maori and Pacific

• Leveraging existing services
  – Linking to existing services and supports
  – Building our Community Health Network and NGO sector
  – Growing our localities approach

• Intervening early can prevent:
  – Avoidable hospitalisations and emergency department use
  – Mental health and addiction service use
  – Conduct and attachment disorders
  – Family violence
  – Suicide and suicidal behaviour
Investing across the life course

Mother, babies and families support
- Identify and intervene early in mental health and social risks
- Linkages to existing services and then providing treatment interventions

School based health
- Critical transitions occur in school years
- Can target schools and achieve good coverage
- Support health, mental health and wellbeing at school
- Connecting to primary care and local services

Youth health service development
- Youth are a critical target population. Significant mental health and wellbeing challenges
- Rainbow youth and gender diversity a major risk factor for suicide and mental health and wellbeing

Wellbeing of older people
- Older people with social and health vulnerabilities are high users of avoidable health services
- Social isolation, frailty support in the community to prevent frailty occurring
Priorities for investment

Mother, babies and families support
• 1st - Support mothers and their families in first weeks of babies life
• Pepi pod support packages for our most vulnerable
• Support those who with mental health risk, and safety risks

School based health
• Prioritising low decile, high need schools
• Develop model of care building on our small current investment
• Youth and family health connecting to local services

Youth health service development
• 1st - Improve access to services for Porirua youth
• 2nd - Improving youth access to primary care in existing services
• 3rd - Rainbow youth and gender diversity support

Wellbeing of older people
• 1st - Specialist older people care in primary care to prevent onset of frailty and support primary care

Develop targeted approaches that leverage off existing services and target inequities.

May be funded by government

Priority for development with 2018/19 start
Mental Health & Wellbeing

Significant government priority.
Community Well-Being Hubs

Sub-regional integrated leadership
Consumer leadership
Planning & commissioning
Clinical governance, quality, specialist support, business support

Community Well-being Hubs

24/7 Phone Support
Screening, advice and referral
Other options

Mobile, inter-agency, multi-discipline team
Holistic self/supported assessment
Rapid response
Recovery support
Family support
Respite
Community support

Local community health networks
Local service users, whanau, iwi, church groups
NGO and local social support agencies
Inpatient support
Mental Health & Wellbeing

MHAIDS Improvements
- Shared care record
- Model of care in rehabilitation

Mental Health Review
- Integration of service management
- Development of Mental Health Localities

Specialist Service Development
- Modelling demand pressures
- Reconfiguring specialist advisory service to other providers
- Infant mental health
- Forensic service demand

Mental Health Inquiry
Outcomes will support greater wellbeing focus and reducing inequalities through alternative models.
The identified areas for investment

Specialist mental health support for:
• Maternal mental health.
• Mental distress and suicidal behaviour.
• Primary health managing mental health and addictions issues
• Our hospitals and emergency departments

Addiction services and the homeless
• Impact of SACAT
• Developing the model of care for addiction
• Te Whare Oki Oki and working with Wellington City Council

Primary mental health
• Greater capacity and early intervention support in primary care
• Prioritised support for maternal and youth health
• Support suicide prevention and wellbeing support

MHAIDS Service Development
• Forensic mental health
• Corrections population
• Infant mental health
• Intensive support for families where attachment and conduct disorders are establishing for many reasons

Priority for re-configuration in 2018/19
Develop models for in 19/20
Priority for development with early 2019 start
Community Health Networks

Providing more care in lower cost settings closer to home.
Community Health Networks

FIGURE 2: SETTINGS OF CARE FOR CAPITAL AND COAST

New settings for care
There are three settings for care to be delivered, all supported with digital technology.

Digitally enabled environment

Home - allowing people to take greater control when and where is convenient to them

Hospitals - allowing hospitals to provide specialist care for those that need it most

Interdisciplinary teams

Community health networks - a central organizing point where we can reach more people, more often
The identified areas

Links to:
- Integrated responses to Specialist Services
- Life Course Services
- Primary mental health
- Specialist mental health support teams
- School based health
- Youth health service development

Primary health
- HCH coverage to 80% of the districts population
- Priority investment to leverage other services to maximise impact

Diagnostic Access
- Diagnostic and POAC access
- Resolving radiology demand management
- Investment in 18/19

After Hours Care
- After hours A&M care across the district
- Prioritising access in Kāpiti and Porirua

Priority for development with 2018/19 start

Project priority for 2019/20 solution
Locality Development

Locality Planning
- Kāpiti priority
- Porirua linked to youth and mothers and families
- Wellington linked to addictions model of care and Te Whare Oki Oki

Disability Services
- Support for sign language users across CCDHB
- Intellectual disabilities clinical specialist to support journeys of care

Localities networks
- Community Circles development
- Social support leveraging existing networks and services

Development for 2019 start with evaluations
Development for 2019 start with evaluation at three years
Integrated specialist services

Understanding the impact of greater mental health and wellbeing and community services on our hospital demand.
Projects to develop solutions

Purpose
• Identify and plan the capacity requirements for surgery, inpatient bed demand and urgent care.
• Focus on considering the impacts of different models of care on demand.

Inpatient bed demand
• Patient flow modelling considering impacts of community development, primary care, regional demand and local demand
• Links to acute flow and ward optimisation (EBHC)

Surgical capacity
• Perioperative and surgical capacity across the hospital network including Hutt Valley
• Theatres, perioperative space, ICU capacity and inpatient care
• Regional Care and Impact of IDFs

Urgent Care
• Emergency department Demand
• HCH and ICC responses to urgent care
• Older persons Community
• ED Mental Health Responses
• Diagnostics & POAC Access
HHS Specialist Services

Quality and safe health services
Identified Areas

Service planning
• Models of care and multidisciplinary team development
• Responses to service reviews and problem solving

Sub-regional & Regional Service Planning
• Regional development of the Cancer Services Network
• Cardiology Services and the development of PCI

Service planning
• Renal Services and dialysis access
• Child Health Services and the Children’s Hospital
• Newborn Baby Services (NICU) (National Services)
• Bowel Screening (deferred till 2019/20)
• Stroke services & Clot Retrieval
Keeping our communities healthy and well

In your home
Giving people better control of health services where and when they need them

In your community
Community health networks help people access the services they need

In your hospital
Providing specialist services to those who need them the most

Ma Tini, Ma Mano, Ka Rapa Te Whai – By joining together we will succeed
Keeping our communities healthy and well

In your home
Giving people better control of health services where and when they need them

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Community health networks help people access the services they need

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Providing specialist services to those who need them the most

Ma tini, ma mano, ka rapa te whai - by joining together we will succeed
EVEN BETTER HEALTH CARE

• Prioritised initiatives to
  – improve operational efficiency and effectiveness
  – develop service delivery models that will be foundational for achieving the goals of the Health System Plan (HSP) - Vision 2030.

• We focus on people and systems, emphasising better outcomes for patients and improving the working environment for staff.
Even better health care – towards whole system investment

**Current: 2017-18**

- Strengthen change capability
- Complete implementation of technology support
- Corporate services.

**Year two**

- Managing cost risks
- Managing our people (FTE) resources well
- Managing our clinical supplies well
- Developing innovation
- Focused use of information

**Year three**

- Changing service delivery models
- Sustained performance management
- Leveraging our service investments
- Impact of service delivery models

**Year four**

- Whole of system commissioning impact
- Leverage our partnership impacts
- Social investment partnership models
Integrated Care Programme

Developing connections so care is delivered in the right settings to improve health outcomes for communities – making best use of technology and the workforce
“Community Healthcare Networks are the central organising point for the delivery of effective and efficient healthcare.”

CCDHB HSP
Community Health Networks

Digitally enabled environment

Community Health Network Enablers
Digital environments and process structures that connect users to the right health services at the right time

Specialist Ambulatory Care
Supporting the future configuration of community based specialist services and the management of healthcare needs

ORA Allied Health
New models of care that enable Allied Health to better meet the needs of people and their whanau in CCDHB

Person, Whanau and Community Centred

Multi Disciplinary Health Teams

Gateway to community based health services
Hospital and Health Services (HHS) Programme

Creating hospital and healthcare services fit for tomorrow... managing our resources well and delivering great outcomes for staff, patients and communities.
Optimal Ward Discovery Phase

Ward 6 South

I’m working at the right level
I want information patient that is accurate
We provide timely and quality care
I have supplies and equipment to do my job
I am able to learn
We are focused on improvement
I go home on time

I feel safe and healthy
I am supported to do my job
My technology helps me do my job
We work as a team.

Māori and Pacific people are central to our design thinking
Our models of care are patient focused
I have more time to care
Patients and family care is optimised
I know what's going on.

Our patients don't wait long
Our technology is optimised
We respect everyone. Cultural awareness is the key
We respect everyone.

Our patients quality of life is optimised
Our patients, families and communities respect us
Our patients, quality of life is optimised
Patient care is optimised

We provide timely and quality care
I have more time to care
I know what's going on.

Optimal Ward Discovery Phase
Ward 6 South
Health System Committee (also known as CPHAC-HAC) - 2.2 Even Better Health Care Update
Optimal Ward expected outcomes

**Desired outcomes**
- Staff are satisfied
- Improved quality and safety
- Staff have time to care
- Staff are safe and well
- Staff work together
- Culture is right

- Families are confident
- Improved quality and safety
- Improved experience of care
- Are treated with respect
- Cultural needs are met
- Quality of life is improved
- Our reputation is improving
- Time in remote hospital reduced

- Improved quality and safety
- Improved experience of care
- Are treated with respect
- Care is optimised, Patients are satisfied
- Improved health and equity for all populations
- Quality of life is improved
- Patients are confident in the system
- Cultural needs are met

- Efficiency is increasing
- Waste is reduced
- Revenue is increasing
- Fiscal gap closing
- Better value for public health system resources
- Culture is right
- Our reputation is improving
MHAIDS Programme

Changing the way Mental Health Addictions and Intellectual Disability services are designed to support communities and staff and ensure CCDHB is better placed to meet future needs.
**EBHC MHAIDS Delivery Model**

**Pipeline Projects (T3)**
- **QIC Building Quality Improvement capacity in MHAIDS**
- **A25 Age split under/over 25 – investigate changing community teams to under and over 25**
- **TAS - TAC Provision, Transition and Vocation project**
- **Hauora Improving outcomes for Māori – reduce Māori treated under MHA (S29) 3DHB**
- **I2025 Implementation of 2025 workforce strategy (3DHB)**
- **WDS Māori and Pasifika workforce development, scholarships**

**Pending Projects**
- **SMI - Aging people with serious mental illness - managing physical care & Mental Health of people with physical disability**
- **MOC(R) - Model of Care REHAB**
  - The model of care has been developed but recommendations need implementing
- **DPC2 - MHAIDS Digital Client Pathway**
  - Further development of shared care record and continuous notes, primary care access, electronic prescribing, MH Act, client access,

**Active Projects**
- **MHOC**
  - The project aims to implement the MHOC no later than February 2019.
- **DHB FTE**
  - Implementing a workforce management solution to optimise workforce management

**Business as Usual Operations**
- **MHOC**
  - Feb 2019
- **DHB FTE**
  - May 2018
Management of all MHAIDs rosters include SMO/RMO, Crisis Resolution Service, Te Haika and inpatient wards.

Management of staff skill mix to meet service demand and inform resource needs.

Deployment of casual resources (clinical and administration)

Bed state management.

Skill Mix / Resource Management.

Centralised Rostering.

Trend Care CAPlan.

Emergency Response & Coordination.

Centralised Security.

Potential: Management and deployment of staff across MHAIDS following a major incident/disaster.

24 hour demand and community electronic whiteboards.

Centralised electronic control of Entry/exit of all secure MHAIDs/ Community service. Capacity for distance monitoring or/and CCTV.

EBHC MHAIDS MHOC Project

Health System Committee (also known as CPHAC-HAC) - 2.2 Even Better Health Care Update
**EBHC MHAIDS Outcome Impact**

**DHB FTE Project**
- Centralised MHAIDS Services
- Organisational understanding of FTE
- Improving employee morale
- Reducing FTE expenses
- Reduced Sick Leave
  - % reduction in sick leave/unpaid leave
  - % increase in staff satisfaction surveys in X sections over Y reporting period

**Reducing FTE expenses**
- % increase in capacity/resource management
- % reduction in service failure

**Reducing financial and non-compliance risk**
- % decrease in incident of service failure
- % reduction in ICT service overhead and maintenance

**Centralised MHAIDS Services**
- Reduced ICT service maintenance costs stable or reduced
- CENTRAL POINT OF INFORMATION AND SECURITY MANAGEMENT
- Provision of real-time resource management

**CENTRALISED COMMON ACTIVITIES AND ENHANCED CONTINUITY OF CARE**
- % increase of role rationalisation attributing to savings
- Disestablishment of vacant roles have no impact on service level metrics and performance measures

**EFFICIENT INTEGRATION OF SERVICE DELIVERY**
- No more than X incidents occurring within a rolling Y month period
- % reduction in sick leave/unpaid leave

**MHOC Project**
- % increase in capacity/resource management
- % reduction in role duplication across sites

**Organisational understanding of FTE**
- % reduction in sick leave/unpaid leave
- % increase in staff satisfaction surveys in X sections over Y reporting period

**Reduced ICT service maintenance costs stable or reduced**
- % increase of role rationalisation attributing to savings
- Disestablishment of vacant roles have no impact on service level metrics and performance measures

---

"I never feel like a burden"
"I Don't feel like I am falling through the cracks"
"There's always someone available"
"No matter where I am, I can get support quickly"
Infrastructure programme
Having the right systems, technology and environment so staff work effectively and the DHB can efficiently manage its capital resources.
Infrastructure programme scope

**Automation of administration systems** – creating automated letters to GPs and automated processes for managing invoices and expenses.

**Facilities and Assets** – generating revenue from improved site occupancy and cost savings from automated tracking of loan equipment like walkers and crutches.

**Processes** – implementing a CCDHB project management framework to drive transparency, consistency and make benefits stick.

**Shared services** – ensuring value for money from our investment in regional and national shared services.
Spotlight on automated GP letters

• A centralised automated mail system with electronic dispatch to GPs will lead to substantial savings for CCDHB.

• Improve relationships and operating efficiencies with primary care.

• Safe default mechanism to ensure correspondence safety.

• Reducing paper based letters lowering the risk of loss of clinical letters.

• The project is 2 weeks ahead of schedule with early adoption by 6 General Practices starting first week of May 2018.
Technology is integral to delivery of the benefits across all programmes
Aligning the technology capability to streamline processes, creating a paperless environment, seamlessly uniting patients, doctors, staff, assets and information throughout the hospital, wider community and homes
Emerging Technology Priorities for EBHC

HHS
- Mobile Workforce
- Electronic Whiteboards
- eReferrals & Bookings
- Virtual Consults
- Integration into Clinical record
- Electronic Patient Observation & Nursing documentation
- Patient Tracking
- Clinical Event and Risk detection (AI)
- Letter to GP
- eMedicines Management

ICC
- Telehealth Enablers
- ePharmacy

MHAIDS
- Mental Health Shared Electronic Record

Health System Committee (also known as CPHAC-HAC) - 2.2 Even Better Health Care Update
Service planning reviews and Qlik implementation
Service Planning Review Implementation

All reviews show need for improved ward-level performance information to improve patient flow.
Qlik Sense: performance improvement

Initial KPIs:
• 28 day readmission
• Seclusion rates
• SAC 1 & 2
• Reportable events
• Annual leave
• Overtime
• Average leave
• FTE
• ALOS
• Theatre measures
• Elective performance
## Cross Organisation Performance

| Engage the front line workforce in barriers to safe care and opportunities to improve |
| Implementing sustainable solutions to systems and resource allocation problems |
| Organise technology (ICT) investments to support strategic priorities enabling fast track solutions |
| Develop whole of CCDHB business cases (primarily ICT focused) in partnership with primary care for solutions to common business problems |
| Develop and trial solutions that will be scaled across the organisation, |
| Linking existing projects and quality improvement initiatives to leverage performance |
RECOMMENDATIONS

It is recommended that the Health System Committee:

a. Notes in 2017 CCDHB will invest $60.8 million in the nationally negotiated PHO Service Agreement of which $56.4m is for our district and the remainder is funded by interdistrict flows from Hutt Valley DHB;

b. Notes that most PHO funding is agreed through the national PHO Services Agreement, including ‘first contact’ services, health promotion, immunisation, and referrals for appropriate interventions and procedures;

c. Notes SIP has taken the lessons from the development of the Older Person Services Dashboard and used the knowledge to develop a draft PHO Services Dashboard to assist CCDHB to monitor and improve performance against the PHO Services Agreement;

d. Endorses the proposed PHO Services Agreement Dashboard with its focus on structural measures, system level performance and impact measures;

e. Notes the dashboard will be updated quarterly (Feb, May, August, and Nov);

f. Recommends to the Board that it requests management to work with PHOs to increase enrolment of Māori in primary care and lift performance from 84% to 95%;

g. Recommends to the Board that it prioritises improved performance in cervical screening, breast screening and heart and diabetes checks, particularly for Māori, as well as Pacific.

h. Request SIP to work with the Pacific and Māori health teams, PHOs and other providers to research and develop further initiatives for reducing ED presentation, ASH and acute medical admission rates for these populations.

APPENDIX:

1. PROPOSED PHO SERVICES AGREEMENT DASHBOARD
Performance (PHO) Dashboard and advise the Board on the identified priorities for focus in 2018/19. It also updates the Health System Committee (HSC) on how Capital & Coast District Health Board (CCDHB) monitors the quality and effectiveness of services provided by PHOs under the nationally negotiated PHO Services Agreement (the Agreement).

1.2 Scope

This paper focuses on services provided by PHOs under the Agreement. It excludes additional investment in primary care through the Health Care Homes project and other services purchased from the same providers, e.g., diabetes, podiatry, primary mental health, and outreach immunisation services. The performance against these contracts will be reported to HSC separately as part of the Health Care Home and NGO reports respectively.

2 BACKGROUND

A well-functioning, strong primary care sector is vital to delivering the New Zealand Health Strategy 2016 and the CCDHB Health System Plan 2030. Primary care supports people, families, and communities by:

- promoting health and wellbeing
- preventing the onset and development of avoidable illness
- delivering equal health outcomes
- assisting people to manage their own health needs.

Primary care services are contracted via PHOs who deliver services through General Practices (GPs) to the people enrolled with the PHO. Enrolment in a PHO or General Practice is voluntary and comes with a number of benefits which can include cheaper doctors' visits and reduced costs of prescription medicines. These benefits are contracted under the Agreement, a nationally negotiated contract that is the principal source of funding for PHOs.

CCDHB holds an Agreement with three PHOs – Compass Health, Cosine Primary Care Network, and Ora Toa PHO – which provide services to the 94 percent of the CCDHB-domiciled population who are enrolled. The services are delivered at one or more of the 59 practices spread across Wellington, Porirua, and the Kapiti Coast. Some practices are Very Low Cost Access (VLCA) practices which have an enrolled population of 50% or more high needs patients and have opted into the VLCA scheme. These practices receive additional funding to maintain patient co-payments at a low level, decreasing the barriers to access for their enrolled population. CCDHB has twelve VLCA practices.

<table>
<thead>
<tr>
<th>PHOs</th>
<th>General Practices</th>
<th>VLCA Practices</th>
<th>Standard Practices</th>
<th>Of these practices,</th>
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<tr>
<td>3</td>
<td>59</td>
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<td>47</td>
<td>18</td>
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<td>Are Health Care Home Practices</td>
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<td>94% of the total CCDHB-domiciled population are enrolled in a PHO</td>
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<td>85% of Māori are enrolled</td>
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<td>100% of Pacific peoples</td>
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</table>
3 THE PEOPLE WE SERVE

At 1 January 2018, 303,851 people are enrolled with one of our PHOs. Of these, 31,838 are Māori (11%) and 22,387 are Pacific peoples (7%). In total 94% of the CCDHB domiciled population are enrolled. The PHO enrolled population reflects the population of people living and working in the catchment in terms of age, gender and locality. It should be noted that the PHO Enrolled population includes individuals domiciled in other DHBs (e.g. Hutt Valley) if they are enrolled with our PHOs.

The lower levels of Māori enrolment are of concern for people enrolled in primary healthcare receive access to lower cost, more effective healthcare. In 2018/19, CCDHB will focus on enrolment of our Māori population working closely with our Māori providers, Māori community and the Māori Partnership Board.

4 INVESTMENT

4.1 DHB Investment

In 2017/18, CCDHB will spend $60.8 million (excluding GST) for services delivered under the three PHO Services Agreements. This expenditure includes:

- $56.4 million for services delivered to CCDHB domiciled patients;
- $4.4 million for services delivered to Hutt Valley DHB domiciled patients who are enrolled at Ropata Medical Centre. This practice is located in the Hutt Valley but funded under the single PHO Services Agreement with Cosine Primary Health Network. CCDHB receives inter district flow reimbursement from Hutt Valley DHB for this expenditure, as well as for other Hutt Valley residents who are registered with a CCDHB general practice.
## 4.2 The services we purchase

<table>
<thead>
<tr>
<th>Service</th>
<th>Definition / Deliverable</th>
<th>Funding 2017/18</th>
</tr>
</thead>
</table>
| **First Contact Services**    | Face to face or technology-enabled consultations to support people and families to *improve, maintain, and restore* their health through:  
  - ongoing health and development assessment and advice  
  - health promotion and education  
  - sexual health services  
  - immunisations  
  - evidence-based screening and risk assessment.                                                                                                                   | $44.8 million   |
| **Access for High Needs Persons** | Activities to reduce barriers to access primary care services for High Need Persons.                                                                                                                                   | $4.3 million    |
| **Care Plus**                 | A coordinated program of intensive clinical management of a person’s health requirements in primary care.                                                                                                             | $4.6 million    |
| **Health Promotion**          | Activities planned with consumers, other providers, and regional public health units which are consistent with population health objectives and public health programmes at national, regional and local levels.       | $0.8 million    |
| **VLCA Sustainability**       | Funding to assist the PHO to develop and implement a tailored sustainability support plan to make VLCA practices more sustainable financially and in workforce.                                                 | $0.2 million    |
| **Free Visits for Under 13s** | Funding for practices to charge zero fees for patients under 13 years of age.                                                                                                                                     | $2.9 million    |
| **Management Fee**            | PHO to provide any management services and carry out any management tasks necessary to provide the Services in accordance with the Agreement.                                                                      | $2.4 million    |
| **PHO Performance Payment**   | Payment for achievement of the two primary care health targets **Better Help for Smokers to Quit** and **Increase Immunisation at 8 months** and participation in System Level Measures improvement initiatives. | $1.7 million    |
| **General Medical Services**  | Claims for First Level Services provided to a casual patient who does not wish to enrol with the PHO and fulfils one or more of the following:  
  - is a child or young person aged 17 years or under  
  - holds a Community Services Card  
  - holds a High Use Health Card.                                                                                                                                      | Fee for service |
| **Immunisation**              | Immunisations delivered to enrolled persons including:  
  - immunisations that are part of the National Immunisation Programme and are set out in the National Immunisation Schedule  
  - immunisations that are not on the National Immunisation Schedule special risk groups                                                                                                           | Fee for service |
This service included 545,000 doctor visits and 329,000 nurse visits for our population. Most services are fully funded, although for most First Contact Services patients pay a co-payment (other than children aged under 13).

4.3 Patient co-payment

VLCA practices

Co-payments for VLCA practices are capped. The maximum fees charged are:

- $0 for children aged 0 to 12 years (free visits for under 13s)
- $12 for adolescents aged 13-17 years
- $18 for adults aged 18 years and over.

To change the amounts paid by patients enrolled at a VLCA practice the change must be agreed at a national level through the national negotiation process.

Other practices

At other practices there are a range of co-payments:

- highest co-payment is $69.90
- average co-payment is $46.01
- minimum co-payment is $0 (excluding Zero Fees for under 13s).

The CCDHB average and highest co-payments are higher than the national average. To change the co-payment amount charged to patients practices follow the local process outlined in the Agreement.

5 PHO SERVICES AGREEMENT 2018/19

Changes to the PHO Services Agreement are negotiated under the PHO Services Agreement Amendment Protocol (PSAAP). The PSAAP group comprises representatives from PHOs, DHBs, the Ministry of Health, and may include PHO Contracted Provider representatives.

Negotiations for changes to the Agreement for 2018/19 are currently in progress and include the initial tranche of NZ Government initiatives to reduce patient co-payments nationally.

6 GOVERNMENT INITIATIVES TO REDUCE PATIENT FEES

The New Zealand Government has four proposed initiatives to improve access to primary health care:

- Extending Zero fees for children under 13 years to children under 14
- Lowering the VLCA co-payment cap by $10 to a maximum co-payment of $8 for adults and $2 for teenagers 14-17 years of age
- Extending VLCA level co-payments to Community Service Card Holders enrolled in VLCA practices
• Increasing Government funding for all practices that lower their co-payments by $10, lowering the average non-VLCA co-payment from $42 to $32 and the maximum co-payment from $69 to $59.

The impact of these potential changes for the population of CCDHB include 65,500 people paying a lower co-payment to see their general practitioner. Specifically:

• 3,500 13 year olds, increasing the coverage of the zero fees programme to a total of 51,000 children under 14 years
• 40,000 people enrolled in VLCA practices
• 22,000 people with Community Services Cards not enrolled in a VLCA practice.

Within CCDHB we have further supported the Health Care Home model to improve access to primary care at a local level.

There will be additional pressure on primary care as a result of reduced co-pays to increase access, as there will be increased utilisation as cost becomes less of a barrier. This is an opportunity to further improve access to primary healthcare as a consequence of this change. We will work closely with our PHOs to ensure the benefits of reduced co-payments makes the maximum contribution to health outcomes. This will require a greater focus on those who experience inequalities focusing on simplifying care for those who have resources and intensifying care for those who experience inequalities, particularly our Māori population who have low levels of enrolment.

7 PHO SERVICES PERFORMANCE DASHBOARD

A draft PHO Services Dashboard has been developed to assist CCDHB to improve our oversight and leadership of services delivered by PHOs under the PHO Services Agreement (Appendix 2).

The proposed indicators for 2018/19 include:

<table>
<thead>
<tr>
<th>Structural measures</th>
<th>What is required to deliver the services?</th>
</tr>
</thead>
<tbody>
<tr>
<td>System level performance</td>
<td>How do we know we are delivering quality services?</td>
</tr>
<tr>
<td>Impact measures</td>
<td>What is the expected change or experience?</td>
</tr>
</tbody>
</table>
7.1 Structural Measures

For the services we provide we monitor the level of activity and engagement in the services provided. The activity measures chosen reflect the need for people to be enrolled in a PHO, engage with the practice, and attend appointments with a doctor and/or nurse.

The dashboard also includes the total expenditure against the PHO Services Agreement across financial years to show the increase in cost as the DHB population increases. The current year expenditure is presented as the total financial year forecast based on year-to-date.

7.2 System Level Performance

Understanding our evidence markers enables CCDHB to ensure that services are meeting system performance requirements. The DHB currently reports on PHO contribution to system performance through the quarterly reporting to the Ministry of Health and subsequent summary presented to the CCDHB Board. It is proposed that the dashboard provides a further level of detail for this performance, focused on equity, for services purchased through the PHO Services Agreement. Multiple other providers contribute to the System Integration measures of Breast Screening and Cervical Screening coverage (e.g. Breast Screen Aotearoa, National Cervical Screening Programme and New Zealand Family Planning).

7.3 Impact Measures

Primary care services are provided to people across all ages, ethnicities, and localities within CCDHB as part of a complex system. Impact measures include the impact on the person and impact on the system. To measure the impact on the person we will use the CCDHB data from the Health Quality & Safety Commission of New Zealand National Patient Experience Survey. Data is presented as a score out of 10 (10 being excellent) and we have included the four survey domains of: coordination, partnership, communication, and physical & emotional needs.

The system impact reporting measures chosen reflect areas where effective primary care plays a key role in system change. Three measures have been included and all are presented as age-standardised rates to reduce the effect of different population age-structures within ethnicity groups. The measures are presented as annual figures and defined as:

- **ED presentations** – rate of PHO enrolled people presenting to Wellington Hospital Emergency Department
- **ASH rate** – rate of PHO enrolled people admitted as an inpatient for ambulatory sensitive hospitalisations
- **Acute Medical Admission rate** – rate of PHO enrolled people admitted to Wellington Hospital under medical purchase unit codes.

7.4 Summary of Indicators

<table>
<thead>
<tr>
<th>Structural Measures</th>
<th>Activity</th>
<th>Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial</td>
<td>Annual Expenditure on PHO Services Agreement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percentage of population enrolled</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Count of enrolled population</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of doctor’s visits</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of nurse’s visits</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percentage of the PHO Enrolled Population who visited a practice in the last year</td>
<td></td>
</tr>
</tbody>
</table>
7.5 Development of Future Indicators

The DHB is working with providers to improve our understanding of how people use our primary and community services and the impacts of these services. One of the mechanisms for this is the inclusion of a new data clause in Primary and Community provider contracts. The first dataset will be received in October 2018 with subsequent analysis expected in 2019. As our understanding matures, additional impact measures will be developed and added to the dashboard to increase the scope of the system overview provided.

Ultimately the dashboard will be structured to include Inputs → Outputs → Outcomes → Impacts for a given measure. The focus on outcomes is an important part of this development. This will include recording the number of non-smokers, not just those who have been offered assistance to assess the outcome for our communities. A further example is cervical screening where recent research has highlighted significant inequalities in outcomes remain for Maori and Pacific women although cervical screening rates continue to increase.

For example, for cervical screening the flow would be:

Funding → General Practice visit and cervical sample taken → Early detection of cervical abnormality → Rates of cervical cancer

7.6 Presenting the Dashboard to HSC Quarterly

The dashboard will be updated quarterly in August, November, February, and May and presented to HSC with a short narrative report describing:

1) outcomes of improvement initiatives for the previous quarter
2) performance issues for the current quarter
3) action plan of improvement initiatives for the coming quarter.

<table>
<thead>
<tr>
<th>System Level Performance</th>
<th>Health Targets</th>
<th>Policy Priorities</th>
<th>System Integration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Better Help for Smokers to Quit</td>
<td>More Heart and Diabetes Checks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increased Immunisation</td>
<td>Immunisation coverage at 24 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Immunisation coverage at 5 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improving Cervical Screening Coverage</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improving Breast Screening Coverage</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Impact Measures</th>
<th>System Impact</th>
<th>Person Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age-standardised ED Presentations</td>
<td>Patient Experience Survey</td>
</tr>
<tr>
<td></td>
<td>Age-standardised ASH rate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Age-standardised Acute Medical Admission rate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coordination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Partnership</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physical &amp; Emotional Needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Communication</td>
<td></td>
</tr>
</tbody>
</table>

| Health System Committee (also known as CPHAC-HAC) - 3.1 Investment In and Performance of CCDHB Primary Health Organisations (PHOS) | 77 |
The draft report is shown below for the draft dashboard in appendix 1 (hard copies will be provided at the meeting). This first draft report highlights inequalities in immunisations, diabetes and heart checks, breast and cervical screening with poor results for Pacific and very poor results for Maori. The dashboard also highlights poor system impacts with higher emergency department presentations, ambulatory sensitive hospitalisations and acute medical admissions. SIP will be able to use this dashboard, and future iterations to target and monitor performance improvements.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Target</th>
<th>Performance</th>
<th>Action Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased Immunisation</td>
<td>95% of infants aged eight months will have completed their primary course of immunisation (six weeks, three months, and five months immunisation events) on time.</td>
<td>95%</td>
<td>94.4%</td>
<td>Outreach immunisation service community health worker has a weekly time slot on radio in which they promote immunisations Rotavirus vaccination is being administered at the correct time point unless contraindicated, meaning fewer catch-ups.</td>
</tr>
<tr>
<td>Immunisation at 24 Months</td>
<td>At least 95% of two year olds are fully immunised and coverage is maintained</td>
<td>95%</td>
<td>93.2%</td>
<td>Practices are given weekly reports and monthly overdue list from the National Immunisation Register to follow up patients.</td>
</tr>
<tr>
<td>Immunisation at 5 Years</td>
<td>At least 95% of four year olds are fully immunised by age 5 years and coverage is maintained</td>
<td>95%</td>
<td>89.5%</td>
<td>Practices are given weekly reports and monthly overdue list from the National Immunisation Register to follow up patients.</td>
</tr>
<tr>
<td>More Heart and Diabetes Checks</td>
<td>90% of the eligible population will have had their cardiovascular risk assessed in the last five years.</td>
<td>90%</td>
<td>89.2%</td>
<td>PHOs are supplying practices with missing patient lists for easy identification of people eligible to receive risk assessments. In addition Saturday clinics are being run by a number of practices, particularly where the population is known to respond to appointment times outside of normal working hours.</td>
</tr>
<tr>
<td>Cervical Screening Coverage</td>
<td>80% of women aged 25 to 69 have had a cervical sample taken in the last three years.</td>
<td>80%</td>
<td>77.3%</td>
<td>Priority clinics are run from Kenepuru hospital organised by the Regional Screening Services PHOs are working with priority practices to incentivise patients to participate in screening</td>
</tr>
<tr>
<td>Breast Screening Coverage</td>
<td>70% of women aged 50 to 69 have had a screening mammogram in the last two years</td>
<td>70%</td>
<td>72.9%</td>
<td>Target has been achieved for the total population but not for Māori (66.9%) or Pacific (69.5%) women. The DHB will work with the regional screening provider Breast Screen Aoteaora and PHOs on generation of missing patient lists.</td>
</tr>
</tbody>
</table>
Health System Committee (also known as CPHAC-HAC) - 3.1 Investment In and Performance of CCDHB Primary Health Organisations (PHOS)
**RECOMMENDATION**

It is recommended that the Committee:

- **a)** **Notes** that this is the first community services provider performance report for the Health System Committee (HSC);
- **b)** **Notes** that in 2017/18 CCDHB will invest $62.4 million in local providers under the nationally negotiated Aged Residential Care Agreements for services that include rest home, continuing care, dementia and psychogeriatric services;
- **c)** **Notes** that in 2017/18 CCDHB will invest $2.1 million in local providers under the nationally negotiated Combined Dental Agreements for services that include oral health services and special dental services for under 18 year olds (predominantly secondary school students);
- **d)** **Notes** that in 2017/18 CCDHB will invest $82.6 million in local providers under the nationally negotiated Community Pharmacy Services Agreements for services that include dispensing and other services provided by community pharmacies and the costs of the pharmaceuticals dispensed;
- **e)** **Notes** the Older Person Service Performance dashboard has been presented to HSC for the first time at this meeting for feedback;
- **f)** **Endorses** the Healthy Ageing Strategy Working group reviewing the older person’s dashboard including the use or interRAI data and acute admissions information to better understand the impact of the investment made by CCDHB;
- **g)** **Endorses** the SIP team working with the DHB Pacific and Maori teams to develop an approach to reducing inequities in accessing community dental services (for secondary school students) and improving outcomes for these communities;
- **h)** **Endorses** the SIP team working with the DHB Pacific and Maori teams, PHOs, community pharmacies and other providers to develop an approach to reducing inequities in pharmaceutical use, which will be linked to the improvement in equity in the use of primary care services (agenda item 3.1).

**APPENDIXES (note hard copies of these will be provided at the meeting)**

1. Older Persons Performance Dashboard
2. Community Dental Claims Dashboard

---

**From**
Rachel Haggerty, Director – Strategy, Innovation & Performance

**Author**
Russell Cooke, Senior System Development Manager  
Jan Marment, Senior System Manager  
Lauren Webster, System Development Manager, Child and Youth  
Sandra Williams, General Manager Primary and Complex Care

**Endorsed by**
Dr Ashley Bloomfield, Interim Chief Executive

**Subject**
Investment and Performance - Aged Residential Care, Community Dental Agreement, Community Pharmacy Service Agreement
1 PURPOSE

The purpose of this paper is to update the Health System Committee (HSC) on the performance of services provided for the CCDHB population under three nationally negotiated agreements: Community Pharmacy Service agreement (CPSA); Community Dental Service agreement (CDA); and Aged Residential Care agreement (ARC).

SIP is developing performance dashboards for monitoring of service investments. This paper includes the first cut on a proposed older person’s performance dashboard.

2 OLDER PERSONS SERVICES PERFORMANCE

In this section we discuss the Older Persons Performance Dashboard and ARC. Monitoring quality in these services to support this potentially vulnerable population is important.

2.1 Older Persons Performance Dashboard

At the February 2018 Board meeting, a paper was presented on the performance dashboard for the Older Person Services, community including aged residential care (ARC), home based support services (HBSS) and Needs Assessment & Coordination (NASC).

Attached as appendix one is a first version of the performance dashboard for these services. Some areas in the Dashboard are not yet populated, including the use of InterRAI to measure individual impact, staffing level assessment and consumer satisfaction scores for ARC.

2.2 Interpretation of the Performance Dashboard

<table>
<thead>
<tr>
<th>Indicators Commentary Table</th>
<th>Target</th>
<th>Performance</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structural Measures: Activity. We have good activity data and we are improving our demographic data.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NASC assessments completed.</td>
<td>95%</td>
<td>98%</td>
<td>People entering residential care should have an interRAI assessment within 6 months and CCDHB consistently exceeds this measure.</td>
</tr>
<tr>
<td>Residential care funding by levels of care.</td>
<td>Within budget</td>
<td>Is within budget</td>
<td>Entry to ARC is tracking under budget. Entry to ARC has increased over the last 3 months. A cohort review of new entries to ARC to look at their journey to inform the Healthy Aging Investment Plan.</td>
</tr>
<tr>
<td>InterRai review</td>
<td>95%</td>
<td>85%</td>
<td>Once a person enters residential care it is expected that they have a review every 6 months. This measure is impacted on by the number of registered nurses who are InterRAI trained in the facility. The % reviewed continues to increase as more nurses are trained.</td>
</tr>
<tr>
<td>HCSS services in our community by person average in last 6 months</td>
<td>Average for same period in 2016/17 was 2,355 clients.</td>
<td>Average over 6 months to Feb 18 was 2,400 clients</td>
<td>The number of clients and hours of support delivered is stable. No age-standardised target has yet been set.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>And by hour</td>
<td>Average hours in same period in 2016/17 was 34,138.</td>
<td>Average hours in last 6 months was 33,053.</td>
<td></td>
</tr>
</tbody>
</table>

**Structural measures: Competence and Compliance**

We monitor competence and compliance through the audit process.

<table>
<thead>
<tr>
<th>Audits completed and number of years certified</th>
<th>23 ARC audits. 16 have 4 year certification, 15 have 3 year certification, 1 has 2 year certification</th>
<th>There is one facility with a 2 year certification. This is after a recent change in management. Access home support had a surveillance audit in January 2018. The audit was against a sub-set of the Home and Community Support Standard and contracts with the DHBs, ACC and Ministry of Health. The process included a review of policies and procedures, clients and staff files and interviews with clients, staff and management.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective actions required and time to completion</td>
<td>ARC 59</td>
<td>ARC 58</td>
</tr>
<tr>
<td>Explore staffing level of assessment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**System Level Performance: Evidence & Quality Markers**

Understanding our evidence markers enables us to ensure services are meeting system performance requirements and are complemented by quality measures.

<table>
<thead>
<tr>
<th>Status of contract KPIs</th>
<th>See February paper</th>
<th>See February paper</th>
<th>Information next available in August 2018. Reporting on the KPIs will be included in the dashboard at that time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responses to Clinical Assessment Protocols (using interRAI) The intervention plans in place when an assessment shows need.</td>
<td></td>
<td></td>
<td>This is a significant opportunity for improvement. This measure has improved for falls but is well below the target for nutrition and physical activity. Access Community Health are working to improve this measure through: additional training for their nurses, requiring team leaders to monitor intervention plans and to report this measure to the DHB weekly.</td>
</tr>
<tr>
<td></td>
<td>90%</td>
<td>Falls 72% Nutrition 44% Physical activity 40%</td>
<td></td>
</tr>
<tr>
<td>Complaints and resolutions</td>
<td>29</td>
<td>21</td>
<td>Of the 8, 5 have been closed in April.</td>
</tr>
<tr>
<td>Consumer satisfaction scores</td>
<td>Not known.</td>
<td>Not known.</td>
<td>To be developed for ARC.</td>
</tr>
</tbody>
</table>
Impact Measures
These include the impact on the system and the impact for the individual

<table>
<thead>
<tr>
<th>Acute Admission Rate of people over 75yrs</th>
<th>293.9 per 1000 in 15/16 total pop</th>
<th>297.5 per 1000 16/17 total pop</th>
<th>Reported as stable. Admission rates for over 75s indicate they are receiving appropriate and timely care in the community. Overall CCDHB has lower admission rates than the NZ average.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute bed days of people over 75 years</td>
<td>23,736 for 2015/16</td>
<td>26,157 for 2016/17</td>
<td>Reported as stable. Added to the measure above we can infer whether the health system is supporting people in the community.</td>
</tr>
<tr>
<td>Admissions to ED from ARC/HCSS</td>
<td>1,127 admissions in 2015/16</td>
<td>1,193 admission in 2016/17</td>
<td>There is commitment by ARC managers and regional managers to reduce inappropriate admissions. SIP monitors and identifies outliers addressing specific issues. Specialist consultations and support to aged care facilities include Nurse Practitioners, Wound Specialists, and Palliative Care.</td>
</tr>
<tr>
<td>Use of interRAI to measure individual impact:</td>
<td>Central Region</td>
<td>CCDHB</td>
<td>Attached as Appendix 1 is the individual infographic from the InterRAI data for CCDHB and the Central Region (for comparison). It shows the increasing complexity and fragility of people being supported at home with 50% at CCDHB assessed as at risk of moving into residential care within 12 months. For comparison in HVDHB the % is 53%, 54% in Wairarapa and 55% for the Central Region. The % reporting living with excruciating pain each day in CCDHB is higher than the central region, HVDHB and Wairarapa DHB.</td>
</tr>
<tr>
<td>Feeling lonely</td>
<td>21%</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>Carers Distressed</td>
<td>23%</td>
<td>23%</td>
<td></td>
</tr>
<tr>
<td>Live in excruciating pain</td>
<td>12%</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>Recurring urinary continence</td>
<td>40%</td>
<td>37%</td>
<td></td>
</tr>
<tr>
<td>Daily cognitive difficulties</td>
<td>23%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Have no enduring power of attorney</td>
<td>32%</td>
<td>27%</td>
<td></td>
</tr>
<tr>
<td>No Advanced Care Plan</td>
<td>90%</td>
<td>95%</td>
<td></td>
</tr>
</tbody>
</table>

The above analysis highlights a number of opportunities for CCDHB (and all DHBs) to understand and use interRAI data to improve performance and manage quality of our older person’s services, and to further understand the utilisation of hospital services by older people and those in residential care and its relationship to current models of care.

A CCDHB healthy aging strategy working group has been established to develop our whole of system approach and investment plan for older people. This group will review this performance information and investigating more deeply the challenges and opportunities.

2.3 Aged Residential Care Services

Aged residential care services are provided at different levels of care:

- Rest Home - people can do some daily tasks themselves but cannot manage safely at home. (e.g. need help during the night)
- Continuing Care – as above and requires a higher level of resource. (e.g. immobile and requires specialist equipment & registered nurse oversight and clinical input)
- Dementia – requires a secure environment (e.g. person wanders and becomes lost)
• Specialised Hospital Services (Psychogeriatric) – requires a high level of staffing resources for people with a very high level of dementia or challenging behaviour within a secure environment.

Entry into long term residential care is based on peoples’ long term support needs. For a person to receive DHB subsidised care, they must meet income and asset limits as assessed by Work and Income. People may be assessed as eligible to be admitted into aged residential care but choose to remain at home.

The average age of admission to residential care has increased from 82 to 84 years since 2011. This reflects in part good availability of home-based support services that allow people to remain in their own homes longer. Most of the time services work very well for the people being cared for but sometimes people don’t get the care they need, in terms of both timing and intensity. There are three strategies in place to work closely with our ARC providers and ensure quality and safety of our services.

2.3.1 Quality and other performance indicators

We monitor closely any complaints and our audit results to make sure that we resolve situations where people aren’t getting the care we expect. Complaints are followed up with the complainant and the provider until we are happy they are resolved. We make sure that the actions resulting from audits are do within the timeframes suggested under the audits.

We share information with managers of ARC facilities at quarterly provider meetings, which allows the facilities to compare themselves in key quality areas and investigate reasons if they are outliers. Most facilities who are outliers in presentation rates to ED and for hospital admission have investigated the likely reasons and taken action to improve the experience for their residents. The dashboard includes a graph on admissions to hospital and ED from ARC.

2.3.2 Complaints

Complaints are received by the DHB from multiple sources including SQUARE, the Ministry of Health and directly to SIP. Complaints are logged and follow the CCDHB complaints process. There have been six complaints to the DHB and one known complaint to the HDC (calendar year to 11 April 2018). We have three complaints open currently. The DHB received several complaints regarding the heat in one facility during the summer months.

2.3.3 Residential Care Audits

These audits are comprehensive and compliance (or not) is a strong indicator of performance. Aged Residential Care Facilities are audited by Designated Auditing Authorities that are internationally certified. They are audited against the Health & Disability Sector Standards and the Aged Residential Care contract. The audit process is overseen by the Ministry of Health’s HealthCERT and any corrective actions required are overseen by CCDHB.

The maximum number of years a facility can be certified is four years. A four-year certification requires few or no corrective actions (usually over two certification periods) and continuous improvements that show the facility has achieved beyond the required standard. The proportion of facilities with four-year certification is increasing as is relatively high in the CCDHB area compared with other DHBs.

A three or four year certification means that the facility is meeting the Health and Disability Sector Standards and requires few if any actions to improve. The DHB expects all their facilities to achieve this standard. SIP works with any facility on corrective actions to ensure that the facility will meet the standards.
Audits completed and the number of years certified, corrective actions, complaints and resolutions, and a range of other indicators measuring ARC performance as part of the older person system are included in the Dashboard.

3 COMMUNITY DENTAL

CCDHB holds a Combined Dental Agreement (CDA) with 44 private dental clinics in its district to enable free access to oral health care for children and (predominantly) young people up to their 18th birthday. This ensures a strong start in oral health and hygiene through early intervention and preventative care, and promotion of positive oral health habits through chair-side education. The agreement design allows for intensification of services for those in greater need and eliminates a key barrier to care for young people in low-income households.

Adolescent oral health utilisation for school-aged youth has been identified by the Ministry of Health as a contributory measure for the Youth System Level measure and is a Ministry Policy Priority (PP12). The target utilisation rate for all DHBs is 85% of adolescents.

The Oral Health Group (OHG) has been in existence since 2004 and is made up of DHB regional and clinical representatives who provide national oversight of the Combined Dental Agreement (CDA). The purpose of the OHG is to provide recommendations to National General Managers of Planning and Funding on changes to the CDA and its associated guidelines and receive, comment on and provide policy advice to the sector.

The OHG maintains a relationship with the New Zealand Dental Association (that represent over 2,500 dentists) and utilizes information, such as from its fees survey, to support discussion and decision-making.

3.1 Service Description

All year eight students have their dental care transferred from the regional dental service (Bee Healthy) to one of the CDA providers (families may choose to opt-out and go to non-CDA provider at their own expense).

The CDA provides a capitated package of services for enrolled adolescents that includes an annual examination, chair-side education on good oral health care and, where required:

- Additional consultations, including examination and diagnosis, prophylaxis, advice on dental care and any special tests and bitewing radiographs considered necessary
- Preventative treatments
- Fissure sealants and fillings to restore teeth that have been affected by tooth decay
- Cleaning to plaque, staining and tartar from teeth
- Extractions to remove teeth that have been badly affected by tooth decay.

Under the CDA, dentists agree to provide oral health services for adolescents (OHSA) only, Special dental services for children and adolescents (SDSA) only, or both service sets. Some treatments require approval from the regional Approving Dental Officer (ADO).

OHSA includes preventive care, chair-side education and some treatments for oral disease and the restoration of tooth tissue. These make up the bulk (92%) of services provided under the CDA.

SDSA include those which support school dental services and include some treatments for oral disease, the restoration of tooth tissue, extractions and other treatments that are beyond the scope of a dental therapist, and some treatment for children and adolescents who cannot access their regular oral health provider. SDSA claims make up 7% of CDA services provided.
3.2 Investment

The price schedule for CDA services is set nationally with the core packages purchased at $111.38 – $150.60 per person according to school decile (with higher payments for those from higher deprivation schools). Our investment on CDA services in 2017/18 is forecast to be $2.146 million.

3.3 The people receiving services

Services are provided to young people from Year 9 at school until the day before their 18th birthday as well as children Year 8 and under who have been referred or officially released early from the school dental service as not being able to be treated by them due to medical or management reasons. Additional efforts are made by a regional adolescent health coordinator to connect with young people who are at Alternative Education Centres or not in school.

Ministry population estimates calculate that there are 16,580 young people eligible for CDA services in our district of whom 17% are Maori, 10% Pacific and 73% ‘Other’.

3.4 Performance Monitoring

CCDHB has not yet developed a performance dashboard for community dental services. Attached as appendix two is the CDA claims dashboard published by the Ministry of Health. There is currently work underway by the CDA Data Analytics Steering Group – a subgroup of the National Oral Health Group – to improve the quality and utility of the CDA claims data.

Below we present further information on analysis of service coverage, to assess service access and the dental activity for this population. This initial information shows that Maori and Asian youth populations have the greatest gap in access followed by the Pacific and Other population and suggests significant inequalities in service access.

3.4.1 Coverage

CCDHB currently has a 77% total coverage rate for young people receiving CDA services. Coverage has been trending upwards towards the Ministry of Health’s PP12 annual target of 85% over the last decade. CCDHB is considered by the Ministry to be ‘partially achieving’ the target as the ‘Other’ ethnicity population exceeds 85% coverage. However, as shown on CDA dashboard, coverage is not equitable with particularly low coverage (55%) of Rangatahi Māori.
3.4.2 Service activity

In the 2017 year, 31,293 service episodes were provided to 12,834 young people (2.4 treatments per young person) under the CDA. The top 10 most commonly claimed services are highlighted in the table below and these account for 87.8% of all services claimed.

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Treatment Description</th>
<th>Number Provided in 2017</th>
<th>As a proportion of services provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion - Decile 7-10</td>
<td>Package of care for adolescents who attends a decile 7-10 school (least deprived). All treatment required (if anything) has been completed.</td>
<td>10,655</td>
<td>34%</td>
</tr>
<tr>
<td>Other preventive treatment</td>
<td>E.g. Scale and polish of teeth.</td>
<td>62,56</td>
<td>20%</td>
</tr>
<tr>
<td>Completion - Decile 4-6</td>
<td>Package of care for adolescents who attends a decile 4-6. All treatment required (if anything) has been completed.</td>
<td>1,908</td>
<td>6%</td>
</tr>
<tr>
<td>Fissure Sealant</td>
<td></td>
<td>1,631</td>
<td>5%</td>
</tr>
<tr>
<td>Two surface (approximo-occlusal) restorations in posterior teeth</td>
<td>This is a posterior filling which involves two surfaces. Commonly it will involve the interproximal tooth structure and is usually diagnosed from bitewing x-rays.</td>
<td>1,575</td>
<td>5%</td>
</tr>
<tr>
<td>Bitewing Radiograph</td>
<td>The most common x-ray taken to diagnose caries.</td>
<td>1,351</td>
<td>4%</td>
</tr>
<tr>
<td>Topical fluoride application</td>
<td>Decay prevention</td>
<td>1,102</td>
<td>4%</td>
</tr>
<tr>
<td>One surface restoration posterior teeth</td>
<td>This is a smaller filling than the 2 surface. The first 3 are expected to be completed as part of the CON1. If more than that then they can apply for high caries treatment planning.</td>
<td>1,084</td>
<td>3%</td>
</tr>
</tbody>
</table>
4 COMMUNITY PHARMACY AGREEMENT

CCDHB forecasts investing $82.6 million in 2018/18 in agreements for community pharmacy services with 60 pharmacies in our district. The agreements cover dispensing and other services provided by community pharmacies and the costs of the pharmaceuticals dispensed. This section of the paper outlines both areas of investment and includes some specialist hospital pharmaceuticals provided by community pharmacies.

<table>
<thead>
<tr>
<th>Pharmacy Funding</th>
<th>Actual 2014_15</th>
<th>Actual 2015_16</th>
<th>Actual 2016_17</th>
<th>Forecast 2017_18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Pharmacy Services</td>
<td>$41,090,023</td>
<td>$44,394,324</td>
<td>$45,692,388</td>
<td>$47,885,682</td>
</tr>
<tr>
<td>Casemix Service Fee</td>
<td>$10,862,443</td>
<td>$12,204,297</td>
<td>$12,903,837</td>
<td>$13,037,586</td>
</tr>
<tr>
<td>LTC Pharmacy Services</td>
<td>$10,648,058</td>
<td>$11,281,528</td>
<td>$11,113,308</td>
<td>$11,693,444</td>
</tr>
<tr>
<td>Glivec &amp; MS Treatments</td>
<td>$2,370,647</td>
<td>$2,198,928</td>
<td>$1,982,300</td>
<td>$1,651,661</td>
</tr>
<tr>
<td>Class B Controlled Drugs</td>
<td>$2,141,088</td>
<td>$2,290,981</td>
<td>$2,413,821</td>
<td>$2,487,455</td>
</tr>
<tr>
<td>Aged Residential Care Pharmacy Services</td>
<td>$2,078,006</td>
<td>$2,122,122</td>
<td>$2,380,301</td>
<td>$2,419,395</td>
</tr>
<tr>
<td>Special Foods Services</td>
<td>$1,183,790</td>
<td>$1,345,688</td>
<td>$1,490,414</td>
<td>$1,770,547</td>
</tr>
<tr>
<td>Pharmacy Clozapine Services</td>
<td>$305,535</td>
<td>$195,927</td>
<td>$195,167</td>
<td>$195,554</td>
</tr>
<tr>
<td>After Hours Over 13s</td>
<td></td>
<td></td>
<td>$13,333</td>
<td>$22,222</td>
</tr>
<tr>
<td>Free After Hours &lt;13s</td>
<td></td>
<td></td>
<td>$35,034</td>
<td>$21,198</td>
</tr>
<tr>
<td>Other</td>
<td>$1,893,256</td>
<td>$1,371,383</td>
<td>$1,388,315</td>
<td>$1,389,752</td>
</tr>
<tr>
<td>Total</td>
<td>$72,572,846</td>
<td>$77,405,179</td>
<td>$79,558,218</td>
<td>$82,574,496</td>
</tr>
</tbody>
</table>

4.1 Pharmacy Service Description

CCDHB funds pharmacies for the dispensing of medicines, the associated advice related to the dispensing, and specific fees for a mixture of other services. The estimated expenditure for these services for the 2017/18 year is $23.9 million.

These services are outlined in the table below.
4.2 National Community Pharmacy Agreement Process

In 2012 a revised contract was negotiated between the community pharmacy agents (Pharmacy Guild, Green Cross etc) and the DHBs (CPSA). The contract was rolled over for the 12 months from July 2017 until June 2018. This year a new contract structure has been proposed. The DHBs have been consulting with Pharmacists, Pharmacies and other affected parties on the final content of IPSCA. The consultation finished on the 10th April and we are waiting on further advice as a result of the outcome of the consultation. The final contract is expected to be available for offer to Community Pharmacies in May with a starting date of 1 July 2018.

4.3 Service Providers

The size of the 60 pharmacies varies significantly. The payments from the DHB vary from $80k for the smallest pharmacy to $1.13 million per year for the largest.

Community Pharmacies are spread throughout the DHB with 43 within the Wellington TLA (1 per 4877 people), 8 in the Kāpiti TLA (1 per 5505 people) and 9 in Porirua TLA (1 per 6226 people). Within the Wellington TLA there is a high concentration of pharmacies within the central business district (n=13) and in the vicinity of the hospital (n=5). In terms of the service fees paid to community pharmacies per capita, CCDHB pays the second to lowest ($71.63) after Auckland DHB ($70.38).

4.4 The population receiving services

In 2016/17 267,272 individuals were dispensed 3.8 million items by community pharmacies. Most of the items are dispensed to people over the age of 50 years, which is in line with the population make up for CCDHB.
Our Maori and Pacific people are likely to be younger than ‘other’ (i.e. non-Maori, non-Pacific) and would appear in the dispensing figures at an earlier age than our ‘other’ population. For all CCDHB the average number of item was 14.2 in 2016/17. Maori and Pacific receive lower numbers of items per patient than ‘other’ even though there is generally a higher burden of disease for these population groups (13.5 and 13.3 respectively).

This is consistent with the findings of PHARMAC that Maori are less likely to access dispensed medicine than non-Māori and Māori access to medicines remains lower despite their health need being higher – leading to greater inequities in health. This was seen in chronic conditions like diabetes, heart disease and respiratory conditions such as asthma and COPD.

The graph below compares the medication spent per head of population for the whole of CCDHB and is uncorrected for age structure and burden of disease. Initial analysis of the relevant cost per ethnic group within different geographical areas in CCDHB strongly highlights some areas of ethnic differentiation. For example in the Kāpiti area in 2017 the expenditure per capita was $144.06 for Maori, $147.64 for Pacific Islanders and $345.13 for the “other” ethnic group. While this is likely to be due to the high numbers of older people within Kāpiti, further work is required to understand this better. In the next update we will present further information to understand more about the people using community pharmacies.

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1 https://www.pharmac.govt.nz/tools-resources/research/maori-uptake-of-medicines/
The equity issues are evident at the dispensing level as well as at the level of medicines expenditure. SIP team will work with the wider sector to develop approaches to improving equity in the use of pharmaceuticals.

4.5 Performance Monitoring

We monitor the level of activity and the competence and compliance of the services delivered for the population served through the audit process. We have good activity data and are improving our demographic data. We have some quality indicators as outlined below in terms of audit and want to do more to understand system level performance. In our next report we will be able to report further on the indicators that show system level performance and measure impact for people.

4.5.1 Quality

The Community Pharmacy Agreement does not have specific quality indicators outside of the ‘licence to operate’ and routine audits. The audits are comprehensive and compliance (or not) is a strong indicator of performance.

4.5.2 Licence to Operate

Before a contract is issued to a pharmacy a licence to operate is required under the Medicines Act 1981. The license authorises the establishment of a pharmacy at a specified site and to carry out pharmacy practice at that site. An initial pharmacy licensing audit of the premises is conducted prior to the Licensing Authority (Medicines Control) granting the licence.

4.5.3 Audits

The Ministry of Health Audit and Compliance Team audits pharmacies on behalf of the DHBs. The audit considers the compliance with legislative requirements and quality requirements in the Pharmacy Service agreement. There have been nine routine audits of CCDHB in the last 12 months and a modest $20k of recoveries in that period. The reports of these audits indicate the number of critical, high, moderate and low risk non-compliances and documents if any action is required by the DHB.
4.6 Pharmaceuticals

PHARMAC is responsible for managing the supply and cost of medicines. DHBs agree the national pharmaceutical budget with PHARMAC each year. As a major area of expenditure for the DHB, we have a strong interest in understanding the utilisation of medications including growth, geographic and equity based perspectives. We expect to invest $58.7 million in medications in 2017/18 (in the community). CCDHB has one of the lower levels of expenditure per head of population ($215) among DHBs and ranks 5th lowest nationally. Auckland is the lowest at $120 per capita and Nelson-Marlborough ranks the highest at $254 per capita.

CCDHB is starting to work more closely with our community pharmacists and primary care on prescribing and utilisation of pharmaceuticals. For your information we have included analysis of the top ten most expensive medicines and the most commonly prescribed.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Use</th>
<th>14/15</th>
<th>15/16</th>
<th>16/17</th>
<th>% change year 1</th>
<th>% change year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adalimumab</td>
<td>Rheumatoid Arthritis</td>
<td>$6,905,697</td>
<td>$7,179,559</td>
<td>$7,325,030</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>Fluticasone + salmeterol</td>
<td>Asthma medication</td>
<td>$2,193,875</td>
<td>$2,318,671</td>
<td>$2,133,680</td>
<td>6%</td>
<td>-8%</td>
</tr>
<tr>
<td>Dabigatran</td>
<td>Antithrombotic Agents</td>
<td>$2,102,889</td>
<td>$2,720,402</td>
<td>$2,094,674</td>
<td>29%</td>
<td>-23%</td>
</tr>
<tr>
<td>Etanercept</td>
<td>Immunosuppressants</td>
<td>$2,267,724</td>
<td>$2,123,322</td>
<td>$2,065,522</td>
<td>-6%</td>
<td>-3%</td>
</tr>
<tr>
<td>Insulin glargine</td>
<td>Diabetes</td>
<td>$1,078,118</td>
<td>$1,288,447</td>
<td>$1,429,202</td>
<td>20%</td>
<td>11%</td>
</tr>
<tr>
<td>Octreotide LAR</td>
<td>Endocrine Therapy</td>
<td>1,241,508</td>
<td>1,339,438</td>
<td>1,400,956</td>
<td>8%</td>
<td>5%</td>
</tr>
<tr>
<td>Truvada</td>
<td>HIV medication</td>
<td>904,345</td>
<td>1,138,385</td>
<td>1,304,763</td>
<td>26%</td>
<td>15%</td>
</tr>
<tr>
<td>Atripla</td>
<td>HIV medication</td>
<td>1,391,382</td>
<td>1,453,923</td>
<td>1,269,017</td>
<td>4%</td>
<td>-13%</td>
</tr>
<tr>
<td>Budesonide with eformoterol</td>
<td>Asthma medication</td>
<td>1,376,972</td>
<td>1,347,926</td>
<td>1,261,909</td>
<td>-2%</td>
<td>-6%</td>
</tr>
<tr>
<td>Raltegravir</td>
<td>HIV medication</td>
<td>534,834</td>
<td>918,956</td>
<td>1,017,631</td>
<td>72%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Many of these are relatively new, expensive drugs that are generally used by a small number of patients. Adalimumab (marketed as Humira) is a monoclonal antibody drug that inhibits inflammation in joints. Recent information suggests that more money is spent on this drug globally than any other drug. Biological monoclonal medications are expensive and a similar drug such as infliximab is the highest cost non-cancer drug in the hospital sector. The other group of drugs strongly represented here are the anti-retrovirals used in the treatment of HIV. These

2 www.pharmac.govt.nz/about/your-guide-to-pharmac/factsheet-01-introduction-to-pharmac/
drugs are used to treat a limited number of patients but can have a huge impact on their quality and quantity of life.

The table below shows the most commonly used medications, which are quite different to the expensive medications above. They are used by much larger groups within the community. While paracetamol is by far the most commonly dispensed, it only costs 15% of the least expensive of the drugs in the table above. The conditions these pharmaceuticals are used for are the more common ailments within the community; pain management, high blood pressure, gastrointestinal issues, infections and asthma.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Use</th>
<th>14/15</th>
<th>15/16</th>
<th>16/17</th>
<th>% change year 1</th>
<th>% change year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paracetamol</td>
<td>Pain relief</td>
<td>147,636</td>
<td>157,131</td>
<td>160,426</td>
<td>6%</td>
<td>2%</td>
</tr>
<tr>
<td>Metoprolol succinate</td>
<td>Blood pressure control</td>
<td>66,757</td>
<td>88,657</td>
<td>122,118</td>
<td>33%</td>
<td>38%</td>
</tr>
<tr>
<td>Methadone HCL</td>
<td>Opiate substitute</td>
<td>102,464</td>
<td>102,204</td>
<td>95,897</td>
<td>0%</td>
<td>-6%</td>
</tr>
<tr>
<td>Omeprazole</td>
<td>GI symptoms</td>
<td>88,972</td>
<td>90,563</td>
<td>92,618</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Salbutamol</td>
<td>Asthma</td>
<td>83,741</td>
<td>84,658</td>
<td>87,524</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>Aspirin</td>
<td>Pain relief</td>
<td>84,950</td>
<td>84,556</td>
<td>84,090</td>
<td>0%</td>
<td>-1%</td>
</tr>
<tr>
<td>Atorvastatin</td>
<td>Lipid lowering statin</td>
<td>97,152</td>
<td>77,731</td>
<td>81,251</td>
<td>-20%</td>
<td>5%</td>
</tr>
<tr>
<td>Amoxicillin</td>
<td>Antibiotic</td>
<td>73,668</td>
<td>80,211</td>
<td>73,287</td>
<td>9%</td>
<td>-9%</td>
</tr>
<tr>
<td>Ibuprofen</td>
<td>Pain relief</td>
<td>57,290</td>
<td>62,992</td>
<td>66,549</td>
<td>10%</td>
<td>6%</td>
</tr>
<tr>
<td>Zopiclone</td>
<td>Sleeping Pill</td>
<td>58,214</td>
<td>61,102</td>
<td>63,308</td>
<td>5%</td>
<td>4%</td>
</tr>
</tbody>
</table>

5 CONCLUSIONS

This report brings together an analysis of $147.1m of investment in our community health system. This reporting is part of our process of improving our understanding of how this investment is working for our population including equity (or not) of access to health services, ensuring these services are high quality and safe, and understanding how they improve health outcomes in our community.

The Health System Committee will receive regular dashboard reports that build the confidence of the Board and identify and monitor opportunities to improve the impact of our investment on our community’s health and wellbeing.
6 APPENDIX ONE: OLDER PERSONS PERFORMANCE DASHBOARD

Capital and Coast DHG: HOP Performance Monitoring Report

### Structural Measures

<table>
<thead>
<tr>
<th>Year</th>
<th>75+ ED Service User Rate per 1000 of Population</th>
<th>75+ Acute Hospital Service User Rate per 1000 of Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>2013/14</td>
<td>2014/15</td>
</tr>
<tr>
<td>Total</td>
<td>2012/13</td>
<td>2013/14</td>
</tr>
<tr>
<td>Acute</td>
<td>2012/13</td>
<td>2013/14</td>
</tr>
<tr>
<td>ED</td>
<td>2012/13</td>
<td>2013/14</td>
</tr>
<tr>
<td>Service</td>
<td>2012/13</td>
<td>2013/14</td>
</tr>
<tr>
<td>User</td>
<td>2012/13</td>
<td>2013/14</td>
</tr>
<tr>
<td>Rate</td>
<td>2012/13</td>
<td>2013/14</td>
</tr>
<tr>
<td>per 1000</td>
<td>2012/13</td>
<td>2013/14</td>
</tr>
<tr>
<td>Population</td>
<td>2012/13</td>
<td>2013/14</td>
</tr>
</tbody>
</table>

### System Level Measures

- **75+ Acute Inpatient Service User Rate per 1000 of Population**
- **75+ Acute Hospital Bed Days**
- **75+ Acute Hospital ALOS**

### Impact Measures

- **Percentage of CAP’s intervention plans for all new CAP triggered assessments, 1 September – 31 November 2017**

### Performance Indicators

- **Access Community Health Complaints and resolutions:**
  - Complaints received: 29
  - Complaints resolved: 25
  - Complaints remaining open: 8

### Evidence & Quality Markers

- **ARC Complaints:**
  - There have been no complaints to the DHG and one known complaint to the HDC3 complaints are open currently. The DHG received several complaints regarding the heat in the facility during the summer months.

### To be Reported when data becomes available

- **Evidence & Quality Markers**
- **ARC Complaints**

### To be developed

- **People Impact:**
  - Use interRAI to measure individual impact
APPENDIX TWO: COMMUNITY DENTAL DASHBOARD

CDA Claims Dashboard - Adolescent Dental Coverage for Capital Coast DHB for 2017 (Interim)

Number and % Unique Adolescent Patients Seen

Service Coverage

% Adolescent Coverage:
Based on DHB of Domicile

# Unique Adolescents by Age and Gender (Contracted DHB)

Total number of unique adolescents seen (based on Contracted DHB): 12,834 (7% NZ total).

Number of Adolescents Seen for the Top 10 Providers (Contracted DHB)

# Adolescents Seen by TA and Quintile (DHB of Domicile)

Please note: some adolescents may visit more than 1 provider and in these cases they are counted multiple times under this...
APPENDIX THREE: INTERRAI INFOGRAPHIC

Older people assessed by interRAI, Capital and Coast DHB – October to December 2017

One of the ways DHBs help older people get the right support at the right time, is to have health professionals complete an assessment of a person’s health and wellbeing. This assessment is known as an interRAI assessment.

The information in this infographic is from interRAI Home Care assessments for people living at home in the community.

We publish the interRAI Home Care assessment results to encourage health professionals, community groups, and family/whānau to check in with older people and see how they are doing.

Notes:
755 interRAI Home Care assessments were completed.
• Based on the Institutional Risk CAP.
** Based on the Urinary Incontinence CAP.

50% have impaired functioning and are at risk of moving into aged residential care within 12 months.*

- 17% report feeling lonely.
- 23% of informal carers express feelings of distress, anger or depression.
- 14% report they live with severe or exacerbating pain each day.
- 37% experience recurring urinary incontinence (even if less than weekly).**
- 20% have cognitive difficulties with everyday decisions such as when to get up, remembering to take their medicines, what clothes to wear, or using a walking frame when leaving the house.
- 27% have no Enduring Power of Attorney (EPOA).
- 95% have no documented Advance Care Plan (ACP).
Older people assessed by interRAI, Central Region – October to December 2017

One of the ways DHBs help older people get the right support at the right time, is to have a health professional complete an assessment of a person’s health and wellbeing. This assessment is known as an interRAI assessment.

The information in this infographic is from interRAI Home Care assessments for people living at home in the community.

We publish the interRAI Home Care assessment results to encourage health professionals, community groups, and family/whānau to check in with older people and see how they are doing.

55% have impaired functioning and are at risk of moving into age residential care within 12 months.*

Through supporting family efforts and community interventions it is possible to avoid premature admission into care.

- 21% report feeling lonely.
- 23% of informal carers express feelings of distress, anger or depression.
- 12% report they live with severe or excruciating pain each day.
- 40% experience recurring urinary incontinence (even if less than weekly).**
- 23% have cognitive difficulties with everyday decisions such as when to get up, remembering to take their medicines, what clothes to wear, or using a walking frame when leaving the house.
- 32% have no Enduring Power of Attorney (EPOA).
- 96% have no documented Advance Care Plan (ACP).

Notes:
- 2167 InterRAI Home Care assessments were completed.
- Based on the Institutional Risk CAP.
- ** Based on the Urinary Incontinence CAP.
**HSC DISCUSSION PAPER**

**Date:** 23 April 2018

<table>
<thead>
<tr>
<th>Author</th>
<th>Chris Lowry, General Manager Hospital &amp; Healthcare Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endorsed by</td>
<td>Ashley Bloomfield, Interim Chief Executive</td>
</tr>
<tr>
<td>Subject</td>
<td>Hospital &amp; Healthcare Services (HHS) Bi-Monthly Performance Report</td>
</tr>
</tbody>
</table>

**RECOMMENDATIONS**

It is recommended that the Committee:

- **a)** Notes that planning is progressing for the winter demand and possible flu outbreak to ensure that we are able to respond to increased demands on services;
- **b)** Notes that the ICU extension project is progressing and is due to be completed by 1 August as per the project plan;
- **c)** Notes that the acute flow work programme is currently being reviewed and activities prioritised to ensure improvements continue to be made;
- **d)** Notes the positive outcome of the recent certification surveillance audit and the reduction in the number of overall recommendations;
- **e)** Notes that performance against the Shorter Stays in ED health target has improved to 90-92% against a target of 95% but remains a challenge for the DHB;
- **f)** Notes that the Electives Target has been achieved year to date;
- **g)** Notes that the DHB remains within the threshold for compliance with the Elective Services and that the performance in this area has been sustained;
- **h)** Notes that performance against the MRI and CT waiting time indicators has remained at a similar level over the past three months and there are plans in place to improve access and performance, in particular:
  - a. Outsourcing of both MRI and CT scans;
  - b. A review of waiting lists by services with a focus on the longest wait;
  - c. The establishment of a demand management group led by the Chief Medical Officer;
  - d. Review of DHB hours of operation with a view to extending these.

**APPENDICES**

1. CCDHB Acute Work Flow Programme

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1. **INTRODUCTION**

1.1 **Purpose**

The purpose of this paper is to inform the Health System Committee of key activities and priorities being progressed through the Hospital and Healthcare Services of CCDHB.
2. DISCUSSION

2.1 Key Strategic Issues / Priorities

2.1.1 Winter Planning

Planning for the winter months is progressing and includes strategies that services will put in place to create additional capacity and manage the seasonal building on the winter plan from last year. Factors taken into consideration in the plan include: an increase in patient volumes and bed days, higher acuity patients and an increase in employee illness.

An Influenza like illness (ILI) outbreak may be a risk based on the recent Northern Hemisphere experience. Alongside the winter planning, an ILI outbreak response plan is also being developed with primary care and public health.

The scope of the plan includes inpatient services and clinical and non-clinical support services. CCDHB now also has a bed forecasting tool “Capacity Planner”, which provides us with the forecast occupancy levels for 2018 based on the last three years activity and forms the basis for projected demand over the winter months.

Principles that underpin the planning include:

- Patient and staff safety is the priority
- Minimise admissions – decide to admit/not admit
- Share the workload and resources, using the Integrated Operations Centre, TrendCare and other management tools to manage risk across the organisation.
- All areas must take responsibility for agreed actions and it is the responsibility of all clinical and operational management staff to ensure their areas are responding as agreed within the plan.

Flexi/Additional Bed Summary

Additional flexi bed capacity has been identified and will be resourced in line with the winter plan for 2017. This includes an additional 10-14 beds in the Clinical Trials Unit and an additional 11 beds at Kenepuru. These additional beds will be resourced from June to October 2018.

The Interventional Radiology Ward (IRW) will continue to resource eight overnight beds from Monday to Saturday to free up ED observation beds at the front door. There will be the potential to flex into these beds over the seven days as required.

An additional two to three additional ICU beds will be resourced on the completion of the expansion of the unit as per the business case. This will increase available resourced beds to 21.

Other initiatives will continue to be progressed and include:

- Improving the Specialty response to ED to support early senior review and decision making
- A continued focus on same day discharges in assessment units
- Focus on the achievement of 30% of discharges occurring before 11am
- Continued focus on assertive planning for long stay and or stranded patients
- A review of training and education over winter
- Staff Influenza vaccination programme - target increased to 80%.
- Point of care testing in ED for flu to assist bed allocation decisions across the seven days of the week.

2.1.2 ICU Expansion

The ICU expansion project is running to plan with key milestones being met to date. ICU’s new non-clinical area opened Tuesday 3 April and staff are settling into their bright and modern space. Demolition of the old ICU non-clinical area began the same day and the demolition has progressed well. All staff involved in
making the move have been acknowledged, including ICT staff who completed their work over the Easter break.

The Wellington Hospitals Foundation has also been acknowledged for providing a new TV for the staffroom, and for lending an original piece of artwork by well-known New Zealand artist Shane Hammond. The artwork is on display at the end of ICU’s new central corridor, and a safety barrier has been installed to protect it.

Construction works have now commenced in the central ICU area meaning there is now more interaction between contractors, staff and patients. Hoardings and other measures are in place to minimise disruption, and there are regular meetings with Infection Control to monitor the works to ensure we maintain the appropriate environment for staff and patients.

2.1.3 Acute Flow Programme
The acute flow improvement programme has continued to progress a number of improvement initiatives across the organisation to support an improvement in acute flow and performance against the shorter stays in ED target. The programme initiatives are summarised in Appendix 1.

The programme is currently being reviewed as part of the Hospital and Healthcare services Even Better Health Care programme identifying where improvements have been made and where we need to focus our efforts over the next year to ensure we achieve the greatest impact.

Current Priorities include:
- ED improvements – the focus continues increasing flow through the Green Zone, increasing the use of the Ambulatory zone, and the use of the Extended Observation Unit
- General medicine – the key focus is on ambulatory care, increasing the number of discharges before 11am with changes to the medical model implemented in March.
- Further improvements in the Surgical Assessment and Planning unit model to support direct transfers from GPs
- Continued focus on improvements in processes to support an increase in the number of patients discharged before 11am across the organisation.
- Timely response for Mental Health acute patients presenting to ED.

Achievements are being seen in acute flow as a result of the improvements that are being made. The time for patients assessed and discharged from ED has improved and is above 95% the majority of the time. There has been an increase in the number of discharges to the transit lounge with 23% of MAPU’s discharged patients are now being sent to the transit lounge. There has been a reduction in the length of stay in MAPU from 36 hours to 28.4 hours. General Medicine experienced the highest number of discharges in March but a lower daily ‘census’ than the same period last year, reflecting a reduced length of stay.

2.1.4 Frailty Project
A project is currently underway focusing on the management of frail older people. The aim of the Frailty project is to support timely and safe discharge to reduce harm from hospital-associated functional decline. This will have an impact on patients staying greater than seven days (“the stranded patient”). There will also be earlier assessment by geriatricians and improved flow to Kenepuru Community Hospital.

Current workstreams include:
- Mobility and patient observation - planning for a nurse focus group is progressing to gain information on barriers to mobility. A stock take of all mobility aids available to staff in ward areas is also underway
- Referrals to whiteboard for Health of the Older People and the CAREful team - whiteboard implementation is to commence in April. This will assist with planning and coordinating care
- Observation and Engagement – this project commenced with an audit of current practice. A research project has been confirmed to look at current and best practice internationally. A clinical trial will be progressed as part of this.
2.2 Quality and Patient Safety

Certification of health care services is a requirement under the Health and Disability Service (Safety) Act 2001 to ensure providers provide safe and reasonable levels of service for consumers. A surveillance audit is undertaken part-way through a service provider’s period of certification. It is not a full audit against all relevant standards, but offers an overview of key aspects of service delivery. The intent is to provide the Ministry with assurance the provider is continuing to meet all relevant standards. The focus of the audit is on service delivery and a review of criteria not fully attained at the previous audit. This applies to affected providers providing a health or disability service that is certified under the Act.

A Certification surveillance audit was undertaken for the hospital and mental health services at CCDHB over three days in April. Preliminary feedback from the auditors was very positive with a number of improvements being noted. Twelve of the previous corrective actions have been closed and two new actions were identified. This gives a total of 16 certification action recommendations (CARs) of which four are rated as moderate and 12 rated as low. The recommendations relate to cultural assessments not always being completed in mental health services, policies and procedures due for review, updating of risks in two areas of the organisation, the credentialling process for medical staff, some improvement still required in patient documentation relating to goals of care and care planning and some aspects of medicines management. The final report is expected by the end of May.

Over the month of March the monthly patient experience survey has focussed on communication. There has been a positive change of three percentage points for our administration staff compared to February 2017 (69% to 72%).

An analysis of feedback relating to the Communication Domain for the quarter September to December 2017 has been completed which identified eight services that were below the average of 8.5. Further analysis of each areas data will now be completed to identify focussed improvements that can be made. This will see an improvement in ratings as the work is progressed.

The overall policy review compliance rate has remained at 73% against a target of 85%. This remains an area of priority. The Management of Reportable Events Policy” has been reviewed in line with the national policy and will go out for consultation early May.

The number of HDC complaints for CCDHB remains within normal variation. During March seven new complaints were received. One of these has been referred to advocacy, one is a request for notes and comment only from CCDHB and one is a direct response to the patient. No further complaints have been progressed to investigation.

2.3 Health Targets

2.3.1 Shorter stays in ED – improving but target not met

Current Performance

Target: 95% of patients will be admitted, discharged, or transferred from the Emergency Department within six hours.

Performance against the SSIED target for Quarter 3 was 90.3% compared with 92% in Quarter 2. Performance for April month to date has improved and is currently at 93.6%.

Total Presentations to ED – March 2018

Presentations for January and February were higher than the same period in the previous year but have been at a similar level for March.
ED Acute Admissions
Acute admissions show an increase month on month compared with 2017. There was an increase of 107 acute admissions in March compared with March 2017.

Summary of key features impacting on target performance
- High volumes continue to impact on flow through the ED and therefore on performance against the shorter stays target. The total ED volumes averaged 179 patients a day for March 2018 (including patients who did not wait). This is a similar level to the volumes recorded in March 2017.
- Occupancy levels in the inpatient wards continue to impact on patient flow and transfer from ED therefore impacting on the time patients are waiting in ED and the shorter stays target.
- The number of acute admissions also has an impact on in bed occupancy levels. There were 2006 acute admissions in March 2018, an increase of 107 compared with March 2017.

Whilst the target has not been met there has been some improvement in the length of time patients are waiting in ED. In the month of March, 95% of all patients were seen and discharged or transferred within 7.37 hours. This is an improvement from 7.45 hours in February.

2.3.2 Improved Access to Elective Surgery – target met
Performance against the total elective health target is 42 unfavourable for the month of March and favourable 125 year to date. Elective surgical purchase units is 406 procedures behind target year to date. This is being offset by over delivery in Elective – Arranged Nonsurgical purchase units which is 530 ahead of target year to date. This is detailed in the following table.

2.3.3 Electives Wait List – Compliance sustained
The March Elective Services Performance Indicator results for ESPI 2 – first specialist assessment, and ESPI 5 - treatment, are not yet confirmed by the Ministry of Health. The
results below are as per our internal reporting which show we remain within the compliance threshold for both measures for March and April.

<table>
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The cardiothoracic wait list remains just below the maximum number of 71.

2.3.4 Better Help for Smokers to Quit In Hospital – target not met

CCDHB achieved 89% against a target of 95% for the month of March.

Achieving the target of 95% continues to be a challenge for the DHB. Work is progressing in the following areas:

- Changes were made to the DHB system in the Emergency Department to facilitate recording of patients given Brief Advice to Quit – this has had a positive impact and ED results have improved from 75% to 91.5%
- The DHB has a Tākiri Mai te Ata smoking cessation advisor visiting the hospital on a regular basis to bridge the gap between hospital stay and enrolment in cessation support services. This ensures patients can maintain nicotine replacement therapy and be supported to maintain Smokefree status on discharge.
- DHB-wide promotion of smoking cessation services available for staff and patients, with referral documents.
- Reprint of the DHB NRT training booklets.

2.3.5 Access to Diagnostics

**Urgent Colonoscopy**

Internal Diagnostic reports for March indicated that 93% of people accepted for an urgent diagnostic colonoscopy received their procedure within two weeks (14 days) against a Target of 90%.

**Target Met.**
Non-Urgent Colonoscopy
Internal Diagnostic reports for March indicated that 81% of people accepted for a non-urgent colonoscopy received their procedure within six weeks (42 days) against a Target of 70%. **Target Met.**

Surveillance Colonoscopy
Internal Diagnostic reports for March indicated that 57% of people waiting for surveillance waited no longer than twelve weeks (84 days) beyond the planned date against a Target of 70%. **Target Not Met.**

The service’s capacity based on historical practice is approximately 230 endoscopy slots per month. Current demand exceeds capacity. This has also been compounded by nursing staff vacancies and sick leave. We are currently outsourcing colonoscopy procedures whilst recruitment for nursing staff is progressed.

2.3.6 Access to Diagnostics – Radiology

**MOH Performance Indicators – CT**

Performance against the CT MOH indicator for non-urgent referrals has levelled over the past three months and is currently at 62% against a target of 95%.

![CT Performance Graph]

The steady increase in the referral rate continues to place demand on the service with an additional 622 referrals received for CT scans this quarter compared to the quarter 3 2016/17 (14% growth). An additional 368 patients were scanned compared with the same period last year.

Urgent CT outpatient imaging continues to be completed within two weeks. These are prioritised and scanned within the clinically appropriate timeframe.

**MOH Performance Indicators – MRI**

Performance against the MRI MOH indicator for non-urgent referrals has levelled over the last three months and is currently sitting at 30% against a target of 85%.
Urgent out-patient MRI imaging referrals are completed within 2 - 3 weeks. These continue to be prioritised and scanned within the clinically indicated timeframe.

There are currently 500 CT and 1200 MRI patients categorised as non-urgent on respective waiting lists outside of the recommended timeframe. This is at a similar level reported in the previous month.

Processes have been put in place to ensure that the clinically indicated timeframes are met for acute and urgent referrals and to maximize the utilisation of current capacity. These include the following:

- Daily rounding reports are provided to Radiologists to enable them to prioritise inpatient referrals. This is discussed at a 9.00am rounding meeting.
- Every Friday a production planning meeting is held with the Clinical Leader, Administration and Management staff looking forward to the next week. All available sessions and resources are reviewed and confirmed.

**Actions to reduce the number of patients waiting**

A number of strategies are in place to assist with reducing the numbers of patients waiting and to improve access for non-urgent referrals. These include:

- Outsourcing both MRI and CT scans.
- A review of waiting lists by services is to be repeated over the next month with a focus on the longest waiting patients. This will confirm the categorisation of the referral and if the scan is still required.
- A demand management group has been established, led by the Chief Medical Officer. The group is working with the specialties to identify actions to reduce demand with a focus on referrals for surveillance in the first instance. The group will also be meeting with the specialties with the highest referral rates to determine how the demand can be managed in line with best practice evidence.
- Options for extending the hours of operation for both CT and MRI scanners (weekend and evening OP appointments) are under development. This involves a review of hours of work and roster options for staff. Discussions to identify the optimal roster options are being progressed with the union and staff over the next month.

A proposal to support the reduction in the number of non-urgent patients waiting and to improve the timeliness of access is also currently under consideration.
26 April 2018

Hon. Dr David Clark
Minister of Health
Private Bag 18041
Parliament Buildings
Wellington 6160

Email: david.clark@parliament.govt.nz

Dear Minister

Re: Implementation of a tax on sugar-sweetened beverages as part of a suite of measures to improve child health especially child oral health

I am writing in my capacity as Chair of Capital & Coast District Health Board on behalf of the Board.

Our DHB has been concerned for some time now regarding rising obesity rates amongst NZ children with a third of NZ children having an unhealthy weight, and over 10% being obese. For the first time in history, NZ children could live shorter lives than their parents as a result of excess weight and obesity.

The burden of obesity and its impacts is greatest on our Pacific and Māori children and those from the deprived communities. We are equally concerned about the poor oral health of some groups of children in our population, including those under five and our Māori and Pacific kids. Our families are living in environments, and often with limited resources, which are not supportive of healthy lives.

Obesity is a major cause of increasing demand and rising costs, straining our hospitals and health services. The risk factors related to obesity can lead to chronic disease and/or limit a person’s ability to work or take part in family and community activities. As a DHB, our efforts and resources are heavily invested in working with people whose health is already being adversely affected as a consequence of established lifestyle patterns. We are also seeing a significant rise in the number of children and young people with obesity related disease, including type 2 diabetes, and dental extractions for children under the age of five. This is not only distressing for the young person and their families but it is preventable and an avoidable cost to our public health system.

CCDHB does invest in a number of primary prevention activities including: Project Energize, a successful programme that reduces childhood obesity; Green Prescription, supporting individuals and families to make lifestyle changes, supporting oral health in schools; and a range of public health initiatives including water in schools. These are insufficient to mitigate the impacts of obesity and poor dental health in our communities.

The Board acknowledges and supports the policy direction your Government is following on this issue. We understand the difficulties with various lobby groups in this highly contentious space and would encourage you to be as proactive as possible, particularly in relation to sugar-sweetened beverages (SSBs), including consideration of the introduction of a tax.
The World Health Organization (WHO) has recently stated there is clear evidence that taxes and subsidies influence purchasing behaviour and that this could be used to curb consumption of sugar-sweetened drinks and hence fight obesity and diabetes. WHO notes in a 2015 report titled *Fiscal Policies for Diet and Prevention of Non-communicable Diseases* that if retail prices of sugar-sweetened drinks are increased by 20 percent through taxation, there will be proportional drop in consumption.

An SSB tax is supported by the NZ dental profession, with the NZ Dental Association and partner organisations’ *Consensus Statement - Sugary Drinks* calling for a tax on SSBs consistent with the WHO guidelines. In addition, the Australian Medical Association has recently publicised its support for a tax on SSBs and urged the Australian Government to act ([http://www.smh.com.au/federal-politics/political-news/advertising-banned-drinks-taxed-vending-machines-removed-doctors-plan-for-war-on-sugar-20180105-h0duw0.html](http://www.smh.com.au/federal-politics/political-news/advertising-banned-drinks-taxed-vending-machines-removed-doctors-plan-for-war-on-sugar-20180105-h0duw0.html)).

At its February 2018 Board meeting, that Capital and Coast Board agreed to:

a) **Endorse** the introduction of a tax on sugar-sweetened beverages (SSBs);

b) **Write** to you and request that the Government move swiftly to implement a tax on SSBs, and strongly consider including artificially-sweetened beverages given that they are also harmful to oral health, as part of a wider set of measures to improve and protect child health;

c) **Communicate** this position publicly and practically support the Government to develop and implement such a tax.

As a health system we touch the lives of many families and continue to identify and implement ways to support healthy communities. Your commitment to school based clinics and ensuring the strength of our health services will also assist us to support healthy communities and families. This would be more effective when the environment supports fewer unnecessary sugar-sweetened beverages and energy drinks.

**Importantly**, we also acknowledge that a tax such as we have suggested will impact on low-decile populations and we are prepared to support those populations with approaches that will assist in the efficacy of such a policy

I trust you will give this request serious consideration. I can assure you that the DHB will fully support you and the Government. Please do get in touch if we can assist in any way.

Yours sincerely

Andrew Blair
Chair
Capital & Coast District Health Board
Acute Flow Programme

CCDHB wide programme focussing on improving patient flow throughout the organisation

Workstreams:
- ED
  - ED team
- MCC
  - MCC team
- Surgical
  - Surgical teams
- Mental Health
  - CRS team/ED
- Cross-directorate
  - IOC
- Paediatrics
  - Paediatric Acute Assessment

Improvement workstreams:
- Green Zone
- EDOU
- Discharge Lounge
- PM/Nights
- Refinements to Zone model
- Corridor
- Patients
- Front of house triaging
- Timely discharge
- Frail Elderly
- Early referral to Geriatrician
- Delirium detection and treatment
- Medical Model/roster redesign
- Ambulatory Care MAPU
- Cancer services review
- Cancer ambulatory MOC
- Transfer of patients to Kene
- Improving mobility
- New beds
- Capplan
- Ortho response to ED
- Fractured NOF pathway
- Ortho direct admit from ED
- 6N timelier discharges
- 7 North timelier discharges
- Direct to SAPU
- GP referrals
- CRS staff in ED
- Patient Pathways
- Escalation process
- Reducing flow into ED
- Triage
- Timely response trial – abdo pain pathway