PUBLIC

HUTT VALLEY DHB / Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**AGENDA v.7** Held on Thursday 25 November, 2020 **Sharp room, Boulcott's Farm Heritage Golf Club, 33 Military Road, Lower Hutt** Zoom meeting ID: 93920320865 Time: 0900 to 1230

2DHB COMBINED HEALTH SYSTEM COMMITTEE

	ITEM	ACTION	PRESENTER	MIN	TIME
1	**PROCEDURAL BUSINESS**			**15**	**09:00**
1.1	Karakia		All members		
1.2	Apologies	**RECORD**	Chair		
1.3	Continuous Disclosure – Interest Register	**ACCEPT**	Chair		
1.4	Confirmation of Draft Minutes	**APPROVE**	Chair		
1.5	Action List	**NOTE**	Chair		
1.6	Annual Work Programme	**APPROVE**	2DHB Director Strategy, Planning and Performance - Rachel Haggerty		
2	**MĀORI AND PACIFIC HEALTH**			**40**	**09:15**
2.1	Aligning Māori Strategies with Whakamaua	**NOTE**	Director Māori Health, Arawhetu Gray Director Māori Health, Kiri Waldegrave		
	MORNING TEA – 15 MIN				
3	**INTEGRATED PERFORMANCE REPORTING**			**80**	**10:10**
3.1	Health Care Home Programme and Community Health Networks	**NOTE**	2DHB Director Strategy, Planning and Performance		
3.1.1	PHO Presentation	**PRESENT**	Bridget Allan, Te Awakairangi PHO Mabli Jones and Chris Fawcett, Tu Ora Compass PHO Helmut Modlik and Teiringa Davis, Ora Toa PHO.	30	
3.2	2DHB Investment for Age-Related Frailty	**NOTE**	2DHB Director Strategy, Planning and Performance GM Commissioning, Complex & Primary Care – Jenny Langton		
3.3	Rheumatic Fever Update	**NOTE**	2DHB Director Strategy, Planning and Performance		
4	**Health System**			**30**	**11:30**
4.1	Ministry of Health Quarter Four Performance and COVID-19 Analysis	**NOTE**	2DHB Director Strategy, Planning and Performance		
5	**OTHER**			**5**	**11:15**
5.1	General Business	**NOTE**	Chair		
5.2	Resolution to Exclude	**APPROVE**	Chair		
Next Meeting: 26 Feb 2021, Location: TBC					

Karakia

Kia hora te marino

Kia whakapapa pounamu te moana

Hei huarahi mā tātou i te rangi nei

Aroha atu, aroha mai

Tātou i a tātou katoa

Hui e! Tāiki e!

Translation

May peace be wide spread

May the sea be like greenstone

A pathway for us all this day

Let us show respect for each other

For one another

Bind us all together!

CAPITAL & COAST AND HUTT VALLEY DISTRICT HEALTH BOARDS

Health System Committee Interest Register

29 September 2020

Name	Interest
Sue Kedgley *Chair*	• Member, Capital & Coast District Health Board • Member, Consumer New Zealand Board • Stepson works in middle management of Fletcher Steel
Dr Ayesha Verrall	• Labour Party List Candidate for 2020 General Election • Member, PHARMAC Pharmacology and Therapeutics Advisory Committee's Immunisations Subcommittee • Member, Association of Salaried Medical Specialists • Member, Australasian Society for Infectious Diseases • Employee, Capital & Coast District Health Board • Employee, University of Otago
Dr Roger Blakeley	• Board Member, Transpower New Zealand Ltd • Director, Port Investments Ltd • Director, Greater Wellington Rail Ltd • Deputy Chair, Wellington Regional Strategy Committee • Councillor, Greater Wellington Regional Council • Economic Development and Infrastructure Portfolio Lead, Greater Wellington Regional Council • Member of Capital & Coast District Health Board • Member, Harkness Fellowships Trust Board • Member of the Wesley Community Action Board • Independent Consultant • Brother-in-law is a medical doctor (anaesthetist), and niece is a medical doctor, both working in the health sector in Auckland • Son is Deputy Chief Executive (insights and Investment) of Ministry of Social Development, Wellington
Josh Briggs	• Councillor, Hutt City Council • Wife is an employee of Hutt Valley District Health Board / Capital & Coast District Health Board
Keri Brown	• Councillor, Hutt City Council • Council-appointed Representative, Wainuiomata Community Board • Director, Urban Plus Ltd • Member, Arakura School Board of Trustees • Partner is associated with Fulton Hogan John Holland
'Ana Coffey	• Father, Director of Office for Disabilities • Brother, employee at Pathways, NGO Project Lead Greater Wellington Collaborative

	• Shareholder, Rolleston Land Developments Ltd
Dr Chris Kalderimis	• National Clinical Lead Contractor, Advance Care Planning programme for Health Quality & Safety Commission • Locum Contractor, Karori Medical Centre • Contractor, Lychgate Funeral Home
Ken Laban	• Chairman, Hutt Valley Sports Awards • Broadcaster, numerous radio stations • Trustee, Hutt Mana Charitable Trust • Trustee, Te Awaikairangi Trust • Member, Hutt Valley District Health Board • Member, Ulalei Wellington • Member, Greater Wellington Regional Council • Member, Christmas in the Hutt Committee • Member, Computers in Homes • Commentator, Sky Television
Vanessa Simpson	• Director, Kanuka Developments Ltd • Relationship & Development Manager, Wellington Free Ambulance • Member, Kapiti Health Advisory Group
Dr Richard Stein	• Chairman and Trustee, Crohn's and Colitis NZ Charitable Trust • Member, Executive Committee of the National IBD Care Working Group • Member, Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy • Clinical Senior Lecturer, University of Otago Department of Medicine, Wellington • Assistant Clinical Professor of Medicine, University of Washington, Seattle • Locum Contractor, Northland DHB, HVDHB, CCDHB • Gastroenterologist, Rutherford Clinic, Lower Hutt • Medical Reviewer for the Health and Disability Commissioner
Paula King	•
Sue Emirali	•
Fa'amatuainu Tino Pereira	•
Kuini Puketapu	• Trustee or manager at Te Runanganui o Te Atiawa • Director of Waiwhetu Medical Group
Teresea Olsen	•
Bernadette Jones	•

Minutes of the Health System Committee

HUTT VALLEY AND CAPITAL AND COAST DISTRICT HEALTH BOARDS
Held on Wednesday 23 September 2020 at 9:30am
Boulcott's Farm Heritage Golf Club, 33 Military Road, Lower Hutt

PUBLIC SECTION

PRESENT COMMITTEE:	Sue Kedgley – Chair Ayesha Verrall Josh Briggs Ken Laban – Deputy Chair Keri Brown Richard Stein Roger Blakeley Chris Kalderimis 'Ana Coffey Fa'amatuainu Tino Pereira (Inu) Paula King Sue Emirali Teresea Olsen Bernadette Jones
STAFF:	Fionnagh Dougan, Chief Executive Officer Kiri Waldegrave, Acting Director Māori Health Arawhetu Gray, Director Māori Health Rachel Haggerty, Director Strategy, Planning and Performance Rachel Pearce, Acting GM Commissioning, Child, Youth and Localities Emma Hickson, Chief Nursing Officer Nicola Holden, Director of the Office of the CE Amber Igasia, Board Liaison Officer
OTHER:	David Smol
APOLOGIES:	Kuini Puketapu Vanessa Simpson 'Ana Coffey – late Josh Briggs – leaving early 11am Keri Brown – leaving early 10:45am

1 PROCEDURAL BUSINESS

1.1 Karakia

The Karakia was led by all.

1.2 APOLOGIES

Noted as above.

1.3 CONTINUOUS DISCLOSURE

1.3.1 Interest Register

Nil.

Moved: Ken Laban **Seconded:** Chris Kalderimis **CARRIED**

1.4 CONFIRMATION OF PREVIOUS MINUTES

The minutes of the Combined Health System Committee held on 22 July 2020, taken with public present, were confirmed as a true and correct record.

- 3.1 – discussion raised the issue around the investment strategy and funding allocation for the strategy. Add an accountability strategy included in the minutes. Development of the implementation plan on the way it will be funded, in the pipeline once the strategy launched. Amended minutes according to note as proposed.
    - Funding strategy for the plan.
    - Accountability mechanism for the Pacific plan.

Moved: Ken Laban **Seconded:** Chris Kalderimis **CARRIED**

1.5 ACTION LIST

Action Number	Status	Assigned	Notes
HSC20-0002	In progress	Board Secretary	Session on the Health Strategy Plan 2030 to be organised and offered to the Boards to attend.
HSC20-0004	In progress	GM MHAIDS	Report is in progress.
HSC20-0007	In progress	Board Secretary	On agenda for 25 Nov.
HSC20-0008	In progress	Director Strategy Planning and Performance	On agenda for 25 Nov, data to be pulled for two quarters (end of Sep) to allow for potential trend info.

It was noted there was another case of Rheumatic Fever in Porirua and it is a priority.

1.6 DRAFT ANNUAL WORK PLAN

The Committee was encouraged to provide feedback on the work plan and if there is anything missing they are wanting to discuss to provide to the Board Liaison Officer.

Moved: Ken Laban **Seconded:** Chris Kalderimis **CARRIED**

2 PRESENTATION

2.1 Strategy, Planning and Performance System Update

Presenter: 2DHB Director Strategy, Planning and Performance

The presentation provided an overview of the two strategies and noted their single aim "equity and better health outcomes for our people." The slides are included below.

2DHB Strategy Presentation

Vision for Change Presentation

DISCUSSION NOTES:

- There was a question raised about investment in early intervention. It was noted investment had previously been refocused to other areas but is now being reinvested into early intervention and working with other partners.

- Information was requested on the possible options for reallocation and resourcing for the Board to reinvest in preventative work. Management noted there are constraints around funding to be sustainable as a tertiary provider. The Health System Committee would like to have the opportunity to have these difficult conversations in the future.
- It was noted the Māori Health Strategies are built on enabling and creating system change.
- A question was raised about an infrastructural system in the community that would be able to respond and work with the DHB on the systemic change needed. The Committee wanted to ensure communities are being enabled to contribute too. Management noted there is a community nursing program in Porirua that is working on household outcomes and systemic changes. Work such as this is being developed and implemented.
- The Committee noted that usual data collection is very individualistic and there needs to be a focus on household outcomes for those communities who are family and whānau centred.
- The Committee emphasised the DHB should be ensuring there is always community engagement. However, it was noted that any plan requires engagement from families and whānau to achieve the outcomes it is aiming for.
- The Committee asked for more information in a future meeting on outcome measures and data profiles for the communities of the 2DHBs to help inform what an outcome measure is for those communities.

ACTION: Management to bring to a future meeting the clinical network transformation and how it's linked to the central region plan.

ACTION: Board Secretary to provide the presentations on the strategies to the Board.

ACTION: Members would like to see overlay of what is the change strategy and how are we going to make this happen to the slides presented in this meeting. Management will overlay the tactics that sit within this context i.e. Whānau Ora, and first 1000 days. Management to present the framework and the transformation of the clinical networks which are based in the provider arms.

ACTION: Management to provide examples of the actions being done on the Strategies and minimising the inequities.

ACTION: Board Secretary and ELT lead to invite clinical partners – PHOs and Clinicians – to future HSC meetings. Create a clear time and parameters for the conversation.

3 STRATEGY AND PERFORMANCE

3.1 2DHB Maternal, Child and Youth Commissioning Update

The report was taken as **read** and the Health System Committee **noted** the update provided.

DISCUSSION POINTS:

- A question was raised about whether the same process can be used to capture data on disability for children and youth as well as chronic illness. Management noted this would be covered in the following Disability Support Advisory Committee by the Disability team.
- Management noted significant effort is made to engage community members and leaders and it is tailored to the piece of work happening. For example, providers pitched their programmes for antenatal education to mums who hadn't previously taken part in classes as these were the women the classes want to engage.
- A question was raised about how the design of services for communities works. Management explained the DHB has intelligence and guided processes that enables providers or community partners to bring their expertise or experience to the table.

- A question was raised about commissioning and how are partner's expectations managed to ensure relationships aren't impacted when expectations aren't met. Management noted boundaries were made clear and communities are not engaged if they aren't ready for change. The process is made as transparent as possible.

Moved: Chris Kalderimis **Seconded:** Ken Laban **CARRIED**

3.2 2DHB Health of Older People Performance Update

The report was taken as **read** and the Health System Committee **noted:**

(a) The impact of pay equity, in-between travel and guaranteed hours on the workforce.

(b) The oversight and monitoring of Aged Residential Care and Home Care Support Services.

(c) The national work programme to improve the funding model to recognise complexity of service delivery particularly in age residential care.

DISCUSSION:

- A question was raised about case mix and staffing levels. Management noted that for most community services that we commission under our contracts it is not a requirement for the DHB to know.
- A question was raised about funding for upskilling staff and management noted part of the pay equity settlement was paying to help increase the staffing skill.
- A question asked if the Committee can be assured the 20 facilities that had not been previously prepared will be well prepared if there was to be another COVID-19 outbreak. It was noted the review feedback has been provided and the facilities are now well prepared.

Moved: Richard Stein **Seconded:** Ken Laban **CARRIED**

4 OTHER

4.1 GENERAL BUSINESS

No other business was noted.

4.2 RESOLUTION TO EXCLUDE THE PUBLIC

Moved: Sue Kedgley **Seconded:** Chris Kalderimis **CARRIED**

The meeting moved into the Public Excluded session.

CONFIRMED that these minutes constitute a true and correct record of the proceedings of the meeting

DATED this .....day of.....2019

Sue Kedgley
Health System Committee Chair

HSC ACTION LOG

Action Number	Date of meeting	Due Date	Date Complete	Status	Assigned	Public or PE	Agenda Item #	Agenda Item title	Description of Action to be taken	How Action to be completed
HSC20-0007	22-Jul-20	26-Feb-21		In progress	Board Secretary	Public	2.2	COVID-19: Impact, lessons learned and the way forward	Addressing homelessness proposed as a topic for a future HSC meeting.	Moved to February agenda
HSC20-0008	22-Jul-20	25-Nov-20		Complete	Director Strategy, Planning and Performance	Public	4.2.1	Rheumatic Fever	Further information on the spike in cases and any information related to lockdown.	On the agenda for 25 Nov 2020, data to be pulled for two quarters (end of Sep) to allow for potential trend information.
HSC20-00013	23-Sep-20	26-Feb-21		In progress	Director Strategy, Planning and Performance	Public	2.1	Strategy, Planning and Performance System Update: - CCDHB Health System Plan - HVDHB Vision for Change	Management to bring to a future meeting the clinical network transformation and how it's linked to the central region plan.	Feb agenda
HSC20-00015	23-Sep-20	31-Mar-20		In progress	Director Strategy, Planning and Performance Directors of Māori Health	Public	2.1	Strategy, Planning and Performance System Update: - CCDHB Health System Plan - HVDHB Vision for Change	Members would like to see overlay of what is the change strategy and how are we going to make this happen to the slides presented in this meeting. Management will overlay the tactics that sit within this context i.e. Whānau Ora, and first 1000 days. Management to present the framework and the transformation of the clinical networks which are based in the provider arms.	Mar agenda
HSC20-00016	23-Sep-20	31-Mar-20		In progress	Director Strategy, Planning and Performance	Public	2.1	Strategy, Planning and Performance System Update: - CCDHB Health System Plan - HVDHB Vision for Change	Management to provide examples of the actions being done on the Strategies and minimising the inequities.	Mar agenda
HSC20-00017	23-Sep-20	26-Feb-21		Complete	Director Strategy, Planning and Performance	Public	2.1	Strategy, Planning and Performance System Update: - CCDHB Health System Plan - HVDHB Vision for Change	Board Secretary and ELT lead to invite clinical partners – PHOs and Clinicians – to future HSC meetings. Create a clear time and parameters for the conversation.	Ongoing.

Work Plan

Year	2020	2021	2021	2021	2021	2021	2021	2021	2021	2021	2021	2021	2021
Month	December	January	February	March	April	May	June	July	August	September	October	November	December
DATE	No Meeting	No Meeting	26	31	No Meeting	26	No Meeting	28	No Meeting	29	No Meeting	24	No Meeting
Strategy													
CCDHB Pro-Equity Implementation/Update			CCDHB Pro-Equity Implementation /Update					CCDHB Pro-Equity Implementation/Update					
CCDHB End of Life Investment Plans				CCDHB End of Life Investment Plans									
2DHB Health System Plan Implementation Plan				2DHB Health System Plan Implementation Plan				2DHB Health System Plan Implementation Plan					
2DHB Investment Plans				2DHB Investment Plans		2DHB Investment Plans		2DHB Investment Plans		2DHB Investment Plans		2DHB Investment Plans	
Māori and Pacific Health													
CCDHB Taurite Ora Action Plan Update				CCDHB Taurite Ora Action Plan Update				CCDHB Taurite Ora Action Plan Update				CCDHB Taurite Ora Action Plan Update	
HVDHB Te Pae Amorangi Action Plan Update			HVDHB Te Pae Amorangi Action Plan Update			HVDHB Te Pae Amorangi Action Plan Update				HVDHB Te Pae Amorangi Action Plan Update			
Sub Regional Pacific Action Plan Update				Sub Regional Pacific Action Plan Update				Sub Regional Pacific Action Plan Update				Sub Regional Pacific Action Plan Update	
Health System													
CCDHB Final Budget 20/21						CCDHB Final Budget 20/21							
HVDHB Final Budget 20/21						HVDHB Final Budget 20/21							
2DHB LTIP Update				2DHB LTIP Update		2DHB LTIP Update		2DHB LTIP Update					
2DHB Indicative Budget 2020/21 - Whole of System Investment				2DHB Indicative Budget 2020/21 - Whole of System Investment									
2DHB Investment Progress Update								2DHB Investment Progress Update		2DHB Investment Progress Update		2DHB Investment Progress Update	
Integrated Performance Reporting													
2DHB Maternity, Child and Youth (MCY) Integrated Performance			2DHB Maternity, Child and Youth (MCY) Integrated Performance			2DHB Maternity, Child and Youth (MCY) Integrated Performance				2DHB Maternity, Child and Youth (MCY) Integrated Performance			
2DHB Urgent and Planned Care Integrated Performance				2DHB Urgent and Planned Care Integrated Performance				2DHB Urgent and Planned Care Integrated Performance				2DHB Urgent and Planned Care Integrated Performance	
2DHB Long-term conditions, complex care and Older people integrated performance			2DHB Long-term conditions, complex care and Older people integrated performance			2DHB Long-term conditions, complex care and Older people integrated performance				2DHB Long-term conditions, complex care and Older people integrated performance			
Regional Public Health Report				Regional Public Health Report				Regional Public Health Report				Regional Public Health Report	
System and Service Planning													
CCDHB Non-Financial MOH Reporting			CCDHB Q1 Non-Financial MOH Reporting	CCDHB Q2 Non-Financial MOH Reporting				CCDHB Q3 Non-Financial MOH Reporting		CCDHB Q4 Non-Financial MOH Reporting			
CCDHB Annual Plan inc. Minister's Letter of Expectations				CCDHB Annual Plan		CCDHB Annual Plan				CCDHB Annual Plan			
CCDHB Regional Services Plan						Regional Final Draft Regional Services Plan							
CCDHB Annual Report													
HVDHB Non-Financial MOH Reporting			HVDHB Q1 Non-Financial MOH Reporting	HVDHB Q2 Non-Financial MOH Reporting				HVDHB Q3 Non-Financial MOH Reporting		HVDHB Q4 Non-Financial MOH Reporting			
HVDHB Annual Plan inc. Minister's Letter of Expectations				HVDHB Annual Plan		HVDHB Annual Plan				HVDHB Annual Plan			
HVDHB Regional Services Plan						Regional Final Draft Regional Services Plan							
HVDHB Annual Report													
Stakeholder engagement													

HSC Discussion – Public

November 2020

Aligning Māori Strategies with Whakamaua	
Action Required **Health System Committee note:** (a) The intention to align Māori Health reporting in 2021 with the Ministry of Health Māori Action Plan, Whakamaua. (b) Taurite Ora and Te Pae Amorangi will continue to be delivered against as separate strategies however, resources and activities will be aligned and shared as appropriate. (c) Both strategies share common themes and actions but place different emphasis and priority on the activities undertaken to achieve them. (d) Updates on Taurite Ora and Te Pae Amorangi achievements will be included in the 3 Dec Board meeting.	
Author	Arawhetu Gray, Executive Director Māori Health Kiri Waldegrave, Director Māori Health
Endorsed by	Fionnagh Dougan, Chief Executive
Presented by	Arawhetu Gray, Executive Director Māori Health
Purpose	Update on proposal to consolidate reporting for Taurite Ora and Te Pae Amorangi and align their respective work programmes with the Ministry of Health Māori Health Strategy: Whakamaua.
Contributors	Jeanette Harris, Project Manager, Māori Health
Consultation	N/A

Executive Summary

As part of the shift to a 2DHB Executive Leadership team reporting against the two Māori Health strategies, Taurite Ora at Capital & Coast DHB and Te Pae Amorangi at Hutt Valley DHB, will be consolidated. The consolidated report will map activities to Whakamaua, the Ministry of Health's Māori Health Strategy 2020 – 2025 to ensure our focus aligns with the governments priorities for the health and disability system.

The separate activities outlined in each strategy will be maintained however opportunities to integrate work programmes as appropriate will be undertaken. This is to ensure greater use of resources to enable successful outcomes against the shared themes. It is important to stay mindful that each region is home to different mana whenua and that partnership with iwi is guided in part by the kaupapa outlined in the strategies.

Strategic Considerations

Service	Alignment with the Whakamaua ensures the services of the DHBs are meeting the MOH and wider health system obligations to Māori.
People	N/A
Financial	Two to three year implementation cost is estimated at $0.5M per annum

Governance	Equity Leadership Team is established

Engagement/Consultation

Patient/Whānau	Targeted involvement with Māori whānau occurs through the Māori health team.
Clinician/Staff	Ongoing involvement with a broad range of staff.
Community	Ongoing active relationships and engagement with Māori communities and leaders.

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
1	Māori Health Equity is under prioritised	CCDHB and HVDHB Boards ELT	Bowtie risk assessment complete. Mitigations require the actions under the two strategies.		

Attachments

Nil. Report follows below.

1. TWO DISTRICT HEALTH BOARDS - MĀORI HEALTH STRATEGY

Alignment with Whakamaua, Ministry of Health (MOH) Māori Health Strategy 2020 - 2025

1.1 CCDHB and HVDHB currently report separately against their respective Māori Health Strategies. The recent establishment of the 2DHB Director Māori Health provides an opportunity to identify synergies across our plans and to map the two DHBs combined progress against the Ministry of Health's Māori Health Plan – Whakamaua.

1.2 *Whakamaua: the Māori Health Action Plan 2020 - 2025* was released by the Ministry of Health earlier this year. The Strategy outlines the government's priorities for the health and disability system, including improving child, mental and general wellbeing by developing a strong and equitable public health and disability system:

1.3 Each will continue to implement our separate work plans and we are committed to identifying opportunities to integrate our programmes where appropriate and share resources to achieve aligned goals. Both strategies share common themes and actions but place different emphasis and priority on the activities undertaken to achieve them.

1.4 The plans were conceived as living documents with the ability to evolve over time and as priorities shift. Moving forward it will become more apparent where combined efforts will make the most difference. It is known that complex change and system shifts cannot be achieved quickly so mahi continues to be organised with a long term focus.

1.5 Relationships with iwi in both regions will be maintained, recognising that each mana whenua will have different priorities. They will be closely engaged with to improve Māori health outcomes and support local-level Māori development and kaupapa Māori service solutions. This maintains the current relationship with mana whenua.

1.6 Regular detailed reporting and dashboards will be provided in 2021. It will give a performance overview of Taurite Ora and Te Pae Amorangi, mapped to Whakamaua. The dashboard we adopt will be similar to the following example. The initiatives are not a complete list of the activities under the workforce heading, but used here to provide an example of how a report may look.

Example:

Whakamaua: Māori health and disability workforce

Purpose: To increase the capacity and capability of the Māori health and disability workforce at all levels of the health and disability system

Areas of focus in Whakamaua

- Pro-equity training
- Review and strengthen recruitment strategies
- Workforce plan and marketing profile
- Workforce data
- Graduate nursing and midwifery framework
- Mana Motuhake for Māori workforce supported
- Career Pathways
- Tuakana Teina

2DHB initiatives that align with Whakamaua

- Develop a pro-Māori Equity training package for all staff
- Develop cultural competencies and expectation for all staff to address racism
- Develop a quality improvement framework which includes goals and metrics related to health equity
- Support our workforce to achieve increased equity outcomes, particularly for Māori, Pacific and people with disabilities (2DHB)
- Co-design innovative models of maternity care with Māori and Pacific women in order to improve outcomes (2DHB)
- Offer education, advice and transport to clients who have previous missed appointments to Breast, Cervical or Colonoscopy Services (2DHB)
- Develop a guide for providers/practitioners to guide conversations with families declining immunisations, with a focus on co-designing with Māori and Pacific families and providers (2DHB)

Capital and Coast initiatives

- Re-establish Tu Pounamu workforce programme

Hutt Valley DHB initiatives

- Develop Kaitaki Haakui positions to supportthe ongoing development of cultural safety frameworks and recruit to the role and commit to a pro-equity programme of work that delivers a clear CCDHB equity goal and direction, an agreed set of equity principles, and an operational framework
- Set action points for Māori health equity and outcomes
- Develop *Matariki Achieving Excellence in Māori* Health annual awards

Indicators	Description	Rationale	Targets	Performance – three year trend Key: Māori — Pacific — Other —	Comments

BOARD DISCUSSION - PUBLIC

November 2020

Health Care Home Programme and Community Health Networks

Action Required

Health System Committee note:

(a) The Health Care Home (HCH) programme to transform primary care is entering its sixth year of operation in CCDHB and its fourth year in HVDHB and has achieved significant population coverage and is showing promising results.

(b) CCDHB commissioned three evaluations of their HCH programme: a mainstream evaluation, a Māori evaluation and a Pacific evaluation. The results are promising.

(c) A Rapid Review also identified that primary care providers felt they were more resilient and better equipped to respond to the challenges of COVID-19.

(d) CCDHB has recognised inherent limitations in the mainstream Health Care Home model for addressing inequities, and responding to Māori aspirations, and partnered with Ngāti Toa to coproduce a different approach to primary capability and integration in Porirua going forward.

(e) As Health Care Home practices mature, our DHBs are investing the released funding in Community Health Networks and the Porirua Integration programme.

Strategic Alignment	Health System Plan 2030 and Vision for Change
Authors	Dorothy Clendon, Interim General Manager, Design and Implementation Catherine Inder, Principal Advisor, Strategy, Planning and Performance
Endorsed by	Rachel Haggerty, Director, Strategy, Planning and Performance
Presented by	Dorothy Clendon, Interim General Manager, Design and Implementation
Purpose	Profile the Health Care Home programme and share the findings of three recent independent evaluations in CCDHB and our impact assessment based on HCH performance targets
Contributors	Sam McLean, Principal Analyst & Team Leader – Analytics Hannah Wignall, System Development Advisor Kirsten Lassey, Service Development Manager Rachel Pearce, Interim General Manager Commissioning, Families and Wellbeing
Consultation	Tū Ora Compass Health and Te Awakairangi Health Network

Executive Summary

The Health Care Home (HCH) model has developed in New Zealand in response to the resource and demand challenges in primary care. In 2016 CCDHB embarked on an ambitious roll-out focused on increasing access to primary care for priority populations and HVDHB embarked on its own HCH implementation in 2017. Both DHBs have achieved significant population coverage over this time.

Impact assessment based on HCH performance targets and three independent evaluations (from Māori, Pacific and mainstream world views) for the CCDHB HCH programme showed promising results but inequities remain for Māori and Pacific.

Community Health Networks (CHN) are one of the corner-stones for transforming our health system by 2030 and high-functioning HCH practices are pivotal to their success. Furthermore, Ora Toa PHO identified that the HCH programme did not embody Māori aspirations. This has highlighted the need to

coproduce models of primary care that and can deliver equity of health outcomes for Maori and Pacific communities.

Now that the HCH model is established CCDHB is moving funding to establish and grow HCH practices towards the establishment of CHNs beginning in Kāpiti (with a year one focus on the health of older people and reducing travel), developing a funding approach for HCH practices entering their sixth year of operation and beyond and the developing the Porirua Integration Project with Ngāti Toa.

Strategic Considerations

Service	The Health Care Home model aims to increase the impact of primary care services on the health and wellbeing of people and communities and the sustainability of the health system.
People	The Health Care Home model aims to increase the capacity and capability of the primary health care workforces to sustainably manage their clinical workloads and improve equity of access and health outcomes for our DHBs' domiciled populations.
Financial	The paper provides information on the value of investment of close to $20.5m to date over a 5 year period from 2016/17.
Governance	Integrated Care Collaborative and Hutt INC Alliance Leadership Teams. The development of the integration projects with shared governance with Ngati Toa, Te Atiawa and Te Atiawa ki Kāpiti.

Engagement/Consultation

Patient/Family	N/A
Clinician/Staff	N/A
Community	N/A

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
None					

Attachments

1. Health Care Homes Model of Care
2. A summary of the findings of the three CCDHB Health Care Home evaluations
3. Series of graphs for ED presentations, acute, and ASH admissions in Health Care Homes compared to non-Health Care Homes - June 2016 to June 2020.

1. PURPOSE

The purpose of this paper is to both profile the roll-out of the Health Care Home (HCH) model in primary care across both Capital & Coast DHB (CCDHB) and Hutt Valley DHB (HVDHB) and their key role in our DHBs' evolving Community Health Networks and Locality Based Integration projects including the Porirua Integration Project; and share the July 2020 findings of three evaluations of the HCH programme in CCDHB that aimed to understand from a Kaupapa Māori, a Pacific World View and mainstream perspective our success implementing the HCH programme and its fitness for purpose and the opportunities for improvement.

2. HEALTH CARE HOMES

2.1 Introduction

The HCH model was developed in response to the resource and demand challenges in primary care. The main drivers for the transformational change were an increasing shortage of GPs, an ageing population and workforce, and increasing hospital demand. The HCH model aimed to improve the impact of primary care on the health and wellbeing of communities and also, the sustainability of the health care system.

2.2 Roll-out

In 2015, the CCDHB Board in partnership with Tū Ora Compass Health, invested in a rapid and comprehensive roll-out of the HCH model. In 2017, CCDHB funding was increased with the goal of enrolling 80 percent of the population in an HCH programme within three years.

In June 2017, the HVDHB Board approved funding for Te Awakairangi Health Network to implement the HCH programme, in as many practices as possible, also over a three year period.

The DHBs' initial investments supported successive tranches of practices to implement the HCH programme, with each practice funded for a three year period. The three evaluations were confined to the CCDHB roll-out as they were commissioned prior to the formation of the 2DHB environment.

The PHOs (Tū Ora Compass Health and Te Awakairangi Health Network) have contributed in parallel to fund the HCH programme, applying their Long Term Conditions and Services to Improve Access funding (Tū Ora Compass Health only).

2.3 Model of Care

Health Care Homes aims to both; keep their enrolled populations well in the community through the transformation of primary care teams and services and confident integration with specialist services; and improve the clinical and financial sustainability of general practise. Primary care practices and teams apply lean quality improvement principles to the development of services focusing on four core domains of health care:

- **urgent and unplanned care** (e.g. creating multiple channels for contacting practices, reserving space for urgent appointments in GP schedules, triage systems and extended hours)
- **proactive care** for those with more complex health or social needs (e.g. Introducing 'Year of Care' plans, shared care appointments and multi-disciplinary team (MDT) meetings)
- **routine and preventative care** aimed at keeping people as well as they can be (e.g. the ManageMyHealth portal and extended hours)

- **business efficiency** for long term sustainability (e.g. expanded and enhanced practice teams, daily practice team huddles).

The New Zealand Health Care Home Collaborative (HCH Collaborative) has recently updated the model of care, with a focus on improving equity and Māori health.

2.4 Leadership

The HCH programme has been led through our DHBs' Alliance Leadership Teams (ALT): the Integrated Care Collaborative (ICC) ALT in CCDHB, and Hutt INC ALT in HVDHB. Each DHB has a steering group that meets regularly to agree practice implementation plans, and to oversee each practice's progress against the four core domains of the HCH model, and towards annual at-risk targets.

The implementation is led by Tū Ora Compass PHO in CCDHB and Te Awakairangi Health Network in HVDHB.

2.5 Health Care Home programme's relationship to Community Health Networks

The CCDHB Health System Plan 2030 describes Community Health Networks (CHN) as key to achieving the vision outlined in the Health System Plan 2030 and the "central organising point for delivering efficient and effective health care, with Health Care Homes at the core" (see the diagram below).

Diagram one: Health System Plan 2030

A CHN has a number of layers, but central are health and community providers who have an interest in improving the health and wellbeing of the local population. A CHN will work to coordinate and organise health service delivery within its geographical region, to meet the health needs of the local population. In 2020, our DHBs are developing the first CHN in Kāpiti building on the platform of seven HCH practices out of the ten practices in the area.

2.6 Driving equity through innovation

In response to recognising that achieving equity requires a more comprehensive response with a focus on integration of services that includes an inter-sectoral response CCDHB has commenced the locality integration project in Porirua. This project is commencing with the development of an integrated

outcomes based contract with Ora Toa. More detail on this approach will be the subject of a separate presentation.

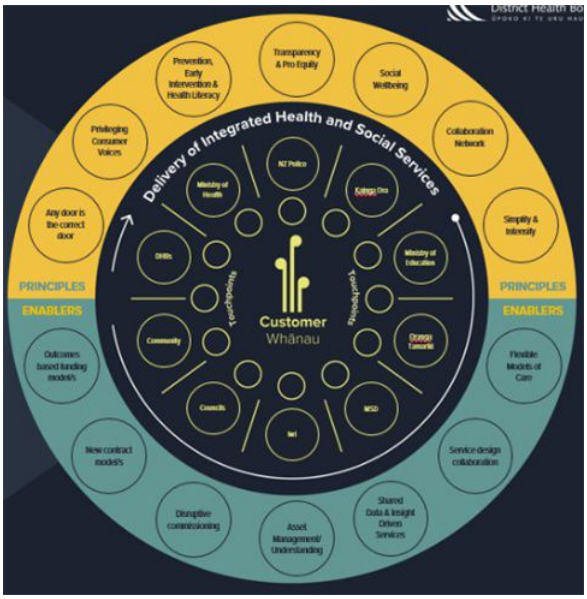


Diagram two: Porirua Integration Plan

3. IMPLEMENTING HEALTH CARE HOMES

3.1 Approach through years one to three and in year 4 for HCH practices

Our DHBs have supported successive tranches of practices, with each practice receiving three years of funding, to implement the HCH programme through:

- change teams led by Tū Ora Compass in CCDHB, and Te Awakairangi in HVDHB, assisting practices to implement the HCH model components
- a base rate per population enrolled for each practice
- a performance-based payment for each practice, based on population and on the achievement of specific health targets (see paragraph 3.4 that reports on these targets).

Over the first three years, practices are expected to implement and embed many of the key aspects of the HCH model and, by the end of this period, to be certified by the HCH Collaborative.

For the first tranche of practices entering year 4 (from 2019/20), CCDHB decided to continue funding of HCHs, albeit at a reduced rate, in order to maintain momentum, and in recognition that some components of the model (in particular, extended hours and participation in MDTs) carry additional costs. From year 4, CCDHB introduced weighting for ethnicity and deprivation into the previously volumes-based funding formula. In HVDHB, funding has been weighted since inception.

The total funding contributions of our DHBs to the HCH programme are:

Annual expenditure on HCH	$ 2016/17	$ 2017/18	$ 2018/19	$ 2019/20	$ 2020/21
Capital and Coast	873,240	2,657,508	3,868,712	4,131,585	3,400,632
Hutt Valley			1,026,040	1,857,236	2,380,586

3.2 Ora Toa PHO's journey

Three Ora Toa PHO practices were included in the first tranche of practices in CCDHB and participated for two years, achieving the one year milestones during that time. In the third year, Ora Toa requested a pause in the programme. The Kaupapa Māori Evaluation (see section 4. below) confirmed that the HCH programme was not a good fit for the Te Aō Māori approach of Ora Toa. This led to the work with Ngāti Toa on the Porirua Integration programme.

3.3 Coverage

The first HCHs are now in year 5 of the programme in CCDHB, and year 3 in HVDHB. Both DHBs have invested in extensive population coverage. CCDHB achieved its target of 80 percent coverage. The HVDHB Board agreed to fund as many practices as possible to adopt the HCH model and has achieved 86 percent coverage. Ora Toa's exit reduced CCDHB's practice coverage from 35 to 32.

Enrolments in HCH programme (excluding Ora Toa practices)	**CCDHB**	**HVDHB**
Number of enrolled population	246,691	122,839
% of enrolled population	82%	86%
% of Maori enrolled population	82%	86%
% of Pacific enrolled population	79%	87%
Number of HCH GP practices	32	15

4. EVALUATING THE CCDHB HEALTH CARE HOMES

4.1 Overview

In 2020, we commissioned three evaluations of the Health Care Home model in CCDHB:

1. A Kaupapa Māori evaluation of the CCDHB Health Care Home Programme – by Tiaho Ltd (Kaupapa Māori evaluation).
2. An evaluation of the Health Care Home programme from a Pacific World View – by Pacific Perspectives (Pacific World View evaluation).
3. A Rapid Review of the Health Care Home Model in Capital and Coast District Health Board – by the International Federation of Integrated Care (Rapid Review).

The Rapid Review incorporates the findings of both the Kaupapa Māori and Pacific World View evaluations. The two evaluations contain rich information from the perspectives of tāngata whenua and Pacific peoples on the HCH model's successes, challenges and opportunities.

The full evaluations are available in the Board Resource Centre. See also Appendix Two for a collated, high level summary of each of the three evaluations.

4.2 Findings

The Rapid Review incorporates the findings of both the Kaupapa Māori and the Pacific World View evaluations and concludes, succinctly, that:

> ***There was a clear need to continue to strengthen and transform primary care.***
>
> ***Change and reach occurred at an ambitious pace.***
>
> ***Some were left behind.***

The journey is just beginning.

Collectively, the evaluations show that change was hard, but worth it. Clinicians and patients valued many parts of the model, including same day appointments, use of the patient portal, shared medical appointments and multidisciplinary team meetings. Timely access to primary care improved. However the proactive care components of the model were harder to implement.

The Kaupapa Māori evaluation describes the HCH model as "promising" and the Pacific World View evaluation describes it as "offering opportunities… to impact positively on Pacific health outcomes."

The Kaupapa Māori and the Pacific World View evaluations are both cautiously positive about the changes introduced by the HCH model in respect of access and coverage, patient experience, provider experience, and efficiency and cohesiveness. The model is delivering better coordinated care that is more accessible, timely, flexible and efficient. However, inequities are yet to be reduced.

The Kaupapa Māori and the Pacific World View evaluations focus attention on ways in which the HCH model needs some rethinking and reimagining if it is to deliver more equitable health outcomes for Māori, for Pacific peoples and for high-needs populations. The Kaupapa Māori evaluation also emphasises the limitations of the biomedical model for Māori, and the need to work closely and authentically to design and implement an HCH model centred on a Māori concept of hauora and Māori principles that protect iwi provider and whānau autonomy.

The Pacific World View evaluation raises questions about whether the HCH model is a good fit for the high health and other intersecting needs of the Pacific community who value care underpinned by continuity and trusted, respectful and understanding relationships. This evaluation suggests a need to consider the trade-offs between efficiency and quality.

The Rapid Review emphasises that **the journey is just beginning**, concluding that:

> *Strong foundations have been laid for system-wide transformation that places people and community at the centre with General Practice more in-support.*

4.3 COVID-19 response

The Rapid Review sought to also understand whether the HCH model assisted primary care with its response to COVID-19. The Rapid Review found that it did – primary care felt they were more resilient and better equipped to respond to the challenges due to: the infrastructure for remote consultations, the established relationships formed through the HCH change process, and their "change-mindset." Tu Ora Compass Health reports that COVID-19 encouraged as-usual primary care to rapidly adopt some HCH approaches.

4.4 Evaluation recommendations

The Rapid Review proposes a two-fold approach to the ongoing roll-out and development of the HCH model in CCDHB:

First, **More ambitious integration with community** through: co-design with customers, a stronger focus on equity, a review of the funding and support mechanisms to reflect new objectives, and changing the current top-down approach to measuring health system performance; and, second, to **Continue strengthening primary care**: review how multi-disciplinary teams can be used to plan more proactive care, review the implementation of 'Year of Care Plan' as part of Long-Term Care, review the use of the risk stratification tool, include mental health and aged residential care in future plans and continue work towards electronic infrastructure to support health and community integration.

The recommendations for improvement in the Kaupapa Māori and Pacific World View evaluations together provide a road-map for embarking on the Rapid Review's recommended **ambitious integration with community**.

Both the Kaupapa Māori evaluation and Pacific World View evaluations focus on the importance of good quality data and reporting to enable comparative analysis by ethnicity and the need for further research and evaluation. Both evaluations reinforce that coproduced, multidisciplinary and intersectoral coordination and approaches will be the game-changers for Māori and Pacific peoples' health and wellbeing.

4.5 Our DHBs' response to the recommendations

We are still absorbing the rich information in the three evaluations. This includes re-evaluating our approach to monitoring the performance of HCH practices and ensuring that the findings inform our approach to their future funding (year 6 and ongoing). The evaluation findings also speak strongly to our plans to transform our health system by 2030, beginning with our work with Ngāti Toa to co-design and co-produce the Porirua Integration programme and our implementation of CHNs.

5 Impacts in CCDHB

Measuring the impact of HCH on the health and wellbeing of communities and its contribution to the sustainability of our DHBs' health care system is complicated. This is due to a range of factors, including the phased approach to HCH implementation both within and across the two DHBs and HCH practices' prioritisation of Māori, Pacific and other high needs populations. From February 2019 on, we anticipate the trends will be increasingly robust because all practices will be in at least year 2 of their HCH journey.

We are confident however that the introduction of the HCH programme, in comparison to other initiatives in place, has delivered the following results:

- performance for Emergency Department presentations is better for all populations covered by the HCH programme – slower growth and reducing for Pacific and 'Total'.
- performance for acute admissions is better for all populations – showing very slow growth – accelerating from 2018/19 – but at a slower rate for populations covered by the HCH programme.

It has had a lesser impact on ASH rates which are more strongly influenced by the social determinants of health including housing.

- performance for ASH admissions covered by the HCH programme is variable for all populations.

These results can be attributed to the HCH model of care:

- ready access to urgent and unplanned care (e.g. availability of acute appointments)
- proactive care for those with more complex needs (e.g. increases in Year of Care Plans and enhanced digital access)
- better routine and preventative care
- improved business efficiency and sustainability.

The graph below demonstrates this "bending of the curve" in CCDHB. The results for 2019/20 are however skewed by the impact of COVID-19 (the dotted orange line) and the across the board reductions in ED presentations, acute, and ASH admissions through lockdown and beyond.

To be inserted

Appendix Three consists of a series of graphs from June 2016 to March 2020 showing performance every 3 months compared to the 2015/2016 baseline for CCDHB ED presentations, acute, and ASH admissions for Māori and Pacific ethnicities and 'Total'. It should be noted that where ED presentations have initially worsened this is attributable to the poor health status of some populations initially prioritised by the HCH programme resulting in improving access to care.

5. NEXT STEPS FOR HEALTH CARE HOMES IN OUR DHBS

The PHOs continue to support practices in both DHBs to continue on their HCH journey with the expectation that those not already certified by the HCH Collaborative, will become so from year three. Next year (2021/22) the HCH programme will reach a new stage: the first tranche of HVDHB practices will enter year 4 and the funding approach will mirror CCDHB's year 4 approach.

CCDHB practices will enter their sixth year and planning is underway to determine what funding, and where, is needed to sustain the changes on an ongoing basis. As CCDHB practices progress through the HCH programme, the released funding is being invested in Community Health Networks.

We will inform the Board of the agreed funding formula for HCH practices in their sixth year of operation and ongoing. We will seek the Board's agreement on the funding required to establish future CHNs in our DHBs.

6.1 Kāpiti Community Health Network

Kāpiti is the first CHN development site and will inform future roll-out across both DHBs. CCDHB and Tū Ora Compass Health are working together to develop the CHN which will bring together health and community providers and the local community, to have oversight of how local services work together and provide coherent options for delivering more care at or closer to home. The main focus in year one is the health of older people/frailty, in particular, reducing travel for acute and planned care and improving access to specialist services.

Over time, and as it develops, the Kāpiti CHN will focus on other population health priority areas including youth, mental health and addiction, and disability. Year one development includes a focus on the following:

- **local governance** – to identify and agree shared goals for the Network, and monitor the Network's progress towards achieving them
- **local operational and clinical leadership** – to drive relationships and services to work in new ways
- **relationships** – described through Memorandum of Understandings/Charters that define the commitment of providers and services
- **community engagement** – identifying opportunities and developing solutions.

6.2 Integrated commissioning in Porirua

We recognised the HCH model was insufficient to deliver equitable outcomes for all Māori, Pacific and people living in areas of high need, ahead of the finalisation of three evaluations. We also understood that the HCH model's biomedical approach is at odds with Māori aspirations and principles.

In response, our DHBs are working actively with Ngāti Toa on the co-design and coproduction of the Porirua Integration programme supporting Ngāti Toa to take the lead and develop an integrated approach to primary and community health service delivery in Porirua from 1 July 2021.

This work is resetting the relationship between CCDHB and Ngāti Toa and positions Porirua to be a leader in the implementation of Tier One service commissioning (strongly promoted in the *Health and Disability System Review*). It is building foundations to realise our DHBs' strategic aspirations including:

- iwi-led priority and investment setting
- greater community leadership around goal setting and monitoring
- investing in kaupapa Māori service delivery models
- commissioning for outcomes.

6.3 Neighbourhoods

In HVDHB, 4 Neighbourhoods have been identified to geographically align specialist services to clusters of general practices, pharmacies and local communities. For example, the General Medicine service at Hutt Hospital has aligned its teams to Neighbourhoods.

A Community Integration Steering Group oversees integration work with Neighbourhoods, and there is a commitment to focus first on the Naenae/Taita/Stokes Valley neighbourhood, which has the highest proportion of priority populations in the Hutt Valley.

The CHN and Neighbourhoods programmes will form a common approach and language, building on their combined strengths as we move forward.

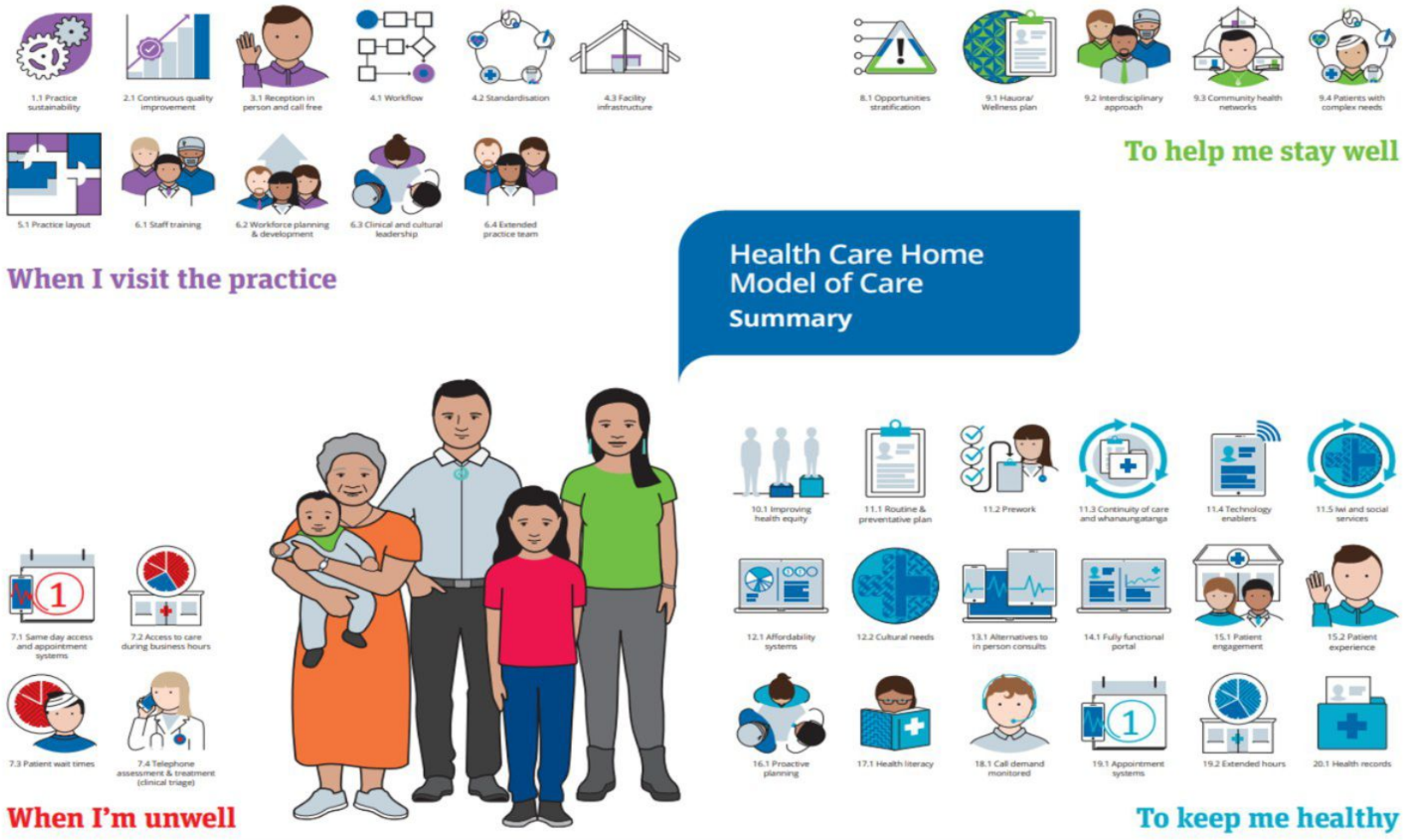
6. CONCLUSION

In summary, our investment in the HCH programme has been a worthwhile one, it has:

- provided better outcomes for patients and the health care system
- helped primary care respond quickly and effectively to COVID-19
- provided key building blocks for the implementation of Community Health Networks and Neighbourhoods
- developed "change skills" across primary care which will assist in many future improvements.

We recognise however that the HCH model primarily responds to demand and resource pressures in primary care. The other strategic projects profiled in this paper (Porirua Integration project coproduced with Ngāti Toa, CHNs and neighbourhoods) are pivotal to the transformation of primary and community care in our DHBs.

APPENDIX ONE – HEALTH CARE HOME MODEL OF CARE



APPENDIX TWO – A SUMMARY OF THE FINDINGS OF THE THREE CCDHB HEALTH CARE HOME EVALUATIONS

Evaluations of the Health Care Home Model in Capital & Coast District Health Board – collated, high-level findings

In 2020, we commissioned three evaluations of the Health Care Home Model (HCH) in Capital & Coast District Health Board (CCDHB):

- Kaupapa Māori evaluation of the CCDHB Health Care Home Programme[1]
- An evaluation of the Health Care Home programme from a Pacific World View[2]
- A Rapid Review of the Health Care Home Model in Capital and Coast District Health Board.[3]

The Rapid Review incorporates the findings of both the Kaupapa Māori and Pacific World View evaluations. These evaluations contain rich information from the perspectives of tāngata whenua and Pacific Peoples on the model's successes, challenges and opportunities.

The Kaupapa Māori and Pacific World View evaluations responded to the same or very similar questions. The evaluation frameworks are set out below:

Kaupapa Māori		Pacific World View
Manaakitanga	Critical success factors	
Whanaungatanga	Key components supporting outcomes	
Rangatiratanga	Unintended benefits and consequences	Unintended benefits and issues
Pae ora	Barriers and challenges	Barriers to implementation
Ōritetanga	Outcomes - Māori vs. Other	
Pūkengatanga	Key features of Kaupapa Māori models of care	
	Model's fitness for purpose	
	Opportunities to improve	

Rapid Review	
Formative	Shared vision, understanding of purpose and buy-in?
	What works and what doesn't?
	Barriers and how they were overcome?
	Lessons for the future?
	Model's maturity against the main building block of integrated care?
Summative	Has the model helped to achieve its stated outcomes?
	Unintended consequences of implementing the model?

[1] Tīaho Limited. July 2020. *Kaupapa Māori evaluation of the CCDHB Health Care Home Programme*. https://www.ccdhb.org.nz/about-us/integrated-care-collaborative-alliance/health-care-home/tiaho-limited-ccdhb-health-care-home-kaupapa-maori-evaluation-final-report-22july2020.pdf. Accessed November 2020.
[2] Pacific Perspectives Limited. July 2020. *An evaluation of the Health Care Home programme from a Pacific World View* https://www.ccdhb.org.nz/about-us/integrated-care-collaborative-alliance/health-care-home/hch-pacific-evaluation-report-final20.pdf. Accessed November 2020.
[3] International Foundation for Integrated Care. August 2020. *A Rapid Review of the Health Care Home Model in Capital and Coast District Health Board*. https://www.ccdhb.org.nz/about-us/integrated-care-collaborative-alliance/health-care-home/ccdhb-hch-evaluation-final-report-14-aug-2020.pdf. Accessed November 2020.

HIGH-LEVEL FINDINGS

A Rapid Review of the Health Care Home Model in Capital and Coast District Health Board

The Rapid Review makes four key points and 10 recommendations at two levels, 'Where to next' and 'Continue strengthening primary care':

There was a clear need to transform primary care – the model provided a call to action and a framework for urgent change - it introduced a proactive model that empowered staff and created needed infrastructure.

Change and reach occurred at an ambitious pace – an ambitious coverage target was achieved (80 percent of the population in three years) - more work is required on prevention, patient-centeredness and, especially, co-production.

Some were left behind – there was not a tailored approach to improving access according to different population needs – the health centric, medical model is in part responsible for this – more work and additional research is required.

The journey is just beginning – the HCH model has had an overall positive impact on primary care and strengthened General Practice – it has bought teams together – it has started to reduce unplanned and emergency admissions – Delivery is more flexible due to improved relationships and technology (this helped with COVID-19) – Readiness for integration beyond health and into the community has increased – Strong foundations have been laid for system-wide transformation that places people and community at the centre with General Practice more in-support.

Where to next – More ambitious integration with community – Co-design with customers – Stronger focus on equity – Review funding and support mechanisms to reflect new objectives – Change the current top-down approach to measuring health system performance.

Continue strengthening primary care – Review how multi-disciplinary teams can be used to plan more proactive care – Review the implementation of 'Year of Care Plan' as part of Long-Term Care – Review the use of the risk stratification tool – Include Mental Health and Aged Residential Care in future plans – Continue work towards electronic infrastructure to support integrated health and community integration.

Kaupapa Māori evaluation of the CCDHB Health Care Home Programme

The Kaupapa Māori evaluation notes many positive changes including:

Access – to health care services improved, through the variety in modes of communication – access to coordinated care increased, through enhanced connections to providers – urgent health needs were met

Patient experience – greater empowerment in decision-making, improved support, strengthened relationships, increased self-management and health literacy, more security and control

Efficiency and cohesiveness – helpful technologies, new roles such as Primary Care Practice Assistants, reconfiguration of reception areas, morning briefings allowing for Te Reo and tikanga through waiata and karakia

However, the Kaupapa Māori evaluation identifies a range of issues and some possible responses:

Model best-described as promising – some issues are technical, and others conceptual and together require a strong commitment to coproduction. The evaluation provides a road-map for improvement and includes a detailed list of both recommended changes at the end of the evaluation.

Ongoing inequity and suspected unconscious biases need investigation – Māori enrolled in an HCH had lower ambulatory sensitive hospitalisation (ASH) rates than Māori who were not however, the ASH rates of 'Other' were half those of Māori, whether enrolled in an HCH or not, and this was consistent over time – a higher proportion of 'Other' are triaged by a GP than Māori; conversely, a higher proportion of Māori than 'Other' are triaged by a Nurse Practitioner

Data limitations – available data was insufficient to support a thorough equity analysis – health workforce data by ethnicity and by role is needed

Kaupapa Māori models of care – many health determinants are not catered for within a biomedical model and existing modes of health service delivery – whānau want to hear Te Reo and access rongoā and for Rangatiratanga in health service provision – the HCH model restricted the autonomy of Māori providers

Accountability – there was limited accountability to communities – implementation was "model-centric"

Funding – presents challenges for Very Low Cost Access Providers – does not cover the full costs – some targets were unrealistic – all against a background of underfunding Māori providers

Provider vision – providers want support to design and implement a HCH model centred on a Māori concept of hauora and founded on Māori principles that protects provider and whānau autonomy

What it will take to empower tāngata whenua to thrive – close consideration of the systemic structures and funding configurations that serve to enable or restrict provider delivery of the model – strengthening respectful relationships – high quality, timely and appropriate ethnicity data – a strong commitment to equity and to Te Tiriti o Waitangi – close and authentic community involvement.

An evaluation of the Health Care Home programme from a Pacific World View Evaluation objectives

Access – Pacific peoples and their families have benefitted – unmet need is being identified – there are more care options – access to urgent and unplanned care and GP consultations have increased while wait-times have decreased - providers have a strong commitment to affordability

Patient experience – trust in the system is increasing – patients are largely on board with the changes

Efficiency and cohesiveness – providers have found the change processes demanding but have committed to the patient-centred, equity-focused goals and benefitted from the range of infrastructural supports provided by the HCH model – the model has encouraged information sharing, intersectoral working and strengthened relationships – providers are exploring shared care initiatives and group education sessions

However, significant adaptations to the HCH model are needed for a large, high-needs Pacific population:

For Pacific Peoples

- face to face delivery and continuity of care are important
- online solutions may not be effective
- translators and interpreters are necessary
- health literacy is an ongoing issue

For providers

- delivering proactive care is challenging
- managing consultation times is challenging
- telephone triage is time intensive and adds to clinical workloads
- Year of Care planning is time intensive and difficult to sustain
- efficiency gains are elusive, particularly for high needs populations
- unclear how efficiency and capability building enable continuity of care

Learnings - What are the key learnings and what needs improvement to achieve health and service outcomes for Pacific?

Four key learnings

1. Pacific patients and families value care that is underpinned by continuity and trusted, respectful relationships where their backgrounds and family contexts are understood. They are seeking and welcome information and engagement that is appropriate to their needs and meets them where they are at.
2. Multidisciplinary approaches are critically important for providing proactive, coordinated, and timely care for Pacific people that is responsive to intersecting factors that compound need.
3. HCH-enabled enhancements and expansions to practice teams are a key enabler for these approaches and are central to the success of the model of care for high need Pacific populations.
4. HCH frameworks and mechanisms to strengthen interdisciplinary and intersectoral coordination offer opportunities to deliver high quality, equitable care to Pacific patients and families and impact positively on Pacific health outcomes.

HCH improvements

- Monitoring frameworks could be improved to better consider the complex experience of Pacific patients and families; offer a more nuanced perspective on practice performance; and reflect an equity-focus for Pacific peoples.
- CCDHB should work with the HCH Collaborative to ensure that it has access to good quality data and reporting that is clinically-informed and conforms to good practice, particularly in terms of comparative analysis by ethnicity and controlling for other variables.
- The monitoring framework should inform equity focused future evaluation of the HCH model of care in relation to Pacific patients and families
- The effectiveness of HCH-enabled enhanced and expanded practice teams should be built on through ongoing workforce training and development
- Strategies and approaches are needed that ensure genuine access to patient portals for Pacific people

HSC DISCUSSION - Public

November 2020

2DHB Investment for Age-Related Frailty

Action Required

Health System Committee endorse, for Board approval:

a) Prioritising system wide commissioning for age-related frailty across the 2DHBs including hospital care to reduce avoidable use of our health care system.

Health System Committee note:

b) HVDHB and CCDHB have identified investment in age-related frailty services as a priority for delivering on the objectives of our sustainability plans

c) Implementing model of care changes is essential to optimise the use of health system resources and deliver better health outcomes for frail older people

d) Initiatives implemented to date include new services in both community and hospital settings

e) Early impact analysis indicates both a financial and performance benefit

f) We are developing a performance framework for frailty that will provide ongoing confidence in the benefits and identify future service development opportunities

g) SPP, with our Maori and Pacific Directorates are prioritising development of models for managing complex care, including long term conditions, for consideration in early 2021.

Strategic Alignment	Responsive services for older people in line with the CCDHB Health System Plan 2030 and the HVDHB Vision for Change
Author	Jenny Langton, GM, Primary and Complex care 2DHB
Presented by	Rachel Haggerty, Director, Strategy Planning and Performance Joy Farley, Director, Provider Services
Purpose	To engage with and seek HSC endorsement of the direction for investing in older people across the 2DHBs
Contributors	Sam Maclean, Principal Analyst and Team Leader Planning and Performance Richard Hall, Financial Analyst, Planning and Performance
Consultation	N/A

Executive Summary

1. The 2DHBs have identified investment in system change in relation to age-related frailty as a priority to optimise the use of our health system and improve health outcomes. People with age-related frailty are high users of our health system, particularly hospital inpatient medical and emergency department services.
2. Frailty affects a wide range of people who have complex health needs, including long term conditions and cancer. This service delivery model change is focused on age-related frailty as this population overuse the health system and alternative systems of care. Other causes of frailty require different clinical service responses.
3. We have developed a whole of system approach to preventing, intervening early and delivering care for those with age-related frailty. It makes better use of a wider health workforce, focuses on earlier intervention, streamlined pathways and enhanced support for people on discharge from hospital.

4. This is a 'simplifying' strategy planned to alleviate acute demand in our hospitals and transition to a more affordable use of resources.
5. We are establishing a 2DHB programme that will support ongoing change, prioritise action and deliver greater connection between initiatives.

Engagement/Consultation

Patient/Family	Feedback and engagement from consumers and their families is an embedded part of the age-related frailty model.
Clinician/Staff	The Health of Older People Integrated Care Leadership Forum has led the development of the service delivery model. This group includes specialist and community clinicians and operational and system leaders.
Community	There has been engagement with community leaders and the communities served in the development of the models of care

1. BACKGROUND

CCDHB and HVDHB have identified investment in system change in relation to age-related frailty as a priority for investment to ensure better outcomes for this population group and to optimise the way our local health system operates. Our sustainability plans recognise acute demand for our hospital services is heavily influenced by presentations from people experiencing age-related frailty. This demand has a significant effect on hospital flow and throughput especially when older people are unable to be discharged in a timely way either due to complex clinical needs or inadequate social/clinical supports in the community.

Lengthy stays in hospital have negative health and wellbeing consequences for older people through accelerated functional decline and difficulty rehabilitating to previous levels of independence. This leads to reduced quality of life and potential need for aged residential care sooner than might otherwise have been the case.

As such, we have begun to redesign and invest in interventions and new services models across our entire health system that:

- Provide alternatives to emergency departments for acute events
- Intervene earlier with access to specialist advice for people who are frail to avoid deterioration requiring hospital level care
- Create streamlined pathways in Wellington regional hospital for people with frailty who present acutely
- Enable earlier discharge from hospital with enhanced rehabilitation support making best use of the skills of our allied health workforce

2. What is frailty?

While there is no consensus definition of frailty it is often described as *"an aging-related syndrome of physiological decline, characterized by marked vulnerability to adverse health outcomes. Frail older patients often present with an increased burden of symptoms including weakness and fatigue, medical complexity, and reduced tolerance to medical and surgical interventions."*[1]

People with frailty do not cope well when exposed to stress such as acute illness or medical interventions. This increases their vulnerability and places them at risk for complications such as falls, pressure injuries, and increased likelihood of admission to long term residential care, disability or death.

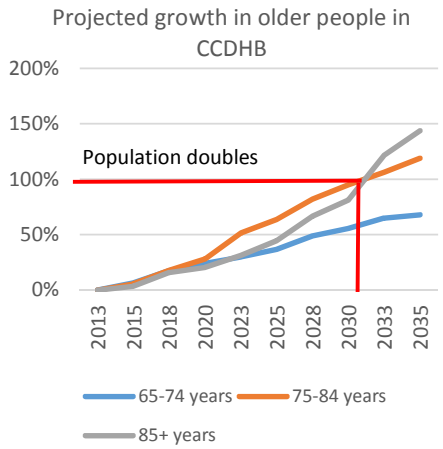
One way to identify frailty is through deficit accumulation, which identifies the most frail, vulnerable older adults through cumulative comorbidities and cumulative illnesses. We also know that frailty is associated with ageing but tends to occur earlier for Māori and Pacific peoples. Therefore an earlier age for these demographic groups should be considered.

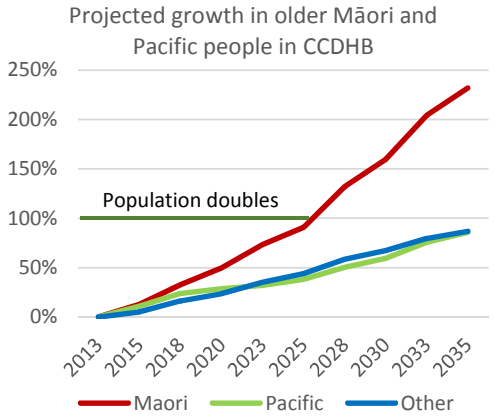
[1] https://www.uptodate.com/contents/frailty

To understand the extent of frailty in our community and inform our actions we analysed data provided by Tū Ora Compass PHO using a deficit accumulation frailty assessment that considers social situation, medications and disability.

3. Our population

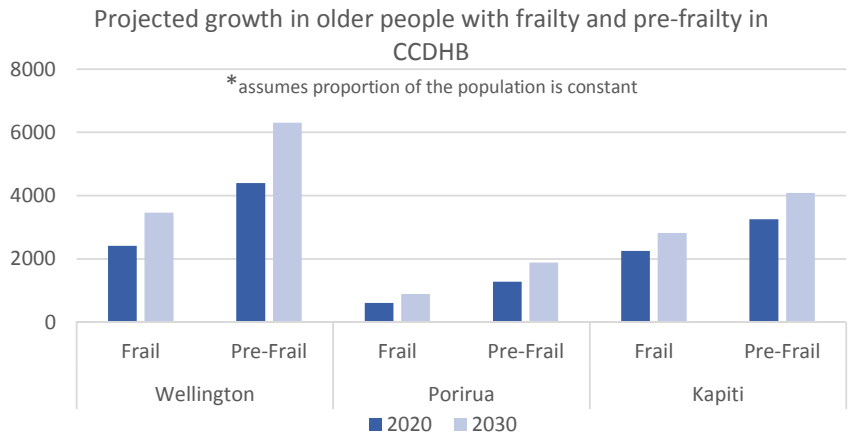
Currently 22,000 older people live in the CCDHB region and 12,000 older people live in the HVDHB catchment. Our older and therefore frail population is projected to grow. This is driven by the significant growth in the number of older people in the region, as our large baby boomer generation shifts into older age brackets. The largest growth is expected be in the 70–79 and 80+ age groups; as our population is living to reach much older ages. Overall, there will be 25,000 extra older people in our health system by 2030 and the older Māori and Pacific population in Wellington will surpass that of Porirua at that point. The proportion of people over 85 will grow fastest and this group is more likely to be frail





For Māori, the population is projected to double by 2025 while the older Pacific population is not expected to double until beyond 2035. Māori and Pacific peoples experience frailty differently; earlier, linked to long term conditions and social complexity. This requires different modes of care and service delivery.

In 2018/19 we analysed a cohort of older people enrolled with Tū Ora Compass Health and identified over 2,000 people as frail and a further 10,000 people as pre-frail.



Most frail people live in Wellington but the largest concentration of frail people is in Kāpiti. For Māori and Pacific peoples the greatest concentration and number of frail older people currently live in Porirua. There are 12,000 older people living in the HVDHB region. We are now planning to complete the analytics to identify frailty and pre-frailty in partnership with Te Awakairangi PHO.

By 2030, if the proportion of people who are frail and pre-frail stay the same, there will be an additional 2,000 frail and just over 3,300 pre-frail people in the CCDHB health system.

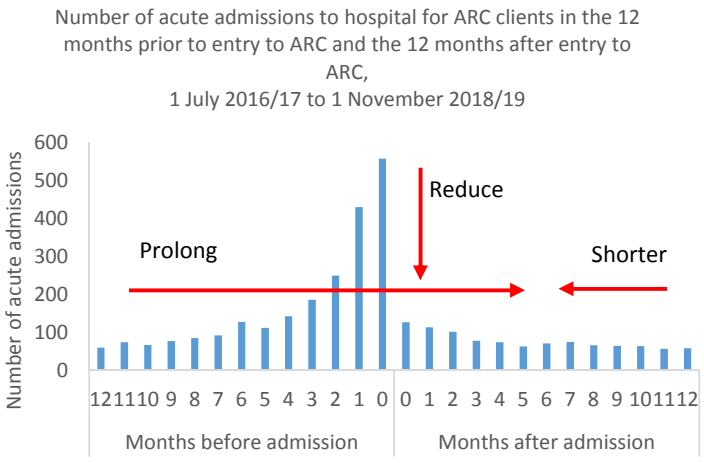
4. Health service utilisation

Older and frail people are high users of the health system. Population growth in this cohort will continue to drive demand for specialist hospital services and increase pressure across our system.

Frail older people:

- Visit their GP more often than others – on average they have 17 consults each year
- Are more likely to have polypharmacy – 50% of over 85s are on 5 or more medicines compared with 20% of 65 to 74 year olds
- Present more often to ED – 26,720 presentations to Wellington ED in 2018/19
- Are more likely to be admitted to hospital via ED – at age 60, 50% of presentation lead to admission and this increases with age
- Stay in hospital longer – acute bed day rate is 4 times higher than the overall population
- Are admitted for medical reasons – 55% of admissions for 65-74 years olds are for medical treatment, 70% of admissions for those 85 and older
- Are more likely to experience hospital acquired harm through delirium, falls and loss of function

Alongside usual primary care and hospital level services, specific supports for age-related frailty centre on aged residential care (ARC) and home and community support services (HCSS).



Before entering an ARC facility, frail people have an acute escalation pathway, which ARC stabilises. In the year before ARC entry people experience an increasing number of acute hospital admissions. To ensure our hospital services are more sustainable and to better manage the ARC budget and finite supply of beds we need to manage this acute escalation well.

We are yet to feel the effect of the Baby Boomer generation on ARC facilities. This reflects practise changes and supporting people to remain at home. This management strategy will not continue to manage increasing demand.

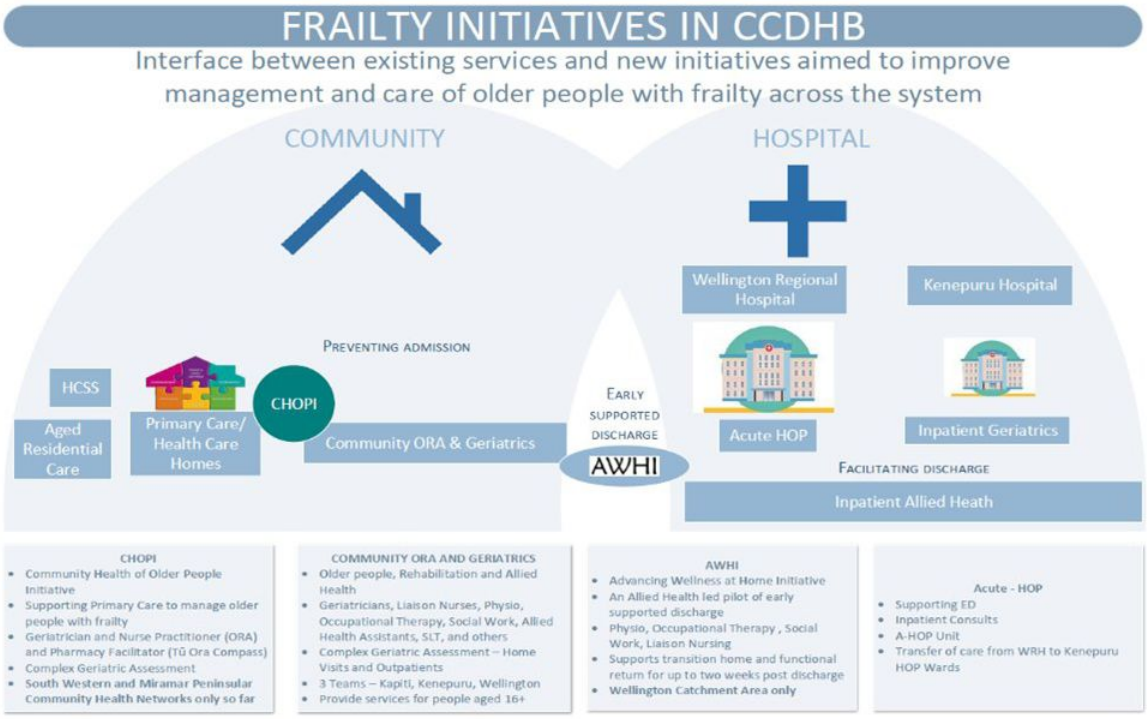
If we don't change our models of care, bed days may increase in line with the population growth. ARC is the highest cost care option (e.g., CCDHB has budgeted $66.5m in ARC for 2020/21). If expenditure

continues to grow, ARC investment will become unsustainable. Our main lever to manage expenditure is to reduce demand.

We also invest in HCSS services to support people to live in their own home for longer. Access to these supports is determined through a comprehensive needs assessment. Home based support services offer care in a lower cost setting but unlike ARC, access to these supports is not means tested. Supporting people at home enables independence and improved access to care has maintained more people at home and managed the risk of demand growth for ARC.

5. Investing in change

At CCDHB we are investing across our health system through primary care settings, within the hospital and with specialty advice to support age-related frailty and deliver care in the most appropriate setting.



Early analysis suggests that whole of system design for frailty is able to support people more effectively. Our responses are providing care in the most appropriate settings, using our health workforce optimally and strengthening pathways and networks. Good system integration is occurring but there remain opportunities to streamline models of care across all settings to deliver further benefits.

1.1. Community Health of Older People Initiative (CHOPI)

CHOPI uses the skills of nurse practitioners and pharmacists along with speciality advice from geriatricians in partnership with general practice to work with frail older people in community settings and avoid hospital admissions. This initiative has so far been piloted in two areas where we identified a large cohort of older people who would potentially benefit from this service. Interventions are wide ranging and include:

- District nurse referral for wound care support and short-term assistance with daily living

Of 4,151 eligible people, **431** seen by CHOPI team
We have invested $400,000. This includes:

- 0.5 FTE Geriatrician SMO
- 2.0 FTE Nurse Practitioner
- 1.0 FTE Pharmacist

Cost per person:
$928

- Referral to home and community support services for help with showering, meals, medication reminders
- Advice on how to optimise the effects of medicines (eg, regular pain relief)

CHOPI costs are averting hospital admissions at a cost of $928 per person. The cost for a hospitalisation is around $6,500 for a general medical admission. Therefore savings of around $5,500 are being made for each admission averted. These are opportunity costs and have allowed us to manage demand for services in Wellington regional Hospital.

Importantly, people are being better supported while remaining at home, avoiding further decline and contributing to better use of hospital capacity. Further funding has been budgeted in 2020/21 which will allow us to start to implement this model more widely. The Community Health Network development in Kāpiti provides an opportunity to apply and test this model in another community with a large older demographic.

1.2. Acute Health Older People (AHOP)

Beginning in May, AHOP was piloted throughout winter with notable success. The service moved frail older people through ED faster and people admitted under the AHOP service are less likely to be readmitted.

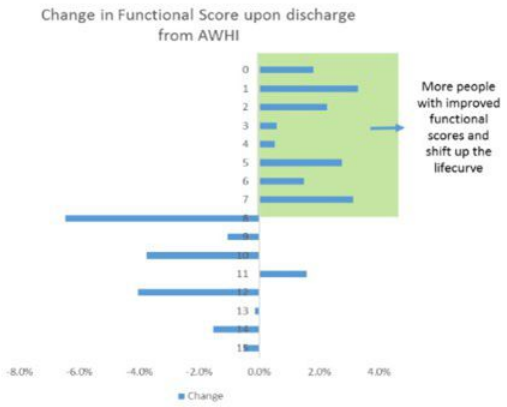
AHOP demonstrates:

- Frail older people get access to specialist care sooner and timely transfer to the right place for the best care
- Shorter stays in ED – 90 minutes quicker
- The length of stay for people 75+ in AHOP was 3.8 days compared with 4 days in general medicine between May and September.
- Proactive responses for Māori and Pacific peoples
- Care that minimises hospital harms to reduce functional decline
- Better connections to other supports (eg AWHI) and integration with the community
- High satisfaction from whānau and staff from both inside and outside of AHOP

Alongside these benefits, our financial analysis indicates an AHOP event costs around $960 less than a general medical event. The pilot made use of existing staff resources to demonstrate effectiveness. Investment in additional FTE is now needed to enable sustainable delivery of this service.

1.3. Early Support Discharge (AWHI)

AWHI works to reduce the functional decline of patients. Upon discharge from AWHI services, patients are likely to have improved functional scores. AWHI optimises the use of our allied health workforce, demonstrates material improvements in outcomes for patients and is showing savings. However, we need to ensure AWHI is being offered equitably to our older Māori and Pacific patients and consider the suitability of this model for them. Ongoing investment in workforce is underway to sustain this service.



802 people have been referred to AWHI with 77% seen by AWHI at home.

- 582 people 65+ (93%)
- 237 people 85+ (38%)

On average, AWHI supports people at home for 19 days.

Fewer Māori and Pacific are seen by AWHI compared to their proportion of our population, and proportion of inpatient population.

333 people also saw a community nurse at home.

525 bed days are estimated to have been saved by AWHI. Taking account of the cost to deliver this service the marginal savings for this investment exceeds $1m.

1.4. Kāpiti Community Acute Response Services (CARS)

Kāpiti CARS aims to reduce travel to Wellington ED and reduce the potential for hospital admission for Kāpiti residents in circumstances where primary care providers supported by enhanced Health Care Home practice teams are well equipped to deliver care. Ambulance diversion underpins the model of care. The model was implemented as one of the measures to address winter demand pressure on hospital flow during 2019. Early results indicated these interventions can have an impact with the pathway for cumulative ED presentations from Kapiti in late July/early August 2019.

Seventy five percent of the people that benefited from Kāpiti CARS were aged 65 years and over. Financial analysis shows that if 10 percent of the people we treat in ED were managed in the community through CARS, the marginal savings could be $60,000 suggesting it is more cost-effective to treat age-related frailty in this way. Importantly, 33 fewer people would present to ED, older people avoid unnecessary travel to hospital and hospital capacity is then available to others. The cost of an ambulance diversion event through CARS is $190.

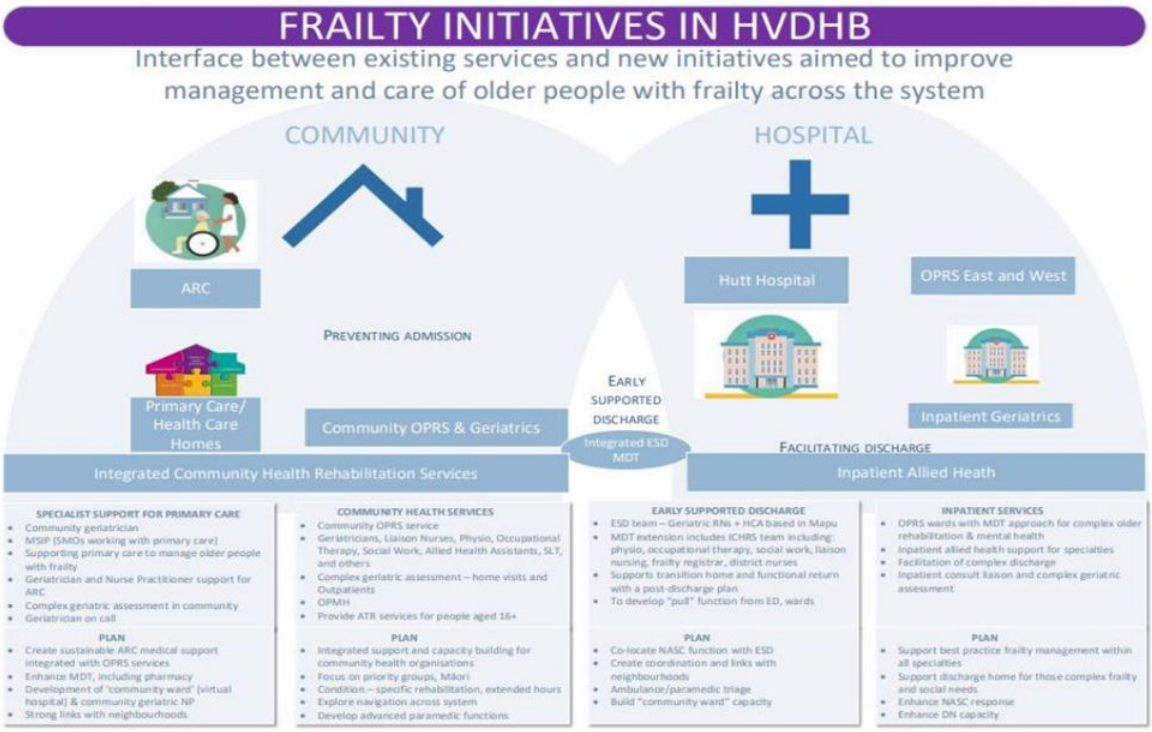
6. What does this tell us?

This suite of interventions is demonstrating the ability to shift the flow of age-related frailty through our system. Early results indicate some marginal savings as a consequence but the most significant benefits lie in optimising the use of each setting of care. Avoiding inpatient admissions for frail older people where possible means these resources can be used for other people who need them. It also means older people are more likely to maintain or regain levels of function that allow them to remain independent for longer. This has the potential to alleviate demand for finite resources within our ARC sector also. Analysis highlights the need for us to be applying a pro-equity lens across these and future activities to ensure we are delivering the best outcomes for our people.

1.5. Extension to the Hutt Valley

Analysis is required to understand the impact of the service models implemented to date in the Hutt Valley. Some activity has parallels with CCDHB such as Early Supported Discharge and we could expect that the benefits being demonstrated in Wellington may also apply.

Understanding the benefits of actions already underway, or planned for, in the Hutt and supporting further development is important for streamlining and prioritising our collective 2DHB work in 2021.



7. Monitoring Performance

Understanding the ongoing impact of our activities through comprehensive performance monitoring is critical for informing future investment/disinvestment and gaps in service delivery across the system. In particular, monitoring and then addressing gaps in care and support for Māori, Pacific and people with disabilities through other complex care responses will be an area of focus.

A performance framework has been developed across 3 dimensions:

- Access
- Quality and Process
- Impact and outcomes

HSC DISCUSSION - Public

November 2020

Rheumatic Fever Prevention Update

Action Required

Health System Committee note:

(a) There have been 15 rheumatic fever notifications in total for 2020 with all cases affecting Māori and Pacific children and young adults predominantly living in Porirua and Lower Hutt.

(b) CCDHB, HVDHB, Lakes DHB and Waikato DHB are the only DHBs that have experienced this increase.

(c) We continue to work on understanding the issues and considering how we work with our communities in response to this significant increase in cases.

(d) In support of timely antibiotic provision for those with rheumatic fever, CCDHB and HVDHB have removed the cap on the age of people eligible to be supported through our rheumatic fever mobile nursing contracts (previously capped at 21 years of age).

(e) Actions are being taken to respond to the increase in cases, including increasing communication campaign activity, creating more options for access to services and strengthening the monitoring and reporting of key data to inform the DHB response.

Strategic Alignment	Taurite Ora, Te Pae Amorangi and Pacific Health Strategy
Author	Aaron Randall, Service Development Manager, Strategy, Planning and Performance
Endorsed by	Rachel Haggerty, Director, Strategy, Planning and Performance
Presented by	Rachel Haggerty, Director, Strategy, Planning and Performance
Purpose	Provide an update on the rheumatic Fever Prevention work programme.
Contributors	Dr Craig Thornley, Medical Officer of Health, Regional Public Health
Consultation	N/A

Executive Summary

This paper provides the Health System Committee with an update in relation to the incidence of rheumatic fever across the CCDHB and HVDHB regions since the last update in July 2020. It also provides an update on the 2DHB response to the recent spike in cases.

There has now been a total of 15 rheumatic fever notifications in 2020, with 11 confirmed cases and 4 possible or suspected cases.[1] There have been a further 6 cases identified (3 confirmed/probable and 3 possible/suspected cases) since the last HSC rheumatic fever update in July 2020. The 6 new identified cases occurred in Porirua and Lower Hutt, continuing the trend of this year's cases affecting Māori and Pacific children and young adults predominantly living in Porirua and Lower Hutt. Two of these cases have occurred in one family.

[1] Patients classified as possible/suspected are those who do not meet diagnostic criteria for rheumatic fever according to the Ministry of Health / Heart Foundation guidelines, but for whom clinicians strongly suspect rheumatic fever is the diagnosis and are managing as such.

Strategic Considerations

Service	The Rheumatic Fever programme is comprehensive and resourced, with a number of identified opportunities to improve the impact of the programme, particularly for Maori and Pacific.
People	There are minimal implications for DHB staff at this time.
Financial	There are no financial implications – the Rheumatic Fever programme is funded primarily by special purpose, MOH funding (77%) and the remainder by confirmed, ongoing 2DHB baseline funding.
Governance	Oversight and monitoring of the rheumatic Fever programme is led by the cross-sectoral and inter-sectoral Well Homes / rheumatic Fever Steering Group. This Group is chaired by a General Practitioner based in Porirua.

Engagement/Consultation

Patient/Family	Not appropriate for this paper.
Clinician/Staff	Subject matter expertise has been sought, as outlined on page 1.
Community	Primary care and NGO providers have informed the future rheumatic Fever programme and priorities, but have not been consulted on this paper.

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating

Attachment/s

1. Updated swabbing data.

1. BACKGROUND

1.1 July HSC update

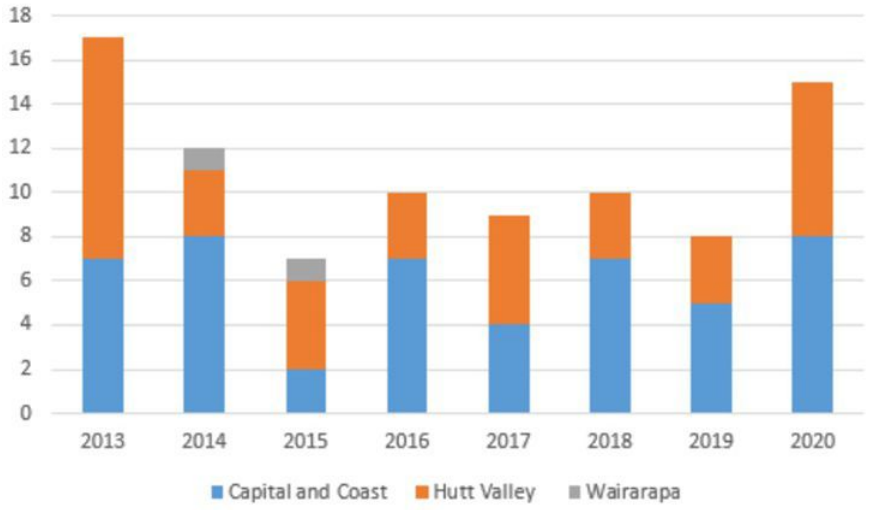
An update on the recent spike in rheumatic fever cases was provided to the HSC for July 2020. Key points from the July 2020 update showed:

- At the time of writing, 9 identified cases of rheumatic fever had been identified since 1 January 2020, with all cases being of either Māori or Samoan ethnicity;
- Analysis of the recent spike in cases showed no causal relationship between the Covid-19 Level 4 lockdown period (23 March – 13 May 2020) and a possible increase in Group A Streptococcus (GAS) transmission due to overcrowding, no indication of clinical errors in treatment and no strong evidence to suggest Covid-related reduced throat-swabbing was linked to the increase in cases;
- What we do know is that this increase in cases is unexpectedly high and more work is required to reduce this case number.

1.2 Notified rheumatic fever cases: January 2005 – November 2020

Rheumatic fever cases in the Greater Wellington region have reduced since the introduction of the national rheumatic Fever Prevention Programme in 2012. However, data for the last 5 years indicates a slight increase in the number of cases from 2015 onwards, with a considerable spike in cases for 2020.

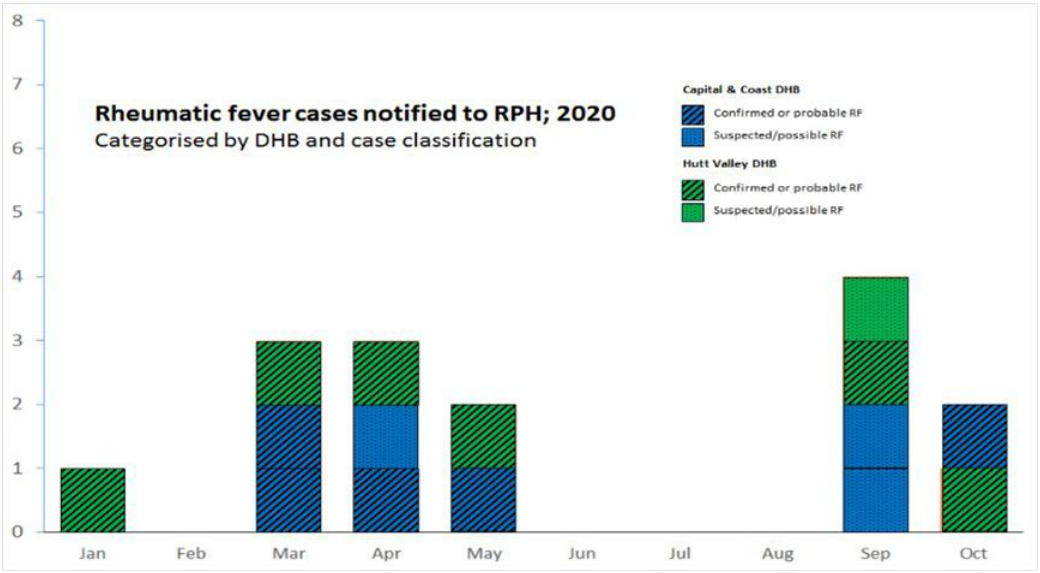
Figure 1: rheumatic fever cases notified in the Greater Wellington Region by DHB (Jan 2013 – Nov 2020)



Additional cases since July 2020

There have been 6 further cases of rheumatic fever identified (3 confirmed/probable and 3 possible/suspected cases) since the last HSC rheumatic fever update provided in July 2020. These cases were also amongst Māori and Pacific children and young adults living in Porirua and Lower Hutt. This brings the total number of rheumatic fever notifications for 2020 to 15 (11 confirmed/probable and 4 possible/suspected cases).

Figure 2: CCDHB and HVDHB combined rheumatic fever notifications for 2020



As with the other cases identified this year there is no known connection between these or any of the previous cases, apart from two cases occurring in the same family.

It should be noted that three of the cases occurring this year sit outside the Ministry of Health (MOH) target age group of 4 – 19 year olds (Table 1 below refers). It should also be noted that the two new cases occurring in the same family are of Tokelauan ethnicity.

Table 1: Cases by age group

Age group (years)	Total YTD	2nd half-year only
5-14	10	4
15-24	2	1
25-34	3	1

Table 2: Cases by ethnicity

Ethnicity	Total YTD	2nd half-year only
Māori	5	2
Samoan	8	2
Tokelauan	2	2*

* Note: these 2 cases are in one family

Table 3: Cases by area of residence

TLA	Total YTD	2nd half-year only
Porirua	7	3
Wellington	1	0
Lower Hutt	7	3

As a comparison to the CCDHB and HVDHB increase in rheumatic fever cases the table below provides this year's national rheumatic fever case data (initial attack and recurrent attack) as of 17 November 2020. These numbers confirm CCDHB and HVDHB as outliers in terms of increased cases of rheumatic fever, alongside Lakes and Waikato DHBs.

Table 4: National rheumatic fever cases 2019 & 2020

District Health Board	2019	2020 (1 Jan. – 17 Nov.)	Change in number of rheumatic fever cases
Capital & Coast	**6**	**8**	+2
Auckland	16	16	-
Bay of Plenty	9	9	-
Canterbury	3	4	+1
Counties-Manukau	64	41	-23
Hawkes Bay	5	6	+1
Hutt Valley	**3**	**7**	+4
Lakes	3	6	+3
MidCentral	7	6	-1
Northland	14	5	-9
Southern	3	1	-2
Tairāwhiti	1	2	+1
Taranaki	1	-	-
Waikato	14	20	+6
Waitemata	21	15	-6
Whanganui	1	-	-
TOTALS	**171**	**146**	

Source: EpiSurv.

At this stage there are no definitive answers as to why the Wellington region has seen more cases than other DHBs. One contributing factor could be the number of cases with possible/suspected diagnoses (i.e. the 4 of the 15 cases diagnosed this year are possible/suspected while 11 are confirmed/probable) but this doesn't account entirely for the variation in CCDHB and HVDHB rates when compared nationally.

SPP and Regional Public Health (RPH) are working together to undertake a comparative analysis of national DHB rheumatic fever performance to identify the possible causes for the variation. We will also be working with the MoH to connect with DHBs who have seen decreased rheumatic fever incidence, with a view to understand the key success factors underpinning there work.

Our activity

1.3 Throat swabbing data for streptococcus

Appendix 1 shows the number of swabs for streptococcus (red bars) compared to previous years (blue dotted-line). While swabbing rates were much lower from May – September 2020 compared to previous years, we have seen October and November swabbing activity levels start to lift to a similar level to previous years.

The spike in streptococcus swabbing from 20 June coincides with an increase in Covid-19 testing activity, following the two positive cases from Auckland. Almost half of the streptococcus swabs in this June spike are from Porirua, where the CBACs test for both COVID-19 and GAS in eligible people. The subsequent reduction in early July aligns with CBAC activity.

SPP will continue to monitor these rates and maintain regular contact with primary care providers on swabbing data through the Covid-19 primary care Incident Management Team (IMT).

1.4 Antibiotics compliance data

Once people have rheumatic fever they must follow an antibiotic regime. RPH antibiotics compliance data shows good coverage across the <16 and 16-21 age groups but reaching those over 22 years of age continues to be an issue (Table 5 below refers). This follows the trend from previous antibiotic compliance data.

Table 5: RPH antibiotics compliance data (1 Jan – 13 Nov 2020)

DHBName	Age Group	Number of RF cases on the register	Total Doses Due	Total Doses Given	Total Doses Delivered Late (>= 5 days)	% of doses delivered late (>= 5 days)	Total Doses Missed	% of doses missed
Capital and Coast	<16	42	411	399	42	11.0	12	3.0
Capital and Coast	16-21	34	281	268	26	10.0	13	5.0
Capital and Coast	>22	8	68	58	22	38.0	10	15.0
Hutt Valley	<16	29	265	261	18	7.0	4	2.0
Hutt Valley	16-21	16	147	142	13	9.0	5	3.0
Hutt Valley	>22	10	81	72	20	28.0	9	11.0
Wairarapa	<16	1	10	10	0	0.0	0	0.0
Wairarapa	16-21	1	10	10	1	10.0	0	0.0
Wairarapa	>22	1	11	5	1	20.0	6	55.0

In support of timely antibiotics provision, CCDHB and HVDHB has removed the cap on the age of people eligible to be supported by our rheumatic fever mobile nursing contracts (previously capped at 21 years of age). This will enable all people on the rheumatic fever register to have access to the provision of free, home or work based antibiotics every month.

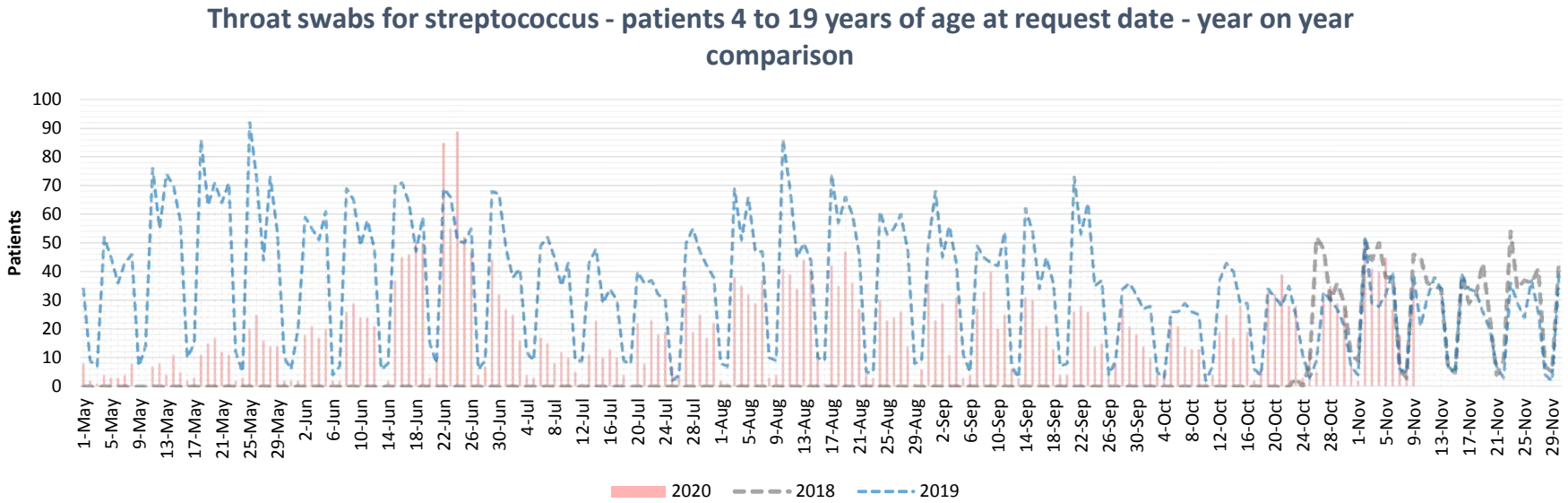
1.5 Rheumatic Fever communications campaign

The 2DHB and RPH Communications teams continue to work with community providers to implement the 2DHB rheumatic fever Communications Plan. A day-by-day calendar of awareness raising messages is being delivered on rheumatic fever, sore throats and maintaining dry, healthy homes via social media, radio and Giggle TV. Work is ongoing to review and understand the effectiveness of these awareness raising activities, to inform future work.

1.6 Māori and Pacific Leadership Forum

One of the key next steps will be to establish a leadership forum with our Māori and Pacific community leadership to identify and plan further actions to respond to this increase in rheumatic fever rates. This work will be a joint activity between the Māori and Pacific Directorate and SPP.

APPENDIX 1: SWABBING DATA



Health System Committee - Discussion

November 2020

2019/20 Quarter 4 Performance and COVID-19 Analysis

Action Required

The CCDHB Board note:

(a) The CCDHB Performance Report COVID-19 Analysis for September 2020.

(b) The CCDHB COVID-19 Recovery Dashboard.

(c) Non-Financial Monitoring Report results for Q4 2019/20.

The HVDHB Board note:

(a) The HVDHB Performance Report COVID-19 Analysis (September 2020).

(b) The HVDHB COVID-19 Recovery Dashboard.

(c) Non-Financial Monitoring Report results for Q4 2019/20.

Strategic Alignment	CCDHBs Health System Plan 2030 HVDHBs Vision for Change
Presented by	Rachel Haggerty, Director, Strategy, Planning & Performance CCDHB and HVDHB
Purpose	This paper provides an overview of the performance reports with COVID-19 analysis and the 2019/20 Quarter 4 Non-Financial Monitoring Reports, as assessed by the Ministry of Health for CCDHB and HVDHB.
Contributors	Peter Guthrie, Manager Planning & Performance, Strategy, Planning & Performance CCDHB and HVDHB Nathan Clark, Manager Strategy and Planning, Strategy, Planning & Performance CCDHB and HVDHB Wikke Bargh-Koopmans, Senior Advisor Accountability, Strategy, Planning & Performance CCDHB and HVDHB
Consultation	N/A

Executive Summary

1. The Ministry of Health (MOH) has provided CCDHB and HVDHB with 'COVID-19 analysis' performance reports as part of the MOH DHB Performance Programme (to provide regular DHB performance reports with detailed analysis of key areas of sector performance).
2. The Performance Reports on COVID-19 (September 2020) for CCDHB and HVDHB focus on the impacts of COVID-19 on DHB financial performance and DHB-funded and provided inpatient and outpatient medical/surgical care between January and June 2020.
3. For CCDHB, MOH notes that CCDHB's deficit against Plan increased from December 2019 but its deficit as a proportion of revenue is less than the peer average, and CCDHB's service delivery related measures generally compare favourably with peers, with the exception of longer average length of stay for planned hospitalisations. Similar to the sector trend, CCDHB residents had fewer unplanned events between January and June 2020, compared to the same period in 2019.
4. For HVDHB, MOH notes that HVDHB's financial performance during this period showed overspend across most major cost categories. HVDHB has a high rate of unplanned

hospitalisations, with higher preventable hospitalisations for Māori / Pacific children under five years than peers, but access to planned inpatient care at HVDHB appears to be greater than in peer DHBs. HVDHB residents had fewer unplanned ED attendances and hospitalisations between January and June 2020, compared to the same period in 2019.

5. The results of the MOH Non-Financial Quarterly Monitoring Reports for Quarter Four 2019/20 have been received for both CCDHB and HVDHB. The Non-Financial Quarterly Monitoring Report gives a picture of DHB performance against performance measures and activities as outlined in the Annual Plan.
6. This is the first Non-Financial Quarterly Monitoring Report for 2019/20. The Q1 report was delayed as the Boards were established. The Q1 and Q2 reports were prepared for the April Board meeting but this meeting was cancelled. The Q3 report was not produced as MOH decided to delay Q3 performance reporting and incorporate it into the Q4 reporting cycle.
7. CCDHB received an 'Outstanding' rating in relation to the 'Engagement and obligations as a Treaty partner' performance indicator, which relates to progress against our annual plan activities to meet our Treaty of Waitangi obligations. CCDHB received an 'Achieved' or 'Partially Achieved' 52 indicators, did 'Not Achieve' 4 indicators and 'No Report' was provided for 1 indicator;
8. HVDHB received an 'Outstanding' rating for the 'Newborn enrolment with General Practice' performance indicator. HVDHB received an 'Achieved' or 'Partially Achieved' 46 indicators, did 'Not Achieve' 5 indicators and 'No Report' was provided for 3 indicators.
9. Specific action plans are in place across both DHBs to improve performance on the 'Not Achieved' performance measures.
10. Both CCDHB and HVDHB use a subset of the Non-Financial Quarterly Reporting indicators to monitor progress implementing the strategic goals in CCDHB's Health System Plan 2030 and HVDHB's Vision for Change.

Strategic Considerations

Strategic goals	CCDHB's 'Health System Plan' Dashboard and HVDHB's 'Vision for Change' Dashboard show progress against implementing our strategic goals and outcomes for our population groups, particularly our goal of achieving equity for Māori and Pacific people. Both DHB have similar strategic goals, expressed in slightly different ways. These goals are: • Promote health and wellbeing / Support people living well • People-focused services in the community / Shift care closer to home • Timely effective care that improved health outcomes / Deliver shorter, safer, smoother care Achieving equity and providing an integrated seamless service is embedded throughout these strategic goals. Overall, performance against our strategic goals is improving slowly, although some indicators are relatively static and equity gaps need to be addressed. We are developing a work programme to progress our strategic goals, improve performance, and eliminate the equity gaps. This work programme includes a focus on pro-equity commissioning, the 2DHB hospital network planning, mental health commissioning, and system integration.
Financial	N/A

Governance	On behalf of the Minister of Health, MOH assesses DHB performance against the DHB non-financial monitoring framework. The DHB non-financial monitoring framework aims to provide a rounded view of performance, including government priorities, using a range of performance indicators. MOH reports DHB performance to the Minister on a quarterly basis.

Engagement/Consultation

Patient/Family	N/A
Clinician/Staff	N/A
Community	N/A

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
Insert risk #	Noncompliance with statutory requirements	Rachel Haggerty	Standard Operating Procedures in place to ensure compliance with the process	2	Low Risk

Attachment/s

The following documents are attached for Board review:

2.1.1 HVDHB Non-Financial Performance Report (Q4 2019/20)

2.1.2 CCDHB Non-Financial Performance Report (Q4 2019/20)

Related Resource Centre documents:

2.1.3 CCDHB Performance Report COVID-19 Analysis (September 2020)

2.1.4 CCDHB COVID-19 Recovery Dashboard

2.1.5 HVDHB Performance Report COVID-19 Analysis (September 2020)

2.1.6 VDHB COVID-19 Recovery Dashboard

HVDHB Non-Financial Performance Report (Q4, 2019/20)

This paper provides an overview of HVDHB's quarter four non-financial performance and includes:

- The results of HVDHB's Non-Financial Quarterly Monitoring Report for Q4 2019/20 as assessed by the Ministry of Health (MoH)
- Comment on the MoH's HVDHB Performance Report with COVID-19 Analysis and HVDHB COVID-19 Recovery Dashboard
- HVDHB's 2019/20 Quarter Four 'Vision for Change' Dashboard.

1. BACKGROUND

Non-financial performance

On behalf of the Minister of Health, the MoH assesses DHB performance against the DHB non-financial monitoring framework. The DHB non-financial monitoring framework aims to provide a rounded view of performance, including government priorities, using a range of performance indicators. The MoH reports DHB performance to the Minister on a quarterly basis.

The framework uses the Government's five main priorities as a central organising method:

Ministry's DHB Performance Programme

The MoH plans to send regular performance reports to DHBs that provide more detailed analysis of key areas of sector performance. DHB Chairs and Chief Executives were provided with Programme reports in December 2019 and May 2020. The most recent report we have received focusses on the impacts of COVID-19.

2. NON-FINANCIAL PERFORMANCE REPORT

In Quarter 4 2019/20, HVDHB received an 'Outstanding' rating for one performance measure (Newborn enrolment with General Practice). We received an 'Achieved' or Partially Achieved' for 46 of the 56 performance indicators, 5 indicators rated as 'Not Achieved' and 3 indicators not being reported.

Achievement	Number of indicators Q2	Number of indicators Q4
Outstanding	1	1
Achieved	33	21
Partially Achieved	16	26
Not Achieved	5	5
Not Reported	1	3

This is a slight decline compared to Q2, when we received an 'Achieved' or Partially Achieved' for 49 performance measures.

HVDHB received three 'Not reported' ratings in Q4 for:

- SS12 Engagement and obligations as a Treaty partner
- PH02 Improving the quality of ethnicity data collection in PHO and NHI registers
- PH03 Improving Maori enrolment in PHOs to meet the national average of 90%.

The reporting for SS12 was missed due to a change over in management staff in the Māori Health Directorate in the middle of reporting period. The information for SS12 will be provided to MoH in the next quarter report. PH02 and PH03 were not reported due to a lack of data supplied by the PHO, despite the best efforts of the portfolio manager to obtain this data.

HVDHB received a 'Not Achieved' rating for five indicators

HVDHB received a 'Not Achieved' rating for the following performance measures:

- CW05 Immunisation coverage - FA2 - 5 year
- CW06 Immunisation coverage - FA3 – HPV
- CW09 Better help for smokers to quit - Maternity
- MH03 Shorter waits for non-urgent mental health and addiction services
- SS13 Improved management for long term conditions FA3 - Cardiovascular health (CVD)w

Specific action plans are in place to improve performance on the 'Not Achieved' performance measures.

HVDHB Annual Plan updates

DHBs were required to provide updates on the delivery of annual plan actions and milestones as part of non-financial performance reporting. Updates must be provided for the 32 planning priorities across the Government's five priority areas. HVDHB's performance for quarter four was rated as follows:

Status Update Report	Final Rating Q4
Improving child wellbeing	Partially Achieved
Improving mental wellbeing	Partially Achieved
Improving wellbeing through prevention	Achieved
Better population health outcomes supported by strong and equitable public health services	Achieved
Better population health outcomes supported by primary health care	Partially Achieved

Delays in delivering against the Annual Plan 2019/20 were mainly caused by COVID-19 and recovery plans are in place to address this.

3. HVDHB PERFORMANCE REPORT WITH COVID-19 ANALYSIS

As part of the MoH's DHB Performance Programme, the MoH has provided us with a 'HVDHB Performance Report with COVID-19 Analysis' and a 'HVDHB COVID-19 Recovery Dashboard'. These focus on the impacts of the COVID-19 pandemic on DHB financial performance and inpatient and outpatient medical / surgical care between January and June 2020.

Hutt Valley DHB's financial performance during this time showed overspend across most major cost categories. Revenue was lower than anticipated, and there was significant above plan growth in personnel and outsourced clinical service costs. The DHB has a high rate of unplanned hospitalisations, with higher preventable hospitalisations for Māori / Pacific children under five years than peers. Access to planned inpatient care appears to greater than in peer DHBs, despite theatre and diagnostic throughput being lower. Hutt Valley DHB residents had fewer unplanned Emergency Department attendances and hospitalisations between January and June 2020, compared to the same period in 2019.

Some key improvement activities are planned and outlined below:

- Improving unplanned hospitalisation and Ambulatory Sensitive Hospitalisations ASH rates is a priority for integration in 2020/21, and integrating Regional Public Health with community commissioning is designed to target this outcome improvement.
- We have a surgeon-led action plan underway to improve theatre utilisation. This includes review of anaesthetic rostering and a proposal for a procedure suite to take small cases out of main theatre.
- Care Capacity Demand Management (CCDM) recommended rosters are being implemented to reduce reliance on outsourced nursing and improve control of this resource.
- Our actual diagnostic throughput is higher than reported to the MoH, as our radiology team inadvertently under reported volumes through both CT and MRI. We have met with the MoH to work through a resolution on the issue, including providing some updated reporting. Wait times for MRI are a challenge - and we are consulting regarding opening up planned sessions at weekends.
- We also have a plan in place to meet the Colonoscopy demand with more sessions, includes working with our private partners to increase capacity. We are also looking at bringing in nurse endoscopists to increase capacity.

4. 20219/20 QUARTER FOUR CCDHB 'VISION FOR CHANGE' DASHBOARD

The MoH's Non-Financial Performance Framework is particularly useful at monitoring quarterly performance against specific indicators. However, it does not adequately monitor longer-term population health (including equity) or system change. We have therefore developed a HVDHB Vision for Change Dashboard (attached) to monitor progress against our longer-term strategic goals and outcomes for our population groups, particularly our goal of achieving equity for Māori and Pacific people.

HVDHB's Vision for Change was developed in 2017 to support and shape the direction and approach the Hutt Valley District Health Board (HVDHB) will take over the next five to ten years in order to achieve our vision of: Health People, Healthy Families, and Healthy Communities. The HVDHB Vision for Change Dashboard uses a subset of the non-financial performance measures to monitor our strategic goals:

- Support people living well
- Shift care closer to home
- Deliver shorter, safer, smoother care.

The subset of indicators chosen are those that we think best reflect system performance and outcomes, including ethnicity gaps. The dashboard also shows the high-level areas of focus and initiatives we are undertaking to achieve each strategic goal. We are developing a work programme to progress our strategic goals and improve performance measures. This work programme includes the following areas of work:

2DHB Hospital Network	Pro-Equity Commissioning	Mental Health Commissioning	System Integration
• Operational/Site Feasibility • 2DHB Operational Integration • Financial Feasibility • Clinical Services Planning	• Iwi Partnership: Integrated Porirua Commissioning, Ora Toa Integrated Contract • Pacific Health Service Development • Integrated Commissioning: Youth One Stop Shop, Mana, Pepi & Tamariki, Complex Care & Long Term Conditions • Inter-sectoral Priorities: Family Violence, Housing, Suicide Prevention	• Crisis & Acute Response, Living Life Well - Community Mental Health & Wellbeing Integration, AOD model of Care • Kaupapa Māori Service Development • Acute Care Continuum MHAIDS/NGO System Integration • Community Mental Health Development: Access & Choice - Primary Care/NGO, Youth Mental Health Response	• Specialty / Hospital Flow: Managing Acute Flow, Managing specialist advice/ e-referrals/outpatients • Community Health Networks / Neighbourhood Development • Planned Care: Production Planning, Planned Care in specialty services and community • Frailty Units, Community Frailty Response
Enablers:	Data & Digital, People & Capability, Financial Management, Workforce, Quality & Safety		

Support people living well

Indicator	Performance	Our Strategic Response
Better help for smokers to quit	Stable	As part of our **COVID-19 Recovery** work plan, we are working in partnership with our PHOs to improve performance in practices where COVID-19 has strained performance for Māori and Pacific.
Childhood immunisations	Drop in 2020 for Māori and Pacific	We are working with our practices, iwi providers, and outreach services in the Hutt Valley to reach children who may not be immunised. Model of care changes are being considered to lift performance.
Elder immunisation	Significant improvement	Our COVID-19 response saw a significant increase in influenza immunisation. **Planning for Winter 2021** will soon be underway to try and sustain this coverage and reduce avoidable winter demand on our hospital services.

Shift care closer to home

Indicator	Performance	Our Strategic Response
Avoidable hospital admissions (0-4 years)	Stable / Equity gaps	Work under **Pro-Equity Commissioning** and **System Integration** will help improve access to urgent and planned care in primary care, which will support achievement of these indicators. This work includes the roll out of the Health Care Home model of care, the development of community health networks (neighbourhood approach), an action plan to improve the First 1000 days of life, the work to improve vaccinations, and a **whole of system response to frailty.**
Avoidable hospital admissions (45-64 years)	Improved / Equity gaps remain	
Percentage of people 75+ living in their own home	New indicator	Our **whole of system response to frailty** supports people to live at home. is includes strategic investments such as the Advancing Wellness at Home Initiative (AWHI) Programme and early supported discharge. Managing frailty is a key part of our **Sustainability Plan**.

Deliver shorter, safer, smoother care

\Indicator	Performance	Our Strategic Response
Acute unplanned readmission	Stable	A number of initiatives are in place to **manage acute flow** through our hospitals, including early supported discharges of older people and improved use of the transit lounge.
Acute hospital bed days per capita	Improving but equity gaps remain	**Integrated Commissioning** has seen packages of care developed to support people in the community. For example, supporting Health Care Homes to receive patients by ambulance who do not require hospital level care.
Shorter Stays in ED	Declining performance	**Managing Acute Flow** is part our Sustainability Plan. Actions include: minimising discharge delays, reducing the number of long stay patients and improve flow between hospitals.

5. NEXT STEPS

Future provisional topics under the MoH's DHB Performance Programme include:

- Workforce planning and financial forecasting (aimed for November 2020)
- Operating theatre and surgical flow performance (aimed for early February 2021)
- Clinical supply use and expenditure profiling (aimed for March 2021)
- Resource allocation and impact on access, quality and cost (aimed for May 2021).

Quarter one non-financial performance reporting for 2020/21 is currently underway with final ratings due to be posted by MoH by 17 November. A report outlining the results will be provided in December.

APPENDIX: Hutt Valley DHB – 2019/20 Quarter Four 'Vision for Change' Dashboard

Support people living well

We will work collaboratively with partners to create healthy environments, eliminate health inequities, and support people to adopt healthy lifestyles.

Areas of focus

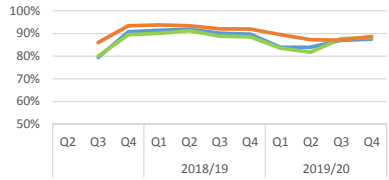
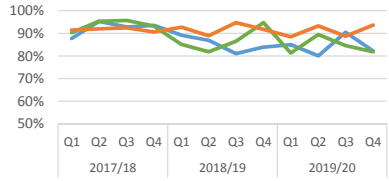
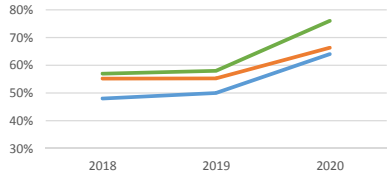
- Prevention, health promotion and public health activities
- Building strong and resilient communities – implementing our Wellbeing Plan
- First 1000 days of life
- Screening for breast, cervical and bowel cancer
- Environmental sustainability
- Achieving health equity

Sub-regional initiatives

- Support our workforce to achieve increased equity outcomes, particularly for Māori, Pacific and people with disabilities (2DHB)
- Co-design innovative models of maternity care with Māori and Pacific women in order to improve outcomes (2DHB)
- Offer education, advice and transport to clients who have previous missed appointments to Breast, Cervical or Colonoscopy Services (2DHB)
- Develop a guide for providers/practitioners to guide conversations with families declining immunisations, with a focus on co-designing with Māori and Pacific families and providers (2DHB)

Local initiatives

- Develop an action plan to improve the wellbeing of children and young people in the Hutt Valley
- Implement the Māori Provider Influenza Vaccine Improvement Project – through marae and outreach-based services
- Co-ordinate the delivery of the Hutt Valley Smokefree Action Plan focusing on priority populations
- Promote, and increase access to, the Hapu Mama programme at Kokiri Marae.
- Deliver the Healthy Active Learning programme to schools and early learning services, with a continued emphasis on low decile schools
- Implement a Bowel Screening Outreach Programme to improve engagement with Māori and Pacific peoples and facilitate their access to timely screening and early treatment of cancers
- Enhance the Well Homes service in partnership with Tu Kotahi Māori Asthma Trust, He Kāinga Oranga and the Sustainability Trust

Indicators	Description	Rationale	Targets		Performance – three year trend	Comments
Indicator 1: Better help for smokers to quit (primary care)	People aged between 15-75 provided smoking cessation advice in primary care	Stopping smoking confers immediate health benefits on all people, and is the only way to reduce smoker's risk of developing a smoking-related disease. Providing smokers with brief advice to quit increases their chances to make a quit attempt, and this is increased if medication and/or cessation support are also provided.	Māori Pacific Non-Māori, Non-Pacific Total	≥90%		Performance has improved, although further work is required. The smokefree coordinator support work in Te Awakairangi PHO appears to be having some impact on performance. We will continue to support primary care to achieve the target, particularly for Maori and Pacific.
Indicator 2: Childhood immunisation	Children fully immunised at 5 years	Children who receive the complete set of age appropriate vaccinations are less likely to become ill from certain diseases. This measure captures all immunisation milestones and emphasises the need for immunisation to be both full, and delivered on time, to achieve outcomes.	Māori Pacific Non-Māori, Non-Pacific Total	≥95%		HVDHB is working with the PHOs and Outreach Immunisation Services to improve Māori and Pacific immunisation coverage. Providers have realised the changes they have implemented to their delivery of care throughout COVID should remain and are reviewing this. Providers are considering community clinics and home visits to deliver national immunisation schedule vaccines.
Indicator 3: Elder immunisation	Percentage of people age 65 years and over that are immunised against influenza, shingles, tetanus, diphtheria and whooping cough	At age 65, immunisation is recommended by the Ministry of Health. These vaccines are free and support older people to stay well. A high performing system should see high uptake of immunisations to keep people healthy.	Māori Pacific Non-Māori, Non-Pacific Total	≥75%		During the COVID-19 response we have seen increased update of influenza immunisation and in particular performance has improved across our priority populations.

Shift care closer to home

We will shift services so they are delivered closer to the people using them, enabling people to receive most of their (non-complex) care within their community or homes.

Areas of focus

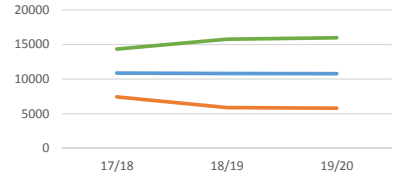
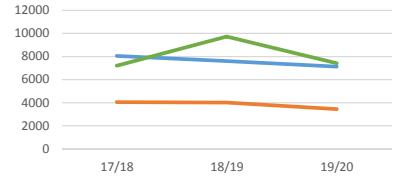
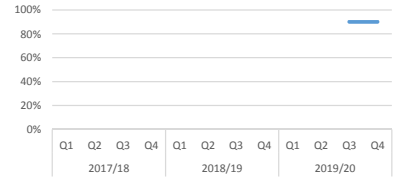
- Early intervention
- Build strong primary and community care
- Health Care Homes
- Placed-based planning – community hubs / neighbourhood approach
- Specialist support for primary care
- Telehealth services
- Management of Long Term Conditions
- Achieving health equity

Sub-regional initiatives

- Support a 2DHB collaborative of Māori and Pacific mental health service providers to develop and implement culturally appropriate and community-based models of care (2DHB)
- Embed telehealth models of care that began during COVID to enable patients to appropriately receive primary and secondary care services (2DHB)
- Develop and begin implementation of a 3DHB suicide prevention and post-vention plan, with a focus on population groups at higher risk of suicide (3DHB)

Local initiatives

- Roll out the Health Care Home patient-centred model of care across the Hutt Valley to every willing practice, achieving the aim of maximum coverage
- Review and implement changes to the Diabetes Self-Management education service to ensure it works for Māori and Pacific populations
- Explore opportunities to shift care 'closer to home' for Orthopaedic/Physio services (through the community Mobility Action Programme)
- Review the Long Term Conditions programme to ensure alignment with Health Care Home and 'Year of Care' planning
- Review our Cardiovascular Disease Risk Assessment programmes, and explore potential partnerships with Māori/Pacific providers
- Pilot a 'neighbourhood approach' to integrated care through the establishment of a community team of nurses and allied health staff supporting 'neighbourhoods' of GP practices Arrange for General Medical Physicians to work in the community with general practices in assigned neighbourhoods and attend practice-based multi-disciplinary team meetings
- Work with Sport Wellington to improve the availability of, and access to, strength and balance activities and programmes to Māori and Pacific older peoples.
- Implement the next phase of the Respiratory Work Programme to address asthma and respiratory related hospital admissions and disparities for Maori and Pacifica.

Indicators	Description	Rationale	Targets		Performance – three year trend	Comments
Indicator 1:	Avoidable hospital admissions (ASH rates 0-4 yrs)	Ambulatory sensitive hospitalisations (ASH) are hospitalisations that could have been avoided through primary care interventions. This indicator also highlights variation between different population groups. ASH rates can be reduced by shifting care closer to home, providing coordinated primary and secondary care services, and improving timely access to high-quality and culturally safe primary care services.	Māori	↓3% (≤11,676)		To improve performance we will increase referrals to Tū Kotahi Māori Asthma Trust and Well Homes. Strengthen primary care follow-up for children post ASH admission. Support enrolment of whānau with a GP on presentation to hospital. Provide increased numbers of supervised tooth brushing, oral health examination and education.
			Pacific	↓2% (≤17,459)		
			Non-Māori, Non-Pacific	↓6% (≤5,791)		
			Total	↓7% (≤8,243)		
Indicator 2:	Avoidable hospital admissions (ASH rates 45-64 yrs)		Māori	↓6% (≤7,271)		We have a number of initiatives underway to improve performance, including implementing the Health Care Home model, increasing influenza vaccination, improved self-management of long term conditions, and community integration of provider arm workforce with primary care.
			Pacific	↓6% (≤7,947)		
			Non-Māori, Non-Pacific	↓2% (≤3,647)		
			Total	↓2% (≤4,443)		
Indicator 3:	Percentage of people 75+ living in their own home	Subsidised age residential care is important for those who need it, but our overall goal is to assist our elderly population to stay well and continue to live independently in their own homes. This requires good access to primary care and, in some cases, home and community support services – including culturally safe household and personal care services.	Māori	TBC		This is a new measure for 2019/20 and will be monitored in 2020/21. 90% of the HVDHB population over age 75+ live in their own home. HVDHB is supporting a whole of system approach to frailty to support people to live at home for as long as possible. This includes strategic investment approaches. Managing frailty is a key part of our Sustainability Plan.
			Pacific			
			Non-Māori, Non-Pacific			
			Total			

Deliver shorter, safer, smoother care

We will coordinate and streamline patient care so that individuals and whānau experience a shorter, safer and smoother journey through our services.

Areas of focus

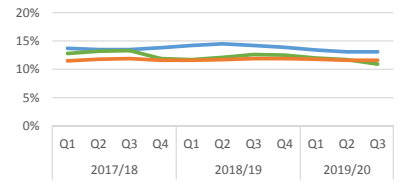
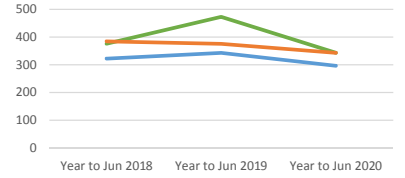
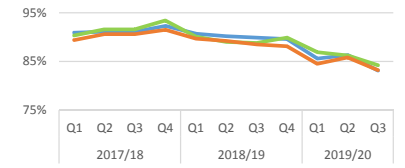
- Timely and effective care
- Safe and efficient hospital services
- Quality improvement activities
- Managing Acute Flow and production planning
- Community, primary and secondary integration
- Achieving health equity

Sub-regional initiatives

- Progress the 2DHB Hospital Network Programme to ensure our services are clinically and financially sustainable (2DHB)
- Develop and implement a reformed 2DHB maternal and neonatal health system plan (2DHB)
- Review and improve consumer data collection and entry in the feedback system (SQUARE) with an emphasis on improving the quality of the data, in particular ethnicity and disability data (2DHB)
- Develop a 2DHB Family Violence Prevention Action Plan (2DHB)
- Implement the 3DHB 'Acute Continuum of Care' to better match need to service provision, enhance coordinated service provision across a range of providers, and improve integration and patient flow through the system (3DHB)
- Develop and implement a mechanism for health information to be easily accessible for disabled people in ways that promote their independence and dignity (3DHB)

Local initiatives

- Extend the Early Supported Discharge service to include AHS&T staff (alongside current Nursing allocation)
- Development of procedure rooms for those non-theatre procedures currently done in theatre
- Improve operating room utilization through the development a second acute theatre
- Implement the Patient Observation Platform at Hutt Hospital to improve efficiency and optimise the use of our nursing, midwifery and medical workforce.
- ED will work with the PHOs to explore and support opportunities for increased management of patients in the community and to build relationships with primary health care

Indicators	Description	Rationale	Targets		Performance – three year trend	Comments
Indicator 1:	Acute unplanned readmission	An unplanned acute (emergency and urgent) hospital readmission is often the result of the care provided to the patient by the health system. We can reduce unplanned acute admissions by ensuring a smooth transition from the hospital back into primary care, and by improving the quality of care in the hospital and in primary care.	Māori	≤11.8%		Our Sustainability Plan has a number of initiatives to improve our acute readmissions rate and improve flow at Hutt Hospital.
			Pacific			
			Non-Māori, Non-Pacific			
			Total			
Indicator 2:	Acute hospital bed days per capita	Acute hospital bed days per capita reflects the demand for acute inpatient services. We can manage this demand by good discharge planning, improving the transition between the community and hospital settings, good communication between providers, managing conditions in primary care settings, and timely access to diagnostics services.	Māori	↓3% (≤564)		To address performance we plan to implement a neighbourhood approach to integrated care, with a focus on a neighbourhood with a high priority population (Māori, Pacific, high deprivation). Implement the Māori Provider Influenza Vaccine Support Project.
			Pacific	↓7% (≤538)		
			Non-Māori, Non-Pacific	↓2% (≤297)		
			Total	↓2% (≤344)		
Indicator 3:	Shorter Stays in ED – patient discharged or transferred with 6 hours (SS10)	ED length of stay is an important measure of the quality of acute care in our public hospitals. The timeliness of treatment is important for patients. Long waiting times are linked to overcrowding and negative clinical outcomes and compromised standards of privacy and dignity for patients.	Māori	95%		To Improve performance we are working to increase acute theatres to improve flow and decrease delays in ED transfers; a MAPU/APU project to provide more appropriate and faster assessment of patients and to manage GP referrals better; focuses patient flow coordination on mornings to move patients faster to avoid bed block.
			Pacific			
			Non-Māori, Non-Pacific			
			Total			

CCDHB Non-Financial Performance Report (Q4, 2019/20)

This paper provides an overview of CCDHB's quarter four non-financial performance and includes:

- The results of CCDHB's Non-Financial Quarterly Monitoring Report for Q4 2019/20 as assessed by the Ministry of Health (MoH)
- Comment on the MoH's CCDHB Performance Report with COVID-19 Analysis and CCDHB COVID-19 Recovery Dashboard
- CCDHB's 2019/20 Quarter Four 'Health System Plan' Dashboard.

1. BACKGROUND

Non-financial performance

On behalf of the Minister of Health, the MoH assesses DHB performance against the DHB non-financial monitoring framework. The DHB non-financial monitoring framework aims to provide a rounded view of performance, including government priorities, using a range of performance indicators. The MoH reports DHB performance to the Minister on a quarterly basis.

The framework uses the Government's five main priorities as a central organising method:

Ministry's DHB Performance Programme

The MoH plans to send regular performance reports to DHBs that provide more detailed analysis of key areas of sector performance. DHB Chairs and Chief Executives were provided with Programme reports in December 2019 and May 2020. The most recent report we have received focusses on the impacts of COVID-19.

2. NON-FINANCIAL PERFORMANCE REPORT

In Quarter 4 2019/20, CCDHB received an 'Outstanding' rating for one performance measure (Engagement and obligations as a Treaty partner). We received an 'Achieved' or Partially Achieved' for 52 of the 58 performance indicators, four (4) indicators rated as 'Not Achieved' and one indicator not being reported.

Achievement	Number of indicators Q2	Number of indicators Q4
Outstanding	0	1
Achieved	31	33
Partially Achieved	18	19
Not Achieved	8	4
Not Reported	0	1

Overall CCDHB saw improved performance ratings compared to the previous quarter. Performance ratings increased for seven indicators and decreased for five indicators.

CCDHB received a 'Not Achieved' rating for four indicators

CCDHB received a 'Not Achieved' rating for the following performance measures:

a. Immunisation Coverage: HPV coverage;
b. Better Help for Smokers to Quit in public hospitals;
c. Better Help for Smokers to Quit – Primary; and
d. Shorter stays in ED

Specific action plans are in place to improve performance on the 'Not Achieved' performance measures.

CCDHB received one 'Not reported' rating in Q4 ('Better help smokers to quit - Maternity'). Processes have been put in place to ensure reporting will recommence for Q1.

CCDHB Annual Plan updates

DHBs were required to provide updates on the delivery of annual plan actions and milestones as part of non-financial performance reporting. Updates must be provided for the planning priorities across the Government's five priority areas. CCDHB's performance for quarter four was rated as follows:

Status Update Report	Achievement
Improving child wellbeing	Partially Achieved
Improving mental wellbeing	Partially Achieved
Improving wellbeing through prevention	Partially Achieved
Better population health outcomes supported by strong and equitable public health services	Achieved
Better population health outcomes supported by primary health care	Achieved

Delays in delivering against the Annual Plan 2019/20 were mainly caused by COVID-19 and recovery plans are in place to address this.

3. CCDHB PERFORMANCE REPORT WITH COVID-19 ANALYSIS

As part of the MoH's DHB Performance Programme, the MoH has provided us with a 'CCDHB Performance Report with COVID-19 Analysis' and a 'CCDHB COVID-19 Recovery Dashboard'. These focus on the impacts of the COVID-19 pandemic on DHB financial performance and inpatient and outpatient medical / surgical care between January and June 2020.

The Performance Report with COVID-19 Analysis shows that CCDHB's deficit against Plan increased from December 2019. This appears to be a mix of larger than planned cost growth and unmet savings targets. However, the deficit as a proportion of revenue is less than the peer average (noting that the average is skewed by Canterbury DHB). The DHB's service delivery related measures generally compare favourably with peers, with the exception of longer average length of stay for planned hospitalisations. Similar to the sector trend, Capital and Coast DHB residents had fewer unplanned events between January and June 2020, compared to the same period in 2019.

Overall operating theatre utilisation is influenced by the restrictions of our operating room production at the Kenepuru site. CCDHB is currently reviewing its casemix selection to improve overall performance across both hospitals and maximise our day stay at Kenepuru. CCDHB is also developing further capacity in one currently underutilised theatre at Wellington Regional Hospital.

4. 20219/20 QUARTER FOUR CCDHB 'HEALTH SYSTEM PLAN' DASHBOARD

The MoH's Non-Financial Performance Framework is particularly useful at monitoring quarterly performance against specific indicators. However, it does not adequately monitor longer-term population health (including equity) or system change. We have therefore developed a CCDHB Health System Plan Dashboard (appended) to monitor progress against our longer-term strategic goals and outcomes for our population groups, particularly our goal of achieving equity for Māori and Pacific people.

The CCDHB Health System Plan 2030 outlines the vision and strategy to transform the health system to ensure equity amongst our populations and support better health and wellbeing throughout the lives of the people in our communities. The CCDHB Health System Plan Dashboard uses a subset of indicators from the Non-Financial Performance Framework to monitor our strategic goals:

- Promote health and wellbeing;
- People-focused services in the community;
- Timely effective care that improves health outcomes.

The subset of indicators chosen are those that we think best reflect system performance and outcomes, including achieving equity. The dashboard also shows the high-level areas of focus and initiatives we are undertaking to achieve each strategic goal. We are developing a work programme to progress our strategic goals and improve performance measures. This work programme includes the following areas of work:

2DHB Hospital Network	Pro-Equity Commissioning	Mental Health Commissioning	System Integration
• Operational/Site Feasibility • 2DHB Operational Integration • Financial Feasibility • Clinical Services Planning	• Iwi Partnership: Integrated Porirua Commissioning, Ora Toa Integrated Contract • Pacific Health Service Development • Integrated Commissioning: Youth One Stop Shop, Mana, Pepi & Tamariki, Complex Care & Long Term Conditions • Inter-sectoral Priorities: Family Violence, Housing, Suicide Prevention	• Crisis & Acute Response, Living Life Well - Community Mental Health & Wellbeing Integration, AOD model of Care • Kaupapa Māori Service Development • Acute Care Continuum MHAIDS/NGO System Integration • Community Mental Health Development: Access & Choice - Primary Care/NGO, Youth Mental Health Response	• Specialty / Hospital Flow: Managing Acute Flow, Managing specialist advice/ e-referrals/outpatients • Community Health Networks / Neighbourhood Development • Planned Care: Production Planning, Planned Care in specialty services and community • Frailty Units, Community Frailty Response
Enablers			
Data & Digital, People & Capability, Financial Management, Workforce, Quality & Safety			

Promote health and wellbeing

Indicator	Performance	Our Strategic Response
Better help for smokers to quit	Stable but equity gaps persistent	As part of our **COVID-19 Recovery** work plan, we are working in partnership with our PHOs to improve performance in practices where COVID-19 has strained performance for Māori and Pacific.
Childhood immunisations	Stable but equity gaps persistent	Through our **Integrated Commissioning** work plan, we are working with our iwi providers and outreach services in Porirua to develop an integrated Mātua, Pepi, Tamariki service to reach children who may not be immunised.
Elder immunisation	Significant improvement	Our COVID-19 response saw a significant increase in influenza immunisation. **Planning for Winter 2021** will soon be underway to try and sustain this coverage and reduce avoidable winter demand on our hospital services.

People-focused services in the community

Indicator	Performance	Our Strategic Response
Avoidable hospital admissions (0-4 years & 45-64 years)	Improving but equity gaps persistent	Improved **system integration** and partnerships between PHOs and NGO provider services contributed to activities that lead to this improved performance for 2019/20. We are working to embed these partnerships.
	Stable but equity gaps persistent	Improving access to urgent and planned care in primary care will support achievement of this indicator. An initial **Community Health Networks** prototype in Kāpiti will prioritise responses towards Māori and Pacific.
People 75+ living in their own home	New indicator	Our **whole of system response to frailty** supports people to live at home. This includes strategic investments such as the Advancing Wellness at Home Initiative (AWHI) Programme. Managing frailty is a key part of our **Sustainability Plan**.

Timely effective care that improved health outcomes

Indicator	Performance	Our Strategic Response
Acute unplanned readmission	Stable but equity gaps persistent	Our Acute Demand Management group has a number of initiatives in place to **manage acute flow** through our hospitals, including early supported discharges of older people and improved use of the transit lounge.
Acute hospital bed days per capita	Improving but equity gaps persistent	**Integrated Commissioning** has seen packages of care developed to support people in the community. For example, supporting Health Care Homes to receive patients by ambulance who do not require hospital level care.
Shorter Stays in ED	Recovering	**Managing Acute Flow** is part our Sustainability Plan. Actions include: minimising discharge delays, reducing the number of long stay patients and improve flow between Wellington and Kenepuru hospitals.

5. NEXT STEPS

Future provisional topics under the MoH's DHB Performance Programme include:

- Workforce planning and financial forecasting (aimed for November 2020)
- Operating theatre and surgical flow performance (aimed for early February 2021)
- Clinical supply use and expenditure profiling (aimed for March 2021)
- Resource allocation and impact on access, quality and cost (aimed for May 2021).

Quarter one non-financial performance reporting for 2020/21 is currently underway with final ratings due to be posted by MoH by 17 November. A report outlining the quarter one results for 2020/21 will be provided in December.

APPENDIX: Capital & Coast DHB – 2019/20 Quarter Four 'Health System Plan' Dashboard

Promote health and wellbeing

We will work collaboratively with partners to create healthy environments, eliminate health inequities, and support people to adopt healthy lifestyles.

Areas of focus

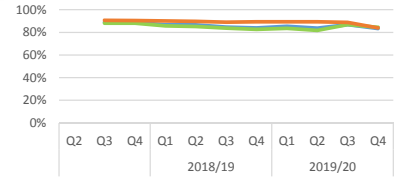
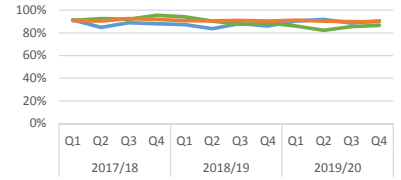
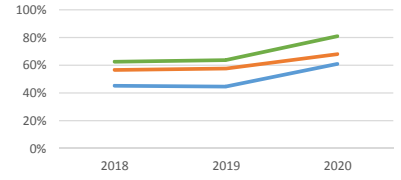
- Prevention, health promotion and public health activities
- Building strong and resilient communities
- First 1000 days of life
- Screening for breast and cervical cancer
- Environmental sustainability
- Achieving health equity

Sub-regional initiatives

- Support our workforce to achieve increased equity outcomes, particularly for Māori, Pacific and people with disabilities (2DHB)
- Co-design innovative models of maternity care with Māori and Pacific women in order to improve outcomes (2DHB)
- Offer education, advice and transport to clients who have previous missed appointments to Breast, Cervical or Colonoscopy Services (2DHB)
- Develop a guide for providers/practitioners to guide conversations with families declining immunisations, with a focus on co-designing with Māori and Pacific families and providers (2DHB)

Local initiatives

- Develop and commit to a pro-equity programme of work that delivers a clear CCDHB equity goal and direction, an agreed set of equity principles, and an operational framework
- Re-establish and update the Tū PounFamu Workforce Programme, including targets for the recruitment, retention and professional development of Māori staff, and workforce development for all staff in Māori health and equity, including cultural leadership, safety and competency, anti-racism and health literacy
- Redesign our breastfeeding service to provide a responsive, culturally appropriate, 7 day service to support to Māori and Pacific mothers, babies and whānau
- CCDHB will provide additional mental health support to work across the five secondary schools in Porirua which have higher Māori and Pacific populations.

Indicators	Description	Rationale	Targets		Performance – three year trend	Comments
Indicator 1: Better help for smokers to quit (primary care)	People aged between 15-75 provided smoking cessation advice in primary care	Stopping smoking confers immediate health benefits on all people, and is the only way to reduce smoker's risk of developing a smoking-related disease. Providing smokers with brief advice to quit increases their chances to make a quit attempt, and this is increased if medication and/or cessation support are also provided.	Māori Pacific Non-Māori, Non-Pacific Total	≥90%		We understand the strain COVID-19 has placed on some high priority practices. Discussions are planned with the priority practices where performance has dropped. This will include discussion about the support needed to lift performance.
Indicator 2: Childhood immunisation	Children fully immunised at 5 years (CW05)	Children who receive the complete set of age appropriate vaccinations are less likely to become ill from certain diseases. This measure captures all immunisation milestones and emphasises the need for immunisation to be both full, and delivered on time, to achieve outcomes.	Māori Pacific Non-Māori, Non-Pacific Total	≥95%		CCDHB is working with Ora Toa PHO our Outreach Immunisation Services to monitor Māori and Pacific immunisation coverage. Since the conversations commenced, we have seen an increase in Māori immunisation rates. Other initiatives are underway to increase enrolment and develop an integrated a Mātua, Pepi, Tamariki service in Porirua.
Indicator 3: Elder immunisation	Percentage of people age 65 years and over that are immunised against influenza	At age 65, immunisation is recommended by the Ministry of Health. These vaccines are free and support older people to stay well. A high performing system should see high uptake of immunisations to keep people healthy.	Māori Pacific Non-Māori, Non-Pacific Total	≥75%		During the COVID-19 response we have seen increased update of influenza immunisation and in particular performance has improved across our priority populations.

Capital & Coast District Health Board

People-focused services in the community

We are committed to developing people-focused service delivery models, and planning our services using 'place' as the basis for health and social supports. Better information about the characteristics of the people being served, shared among those delivering services, is central to succeeding with this approach. It has the potential to reduce health care costs over time as communities increasingly support their own health and wellbeing.

Areas of focus

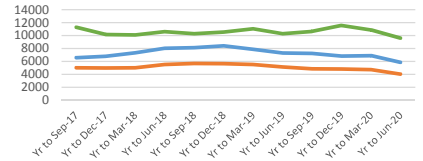
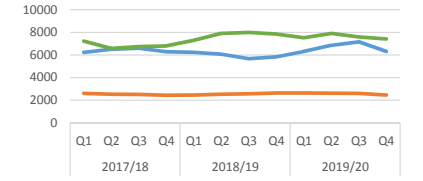
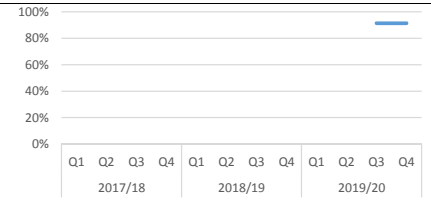
- Homes as a place of care
- Community Mental Health and Wellbeing Hubs
- Build strong primary and community care
- Early intervention
- Health Care Homes
- Specialist support for primary care
- Telehealth services
- Management of Long Term Conditions
- Achieving health equity

Sub-regional initiatives

- Embed telehealth models of care that began during COVID to enable patients to appropriately receive primary and secondary care services (2DHB)
- Support a 2DHB collaborative of Māori and Pacific mental health service providers to develop and implement culturally appropriate and community-based models of care (2DHB)
- Develop and begin implementation of a 3DHB suicide prevention and post-vention plan, with a focus on population groups at higher risk of suicide (3DHB)

Local initiatives

- Work with local communities to implement the locality commissioning plan, place-based initiatives, and integrated service delivery models in Porirua, Wellington and Kāpiti
- Reduce hospital admissions by improving local community urgent care capacity and implementing community-based planned care through Community Health Networks
- Develop an integrated community mental health and wellbeing hub model that will provide a timely response at a local community level to those who present in distress
- The DHB and RPH will work with communities to deliver initiatives that promote healthy nutrition and physical activity with a localities focus (eg, via the Porirua regeneration project).
- The DHB will continue to work with PHOs to share best practices for early cardiovascular risk assessment and management for people with moderate to high cardiovascular risk across general practices from those delivering the most equitable outcomes
- Implement initiatives to improve equitable access to and outcomes from culturally appropriate self-management education and support services
- Community pharmacies in Porirua to measure urate levels and adjust medication dosage where appropriate to prevent Gout, with a focus on Māori and Pacific

Indicators	Description	Rationale	Targets		Performance – three year trend	Comments
Indicator 1:	Avoidable hospital admissions (ASH rates 0-4 yrs)	Ambulatory sensitive hospitalisations (ASH) are hospitalisations that could have been avoided through primary care interventions. This indicator also highlights variation between different population groups. ASH rates can be reduced by shifting care closer to home, providing coordinated primary and secondary care services, and improving timely access to high-quality and culturally safe primary care services.	Māori	↓6% (≤6,421)		System partners improved vaccination rates for Maori and Pacific through improved delivery of health services for young babies and mothers. Improved partnerships with PHOs and NGO provider services contributed to activities that lead to this improved performance for 2019/20.
			Pacific	↓6% (≤10,865)		
			Non-Māori, Non-Pacific	↓2% (≤4,726)		
			Total	↓2% (≤5,818)		
Indicator 2:	Avoidable hospital admissions (ASH rates 45-64 yrs)		Māori	↓6% (≤6,575)		To address performance we are focusing on access to acute care and planned care in primary care practices, including CVD risk assessments and follow up, smoking cessation, and wrap around services for those who have had an ASH event. Development of a Community Health Network in Kapiti will prioritise Māori and Pacific health outcomes.
			Pacific	↓6% (≤7,075)		
			Non-Māori, Non-Pacific	↓2% (≤2,623)		
			Total	↓2% (≤3,267)		
Indicator 3:	Percentage of people 75+ living in their own home	Subsidised age residential care is important for those who need it, but our overall goal is to assist our elderly population to stay well and continue to live independently in their own homes. This requires good access to primary care and, in some cases, home and community support services – including culturally safe household and personal care services.	Māori	TBC		This is a new measure for 2019/20 and will be monitored in 2020/21. 91% of the CCDHB population over age 75+ live in their own home. CCDHB is working to develop a whole of system approach to frailty that supports people to live at home for as long as possible. This includes strategic investment approaches such as CHOPI, AWHI and AHOP. Managing frailty is a key part of our Sustainability Plan.
			Pacific			
			Non-Māori, Non-Pacific			
			Total			

Capital & Coast District Health Board

Timely effective care that improves health outcomes

A core function of our health system is to provide health care that responds to acute and planned clinical need, including the delivering of babies. We need to be able to respond promptly and effectively using service delivery models that help improve clinical and health outcomes.

Areas of focus

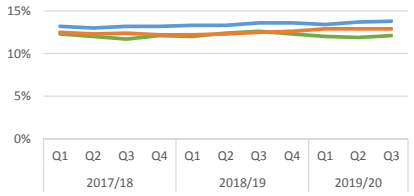
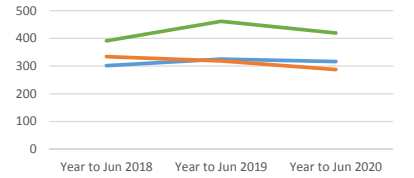
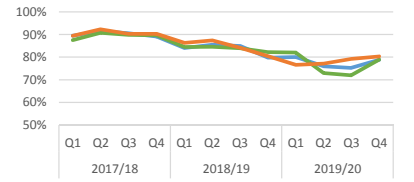
- Timely and effective care
- Safe and efficient hospital services
- Quality improvement activities
- Managing Acute Flow and production planning
- Community, primary and secondary integration
- Support end of life with dignity
- Achieving health equity

Sub-regional initiatives

- Progress the 2DHB Hospital Network Programme to ensure our services are clinically and financially sustainable (2DHB)
- Review and improve consumer data collection and entry in the feedback system (SQUARE) with an emphasis on improving the quality of the data, in particular ethnicity and disability data (2DHB)
- Develop a 2DHB Family Violence Prevention Action Plan (2DHB)
- Develop and implement a reformed 2DHB maternal and neonatal health system plan (2DHB)
- Implement the 3DHB 'Acute Continuum of Care' to better match need to service provision, enhance coordinated service provision across a range of providers, and improve integration and patient flow through the system (3DHB)
- Develop and implement a mechanism for health information to be easily accessible for disabled people in ways that promote their independence and dignity (3DHB)

Local initiatives

- Improve patient flow by developing an acute frailty pilot within existing beds, rolling out early supported discharge enabled by the Advanced Wellness at Home Initiative (AWHI), increasing the proportion of dischargers earlier in the day, and increasing specialist rounding at weekends.
- Implement a mental health model of care in ED and enhance the support to mental health and addiction patients who present to ED
- Develop responsive end of life care for whānau and families, informed by engagement and research, with a specific focus on meeting the needs of Māori whānau and Pacific families

Indicators	Description	Rationale	Targets		Performance – three year trend	Comments
Indicator 1:	Acute unplanned readmission	An unplanned acute (emergency and urgent) hospital readmission is often the result of the care provided to the patient by the health system. We can reduce unplanned acute admissions by ensuring a smooth transition from the hospital back into primary care, and by improving the quality of care in the hospital and in primary care.	Māori Pacific Non-Māori, Non-Pacific Total	≤12.4%		Acute demand management work group has a number of initiatives in trial and implementation to improve our acute readmissions rate, including supportive discharges of older persons, better discharge summaries and using transit lounge nurses to review discharge instructions with patients being discharged.
Indicator 2:	Acute hospital bed days per capita	Acute hospital bed days per capita reflects the demand for acute inpatient services. We can manage this demand by good discharge planning, improving the transition between the community and hospital settings, good communication between providers, managing conditions in primary care settings, and timely access to diagnostics services.	Māori Pacific Non-Māori, Non-Pacific Total	↓2% (≤533) ↓2% (≤573) ↓2% (≤290) ↓2% (≤328)		Packages of care were commissioned to support people in the community including: supporting Health Care Homes to receive patients from ambulance; CHOPI to support primary care to manage frailty in the community and AWHI to support early discharge when appropriate for the patient.
Indicator 3:	Shorter Stays in ED – patient discharged or transferred with 6 hours (SS10)	ED length of stay is an important measure of the quality of acute care in our public hospitals. The timeliness of treatment is important for patients. Long waiting times are linked to overcrowding and negative clinical outcomes and compromised standards of privacy and dignity for patients.	Māori Pacific Non-Māori, Non-Pacific Total	95%		Actions that we are taking to address barriers to performance include: projects that avoid acute patient admissions, efficient hospital inpatient management to avoid delays in discharge, a targeted focus on long stay patients, enhanced multidisciplinary board rounding, reducing bed days in cancer services, and reducing length of stay at Kenepuru to improve flow from Wellington hospital.

Capital and Coast DHB and Hutt Valley DHB

Combined Health System Committee

Meeting to be held on 25 November 2020

Resolution to exclude the Public

Moved that the public be excluded from the following parts of the proceedings of this meeting, namely:

- for the Agenda items and general subject matter to be discussed as set out in the first column in the table below,
- on the grounds under clause 34 of Schedule 3 to the New Zealand Public Health and Disability Act 2000 as set out in the second column in the table below and
- for the reasons set out in the third column of the table below (including reference to the particular interests protected by the Official Information Act, where applicable).

TABLE

Agenda item and general subject of matter to be discussed	Grounds under clause 34 on which the resolution is based	Reason for passing the resolution in relation to each matter, including reference to OIA where applicable
Confirmation of minutes of previous meeting (public excluded session) and Matters Arising from those minutes.	paragraph (a) i.e. the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982	OIA, section 9(2)(ba) to protect information which is subject to an obligation of confidence where the making available of that information would be likely to prejudice the supply of information from the same source, and it is in the public interest that such information should continue to be supplied. OIA, section 9(2)(j) to enable this organisation to carry on, without prejudice or disadvantage, commercial and industrial negotiations.
Action Register	As above	As above

NOTE
The Act provides that every resolution to exclude the public shall be put at a time when the meeting is open to the public, and the text of that resolution (or copies of it) must:

- be available to any member of the public who is present; and
- form part of the minutes of the board or committee.