PUBLIC

HUTT VALLEY DHB / Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**AGENDA** Held on Wednesday 28 July 2021 Location: Kāpiti District Council Chambers, Ground Floor, 175 Rimu Road, Paraparaumu Zoom meeting ID: 878 1795 0109 Time: 1000 to 0100

2DHB COMBINED HEALTH SYSTEM COMMITTEE

	ITEM	ACTION	PRESENTER	TIME	MIN	PG
1	**PROCEDURAL BUSINESS**			**10.00**	**10**	
1.1	Karakia		All Members			2
1.2	Apologies	**RECORD**	Chair			
1.3	Continuous Disclosure – Interest Register	**ACCEPT**	Chair			3
1.4	Confirmation of Draft Minutes from meeting dated 26 May 2021	**APPROVE**	Chair			6 11
1.5	Action List	**NOTE**	Chair			13
1.6	Work Programme	**DISCUSS**	2DHB Director Strategy, Planning and Performance			14
2	**COMMUNITY ENGAGEMENT**					
2.1	Kāpiti Health Advisory Group – update and demonstration of local health directory	**NOTE***	Chair, Kāpiti Health Advisory Group – Dr Colin Feek Kāpiti Health Advisory Group – Sandra Daly	10.10	20	
2.2	Kāpiti Community Health Network Update 2.2.1 Attachments 1-3	**NOTE**	Tu Ora Compass – Dr Chris Fawcett	10.30	30	15
3	**REPORTING**					
3.1	Health Outcomes for Kāpiti Residents 3.1.1 Attachment 1	**NOTE**	Senior System Development Manager, Design and Implementation – Dorothy Clendon System Development Advisor – Hannah Wignall	11.00	20	41 46
3.2	Localities and Community Networks – Our Approach	**NOTE**	2DHB Director Strategy, Planning and Performance	11.20	20	63
4	**COMPLIANCE**					
4.1	Regional Public Health Report	**NOTE**	GM Regional Public Health – Peter Gush	11.40	20	73
4.2	Q3 Non-Financial MOH Reporting – 2020/2021 4.2.1 CCDHB Non-Financial Performance Report 4.2.2 HVDHB Non-Financial Performance Report	**NOTE**	2DHB Director Strategy, Planning and Performance	12.00	20	77 82 94
5	**OTHER**					
5.1	General Business	**NOTE**	Chair	12.20	10	

DATE OF NEXT HSC MEETING:
Wednesday 29 September 2021, 9am-1pm, Boardroom, Pilmuir House, Hutt Hospital

**** No paper at the meeting – presentation only***

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

2DHB Health Systems Committees

Interest Register

22/07/2021

Name	Interest
Sue Kedgley *Chair*	• Member, Consumer New Zealand Board
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

Ria Earp	• Board Member, Wellington Free Ambulance
	• Board Member, Hospice NZ
	• Māori Health Advisor for:
	  ○ Health Quality Safety Commission
	  ○ Hospice NZ
	  ○ Nursing Council NZ

	○ School of Nursing, Midwifery & Health Practice ○ Te Hauora Rūnanga o Wairarapa (Community Mental Health & Addiction Services, Wairarapa) ○ Royal Australian New Zealand College of Obstetrics & Gynecology • Former Chief Executive, Mary Potter Hospice 2006 -2017
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 • Member, E tū Union • Commentator, Sky Television
Vanessa Simpson	• Director, Kanuka Developments Ltd • Executive Director Relationships & Development, Wellington Free Ambulance • Member, Kapiti Health Advisory Group
Dr Richard Stein	• Visiting Consultant at Hawke's Bay DHB • 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 • Member, Muscular Dystrophy New Zealand (Central Region) • 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	• Nil
Fa'amatuainu Tino Pereira	•

Kuini Puketapu	• Trustee or manager at Te Runanganui o Te Atiawa • Director of Waiwhetu Medical Group
Teresea Olsen	•
Bernadette Jones	• Director, Foundation for Equity & Research New Zealand • Co-Chair, Tāngata Whakaha Roopu, Subregional Māori Disability Group • Co-Chair, 3DHB Sub-Regional Disability Advisory Group • Executive Committee member Muscular Dystrophy Central Region • Board member, My Life My Voice Charitable Trust • Member, Health Research Council NZ, College of Experts • Senior Research Fellow, University of Otago Wellington • Husband, Tristram Ingham, is a board member of CCDHB • Director, Miramar Enterprises Limited

Minutes of the Health System Committee

HUTT VALLEY AND CAPITAL AND COAST DISTRICT HEALTH BOARDS
Held on Wednesday 26 May 2021 at 10:00am
Level 1 Boardroom, Pilmuir House, Hutt Hospital

PUBLIC SECTION

PRESENT

COMMITTEE:
Sue Kedgley, Chair
Josh Briggs
Keri Brown
Richard Stein
Roger Blakeley
Vanessa Simpson (zoom)
Chris Kalderimis
Ria Earp
Sue Emirali (zoom)
Fa'amatuainu Tino Pereira (Inu)
Paula King (zoom)
Prue Lamason

STAFF:
Fionnagh Dougan, Chief Executive Officer
Rachel Haggerty, Director Strategy, Planning and Performance
Helen Mexted, Director Communications and Engagement
Joy Farley, Director Provider Services
Chris Kerr, Chief Nursing Officer
Christine King, Allied Services
Sisira Jayathissa, Chief Medical Officer HVDHB
Sally Dossor, Board Secretary
Meila Wilkins, Board Liaison Officer

APOLOGIES:
Ken Laban
'Ana Coffey
Bernadette Jones
David Smol

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.

1.4 CONFIRMATION OF PREVIOUS MINUTES

The minutes of the Combined Health System Committee meeting held on 31 March 2021 (public section) were confirmed as a true and correct record.

Moved:	**Seconded:**	
Roger Blakeley	Keri Brown	**CARRIED**

1.5 ACTION LIST

The list was taken as read and accepted by the Committee.

Moved:	**Seconded:**	
Sue Kedgley	Keri Brown	**CARRIED**

1.6 DRAFT ANNUAL WORK PLAN

The plan as currently formulated was noted, and management advised that they are reworking the work plan in light of health system reform. At the current time the work of the Transition Unit is in its early stages, however by the next meeting (28 July 2021) there will be more information. At a high level, the Chief Executive noted that the 2DHB long-term strategy is aligned with the health system reform and direction of the early work of the Transition Unit.

Committee members requested that as a general rule, there are background papers to support agenda items (rather than 'presentation only' items) so that the Committee has context.

Committee members also requested that management consider how members will be kept updated on Transition matters over the next 12 months.

Moved:	**Seconded:**	
Josh Briggs	Chris Kalderimis	**CARRIED**

ACTION:

- Management to advise how it will keep the Committee (and Board) advised of Transition matters

2 STRATEGY

2.1 UPDATE ON 2DHB HOSPITAL NETWORK – PRESENTATION

The Chief Executive made some preliminary comments. The Director Strategy, Planning and Performance introduced the presentation (on behalf of the Director Provider Services, who was unavailable) and introduced Jamie Duncan and Lisa Farrelly who spoke to the presentation and answered questions.

Hospital Network.pptx

Discussion Notes:

- Explore opportunities for better connections and to improve the continuum of services – which all improve the patient journey
- Recognised need to optimise infrastructure and rethink where services are delivered and where capacity can be optimised
- This work is important and action is required now to optimise capacity, and then also feed into the Health New Zealand work stream on infrastructure
- We know that the people in our region move around a lot – which makes delivery challenging
- Simplify care for those that can access services easily, and respond with a more complex solutions for those that need more complex care. It will mean we will not always have every service on every site.
- The Dialysis unit at Hutt Hospital is an example where the response is tailored to the needs of our local population and is an example of the approach to services across the 2DHBs.
- A whole of system approach –is taken and hospital care is part of the system. The decision of the Board to support the 2 Hospital network underpins this work and this leadership underpins the work.
- Across the 2DHBs, there is an infrastructure issue and there is no 'do nothing' option. Decisions need to be made, which require significant planning and work, and that comprehensive planning is underway.
- The system is under pressure and there are issues to be dealt with now (and will be covered in the later agenda items) and this presentation sets the context for that.

3 HEALTH SYSTEMS

3.1 ACUTE FLOW – PRESENTATION

The Director Strategy, Planning and Performance introduced the presentation (on behalf of the Director Provider Services, who was unavailable) and introduced Jamie Duncan and Lisa Farrelly who spoke to the presentation and answered questions.

Acute Flow.pptx

Discussion notes

- The presentation drew the distinction between the health care system and the hospital system. Acute flow at a system level describes the flow of all acute patients through our health system.
- Early intervention and prevention are incredibly important to reducing demand.
- Highlighted the importance of understanding how the hospital system works. Hospital system can determine how safe they are, how flow is managed and how they keep people moving through the system.
- The hospital system is based on safe care, delivering equity and clinical excellence.
- Outlined current investments to improve acute flow and mitigate acute demand, in particular, initiatives targeted at older persons.
- Discussed trends including:

- Trends show a decrease in people presenting at ED at both HV and CC. All ethnicities except Māori Children (0-15 years) are driving the decrease. Ongoing work is being done determine the reasons for this.

Action:

- Add to the action list:
  - Further information on primary care as part of the prevention (and early intervention) process and how it correlates with demand for acute care. Is data available to show the relationship between the access to services (eg appointment wait times) and demand for acute services. If this data is available, is it available by ethnicity, nature of presentation, locality/suburb.
  - Information requested on workforce issues, future delivery models, and workforce innovation opportunities, especially in the context of workforce shortages.

3.2 PLANNED CARE PERFORMANCE 2DHB

The paper was taken as read. The Director Strategy, Planning and Performance answered questions about the MOH allocation and noted that it will be a matter of Heath New Zealand to resolve.

Moved:	**Seconded:**	
Roger Blakeley	Josh Briggs	**CARRIED**

3.3 BOWEL SCREENING – PRESENTATION

The presentation was given by:
Robert Blaikie, Service Group Manager, Medical Ward
Colin Spratt, Operations Manager Specialist Services

Bowel Screening.potx

Noted:

- The team gave an overview of the National Bowel Screening Programme and then spoke to the work of the programme at each DHB.
- A question was asked about lowering the age of screening, in particular for Māori and Pacific, and it was noted that the Ministry will not engage on this until the National rollout is complete.
- Paula King invited the team to contact her about faciliting discussions with manawhenua – should that assist with the rollout of the programme.
- There is an equity plan for the rollout programme (that will be distributed to members on request).

For HVDHB:

- The screening service is meeting the key indicators for outcomes, which is being shown in positive outcomes for detectable and treatable cancers

For CCDHB:

- The later start date in terms of the National rollout was noted (from HVDHB) and that CCDHB was therefore at a much earlier stage of the programme. There are workforce challenges that are being worked through.

3.4 MINISTRY OF HEALTH – WORKFORCE ISSUES

This item did not proceed as the Deputy Director- Workforce issues was unavailable due to an unforeseen commitment.

4 OTHER

4.1 GENERAL BUSINESS

The Chief Digital Officer (Tracy Voice) attended the meeting to brief the Committee on cyber-security issues and answer questions in light of the recent ransomware attacks at the Waikato District Health Board.

4.2 RESOLUTION TO EXCLUDE THE PUBLIC

Moved:	**Seconded:**	
Sue Kedgley	Roger Blakeley	**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.....2021

Sue Kedgley
Health System Committee Chair

Minutes of the Health System Committee

HUTT VALLEY AND CAPITAL AND COAST DISTRICT HEALTH BOARDS
Held on Wednesday 26 May 2021 at end of the Public Session
Level 1 Boardroom, Pilmuir House, Hutt Hospital
PUBLIC EXCLUDED SECTION

PRESENT

COMMITTEE:	Sue Kedgley, Chair Josh Briggs Keri Brown Richard Stein Roger Blakeley Vanessa Simpson (zoom) Chris Kalderimis Ria Earp Sue Emirali (zoom) Fa'amatuainu Tino Pereira (Inu) Paula King (zoom) Prue Lamason
STAFF:	Fionnagh Dougan, Chief Executive Officer Rachel Haggerty, Director Strategy, Planning and Performance Helen Mexted, Director Communications and Engagement Joy Farley, Director Provider Services Chris Kerr, Chief Nursing Officer Christine King, Allied Services Sisira Jayathissa, Chief Medical Officer HVDHB Sally Dossor, Board Secretary Meila Wilkins, Board Liaison Officer
APOLOGIES:	Ken Laban 'Ana Coffey Bernadette Jones David Smol

1.1 CONFIRMATION OF PREVIOUS MINUTES

The minutes of the Combined Health System Committee meeting held on 31 March 2021 (public section) were confirmed as a true and correct record.

Moved:	**Seconded:**	
Roger Blakeley	Keri Brown	**CARRIED**

1.2 COVID-19 VACCINATION UPDATE

The Director Strategy, Planning and Performance presented and was available for questions.

The Committee noted the progress of the COVID-19 vaccine roll out to date 22 May 2021.

The meeting closed at 12:46pm

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 AS AT 22/07/2021

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.	September 2021 Meeting agenda
HSC21-03	31-Mar-21	TBC - 2022		In progress	Director Strategy, Planning and Performance	Public	2.2	2DHB Primary Birthing Facilities Approach	Director Strategy, Planning and Performance to bring the Maternity 2DHB plan when completed.	In progress.
HSC21-04	31-Mar-21	26-May-21		In progress	Director Strategy, Planning and Performance	Public	2.2	2DHB Primary Birthing Facilities Approach	Bring back the decision on whether this work is a priority after approving the 2DHB Hospital Network.	To be decided once Board reviews work progamme in light of Health System Review.
HSC21-05	26-May-21	28-Jul-21		In progress	Board Secretary	Public	3.1	Acute Flow	Information was requested on workforce issues, future delivery models, and workforce innovation opportunities, especially in the context of workforce shortages.	Refer Ministry of Health, Health Workforce update for July 2021. Address: https://moh-healthworkforce.createsend1.com/t/ViewEmail/i/DFE50464442FEF5B2540EF23F30FEDED
HSC21-06	26-May-21	28-Jul-21		In progress	Director Strategy, Planning and Performance	Public	3.1	Acute Flow	Further information on primary care as part of the prevention (and early intervention) process and how it correlates with demand for acute care. Is data available to show the relationship between the access to services (eg appointment wait times) and demand for acute services. If this data is available, is it available by ethnicity, nature of presentation, locality/suburb.	Update will be provided at the meeting.
HSC21-07	26-May-21	N/A		Complete	Board Secretary	Public	1.6	Draft Annual Work Plan	Committee members requested that management consider how members will be kept updated on Transition matters over the next 12 months. Management to advise how it will keep the Committee (and Board) advised of Transition matters.	Transition Unit newsletters and information sent to the Board as and when it becomes available. CE updates the whole Board on a monthly basis and verbal updates will be provided as appropriate.

HSC WORK PLAN 2021/22 AS AT 22/07/2021			
	29 September 2021 Hutt Valley 9am – 1pm	**24 November 2021 Capital & Coast 9am – 1pm**	**6 month period – to 30 June 2022 Number of meetings and dates TBC**
Strategic Priorities			
Our Hospitals	Planned Care	Maternity and Women's Health	
	Responding to System pressure	2DHB Hospital Network	
Commissioning and Community	Integrated Primary Care and Acute Demand	Complex Care and Frailty	Community and Locality Integration
	Focus on Homelessness	Intersectorial priorities	
Mental Health and Addiction Services	Community Mental Health and Addictions Networks	Kaupapa Māori and MHA development	
Enablers	Data and Digital – Health System	Workforces	Infrastructure
Integrated Performance Reporting			
Regional Public Health Report		Regional Public Health Report (note last report 28 July 2021).	Regional Public Health Report (note last report 24 November 2021).
System and Service Planning			
Non-Financial MOH Reporting • **CCDHB** • **HVDHB**	2020/21 - Quarter 4	2021/22 – Quarter 1	2021/22 – Quarter 2/3
Annual Plan (for both DHBs)	Planning process for 2022/2023 – subject to confirmation of process required for Health New Zealand.		
Matters arising and other items			
	Eating Disorders		

Health System Committee

28 July 2021

Kāpiti Community Health Network Update

Action Required

The 2DHB Health System Committee notes:

(a) Kāpiti CHN is the first Network to be developed within the district, with establishment beginning in July 2020.

(b) The Kāpiti CHN is being developed in partnership with mana whenua (Te Ātiawa ki Whakarongotai), CCDHB and Tū Ora Compass Health in the first instance.

(c) Development of Kāpiti CHN in year one has been delivered in two overlapping phases; Development and Establishment of the Network Foundations and Implementation of a Network team and work programme.

(d) We will continue to invest in the development and implementation of Kāpiti CHN in 2021/22. Learnings from Kāpiti and alignment with the planning for locality networks through Health NZ, will inform the roll-out of Networks across the district.

Strategic Alignment	Health System Plan 2030
Authors	Hannah Wignall, System Development Advisory, Design and Implementation
Endorsed by	Rachel Haggerty, Director, Strategy, Planning and Performance
Presented by	Dr Chris Fawcett, Tū Ora Compass Health
Purpose	Provide an update on the first year of the development and implementation of Kāpiti Community Health Network
Contributors	Mary Cleary Lyons, General Manager, Design and Implementation
Consultation	Tū Ora Compass Health and Te Ātiawa ki Whakarongotai

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 has achieved significant population coverage over 6 years.

Community Health Networks (CHN or Networks) are one of the corner-stones for transforming our health system by 2030 and well-functioning HCH practices are pivotal for their success. Capital and Coast (CC) and Hutt Valley (HV) DHBs have been developing locality based approaches across our districts over the last 3+ years.

This direction of travel was clearly articulated in the CCDHB Health System Plan 2030, which articulated the creation of geographically based Community Health Networks and working in localities with our Intersectoral partners. CHNs are described in the Health System Plan as the central organising point for delivering effective and efficient health care. Networks build on a comprehensive roll out of HCHs

across the DHBs and we are directing released funding used to establish and grow HCH practices towards the establishment of Networks.

Kāpiti CHN is the first Network to be developed, with establishment beginning in July 2020. Kāpiti CHN is a network of health providers who are supported to coordinate and organise health service delivery to better meet the needs of and achieve equitable care for the Kāpiti population.

The Kāpiti CHN is being developed in partnership with mana whenua (Te Ātiawa ki Whakarongotai), CCDHB and Tū Ora Compass Health in the first instance. Development of the Kāpiti CHN in year one has been delivered in two overlapping phases:

- Development and Establishment of the Network Foundations; and
- Implementation of a Network

Strategic Considerations

Service	A Community Health Network will work to coordinate and organise health service delivery within a geographical region, to reduce the equity gap and improve the health and wellbeing of the local population.
People	The implementation of Kāpiti CHN provides dedicated resource for Network Management, Project Management, Relationship building and Network Governance so that a Network work programme can be delivered to improve equity and health outcomes for the people of Kāpiti.
Financial	This paper provides information on the value of investment in Kāpiti CHN of close to $700,000 over two years (2020/21 and 2021/22).
Governance	Integrated Care Collaborative Alliance Leadership Teams and Kāpiti CHN Establishment Governance Group

Attachment/s

1. Article - New Community Health Network Established for Kāpiti – December 2020
2. Kāpiti CHN Governance Group – Progress Report May 2021
3. Kāpiti CHN Year one – Power point presentation

Purpose

The purpose of this paper is to provide an update to the Health System Committee (HSC) on the first year of Kāpiti CHN development and implementation.

Kāpiti Community Health Network – Year One

Kāpiti CHN is a network of health providers who are supported to coordinate and organise health service delivery to achieve equity and better meet the needs of the Kāpiti population.

Kāpiti CHN establishment began in July 2020 and is being developed in partnership with mana whenua (Te Ātiawa ki Whakarongatai), CCDHB and Tū Ora Compass Health (Tū Ora) in the first instance. These three organisation are joined by representation from the Kāpiti Health Advisory Group (KHAG) in the Kāpiti CHN Establishment Governance Group.

Early Milestones

There have been a number of milestone events for the Kāpiti Network in year one. In September 2020, an inaugural Network workshop was held with local providers. The aim of the workshop was to create a shared understanding of a Community Health Network and to hear from providers about what principles and values they wanted to underpin a Network.

The inaugural Kāpiti CHN Establishment Governance meeting was held in November 2020. The Group now meets bi-monthly and is in place to enable the successful set up of the Kāpiti Network.

A foundation event for Kāpiti CHN was held in December 2020, which marked the beginning of Kāpiti CHN journey. Attendees were welcomed by Te Ātiawa and heard from CCDHB and Tū Ora on the vision for the Network in improving the health and wellbeing of people living in Kāpiti. The event and was well attended and met with interest by local providers (Attachment One).

In year one Kāpiti CHN has been delivered in two overlapping phases:

- Development and establishment of the Network Foundations; and
- Implementation of a Network

Network Development and Establishment

The development and establishment phase has involved defining and building the foundations for successful integration, system (re)design and developing strong network relationships. Much of the foundational work is underway in Kāpiti and will continue, with oversight from the Establishment Governance Group in year two. This work includes the development of:

- a draft Network Charter, which defines shared values and principles which guide and underpin providers when working together
- a Network Operating Model, which details how the Network Operations Team will work to develop and deliver on a shared work programme
- a Network stakeholder Engagement plan, which allows for the Network Operations Team to have a systematised approach to engagement, with the aim of making sure the right information goes to the right people at the right time
- a draft Network Outcome Framework, which guides the work underway in the Network to ensure the wider impacts on health outcomes are measured and achieved
- understanding Network data management. For example a framework which would support and guide providers when information is shared within a Network
- establishing the terms and membership for ongoing Network governance

Network Implementation

Implementation of the Network itself began this year, with the appointment of a Kāpiti CHN Establishment Governance Group, a Network Operations Team and a Network work programme.

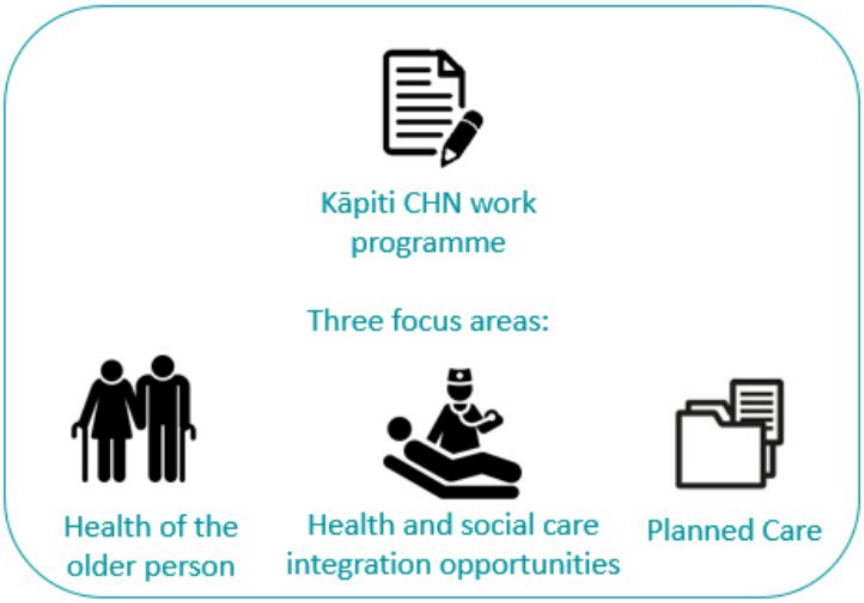
In partnership with the DHB and Te Ātiawa, the DHB has commissioned Tū Ora to lead the multi-agency Network Operations Team in Kāpiti. The Team is tasked with:

- leading and managing the Kāpiti CHN Work Programme and associated projects
- strengthening relationships between providers in Kāpiti

- working with people, whanau and communities when designing solutions for improved care
- supporting and managing the Kāpiti CHN Establishment Governance Group
- supporting development of key CHN foundational work (as described above)

The Kāpiti CHN Work Programme outlines shared local priorities through which providers work together on new and re-design initiatives to improve health services for the local population. Attachment Two is an example of a Work programme progress report from June 2021.

Local priorities were identified through a combination of; local priorities (including identified priorities of the Kāpiti Health Advisory Group), iwi priorities, data insights and strategic direction. In year one, the three Kāpiti CHN focus areas are:



The Network operating model and work plan development process ensures that every opportunity or project identified goes through a process to ensure that equity and improving health outcomes for people, whanau and the local community is central to the work undertaken in a Network.

Work is underway under each of the Network focus areas. One example of work underway in the Health of the Older Persons work stream, is an integration opportunity with Wellington Free Ambulance and Community ORA. When a person calls WFA they may not be unwell enough to warrant hospital transfer with a number of WFA call outs coded as status 3, not immediately life threatening or status 4, stable. During the period 1/1/2019 - 30/04/2021, there was a total of 7,932 status 3 and 4 Kāpiti residents (over 65 or over 55 for Māori or where ethnicity was not stated)) seen by WFA.

- 59% were transported to Wellington Regional Hospital Emergency Department;
- 6% were transported to a non-ED destination e.g., the delivery suite, MAPU or local ambulance redirection.
- 36% not transported so were treated at the scene or home and discharged.

The Network Team, CCDHB Community ORA and Wellington Free Ambulance are undertaking discovery and design work in this space with the aim to reduce transporting patients and admission to hospital by referral direct to the ORA community Team in Kāpiti. The Networks is also focused on looking at opportunities in this space with other providers.

Over time as the Network develops there will be focus on other population health priority areas (such as youth). In addition, the Kāpiti CHN will both lead a work programme focused on local priorities and build on and support existing initiatives and system changes, such as:

- Kāpiti Ambulance Diversion Scheme
- Community Health of Older People Initiative (CHOPI)
- AWHI – early supported discharge
- Pepe Ora – a provider Network and online tool for maternal services

Next Steps in Kāpiti

In the future system operating model, primary and community services will be commissioned closer to communities – through 'localities'. Health systems will be delivered through networks of providers with a focus on shared outcomes, specific to their community.

The locality approach offers a platform to implement a population health approach. The development of Kāpiti CHN does and will continue to align closely with the strategic direction of the health and disability system reforms

In year two of the development and implementation of Kāpiti CHN we will continue to Partner with Te Ātiawa and Tū Ora to continue to develop the foundations of a Network, including defining; ongoing Network governance, the Kāpiti Network outcome framework, a Network data management framework and improving the Kāpiti CHN work programme and reporting.

In year two, we will continue to invest in and expand the multi-agency Network Operations Team. We will also empower the Network to prototype and test working in new ways to improve health outcomes for Kāpiti residents.

The Operations Team will continue to:

- Lead and manage the Kāpiti CHN Work Programme
- Work to develop deeper understanding of what a Network means to a community
- Re-order existing services to promote smoother, more efficient patient journeys and to make services more Inclusive and accessible
- Develop more “new” initiatives addressing issues coming from conversations with Network members (providers) and stakeholders

The DHB is focused on improving the performance of our health system and encouraging better health and wellbeing and more equitable outcomes for the Kāpiti community. We recognise the inequities experienced by our priority populations: Māori, Pacific peoples and disabled people. Development of Networks, other initiatives and future work will have a priority of closing these equity gaps.

Network Development across CCDHB & HVDHB

The Kāpiti Network experience will inform the creation of other Networks in CCDHB and HVDHB. We are also best placed to use our learnings and work within Health NZ to continue the Locality Network journey.

New Community Health Network Established For Kāpiti

December 5, 2020 (https://kapitiindependentnews.net.nz/new-community-health-network-established-for-kapiti/)

Capital & Coast and Hutt Valley DHBs' have announced the birth of a community health network for Kāpiti — to improve the health of the local population and achieving equality of health outcomes.

The is described as a step forward for Kāpiti healthcare services,

L-R: Joint Chair Hutt Valley and Capital & Coast DHBs David Smol; Dorothy Clendon, manager Community Health Network lead Hutt Valley and Capital and Coast DHBs; Dr Chris Fawcett Medical Director Tū Ora Compass Health; Martin Hefford Chief Executive Tū Ora Compass Health; Fionnagh Dougan Chief Executive Hutt Valley and Capital & Coast DHB; André Baker Chair Te Ātiawa ki Whakarongotai Charitable Trust Board.

The DHBs' joint Chief Executive Fionnagh Dougan and joint Board Chair David Smol made the annucement.

Shared goals

"Community health networks are all about partnerships and relationships. Within a network, providers work together to…organise health service delivery to achieve shared goals," says Fionnagh.

"Kāpiti is the first network to be established in our region…and its development will inform how we approach networks in other areas."

Te Ātiawa ki Whakarongotai, CCDHB, and Tū Ora Compass Health will develop the network with other health providers – including GPs, community pharmacists, Aged Residential Care facilities, home and community support services, and NGOs.

Almost 100 people, from healthcare providers to potential users of the service, attended the network launch at Paraparaumu's Southward Car Museum.

The two boards say a lot of good work is already underway in Kāpiti, and there are many established collaborations. There is a strong foundation through the Health Care Home programme, which has strengthened primary care across the district.

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We want to see Te Reo taking our lives

We believe people matter mor

We believe in speaking truth t

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Māori politics was dominated
influential MPs (and sometime
ministers) Māui Pōmare (Wai
photo above) and **Apirana Ng
(https://nzhistory.govt.nz/no**

The 1920's also saw the rise o
**Wiremu Rātana
(https://nzhistory.govt.nz/no**
religious movement, and the e
of **Te Puea Hērangi
(https://nzhistory.govt.nz/no**
Waikato.

Ngata worked hard to foster M
scholarship and education an
traditional arts and culture.

He convinced the government
Board of Maori Ethnological R
(1923), a Maori Purposes Fun
Board (1924) and a School of
and Crafts in Rotorua (1927).

The Reform government also
tentative steps towards settlin
longstanding Māori grievance

Agreements with Te Arawa in
Ngāti Tūwharetoa in 1926 rec
respective rights over the Rot
and Lake Taupō, and led to th
establishment of trust boards
government funding.

Commissions of inquiry which
Ngāi Tahu grievances (1920–
Waikato and Taranaki confisc
27) recommended that modes
compensation be paid.

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KĀPITI COMMUNITY HEALTH NETWORK

PROGRESS REPORT

Author(s): Sarah Duncan
Ann Gregory
Hannah Wignall

Date Prepared: 10 May 2021

1. Purpose

This report is the interim brief update as discussed at the last Governance Group meeting. The intent of this report is to provide a brief overview and any significant updates on work being done on behalf of the Kāpiti Community Health Network.

2. Recommendations

That the Governance group notes the progress and provides feedback and comments as needed.

Kāpiti Community Health Network activity in April 2021:

- CCHDB have completed the process of appointing a new Co-Chair to replace Dame Karen Poutasi, Dr Colin Feek will now join the Establishment Governance Group.
- Chantelle Smith from Te Ātiawa Whakarongotai has joined the Operations team
- April's Kāpiti CHN Newsletter was distributed
- The Operations team has continued to make visits to local providers outlining the role of the Community Health Network.

Kāpiti CHN work streams:

1) Health of the Older Person

Projects currently being scoped:

- **Polypharmacy & post-discharge medicine review**
  Meetings with DHB, Clinical Pharmacists, other regions offering medicine review services in the community held and some community pharmacy providers. Looking at ways to prioritise discharged patients for review (eg, Ethnicity, LOS, Quintile) and link with providers to provide end to end service. Aim: to decrease readmissions, decrease falls related to polypharmacy, improve links between all pharmacy providers and general practice.
- **Minor Fractures**
  Background data collected on numbers of people seen in ED and Team Medical with minor fractures. Now looking at differentiating why people being seen at Team Medical vs ED. Currently people seen via CARS or at ED have no cost associated with being seen however if self-present at Team Medical then there is cost even for CSC / high needs groups.
- **Mental Health**
  The Geriatricians and Mental Health Service for Older people are keen to explore the opportunities to work close with GPs in the Kāpiti Community Health network. Discussions with general practice have been held to plan the way forward.

2) Health and social care integration opportunities to address social complexity

Projects underway:

Housing complex – Now three strands of work; general health, mental health, and disability

- Health team – Friday health clinics being held nearby continuing. Residents feedback on the service and other needs being collated. They have identified budget and counselling services as being high priority. A potential Counsellor has been identified and the clinic team are linking with them to begin provision. A potential budget service provider has been identified, a meeting is being arranged to discuss potential provisions and accessing funding to allow this to happen. The health team is reviewing their service to rationalise after the

initial surge of input. This will free capacity to look at other high needs populations to begin work with them.

- Transfers to hospital remain lower overall comparing 2021 (with health clinic input) to 2020, April 2020 was the level 4 rahui so lower numbers of Wellington Free Ambulance intervention were to be expected.
- Contacts have been made with mental health, drug and alcohol related NGO's that provide services to residents at the housing complex. A meeting with all involved is planned during May to identify the gaps in service and how services can best be coordinated.
- Contact to begin with disability providers linked to Housing complex.

3) Primary care options for planned care

- **Ophthalmology**

A 2DHB project team has been set up to begin to design equitable ophthalmology ambulatory care service delivery models for CCDHB and HVDHB and create a plan for how we will get from our current state to our future state (including digital enablers). This is a long-term project and is in the initial stages.

- **Glaucoma**

  During COVID community ophthalmology providers were asked to provide screening and monitoring for glaucoma patients. This has now stopped. Community providers feel they have the skills to continue with this service. This project is in the initial stages of scoping and will be discussed at the next Governance Group meeting. It is likely to feed into the work above.

4) Other work being developed that directly or indirectly involves the Kāpiti Network

- An education session focussed on equity but covering other topics and supporting Networking is being developed that will be run from Te Ātiawa Whakarongotai' s marae. Proposed date is Saturday July 24th.
- Local electric company is interested in providing AI to predict when older people are at risk of falls, initial meeting has been planned for May.
- A Safer Kāpiti (ASK) Hospital Shuttle – CCDHB has committed to contribute funding to the ASK Shuttle until June 2022. The aim of the shuttle service is to provide outpatient transport services for Kāpiti residents to and from Wellington hospital and Kenepuru hospital. The Shuttle is wheelchair accessible and runs to Wellington hospital, 4 days a week (Monday – Thursday).

What is happening in May 2021

- Ann is attending a Central Region Age-related frailty forum being run jointly run by TAS and the Francis group. The forum will bring together a diverse group including Māori providers, DHB and NGOs from across the Central Region to begin to a new model of care for those with or a risk of age-related frailty.

- Scan general practice providers to be held to see if they feel there are any issues that need addressing with regards to DHB psych geri / geriatric service provision to feed into discussion.

Meetings to be held in the next month include:

- Linking with work developing the Fracture Liaison service
- Meeting with community pharmacy services
- Meeting with community Ophthalmology services
- A meeting with MSD health advisor and disability advisor is scheduled to discuss working together going forward.
- Meeting with the housing complex health team
- Meeting with Coastal Medical clinicians

The next Kāpiti CHN Establishment Governance Group Meeting is 14 June.

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Kāpiti Community Health Network

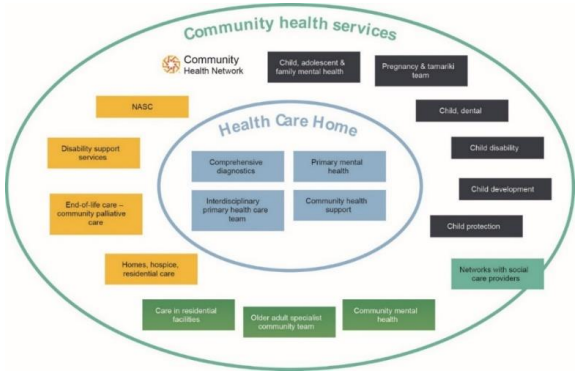
Welcome

Community Health Network

A Community Health Network will work to coordinate and organise health service delivery within a geographical region, to meet the health needs of the local population.

The Network Will:

- Provide equitable care that better meets the needs of a Network population
- Be a supportive mechanism to coordinate and organise health service delivery within a defined area
- Strengthen whakawhanaungatanga (relationships) and improve connectivity and integration with providers in a Network
- Work with people, whanau and communities when designing solutions for improved care



Health and Disability System Reforms

Locality Networks

- In the future system operating model, primary and community services will be commissioned closer to communities – through 'localities'.
- Health systems will be delivered through networks of providers with a focus on shared outcomes, specific to their community.
- The locality approach offers a platform to implement a population health approach to address the wider lifestyle, environmental and socioeconomic factors that impact on people's health and wellbeing.
- The development of Kāpiti CHN aligns closely with the strategic direction of the health and disability system reforms

The Start Of A Journey

- CCDHB is working with Te Ātiawa ki Whakarongotai and Tū Ora Compass Health to develop and implement a Community Health Network in Kāpiti, beginning this year.
- Kāpiti Community Health Network is not a new entity, but a team of local leaders and providers dedicated to re-aligning and strengthening local health service provision for the benefit of Kāpiti people and whanau.
- The Kāpiti Community Health Network experience will inform the creation of other Networks in CCDHB and HVDHB. We are also best placed to use our learnings and work within Health NZ to continue the Locality Network journey.

Kapiti CHN Foundation Event

- This event marked the start of the journey and shared the vision for the Kāpiti Community Health Network in improving the health and wellbeing of people living in Kāpiti.
- It was also a great opportunity for local providers to connect with one another and to think about how they could be involved in the Network.

Kāpiti CHN Year One

In partnership with Te Ātiawa and Tū Ora in 2020/21 we have established:

A Kāpiti Network Operations Team

Key Foundational Documents

Kāpiti CHN Establishment Governance Group

CHN relationships

Kāpiti CHN work programme

Three focus areas:

Health of the older person

Health and social care integration opportunities

Planned Care

Kāpiti CHN Work Programme

Health of the older person

Discovery phase

- WFA and Community ORA referral pathways
-Post discharge pharmacy response
-Minor fractures: integration with primary care and DHB physiotherapy
-Geriatric and Psychogeriatric service alignment
-Falls prevention: in-home movement sensors

Health and social care integration opportunities

Active projects

-Co-ordinated care for vulnerable populations
-Mauri Ora Wānanga for Kāpiti health providers

Discovery phase

-Hepatitis C: point of care testing

Planned Care

The Network Team is supporting the DHB to understand how CHNs can support re-design work underway for improving:

- Access to Specialist advice
- Access and use of Primary Options for Ambulatory Care (POAC)
- Patient pathways for Ophthalmology and Respiratory services

HOP Project: WFA and Community ORA referral pathways

- When a person calls WFA they may not be unwell enough to warrant hospital transfer with a number of WFA call outs coded as status 3, not immediately life threatening or status 4, stable.
- During the period 1/1/2019 - 30/04/2021, there was a total of 7,932 status 3 and 4 Kāpiti residents (over 65 or over 55 for Māori or where ethnicity was not stated)) seen by WFA.
    - 59% were transported to Wellington Regional Hospital Emergency Department;
    - 6% were transported to a non-ED destination e.g., the delivery suite, MAPU or local ambulance redirection.
    - 36% not transported so were treated at the scene or home and discharged.

The Network Team, CCDHB Community ORA and Wellington Free Ambulance are undertaking discovery work in this space with the **aim:** to reduce transporting patients and admission to hospital by referral direct to the ORA community Team in Kāpiti.

A number of early **Opportunities** have already been identified:

- WFA to Community ORA direct referral pathways
- WFA access to short term equipment support
- Community ORA short-term respite support/observation in the home

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Health and Social Integration Project: M Housing Complex

One local residence was identified by multiple agencies (including iwi, general practice, WFA, Council and NGO's) as being in particular need of innovative support. **What we know**:

- There are over 20 agencies that support residents in different capacities
- In 2020, WFA had 69 call outs here (0.675 calls per person per year, which is 6.7 times higher than the average)
- One third of the residents have attended ED in the past 12 months and of those just over half were admitted
- One fifth of the residents have had an ASH admission in the past 12 months

The Network has brought together a variety of agencies under three workstreams (health, mental health and social wellbeing) to look at how health and social support is provided to this group of people. **The aim is to**

- Improve health and wellbeing of this community
- Improve service access and coordination to more effectively meet the needs of this community
- To create a scalable and effective health and social care solution that can be embedded into other communities

Network Work underway:

- Onsite Friday health clinic – primary care led and evolving with resident feedback and established partnerships (counselling and budgeting needs identified and embedded)
- Provider workshops focused on service re-design and developing new models of care
- Develop a new way of working that could be a prototype for the wider Network

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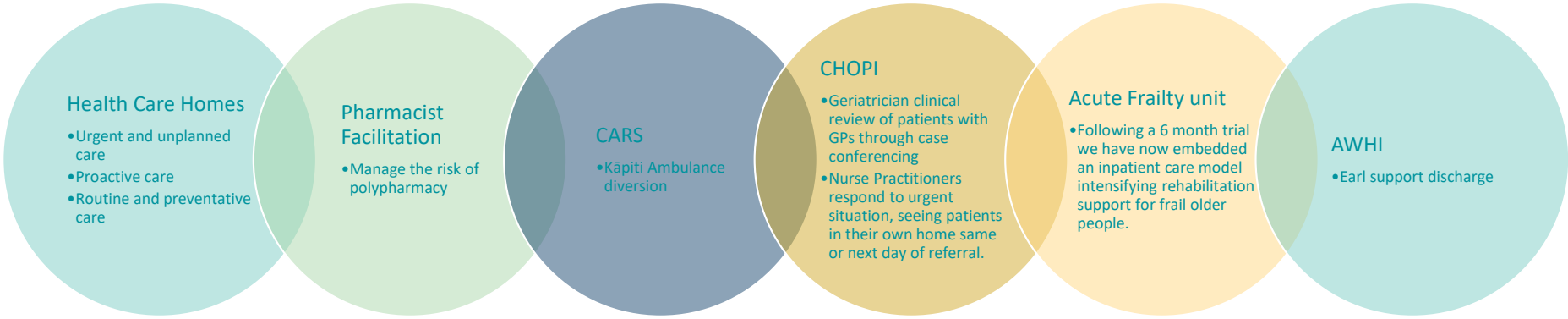
What does the future look like in Kāpiti for local and whole of system commissioning?

The Kāpiti CHN will both lead a work programme focused on local priorities and Build on and support existing initiatives and system changes.

Over time as the Network develops there will be focus on other population health priority areas (such as youth)

We are investing across the system to support older people with frailty and deliver care in the most appropriate setting for their needs:



13

Next Steps for the Network

- Continue to partner with Te Ātiawa and Tū Ora to develop the foundations of a Network, including defining ongoing Network Governance, a Kāpiti CHN outcome framework and a Network data management framework.
- Increase the investment in Kāpiti CHN for year two:
  - Continue to invest in a multi-agency Network Operations Team who will:
    - Lead and manage the Kāpiti CHN Work Programme, through:
    - Work to develop deeper understanding of what a Network means to a community
  - Expand the Operations Team to include District Nursing Leadership and explore opportunities to expand increase the capability and capacity of the Operations Team.
  - Empower the Network to prototype and test working in new ways to improve health outcomes for Kāpiti residents
- Continue to align with system change and existing initiatives

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Pro-equity

- The DHB is focused on improving the performance of our health system and encouraging better health and wellbeing and more equitable outcomes for the Kāpiti community
- We recognise the inequities experienced by our priority populations: Māori, Pacific peoples and disabled people
- Development of Networks, other initiatives and future work will have a priority of closing these equity gaps

Health System Committee

28 July 2021

Health Outcomes for Kāpiti Residents

Action Required

The 2DHB Health System Committee notes:

(a) that looking at a range of indicators for mothers and babies, children, youth, people living with long term conditions and older people, Kāpiti residents generally experience better health outcomes than residents living in other areas served by CCDHB.

(b) that despite this, the equity gap persists with poorer outcomes in almost every area reviewed for Māori and Pacific peoples. Data is not available to assess the position for disabled people.

(c) there has been a continued increase over time in the amount of outpatient services provided either face to face locally or via telehealth in the Kāpiti district.

Strategic Alignment	Health System Plan 2030
Authors	Mary Cleary Lyons, General Manager, Design and Implementation
Endorsed by	Rachel Haggerty, Director, Strategy, Planning and Performance
Presented by	Rachel Haggerty, Director, Strategy, Planning and Performance
Purpose	Provide an update on health outcomes for Kāpiti residents
Contributors	Hannah Wignall, System Development Advisory, Design and Implementation
Consultation	N/A

Executive Summary

Developing services in the Kāpiti district remains a significant priority for CCDHB.

Through implementation of the Kāpiti Community Health Network and through other service development initiatives we remain focused on improving equity and health outcomes for the people of Kāpiti.

This paper provides an overview of health outcomes and access to specialist services for the people of Kāpiti. Through analysis and monitoring of health outcomes we are able to support the DHB and the Kāpiti Community Health Network (CHN) to develop priorities for action. We are also better able to deliver and design services that address local needs.

The data shows that Kāpiti residents generally experience better health outcomes than residents living in other areas served by CCDHB. However, the equity gap persists in Kāpiti with poorer outcomes in almost every area reviewed for Māori and Pacific peoples. The DHB will continue to prioritise work in this area.

Strategic Considerations

Service	Analysis and monitoring of population health outcomes supports CCDHB and the Kāpiti Community Health Network to develop priorities for action
People	Monitoring of health outcomes ensures the DHB remains focused on actions to improve equity and health outcomes for the people of Kāpiti.
Financial	N/A
Governance	Integrated Care Collaborative Alliance Leadership Teams and Kāpiti CHN Establishment Governance Group

Attachment/s

1. Health outcomes and access to specialist services for people of the Kāpiti Coast District – Power point presentation

Purpose

The purpose of this paper is to provide an update to the Health System Committee (HSC) on health outcomes and access to specialist services for people of the Kāpiti Coast District. The data for all indicators referred to below is contained within the power point slides attached to this presentation.

Health Outcomes for People of the Kāpiti Coast District

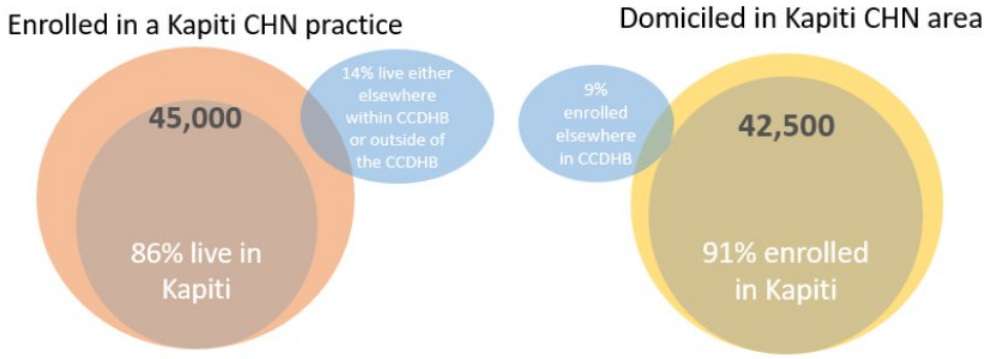
Kāpiti People

Around 54,000 people call the Kāpiti Coast District Home, including the Ōtaki community which is not within CCDHB district[1]. Within the Kāpiti CHN area there are 10 primary care practices, with an enrolled population of around 45,000. Of those enrolled at a Kāpiti CHN practice, 12% are Māori and 2% are Pacific. There is also a large and growing proportion of older people in Kāpiti (27% aged over 65) and a large number of Aged Residential Care facilities in Kāpiti. It is also estimated that around 15,000 people in Kāpiti live with a disability.

The figure below describes the differences between people in the enrolled and domiciled Kāpiti populations. When developing and delivering services and system change through the Kāpiti

[1] ***An MoU exists between MidCentral DHB and CCDHB in relation to the provision of health care for residents of the Ōtaki area.***

Community Health Network it is appropriate to consider both views:



The following section provides an overview of the indicators selected that best describe the health outcomes for Kāpiti residents in different population groups. The data for all indicators referred to below is contained within the power point slides attached to this presentation.

Health outcomes for Kāpiti mothers and babies

The three indicators selected here are:

- % of mothers registered with a Lead Maternity Carer (LMC) in their first trimester
- % of mothers smokefree 2 weeks post-natally
- % of mothers breastfeeding 2 weeks post-natally

These three indicators all provide good measures of the healthcare received by mothers and their babies and the numbers of babies getting a good start to life.

Kāpiti mothers and babies are doing better than those in Wellington and Porirua. In addition, Māori and Pacific mothers and babies have better outcomes than in other parts of our district. However, there is still an equity gap within Kāpiti.

Health outcomes for Kāpiti children

The three indicators selected here are:

- % of 5 year olds who are cavies free
- Rate per 100,000 of children admitted to hospital for avoidable respiratory conditions
- % of children who are fully immunised at 2 years of age

The indicators chosen give a good indication of access to healthcare for children and the other factors that support good health such as nutrition and housing.

Health outcomes for children in Kāpiti are better than for Wellington and Porirua children and in most cases Maori and Pacific children also have better health outcomes. However, there is an equity gap within Kāpiti with Maori children and Pacific children 2.3 and 2.8 times respectively, more likely to be admitted for avoidable respiratory conditions.

Health outcomes for Kāpiti youth

The three indicators selected here are:

- % of 12 year olds who are cavity free
- % of youth enrolled with general practice
- % of youth immunised against measles

The indicators chosen give a good indication of access to healthcare for Kāpiti youth.

On average outcomes for Kāpiti youth are equal to Wellington and Porirua youth. Again in this area we see the persistent equity gap in outcomes for Maori and Pacific youth.

Health outcomes for Kāpiti residents living with a long term condition

The three indicators selected here are:

- Rate per 100,000 of adults admitted for avoidable respiratory conditions
- Rate per 100,000 of adults admitted for avoidable cardiovascular conditions
- % of patients with diabetes with safer blood glucose control

These indicators provide a measure of how well the system is supporting residents with long term conditions.

In this area generally Kāpiti residents experience better health outcomes. However, there are some differences in the data especially for admission rates for cardiovascular disease for the 'other' ethnicity category where Kāpiti residents have higher admission rates. The equity gap is particularly apparent in the admission rates for avoidable respiratory conditions.

Health outcomes for Kāpiti residents living with mental health issues

The three indicators selected here are:

- % utilisation of mental health and addiction services
- % people referred for mental health services seen within 8 weeks
- Rate per 100,000 ED presentations for mental health conditions

The indicators give a good indication of access to mental health services for Kāpiti residents.

The data demonstrates that there is an opportunity to better serve the people of Kāpiti living with mental health issues particularly in terms of waiting times for services. Again, across all three chosen indicators there is evidence of an equity gap for Maori and Pacific peoples.

Health outcomes for Older people in Kāpiti

The three indicators selected here are:

- % of 65+ year olds supported at home
- Acute bed day rate per 100,000 for age 65+
- % age 65+ readmitted to hospital within 28 days

These indicators give a good indication of how well older people's healthcare needs are met in the community.

Overall outcomes for older adults in Kāpiti compare well against the rest of CCDHB but there is a significant equity gap when comparing the rate of acute bed days for Maori and Pacific peoples.

Access to Specialist Services for People of the Kāpiti Coast District

Access to specialist services locally is an important issue for Kāpiti residents. The Kāpiti Health Centre in Paraparaumu is a CCDHB facility which, outpatient services including; specialist clinics, district nursing, community allied health, community mental health, child and family and maternity services.

The data provided in the slides attached shows a continued increase over time in the amount of outpatient services provided either face to face locally or via telehealth. We saw a spike in telehealth appointments in March 2020 due to the first Covid lockdown but even when we adjust for this spike we can see there is an ongoing increase in the use of telehealth to deliver services particularly in geriatrics and oncology.

There are also increases in the amount of district nursing and allied health appointments at Kāpiti Health Centre over the last 4 years.

The Kāpiti Network will continue to prioritise work in this area as we recognise that even with these increases it is still the case that Kāpiti residents must travel outside the area for specialist care over 90% of the time.

Health outcomes and access to specialist services for people of the Kāpiti Coast District

The Kāpiti Coast Population

- Around 43,000 people live in the Kāpiti Coast (excluding Ōtaki)
- The mana whenua are Te Atiawa Ki Kāpiti
- There are 10 primary care practices within the Kāpiti CHN area, with an enrolled population of around 45,000
  - 12% identify as Māori and 2% identify as Pacific.
  - 27% are aged over 65 and the population is aging
  - Around 15,000 (est) people in Kāpiti live with a disability
- There are a significant number of NGOs and community provider organisations.

Health outcomes for Kāpiti mothers and babies are better than Wellington and Porirua. In most cases, Māori and Pacific Kāpiti mothers and babies also have better health outcomes. However, there is an equity gap within Kāpiti.

More Kāpiti mothers are registered with a Lead Maternity Carer in their 1st trimester

Māori: 82% ⇧
Pacific: 62% ⇩
Other: 90% ⇧

Wellington
Māori: 69% Pacific: 51%
Other: 86%

Porirua
Māori: 69% Pacific: 49%
Other: 86%

More Kāpiti mothers are smokefree 2 weeks postnatal

Māori: 86% ⇧
Pacific: 85% ⇩
Other: 98% ⇧

Wellington
Māori: 86% Pacific: 91%
Other: 99%

Porirua
Māori: 81% Pacific: 89%
Other: 96%

More Kāpiti mothers are breastfeeding 2 weeks Postnatal

Māori: 78% ⇩
Pacific: 77% ⇩
Other: 77% ⇩

Wellington
Māori: 73% Pacific: 71%
Other: 76%

Porirua
Māori: 71% Pacific: 60%
Other: 77%

⇧ ⇩ Arrows indicate whether figures are rising or falling compared to 2019

Data: 2020 Calendar Year

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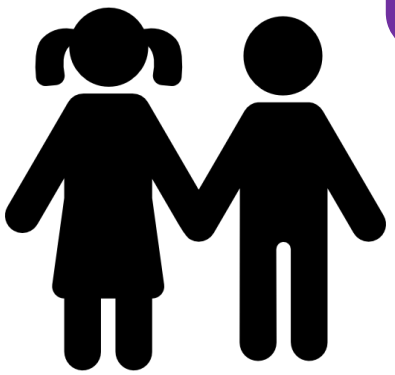
Health outcomes for Kāpiti children are better than Wellington and Porirua children. In most cases, Māori and Pacific children also have better health outcomes. However, there is an equity gap within Kāpiti.



More Kāpiti 5 year olds are cavity free	Fewer Kāpiti children (0-4 years) are admitted for avoidable respiratory conditions (per 100,000)	More Kāpiti children are fully immunised at 2 years of age
Māori: 61% 〓 **Pacific: -%*** **Other: 81% ⇧**	**Māori: 1978 ⇩** **Pacific: 2410 ⇩** **Other: 856 ⇩**	**Māori: 89% ⇧** **Pacific: 100% 〓** **Other: 94% ⇧**
Wellington Māori: 51% Pacific: 61% Other: 78%	Wellington Māori: 2373 Pacific: 4538 Other: 1889	Wellington Māori: 87% Pacific: 83% Other: 93%
Porirua Māori: 51% Pacific: 40% Other: 74%	Porirua Māori: 2908 Pacific: 2700 Other: 1353	Porirua Māori: 85% Pacific: 93% Other: 93%

⇧ ⇩ Arrows indicate whether figures are rising or falling compared to 2019

Data: 2020 Calendar Year

HUTT VALLEY DHB

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Health outcomes for Kāpiti youth are on average equal to Wellington and Porirua youth. In most cases, Māori and Pacific youth and babies also have better health outcomes. However, there is an equity gap within Kāpiti.

More Kāpiti youth are cavity free at age 12

Māori: 61% 〓
Pacific: -%*
Other: 81% ⇧

Wellington
Māori: 51% Pacific: 61%
Other: 78%

Porirua
Māori: 51% Pacific: 40%
Other: 74%

More Kāpiti youth are enrolled with a general practices

Māori: 86% 〓
Pacific: 80% ⇩
Other: 95% ⇧

Wellington
Māori: 73% Pacific: 89%
Other: 82%

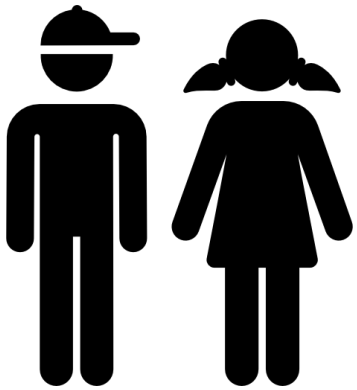
Porirua
Māori: 97% Pacific: 90%
Other: 83%

More Kāpiti youth are immunisation against measles

Māori: 52%
Pacific: 49%
Other: 60%
April 2021

Wellington
Māori: 52% Pacific: 55%
Other: 47%

Porirua
Māori: 56% Pacific: 56%
Other: 57%



⇧ ⇩ Arrows indicate whether figures are rising or falling compared to 2019

Data: 2020 Calendar Year

HUTT VALLEY DHB

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Kāpiti residents living with long term conditions have better health outcomes on average than Wellington and Porirua residents. In most cases, Māori and Pacific Kāpiti residents also have better health outcomes. However, there is an equity gap within Kāpiti.

Fewer Kāpiti adults are admitted for avoidable respiratory conditions (per 100,000)	Fewer Kāpiti adults are admitted for avoidable cardiovascular conditions (per 100,000)	More Kāpiti patients with diabetes have safer blood glucose control
Māori: 684 ⇧ Pacific: 1,290 ⇧ Other: 215 ⇩	**Māori: 1,027 ⇩ Pacific: 1,290 ⇩ Other: 1,344 ⇩**	**Total: 70% ⇩**
Wellington Māori: 1199 Pacific: 932 Other: 151	Wellington Māori: 1531 Pacific: 2538 Other: 931	Wellington: Total: 60%
Porirua Māori: 1041 Pacific: 584 Other: 254	Porirua Māori: 2044 Pacific: 2303 Other: 976	Porirua: 54%

⇧ ⇩ Arrows indicate whether figures are rising or falling compared to 2019

Data: 2020 Calendar Year

HUTT VALLEY DHB

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

There is an opportunity to better serve the people of Kāpiti living with mental health issues. In most cases, Māori and Pacific residents have better health outcomes. However, there is an equity gap within Kāpiti.

More Kāpiti residents utilise mental health and addiction services (% of population)	There is an opportunity to improve wait times for Kāpiti residents referred to mental health services and be seen within 8 weeks	Fewer Kāpiti residents present to ED for mental health conditions (per 100,000)
Māori: 5.9% 〓 **Pacific: 4.8% ⇩** **Other: 3.2% 〓**	**Māori: 88% 〓** **Pacific: 90% ⇩** **Other: 90% 〓**	**Māori: 584 ⇧** **Pacific: 733 ⇧** **Other: 367 ⇩**
Wellington Māori: 5.7% Pacific: 3.7% Other: 2.7%	Wellington Māori: 93% Pacific: 94% Other: 89%	Wellington Māori: 1034 Pacific: 574 Other: 547
Porirua Māori: 6.3% Pacific: 4.7% Other: 3.0%	Porirua Māori: 93% Pacific: 95% Other: 89%	Porirua Māori: 712 Pacific: 314 Other: 365

⇧ ⇩ Arrows indicate whether figures are rising or falling compared to 2019

Data: 2020 Calendar Year

Older People living in Kāpiti have better health outcomes than older people living in Wellington and Porirua. In most cases, Māori and Pacific Kāpiti also have better health outcomes. However, there is an equity gap within Kāpiti.

More Kāpiti 65+ year olds are supported at home	There are fewer acute bed days for Kāpiti 65+ year olds (per 100,000)	Fewer Kāpiti 65+ year olds are readmitted to hospital within 28 days
Māori: 5% 〓 **Pacific: 12% 〓** **Other: 6% 〓**	**Māori: 703 ⇧** **Pacific: 1,121 ⇩** **Other: 767 〓**	**Māori: 17% 〓** **Pacific: 4% ⇩** **Other: 13% 〓**
Wellington Māori: 5% Pacific: 7% Other: 4%	Wellington Māori: 1456 Pacific: 1774 Other: 706	Wellington: Māori: 18% Pacific: 14% Other: 14%
Porirua Māori: 4% Pacific: 4% Other: 4%	Porirua Māori: 1028 Pacific: 910 Other: 897	Porirua: Māori: 18% Pacific: 21% Other: 17%

⇧ ⇩ Arrows indicate whether figures are rising or falling compared to 2019

Data: 2020 Calendar Year

HUTT VALLEY DHB

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Services Delivered in Kāpiti

Mothers and Babies

- Obstetrics and Antenatal (16 hours/4 clinics per month)
- Paediatric Clinics including specialist Diabetology, Endocrinology and Dieticians (39 hours/8 clinics per month)
- Primary Maternity Birthing Unit with two post natal beds
- New born hearing service (1 day a week)

Older Persons

- Older Adults Allied Health (Ora) service including treatment for older adults with complex needs and prevention of avoidable admissions to acute care (Mon-Fri 8am – 4pm)
- Geriatrician including Parkinson's clinic (3 hours per month)
- Occupational and Physiotherapy for Older persons (available Mon-Fri 8am – 4pm)
- District Nursing providing care in aged residential facilities

Children

- Paediatric Developmental (3 ½ hours per month)
- Multidisciplinary Child Development Team (3 days per week)
- Child Adolescent Mental Health Service (as required)
- District Nursing Enuresis programme that focuses on child bed wetting (available 8am – 4.30pm as required)

Long Term Conditions

- Diabetes/Endocrine clinics (3 days per month) (daily nurse)
- Cardiology clinics including rehabilitation, a Heart Failure Nurse (27 hours/4 per month)
- Electrocardiograph clinic (by appointment)
- Rehabilitation Allied Health (ORA) service for assessment of chronic conditions (Mon-Fri 8am – 4pm)

Youth

- Child and Adolescent Community Alcohol and Drug Service (as required)
- Child and Adolescent Mental Health Service including Māori Mental Health Team (as required)
- Eating Disorder Team (as required)
- Early Intervention service (8am – 4.30pm as required)

Mental Health

- Specialist Mental Health: Adult and Older persons service, Māori specialist team, Child and Adolescents, and Maternal Teams (as required)
- TACT team who work with patients under the mental health act or who are homeless (as required)
- Crisis Team (as required)

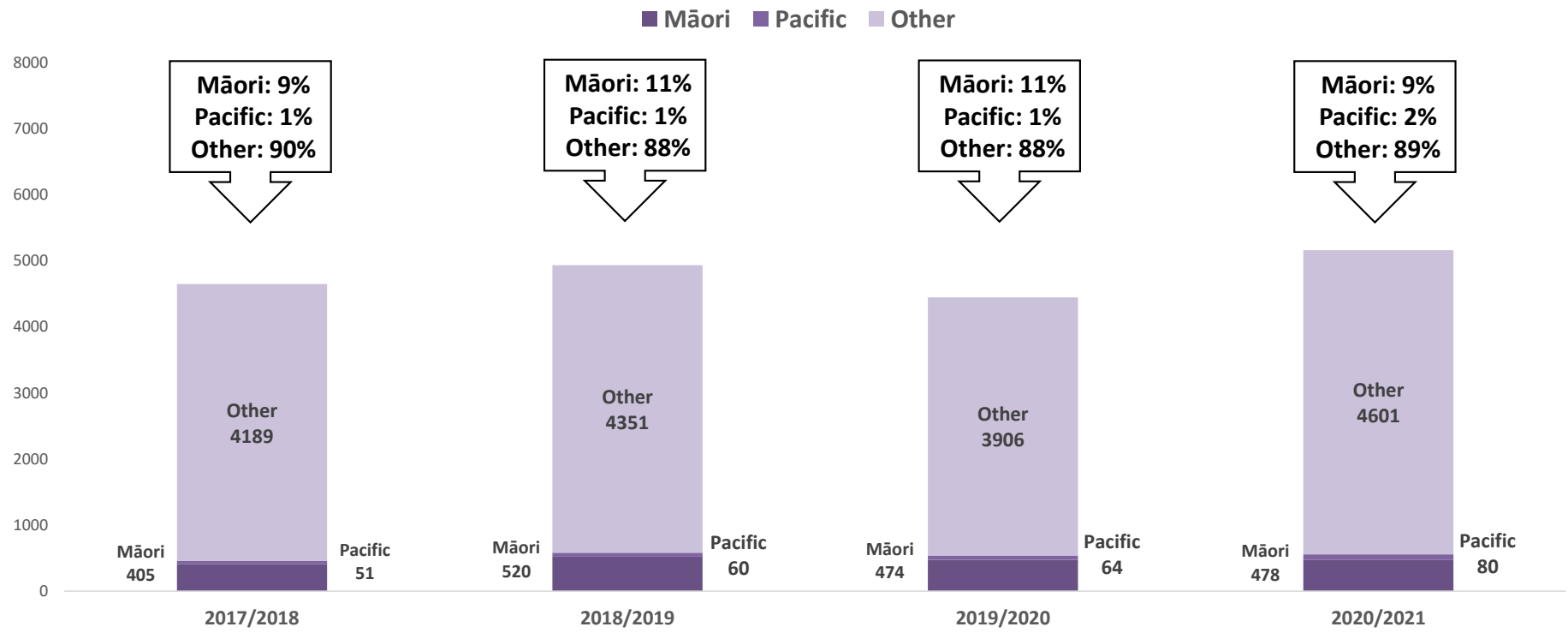
HUTT VALLEY DHB

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

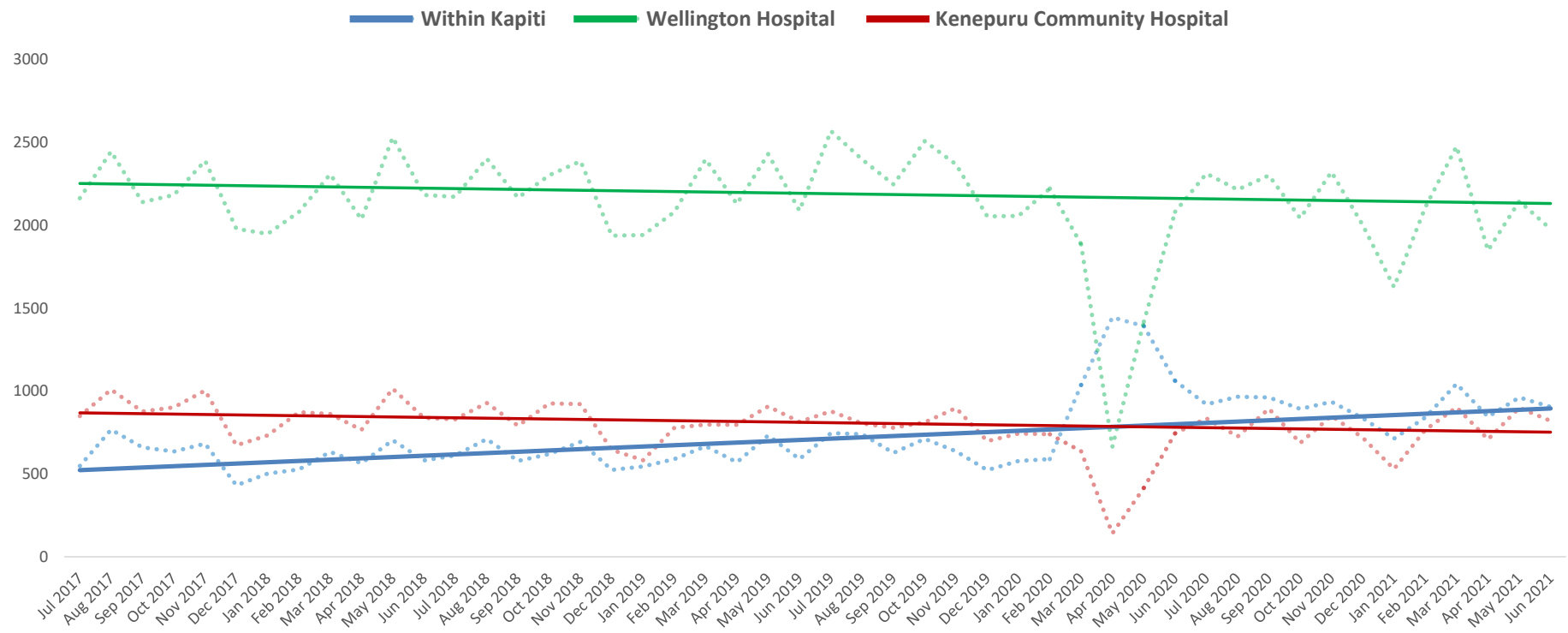
Specialist Outpatients Service for Kāpiti Residents

Specialist Outpatients

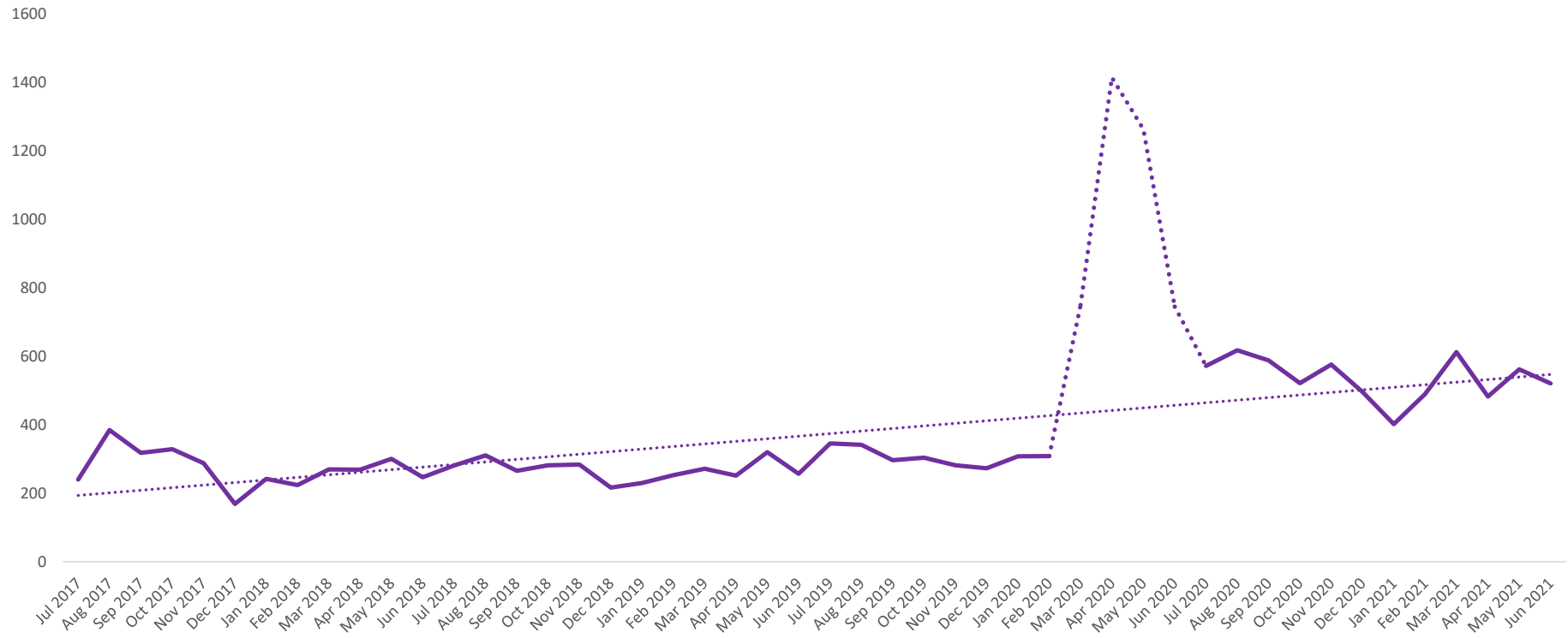
After a dip in 2019/20, Specialist Outpatient events at Kāpiti Health Centre for Kāpiti residents have been has seen an 16% increase in the 2020/21 financial year.



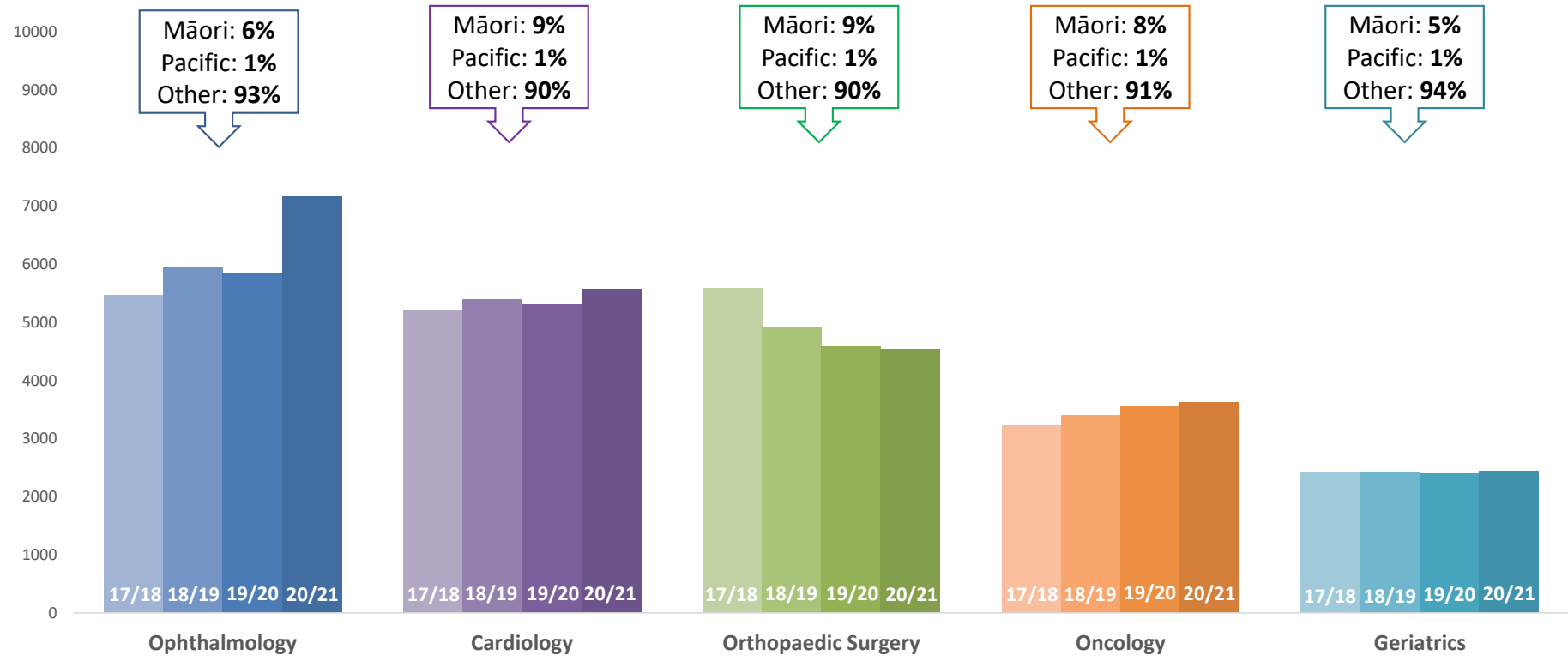
Specialist Outpatient events for Kāpiti residents within Kāpiti is increasing while events outside of Kāpiti are decreasing.



We saw a spike in Telehealth appointments in March 2020 due the first COVID19 lockdown, but ever since we seen an increase in both Telehealth and Home visit appointments.

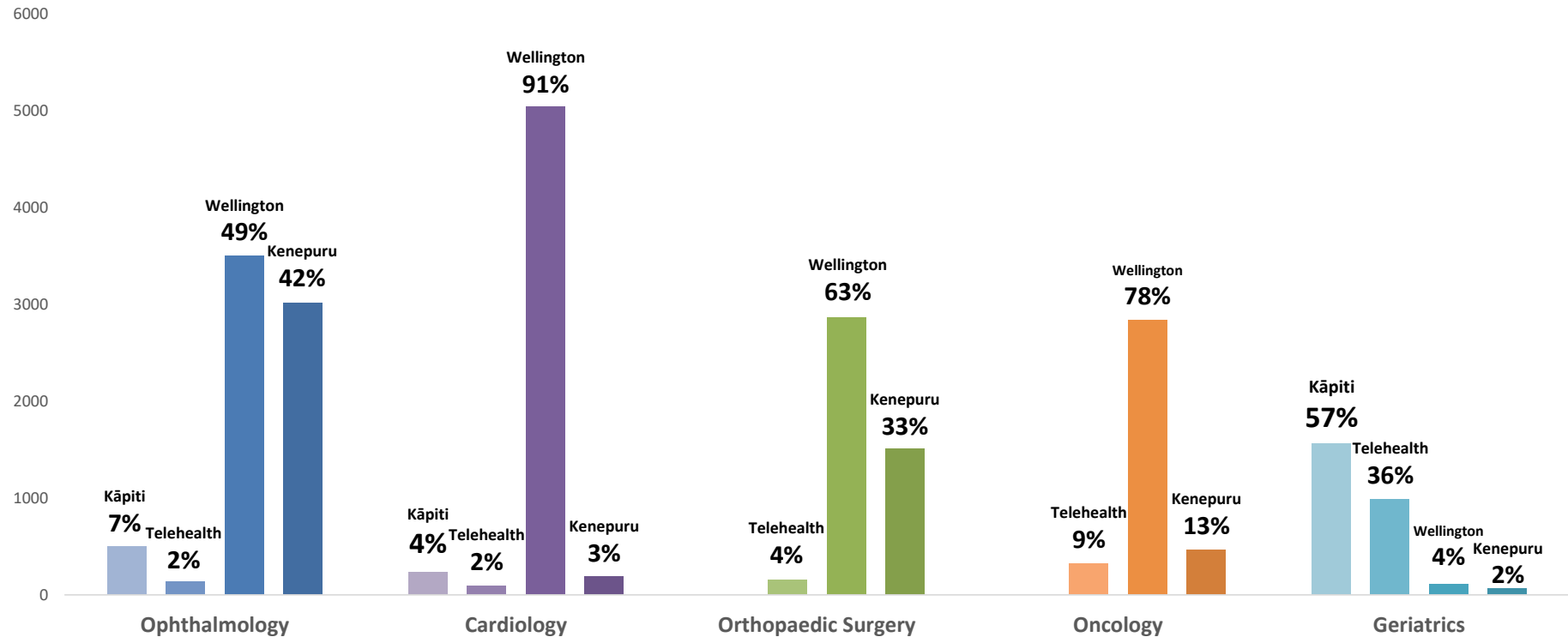


The Top 5 outpatient specialities for Kāpiti residents are Ophthalmology, Cardiology, Orthopaedics, Oncology, and Geriatrics



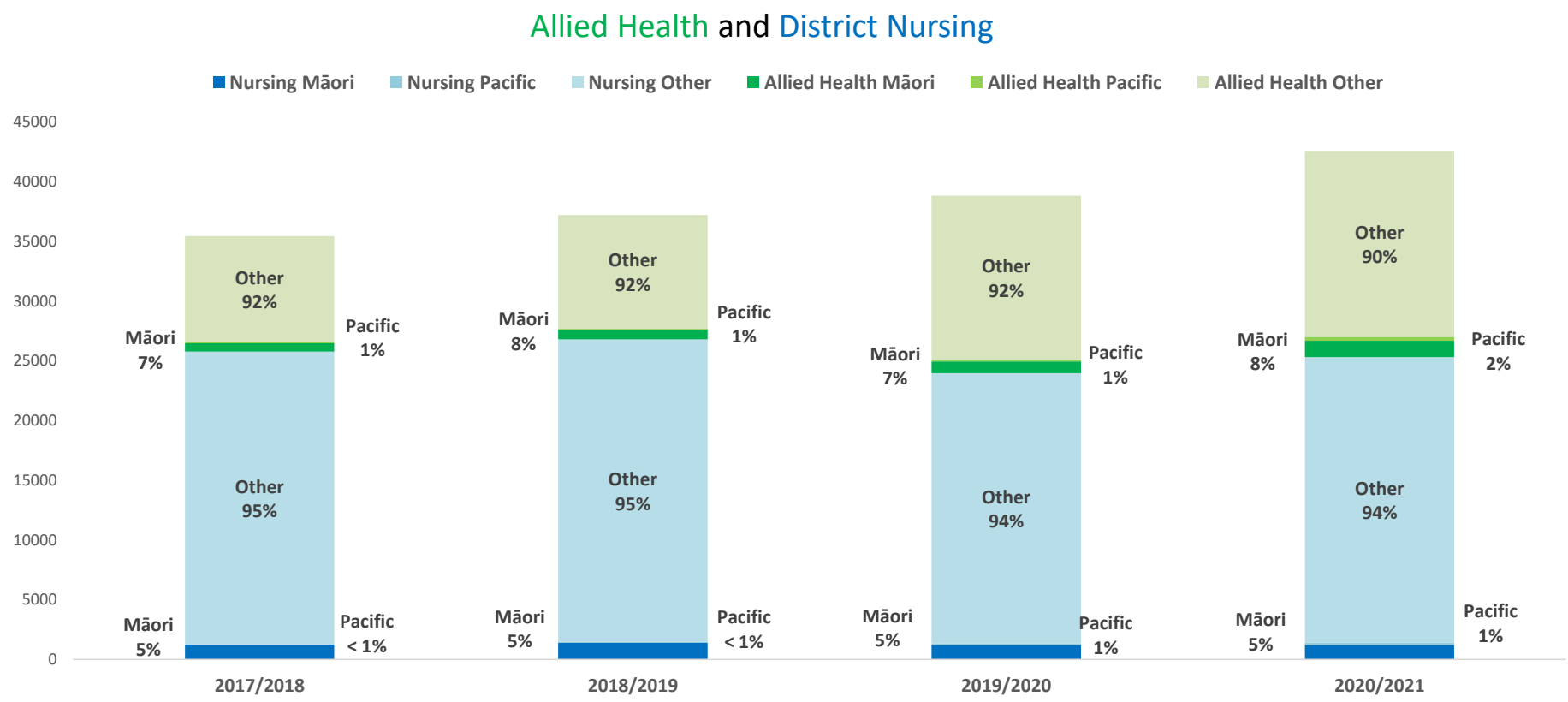
Top 5 Outpatient Specialities for Kāpiti Residents (2020/21)

For four of the top five specialities, Kāpiti residents must travel outside of Kāpiti over 90% of the time for appointments. This is due to the need for certain hospital grade equipment that could not be facilitated in Kāpiti. Over 90% of Geriatric outpatient appointments are completed in Kāpiti.



Allied Health and District Nursing Services for Kāpiti residents

There has been a 5% increase in Nursing services and a 16% increase in Allied Health services provided by Kāpiti Health Centre for Kāpiti residents in 2020/21.



Health System Committee

28 July 2021

Localities and Community Networks – Our Approach	
The 2DHB Health System Committee notes: (a) our approach to localities and community networks	
Strategic Alignment	CCDHB Health System Plan 2030 HVDHB Vision for Change
Presented by	Rachel Haggerty, Director Strategy, Planning & Performance CCDHB & HVDHB
Purpose	This paper provides an overview of the CCDHB and HVDHB approach to locality integration and community health networks.
Contributors	Mary Cleary Lyons, General Manager, Design and Implementation Catherine Inder, Principal Advisor, Commissioning Mental Health and Addictions Hannah Wignall, System Development Advisory, Design and Implementation
Consultation	N/A

Executive Summary

Capital and Coast (CC) and Hutt Valley (HV) DHBs have been developing locality based approaches across our districts over the last 3 years. This direction of travel was clearly articulated in the CCDHB Health System Plan 2018, which articulated the creation of geographically based Community Health Networks and our intent to work in localities with our Intersectoral partners.

The work has progressed through three channels developing the relationships, trust, understanding, skill and capability to integrate health service delivery to improve outcomes in our communities. These three channels are:

- Locality Planning
- Locality integration, partnering with Ngati Toa o Rangatira in the Porirua community;
- Developing a prototype Community Health Network within the Kāpiti community;
- Developing mental health and addiction networks with our community providers.

Developing strong and trusted relationships is key to developing Networks, and our DHBs have prioritised this in a number of ways over recent years. This has required relationship building with iwi, mana whenua, primary healthcare organisations, Maori and Pacific providers and our wider NGO partners.

These developments have improved our health system performance and are making a small, but measurable impact on equity and outcomes. Scale across our districts will be necessary to achieve the potential of this system transformation. We are optimistic that this will be supported by the implementation of Health NZ and the Māori Health Authority.

Strategic Considerations

Strategic goals	The NZ Health System Review has explicitly adopted a locality based approach to the commissioning and integration of community services. CCDHB, and now HVDHB, have been implementing a people and placed based approach to health service development and delivery since 2017. This paper outlines our approach, and learning, as we prepare for a transition to Health New Zealand.
Financial	Part of current budget.
Governance	Governed by a series of relationships with our Mana Whenua, community, clinical and sector partners.

Attachment/s

1. Nil

Capital & Coast and Hutt Valley DHBs – Our Localities

Our Journey so far

Capital and Coast (CC) and Hutt Valley (HV) DHBs have been developing locality based approaches across our districts over the last 3 years. This direction of travel was clearly articulated in the CCDHB *Health System Plan 2018,* which articulated the creation of geographically based Community Health Networks and work in localities with our Intersectoral partners.

The work has progressed through three channels – developing the relationships, trust, understanding, skill and capability to integrate health service delivery to improve outcomes in our communities. These three channels are:

- Locality Planning
- Locality integration partnering with Ngati Toa o Rangatira in the Porirua community;
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Developing strong and trusted relationships is key to developing Networks, and our DHBs have prioritised this in a number of ways over recent years. This has required relationship building with iwi, mana whenua, primary healthcare organisations, Maori and Pacific providers and our wider NGO partners.

Our growing partnerships with local iwi are at the centre of locality development. This has been supported by a commitment to investment and service development in our Māori providers to increase the extent and capability of these providers. This has included directing Healthcare Home funding to a Māori directed model with Ora Toa PHO.

The Integrated Care Collaborative (ICC) and Hutt Inc alliancing with primary care has strengthened our relationship with our Primary Healthcare Organisations. This has been strengthened by our partnership with Tū Ora Compass Health (Tū Ora), Te Awakairangi and Cosine to roll out Health Care Homes across both districts.

Investing in our NGO sector by correcting disinvestment decisions of the past, ensuring annual increments to reflect cost growth, increasing service and developing agreed health system design that

reflects Maori, Pacific, youth, gender and sexual diverse and other communities to drive equity of outcome.

Locality Planning

A locality based planning approach is the genesis of our overall approach to improving health outcomes in our communities. To improve outcomes we must seek to understand who people are, and where they live, to establish systems of healthcare that support the strengths of communities and families to be well.

Understanding the needs of communities

Understanding the needs of communities is a key tenant of our mahi. People and place based analysis to inform the needs of different populations across our districts has identified new perspectives on the relationships between people, their communities and their wellbeing.

These approaches are informing service development and new models of care in many areas. In addition, data analysis is important in ensuring that we identify inequities and use this to drive prioritisation.

Geographical Boundaries

Supporting this locality based approach we are increasingly organising primary and community services into geographically defined networks. These boundaries are not firm but create the organising principles of how we approach healthcare delivery and engaging with people.

Initially CCDHB defined eight geographical populations, each with populations of 20-50,000 people. In 2020, the Kāpiti CHN was launched with the intention of informing rollout of CHNs across the district. Since launching Kāpiti, we now think that 8 is too many Networks, and that it would make sense to align Networks to TLAs where possible, with iwi rohe.

In the Hutt Valley, 4 Neighbourhoods were initially signalled, and analysis of the population in each network was undertaken. We will be working with mana whenua and our communities to determine appropriate boundaries for Hutt Valley over the next 6 months. Our challenge in the Hutt Valley is to recognise the unique factors and issues that are experienced by key communities such as Wainuiomata which experience a high burden of health inequalities and therefore need focused attention but which may be too small to function as a locality in and of themselves.

Boundaries between DHBs in element of create tension. The newly created Kāpiti CHN's northernmost boundary is Peka, aligned with the DHB boundary. However the iwi rohe extends north to Otaki. While there is a Memorandum of Understanding in place between MidCentral and CCDHBs, this creates confusion for people living outside of the DHB their GP belongs to, and vice versa. This is an issue potentially resolved by the proposed Health reform.

Data Intelligence and Governance

Creating our locality based approach has required a different approach to data sharing arrangements to inform planning, service choices and manage performance.

Data sharing arrangements

CCDHB and HVDHB have data sharing arrangements in place with primary and community providers. These are governed by Data Sharing Agreements which have undergone a comprehensive Privacy Impact Assessment. The data sharing agreements that we have in place have enabled deeper insights into the needs of our localities and resulted in a number of community commissioning initiatives.

In addition, we share data via the Data Exchange with some primary and community providers. The Data Exchange is a mechanism for sharing large volumes of data between organisations in a regular and automated, yet secure and appropriate manner. The Data Exchange is a cloud based technology that

moves data between partner organisations (e.g. DHBs and Primary Health Organisations (PHOs) or NGOs). Sharing data via Data Exchange supports insight into system-wide performance and the effectiveness of service delivery. This also enables us to improve the quality of our datasets to reflect system level activity.

Enabling Maori sovereignty over health information

As part of our integrated commissioning with Ngāti Toa and Te Ātiawa, CCDHB and HVDHB are exploring how we can share data with mana whenua on their population. Proactively sharing data that our iwi providers hold on their own clients will enable more integrated and responsive services that better support the aspirations of iwi and the health needs of their communities. We anticipate this work occurring as part of Networks. Any data management framework for a Network should also align with the principles of Māori Data Sovereignty and Te Tiriti o Waitangi.

CCDHB and HVDHB work to ensure data sovereignty is upheld when sharing data with providers. For example, data shared via the Data Exchange is retained exclusively in New Zealand.

Locality Integration

Integrating service delivery within localities, to support communities, is a process of locality based planning, strengthening our Mana Whenua relationships, developing comprehensive primary care and building health delivery networks.

Building an iwi relationship with Ngāti Toa o Rangatira

Over the last 3 years we have sought to strengthen our partnership with Te Rūnanga O Toa Rangatira (Ngāti Toa) as mana whenua in Porirua.

The early stages of this work was ensuring we optimally support sustainable and effective core primary and community care delivery. We identified and corrected historical funding inequities to core services such as outreach immunisation and Well Child Tamariki Ora. We've supported Ora Toa to develop innovative and implement new service models of care that better meet the needs of their population (for example, see Mātua, Pepi, Tamariki described below and wahakura wanānga). Where we've supported new ways of working, we've commissioned kaupapa Māori evaluation to refine and embed innovation into 'BAU' practice, for example with antenatal education.

In February 2020, CCDHB developed an integrated commissioning approach prototype for Porirua, for consideration by the *Health and Disability System Review* group. The proposal was included in the final Review report as a case study for Tier 1 Service integration.

This work recognises the strength of Ngāti Toa as a natural lead for integration of health and social services and support for Porirua families. Therefore, CCDHB are working in partnership with (Ngāti Toa)) to build the capacity and capability in both our teams to support an integrated, contemporary approach to commissioning for the resident population of Porirua. The new integrated contract will transition over 24 contracts to a single integrated contract from 1 October 2021.

We've partnered to understand investment into Ngāti Toa, agree on shared outcomes for the Porirua community and an intervention logic and measurement framework to support service and system performance under the new integrated contract. This capability building is a key foundation for a future Network in this area.

CCDHB funded and supported Ngāti Toa to develop their integrated operating model – Whiti Te Ra Mauri Ora. As part of this work, Ngāti Toa have mapped workflows across their health and social services (commissioned and/or funded by a range of providers including but not limited to DHB, MoH, and the rūnanga itself), to define their integrated responses for whanau. To support integrated working, Ngāti Toa have invested in new IT infrastructure that will support people/whanau-centred data collection and reporting (Whanau Tahi) which links to their primary care PMS.

Based on this investment and the 12 months of work done with Ngāti Toa, both CCDHB and Ngāti Toa are more mature partners (commissioner partner and provider partner respectively). Both organisations are better skilled and resourced to begin work on Porirua CHN development work. The integrated contact is a more contemporary contracting approach for place-based, outcomes driven commissioning.

This approach is now being developed with Te Ati Awa ki te Upoko o Te Ika a Maui as mana whenua relationship. Strengthening this relationship with mana whenua is partnered with the building of relationships with our Maori providers, including our urban and community Marae.

Community Relationships

As well as supported by Mana Whenua relationships we maintain active relationships with our communities and their leaders. We have been supporting our Pacific community leadership. The development of Pacific Provider Networks is now being strengthened by an investment in facilitation. This includes approaches such as the Kāpiti Health Advisory Group (a mayoral group), the Mental Health and Addiction Lived Experience Advisory Group. Furthermore we privilege the voice of lived experience experts in our design, procurement and establishment processes for services.

Community Health Networks

Community Health Networks (CHNs or Networks) are described as the central organising point for delivering effective and efficient health care. CHNs build on a comprehensive roll out of Health Care Homes across both districts.

The Kāpiti CHN is leading a work programme focused on local priorities **and** Build on and support existing initiatives and system changes. Over time as the Network develops there will be focus on other population health priority areas (such as youth).

Kāpiti Community Health Network

The Kāpiti Community Health Network (CHN) establishment began in July 2020. Kāpiti CHN is a network of health providers who are supported to coordinate and organise health service delivery to better meet the needs of and achieve equitable care for the Kāpiti population.

The Kāpiti CHN is being developed in partnership with mana whenua (Te Ātiawa ki Whakarongatai), CCDHB and Tū Ora Compass Health (the local PHO) in the first instance. These three organisation are joined by representation from the Kāpiti Health Advisory Group in the Kāpiti CHN Establishment Governance Group (Terms of Reference attached as KRD #)

This has involved defining and building the foundations for successful integration, system (re)design and developing strong network relationships. Much of the foundational work is underway in Kāpiti and includes the development of:

- a Network Charter, which defines shared values and principles which guide and underpin providers when working together
- a Network Operating Model, which details how the Network Operations Team will work to develop and deliver on a shared work programme
- a Network Outcome Framework, which guides the work underway in the Network to ensure the wider impacts on health outcomes are measured and achieved
- a Network Data management Framework, which will support and guide providers when information is shared within a Network

In 2020/21, the DHB commissioned Tū Ora to lead a multi-agency Network Operations Team which is tasked with:

- leading and managing the Kāpiti CHN Work Programme and associated projects

- strengthening relationships between providers in Kāpiti
- working with people, whanau and communities when designing solutions for improved care
- supporting and managing the Kāpiti CHN Establishment Governance Group
- supporting development of key CHN foundational work (as described above)

The Kāpiti CHN Work Programme outlines shared local priorities through which providers work together on new and re-design initiatives to improve health services for the local population. The local priorities were identified through a combination of; local priorities (including identified priorities of the Kāpiti Health Advisory Group), iwi priorities, data insights and strategic direction. In year one the three Kāpiti CHN focus areas are:

- Health of the Older Person
- Health and social care integration opportunities
- Planned care

Over time, funding for the Health Care Home programme is transitioning to support CHN development. Kāpiti CHN is the first off the rank, and was launched in 2020. The Kapiti CHN moves from strength to strength, supporting local providers to coordinate their efforts to address priority issues for the local population.

Mental Health and Addiction Collaborative Networks and Forums

Our DHBs are taking a whole-of-population approach to redesigning the mental health and addiction (MHA) system to address inequities and utilising *He Ara Oranga* investment to grow services to meet the full continuum of care.

A MHA network enables providers and stakeholders to coordinate and improve service delivery through the development of shared concern and responsibility for individual, service and system outcomes. The MHA network participants lead the network with health/locality commissioners providing backbone support (facilitation, coordination, project resource).

Importantly, networks connect easily with other networks facilitating formal (for example, representation) and informal (at the project or client-level) contributions to each other's work whether across agency or health service boundaries.

A well-functioning MHA network provides a level playing field for all providers and stakeholders that nurtures the collaborative leadership and collective spirit necessary to deliver distributed, community-based services and improve equity, access, quality and outcomes and is self-sustaining.

Building our MHA Networks

Across our 2DHBs we have established a range of collaborative networks/forums that are contributing to growing the collective spirit necessary to implement new integrated models of care and improve equity for our priority populations. These are at different stages of maturity.

Our providers are committed to collaborative service delivery however many lack the tools and experience to do so successfully, especially when complexity (involving issues of consent, information sharing, after hours systems, intersectoral working) conspires to defeat their good intent.

Our DHBs' collaborative networks and forums

While our existing collaborative networks and forums are creating effective partnerships and creating change in their areas of focus, they do not cover the full range of connected service delivery necessary for a whole-of population MHA system of care.

The collaborative networks and forums and activities covered in this section are:

- Acute Care Continuum Collaborative (and the successor collaborative planned)
- Alcohol and Other Drug (AOD) Model of Care Collaborative
- Greater Wellington Wellbeing Collaborative
- Lived Experience Advisory Group (LEAG)
- Navigate Regional Group
- Suicide Prevention and Postvention programme
- Te Ara Pai.

Acute Care Continuum Collaborative

The Acute Care Collective Forum (ACC Collective Forum) was set up to be a coordinating enabler for the Acute Care Continuum Model of Care. The members are services that are collectively responsive to the full range of acute needs presenting at any point in the acute system and represent the full MHA spectrum (tertiary, secondary and community and primary care sectors). The ACC Collective Forum is responsible for delivering a flexible, fully responsive acute system of care by supporting engagement to build trust and solving challenges to implement system change; coordinate project activities; and to coproduce solutions.

The ACC Collective Forum was originally made up of MHAIDS operational managers, whanau and lived experience representatives, managers from Hutt based MHA community based acute care services, Link people and 2DHB Strategy, Planning and Performance representatives.

It is currently extending its membership will incorporate primary care representatives and broader MHA and NGO representation from across both the Hutt and Wellington regions. There is real opportunity to create a well-functioning, collaborative network across a broad continuum of care if the network is set up well and managed carefully.

AOD Model of Care Collaborative

The collaboratively developed Alcohol and Other Drug (AOD) Model of Care proposes a whole-of-population approach to reducing substance-related harms by enabling early intervention in places that work for the people experiencing and exposed to the harms. The Model of Care identifies five priority pathways (for Māori, Pacific people, young people, people living rurally or remotely, people with severe problems).

The AOD Model of Care Collaborative (the AOD Collaborative) is key to enabling a coordinated approach to the implementation of new AOD services. The goal of the AOD Collaborative is to build the relationships that are needed to implement the priority pathways. It has representatives from people with lived experience, PHO, Regional Public Health, NGO AOD providers, DHB mental health and addiction clinicians and operational managers, Kaupapa Māori AOD providers, and a Pacifica AOD provider. It also incorporates the Youth Coexisting Problems Collaborative - specialist providers who deliver services for youth.

Greater Wellington Wellbeing Collaborative

The Greater Wellington Wellbeing Collaborative (GWWC) is a 3DHB network of organisations. GWWC governs the Access & Choice / Integrated Primary Mental Health & Addiction Services implementation

team. GWWC's purpose is to provide a mechanism for DHBs, PHOs and NGOs to share information, build on existing knowledge, develop expertise and solve problems for a common purpose. This collaboration aims to contribute to creating a system wide vision for mental health and addiction services across the continuum for the sub-region. It has been led by Tū Ora Compass ion the regions behalf.

Mental Health & Addictions Support Pathways is a recently formed GWWC sub-group. Membership includes: Tū Ora, MHAIDS and 2DHB Strategy, Planning and Performance representatives. The sub-group aims to build relationships between key stakeholders and develop clear support pathways (referral pathways) between primary and secondary MHA care to improve the experience and outcomes for people accessing support.

Lived Experience Advisory Group

The 3DHB Lived Experience Advisory Group (LEAG) was established in 2018 recognising the gap in lived experience leadership across the MHA system of care. A previous group had been in hiatus for some time.

The objectives of LEAG are:

- To guide and support the work of the mental health and addiction teams within funding and planning across the 3DHBs.
- To provide feedback (two way) between the 3DHBs and people and whānau with a lived experience of mental health and addiction in the community
- To identify individuals (minimum of two) with specific expertise to provide advice on specific projects e.g. sit on Steering groups
- To identify individuals with specific expertise to peer review written documents and other material
- To identify needs and solutions, and present these to the 3 DHB mental health and addiction planning and funding teams.

LEAG meets at least quarterly and members are represented on all the collaborative forums and networks ensuring lived experience voices are heard.

Suicide Prevention and Postvention programme

The Suicide Prevention and Postvention Programme (the SPP Programme) is a 3DHB initiative. The SPP Programme aligns with *He Tapu te oranga o ia tangata: Every Life Matters Suicide Prevention Action Plan 2019-2029* and aims to reduce suicide and improve well-being for all people across the sub-region.

The SPP programme takes a locality-based approach to suicide prevention and includes four focus areas: health promotion, prevention, intervention and postvention. To ensure a networked response to these four areas, the programme's initiatives include coordinating with local iwi, community groups, agencies and services across the sub-region as well as partnering with regional (e.g. Regional Public Health) and national agencies (e.g. The Suicide Prevention Office). By working locally, across the sub-region and nationally, the SPP programme aims to establish a consistent approach to suicide prevention that will improve the well-being of people within and across localities.

A SPP Governance Group provides governance and includes representatives from local working groups and expert advisors.

Te Ara Pai

The Te Ara Pai collaborative is an NGO-led collaborative responsible for coordinating referrals to NGO providers. Te Ara Pai focuses on service quality improvements and the developing collaborative partnerships necessary for greater service integration for tangata whaiora.

Te Ara Pai services are NGO delivered community support services working in partnership with DHB clinical services to assist people in their mental health recovery. Te Ara Pai services include: Navigation, Home Based Support, Housing facilitation, Employment Support, Family/Whānau Support, Health and Wellbeing Facilitation and Personal Connections and Skills for Life.

The Te Ara Pai collaborative includes the following providers: Pathways, Workwise, LinkPeople, Vaka Tautua, Emerge Aotearoa, Artareira, Te Waka Whaiora and the DHB Needs Assessment Service Coordination Service (the NASC).

Having an Impact on Health Outcomes

Below we outline

Kāpiti Ambulance Redirection

The development of ambulance re-direction in Kāpiti is an example of how by working together with the community, innovative ways to address complex problems can be created. This was a precursor to the formal establishment of the Kāpiti CHN, but brought together community representatives, local primary care and community providers, and the DHB to address the issue of people being transported to Wellington Hospital from Kāpiti for relatively minor medical reasons. The redirection programme enables Wellington Free Ambulance to call a person's GP and, with agreement, take them to their GP instead of to hospital. This has been shown to reduce impact on ED presentations and admissions for people from Kāpiti, and saves people the inconvenience of having to make their way home to Kāpiti.

Multidisciplinary teams in Health Care Homes

As part of the Health Care Home roll out in CCDHB, emphasis and effort was placed on creating meaningful Multi-Disciplinary Team interactions between primary care and other community services supporting their patients in the community. Practices host bimonthly MDT meetings to discuss specific cases with professionals from Community Nursing, Allied Health, NASC and palliative care services. This is now well embedded in the model of care in CCDHB.

In 2020 CCDHB commissioned the International Federation of Integrated to evaluate the HCH programme, which provides some insight into the benefits and challenges of the MDT approach, and suggests next steps for greater integration.

https://www.ccdhb.org.nz/about-us/integrated-care-collaborative-alliance/health-care-home/ccdhb-hch-evaluation-final-report-14-aug-2020.pdf

The roll out of Health Care Homes was also evaluated from a Pacific world view, with valuable insights into the parts of the approach that worked well and not so well for Pacific people.

https://www.ccdhb.org.nz/about-us/integrated-care-collaborative-alliance/health-care-home/hch-pacific-evaluation-report-final20.pdf

Community Health of Older People Initiative (CHOPI)

CHOPI was implemented in two CHN areas in the Wellington locality in 2018. CHOPI integrates Health of Older People specialist services across the DHB and PHO, and drives specialist advice and review closer to Primary Care. Specialists are available to Primary Care by phone and undertake regular case conferences at GP practices, and nurse practitioners respond and review quickly. Primary care based Pharmacy Facilitators work with GPs to identify medication issues and opportunities for patients in their practice.

Integrated models of care in the Hutt Valley

The General Medical Service aligned their SMOs with Primary Care Practices in the Hutt Valley, such that each general medicine team is assigned to one of the four Neighbourhoods. Regular engagement with the practices in each Neighbourhood is now an important part of all General Medical SMOs roles, to provide peer support, specialist support, and share concerns, ideas and issues.

Palliative Care have three Palliative Care Facilitators (PCFs) that are allocated a region across the Valley. PCFs meet regularly with practices, and work particularly closely with Practice Nurses to provide support and take part in MDTs.

District Nurses have allocated teams for geographical regions in the Valley). Not only does this reduce travel time, but it gives practices a named senior district nurse to go to with concerns or questions. District Nurses do, at times, take part in MDTs at the practices.

IT enablers

IT enablers are key to improving integrated models of care. In CC and HV DHBs we are yet to establish an integrated platform that enables shared care across providers. We have recently tendered for an e-referrals solution that will also enable 2 way communication between specialists and primary care. Furthermore, Ngāti Toa have invested in Whanau tahi.

Focusing our Effort

For the 2021/22 year we are intensifying our network approaches to ensure they are more embedded and able to easily transition in to the new Healthcare NZ and Maori Health Authority arrangements.

Health System Committee

28 July 2021

Regional Public Health Update	
Action Required **The 2DHB Health System Committee notes:** (a) this regular update from Regional Public Health (b) this update on COVID-19, vaping in schools and food systems	
Strategic Alignment	The activities outlined in this update align with the Health System Plan 2020 outcomes for wellbeing, people centred, equity and prevention. It also aligns with Hutt Valley DHB vision for change, the Hutt Valley DHB Māori Health Strategy – Te Pae Amorangi, the CCDHB Māori Health Strategy - Taurite Ora and the 3DHB Pacific Plan.
Authors	Kiri Waldegrave, Team Leader, Analytical & Policy Team, Regional Public Health Leanne Dawson, Acting General Manager, Regional Public Health
Endorsed by	Rachel Haggerty, Director Strategy Planning and Performance
Presented by	Peter Gush, General Manager – Regional Public Health
Purpose	The purpose of this paper is to provide the 2DHB Health System Committee with an update on Regional Public Health.
Contributors	Kiri Waldegrave, Team Leader, Analytical & Policy Team, Regional Public Health Leanne Dawson, Acting General Manager, Regional Public Health
Consultation	N/A

Executive Summary

1. This report follows previous Regional Public Health updates to the Health Systems Committee, the most recent being for the March 2021 meeting. This paper updates the committee on Regional Public Health activity across the following areas and is for noting only:
    a. Covid-19
    b. Vaping in Schools
    c. Food Systems

Strategic Considerations

Service	Working in partnership with community providers is critical to success in our population health priorities including vaping and food security.
People	The RPH COVID response team continues to refine and improve our capability to response.
Financial	N/A
Governance	N/A

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
TBC	There is a risk registered as to our ongoing ability to surge and manage local risks and outbreaks.	P Gush	Resurgence planning is sophisticated and reflects a split team model.	High	Moderate

Attachment/s

Nil.

COVID- 19

RPH was the lead public health unit in the recent response to the June Sydney Wellington case of COVID-19. Immediately prior to being confirmed with COVID-19 in Australia, the case travelled to Wellington for two days. Concern was particularly heightened given it was possible the traveller was infected with the highly contagious Delta variant, which was later proven. Seventeen locations of interest were identified, with a total of 2726 contacts. All contacts required isolation and testing based on protocols dependant on their risk categorisation. A national response was activated to manage this workload.

As part of this response, RPH:

- undertook the initial case scoping and assessment of risks to exposed groups, and took part in high-level government briefings
- activated a seven day per week roster of dedicated COVID-19 contact tracing staff. This was expanded to five teams across three bases (Hutt, Porirua, Wairarapa) during the peak of the response.
- undertook the management of 246 contacts, which involved daily symptom checks, chasing test results and resolving manaaki/welfare issues. Many of the contacts delegated to RPH required specialised input, either regarding the development of symptoms or challenges meeting isolation and testing requirements.
- liaised closely with the national contact tracing centre, local testing centres and general practitioners to ensure contacts were correctly entered into the national contact tracing database and received appropriate follow-up.

A number of valuable lessons were learnt throughout this response. A key learning was the need to further develop community accommodation plans for contacts required to isolate but who did not have a suitable place to stay in Wellington. In line with recent guidance from the Ministry of Health, RPH expects to work closely with DHBs as they lead the planning and commissioning of Community MIQ (Managed Isolation and Quarantine facilities). This will require ongoing multi-agency work. Additional areas of work include, improving the interface with community testing centres and their testing of contacts, and streamlining RPH processes to effectively scale-up to manage high volumes of contacts.

RPH has undertaken a wide range of COVID-19 work that has continued in parallel with this response. Chief among these in terms of complexity and rapidity of change has been the quarantine-free travel (QFT) programme, both for implementing traveller assessment and referral processes, and for rapidly modifying approaches in response to QFT suspension. Other areas of work include upskilling staff on case and contact management, responding to issues arising in travellers in managed isolation and

quarantine, managing concerns arising among maritime workers arriving on incoming vessels, and building RPH's internal capacities.

Vaping in Schools

Vaping is an increasing concern for schools in our region, with a number of principals and teachers seeking RPH support to address vaping and to educate students on the health effects. There has also been increased media attention on this issue recently.

In 2017 a Lower Hutt High School identified that 60% of students surveyed were casual vapers with 40% of those students being non-smokers. These local figures are comparable with 2019 national data showing 40% of 14 to 15 year olds had 'ever tried vaping' with the figure ranging between 30 and 60 percent depending on ethnicity, gender and school decile. While few students report using vape devices on a regular basis there remain concerns that the use of an addictive substance will lead to a new generation of nicotine users. There have also been reports of children in intermediate and primary school experimenting with vaping.

The visibility of vape retail stores, increasing numbers of vape users and advertising of the products, means more young people are exposed to vaping products. Vaping has significant appeal to young people with products infused with fun and appealing flavours, a level of social popularity, and products cheaper to purchase than tobacco.

How is RPH responding?
To better understand the impact of vaping on young people, RPH (in partnership with researchers) is initiating local research with school students to deepen our understanding of vaping among young people and to explore solutions together. The outcomes of this work will feed in to ministerial and parliamentary processes to ensure regulatory systems are responsive to risks for youth, and will also help to inform local advocacy efforts.

Education on smoking harm is generally not very effective at discouraging use and may in fact raise awareness of the products, triggering curiosity and experimentation. Instead, RPH has supported youth leaders at Wainuiomata High School, St Bernard's College, Sacred Heart College, and Wellington College, to inform councils and parliamentary select committees about the risks to young people from vaping. They want vape products to be less visible, and only supplied to those who require them without exposure to the wider public. RPH can work with schools to develop policies that support staff and students to become smoke free and vape free and to ensure tamariki know where to seek help for any addictions.

RPH supported recent regulatory changes to address vaping, and our promotion activities and compliance testing now reflect these e.g. encouraging schools to prominently display smokefree and vape free signage.

- From November 2020 the existing prohibitions on the sale of tobacco products and herbal smoking products to minors (those under 18 years) was extended to vaping products.
- From May 2021 it became law for all schools and early childhood centres to be smokefree and vape free.

RPH works with local councils to support smokefree and vape free environments. Porirua City has banned smoking and vaping in playgrounds, sports fields, the city centre an Cobham Court, on beaches, skate parks, council owned carparks and in bus stops and bus shelters. Wellington City and Hutt City councils have designated similar public spaces as vape and smokefree.

These actions are all reflected in the Hutt Valley Tobacco Control Action Plan, to support smokefree environments, policy and legislation.

Food Systems

Food is a basic human need and right for everyday life however too many whānau across the Wellington Region are experiencing the impacts of a food system that is not meeting their fundamental need. Our current food system does not provide our communities with equitable access to food that is nutritionally adequate and affordable.

In 2020/21 RPH and Common Unity Project Aotearoa (CUPA) co-hosted 'Kai and our community' hui in four different locations across the greater Wellington region with a total of 130 participants. These identified:

- how fragile our current linear food system is, creating dependency on food charity for those who can't afford to participate
- the need for a more local and circular food system with communities designing what their local food system looks like.

During and following the COVID-19 lockdown in 2020 local marae mobilised quickly servicing a very high number of people in need in the community. The most affected family members needing kai were tamariki and the most identified ethnicity was Māori. Takiri Mai Te Ata Whānau Ora collective distributed more than 26,000 food packs to over 31,000 whānau members.

How is RPH responding?
RPH is working with partners to build a food resilient region where everyone has access to good food together with our communities.

At a local level, in partnership with CUPA (Community Unity Project Aotearoa), we are bringing community food partners together in a number of locations to build equitable, resilient and sustainable model local food systems. For example, the Hutt Valley Food Resilience network includes initiatives such as mapping of fruit trees and the introduction of a community table where the community swaps, pays-it-forward with excess home grown crops, offers tuition, seedlings, seeds and plants. RPH is also connecting to and supporting other local council and community food initiatives in Wellington, Porirua and Kapiti.

This local work is directly informing our input to local and regional authority planning and we are working with council officers and the Mayoral Forum to address food system challenges at a regional level. This strongly aligns with council efforts to increase resilience to climate change and other public health threats.

The draft Wellington Regional Growth Framework (WRGF) is a spatial plan outlining a vision for how the Wellington region will grow, change and respond to key urban development challenges. A three year work programme has recently been approved which includes the development of a regional strategy for food production to ensure food security and efficient supply chains.

RPH is working closely with the WRGF Director to:

- support the consideration of health and equity issues (including for the food system), in the framework's work programme e.g. structure plans, climate change, regional food strategy development
- ensure appropriate representation of community food partners and to ensure communities' voices are heard.

Health System Committee

28 July 2021

Q3 Non-Financial MOH Reporting – 2020/2021

Action Required

The Health System Committee notes:

(a) the summary from two key reports:

i. CCDHB and HVDHB's Non-Financial Quarterly Monitoring Report for Q3 2020/21 (January to March 2021) – refer Attachment 1 and 2

ii. CCDHB and HVDHB's Q3 2020/21 Health System Plan and Vision for Change dashboard – refer Appendices to Attachment 1 and 2.

(b) that CCDHB received an 'Achieved' or 'Partially Achieved' for 40 indicators, and 'Not Achieved' for 7 indicators.

(c) that HVDHB received an 'Achieved' or 'Partially Achieved' for 39 indicators, and 'Not Achieved' for 7 indicators. This is a decrease on Q2 performance.

(d) that this decrease on Q2 performance is driven by immunisation targets falling from 'achieved' to 'not-achieved'. This is consistent with the rest of New Zealand.

(e) that the recommissioning of immunisation services is now being considered, alongside quality improvement initiatives.

(f) overall results for CCDHB and HVDHB demonstrates:

i. performance deterioration in immunisation targets reflecting a timing change in the age for MMR immunisations and a greater number of declines to vaccination offerings;

ii. a community health system delivering well for the majority of indicators with a persistent pressure points posing challenges; and,

iii. a hospital system working hard under the pressures of increased seasonal acute demand and bed pressures.

(g) that the reduction of midwifery support in our communities appears to be contributing to a reduction in the number of women exclusively breastfeeding.

Strategic Alignment	CCDHB Health System Plan 2030 HVDHB Vision for Change
Presented by	Rachel Haggerty, Director Strategy, Planning & Performance CCDHB & HVDHB
Purpose	This paper provides an overview of performance and the Quarter 3 2020/21 Non-Financial Monitoring Report results, as assessed by the Ministry of Health for CCDHB and HVDHB.
Contributors	Peter Guthrie, General Manager Planning & Performance, Strategy, Planning & Performance CCDHB & HVDHB Nathan Clark, Manager Strategy and Planning, Strategy, Planning & Performance CCDHB and HVDHB Sam McLean, Team Leader Analytics, Strategy, Planning & Performance CCDHB & HVDHB
Consultation	N/A

Executive Summary

Non-financial performance for HVDHB and CCDHB as assessed by the Ministry of Health (MOH) for Q3 2020/21 indicates a decline in performance compared with Q2. The final results show that both HVDHB and CCDHB continue to meet most of the MOH performance targets, the Immunisation Coverage targets fell to a 'not achieved' status since Q2, and equity gaps remain a persistent challenge.

When comparing the indicators that are common across Q2 and Q3 2020/21, performance ratings improved or remained the same across 34 measures for HVDHB and 29 indicators for CCDHB.

	HVDHB	CCDHB
	Number of indicators Q3 2020/21	Number of indicators Q3 2020/21
Outstanding	0	0
Achieved	24	24
Partially Achieved	15	16
Not Achieved	7	7
Not Assessed	0	0

HVDHB and CCDHB received a 'Not Achieved' rating in relation to the following performance measures. Specific action plans are in place to improve performance against the 'Not Achieved' performance measures with a particular focus on improving performance for our Māori and Pacific populations. The actions being progressed are described in the attached paper.

This includes a significant rethink as to the way we plan the delivery of childhood immunisations. The opportunity to adopt a pro-equity approach, built on the learnings of the COVID vaccine is being considered.

Child health breast feeding has declined by a small number of 4%; this is a decline of 29 women at Capital Coast and 11 at Hutt Valley. This is a further reflection of the significant pressure on midwifery resources meaning less time is available to support women to establish breast feeding practise.

These changes have driven an overall decline in child wellbeing moving from Achieved to Partially Achieved.

HVDHB received a 'Not Achieved' rating in relation to the following performance measures:	CCDHB received a 'Not Achieved' rating in relation to the following performance measures:
• Immunisation coverage (at 8 months) • Immunisation coverage (at 2 years) • Immunisation coverage (at 5 years) • Child Health (Breastfeeding) • Better Help for Smokers to Quit – Primary Care • Better Help for Smokers to Quit – Maternity • Shorter stays in Emergency Departments.	• Immunisation coverage (at 8 months) • Immunisation coverage (at 2 years) • Immunisation coverage (at 5 years) • Child Health (Breastfeeding) • Better Help for Smokers to Quit – Primary Care • Better Help for Smokers to Quit – Hospitals • Shorter stays in Emergency Departments.

DHBs are also required to provide updates to MOH in relation to the delivery of actions and milestones included in the Annual Plans. The final results show that HVDHB and CCDHB have continued to gain achieved and partially achieved status across all Government Planning Priorities with particular challenges being worked through for 'Improving Child Wellbeing' which has shifted from Achieved to Partially Achieved.

Government Planning Priorities	HVDHB	CCDHB
Give practical effect to He Korowai Oranga – the Māori Health Strategy	Achieved	Achieved
Improving Sustainability	Achieved	Achieved
Improving child wellbeing	Partially Achieved	Partially Achieved
Improving mental wellbeing	Partially Achieved	Partially Achieved
Improving wellbeing through prevention	Partially Achieved	Partially Achieved
Better population health outcomes supported by strong and equitable public health services	Partially Achieved	Partially Achieved
Better population health outcomes supported by primary health care	Partially Achieved	Partially Achieved

Our Vision for Change and Health System Plan dashboards monitor progress against our strategic goals and outcomes for our population groups, particularly our goal of achieving equity for Māori and Pacific.

We see that the positive impacts of COVID on ambulatory sensitive hospitalisations and acute bed days is demonstrated. We also see the pressure of key changes in immunisations resulting in non-performance. This is expected to recover. Reductions in the number of women exclusively breast feeding appears to be driven by reductions in the availability of midwifery and the reduction in the proportion of those 75+ living independently reflects a greater proportion of this population becoming very old and unable to be independent.

Indicator	Outlook
Better help for smokers to quit (primary care)	HVDHB performance remains stable and close to target. CCDHB performance continues to deteriorate. The DHB is working closely with the PHOs to shift the trend.
Childhood immunisations	HVDHB childhood immunisation rates remains constant within a stable range just below target level and the work of the DHB is to get immunisation services performing above target. CCDHB childhood immunisation rates now show a consistent decline in performance and the DHB is working with immunisation services to shift the trend.
Older people immunisation	HVDHB and CCDHB influenza immunisation rates peaked in 2020 because of the national emergency COVID-19 response. Performance in 2021 (year to date) is behind 2020 but still higher than 2019.
Avoidable hospital admissions (0-4 years)	HVDHB and CCDHB observed a marked decline in childhood ASH rates, and in particular for Māori and Pacific children related to the national emergency COVID-19 lockdowns. Rates are now stabilising and are on average 24% lower than the peak observed immediately prior to March 2020.
Avoidable hospital admissions (45-64 years)	HVDHB and CCDHB observed a decline in adult ASH rates and in particular for Māori and Pacific related to the national emergency COVID-19 lockdowns (although the trend is less pronounced than for children). Rates are now stabilising and are on average 20% lower than the peak observed immediately prior to March 2020.
People 75+ living in their own home	In HVDHB and CCDHB, more than 90% of people aged 75 years and older continue to live in their own homes. However, the trend is declining and has done for the last year. The drivers for this are being further investigated

	and appears to reflect the proportion of very old people increasing.
Acute unplanned readmission	Overall, readmission rates are stable. However, rates for Māori and Pacific in HVDHB are showing the first signs of persistent increase and this is also observed for Pacific at CCDHB. The Hospital Network programme will support increased capacity and expected improvements.
Acute hospital bed days per capita	In HVDHB, acute bed days are stable or declining for all populations, including Māori and Pacific. In CCDHB, there was a marked increase from Q1 to Q2 which the DHB stabilised in Q3. The plan for Q4 and 2021/22 is to return to the rates seen in Q1.
Shorter Stays in ED	For HVDHB, there was a significant improvement in performance during the COVID-19 lockdown. Since, performance has gradually declined to the 2019/20 level even though the system is under more pressure. For CCDHB, performance has significantly declined and is fluctuating related to seasonal demand and bed pressures.

Strategic Considerations

Strategic goals	CCDHB's 'Health System Plan' Dashboard and HVDHB's 'Vision for Change' Dashboard show performance 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.
Financial	N/A
Governance	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 Ministry reports DHB performance to the Minister on a quarterly basis.

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
TBC	Non achievement of child wellbeing performance	Rachel Haggerty	Implementation of commissioning strategy and quality improvement.	3	Med Risk

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

Attachment/s

1. CCDHB Non-Financial Performance Report (Q3 2020/21)
2. HVDHB Non-Financial Performance Report (Q3 2020/21)

CCDHB Non-Financial Performance Report (Q3 2020/21)

This paper provides an overview of CCDHB's Q3 2020/21 non-financial performance and includes:

- The results of CCDHB's Non-Financial Quarterly Monitoring Report for Q3 2020/21 as assessed by the Ministry of Health (MoH)
- A comparison of Q3 2020/21 results with HVDHB.
- CCDHB's Q3 2020/21 'Health System Plan' Dashboard.

BACKGROUND

Non-financial performance

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

The reporting is against the Government priorities below.

The MOH now plans to send regular performance reports to DHBs with detailed analysis against key areas of sector performance. We will report performance against these when they are available.

NON-FINANCIAL PERFORMANCE REPORT

In Q3 2020/21, CCDHB received an 'Achieved' or 'Partially Achieved' for 40 of the 47 performance indicators assessed and 7 indicators rated as 'Not Achieved'.

Achievement	Number of indicators Q3 2020/21	Number of indicators Q2 2020/21
Outstanding	0	1
Achieved	24	30
Partially Achieved	16	19
Not Achieved	7	4
Not Assessed	0	5

When comparing the indicators that are common across Q2 and Q3 2020/21, overall CCDHB performance declined in comparison to the previous quarter. Performance ratings improved against 2 indicators, stayed the same for 27 indicators, and decreased against 7 indicators.

CCDHB received a 'Not Achieved' rating against seven indicators

1. Immunisation coverage (at 8 months)
2. Immunisation coverage (at 2 years)
3. Immunisation coverage (at 5 years)
4. Child Health (Breastfeeding)
5. Better Help for Smokers to Quit – Hospitals
6. Better Help for Smokers to Quit – Primary Care
7. Shorter stays in Emergency Departments

The key shift was the decline in the immunisation results with a movement from achieved to non-achieved and a deterioration in Child Health breastfeeding. These shifts are unexpected and reflect a community care system under pressure. Strategies are being implemented to improve performance.

The shorter stay in Emergency Departments remains persistent as our hospitals are unable to meet demand.

Immunisation coverage (at 8 months; at 2 years; at 5 years)

Target: 95% of children are fully immunised at the milestone age.

- Māori: 78% at 8 months; 81% at 2 years; 80% at 5 years
- Pacific: 83% at 8 months; 84% at 2 years; 87% at 5 years
- Non-Māori, non-Pacific: 95% at 8 months; 95% at 2 years; 88% at 5 years

Childhood immunisation coverage has been deteriorating across our two DHBs and the country. It is promising that finalised Q4 2020/21 results show improvements at the 8 month milestones for both CCDHB and HVDHB. However, there have been further deteriorations in performance at 2 year and 5 year milestones. SPP and our PHO partners are both highly engaged and motivated to improve performance. With the remediation actions in place, we are confident performance will continue to lift over the coming quarters.

Our 2DHB analytics team has conducted an in-depth analysis of our immunisation results from 2018/19 to 2020/21 to gain a clearer picture of performance, and to identify where our efforts should be focussed to lift performance. Key findings from the analysis show:

- MoH changes to the MMR schedule (effective in October 2020) have contributed to an increase in children categorised as 'not fully immunised.' Our analysis shows:
    - the number of MMR events overall remains steady or higher than usual, but there has been a shift toward younger ages, in line with the MoH directives around prioritising the implementation of the schedule change (see Figure 1 below);
    - a drop in coverage from November 2020 (the schedule change was introduced in October 2020), but that coverage rates continue to improve as primary care 'catches up' with the change; and
    - an increase in referrals to Outreach Immunisation Services (OIS) for 12-15 month olds needing 'catch-up' doses. For example, Tū Ora Compass' referrals number increased by 100% from 53 in Q4 2019/20 to 107 in Q1 2020/21.
- Outreach Immunisation Services (OIS) are seeing an increase in outright declines from families not wanting further engagement or information. OIS are also noticing an increase in referrals for (often transient) families not yet enrolled with a GP.
- The rate of declines, especially amongst our Māori population, have significantly impacted our ability to improve vaccination rates. For Q3 and Q4 2020/21, decline rates across all milestone ages ranged between 2.5% - 3.6% for CCDHB and 4.1% - 4.8% for HVDHB. With a target of 95% immunisation coverage, this leaves very little margin.

The Improvement Plan focuses on:

- developing a pro-equity commissioning approach adopting the learnings of our COVID vaccine programme;
- performance improvement where our analysis shows are adversely impacting on performance including decline choices; outreach immunisation; and monitoring performance.

The greatest challenge is in moving to a model where reaching our priority populations is not dependent on outreach immunisation services. These services have increasing referrals and increasing declines. What we know from our COVID Vaccine programme is that commissioning vaccination, with our priority populations (Maori, Pacific & Disability), in addition to the mainstream General Practise system can be more successful. This approach may not be cost neutral but will be developed as the equity gains may be worth a small investment.

Other current improvement initiatives underway include:

- We have commissioned Mokopuna Solutions, a kaupapa Māori organisation, to provide community insights on factors that influence a family's decision to decline vaccinations. Declines are a major barrier to meeting our immunisation targets. Their report will provide valuable insights into how both DHBs might change its approach to the delivery of immunisation services to these families and whānau.
- We are extending the CCDHB Immunisation Network to include HVDHB providers, on the basis it is an active and effective improvement group that could strengthen cross-sectoral working in the Hutt Valley.
- We continue to enrol families and whānau presenting to Kenepuru Accident & Medical to ensure that vulnerable and/or transient families in Porirua will receive timely pre-call and re-call messages about immunisation through a coordinated primary care service.

We will continue with our targeted approach to lift immunisation knowledge, awareness and support in Māori and Pacific communities.

Child Health (Breastfeeding)

Target: 80% of infants are exclusively or fully breastfed at 3 months of age.

- Māori: 56%
- Pacific: 40%
- Non-Māori, non-Pacific: 66%

The factors influencing breastfeeding choices and behaviours are complex and varied, particularly for Māori and Pacific women. Colonisation has disrupted embedded breastfeeding practices in families and communities. A lack of continuity in support throughout the first 1,000 days, exacerbated by ongoing midwifery shortages, decrease women's confidence and support to continue to breastfeed. Pressure on women to return to work also impacts breastfeeding rates.

Given the complexity of factors impacting breastfeeding, our DHB designs whole-of-systems responses and targets marginal investment strategically to lit performance. For example, we work across the entire first 1000 days provider network to increase knowledge, embed consistent messages and grow the breastfeeding workforce. We target our investment in contracted services that target those groups our health system persistently fails to reach; namely, Māori, Pacific and young mothers.

In CCDHB, Māori and Pacific babies and babies from areas of high deprivation are significantly less likely to be breastfed. We also see the largest drop off in breastfeeding activity between 2 weeks and 3 months. Therefore, our initiatives to improve breastfeeding rates are aimed at Māori and Pacific population and communities that support women once they have been discharged from maternity services.

CCDHB funds a range of community providers to run antenatal education classes with breastfeeding content. Current improvement initiatives underway include:

- A maternal health coordinator role is now in place and leading improvements to the peer counsellor programme and supporting community focussed breastfeeding session.
- A professional development fund has been established to train 1 Pacific and 3 Māori Lactation Consultants within the CCDHB region.
- Re-design of the DHB's breastfeeding service to deliver timely responses to Māori and Pacific mums. This re-design includes a transition from a 5 day a week service to a 7 day service and proactive calls post discharge for all Māori and Pacific mums.

Our Provider Arm delivers:

- We have a Community Breastfeeding team which comprises a team of Lactation Consultants and Breastfeeding Advocates. The teams provide a mixed-model service including home visits, inpatient support, and community based clinics and drop-in sessions. We are in the process of transitioning this team to a Māori and Pacific breastfeeding team.
- CCDHB is an accredited Baby Friendly Hospital Initiative (BFHI) provider, which requires our facilities to meet specific standards around promoting and supporting exclusive breastfeeding. As a BFHI organisation, CCDHB delivers a range of inpatient support and services including an antenatal expressing service and daily "Little Latch On" classes.

We will continue with our targeted approach to lifting breastfeeding knowledge, awareness and support in Māori and Pacific communities.

Better Help for Smokers to Quit – Primary Care, Public Hospital, Maternity

Primary Care

Target: 90% of enrolled patients who smoke are offered brief advice to quit smoking.

- Māori: 74%
- Pacific: 79%
- Non-Māori, non-Pacific: 73%

Current improvement initiatives underway in primary care include:

- Working with our PHOs to deliver their "every patient, every time" approach for smoking conversations with patients.
- Working with our PHOs to establish stronger connections with smoking cessation support services.
- Understanding where PHOs and practices may require additional support as they support the delivery of COVID vaccinations and other health needs in their communities.

Public Hospitals

Target: 95% of hospitalised patients who smoke are offered brief advice to quit smoking.

- Māori: 79%
- Pacific: 83%
- Non-Māori, non-Pacific: 79%

Current improvement initiatives underway in our hospitals include:

- Investigating options to improve the electronic documentation that smoking cessation advice was provided and improve our smoking cessation data. We have identified that the majority of missed electronic documentation occurs in ED as the electronic record does offer the ability to document that smoke cessation advice has been provided. We are investigating options to resolve this issue. This activity is not always documented and then transcribed to the coded data.
- We continue to encourage all clinicians (medical and nursing) outside of our ED to provide smoking cessation advice and confirm this through electronic documentation.

Shorter stays in Emergency Departments

Target: 95% of people are seen, treated and discharged from ED within 6 hours

- Māori: 66%
- Pacific: 61%
- Non-Māori, non-Pacific: 66%

Recently, there has been increased attention and discussion about acute demand and presentations to hospital Emergency Departments across New Zealand. Addressing capacity constraints and mitigating rising acute demand is important for making sure that people receive appropriate and timely and equitable access to acute care.

At the request of the Ministers of Health and Director General Health, the Ministry of Health is developing a programme of work around acute demand. This work takes a whole sector perspective and includes community, primary care and hospital services. CCDHB and HVDHB are currently supporting the Ministry of Health to deliver this programme by providing analytics and service insights.

Overall, our performance is driven by the current capacity constraints across our 2DHB Hospital Network. Destravis has been engaged to provide options on the best use of facilities across HVDHB and CCDHB in the 2DHB Hospital Network in the medium to long term.

In response to capacity constraints we are undertaking the following:

- A project is currently underway to deliver options to improve the design and layout of the Emergency Department and acute assessment areas at Wellington Regional Hospital for patients, whānau and clinicians.
- We are also identifying options for increasing theatre and bed capacity across our three hospitals within the next two years while optimising use of current capacity.
- We are implementing a number of specific initiatives to improve the timely delivery of care to patients in ED, particularly at busy times (i.e. weekends). These initiatives include: improving nursing capacity, night shift resourcing and Phlebotomy support.

A range of strategies underway to manage acute demand in both community and hospital settings:

- We are addressing increasing demand by tailoring service provision, as much as it is possible, to meet acute patient needs i.e. we have an acute frailty unit pathway.
- We are planning for winter by planning to fund additional inpatient capacity with the provision of beds and physical spaces, and fund improved patient flow.
- Subject to finalising budget 2021/22, we are Investing in our communities to deliver more acute care closer to home and before health need require an emergency department.

We continue to develop a more targeted approach to acute demand for Māori and Pacific.

Comparing CCDHB and HVDHB Q2 2020/21 Results

CCDHB and HVDHB received very similar results for Q2, as shown below.

	CCDHB	HVDHB
Achievement	**Number of indicators Q3 2020/21**	**Number of indicators Q3 2020/21**
Outstanding	0	0
Achieved	24	24
Partially Achieved	16	15
Not Achieved	7	7
Not Assessed	0	0

Comparison with national results

The MOH is developing balanced scorecards and heat-maps that compare performance across DHBs. The MOH have advised this information will not be available until the end of July 2021.

CCDHB Annual Plan updates

DHBs are required to provide updates in relation to 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 priority areas. CCDHB's performance for Q3 2020/21 was rated as follows:

Status Update Report	Ratings – Q3	Ratings – Q2
Give practical effect to He Korowai Oranga – the Māori Health Strategy	Achieved	Achieved
Improving Sustainability	Achieved	Achieved
Improving child wellbeing	Partially Achieved	Achieved
Improving mental wellbeing	Partially Achieved	Partially Achieved
Improving wellbeing through prevention	Partially Achieved	Partially Achieved
Better population health outcomes supported by strong and equitable public health services	Partially Achieved	Partially Achieved
Better population health outcomes supported by primary health care	Partially Achieved	Partially Achieved

The ratings for quarter three were identical to quarter two, except we were given Partially Achieved for Improving Child Wellbeing in quarter three. This result was due to delayed progress against actions under the 'family violence and sexual violence' area of the Improving Child Wellbeing section in our annual plan.

CCDHB 'HEALTH SYSTEM PLAN' DASHBOARD

The MoH's Non-Financial Performance Framework is particularly useful for 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 Dashboard uses a subset of indicators from the Non-Financial Performance Framework to monitor performance in relation to 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 which best reflect system performance and outcomes, including achieving equity. The dashboard also shows the high-level areas of focus and the initiatives we are delivering on to achieve each strategic goal.

Promote health and wellbeing

Indicator	Performance	Our Strategic Response
Better help for smokers to quit	Declining trend and below target	We continue to work with our PHOs to embed consistent process to achieve this target and our ability to achieve equity for Māori and Pacific. Our engagement with **Takiri Mai Te Ata Regional Stop Smoking Service** has identified there are fewer referrals for smoking cessation services. We are working with PHOs to encourage referrals to Takiri Mai Te Ata for smoking cessation alongside improving performance. Tū Ora has implemented a new approach emphasising smoking cessation uptake rather than advice with an equity focus for Māori and Pacific.
Childhood immunisations	Declining trend and below target	We have developed an **Immunisation Improvement Plan** focused on working with kaupapa Māori providers and outreach services to reach children who may not be immunised. Our plan focuses on strengthening the Outreach Immunisation Service, extending the CCDHB Immunisation Network to include HVDHB providers and gaining insights on factors that influence decisions to decline vaccinations.
Elder immunisation	Performance behind 2020 but higher than 2019	We saw a significant increase in influenza immunisation and aim to sustain coverage (alongside COVID-19) to reduce avoidable winter demand. Our **2DHB Influenza Working Group** is targeting 75% coverage for people aged 65+; performance for Māori is 53%; Pacific is 69%; and Total is 63%. Our 2DHB COVID-19 vaccination response in aged residential care facilities is complete and planning for Group 3 and 4 is underway.

People-focused services in the community

Indicator	Performance	Our Strategic Response
Avoidable hospital admissions (0-4 years & 45-64 years)	Improving trend and stabilised	We are working with our community and primary care partners to implement our **System Level Measures Plan** with a focus on reducing avoidable admissions for respiratory and skin conditions. We are working on automated referrals to **Porirua Asthma Service** which is operated by Ngāti Toa. Regional Public Health is also piloting an extension to the **Porirua Children's Ear Service** to include skin infections. This service is free for children and is provided by a nurse with specialist training in ear health and skin care.
	Improving trend and stabilised	We are working to **improve access to urgent and planned care** in primary care, which will support achievement of this indicator. This includes the development of **Community Health Networks** and the Kāpiti prototype prioritising responses for Māori and Pacific. We are working with our health care homes to have proactive risk stratification tools to ensure care plans are in place self-manage long term conditions with primary care and keep people out of hospital. In Porirua, Vaka Atafaga is the Pacific Neighbourhood Nursing Service. Patients can be referred to the service for culturally responsive community based support following an avoidable admission.
People 75+ living in their own home	Declining trend	Our **whole of system response to frailty** supports people to live at home. This includes strategic investments such as the Community Health of Older People Initiative (**CHOPI**), Acute Health of Older Person Service (**AHOP**) and Advancing Wellness at Home Initiative (**AWHI**). Our primary care providers are proactively screening patients who are at risk of falling and supporting these patients with **strength and balance programmes** to support muscle and bone strength which ensures people remain safely mobile and active at home.

Timely effective care that improves health outcomes

Indicator	Performance	Our Strategic Response
Acute unplanned readmission	Trend is stable	We are developing community responses to population drivers of **acute flow** alongside approaches to maximise the productivity and efficiency of our hospital system. Our Advancing Wellness at Home Initiative (**AWHI**) sees more people discharged from hospital earlier and with enhanced support from our nursing and allied health workforce in the community to prevent readmission. In parallel, the **Hospital Network** programme is exploring our short and medium term options for expansion of **2DHB bed and theatre capacity**. This work will ensure that we have space to appropriately manage patients and balance the delicate relationship between length of stay and acute readmissions. We are also working to facilitate the smooth transition of patients back to their primary care provider with appropriate specialist support through our Community Health Network prototype in Kāpiti.
Acute hospital bed days per capita	Trend is stable or improving	
Shorter Stays in ED	Declining trend	We are redesigning **Front of Whāre** (ED and acute assessment units) to facilitate delivery of contemporary models of care and ensure facilities are appropriately sized to meet demand. **General adult bed occupancy** at Wellington and Kenepuru hospital continues to exceed 90% and we are working to identify barriers to discharge and streamline transfers between Wellington and Kenepuru hospitals. We are working to improve acute crisis support in ED to reduce waiting times for our patients requiring mental health support.

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ŪPOKO KI TE URU HAUORA

APPENDIX: Capital & Coast DHB – 2020/21 Quarter Three '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

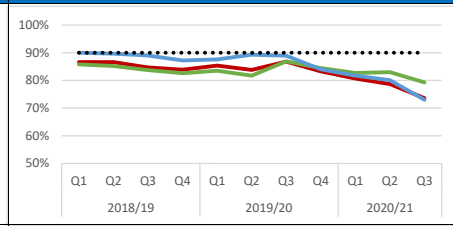
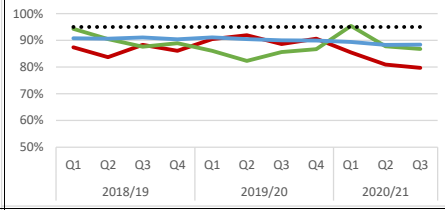
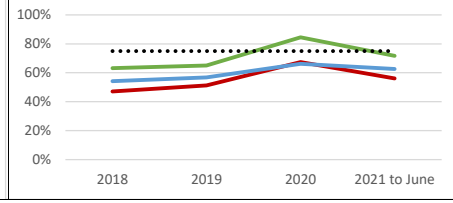
- Prevention, health promotion and public health activities
- Building strong and resilient communities
- First 1000 days of life
- Screening for breast and cervical cancer
- Environmental sustainability
- Achieving health equity

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 Pou Famu 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 continue to work with our PHOs to embed consistent process to achieve this target and our ability to achieve equity for Māori and Pacific. Takiri Mai Te Ata Regional Stop Smoking Service are identifying fewer referrals to their service. We are working with PHOs to encourage referrals to Takiri Mai Te Ata for smoking cessation and improved performance. This complements Tū Ora Compass Health's renewed focus on cessation support for Māori and Pacific patients.
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%		We are working with primary care, Regional Public Health and Outreach Immunisation Services to improve Māori and Pacific immunisation coverage. In the year of immunisation, we are confident our providers are working to deliver immunisations on time. Although, they are challenged by schedule changes, and multiple immunisation campaigns including measles, influenza and COVID-19, as well as increasing rates of decline.
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. It is our aim to sustain this performance alongside rollout of the COVID-19 vaccine. Our 2DHB COVID-19 vaccination response in aged residential care facilities is complete and planning for Group 3 and 4 is underway.

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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

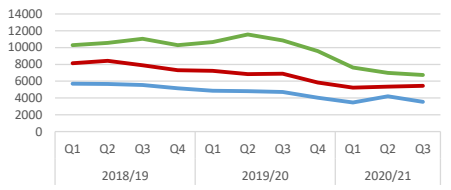
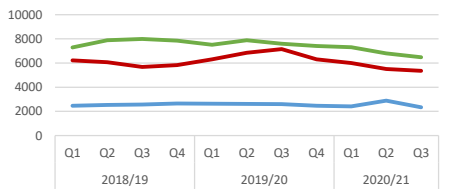
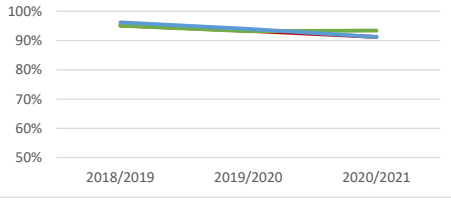
- Homes as a place of care
- Community Mental Health and Wellbeing Hubs
- Build strong primary and community care
- Early intervention
- Health Care Homes
- Specialist support for primary care
- Telehealth services
- Management of Long Term Conditions
- Achieving health equity

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	Avoidable hospital admissions (ASH rates 0-4 years)	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)		We are focused on reducing avoidable admissions for respiratory and dental conditions. We are automating referrals to Porirua Asthma service which is operated by Ngāti Toa. Regional Public Health is also piloting an extension to the Porirua Children's Ear Service to include skin infections. This service is free for children and is provided by a nurse with specialist training in ear health and skin care.
			Pacific	↓6% (≤10,865)		
			Non-Māori, Non-Pacific	↓2% (≤4,726)		
			Total	↓2% (≤5,818)		
Indicator 2: Avoidable hospital admissions	Avoidable hospital admissions (ASH rates 45-64 years)		Māori	↓6% (≤6,575)		We are working to improve access to urgent and planned care in primary care, which will support achievement of this indicator. This work includes the development of Community Health Networks and the Kāpiti prototype. In Porirua, Vaka Atafaga is the Pacific Neighbourhood Nursing Service. Patients can be referred to the service for culturally responsive community based support following an avoidable admission
			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		We are supporting a whole of system approach to frailty so people live at home for as long as possible. This includes strategic investments us as the Community Health of Older People Initiative (CHOPI), Acute Health of Older Person Service (AHOP) and Advancing Wellness at Home Initiative (AWHI). Our primary care providers are proactively screening patients who are at risk of falling and supporting these patients with strength and balance programmes.
			Pacific			
			Non-Māori, Non-Pacific			
			Total			

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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

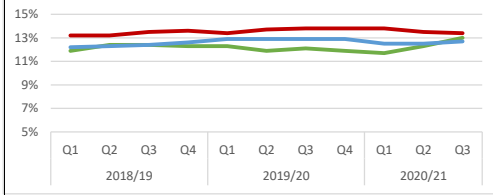
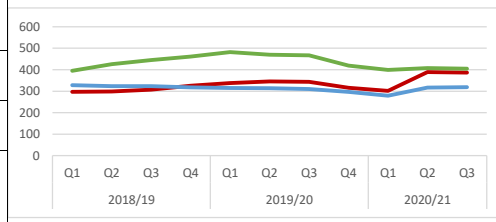
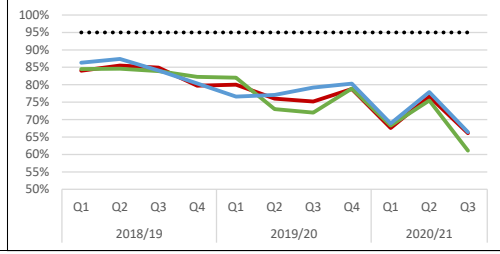
- Timely and effective care
- Safe and efficient hospital services
- Quality improvement activities
- Managing Acute Flow and production planning
- Community, primary and secondary integration
- Support end of life with dignity
- Achieving health equity

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 (28 day)	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%		We are developing community responses to population drivers of acute flow alongside approaches to maximise the productivity and efficiency of our hospital system. Our Advancing Wellness at Home Initiative (AWHI) sees more people discharged from hospital earlier and with enhanced support from our nursing and allied health workforce in the community to prevent readmission.
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)		Through our Hospital Network programme we are exploring short and medium term options for expansion of 2DHB bed and theatre capacity. This work will ensure that we have space to appropriately manage patients and balance the delicate relationship between length of stay and acute readmissions. We are also working to facilitate the smooth transition of patients back to their primary care provider with appropriate specialist support through our Community Health Network prototype in Kāpiti.
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%		We are redesigning Front of Whāre (ED and acute assessment units) to facilitate delivery of contemporary models of care and ensure facilities are appropriately sized to meet demand. General adult bed occupancy at Wellington and Kenepuru hospital continues to exceed 90% and we are working to identify barriers to discharge and streamline transfers between Wellington and Kenepuru hospitals. We are working to improve acute crisis support in ED to reduce waiting times for our patients requiring mental health support.

HVDHB Non-Financial Performance Report (Q3 2020/21)

This paper provides an overview of HVDHB's Q3 2020/21 non-financial performance and includes:

- The results of HVDHB's Non-Financial Quarterly Monitoring Report for Q3 2020/21 as assessed by the Ministry of Health (MOH)
- A comparison of Q3 2020/21 results with CCDHB.
- HVDHB's Q3 2020/21 'Vision for Change' Dashboard.

BACKGROUND

Non-financial performance

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

The reporting is against the Government priorities below.

The MOH now plans to send regular performance reports to DHBs with detailed analysis against key areas of sector performance. We will report performance against these when they are available.

NON-FINANCIAL PERFORMANCE REPORT

In Quarter 3 2020/21, HVDHB received an 'Achieved' or 'Partially Achieved' for 39 of the 46 performance indicators assessed and 7 indicators rated as 'Not Achieved'.

Achievement	Number of indicators Q3 2020/21	Number of indicators Q2 2020/21
Outstanding	0	0
Achieved	24	29
Partially Achieved	15	19
Not Achieved	7	4
Not Assessed	0	5

When comparing the indicators that are common across Q2 and Q3 2020/21, overall HVDHB performance declined in comparison to the previous quarter. Performance ratings improved against 1 indicator, stayed the same for 33 indicators, and decreased for 5 indicators.

HVDHB received a 'Not Achieved' rating against seven indicators

HVDHB received a 'Not Achieved' rating in relation to the following performance measures:

1. Immunisation coverage (at 8 months)
2. Immunisation coverage (at 2 years)
3. Immunisation coverage (at 5 years)
4. Child Health (Breastfeeding)
5. Better Help for Smokers to Quit – Primary Care
6. Better Help for Smokers to Quit – Maternity
7. Shorter stays in Emergency Departments

Specific action plans are in place to improve performance against the 'Not Achieved' performance measures. The actions being progressed are described below.

Immunisation coverage (at 8 months; at 2 years; at 5 years)

Target: 95% of children are fully immunised at the milestone age.

- Māori: 77% at 8 months; 81% at 2 years; 83% at 5 years
- Pacific: 89% at 8 months; 89% at 2 years; 83% at 5 years
- Non-Māori, non-Pacific: 93% at 8 months; 93% at 2 years; 90% at 5 years

Childhood immunisation coverage has been deteriorating across our two DHBs and the country. It is promising that finalised Q4 2020/21 results show improvements at the 8 month milestones for both CCDHB and HVDHB. However, there have been further deteriorations in performance at 2 year and 5 year milestones. SPP and our PHO partners are both highly engaged and motivated to improve performance. With the remediation actions in place, we are confident performance will continue to lift over the coming quarters.

Our 2DHB analytics team has conducted an in-depth analysis of our immunisation results from 2018/19 to 2020/21 to gain a clearer picture of performance, and to identify where our efforts should be focussed to lift performance. Key findings from the analysis show:

- MoH changes to the MMR schedule (effective in October 2020) have contributed to an increase in children categorised as 'not fully immunised.' Our analysis shows:
    - the number of MMR events overall remains steady or higher than usual, but there has been a shift toward younger ages, in line with the MoH directives around prioritising the implementation of the schedule change (see Figure 1 below);
    - a drop in coverage from November 2020 (the schedule change was introduced in October 2020), but that coverage rates continue to improve as primary care 'catches up' with the change; and
    - an increase in referrals to Outreach Immunisation Services (OIS) for 12-15 month olds needing 'catch-up' doses. For example, Tū Ora Compass' referrals number increased by 100% from 53 in Q4 2019/20 to 107 in Q1 2020/21.
- The emphasis on delivering COVID-19 vaccinations and the redeployment of the immunisation workforce has had a significant impact on the performance of smaller PHOs and GP practices in the region.
- Outreach Immunisation Services (OIS) are seeing an increase in outright declines from families not wanting further engagement or information. OIS are also noticing an increase in referrals for (often transient) families not yet enrolled with a GP.
- The rate of declines, especially amongst our Māori population, have significantly impacted our ability to improve vaccination rates. For Q3 and Q4 2020/21, decline rates across all milestone

ages ranged between 2.5% - 3.6% for CCDHB and 4.1% - 4.8% for HVDHB. With a target of 95% immunisation coverage, this leaves very little margin.

Improving immunisation coverage continues to be a focus for HVDHB. Current improvement initiatives underway include:

- We have commissioned Mokopuna Solutions, a kaupapa Māori organisation, to provide community insights on factors that influence a family's decision to decline vaccinations. Declines are a major barrier to meeting our immunisation targets. Mokopuna Solutions is working with Māori and Pacific families and whānau to understand how the CCDHB and HVDHB communities think and feel about childhood immunisations. Their report will provide valuable insights into how both DHBs might change its approach to the delivery of immunisation services to these families and whānau.
- We are extending the CCDHB Immunisation Network to include HVDHB providers, on the basis it is an active and effective improvement group that could strengthen cross-sectoral working in the Hutt Valley.
- Strengthening the Outreach Immunisation Service is a key priority for HVDHB. Our focus is on understanding the strengths and weaknesses of the current operation model and how to maximise the networks between general practices, the Outreach Immunisation Service and Regional Public Health.

We will continue with our targeted approach to lift immunisation knowledge, awareness and support in Māori and Pacific communities.

Child Health (Breastfeeding)

Target: 80% of infants are exclusively or fully breastfed at 3 months of age.

- Māori: 47%
- Pacific: 45%
- Non-Māori, non-Pacific: 64%

In HVDHB, Māori and Pacific babies and babies from areas of high deprivation are significantly less likely to be breastfed. We also see the largest drop off in breastfeeding activity between 2 weeks and 3 months. Therefore, our initiatives to improve breastfeeding rates are aimed at Māori and Pacific population and communities that support women once they have been discharged from maternity services.

The factors influencing breastfeeding choices and behaviours are complex and varied, particularly for Māori and Pacific women. Colonisation has disrupted embedded breastfeeding practices in families and communities. A lack of continuity in support throughout the first 1,000 days, exacerbated by ongoing midwifery shortages, decrease women's confidence and support to continue to breastfeed. Pressure on women to return to work also impacts breastfeeding rates.

Given the complexity of factors impacting breastfeeding, our DHB designs whole of systems responses and targets marginal investment strategically to lit performance. For example, we work across the entire first 1000 days provider network to increase knowledge, embed consistent messages and grow the breastfeeding workforce. We target our investment in contracted services that target those groups our health system persistently fails to reach; namely, Māori, Pacific and young mothers.

Breastfeeding messages and education ante-natally is known to have a positive impact on breastfeeding rates. HVDHB is currently mid-way through a 'disruptive' procurement process to recommission its investment in antenatal education. Key features of this process include:

- Increase in funding invested in antental education across the DHB's catchment.

- Increased proportion of antenatal education investment being directed to kaupapa Māori and Pacific specific solutions. We are targeting our investment toward solutions that engage Māori, Pacific and young mums living in the Hutt Valley (these are the groups traditionally less likely to engage in antenatal education and breastfeed).
- Through the procurement process we are inviting providers to propose alternate ways to deliver education that resonate with the groups we persistently fail to reach.
- The proposals will be presented to a panel of mothers who will make recommendations to SPP about which solutions should be awarded contracts through the process.

HVDHB recently contracted a breastfeeding education specialist to deliver a programme that will build a community of support for Māori, Pacific, Indian women and women with disabilities on their breastfeeding journey across CCDHB and HVDHB. The programme will consist of two components:

1) Breastfeeding education/promotion targeting Māori and Pacific communities

2) Training breastfeeding kaiāwhina.

HVDHB continues to deliver breastfeeding antenatal education through our breastfeeding network of midwives, primary care, Well Child/Tamariki Ora providers and lactation consultants. Lactation consultants also provide support through our community kaupapa Māori provider and the DHB's provider arm.

HVDHB is an accredited Baby Friendly Hospital Initiative (BFHI) provider, which requires our facilities to meet specific standards around promoting and supporting exclusive breastfeeding. As a BFHI organisation, HVDHB delivers a range of inpatient support and services including an antenatal expressing service.

We will continue with our targeted approach to lifting breastfeeding knowledge, awareness and support in Māori and Pacific communities.

Better Help for Smokers to Quit – Primary Care, Maternity

Primary Care

Target: 90% of enrolled patients who smoke are offered brief advice to quit smoking.

- Māori: 86%
- Pacific: 90%
- Non-Māori, non-Pacific: 87%

Current improvement initiatives underway in primary care include:

- Working with our PHOs to deliver their "every patient, every time" approach for smoking conversations with patients.
- Working with our PHOs to establish stronger connections with smoking cessation support services.
- Understanding where PHOs and practices may require additional support as they support the delivery of COVID vaccinations and other health needs in their communities.

Maternity Services

Target: 90% of pregnant women who smoke upon registration with a DHB-employed midwife or Leader Maternity Carer are offered brief advice to quit smoking.

- Māori: 80%
- Total: 75%

Current improvement initiatives underway in maternity services include:

- Supporting Kokiri Marae with their Hapu Mama programme designed to incentivise pregnant women and their partners to quit smoking. We are exploring how their Hapu Mama practitioners could support patients in Hutt Hospital.

- Maternity Services is investigating the use of e-Learning and Webinar modules to train staff on how to have smokefree conversations.
- Our smoke free coordinator is available to help clinical staff with education and support to deliver smoking cessation support to patients.
- An eReferral is being developed to enable easy referral to stop smoking providers in the community from all staff including midwifery, nursing and allied staff.

Shorter stays in Emergency Departments

Target: 95% of people are seen, treated and discharged from ED within 6 hours

- Māori: 85%
- Pacific: 85%
- Non-Māori, non-Pacific: 83%

Recently, there has been increased attention and discussion about acute demand and presentations to hospital Emergency Departments across New Zealand. Addressing capacity constraints and mitigating rising acute demand is important for making sure that people receive appropriate and timely access to acute care with equitable health outcomes. At the request of the Ministers of Health and Director General Health, the Ministry of Health is developing a programme of work around acute demand. This work takes a whole sector perspective and includes community, primary care and hospital services. CCDHB and HVDHB are supporting the Ministry of Health deliver this programme and providing analytics and insights.

Overall, our performance is driven by the current capacity constraints across our 2DHB Hospital Network. Destravis has been engaged to provide options on the best use of facilities across HVDHB and CCDHB in the 2DHB Hospital Network in the medium to long term.

In response to capacity constraints we are undertaking the following projects:

- We are redesigning the front doors of our hospitals to ensure smoother flow of people receiving care through the system, and making most effective use of resources by delivering the appropriate level of care in the lowest cost setting (cost being time & travel for patients and cost of delivering care).
- We are identifying options for increasing theatre and bed capacity across our three hospitals within the next two years while optimising use of current capacity

A range of strategies underway to manage acute demand in both community and hospital settings:

- We are planning for winter by planning to fund additional inpatient capacity with the provision of beds and physical spaces, and fund improved patient flow.
- Subject to finalising budget 2021/22, we are Investing in our communities to deliver more acute care closer to home and before health need require an emergency department.

We continue to develop more targeted approach to acute demand for Māori and Pacific.

Comparing HVDHB and CCVDHB Q3 Results

HVDHB and CCDHB received very similar results for Q2, as shown below.

	HVDHB	CCDHB
Achievement	**Number of indicators Q3 2020/21**	**Number of indicators Q3 2020/21**
Outstanding	0	0
Achieved	24	24

Partially Achieved	15	16
Not Achieved	7	7
Not Assessed	0	0

Comparison with national results

The MOH is developing balanced scorecards and heat-maps that compare performance across DHBs. The MOH have advised this information will not be available until the end of July 2021.

HVDHB Annual Plan updates

DHBs are required to provide updates in relation to 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 priority areas. HVDHB's performance for Q3 2020/21 was rated as follows:

Status Update Report	Ratings – Q3	Ratings – Q2
Give practical effect to He Korowai Oranga – the Māori Health Strategy	Achieved	Achieved
Improving Sustainability	Achieved	Achieved
Improving child wellbeing	Partially Achieved	Achieved
Improving mental wellbeing	Partially Achieved	Partially Achieved
Improving wellbeing through prevention	Partially Achieved	Partially Achieved
Better population health outcomes supported by strong and equitable public health services	Partially Achieved	Partially Achieved
Better population health outcomes supported by primary health care	Partially Achieved	Partially Achieved

The ratings for quarter three were identical to quarter two, except we were given Partially Achieved for Improving Child Wellbeing in quarter three. This result was due to delayed progress against actions under the 'family violence and sexual violence' area of the Improving Child Wellbeing section in our annual plan.

HVDHB 'VISION FOR CHANGE' DASHBOARD

The MOH's Non-Financial Performance Framework is particularly useful for 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 (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 HVDHB Vision for Change 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 Dashboard uses a subset of indicators from the Non-Financial Performance Framework to monitor performance in relation to our strategic goals:

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

The subset of indicators chosen are those which best reflect system performance and outcomes, including achieving equity. The dashboard also shows the high-level areas of focus and the initiatives we are delivering on to achieve each strategic goal.

Support people living well

Indicator	Performance	Our Strategic Response
Better help for smokers to quit	Trend is stable but below target	We continue to work with our PHOs to embed consistent process to achieve this target and our ability to achieve equity for Māori and Pacific. Our engagement with **Takiri Mai Te Ata Regional Stop Smoking Service** has identified there are fewer referrals for smoking cessation services. We are working with PHOs to encourage referrals to Takiri Mai Te Ata for smoking cessation alongside improving performance.
Childhood immunisations	Trend is stable but below target	We have developed an **Immunisation Improvement Plan** focused on working with kaupapa Māori providers and outreach services to reach children who may not be immunised. Our plan focuses on strengthening the Outreach Immunisation Service, extending the CCDHB Immunisation Network to include HVDHB providers and gaining insights on factors that influence decisions to decline vaccinations.
Older people immunisation	Performance behind 2020 but higher than 2019	We saw a significant increase in influenza immunisation and aim to sustain coverage (alongside COVID-19) to reduce avoidable winter demand. Our **2DHB Influenza Working Group** is targeting 75% coverage for people aged 65+; performance for Māori is 61%; Pacific is 69%; and Total is 62%. Our 2DHB COVID-19 vaccination response in aged residential care facilities is complete and planning for Group 3 and 4 is underway.

Shift care closer to home

Indicator	Performance	Our Strategic Response
Avoidable hospital admissions (0-4 years & 45-64 years)	Improving trend and stabilised	We are working with our community and primary care partners to implement our **System Level Measures Plan** with a focus on reducing avoidable admissions for respiratory and dental conditions. We are encouraging referrals to **Tū Kotahi Asthma Service** and **Well Homes** from midwives, Lead Maternity Carers and Well Child Tamariki Ora nurses to increase access to healthy housing interventions to manage respiratory conditions. **Bee Healthy** is strengthening oral health promotion outside of the core dental hubs in pre-schools through their knee-to-knee approach. This is where the parent and dentist sit face to face with their knees touching while the child receives their examination and health promotion advice is shared with parents.
	Improving trend and stabilised	We are working to **improve access to urgent and planned care** in primary care, which will support achievement of this indicator. This work includes the roll out of the Health Care Home model of care, the development of community health networks (neighbourhood approach), and improving primary care access to our specialist hospital workforce for support and advice. There is a Pacific Nursing Service in the Hutt Valley working with families with complex clinical and social needs.
Percentage of people 75+ living in their own home	Declining trend	Our **whole of system response to frailty** supports people to live at home for longer. This includes strategic investments such as the expanded Early Supported Discharge team which is focused on mild-moderate stroke, and medical patients that can be supported to leave hospital early. Our Hutt Valley **clinical pharmacists are reviewing medications** to reduce the risk of falls and fractures that may result in long stays in rehabilitation. Our **in-home strength and balance** program supports muscle and bone strength which ensures people remain safely mobile and active.

Deliver shorter, safer, smoother care

\Indicator	Performance	Our Strategic Response
Acute unplanned readmission	Trend is stable	We are developing community responses to population drivers of **acute flow** alongside approaches to maximise the productivity and efficiency of our hospital system. Our Early Supported Discharge (**ESD**) programme sees more people discharged from hospital earlier and with enhanced support from our nursing and allied health workforce in the community to prevent readmission. In parallel, the **Hospital Network** programme is exploring our short and medium term options for expansion of **2DHB bed and theatre capacity**. This work will ensure that we have space to appropriately manage patients and balance the delicate relationship between length of stay and acute readmissions. We are also working to facilitate the smooth transition of patients back to their primary care provider with appropriate specialist support through community integration.
Acute hospital bed days per capita	Trend is stable or improving	

Shorter Stays in ED	Declining trend	We are redesigning **Front of Whāre** (ED and acute assessment units) to facilitate delivery of contemporary models of care and ensure facilities are appropriately sized to meet demand. We are adjusting the efficiency of our operating model, including a data driven review of our nursing roster to better match workforce with demand and improve use of our Assessment and Planning Unit for patients that require specialist consultation. Based on feedback from our patients, we have implemented a 'Nurse First' model which means our community will be seen by a member of our nursing staff first rather than our clerical team.

APPENDIX: Hutt Valley DHB – 2020/21 Quarter Three '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

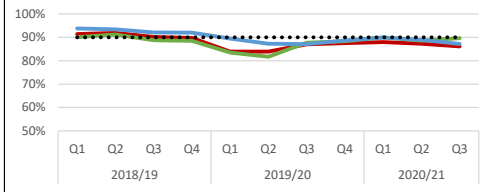
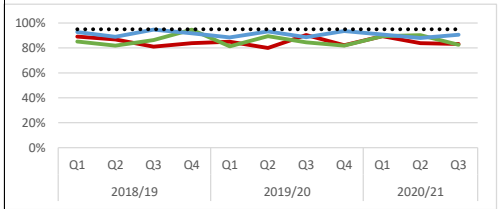
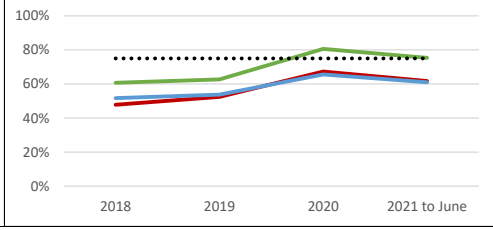
- Prevention, health promotion and public health activities
- Building strong and resilient communities – implementing our Wellbeing Plan
- First 1000 days of life
- Screening for breast, cervical and bowel cancer
- Environmental sustainability
- Achieving health equity

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 Hapū 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%		We continue to work with our PHOs to embed consistent process to achieve this target and our ability to achieve equity for Māori and Pacific. Takiri Mai Te Ata Regional Stop Smoking Service are identifying fewer referrals to their service. We are working with PHOs to encourage referrals to Takiri Mai Te Ata for smoking cessation and improved performance.
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 primary care, Regional Public Health and Outreach Immunisation Services to improve Māori and Pacific immunisation coverage. In the year of immunisation, we are confident our providers are working to deliver immunisations on time. Although, they are challenged by schedule changes, and multiple immunisation campaigns including measles, influenza and COVID-19, as well as increasing rates of decline.
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. It is our aim to sustain this performance alongside rollout of the COVID-19 vaccine. Our 2DHB COVID-19 vaccination response in aged residential care facilities is complete and planning for Group 3 and 4 is underway.

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

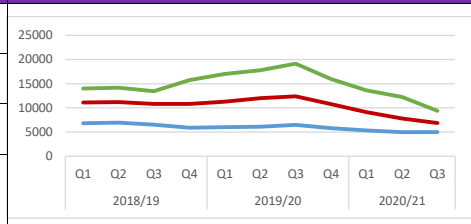
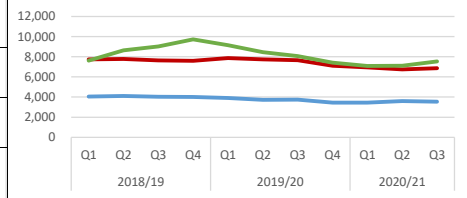
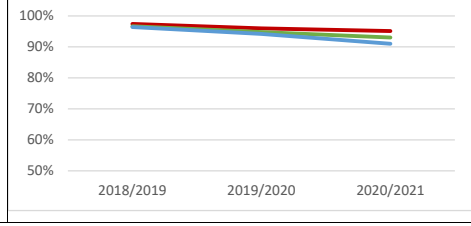
- Early intervention
- Build strong primary and community care
- Health Care Homes
- Placed-based planning – community hubs / neighbourhood approach
- Specialist support for primary care
- Telehealth services
- Management of Long Term Conditions
- Achieving health equity

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 years)	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)		We are focused on reducing avoidable admissions for respiratory and dental conditions. We are encouraging referrals to Tū Kotahi Asthma Service and Well Homes from midwives, Lead Maternity Carers and Well Child Tamariki Ora nurses to increase access to healthy housing interventions to manage respiratory conditions. Bee Healthy is strengthening oral health promotion outside of the core dental hubs in pre-schools through their knee-to-knee approach.
			Pacific	↓2% (≤17,459)		
			Non-Māori, Non-Pacific	↓6% (≤5,791)		
			Total	↓7% (≤8,243)		
Indicator 2:	Avoidable hospital admissions (ASH rates 45-64 years)		Māori	↓6% (≤7,271)		We are working to improve access to urgent and planned care in primary care, which will support achievement of this indicator. This work includes the roll out of the Health Care Home model of care, the development of community health networks (neighbourhood approach), and supporting primary care access to our specialist hospital workforce for support and advice.
			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		We are supporting a whole of system approach to frailty so people live at home for as long as possible. This includes strategic investments such as the expanded Early Supported Discharge team which is focused on mild-moderate stroke, and medical patients that can be supported to leave hospital early. Primary Care clinical pharmacists are also reviewing medications to reduce the risk of falls and fractures that may result in long stays in rehabilitation.
			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

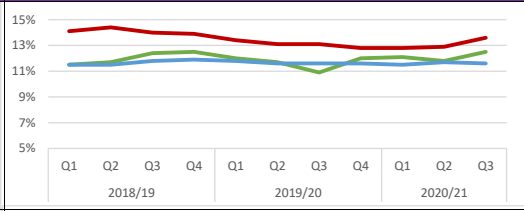
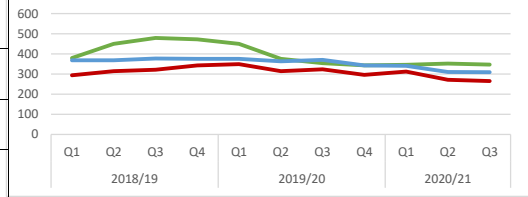
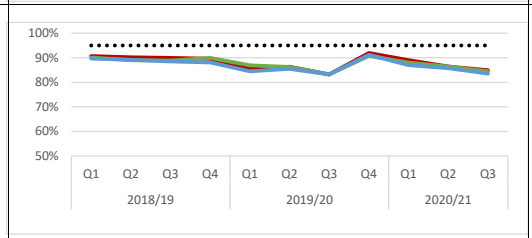
- Timely and effective care
- Safe and efficient hospital services
- Quality improvement activities
- Managing Acute Flow and production planning
- Community, primary and secondary integration
- Achieving health equity

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 Pacific Non-Māori, Non-Pacific Total	≤11.8%		We are developing community responses to population drivers of acute flow alongside approaches to maximise the productivity and efficiency of our hospital system. Our Early Supported Discharge (ESD) programme sees more people discharged from hospital earlier and with enhanced support from our nursing and allied health workforce in the community to prevent readmission.
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	↓3% (≤564) ↓7% (≤538) ↓2% (≤297) ↓2% (≤344)		Through our Hospital Network programme we are exploring short and medium term options for expansion of 2DHB bed and theatre capacity. This work will ensure that we have space to appropriately manage patients and balance the delicate relationship between length of stay and acute readmissions. We are also working to facilitate the smooth transition of patients back to their primary care provider with appropriate specialist support through community integration.
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%		We are redesigning Front of Whāre (ED and acute assessment units) to facilitate delivery of contemporary models of care and ensure facilities are appropriately sized to meet demand. We are adjusting the efficiency of our operating model, including a data driven review of our nursing roster to better match workforce with demand and improve use of our Assessment and Planning Unit for patients that require specialist consultation. Based on feedback from our patients, we have implemented a 'Nurse First' model which means our community will be seen by a member of our nursing staff first rather than our clerical team.