PUBLIC

HUTT VALLEY DHB / Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**AGENDA** Held on Wednesday 29 September 2021 Location: Zoom Zoom meeting ID: 878 1795 0109 Time: 9am

2DHB COMBINED HEALTH SYSTEM COMMITTEE

	ITEM	ACTION	PRESENTER	PG
1	**PROCEDURAL BUSINESS**			
1.1	Karakia		All Members	2
1.2	Apologies	**RECORD**	Chair	
1.3	Continuous Disclosure – Interest Register	**APPROVE**	Chair	3
1.4	Confirmation of Draft Minutes from meeting dated 28 July 2021	**APPROVE**	Chair	6
1.5	Matters arising from previous meetings	**NOTE**	Chair	12
1.6	Work Programme	**DISCUSS**	Chair	13
2	**STRATEGIC PRIORITIES**			
2.1	Planned Care Performance and Impact of COVID-19 Lockdown in 2021	**NOTE**	Director Provider Services 2DHB Director Strategy, Planning and Performance	14
2.2	Integrated Primary Care and Acute Demand	**NOTE***	Director Provider Services 2DHB Director Strategy, Planning and Performance	
3	**COMPLIANCE**			
3.1	Ministry of Health Non-Financial Performance Report – 2020/21 Quarter 4 3.1.1 Attachment 1 – HVDHB 3.1.2 Attachment 2 – CCDHB	**NOTE**	2DHB Director Strategy, Planning and Performance	23 28 37
4	**OTHER**			
4.1	COVID-19 Response	**NOTE***	Chief Executive Director Strategy, Planning and Performance	
4.2	Central Region Eating Disorder Service	**NOTE**	Executive Director MHAIDS Executive Clinical Director MHAIDS	46
4.3	Homelessness, health and COVID-19	**NOTE**	2DHB Director Strategy, Planning and Performance	52
4.4	General Business	**NOTE**	Chair	

DATE OF NEXT HSC MEETING:
Wednesday 24 November 2021, 9am, Boardroom, Level 11 Grace Neill Block, Wellington Regional 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

22/09/2021

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 • 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 27 July 2021 at 10:00am
Kāpiti Coast District Council Chambers – 175 Rimu Road, Paraparaumu

PUBLIC

PRESENT

COMMITTEE: Sue Kedgley, Chair
Ken Laban, Deputy Chair (Zoom)
'Ana Coffey (Zoom)
Josh Briggs
Richard Stein
Roger Blakeley
Vanessa Simpson (zoom)
Chris Kalderimis
Ria Earp (Zoom)
Sue Emirali
Paula King (Zoom)
David Smol

APOLOGIES Keri Brown
Bernadette Jones
Fa'amatuainu Tino Pereira

STAFF: Fionnagh Dougan, Chief Executive Officer
Rachel Haggerty, Director Strategy, Planning and Performance
Christine King, Allied Services
Sally Dossor, Board Secretary
Meila Wilkins, Board Liaison Officer

1 PROCEDURAL BUSINESS

The meeting started at 10.05am

1.1 Karakia

Josh Briggs led the Karakia.

1.2 APOLOGIES

Noted as above.

1.3 CONTINUOUS DISCLOSURE

1.3.1 Interest Register

Vanessa Simpson signalled her involvement in a number of items on the agenda and membership with the Kāpiti Coast Advisory Board.

1.4 CONFIRMATION OF PREVIOUS MINUTES

The minutes of the Combined Health System Committee meeting held on 26 May 2021 (public and public excluded sections) were confirmed as a true and correct record.

	Moved:	**Seconded:**	
Public	Sue Kedgley	Roger Blakeley	**CARRIED**
Public excluded	Sue Kedgley	Chris Kalderimis	**CARRIED**

1.5 ACTION LOG

A number of actions can now be noted as complete:

- HSC- 01 – On agenda for 29 September 2021.
- HSC21-03 & 04: These actions to be merged into one. The 2DHB Maternity Strategy will be considered at the 24 November 2021 meeting.
- HSC – 05 – Information provided.
- HSC- 06: This is on the agenda for the 29 September 2021 meeting.

HSC21-07: the Committee agreed that staff will give a verbal update on matters relating to the transition to Health New Zealand during the general business section of remaining HSC meetings.

Moved:	**Seconded:**	
Sue Kedgley	Josh Briggs	**CARRIED**

1.6 WORK PLAN

The Committee noted the workplan for 2021 and 2022.

Moved:	**Seconded:**	
Sue Kedgley	Roger Blakeley	**CARRIED**

2 COMMUNITY ENGAGEMENT

2.1 KĀPITI HEALTH ADVISORY GROUP – UPDATE AND DEMONSTRATION OF LOCAL HEALTH DIRECTORY

Dr Colin Feek, Chair, Kāpiti Health Advisory Group (KHAG), and Sandra Daly, Kāpiti Health Advisory Group presented

Notes:

- The Chair introduced the Kāpiti Health Advisory Group and welcomed the opportunity for the Committee to meet in Kāpiti.
- KHAG discussed the launch of the website and demonstrated it to the Committee.
- Discussion on frailty and services for the elderly in Kāpiti, noting 90% of geriatrics services provided locally but travel is required for other specialist services (10%).
- Work is continuing on building and delivering better services in the localities.

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

2.2 KĀPITI COMMUNITY HEALTH NETWORK UPDATE

Dr Chris Fawcett, Tu Ora Compass spoke to the paper and slides.

The Health System Committee noted:

(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

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

Notes:

- 'Plugging the equity gap' noted as a strong theme throughout the work done.
- There is a GP capacity issue in Kāpiti (which reflects the national experience), strong focus on using the current resources more efficiently.
- Increased services Kāpiti, such as an ophthalmology clinic, have been successful in preventing people from having to drive to Wellington.
- Improving the locality models is a key piece of work in the Transition Unit and specifically understanding there areas which are underfunded and under resourced so that the new system can address.
- Palliative care and services for youth are particularly challenging issues and resources are limited.
- The Committee noted the slides attached below.

KCHN Presentation year one.pdf

3 REPORTING

3.1 HEALTH OUTCOMES FOR KĀPITI RESIDENTS

The Senior System Development Manager, Design and Implementation presented and spoke to the slides and paper.

The 2DHB Health System Committee noted:

(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.

Moved:	**Seconded:**	
Roger Blakeley	Chris Kalderimis	**CARRIED**

Notes:

- Part of the journey had been to work with KHAG and the PHOs.
- Noted sustained equity in the system. When comparing the Kāpiti locality to other localities such as Porirua, the equity gap is not as prevalent, but the gap is still stark. The focus moving forward is reducing the equity gap.
- Highlighted importance of data in terms of ability to benchmark across different areas and measures, particularly children and young people, to determine what is leading to different outcomes.
- Reform offers exciting opportunity to invest and support Hauora Māori.
- Discussion on Telehealth, noting work done with Healthcare Home Collaborative to extend and develop access to telehealth. Further work is being done on how to ensure growth is done in an equitable way.

3.2 LOCALITIES AND COMMUNITY NETWORKS

The 2DHB Director Strategy, Planning and Performance spoke to the paper and was available for questions.

The 2DHB Health System Committee notes:

(a) our approach to localities and community networks

Moved:	**Seconded:**	
Roger Blakeley	Sue Kedgley	**CARRIED**

Notes:

- Locality planning approach is underpinned by principle of 'start with where people live and who they are'. This approach is about ensuring that everything is done through a Kāpiti lens, rather than through a provider lens.
- Noted it was exciting that the new system does not have artificial 'DHB' boundaries – for example, an artificial line between Kāpiti and Otaki. Work can now be done with communities as they define themselves in the new system.
- Data governance with Māori has been established.

- Important to grow participation of communities in our system design, rather than just having consumers providing feedback.
- Reforms will allow locality based approaches, commissioning and working with community is the premise of all community and primary healthcare.
- HNZ is about taking away the barriers, and the separation of the hospital investment from the community investment will be powerful in progressing some of the work.
- The trust, capability and infrastructure (and lessons) that has been built will be shared with the Transition Unit in submissions.
- A programme of work is being developed in Hutt Valley (including Wainuiomata). Work is being done on Miramar and Strathmore localities as part of wider Wellington work.
- This work is on the HSC workplan.

Ken Laben left the meeting at 11.15am

4 COMPLIANCE

4.1 REGIONAL PUBLIC HEALTH REPORT

The paper was taken as read. The General Manager Regional Public Health was available for questions.

The 2DHB Health System Committee note:

(a) this regular update from Regional Public Health
(b) this update on COVID-19, vaping in schools and food systems

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

Notes:

- Highlighted excellent response to recent Covid positive case from Sydney.
- The Committee discussed the issues with vaping and the role of DHBs in the regulatory work that is being led nationally.
- New regulations are trying to restrict access to vapes by youth, however there are challenges, given the online access to vape devices and refills.
- Applications for Specialty Vaping Retailers are open next month.

Vanessa Simpson left the meeting at 12pm
Paula King left the meeting at 12.30pm

4.2 Q3 NON-FINANCIAL MOH REPORTING – 2020/2021

The 2DHB Director Strategy, Planning and Performance presented

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.

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

Moved:	**Seconded:**	
Sue Kedgley	Josh Briggs	**CARRIED**

Notes:

- Decline in performance on breast feeding rates can be correlated to some people not having a Lead Maternity Carer. There is a shortage of LMCs available.
- Community midwifery teams have been set up as part of the response, as well as training more Māori and Pacific lactation consultants.
- Shortage of skilled midwives continues to be an issue.
- Educational work is beginning on other areas of workforce that work with mothers, children and babies, so they can pick up on social determinants such as breastfeeding, so that it becomes everyone's job.
- Access to the shingles vaccine was discussed, and the advantages of increasing access. However these are Ministry policy setting decisions and not understood to be a priority at present.

David Smol left the meeting at 12.50

The meeting closed at 12:57pm

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

HSC ACTION LOG AS AT 22/09/2021

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
HSC21-07	26-May-21	Ongoing		In progress	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.	Staff will give a verbal update on matters relating to the transition to Health New Zealand during the general business section of remaining HSC meetings.

HSC WORK PLAN 2021/22 AS AT 23/09/2021			
	24 November 2021 Capital & Coast 9am – 1pm	**16 March 2022 Hutt Valley 9am – 12pm**	**Placeholder meeting 8 June 2022 Capital & Coast 9am – 12pm**
Strategic Priorities			
Our Hospitals	2DHB Maternal and Neonatal Health System Strategy		
	2DHB Hospital Network		
Commissioning and Community	Complex Care and Long-term Conditions.	Community Network Development	
	Intersectoral priorities	Locality Integration	
Enablers	**TBC**	**TBC**	
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	2021/22 – Quarter 1	2021/22 – Quarter 2	
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			

Health System Committee

29 September 2021

Planned Care Performance and Impact of COVID-19 Lockdown in 2021	
Action Required **The Committee notes** (a) the increasing service delivery and financial risks within Planned Care services at both Capital & Coast and Hutt Valley DHBs.	
Strategic Alignment	Delivery to our agreed levels of Planned Care is one of the 2021/22 DHB strategic priorities and planned care is core component of access to services for the populations that we serve.
Presented by	Rachel Haggerty, Director, Strategy, Planning and Performance Joy Farley, Director Provider Services
Endorsed by	Fionnagh Dougan, Chief Executive
Purpose	To provide an overview of Planned Care service delivery and performance for Hutt Valley and Capital & Coast DHBs in 2020/21 and describe the impact of and recovery planning following the 2021 COVID-19 lockdown.
Contributors	Lisa Smith, Team Leader Hospital Network, Commissioning Hospital & Specialty Services 2DHB Delwyn Hunter, Group Manager Surgery, Women's and Children's CCDHB Rhondda Knox, Service Group Manager Surgery, Women's and Children's HVDHB Jamie Duncan, General Manager Commissioning Hospital & Specialty Services 2DHB

Executive Summary

1. The Planned Care Funding Schedule is a targeted investment in DHBs made by the Ministry of Health in a bid to ensure access to Planned Care treatments for the population of each District. For 2021/22 the funding available for Planned Care is $13.9 million for Hutt Valley and $26.8 million for Capital & Coast DHB.
2. Hutt Valley achieved the Planned Care funding schedule targets in 2020/21 whereas Capital & Coast DHB did not.
3. Both DHBs continue to have larger waiting lists than possible annual throughput allows, indicators of this are:
    a. The number of people waiting longer than 120 days for treatment (ESPI5). At the end of June 2021, Hutt Valley DHB had 902 people on the ESPI5 waiting list and Capital & Coast had 372 people.
    b. The total size of the waiting list. Hutt Valley's waiting list has grown by 400 people compared to 2019 and Capital & Coast's has grown by 1,000 people.

4. The 2021/22 financial year started in July with nursing strikes, an RSV outbreak, and ongoing acute demand pressures. August then brought a COVID-19 lockdown in which resulted in Capital & Coast cancelling 700 surgeries and Hutt Valley cancelling 109 surgeries. These surgeries will be rescheduled, further increasing the waiting list size, but there is little capacity for additional surgery.
5. DHB capacity to provide surgery has not increased during this time and both DHBs are maximising utilisation of current theatre and bed capacity as well as private hospital outsourcing capacity. Provision of care is carefully managed by waiting lists and, as always, prioritisation for treatment is based on clinical acuity.

Strategic Considerations

Service	Access to Planned Care services is likely to be subject to ongoing constraint due to acute demand, industrial action and further COVID-19 outbreaks or lockdowns. Service access is prioritised based on clinical acuity.
People	Nil
Financial	Planned Care funding is at-risk revenue available from the Ministry of Health based on performance, with additional waitlist improvement funding available again in 2021/22 for service delivery and innovations to reduce waitlists. This funding is at significant risk based on service delivery and demand before, and as a result of, the COVID-19 lockdown 2021.
Governance	Planned Care is one of the eleven Board strategic priorities for 2021/22.

Engagement/Consultation

Patient/Family	n/a
Clinician/Staff	n/a
Community	n/a

Attachments

N/A

Introduction

Purpose

The purpose of this paper is to provide the Health System Committee with an update on performance in relation to Planned Care targets across Hutt Valley and Capital & Coast DHBs and begin to describe the impact of and recovery from the COVID-19 Lockdown in August/September 2021.

Previous papers

This paper builds upon the Planned Care Performance 2DHB paper presented at the 26 May 2021 Health System Committee meeting. That paper provided an overview of the funding and monitoring of planned care performance.

Scope

Planned Care encompasses the patient journey from referral to follow up (figure 1). For the purposes of this paper we will focus on first specialist assessments and treatments, and the associated waitlists for each.

Figure 1. A typical planned care patient journey, showing the aspect of the journey directly funded by the Planned Care Initiative funding.

Investment and Production Planning for Planned Care 2021/22

DHB of Domicile perspective

The Planned Care Funding Schedule is a targeted investment in DHBs by the Ministry of Health in a bid to ensure access to Planned Care treatments for the population of each District. For 2021/22 the funding available for Planned Care in each DHB is $13.94 million for Hutt Valley and $26.82 million for Capital & Coast DHB.

The specialty level targets within this investment were set and confirmed with the Ministry of Health in early September. In setting targets, the DHBs focused on areas where standard intervention rates were at or below national averages and/or acute demand has impacted the ability to provide Planned Care in 2020/21. This was balanced with Provider Arm capacity to deliver care in the constrained environment. Specialty level targets for Planned Care deliver for the population of each DHB in 2021/22 are shown in tables 1 and 2. This is a DHB of Domicile view.

DHB of Service perspective

Hutt Valley and Capital & Coast DHBs also play an important role in delivery of Planned Care for the populations of other Districts. As tertiary DHBs the planned element of care provided by our Hospitals is categorised as Planned Care. Targets for Planned Care from a DHB of Service perspective are set through the IDF negotiating process and, along with the DHB of Domicile planned care targets, are monitored through each DHB's Price Volume Schedule.

Table 1. Planned Care Initiative targets for planned surgery for the population of Capital & Coast DHB.

Planned Care Intervention - Inpatient Surgical Discharges							
Description Information						Total Planned Activity	
DHB Code	Group	PUC	Purchase Unit Description	Unit of Measure	GL Code	Discharges	CWD
091	Non Surg	Non Surgic	Non Surgical PUC with Surgical DRG	CWD	6275	415	854.90
Non Surgical PUC TOTAL						***415***	***854.90***
091	Surg	S00.01	General Surgery – Inpatient Services (DRGs)	CWD	6275	1,747	2,473.66
091	Surg	S05.01	Anaesthesia Services (inpatient)	CWD	6275	97	38.95
091	Surg	S15.01	Cardiothoracic – Inpatient Services (DRGs)	CWD	6275	147	852.70
091	Surg	S25.01	Ear Nose and Throat – Inpatient Services (DRGs)	CWD	6275	827	735.96
091	Surg	S30.01	Gynaecology – Inpatient Services (DRGs)	CWD	6275	1,690	1,430.55
091	Surg	S35.01	Neurosurgery – Inpatient Services (DRGs)	CWD	6275	143	469.21
091	Surg	S40.01	Ophthalmology – Inpatient Services (DRGs)	CWD	6275	1,730	961.30
091	Surg	S45.01	Orthopaedics – Inpatient Services (DRGs)	CWD	6275	1,755	3,669.45
091	Surg	S55.01	Paediatric Surgical Services (DRGs)	CWD	6279	364	269.57
091	Surg	S60.01	Plastic & Burns – Inpatient Services (DRGs)	CWD	6275	849	857.20
091	Surg	S70.01	Urology – Inpatient Services (DRGs)	CWD	6275	544	761.62
091	Surg	S75.01	Vascular Surgery – Inpatient Services (DRGs)	CWD	6275	410	655.99
Surgical PUC TOTAL						***10,303***	***13,176.16***
Planned Care Inpatient Surgical Discharges TOTAL						**10,718**	**14,031.06**

Table 2. Planned Care Initiative targets for planned surgery for the population of Hutt Valley DHB.

Planned Care Intervention - Inpatient Surgical Discharges							
Description Information						Total Planned Activity	
DHB Code	Group	PUC	Purchase Unit Description	Unit of Measure	GL Code	Discharges	CWD
092	Non Surg	Non Surgic	Non Surgical PUC with Surgical DRG	CWD	6275	270	603.26
Non Surgical PUC TOTAL						***270***	***603.26***
092	Surg	S00.01	General Surgery – Inpatient Services (DRGs)	CWD	6275	966	1,498.12
092	Surg	S05.01	Anaesthesia Services (inpatient)	CWD	6275	14	6.38
092	Surg	S15.01	Cardiothoracic – Inpatient Services (DRGs)	CWD	6275	69	463.06
092	Surg	S25.01	Ear Nose and Throat – Inpatient Services (DRGs)	CWD	6275	499	439.55
092	Surg	S30.01	Gynaecology – Inpatient Services (DRGs)	CWD	6275	824	765.20
092	Surg	S35.01	Neurosurgery – Inpatient Services (DRGs)	CWD	6275	76	247.84
092	Surg	S40.01	Ophthalmology – Inpatient Services (DRGs)	CWD	6275	799	425.62
092	Surg	S45.01	Orthopaedics – Inpatient Services (DRGs)	CWD	6275	849	1,934.07
092	Surg	S55.01	Paediatric Surgical Services (DRGs)	CWD	6279	220	156.17
092	Surg	S60.01	Plastic & Burns – Inpatient Services (DRGs)	CWD	6275	680	595.22
092	Surg	S70.01	Urology – Inpatient Services (DRGs)	CWD	6275	344	467.65
092	Surg	S75.01	Vascular Surgery – Inpatient Services (DRGs)	CWD	6275	198	373.84
Surgical PUC TOTAL						***5,538***	***7,372.71***
Planned Care Inpatient Surgical Discharges TOTAL						**5,808**	**7,975.97**

Production planning and monitoring of planned care

The two perspectives of Planned Care also have their own production plans for monitoring of performance. Waiting lists for planned care are linked to the DHB of Service production plan and together show whether the DHB is on track for service delivery (treatment) and management of throughput/demand (waiting lists). In contrast, the DHB performance for their population is monitored against the DHB of Domicile production plan. Because we are tertiary DHBs there is significant overlap in the two plans but they should be considered separately.

2020/21 Planned Care Delivery

The service delivery in the last financial year (2020/21) will have a significant impact on performance in this financial year (2021/22). At the beginning of the last financial year both DHBs had larger than normal waiting lists as a result of the 2020 COVID-19 lockdown and the wider health system constraints including industrial action, vulnerable workforce, outsourcing constraints and increasing acute demand. This impacted on performance for the following 12 months.

End of financial year position of each DHB

Going into 2021/22 the two DHBs were in different positions to one another. Hutt Valley achieved the Planned Care funding schedule last financial year (table 3) whereas Capital & Coast DHB did not.

Table 3. Performance against the DHB Planned Care Funding Schedules in 2020/21

Category	% of Planned Care Funding Schedule targets achieved in 2020/21 by **Hutt Valley DHB**	% of Planned Care Funding Schedule targets achieved in 2020/21 by **Capital & Coast DHB**
Planned care discharges	100.7%	93.7%
Planned care caseweights	99.4%	98.8%

Both DHBs continue to have larger waiting lists than annual capacity throughput allows. One indicator of this is the number of people waiting longer than 120 days for either their first specialist appointment (ESPI2) or treatment (ESPI5). At the end of 2020/21 Hutt Valley DHB had 571 people on the ESPI2 waiting list and 902 people on the ESPI5 waiting list. Capital & Coast had 46 people on the ESPI2 waiting list and 372 people on the ESPI5 waiting list. Hutt Valley DHB performs less surgery each year than Capital & Coast thus the considerably bigger waiting list at Hutt Valley is a concern that will be carefully managed.

Drivers of performance in 2020/21

Capital & Coast DHB has a strong relationship with and reliance on private hospital providers to deliver the planned care funding schedule each year. In 2020/21 this was no different, but the quantum of work requiring outsourcing was increased due to growth in IDF and acute demand. However the capacity and appetite in the private market to deliver this surgery was markedly decreased. The DHB was unable to outsource 584 procedures compared to plan. This impact underpins the low discharge achievement and is also reflected in the ESPI5 waiting list at the end of the financial year.

Hutt Valley DHB delivers most care in-house and in 2020/21 increased service delivery opportunities by performing a number of Saturday operating lists and other initiatives to increase throughput. There was also a concerted effort to increase outsourcing to private providers, although as for Capital & Coast there was limited capacity to be utilised in the private market. This approach allowed Hutt to achieve the planned care funding schedule target but not deliver additional care (that would have been funded also by the Ministry of Health) to reduce the waiting list size.

In addition, both DHBs experienced challenges in workforce recruitment, retention and sickness as well as maintenance requirements for theatres. These impacts along with significantly increased acute demand in the system combined to hamper the ability to address increased waiting lists and increased demand from the population for both acute and planned care. As a result both DHBs had hundreds of people overdue for surgery (ESPI5 waiting list) going into the 2021/22 financial year.

The quantum of the backlog can be seen in figures 2 and 3 below. The number of people waiting longer than 120 days for treatment at each DHB is markedly increased compared to 2019 levels and the total waiting list size has grown significantly (by approximately 1,000 people at Capital & Coast DHB and 400 people at Hutt Valley).

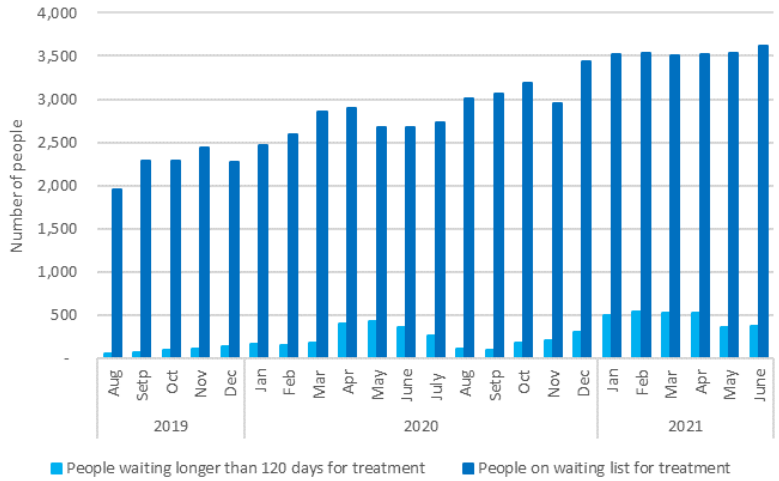


Figure 2. Waiting list for treatment at Capital & Coast DHB August 2019 to June 2021. The total waiting list size has grown significantly since 2019 and the number of people waiting longer than 120 days is also significantly higher.

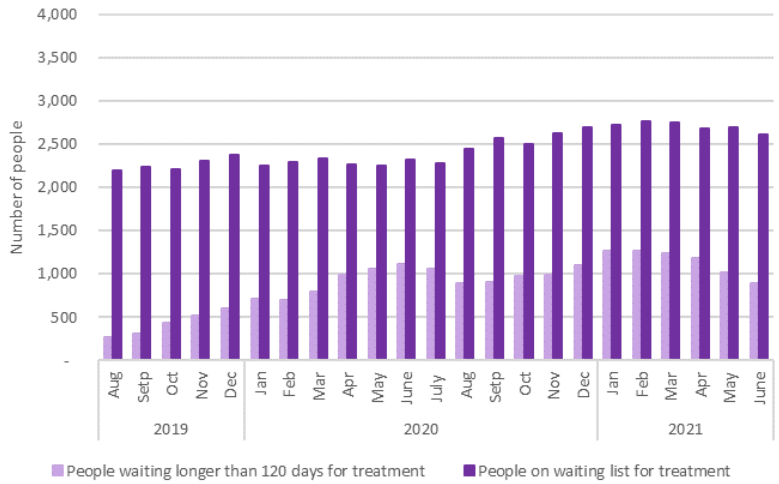


Figure 3. Waiting list for treatment at Hutt Valley DHB August 2019 to June 2021. The total waiting list size has grown significantly since 2019 and the number of people waiting longer than 120 days is also significantly higher.

Importantly, DHB capacity to provide surgery has not increased during this time and both DHBs are maximising utilisation of current theatre and bed capacity. Provision of care in this situation is carefully managed by waiting lists and, as always, prioritisation for treatment is based on clinical acuity.

Planned Care status in July and early August 2021

Delivery of Planned Care in the first month of this financial year was tracking at or close to plan. Hutt Valley delivered to target and Capital & Coast were 44 surgeries behind. Both DHBs were using internal capacity, additional operating lists and outsourcing to mitigate the impact of strikes, acute demand and a respiratory syncytial virus (RSV) outbreak.

Acute Demand and RSV

Acute demand continues to impact upon the provision of Planned Care. With our hospital system at capacity with regard to emergency department and bed capacity when there are large volumes of unwell acute patients then planned care is cancelled. In July and August 2021 there was an RSV outbreak across New Zealand. In Hutt Valley and Capital & Coast DHBs both paediatric and older adult populations had significantly more medical admissions. Planned Care was disrupted, as surgical beds were reallocated to meet the increase in medical demand.

Nursing strike and the beginning of lockdown 2021

DHB NZNO members were due to strike for 8 hours on Thursday 19 August 2021. Preparation for this strike was well underway and the hospitals had ramped down surgical interventions and occupancy. This was impacting planned care performance for August 2021 and the DHBs were behind production plans. However, this also meant that when the COVID-19 level 4 lockdown was announced and began on Tuesday 17 August 2021 the hospitals were already at lower occupancy than the typical 95-100% which was good preparation for the lockdown period.

COIVD-19 Lockdown 2021

The August 2021 COVID-19 lockdown in Wellington was comprised of the following levels:

Level 4	11:59PM Tuesday 17 August 2021 to 11:59PM Tuesday 31 August 2021
Level 3	11:59PM Tuesday 31 August 2021 to 11:59PM Tuesday 7 September 2021
Level 2	11:59PM Tuesday 7 September 2021

For the duration of the Level 3&4 lockdown the DHBs preserved workforce capacity by creating split rosters and work bubbles. Surgery continued for acute patients and non-deferrable elective patients only.

In previous lockdowns the DHBs access private hospitals to continue to provide reduced levels of planned care. This was not as successful for the 2021 lockdown as private hospitals changed their approach. In one instance previously a provider was a big source of wet-lease capacity but was closed for lockdown 2021.

The impact of lockdown was that unless urgent or non-deferrable, elective Planned Care surgeries were cancelled, 109 at Hutt Valley and 702 at Capital & Coast DHBs. These patients will be rescheduled and receive their surgery. The DHBs have been working closely together to ensure patients are assessed and treated based on clinical urgency. This has been particularly so for urgent cancer patients.

The impact of this is delays for people and increasing waiting lists for DHBs. The impact of the increased waiting lists and demand created by the lockdown, as experienced after the 2020 lockdown, will not be fully known for a number of months however already the number of people waiting longer than 120 days for surgery is growing (figures 4 and 5).

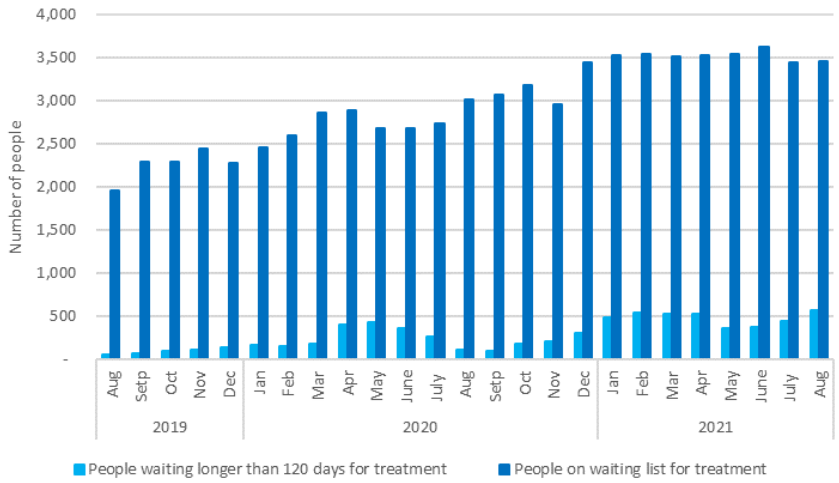


Figure 4. Waiting list for treatment at Capital & Coast DHB August 2019 to August 2021. The number of people waiting longer than 120 days for treatment is rising again.

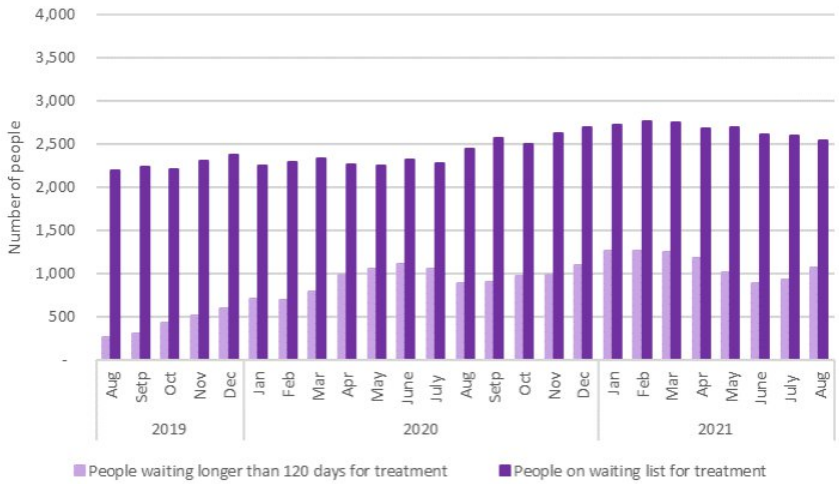


Figure 5. Waiting list for treatment at Hutt Valley DHB August 2019 to August 2021. The number of people waiting longer than 120 days for treatment is rising again.

Recovery Planning

Both Hutt Valley and Capital & Coast DHBs are in the early phases of recovery planning for their populations.

Outsourcing

The DHBs are mid-RFP process with private hospital providers for outsourcing surgical procedures and additional theatre & bed capacity through wet lease arrangement. Both RFPs are expected to be completed and contracts in place by the end of 2021. This will provide more certainty of capacity in the private market and allow more detailed planning both now and into future years to secure capacity in 'normal times' and potentially different arrangements in lockdown scenarios. However, there is no certainty that additional capacity is available in the private sector to be accessed.

Waitlist improvement funding

The DHBs continue to be able to access waiting list improvement funding from the Ministry of Health. This funding is supporting innovative projects in the specialties of Gynaecology, ENT, Orthopaedics, Ophthalmology & Respiratory services along with a mobile CT solution for the northern corridor of Wellington and a 5-room procedure suite at Hutt Hospital. These projects are in the implementation phase.

There is further funding available to the DHBs if the ESPI2 and ESPI5 waiting lists are reduced along agreed trajectories. Funding is contingent on meeting milestones in these trajectories. The trajectories were revised in May 2021 and do not account for the impacts of the COVID-19 lockdown. DHBs are awaiting advice from the Ministry of Health on how this funding will be accessed or available in the post-lockdown state.

Conclusion

Capacity to provide Planned Care surgery is being disrupted by acute demand, RSV outbreaks, industrial action, and further COVID-19 lockdowns. Access to Planned Care services is prioritised based on clinical acuity, however there remains a service delivery and financial risk that in the constrained environment the DHBs will not be able to deliver the full planned care funding schedule nor reduce waiting list size so that people are treated within 120 days.

Both DHBs are maximising utilisation of current theatre and bed capacity as well as private hospital outsourcing capacity. Investment in innovation will help to provide alternative solutions for people to access and reduce the number of people requiring treatment, these will take time to implement.

The DHBs remain committed to providing Planned Care to the populations that we serve.

Health System Committee

29 September 2021

Ministry of Health Non-Financial Performance Report – 2020/21 Quarter 4

Action Required

The Committee notes :

(a) that this report provides a summary from two key reports:

i. CCDHB and HVDHB's Ministry of Health (MoH) Non-Financial Quarterly Monitoring Report for Q4 2020/21 (April to June 2021).

ii. CCDHB and HVDHB's Q4 2020/21 Health System Plan and Vision for Change dashboard.

(b) that for the 56 indicators rated by MoH this quarter, CCDHB received 1 'Outstanding' rating, 30 'Achieved' ratings, 18 'Partially Achieved' ratings and 7 'Not Achieved' ratings. This is an improvement on CCDHB's Q3 result.

(c) that for the 56 indicators rated by MoH this quarter, HVDHB received 1 'Outstanding' rating, 28 'Achieved' ratings, 19 'Partially Achieved' ratings and 8 'Not Achieved' ratings. This is similar to HVDHB's Q3 result.

(d) that specific action plans are in place to improve performance against the 'Not Achieved' performance measures, including strategies to improve our immunisation and smoking cessation advice results.

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

(f) overall results for CCDHB and HVDHB demonstrate:

i. performance deterioration in immunisation targets reflecting the impact of 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 both CCDHB and HVDHB received 'Outstanding' ratings for the 'Engagement and obligations as a Treaty partner' indicator, which is recognition of our efforts in this area.

(h) that both CCDHB and HVDHB improved their performance rating for the 'Shorter Stays in Emergency Departments' indicator, which moved from a 'Not Achieved' rating in Q3 to a 'Partially Achieved' rating in Q4.

(i) that the recent Alert Level 3 and 4 lockdown period is likely to impact performance in the Q1 2021/22 results, as some activities cannot be performed during lockdown and resources have also been temporary diverted into swabbing and vaccination efforts.

Strategic Alignment	CCDHB Health System Plan 2030 HVDHB Vision for Change
Presented by	Rachel Haggerty, Director Strategy, Planning & Performance CCDHB & HVDHB

Endorsed by	Fionnnagh Dougan, Chief Executive 2DHB
Purpose	This paper provides an overview of performance and the Quarter 4 2020/21 Non-Financial Monitoring Report results, as assessed by the Ministry of Health.
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 MoH for Q4 2020/21 indicates a slightly better performance compared with Q3. The final results show that both HVDHB and CCDHB continue to meet most of the MoH performance targets. The immunisation coverage and smoking cessation targets remain a challenge that we are working to address.

When comparing the indicators that are common across Q3 and Q4 2020/21, performance ratings improved or remained the same across 37 indicators for HVDHB and 38 indicators for CCDHB.

	HVDHB	CCDHB
	Number of indicators Q4 2020/21	Number of indicators Q4 2020/21
Outstanding	1	1
Achieved	28	30
Partially Achieved	19	18
Not Achieved	8	7
Not Assessed	0	0

HVDHB and CCDHB received a 'Not Achieved' rating in relation to the following performance measures.

HVDHB - 'Not Achieved' ratings	CCDHB 'Not Achieved' ratings
• Immunisation coverage (at 8 months) • Immunisation coverage (at 2 years) • Immunisation coverage (at 5 years) • Immunisation coverage (HVP coverage) • Breast screening coverage • Better Help for Smokers to Quit – Primary Care • Better Help for Smokers to Quit – Maternity • Planned Care Measures	• Immunisation coverage (at 8 months) • Immunisation coverage (at 2 years) • Immunisation coverage (at 5 years) • Immunisation coverage (HPV coverage) • Breast screening coverage • Better Help for Smokers to Quit – Hospitals • Better Help for Smokers to Quit – Primary Care

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.

Immunisation coverage

Performance deterioration in the childhood immunisation targets reflect a greater number of declines to vaccination offerings and a timing change in the age for measles, mumps and rubella (MMR)

immunisations.[1] Meeting the immunisation targets continue to be a challenge across all DHBs. As a 2DHB system, we did not immunise the following children in Q4.

- **8 months:** we needed to reach 50 children in total to achieve the target. 86% were Māori and 14% were Pacific.
- **2 years:** we needed to reach 80 children in total to achieve the target. 74% were Māori and Pacific.
- **5 years**: we needed to reach 144 children in total to achieve the target. 49% were Māori and Pacific.
- **HPV**: we needed to reach 660 more children to achieve target. 49% were Māori and Pacific.

These results emphasize the importance of our pro-equity approach. 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. We are currently examining how our outreach immunisation service functions and how we can improve the current system.

Declines are a major barrier to meeting our immunisation targets. We have therefore commissioned Mokopuna Solutions, a kaupapa Māori organisation, to provide community insights on factors that influence a family's decision to decline vaccinations. Their report is expected within the next month and will provide valuable insights into how we could change our approach to the delivery of immunisation services to these families.

Breast screening coverage

As a 2DHB system, we needed to screen 1,920 more women aged 45-69 years of age to meet the target in Q4. 53% were Māori and Pacific women. We continue to focus our efforts on improving our screening coverage for Māori and Pacific women. Saturday and extended after-hours weekday clinics are currently done with staff volunteering to work. We are working through a consultation process to acknowledge their extended working hours and formalise this arrangement. Transport is offered to assist priority women who are overdue or unscreened to attend a screening clinic. Our Māori and Pacific providers engage with their patients to support and encourage breast screening uptake. We are also working with our PHO providers and GP practices to data match women to identify and actively follow up with women that have not enrolled in the breast screening programme.

Better Help for Smokers to Quit

We are continuing to work with our PHOs to ensure that smoking conversations are increased in primary care, and an "every patient, every time" approach is applied to patients who smoke. In our hospitals, we continue to encourage all clinicians (medical and nursing) to provide smoking cessation advice and confirm this through electronic documentation.

As a 2DHB system, our data shows that smoking cessation advice was not provided to the following people, in the following settings, in Q4.

- **Primary Care:** we needed to reach 6,450 more people. 1,848 more Māori and 766 more Pacific; 3,926 more non-Māori, non-Pacific.
- **Hospital (CCDHB):** we needed to offer brief advice to quit smoking to 235 more inpatients. 67 were Māori and 21 Pacific; 147 were non-Māori, non-Pacific.

[1] From 1 October 2020 a change to the vaccination schedule introduced a new event at age 12 months, so that the MMR vaccine is now given at 12 months (first dose) and 15 months of age (second dose), rather than 15 months and 4 years. This has required primary care vaccination services to follow-up with the children in the gap between 15 months and 4 years, as well as deliver the 12 and 15 month immunisations, until we have caught up with the change.

- **Maternity (HVDHB):** we needed to reach 11 more mothers. 7 were Māori.

Planned Care measures (HVDHB)

Planned Care measures did not meet compliance targets at HVDHB. HVDHB providers needed to deliver 45 caseweights. Work is progressing to improve performance and the Ministry noted it its assessment that "there is good oversight of service delivery and issues and plans are in place to move towards compliance."

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.

Government Planning Priorities	HVDHB	CCDHB
Give practical effect to He Korowai Oranga – Māori Health Strategy	Achieved	Achieved
Improving Sustainability	Partially Achieved	Partially Achieved
Improving child wellbeing	Achieved	Achieved
Improving mental wellbeing	Achieved	Achieved
Improving wellbeing through prevention	Partially Achieved	Partially Achieved
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.

A summary of the indicators and outlook is provided below.

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 remain within a stable range just below target level. The DHB is working with immunisation services to improve performance. 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. Year to date performance in 2021 is behind 2020 but still higher than 2019.
Avoidable hospital admissions (0-4 years)	There is a marked decline at HVDHB and CCDHB for childhood ASH rates, in particular for Māori and Pacific, since the 2020 national emergency COVID-19 lockdowns. Rates are now stabilising and are on average 24% lower than the peak observed immediately prior to March 2020. Increases in hand hygiene and border closures have had the most significant impact on reducing ASH rates, particularly respiratory and skin conditions.
Avoidable hospital admissions (45-64 years)	HVDHB and CCDHB observed a decline in adult ASH rates and in particular for Māori and Pacific since the 2020 national emergency COVID-19 lockdowns (although the trend is less pronounced 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 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 appear to reflect an increasing proportion of the very old.

Acute unplanned readmission	Overall, readmission rates are stable. However, rates for Māori and Pacific in HVDHB are showing signs of persistent increase and this is also observed for Pacific at CCDHB. The Hospital Network programme will support increased capacity and expected improvement in performance.
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. We have a number of community initiatives in place (CARS, CHOPI, AHOP and AWHI) that should reduce our acute bed day rates over time.
Shorter Stays in ED	There was a significant lift in performance during the 2020 COVID-19 lockdown, followed by a decline from Q4 2019/20 (June 2020) and then relatively stable performance. To improve performance we have streamlined transfers between hospitals, and previously unused capacity or admission spaces are being utilised to relieve the impact of access block at the front door. Work is also continuing on more sustainable long-term solutions. We are redesigning ED and acute assessment units to facilitate delivery of contemporary models of care and ensure facilities are appropriately sized to meet demand. We are also working to improve acute crisis support in ED.

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. 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 improves health outcomes / Deliver safer care Achieving equity and providing integrated service is embedded in these 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
	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 (Q4 2020/21) – including appendices
2. HVDHB Non-Financial Performance Report (Q4 2020/21) – including appendices

HVDHB Non-Financial Performance Report (Q4 2020/21)

This paper provides an overview of HVDHB's Q4 2020/21 non-financial performance and includes:

- HVDHB's Q4 results as assessed by the Ministry of Health (MoH).
- A comparison of Q4 results with CCDHB.
- HVDHB's Q4 2020/21 'Vision for Change' Dashboard (Appendix One).
- Heat maps showing the DHB and national Q3 results[1] (Appendix Two).

1. 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.

NON-FINANCIAL PERFORMANCE REPORT

In Q4 2020/21, HVDHB achieved compliance for 48 of the 56 performance indicators assessed (86%).[2] We received a 'Not Achieved' rating for 7 indicators (14%). This is an improvement on our Q3 result (15%).

HVDHB received an 'Outstanding' rating for the 'Engagement and obligations as a Treaty partner' indicator, in recognition of the work we have completed in this area.

Achievement	Number of indicators Q4 2020/21	Number of indicators Q3 2020/21
Outstanding	1	0
Achieved	28	24
Partially Achieved	19	15
Not Achieved	8	7
Not Assessed	0	0

When comparing the indicators that are common across Q3 and Q4 2020/21, overall HVDHB performance declined slightly. Performance ratings improved against 4 indicators, stayed the same for 33 indicators, and decreased for 6 indicators.

[1] Q3 results are shown because the MoH process for developing these heat maps runs two months behind this report.
[2] 'Achieved compliance' means we received an 'Outstanding', 'Achieved' or 'Partially Achieved' rating.

We were pleased to see the 'Shorter Stays in Emergency Departments' indicator move from a 'Not Achieved' rating in Q3 to a 'Partially Achieved' rating in Q4. To improve performance we have streamlined transfers between hospitals, and previously unused capacity or admission spaces are being utilised to relieve the impact of access block at the front door. Work is also continuing on more sustainable long-term solutions. We are redesigning ED and acute assessment units to facilitate delivery of contemporary models of care and ensure facilities are appropriately sized to meet demand. We are also working to improve acute crisis support in ED.

HVDHB received a 'Not Achieved' rating against eight 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. Immunisation coverage (HVP coverage)
5. Improving breast screening coverage and rescreening
6. Better Help for Smokers to Quit – Primary Care
7. Better Help for Smokers to Quit – Maternity
8. Planned Care Measures.

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

Immunisation coverage

Childhood immunisation coverage has been deteriorating across the country. Performance deterioration in the childhood immunisation targets reflect a greater number of declines to vaccination offerings and a timing change in the age for measles, mumps and rubella (MMR) immunisations.[3]

Equity gaps in the data emphasize the importance of our pro-equity approach. 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. We are currently examining how our outreach immunisation service functions and how we can improve the current system.

Declines are a major barrier to meeting our immunisation targets. We have therefore commissioned Mokopuna Solutions, a kaupapa Māori organisation, to provide community insights on factors that influence a family's decision to decline vaccinations. Their report is expected within the next month and will provide valuable insights into how we could change our approach to the delivery of immunisation services to these families.

Breast screening coverage

As a 2DHB system, we needed to screen 1,920 more women aged 45-69 years of age to meet the target in Q4. 53% were Māori and Pacific women. We continue to focus our efforts on improving our screening coverage for Māori and Pacific women. Saturday and extended after-hours weekday clinics are currently done with staff volunteering to work. We are working through a consultation process to acknowledge their extended working hours and formalise this arrangement. Transport is offered to assist priority women who are overdue or unscreened to attend a screening clinic. Our Māori and Pacific providers engage with their patients to support and encourage breast screening uptake. We are also working with our PHO providers

[3] From 1 October 2020 a new event was added at age 12 months so that MMR vaccine is now given at 12 months and 15 months of age, rather than 15 months and 4 years. This has required us to immunise the children in the gap between 15 months and 4 years, as well as the 12 and 15 month immunisations, until we have caught up with the change.

and GP practices to data match women to identify and actively follow up with women that have not enrolled in the breast screening programme.

Better Help for Smokers to Quit

We are continuing to work with our PHOs to ensure that smoking conversations are increased in primary care, and an "every patient, every time" approach is applied to patients who smoke. In our hospitals, we continue to encourage all clinicians (medical and nursing) to provide smoking cessation advice and confirm this through electronic documentation.

Planned Care measures (HVDHB)

Planned Care measures did not meet compliance targets at HVDHB. HVDHB providers needed to deliver 45 caseweights. Managing acute care against the delivery of specialist planned care assessments or treatment within 120 days continues to be a major challenge. However, we are making progress against our long-wait patients and are on track to achieve the recovery wait list trajectories. We continue to liaise weekly with the Ministry's planned care team and are working with them to improve elective flow. We are also continuing with the 2DHB Bed & Theatre Capacity project to identify and deliver solutions for short to medium term improvement in operating theatre capacity across our three hospitals. The Ministry noted it its assessment of our performance that "there is good oversight of service delivery and issues and plans are in place to move towards compliance".

Comparing HVDHB and CCVDHB Q4 2020/21 Results

HVDHB and CCDHB received very similar results for Q4, as shown below.

	HVDHB	CCDHB
Achievement	**Number of indicators Q4 2020/21**	**Number of indicators Q4 2020/21**
Outstanding	1	1
Achieved	28	30
Partially Achieved	19	18
Not Achieved	8	7
Not Assessed	0	0

Comparison with national results

MoH has developed heat maps that compare performance across DHBs. Their process runs two months behind this report. The heat maps for Q3 results are attached as Appendix Two. Based on the Q3 heat maps, performance for CCDHB and HVDHB is the same or above the average of other DHBs against the seven Government priorities.

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 Q4 2020/21 was rated as follows:

Status Update Report	Ratings – Q4	Ratings – Q3
Give practical effect to He Korowai Oranga – Māori Health Strategy	Achieved	Achieved
Improving Sustainability	Partially Achieved	Achieved
Improving child wellbeing	Achieved	Achieved
Improving mental wellbeing	Achieved	Partially Achieved
Improving wellbeing through prevention	Partially Achieved	Partially Achieved
Strong and equitable public health services	Partially Achieved	Partially Achieved
Better population health outcomes supported by primary care	Partially Achieved	Partially Achieved

The ratings for Q4 are better than Q3 overall. We have been preparing for the quarter one status updates for the start of the 2021/22 year. This has included a new SharePoint site with streamlined processes to make is easier for staff to provide their status updates to MoH. We are therefore expecting to see an improvement in our ratings in the next quarter.

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 (Appendix One) 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 a consistent process to achieve this target and equity for Māori and Pacific. We are working with PHOs to encourage referrals to **Takiri Mai Te Ata Regional Stop Smoking Service**. Tū Ora has implemented a new approach emphasising smoking cessation uptake (rather than just advice) with an equity focus for Māori and Pacific.
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 'declines'.
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+. Our 2DHB COVID-19 vaccination response in aged residential care facilities is complete.

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 encouraging referrals to **Tū Kotahi Asthma Service** and **Well Homes** from primary health care (including midwives and Well Child Tamariki Ora nurses) to increase access to healthy housing interventions to reduce avoidable admissions for respiratory conditions. **Bee Healthy** is strengthening oral health promotion outside of the core dental hubs in pre-schools (child is examined 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, and improving primary care access to our specialist 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** programme 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** programme sees more people discharged from hospital earlier, 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 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.
Acute hospital bed days per capita	Trend is stable or improving	
Shorter Stays in ED	Trend is stabilising	The 'Shorter Stays in Emergency Departments' indicator moved from a 'Not Achieved' rating in Q3 to a 'Partially Achieved' rating in Q4. To improve performance we have streamlined transfers between hospitals, and **previously unused capacity or admission spaces are being utilised** to relieve the impact of access block at the front door. Work is also continuing on more sustainable long-term solutions. We are **redesigning ED and acute assessment units** to facilitate delivery of contemporary models of care and ensure facilities are appropriately sized to meet demand. We are also working to **improve acute crisis support in ED.**

Appendix One: Hutt Valley DHB – 2020/21 Quarter Four 'Vision for Change' Dashboard

Support people living well

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

Areas of focus

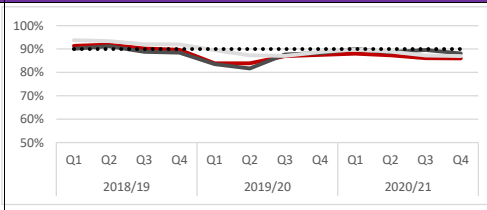
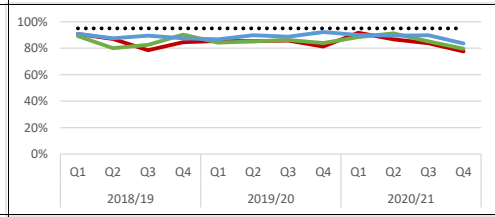
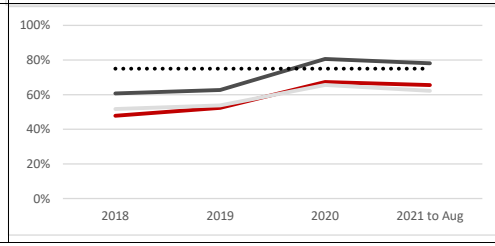
- Prevention, health promotion and public health activities
- Building strong and resilient communities – implementing our Wellbeing Plan
- First 1000 days of life
- Screening for breast, cervical and bowel cancer
- Environmental sustainability
- Achieving health equity

Sub-regional initiatives

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

Local initiatives

- Develop an action plan to improve the wellbeing of children and young people in the Hutt Valley
- Implement the Māori Provider Influenza Vaccine Improvement Project – through marae and outreach-based services
- Co-ordinate the delivery of the Hutt Valley Smokefree Action Plan focusing on priority populations
- Promote, and increase access to, the 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%		Primary care report challenges posed by patient complexity and being unable to meet patients' needs and deliver ABC advice during a 15 minute consult. Our PHOs are collaborating with Takiri Mai te Ata Regional Stop Smoking Service to increase the number of patients being referred to smoking cessation services, in particular Māori and Pacific. We expect that this partnership will assist primary care to move away from a recurring ABC cycle.
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%		Changes to the immunisations schedule in October 2020 is having a significant impact on performance. There is a sizeable cohort primary care is having to 'catch up' in order to complete the schedule ahead of the 2 year and 5 year milestones Mokopuna Solutions has been commissioned to explore the thoughts, feelings and beliefs of our Māori and Pacific whānau towards childhood immunisations. This report will drive future work to decrease decline rates.
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 2020 COVID-19 response we saw an increased update of influenza immunisation and in particular performance has improved across our priority populations. Our performance has been sustained at a rate higher than 2019 while also rolling out the COVID-19 vaccine in line with the Ministry of Health plan.

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

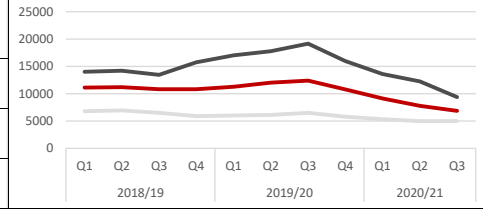
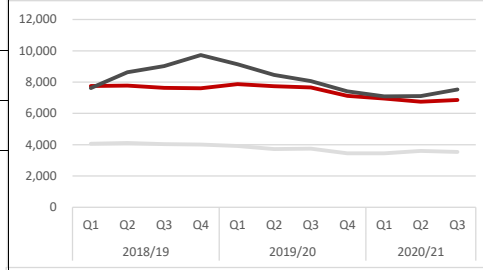
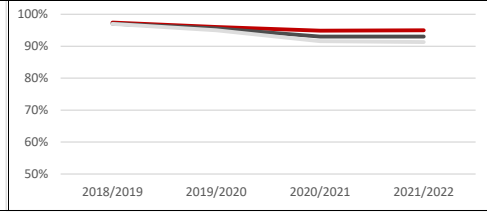
- Early intervention
- Build strong primary and community care
- Health Care Homes
- Placed-based planning – community hubs / neighbourhood approach
- Specialist support for primary care
- Telehealth services
- Management of Long Term Conditions
- Achieving health equity

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	≤11,676		Our SLM plan outlined our actions to improve performance, including increased referrals to Tū Kotahi Māori Asthma Trust and Well Homes, and strengthening primary care follow-up for children post ASH admission. While some of this reduction is likely to be due to lower rates of respiratory infection as a result of COVID-19 restrictions, however most actions in the SLM Plan were completed and added to performance.
			Pacific	≤17,459		
			Non-Māori, Non-Pacific	≤5,791		
			Total	≤8,243		
Indicator 2:	Avoidable hospital admissions (ASH rates 45-64 years)		Māori	≤7,271		Cardiovascular conditions (angina and chest pain, myocardial infarction and congestive heart failure), cellulitis respiratory conditions are the top presenting conditions, particularly for Māori and Pacific peoples. To address these areas we are focusing on access to acute care in primary care practices through the continued roll out of our Health Care Home programme, which sill support and enhanced focus on CVD risk assessments and follow up support, smoking cessation support, and wrap around services for those who have had an ASH event to prevent future events.
			Pacific	≤7,947		
			Non-Māori, Non-Pacific	≤3,647		
			Total	≤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		90% of the HVDHB population over age 75+ live in their own home. HVDHB is supporting a whole of system approach to frailty to support people to live at home for as long as possible. This includes strategic investment approaches. Managing frailty is a key part of our Sustainability Plan.
			Pacific			
			Non-Māori, Non-Pacific			
			Total			

Deliver shorter, safer, smoother care

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

Areas of focus

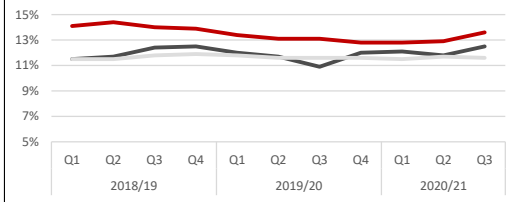
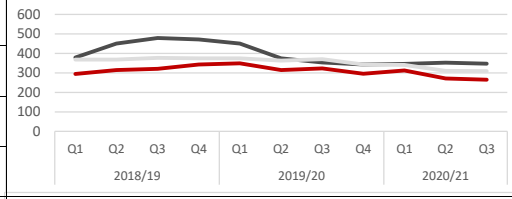
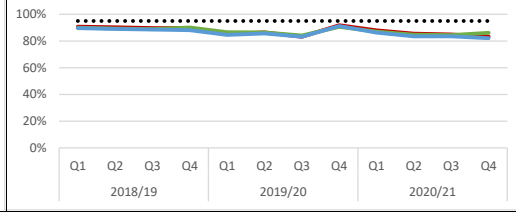
- Timely and effective care
- Safe and efficient hospital services
- Quality improvement activities
- Managing Acute Flow and production planning
- Community, primary and secondary integration
- Achieving health equity

Sub-regional initiatives

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

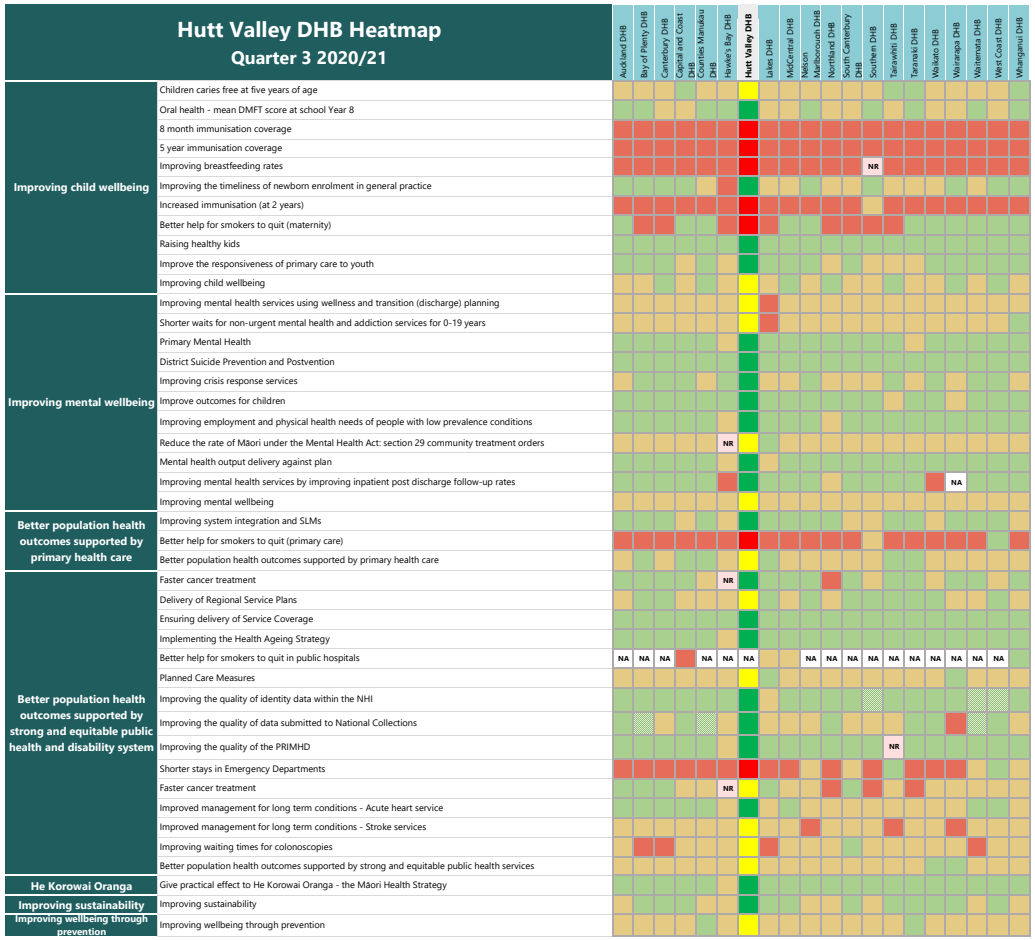
Local initiatives

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

Indicators	Description	Rationale	Targets		Performance – three year trend	Comments
Indicator 1:	Acute unplanned readmission	An unplanned acute (emergency and urgent) hospital readmission is often the result of the care provided to the patient by the health system. We can reduce unplanned acute admissions by ensuring a smooth transition from the hospital back into primary care, and by improving the quality of care in the hospital and in primary care.	Māori Pacific Non-Māori, Non-Pacific Total	≤11.8%		Our Sustainability Plan has a number of initiatives to improve our acute readmissions rate and improve flow at Hutt Hospital.
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	≤564 ≤538 ≤297 ≤344		<u>Community initiatives to manage inflow</u>: We are developing our community responses to population drivers alongside approaches to maximise the productivity and efficiency of our hospital system, including: a neighbourhood approach to integrated care, with a focus on a neighbourhood with a high priority population (Māori, Pacific, high deprivation).
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%		<u>Hospital initiatives to improve in-hospital flow</u> – We are embarking a project to redesign the 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. In parallel, we are exploring our short and medium term options for expansion of bed and theatre capacity. These options are being developed within the context of the Hospital Network programme

Appendix Two **Hutt Valley DHB Heatmap** **Quarter 3 2020/21**

Hutt Valley DHB Heatmap
Quarter 3 2020/21



Quarter 3 2020/21 Performance Summary

	Achieved	21
	Partially Achieved	15
	Not Achieved	7
NR	No Report	0
	Outstanding achievement	0
NA	Not Applicable	1

Regional Performance - National Priorities

	Northern Region	Midland Region	Central Region	South Island Region
Data & Digital				
Workforce				
Hepatitis C				
Cardiac Services				
Stroke Services				
Dementia Care				

Tracking to plan
Not tracking to plan but adequate resolution plan in place
Not achieved - no adequate resolution plan or delays in implementation

Central Region

For Stroke Services in the Central region, there is good depth and range of work progressing for prevention and acute and rehab stroke services. This reflects the importance of the regional focus to support improved stroke services as well as improved equity for all stroke patients. The partially achieved status is due to a lack of reporting for the Workforce component. The Ministry is currently following up with TAS regarding this and expects to see more information in the following quarter.

DHB reported progress against annual plan actions and self-nominated highlight	Areas of Performance Concerns
Improving child wellbeing	**Improving child wellbeing**
Sub-regional meeting held in Q1. Diversity emerged as a key theme for focus. CCDHB completed a retrospective pre-term audit in 2019-2020 and findings will assist regionally. Work continues on developing a HVDHB co-design Māori maternity plan to assist with reducing preterm birth rate for hapu Māori. PMMRC/NMMG Q2 -3 sector wide recommendations to introduce actions reduce preterm birth. A LGBTQIA forum is scheduled for December. This will assist us to work in partnership with the LGBTQIA+ community to build an inclusive service and model of care. As part of our 3DHB agreed MQSP action there is an ongoing work with the celebrating diversity campaign 2021-2023. BFHI accreditation audit was completed in November. We received notification from NZBA 23 March that Hutt Maternity have achieved their 5th Baby Friendly Hospital Initiative accreditation . Recommendations from this will be applied. Hutt Valley Maternity Action Trust supportive of partnering with HVDHB in additional breastfeeding supports. Initial training to key DHB providers occurred at HVDHB on 21 January 2021. Women's and Children's Service projects will be supported to use the Health Equality Assessment Tool Framework moving forward to evaluate services, and develop new quality improvements. We will be working in partnership with our Māori leaders in providing further cultural competency training throughout the year.	Immunisation coverage - Further analysis of the increase in declines to be carried out and shape future actions to boost vaccine confidence among Māori and Pacific families. Focus on outreach and connections into other related services should help improve coverage rates from Q4.
Improving mental wellbeing	**Improving mental wellbeing**
The following change ideas are being tested or have been implemented: use of safety huddles (implemented on Te Whare Ahuru), post seclusion reviews with service users (implemented on Te Whare o Matairangi, testing is about to begin on Te Whare Ahuru). Service users have expressed their appreciation for having the time to talk through their experience of seclusion and have been able to identify areas that could be improved, post seclusion team reviews (testing on both acute units, plans to test on Tāwhirimātea). Similarly useful learning is arising from the post seclusion team reviews: Chalk walls to encourage creative expression, weekly community meeting in Te Rangi Marie (Te Whare Ahuru) to improve communication between staff and service users. Plans are being progressed to purchase gym equipment to allow people to expend energy in healthy ways, headphones offered to people in Te Rangi Marie to access apps for distraction, or to self-soothe. Three Māori NESPS and a Māori RN have recently joined the Te Whare Ahuru team. Three Māori NESPs have also joined the Te Whare o Matairangi team, teams are beginning to access the Implicit Bias e-learning programme, introducing a mihi whakatau process for all new admissions.	
Better population health outcomes supported by primary health care	**Better population health outcomes supported by primary health care**
15 out of 19 practices are now on the HCH programme, with 84% coverage of the enrolled population enrolled in a HCH, and similar coverage for priority populations (Māori, Pacific and quintile 5)	
Better population health outcomes supported by strong and equitable public health and disability system	**Better population health outcomes supported by strong and equitable public health and disability system**
A suite of capability building options is now available and we are evaluating additional options for alignment, sustainability and to ensure they are fit for purpose. A new 2DHB Director of Māori Health has been appointed to coordinate our work to acheive Māori equity across the two DHBs. We have also amalgamated the two Māori relationship boards into one 2DHB Māori Council to represent the interests of mana whenua across the two DHBs. We are developing a Pro-Equity Policy Framework supported by advanced analytics and insights into our investment choices. We are developing a Māori communications programme with messages, premised on Māori korero, encouraging whānau to be well, stay well and live well. Te Reo used in job titles, workforce understanding of Māori health and equity increased, workforce development focussed on cultural leadership, safety and competency embedded. A suite of capability building options is now available and we are evaluating additional options for alignment, sustainability and to ensure they are fit for purpose. We are developing a Pro-Equity Policy Framework supported by advanced analytics and insights into our investment choices. We are developing a Māori communications programme with messages, premised on Māori korero, encouraging whānau to be well, stay well and live well.	
Improving wellbeing through prevention	**Improving wellbeing through prevention**
Work in partnership with Sport Wellington and the Ministry of Education to provide the Healthy Active Learning programme to schools and early learning services, with a continued emphasis on (a) water-only and (b) low decile schools with higher numbers of Māori and Pacific students. We will report on the number of Early Learning Services, primary, intermediate and secondary schools that have current water-only (including plain milk) policies and healthy food policies (that are consistent with the Ministry of Health's Eating and Activity Guidelines. (RPH - core function: health promotion) Work is progressing well and is on track. A focus of the programme is to ensure we are reflecting community needs and working with community to achieve what is meaningful in the areas of water only schools, healthy active learning, plus new the MoH toolkit for schools/ECE's and healthy food guidelines.	
Give practical effect to He Korowai Oranga - Māori Health Strategy	**Improving sustainability - DHB nominated highlight**
	HVDHB - Planned Care: Work with Te Awakairangi Health to 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 of the enrolled population. We aim to roll out the model to all willing practices by the end of 2020/21 – as close to 100% coverage as possible. (This is also a Planned Care activity) Q3 update: 15 out of 19 practices are now on the HCH programme with 84% coverage of the enrolled population enrolled in a HCH and similar coverage for priority populations (Māori, Pacific and quintile 5)

CCDHB Non-Financial Performance Report (Q4 2020/21)

This paper provides an overview of CCDHB's Q4 2020/21 non-financial performance and includes:

- CCDHB's Q4 results as assessed by the Ministry of Health (MoH).
- A comparison of Q4 results with HVDHB.
- CCDHB's Q4 2020/21 'Health System Plan' Dashboard (Appendix One).
- Heat maps showing the DHB and national Q3 results[1] (Appendix Two).

1. 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.

NON-FINANCIAL PERFORMANCE REPORT

In Q4 2020/21, CCDHB achieved compliance for 49 of the 56 performance indicators assessed (88%).[2] We received a 'Not Achieved' rating for 7 indicators (12%). This is an improvement on our Q3 result (15%).

CCDHB received an 'Outstanding' rating for the 'Engagement and obligations as a Treaty partner' indicator, in recognition of the work we have completed in this area.

Achievement	Number of indicators Q4 2020/21	Number of indicators Q3 2020/21
Outstanding	1	0
Achieved	30	24
Partially Achieved	18	16
Not Achieved	7	7
Not Assessed	0	0

When comparing the indicators that are common across Q3 and Q4, overall CCDHB performance improved slightly. Performance ratings improved against 5 indicators, stayed the same for 33 indicators, and decreased against 4 indicators.

[1] Q3 results are shown because the MoH process for developing these heat maps runs two months behind this report.
[2] 'Achieved compliance' means we received an 'Outstanding', 'Achieved' or 'Partially Achieved' rating.

We were pleased to see the 'Shorter Stays in Emergency Departments' indicator move from a 'Not Achieved' rating in Q3 to a 'Partially Achieved' rating in Q4. To improve performance we have streamlined transfers between hospitals, and previously unused capacity or admission spaces are being utilised to relieve the impact of access block at the front door. Work is also continuing on more sustainable long-term solutions. We are redesigning ED and acute assessment units to facilitate delivery of contemporary models of care and ensure facilities are appropriately sized to meet demand. We are also working to improve acute crisis support in ED.

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. Immunisation coverage (HPV coverage)
5. Breast screening coverage
6. Better Help for Smokers to Quit – Hospitals
7. Better Help for Smokers to Quit – Primary Care.

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

Immunisation coverage

Childhood immunisation coverage has been deteriorating across the country. Performance deterioration in the childhood immunisation targets reflect a greater number of declines to vaccination offerings and a timing change in the age for measles, mumps and rubella (MMR) immunisations.[3]

Equity gaps in the data emphasize the importance of our pro-equity. 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. We are currently examining how our outreach immunisation service functions and how we can improve the current system.

Declines are a major barrier to meeting our immunisation targets. We have therefore commissioned Mokopuna Solutions, a kaupapa Māori organisation, to provide community insights on factors that influence a family's decision to decline vaccinations. Their report is expected within the next month and will provide valuable insights into how we could change our approach to the delivery of immunisation services to these families.

Breast screening coverage

As a 2DHB system, we needed to screen 1,920 more women aged 45-69 years of age to meet the target in Q4. 53% were Māori and Pacific women. We continue to focus our efforts on improving our screening coverage for Māori and Pacific women. Saturday and extended after-hours weekday clinics are currently done with staff volunteering to work. We are working through a consultation process to acknowledge their extended working hours and formalise this arrangement. Transport is offered to assist priority women who are overdue or unscreened to attend a screening clinic. Our Māori and Pacific providers engage with their patients to support and encourage breast screening uptake. We are also working with our PHO providers and GP practices to data match women to identify and actively follow up with women that have not enrolled in the breast screening programme.

[3] From 1 October 2020 a change to the vaccination schedule introduced a new event at age 12 months, so that the MMR vaccine is now given at 12 months (first dose) and 15 months of age (second dose), rather than 15 months and 4 years. This has required primary care vaccination services to follow-up with the children in the gap between 15 months and 4 years, as well as deliver the 12 and 15 month immunisations, until we have caught up with the change.

Better Help for Smokers to Quit

We are continuing to work with our PHOs to ensure that smoking conversations are increased in primary care, and an "every patient, every time" approach is applied to patients who smoke. In our hospitals, we continue to encourage all clinicians (medical and nursing) to provide smoking cessation advice and confirm this through electronic documentation.

Comparing CCDHB and HVDHB Q4 2020/21 Results

CCDHB and HVDHB received very similar results for Q4, as shown below.

	CCDHB	HVDHB
Achievement	**Number of indicators Q4 2020/21**	**Number of indicators Q4 2020/21**
Outstanding	1	1
Achieved	30	28
Partially Achieved	18	19
Not Achieved	7	8
Not Assessed	0	0

Comparison with national results

MoH has developed heat maps that compare performance across DHBs. Their process runs two months behind this report. The heat maps for Q3 results are attached as Appendix Two. Based on the Q3 heat maps, performance for CCDHB and HVDHB is the same or above the average of other DHBs against the seven Government priorities.

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 Q4 2020/21 was rated as follows:

Status Update Report	Ratings – Q4	Ratings – Q3
Give practical effect to He Korowai Oranga – Māori Health Strategy	Achieved	Achieved
Improving Sustainability	Partially Achieved	Achieved
Improving child wellbeing	Achieved	Partially Achieved
Improving mental wellbeing	Achieved	Partially Achieved
Improving wellbeing through prevention	Partially Achieved	Partially Achieved
Strong and equitable public health services	Partially Achieved	Partially Achieved
Better population health outcomes supported by primary care	Partially Achieved	Partially Achieved

The ratings for Q4 are better than Q3 overall. We have been preparing for the quarter one status updates for the start of the 2021/22 year. This has included a new SharePoint site with streamlined processes to make is easier for staff to provide their status updates to MoH. We are therefore expecting to see an improvement in our ratings in the next quarter.

CCDHB 'HEALTH SYSTEM PLAN' DASHBOARD

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 (Appendix One) 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 a consistent process to achieve this target and equity for Māori and Pacific. We are working with PHOs to encourage referrals to **Takiri Mai Te Ata Regional Stop Smoking Service**. Tū Ora has implemented a new approach emphasising smoking cessation uptake (rather than just 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 'declines'.
Elder immunisation	Performance behind 2020 but higher than 2019	We aim to sustain high coverage (alongside COVID-19) to reduce avoidable winter demand. Our **2DHB Influenza Working Group** is targeting 75% coverage for people aged 65+. Our 2DHB COVID-19 vaccination response in aged residential care facilities is complete.

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 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 to self-manage long term conditions and keep people out of hospital. In Porirua, patients can be referred to Vaka Atafaga, the Pacific Neighbourhood Nursing Service, for culturally responsive community-based support following an 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. 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 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	Trend is stabilising	The 'Shorter Stays in Emergency Departments' indicator moved from a 'Not Achieved' rating in Q3 to a 'Partially Achieved' rating in Q4. To improve performance we have streamlined transfers between hospitals, and **previously unused capacity or admission spaces are being utilised** to relieve the impact of access block at the front door. Work is also continuing on more sustainable long-term solutions. We are **redesigning ED and acute assessment units** to facilitate delivery of contemporary models of care and ensure facilities are appropriately sized to meet demand. We are also working to **improve acute crisis support in ED.**

Appendix One: Capital & Coast DHB – 2020/21 Quarter Four 'Health System Plan' Dashboard

Promote health and wellbeing

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

Areas of focus

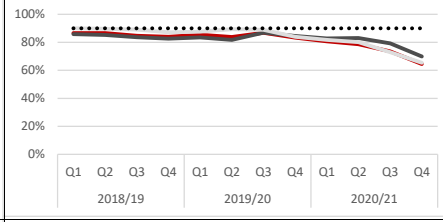
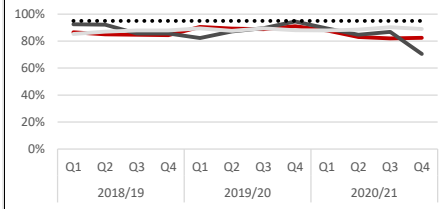
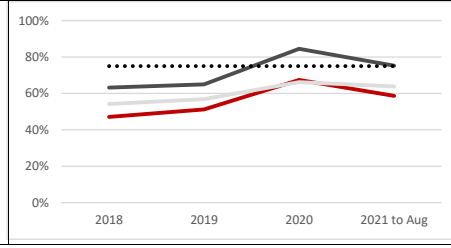
- Prevention, health promotion and public health activities
- Building strong and resilient communities
- First 1000 days of life
- Screening for breast and cervical cancer
- Environmental sustainability
- Achieving health equity

Sub-regional initiatives

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

Local initiatives

- Develop and commit to a pro-equity programme of work that delivers a clear CCDHB equity goal and direction, an agreed set of equity principles, and an operational framework
- Re-establish and update the Tū 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%		Primary care report challenges posed by patient complexity and being unable to meet patients' needs and deliver ABC advice during a 15 minute consult. Our PHOs are collaborating with Takiri Mai te Ata Regional Stop Smoking Service to increase the number of patients being referred to smoking cessation services, in particular Māori and Pacific. We expect that this partnership will assist primary care to move away from a recurring ABC cycle.
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%		Changes to the immunisations schedule in October 2020 is having a significant impact on performance. There is a sizeable cohort primary care is having to 'catch up' in order to complete the schedule ahead of the 2 year and 5 year milestones Mokopuna Solutions has been commissioned to explore the thoughts, feelings and beliefs of our Māori and Pacific whānau towards childhood immunisations. This report will drive future work to decrease decline rates.
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 2020 COVID-19 response we saw an increased update of influenza immunisation and in particular performance has improved across our priority populations. Our performance has been sustained at a rate higher than 2019 while also rolling out the COVID-19 vaccine in line with the Ministry of Health plan.

Capital & Coast District Health Board

People-focused services in the community

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

Areas of focus

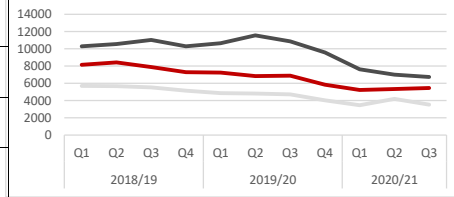
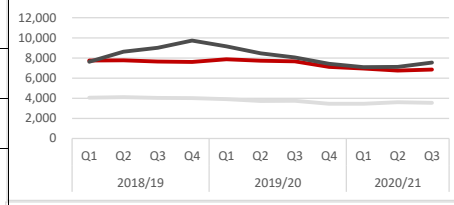
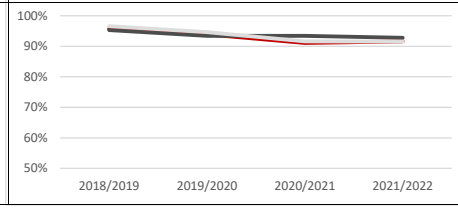
- Homes as a place of care
- Community Mental Health and Wellbeing Hubs
- Build strong primary and community care
- Early intervention
- Health Care Homes
- Specialist support for primary care
- Telehealth services
- Management of Long Term Conditions
- Achieving health equity

Sub-regional initiatives

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

Local initiatives

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

Indicators	Description	Rationale	Targets		Performance – three year trend	Comments
Indicator 1:	Avoidable hospital admissions (ASH rates 0-4 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	≤6,421		To meet this target, CCDHB needed to achieve 17 fewer events for Māori (achieved 45 fewer events), 38 fewer events for Pacific (achieved 72 fewer events) and 12 fewer events for non-Māori/non Pacific (achieved 148 fewer events). While some of this reduction is likely to be due to lower rates of respiratory infection as a result of COVID-19 restrictions, however most actions in the SLM Plan were completed.
			Pacific	≤10,865		
			Non-Māori, Non-Pacific	≤4,726		
			Total	≤5,818		
Indicator 2:	Avoidable hospital admissions (ASH rates 45-64 years)		Māori	≤6,575		Cardiovascular conditions (angina and chest pain, myocardial infarction and congestive heart failure) and cellulitis are the top presenting conditions, particularly for Māori and Pacific peoples. To address these areas we are focusing on access to acute care in primary care practices, CVD risk assessments and follow up support, smoking cessation support, and wrap around services for those who have had an ASH event to prevent future events.
			Pacific	≤7,075		
			Non-Māori, Non-Pacific	≤2,623		
			Total	≤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		91% of the CCDHB population over age 75+ live in their own home. CCDHB is working to develop a whole of system approach to frailty that supports people to live at home for as long as possible. This includes strategic investment approaches such as CHOPI, AWHI and AHOP. Managing frailty is a key part of our Sustainability Plan.
			Pacific			
			Non-Māori, Non-Pacific			
			Total			

Capital & Coast District Health Board

Timely effective care that improves health outcomes

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

Areas of focus

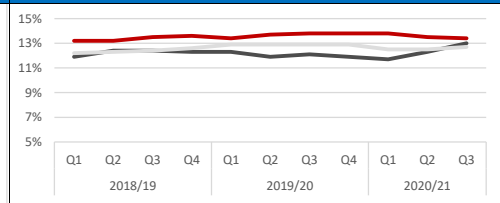
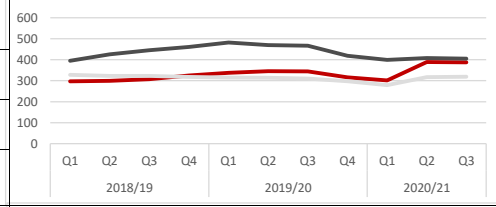
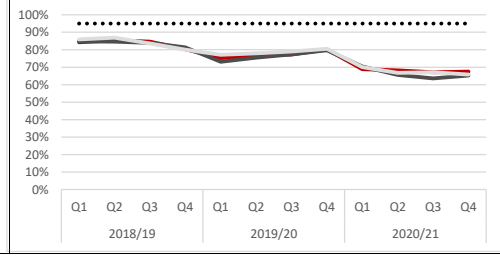
- Timely and effective care
- Safe and efficient hospital services
- Quality improvement activities
- Managing Acute Flow and production planning
- Community, primary and secondary integration
- Support end of life with dignity
- Achieving health equity

Sub-regional initiatives

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

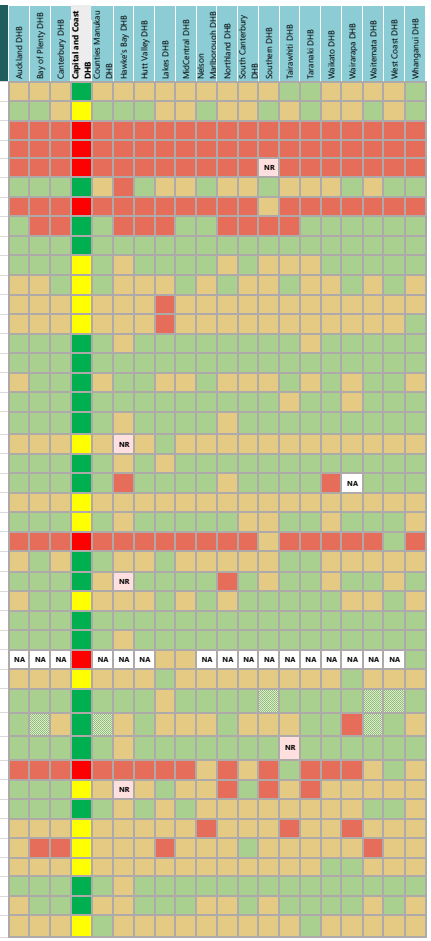
Local initiatives

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

Indicators	Description	Rationale	Targets		Performance – three year trend	Comments
Indicator 1:	Acute unplanned readmission (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%		Acute demand management work group has a number of initiatives in trial and implementation to improve our acute readmissions rate, including criteria led discharges, streamlined discharge processes, supportive discharges of older persons, better discharge summaries and using transit lounge nurses to review discharge instructions with patients being discharged.
Indicator 2:	Acute hospital bed days per capita	Acute hospital bed days per capita reflects the demand for acute inpatient services. We can manage this demand by good discharge planning, improving the transition between the community and hospital settings, good communication between providers, managing conditions in primary care settings, and timely access to diagnostics services.	Māori Pacific Non-Māori, Non-Pacific Total	≤533 ≤573 ≤290 ≤328		Community initiatives to manage inflow: We are developing our community responses to population drivers alongside approaches to maximise the productivity and efficiency of our hospital system, including: ambulance diversion initiative (CARS), services that address demand for our ageing population (CHOPI, AHOP & AWHI).
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%		Hospital initiatives to improve in-hospital flow – We are embarking a project to redesign the 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. In parallel, we are exploring our short and medium term options for expansion of bed and theatre capacity. These options are being developed within the context of the Hospital Network programme.

Capital and Coast DHB Heatma Quarter 3 2020/21

Capital and Coast DHB Heatmap
Quarter 3 2020/21



Quarter 3 2020/21 Performance Summary

	Achieved	21
	Partially Achieved	16
	Not Achieved	7
NR	No Report	0
	Outstanding achievement	0
NA	Not Applicable	0

Regional Performance - National Priorities

	Northern Region	Midland Region	Central Region	South Island Region
Data & Digital				
Workforce				
Hepatitis C				
Cardiac Services				
Stroke Services				
Dementia Care				

Tracking to plan
Not tracking to plan but adequate resolution plan in place
Not achieved - no adequate resolution plan or delays in implementation

Central Region

For Stroke Services in the Central region, there is good depth and range of work progressing for prevention and acute and rehab stroke services. This reflects the importance of the regional focus to support improved stroke services as well as improved equity for all stroke patients. The partially achieved status is due to a lack of reporting for the Workforce component. The Ministry is currently following up with TAS regarding this and expects to see more information in the following quarter.

DHB reported progress against annual plan actions and self-nominated highlight	Areas of Performance Concerns
Improving child wellbeing	**Improving child wellbeing**
CCDHB has contracted Te Ao Marama Tapui Ltd to provide community based midwifery services to Māori and Pacific women in Porirua. This provides support for 5 new, additional FTE of Māori and Pacific LMCs in Porirua. Work between CCDHB and community based scanning providers is being progressed. The focus on this work is increase access and uptake for Māori and Pacific women.	Immunisation coverage - Further work to be undertaken on declines and vaccine confidence among Māori and Pacific families with links to Kenepuru A&M and further rollout of the Mātua, Pēpi, Tamariki service.
Improving mental wellbeing	**Improving mental wellbeing**
Service users have expressed their appreciation for having the time to talk through their experience of seclusion and have identified areas that could be improved. Chalk walls to encourage creative expression, weekly community meeting in Te Rangi Marie to improve communication between staff and service users. Increasing the availability of sensory modulation activity in Te Rangi Marie. Plans are progressing to purchase gym equipment to allow people to expend physical energy in healthy ways. Headphones offered to people in Te Rangi Marie to access apps for distraction, or to self-soothe. Three Māori NESPS and a Māori RN have joined the Te Whare Ahuru team. Three Māori NESPs have also joined the Te Whare o Matairangi team, weekly education sessions with the cultural educator looking at how staff can work in a culturally safe way, teams are beginning to access the Implicit Bias e-learning programme, introducing a mihi whakatau process for all new admissions. An audit of prescribing for acute behavioural disturbance is underway. A sensory modulation working group has been established and recently sent out a survey to all clinical teams in MHAIDS to establish how the intervention is being used.	
Better population health outcomes supported by primary health care	**Better population health outcomes supported by primary health care**
Our Diabetes Clinical Network met in December after a hiatus due to COVID and staff shortages. They discussed system performance data which shows an impact from COVID. The group next meets in February and will consider quality improvement opportunities to address equity gaps.	
Better population health outcomes supported by strong and equitable public health and disability system	**Better population health outcomes supported by strong and equitable public health and disability system**
A suite of capability building options is now available and we are evaluating additional options for alignment, sustainability and to ensure they are fit for purpose. A new 2DHB Director of Māori Health has been appointed to coordinate our work to acheive Māori equity across the two DHBs. We have also amalgamated the two Māori relationship boards into one 2DHB Māori Council to represent the interests of mana whenua across the two DHBs. Supporting our workforce to achieve increased equity outcomes, particularly for Māori, Pacific and people with disabilities. Milestones include: Te Reo used in job titles, workforce understanding of Māori health and equity increased, workforce development focussed on cultural leadership, safety and competency embedded. A suite of capability building options is now available and we are evaluating additional options for alignment, sustainability and to ensure they are fit for purpose. We are developing a Pro-Equity Policy Framework supported by advanced analytics and insights into our investment choices. We are developing a Pro-Equity Policy Framework supported by advanced analytics and insights into our investment choices. We are developing a Māori communications programme with messages, premised on Māori korero, encouraging whānau to be well, stay well and live well.	
Improving wellbeing through prevention	**Improving wellbeing through prevention**
CCDHB have continued to work in co-design with #YouthQuake at every stage. #YouthQuake and CCDHB are in the final stage of contracting for the Porirua YOSS with Te Runanga o Toa Rangatira who are collaborating with Partners Porirua to provide the service. This is a milestone for rangatahi in Porirua.	
Give practical effect to He Korowai Oranga - Māori Health Strategy	**Improving sustainability - DHB nominated highlight**
We are developing a cultural competency workforce plan to set core competencies for all staff to achieve health equity and improve Māori health outcomes. The first phase will be to establish the current status (baseline data) within our workforce. We are training staff to use the Health Equity Assessment Tool (HEAT) to help staff when planning, trialling and implementing initiatives to ensure they address inequity for Māori.	Continuing work to develop the Kapiti Community Health Network. Priority areas have been agreed including targeted interventions to support high needs group in housing complex with socially complex residents with high health needs and interventions for frail elderly. Work has commenced to understand utilisation of planned care within the network population and to consider areas where services could be provided within the network rather than in hospital. CCDHB are taking a partnership approach to developing Kāpiti CHN and are working alongside Te Ātiawa ki Whakarongtai and Tū Ora Compass Health (Tū Ora).

Health System Committee

29 September 2021

Central Region Eating Disorder Service

Action Required

The Health System Committee notes:

(a) the contents of this report

Authors	Karla Bergquist, Executive Director Paul Oxnam, Executive Clinical Director
Endorsed by	Fionnagh Dougan, Chief Executive, 2DHBs
Presented by	Karla Bergquist, Executive Director Paul Oxnam, Executive Clinical Director
Purpose	This paper is to provide a briefing on the Central Region Eating Disorder Service (CREDS)
Contributors	Karla Bergquist, Executive Director Paul Oxnam, Executive Clinical Director
Consultation	N/A

Executive Summary

CREDS has seen a significant increase in demand for both residential inpatient and outpatient services. There has been a lot of media attention recently in relation to the long waiting lists and vacancy issues. The purpose of this paper is to provide the HSC with an overview of CREDS, what it provides, vacancies, access and demand, and improvement activity.

Strategic Considerations

Service	All MHAIDS services are committed to delivering safe, quality care to patients and whānau, and ensuring staff safety.
Financial	Poor patient outcomes and harm can have a direct financial impact on the performance of our DHBs.
Governance	We will strengthen quality and safety at every level through effective leadership, integrated governance and defined accountabilities across the health and disability system of the 2DHBs, including MHAIDS.

Engagement/Consultation

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

Introduction

1. The Central Region Eating Disorder Service (CREDS) provides a range of treatment and support services for people with eating disorders, from dietetic support through to residential care. The service is based in Johnsonville and delivers services to people living in the Wellington, Hutt Valley, Wairarapa, MidCentral, Whanganui and Hawke's Bay districts.
2. The services offered to each person and their whānau varies depending on their age, physical health, and the type of eating disorder they present with.
3. The CREDS has six residential beds available to clients requiring inpatient treatment as part of their recovery.
4. The CREDS has a close relationship with the medical and paediatric teams at Wellington Regional Hospital who support clients with co-existing medical conditions such as physical compromise due to low weight, or other physical complications resulting from their eating disorder.

Staffing

5. The CREDS multidisciplinary team includes Senior Medical Officers, a Psychiatry Registrar, Clinical Psychologists, Registered Nurses, Support Workers, Social Workers, Psychotherapists, Occupational Therapists and Dieticians.
6. The CREDS has funding for 19.2 FTE and there are currently 3.3 FTE vacancies.

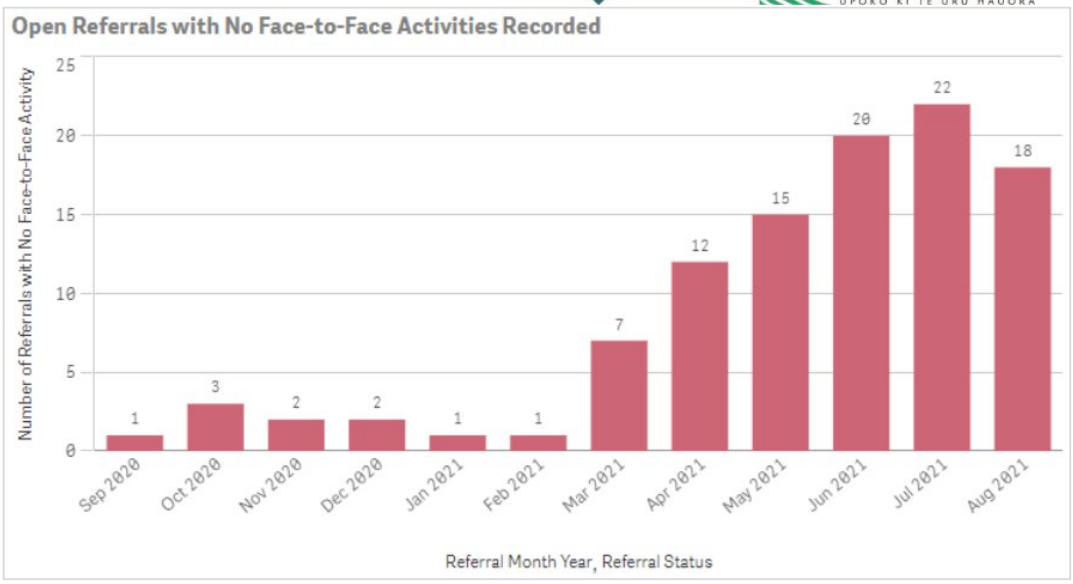
Demand

Waitlists

7. Across New Zealand, there has been an increase in demand for eating disorder services, particularly for young people. CREDS is managing a significant waitlist. Over the past ten years, referrals have nearly doubled overall, and have tripled for those aged 18 and under.

8. A client can be on multiple waitlists within the service at one time, depending on the treatment required by the individual after assessment (e.g. family therapy, individual therapy, day programme, residential treatment and dietetic support).

9. As of June 2021, the CREDS was carrying a caseload of 320 people, with 104 people on the service's waitlist. The mean wait time to first face-to-face contact during the first six months of 2021 was 69.1 days. The mean for 2020 was 81.9 days and for 2019 it was 42.6 days. There is provision for people to be seen more urgently if it is indicated as necessary upon their clinical presentation.



Admissions

10. Admissions to CREDS between 1 January 2010 and 31 December 2020 broken down by age and gender:

Sex / Age Group	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Female	**33**	**44**	**43**	**32**	**35**	**24**	**46**	**51**	**56**	**52**	**45**
0 - 14								2		6	1
15 - 19	10	17	22	15	23	18	23	21	20	17	9
20 - 24	14	14	13	9	8	2	10	15	21	13	15
25 - 29	4	1	4	4	3	2	8	2	3	5	10
30 - 34		3		3			4	4	6	2	2
35 - 39	1	3						3	1	1	1
40 - 44	4	5			1			2		1	1
45 - 49		1		1		2	1				
50 - 54			4					2	2	2	
55 - 59									1	3	2
60 - 64									2	2	4
Male	**4**	**1**	**4**	**2**	**4**	**1**	**3**	**3**	**2**		**2**
0 - 14			2								
15 - 19			2	2	2	1	1	3	2		1
20 - 24		1			2		2				
25 - 29	2										
30 - 34											1
35 - 39	2										
Non-binary										**1**	
20 - 24										1	
Grand Total	**37**	**45**	**47**	**34**	**39**	**25**	**49**	**54**	**58**	**53**	**47**

11. The number of people who have accessed outpatient specialised eating disorder services between 1 January 2010 and 31 December 2020, by sex and age:

Sex / Age Group	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Female	**157**	**162**	**137**	**171**	**158**	**181**	**161**	**214**	**227**	**265**	**252**
0 - 14	9	8	13	25	12	17	13	18	22	27	44
15 - 19	40	51	55	64	76	86	70	89	101	108	102
20 - 24	44	46	35	40	39	35	42	49	40	64	65
25 - 29	25	18	11	16	18	18	12	18	24	31	19
30 - 34	14	16	9	6	3	8	12	15	14	11	7
35 - 39	8	8	3	3	1	3	4	8	5	8	6
40 - 44	7	9	6	8	2	7	5	5	6	5	3
45 - 49	4	3	2	3	4	4	2	6	6	1	3
50 - 54	1	2	4	4	1	1	1	2	4	4	2
55 - 59	1			1	2		2		3	3	
60 - 64	1		2			3		3	1	1	1
65 +	3	1		1			1	1	2	2	1
Male	**14**	**8**	**8**	**7**	**4**	**12**	**16**	**20**	**21**	**21**	**19**
0 - 14	2		3	2		2	4	5	4	4	7
15 - 19	5	5	3	2	3	5	7	8	8	8	4
20 - 24	1	1	1		1	3	3	3	3	2	1
25 - 29	3	1		1		1		1	5	3	4
30 - 34	1	1	1	1			1			1	2
35 - 39	2					1				2	
40 - 44				1			1	1	1		
45 - 49								1			
50 - 54										1	
55 - 59								1			
65 +											1
Unknown										**1**	
15 - 19										1	
Grand Total	**171**	**170**	**145**	**178**	**162**	**193**	**177**	**234**	**248**	**287**	**271**

12. Admission and community referrals to CREDS for 2021:

Month	Community Referrals Received	Admissions
Jan 2021	26	3
Feb 2021	24	1
Mar 2021	39	4
Apr 2021	32	3
May 2021	23	4
Jun 2021	31	8
Jul 2021	29	4
Aug 2021	19	3
Year-to-date Total	**223**	**30**
Unique Individuals	**219**	**25**

Eating Disorder related hospital stays for other areas of the 3DHBs

13. Between 2010 and 2020, 488 people were admitted to other parts of Capital & Coast DHB (including Rangatahi Regional Inpatient Service) for eating disorder related treatment. In 2010, the number was 25 for one year and in 2020 this increased to 88.

14. For HVDHB, 1984 people were admitted between 2010 and 2020. 11 people were admitted in 2010 and 24 in 2020.

15. For WrDHB, 49 people were admitted between 2010 and 2020. Two people were admitted in 2010, increasing to 10 people in 2020.

Improvement activity

16. In May, CREDS began two intensive evidence-based group therapy programmes for waitlisted clients – one for bulimia nervosa and one for anorexia nervosa. This will improve access, enhance client safety, minimise illness impact and reduce reliance on inpatient hospital services.

17. CREDS is remobilising and retraining staff in contemporary, evidence-based family treatment modalities. This will improve capability within the team and reduce wait times.

18. An increasing number of Māori are presenting with eating disorders. To improve the service's ability to provide culturally appropriate responses, CREDS has applied a focus on Māori health at the upcoming National Eating Disorder Forum. The service has also recently employed its first Māori clinical psychologist.

19. CREDS is building capacity in the Central Region by offering three multi-day training events around the region. Capital & Coast DHB is the in New Zealand to offer MANTRA training, a new and highly effective treatment approach developed at the Maudsley

20. The building in which CREDS is currently located is no longer fit for purpose. The building is owned by Kainga Ora, who are attempting to find a new location. Despite an extensive search a suitable alternative is yet to be found.

Health System Committee–Public

29 September 2021

Homelessness, health and COVID-19

Action Required

The Committee notes:

(a) This update on homelessness and how the 2DHBs contribute to addressing this important issue.

(b) Homelessness is part of a wider issue in a housing continuum that faces significant challenges. Working towards a solution requires coordinated cross agency collaboration.

(c) A strategic priority project around emergency housing is a priority this year. Emergency housing is considered a subset of homelessness.

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.
Author	Kiri Waldegrave, Team Leader, Analytical & Policy Team, Regional Public Health
Endorsed by	Rachel Haggerty, Director Strategy Planning and Performance
Presented by	Kiri Waldegrave, Team Leader, Analytical & Policy Team, Regional Public Health Rachel Haggerty, Director Strategy Planning and Performance
Purpose	The purpose of this paper is to report back to HSC the DHBs' contribution to serving the homeless population. This paper distinguishes between health services and public health approach to homelessness.
Contributors	Rachel Pearce, General Manager Commissioning, Families and Wellbeing, 2DHB Strategy Performance & Planning (SPP) Simone Bibby, Public Health Advisor, Analytical & Policy Team, Regional Public Health
Consultation	N/A

Executive Summary

At the 22 July 2020 Health System Committee (HSC) meeting an update was given about COVID-19: Impact, lessons learned and the way forward. During the discussion the HSC expressed interest in homelessness and proposed a report on this issue come back to a future HSC meeting.

Homelessness is part of a wider housing continuum that faces significant challenges. Working towards a solution requires cross agency collaboration. The purpose of this paper is to report back to HSC on the DHBs' contribution to serving the homeless population.

Many teams across the 2DHBs are consolidating relationships with our community and agency partners to address the wider housing continuum issues and prevent people reaching the homelessness end of that continuum. In terms of immediate responses, as DHBs we do not have housing solutions to offer; however, we can intensify our treatment services and support our interagency partners in their work.

This paper outlines existing, established DHB delivered and funded services that support homeless people. It also provides a brief update on the Board endorsed 2021/22 strategic priority project around emergency housing.

Strategic Considerations

Service	Not applicable. This paper does not propose any changes to existing services.
People	Not applicable. This paper does not propose any changes that will impact on employees or contracted staff. It does outline the DHBs' work to support the homeless population in our communities.
Financial	There are no immediate financial implications associated with this paper.
Governance	N/A

Engagement/Consultation

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

Attachment/s

1. The acute demand associated with homelessness across Hutt Valley and Capital & Coast DHBs
2. DRAFT Housing Continuum

Background

At the 22 July 2020 Health System Committee meeting, an update was given about COVID-19: Impact, lessons learned and the way forward. During the discussion the HSC expressed interest in address the issue of homelessness and proposed a report come back to a future HSC meeting.

What is homelessness?

The Severe Housing Deprivation in Aotearoa New Zealand, 2018 report[1] serves as a reminder that those experiencing homelessness are not only those people who are visible on the streets, but includes those who have nowhere to go but night shelters or refuges, those who have to live in a motel, and those who have to stay with friends or whānau, who may already have a full house of their own.

Hutt City Council (HCC) defines homelessness as "as a living situation where people have no option to acquire safe and secure housing. This includes sleeping rough or in vehicles, living temporarily with friends or family or in hostels, motels or overcrowded or unsafe dwellings"[2]. By this definition emergency housing is considered as homeless.

[1] https://www.hud.govt.nz/news-and-resources/statistics-and-research/2018-severe-housing-deprivation-estimate/
[2] huttcity.govt.nz/Your-Council/Projects/homelessness/

In its Homelessness Strategy, the HCC documents the underlying causes of homelessness; "the underlying causes of homelessness are structural – poverty, a lack of affordable homes, and government policy. There are also a number of personal triggers and interrelated factors that can contribute to people losing their homes and these include poor physical or mental health, inadequate income and financial problems, relationship breakdown or family violence, and alcohol and drug abuse. Age is also a factor, with young people being particularly vulnerable to homelessness. All it can take to push a family out of its home is redundancy, unexpected costs, relationship breakdown, or a period of illness."

How and where does homelessness present in our 2DHB community?

While there is a lack of robust data defining the scale and spread of the challenge, there are analytics and insights that shows that homelessness is persistent and increasing across our 2DHB region.

Researchers at the University of Otago have investigated census data and shown that in 2013, 41,000 New Zealanders were severely housing deprived. 4,197 of these households were sleeping rough and 8,445 were living in non-private dwellings such as emergency accommodation and boarding houses, while 28,563 lived in crowded and other inadequate housing[3].

Hutt City Council identified in their 2018 homelessness research that the number of homeless households in Lower Hutt increased by 41% between the Census in 2006 and 2013.

Ministry of Housing and Urban Development (HUD) indicate that the severely housing deprived population is disproportionately young, with close to half aged under 25 years of age. Māori and Pacific people's severe housing deprivation prevalence rates were three and five times the European rate, respectively.

Another measure of homelessness is the Emergency Housing Special Needs Grant (EH SNG) which helps individuals and families with the cost of staying in short-term accommodation if they are unable to access one of HUD's contracted transitional housing places[4]. In the greater Wellington region for the quarter ending 30 June 2021, there have been 3,614 grants made supporting 1,039 households. The total amount granted in the quarter ending 30 June 2021 was $12,290,086[5].

What do we know about homeless people's health needs and utilisation?

Attachment 1 provides data on the utilisation of DHB delivered services by homeless people in our area.

The homeless community are high users of our emergency departments. Between 2016 and 2020, there has been a 60% increase in presentations to Wellington ED for homeless people. The most

[3] Amore K. Severe Housing Deprivation in Aotearoa/New Zealand 2001 – 2013, (University of Otago, 2016). http://www.healthyhousing.org.nz/wp-content/uploads/2016/08/Severe-housing-deprivation-in-Aotearoa-2001-2013-1.pdf

[4] https://www.hud.govt.nz/assets/News-and-Resources/Statistics-and-Research/Public-housing-reports/Regional-factsheets-June-2021/Housing-regional-factsheets-June-2021-Wellington.pdf

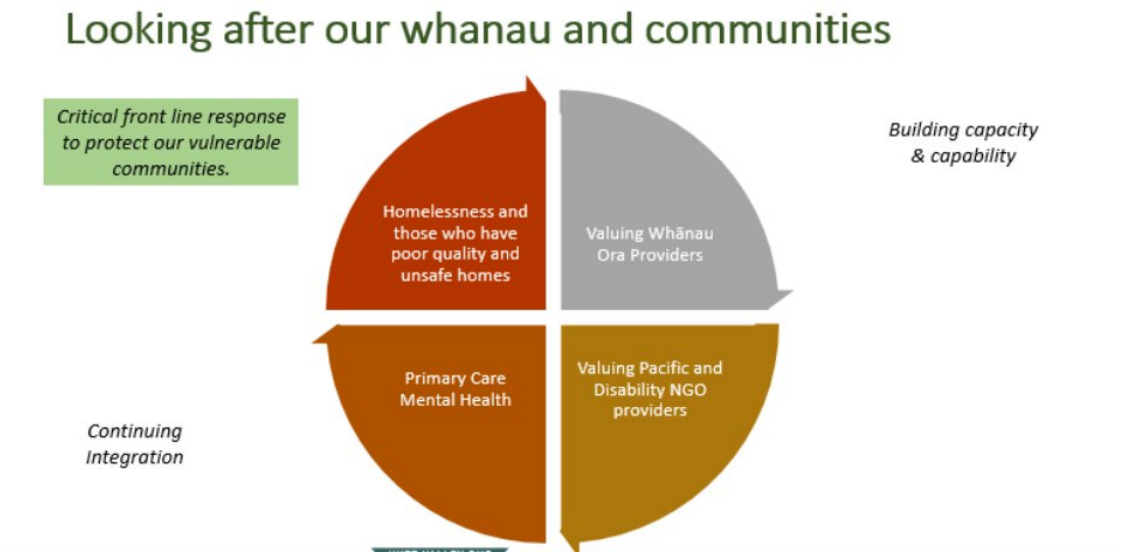
[5] https://www.hud.govt.nz/assets/News-and-Resources/Statistics-and-Research/Public-housing-reports/Regional-factsheets-June-2021/Housing-regional-factsheets-June-2021-Wellington.pdf

significant growth has been in presentations for the episodically homeless, having more than doubled in that time.

Overall, 66% of presentations were physical health related while 31% were mental health related. Between 2016 and 2020, the number of physical health related presentations increased 53% while mental health related presentations increased 80%. Within the same timeframe, secondary mental health service usage by the homeless cohort had only increased 10%.

What are our DHBs doing?

At the 22 July 2020 HSC meeting the following slide was presented. As part of our COVID-19 response, it a priority to look after our whānau and communities, for example those who are homeless or live in poor quality and unsafe housing, through continuing integration.



Throughout the COVID-19 response, the 2DHB team, including Regional Public Health (RPH), continue to grow their relationships with external stakeholders such as the Homelessness Prevention service run by Takiri Mai te Ata Whanau Ora Collective and the Ministry of Social Development to ensure critical front line response to protect vulnerable communities. Through both the 2020 and 2021 COVID-19 lockdowns, the DHB ensured there were clear and well communicated process to identify and support the unique needs of homeless people through lockdowns.

Outside of COVID-19 responses, DHBs have a small number of targeted services available to support homelessness. Most of the DHBs investment in homelessness support is mental health services, public health services and ED services. These are outlined below.

Mental health

Te Roopu Āramuka Whāroaroa (Āramuka) is a small team that works alongside TACT (Team for Assertive Community Treatment). They specifically work with people who are homeless but do not necessarily have a mental health illness. Āramuka was implemented in November 2010 to improve the health and wellbeing of people with complex needs who are homeless. Āramuka consists of a multi-partnership approach which supports an integrated, collaborative service provision for a small group of priority people who are homeless and furthest from having their needs met across secondary and primary care.

Examples of what Āramuka provide for its clients include:

- **psychologists** who provide non-drug treatments like cognitive behavioural therapy (CBT), and eye movement desensitisation reprocessing (EMDR) to provide tools for people to better manage stress and mitigate their problems.
- **mental health nurses** help with medication, advocacy and assessment.
- **occupational therapists** who have skills to engage clients in everyday activities of interest, paid or volunteer work, outside interests and activities to get you on the road to feeling better.
- **social workers** who provide talking therapy, support with families, psychosocial education, support with social services and connecting people with communities.
- **Psychiatrists** who can prescribe medication if it is the best option.

Āramuka can be accessed initially through Te Haika, the 24/7 mental health and addiction contact centre.

Emergency Department services

Emergency Departments are available 24/7 to support people with a range of urgent physical and mental health needs. Attachment 1 outlines ED utilisation for homeless people between 2016 and 2020.

Public health

Homelessness and emergency housing are at the pointy end of the broad housing continuum. Intervention at all levels is required to help reduce the number of people experiencing homelessness. RPH are actively engaged in a number of cross agency collaborations to address issues along the housing continuum, as outlined in Table 1 below.

Table 1: Organisations RPH and the 2DHBs are working with to address housing

Organisation	Description	RPH/DHB involvement
Wellington and Porirua Cross Sector Strategic Leadership group ending homelessness	This group provides leadership for cross sector initiatives aimed at ending homelessness in Wellington and Porirua	Member of Leadership group
Homelessness Prevention service run by Takiri Mai te Ata Whanau Ora Collective	The Homelessness Prevention Service aims to support whānau living in private rentals, kainga ora in Lower Hutt who are at risk of becoming homeless without early intervention. We also support whānau living in or in need of Emergency or Transitional Housing, Homeless in the Home whānau are also welcome. The Homelessness Prevention team will: Provide a FREE service for whānau • Support whānau living in private rentals and Kainga Ora properties • Offer support from our specialist team which	Member of the Lower Hutt Housing and Homelessness Network

	includes:- ○ Healthy Living Kaiārahi ○ Sustaining Tenancies Kaiārahi ○ Budget Advice Kaiārahi with our partner Petone Budget Service Incorporated ○ Wā Kāinga Hub Kaiarahi – supporting whanau in Emergency Housing, Trasitional Housing, Homeless in the Home etc. • Support whānau living in **Lower Hutt** • We cover the whole population including Māori, Pacific and other whānau • Support and advocate for whānau with their landlord • Connect whānau with health and social services Wā Kāinga Hub – providing Housing Advice clinics in the Lower Hutt community including Naenae, Petone, Wainuiomata and Lower Hutt CBD. Wā Kāinga Hub – whānau housing training programme to be launched October 2021	
Hutt City Council, Lower Hutt Homelessness Strategy	Following in-depth engagement, Council and partners agreed the Lower Hutt homelessness Strategy. Council has funded actions under the action plan for this strategy. Housing is a major issue for Council and we will work alongside our partners in the city and in Government to improve the response to homelessness and the delivery of suitable and affordable homes.	Policy advice and support in the development of the Lower Hutt Homelessness Strategy
Well Homes A partnership between Tū Kotahi Māori Asthma Trust, Sustainability Trust, Regional Public Health and He Kainga Oranga	Well Homes helps whānau to live in a warm, dry, safe and healthy home. Well Homes is a housing coordination service for the Wellington Housing assessors visit a home to conduct healthy housing assessments and provide education. They link whānau to appropriate services such as insulation, heating, curtain banks, beds, bedding, carpets, rugs, financial assistance and social housing providers. We have an automated referral system, so people admitted to hospital with respiratory problems are automatically offered the service. Through Well Homes RPH is able to maintain and develop relationships with the Ministry of Social Development and Kainga Ora.	Continued to support and enhance the Well Homes service, which supports whānau to make their homes warmer, safer and drier.
Wellington Regional Healthy Housing Group	https://www.wrhhg.org.nz/ WRHHG develops creative and scaled solutions to Wellington region's poor housing quality through our collaborative cross-sectoral leadership.	Founding member of steering and working groups. Financial contributor for the executive

	We operate through a collective impact model and commit to upholding Te Tiriti o Waitangi principles, working in partnership to reduce housing and housing-related health inequalities. Members: https://www.wrhhg.org.nz/members-list/ Strategy and Action Plan https://www.wrhhg.org.nz/strategy-and-action-plan/	officer role of the WRHHG.
University of Otago (Wellington) **He Kainga Oranga Housing and Health Research Programme (via Wellhomes)**	https://www.healthyhousing.org.nz/ He Kainga Oranga, the Housing and Health Research Programme, examines and clarifies the links between Housing and Health. Although the association between poor housing and ill health is known, the links that make up the causal chain have until recently been poorly understood. Conducting our own studies and examining existing evidence enables us to identify and evaluate housing-related interventions to improve individual, family and community health. Our multi-disciplinary team has expertise in both qualitative and quantitative disciplines. We are based at the University of Otago, Wellington. We are funded by the Health Research Council of New Zealand and Ministry of Business, Innovation & Employment.	Engagement via Well Homes

Future opportunities

Public health response

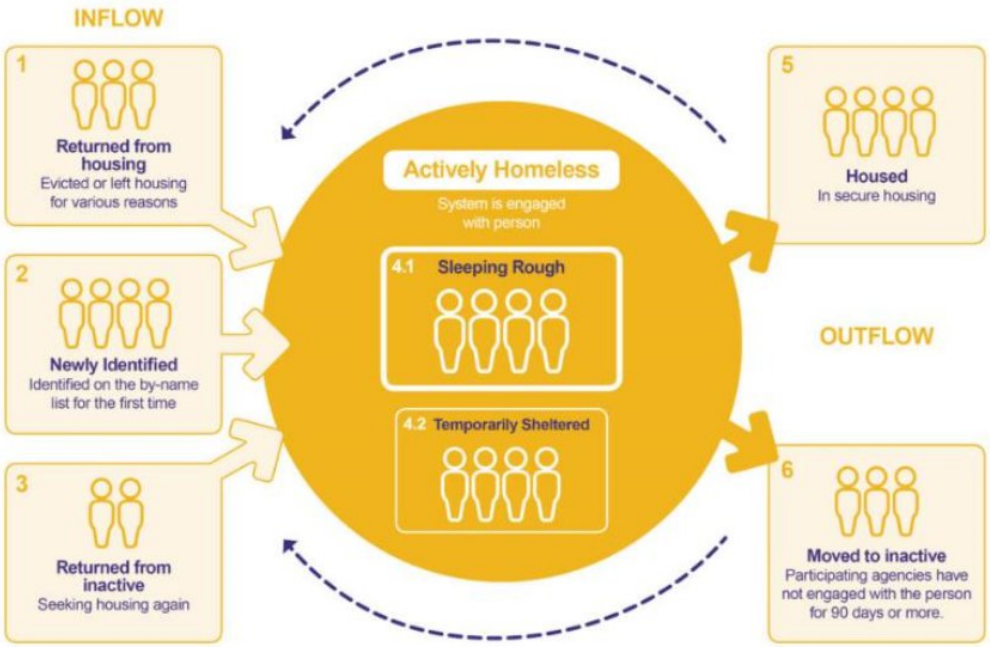
There is room for the health sector to be involved in supporting everyone in the Wellington region living in warm, dry and safe housing[6] . Our role is not to invest in bricks and mortar housing solutions; it is about simplifying and intensifying our treatment services and continuing to influence and support cross agency efforts to end homelessness and ensure people are living in warm dry safe homes.

Some of the cross agency work we will keep doing to achieve this is supporting initiatives like:

- Tuanui – Wainuiomata Healthy Homes for All;
- The Hutt City Council Homelessness Strategy; and
- The Porirua Cross Sector Strategic Leadership group ending homelessness who are looking at how to collate and present timely data on homelessness. One model being considered is the

[6] The Wellington Regional Healthy Housing group vision

Adelaide Zero Project Dashboard which clearly articulates some pathways and data points for people who find themselves homeless. (see below)



2021/22 Support for Emergency and Social Housing

The "Intersectoral Priorities" Strategic Priority includes a project to enhance primary care support provided to people in emergency and social housing. In addition to removing barriers to care for people and whanau living in temporary and transitional housing, the project aims to ensure people are enrolled with primary care so that ongoing health needs are met.

In the remaining months of 2021, SPP will work with service and community partners to develop a business case to delivery primary health care in an innovative and response way. It is anticipated that the business case will be completed in December 2021, with a view to commence procurement for new services in February 2022, with service delivery to commence in March and April 2022.

The acute demand associated with homelessness across Hutt Valley and Capital & Coast DHBs

The StatsNZ definition of Homelessness was used

"Living situations where people with no other options to acquire safe and secure housing:

- *are without shelter*
- *in temporary accommodation*
- *sharing accommodation with a household; or,*
- *living in uninhabitable housing"*

Various data sources were used to apply this definition this definition (see appendix 1 & 2).

3,003 individuals were identified who were homeless at some stage during the 2019 and 2020 calendar years.

The homeless population can be segmented using the *'Types of Homelessness'* model

Transitionally Homeless

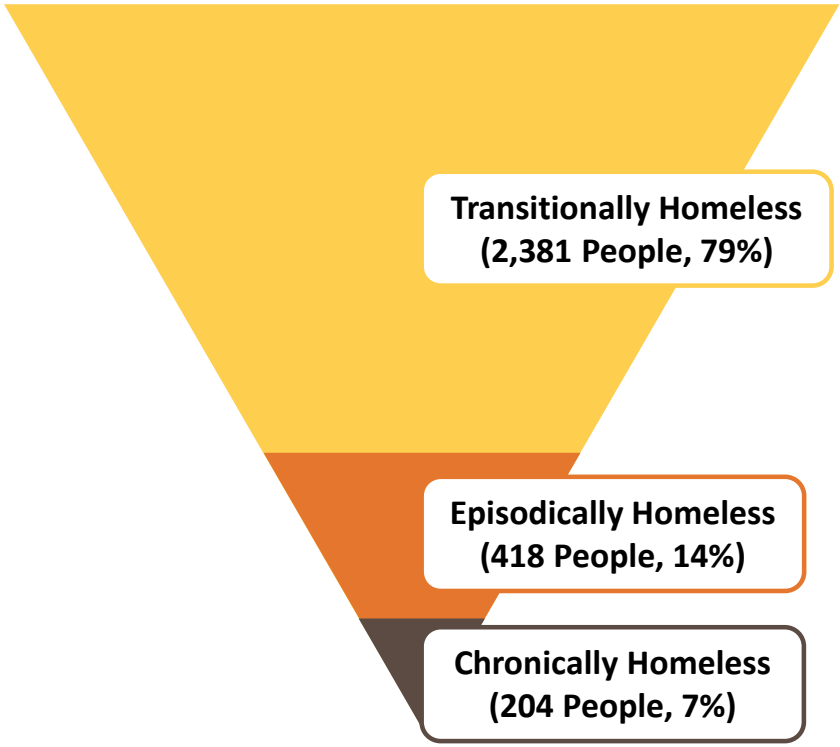
- People who are only homeless for a short period of time. Likely due to a situational crisis causing them to lose stable accommodation.
- Less than 30 days

Episodically Homeless

- People with a recurring pattern of temporary homelessness. Likely due to unstable financials or addiction problems.
- More than 30 days, less than 1 year

Chronically Homeless

- People who have been persistently homeless for over a year. Likely due to a range of compounding factors (education, long term conditions, etc.)
- Longer than 1 year



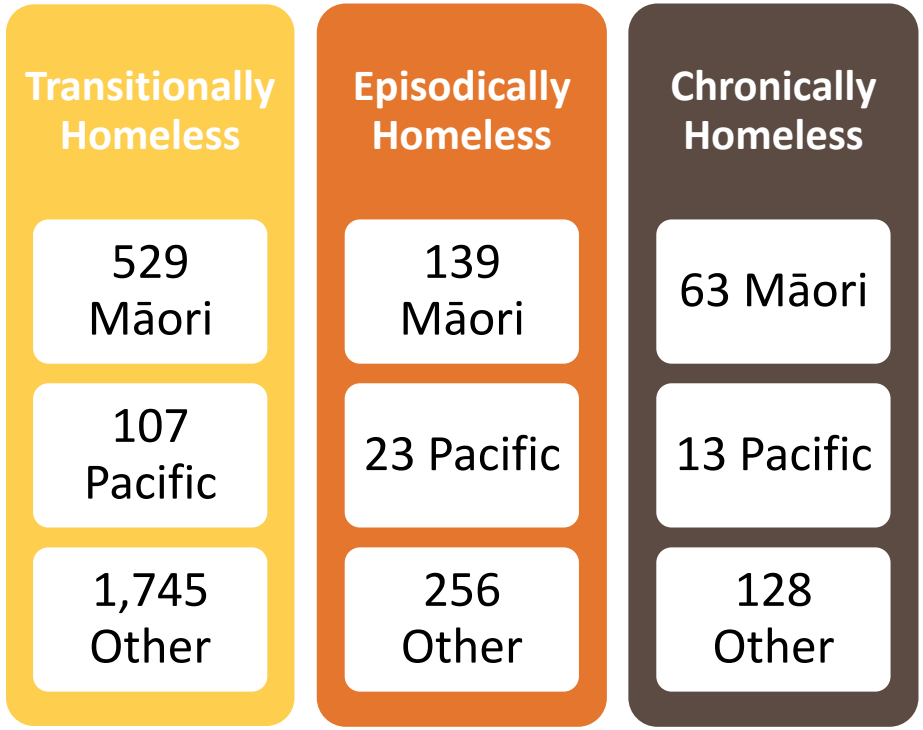
Source: Sam Tsemberis, Founder, Pathways to Housing.

Who are they?

Māori and Pacific are over-represented in homelessness statistics and more likely to experience longer term homelessness

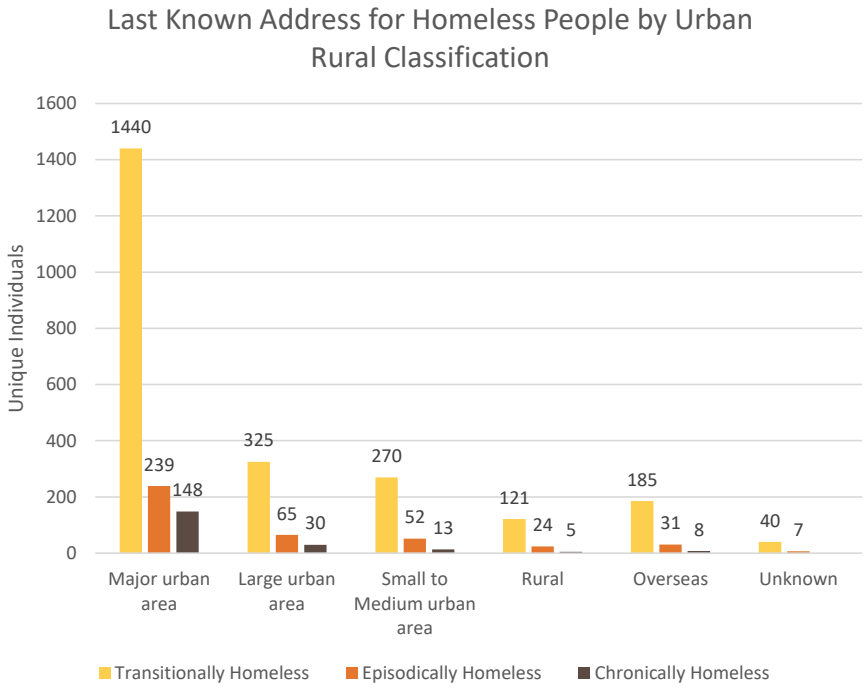
- Of the 3,003 people identified as homeless
  - 24% are Māori,
  - 5% are Pacific,
  - 71% are non-Māori, non-Pacific.

- Māori and Pacific are over-represented in the episodically and chronically homeless group
  - 32% are Māori
  - 6% are Pacific



Where do they reside?

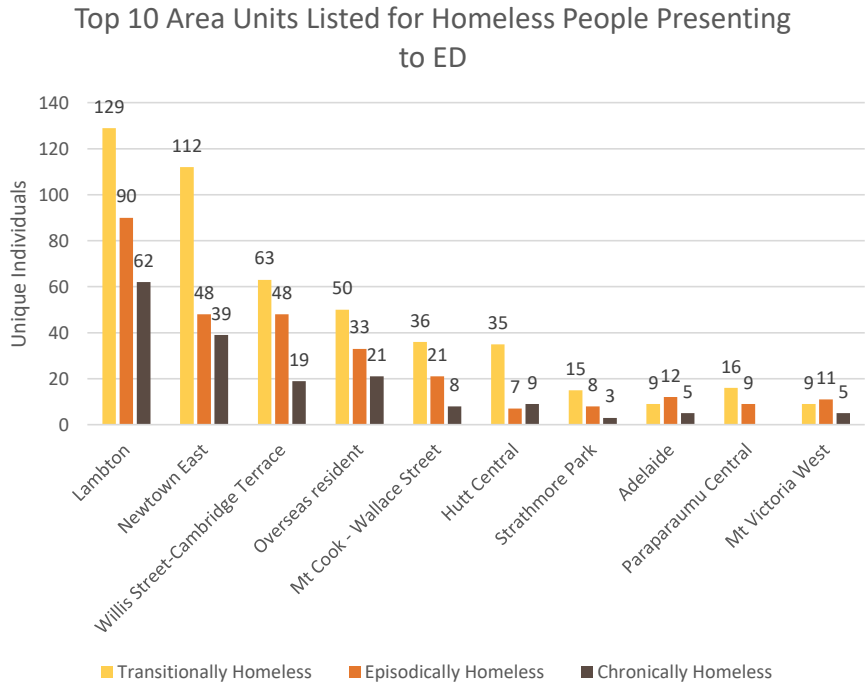
- The last known address for people identified as homeless was in major urban areas.
  - 65% of addresses listed were within 2DHB localities.
  - Anecdotal evidence suggests that this is due to the lack of support services in smaller and rural areas.



Where do they reside?

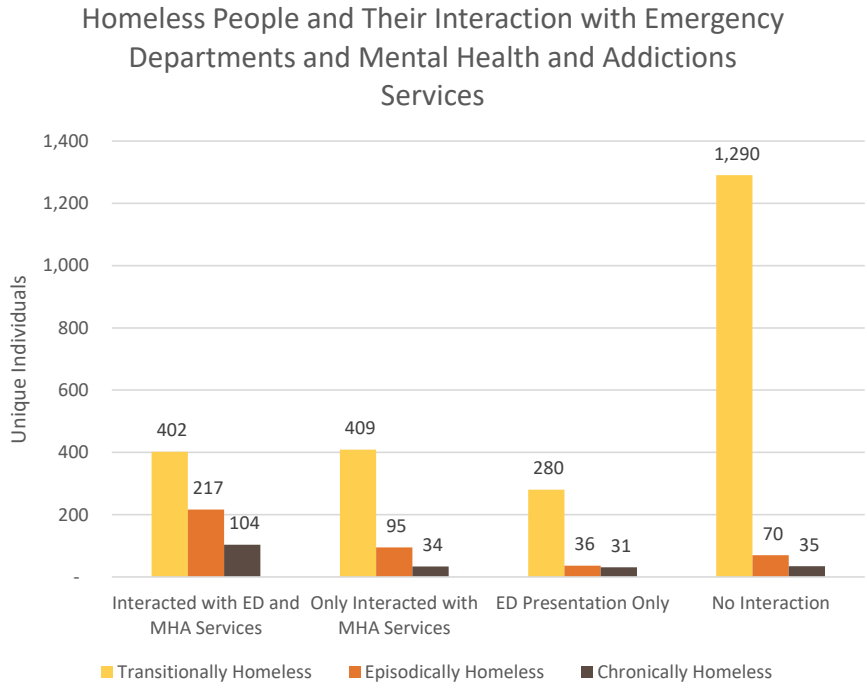
- Homeless people presenting to ED list some common areas when asked where they lived:
  - Lambton
  - Newtown East
  - Willis Street – Cambridge Terrace
  - Mt Cook – Wallace Street
  - Hutt Central.

- These areas were chosen likely due to the primary homeless shelters and support services located in these areas.



Interaction with Services

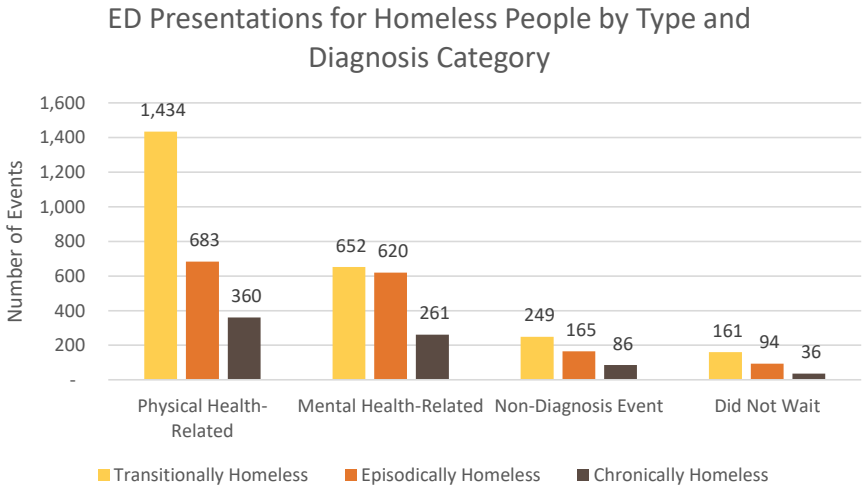
- The majority of transitionally homeless (54%) had not interacted with ED or MHA services at all in 2019 and 2020.
- In contrast, the majority of episodically and chronically homeless (52%) had interacted with both ED and MHA services at some point in 2019 and 2020.



1,075 homeless people presented a total of 4,775 times to 2DHB EDs

- The primary reason for presentation to ED was physical health related:
  - 76% of homeless people had presented for physical health reasons at some point in 2019 or 2020.
- The majority of episodically and chronically homeless presented to ED for mental health reasons:
  - 65% of episodically and chronically homeless people presented for mental health reasons in 2019 and 2020. For transitionally homeless that figure is 37%.

Transitionally Homeless	Episodically Homeless	Chronically Homeless
687 People	253 People	135 People
2,464 Presentations	1,537 ED Presentations	733 ED Presentations

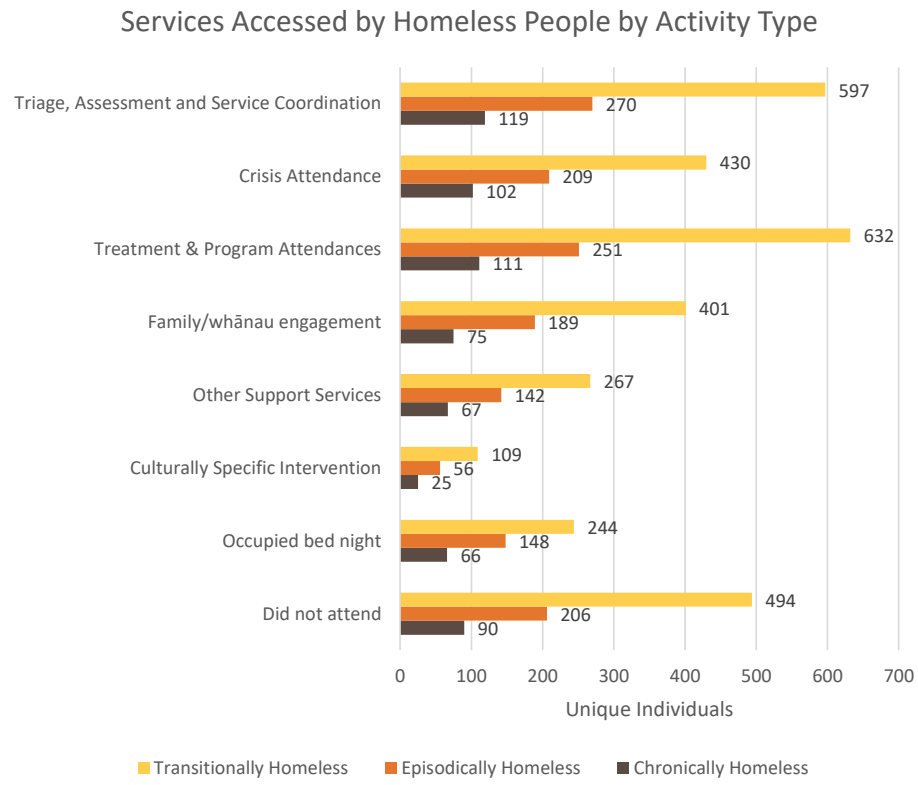


There are two key pathways into specialist mental and addiction services:

- a triage service like Te Haika; or
- a crisis assessment team

- Due to the range of problems afflicting people identified as homeless, access to mental health services is obstructed:
  - Te Haika declined 49% of homeless people during triage into specialist mental health services. For the general population people, this rate was 29%.
  - 83% of homeless people who were declined by Te Haika went on to have a crisis attendance.

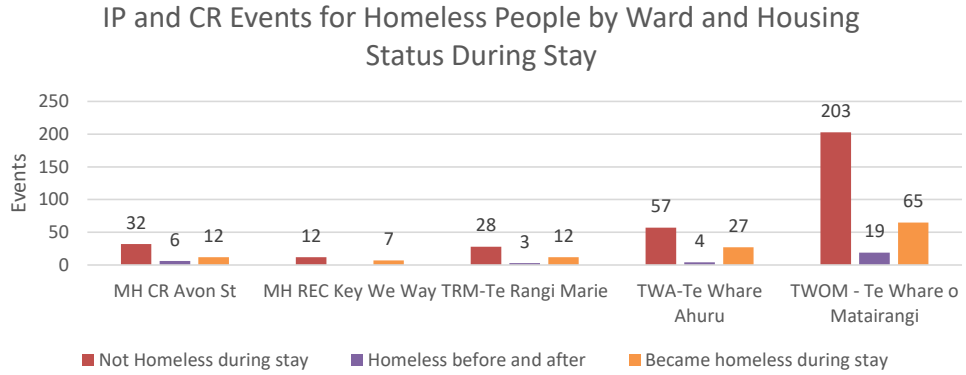
"...Research [shows] that successful exit from homelessness relies as much on access to support...as the housing itself."

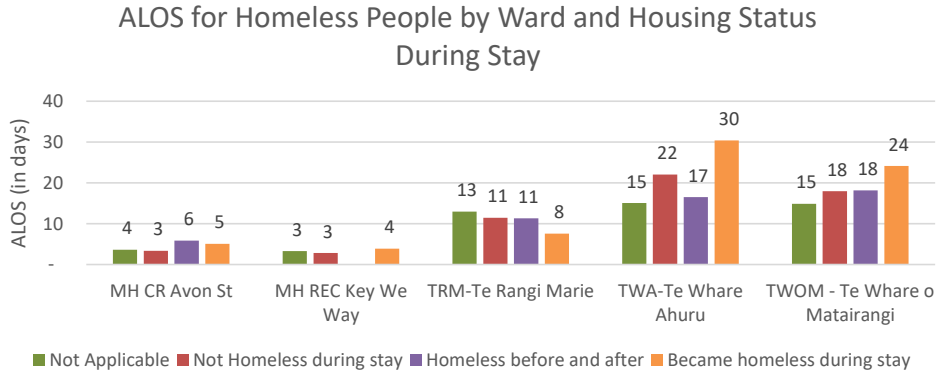


For some people, being admitted to hospital or a residential facility can risk losing stable accommodation

- During analysis, the Acute Care Continuum working group raised concerns about people losing stable accommodation during an admission to Inpatient (IP) and Crisis Respite (CR) facilities.

- A sample was analysed to better understand the nature of these incidents.
  - Of the 449 events analysed, 112 resulted in people becoming homeless during their stay (25%).
  - For admissions to Te Whare Ahuru, the average length of stay (ALOS) doubled for those who became homeless during their stay.
  - Those who became homeless during their stay at Te Whare o Matairangi stayed for 60% longer on average.





Note: Not Applicable refers to non-homeless people to provide a baseline comparator

In summary:

- Homelessness can be experienced for a short time or a long time. The longer one remains homeless, the harder it seems to reintegrate into society.
- For the most part, people who access recovery support services and transitional accommodation quickly are able to recover.
- Meanwhile, those suffering from long term homelessness are likely to develop further problems due to their unstable and unsuitable living conditions.

Transitionally homeless	Episodically and chronically homeless
Short term crisis that causes a temporarily destabilised living situation	Long term unstable and unsuitable living conditions
Able and wanting to get temporary accommodation and improve their situation	Long term conditions or issues that make it difficult to improve their situation
Low levels of interaction with the health sector	High levels of interaction with the health sector (particularly ED and Mental Health/Addiction)

Next steps

- Conduct qualitative research and design a complexity grid tool that identifies at-risk factors contributing towards homelessness.
- Engage with peer organisations like Regional Public Health, Kokiri Marae, and DCM to co-design a whole-of-system framework for remedying homelessness.
- Create two separate approaches: One for the chronically and episodically homeless, and one for the transitionally homeless.
- Providing follow-up support in homeless shelters and resource in emergency departments to address their needs in a safe, non-discriminatory space.

Appendix one:
defining types of homelessness

Datasource/Homeless Category Definition	Transitionally Homeless	Episodically Homeless	Chronically Homeless
Conformed_Patient	A single entry with address as 'No Fixed Abode', or known service provider of supported accommodation	More than one entry with address as 'NFA', or known service provider of supported accommodation with a duration less than one year	More than one entry with address as 'NFA', or known service provider of supported accommodation with a duration less than one year
ED_Event	ED notes list housing/homeless as a problem		
MH_Supplementary Consumer Record	Single collection with Accommodation Status as 'Homeless'	Between two and six collections with Accommodation Status as 'Homeless'	More than six collections with Accommodation Status as 'Homeless'
PRIMHD	A referral with housing support services	More than one referral with housing support services	

Appendix Two:
Known Addresses for Supported Accommodation

- Wellington Night Shelter (304 Taranaki Street)
- Men's Night Shelter (138 Owen Street, 285 Hereford Street)
- Homeless Shelter (Pringle Avenue)
- Women's Refuge Centre
- DCM (2 Lukes Lane)
- MASH Trust (18 Anderson Street, 1 Ribbonwood Terrace, 8 Baffin Grove, 601 Main Street)
- PATHWAYS Trust (28 Hanson Street, 719A Fergusson Drive)
- Salvation Army
- Beach Street Emergency Shelter
- Emergency Housing
- Transitional Housing

Attachment 2: Draft Housing Continuum