CAPITAL & COAST DISTRICT HEALTH BOARD

Health System Committee

Public Agenda

17 APRIL 2019

Board Room, Level 11, Grace Neill Block, Wellington Regional Hospital
9am to Midday

	ITEM	ACTION	PRESENTER	MIN	TIME	PG
1 PROCEDURAL BUSINESS					9am	
1.1	Karakia					
1.2	Apologies	**Records**	F Wilde			
1.3	Continuous Disclosure – Interest Register	**Accepts**	F Wilde			2
1.4	Confirmation of Draft Minutes 13 March 2019	**Approves**	F Wilde			5
1.5	Matters Arising	**Notes**	F Wilde			
1.6	Action List	**Notes**	F Wilde			11
1.7	Annual Work Programme	**Approves**	R Haggerty			14
2 PRESENTATION						
2.1	Acute Planning	**Notes**	R Haggerty			15
3 DECISION						
3.1	Porirua Skin Project Update	**Endorses**	R Haggerty			44
4 DISCUSSION						
4.1	AOD Model of Care Appendix 1 Stakeholder Engagement Map Appendix 2 FTE per Physical Location Appendix 3 Kaupapa Māori FTE Appendix 4 Investment Opportunities	**Notes**	R Mariner and A Nelson			51 56 57 58 59
4.2	3DHB ICT Strategy	**Notes**	R Anthony			60
4.3	Citizens Health Council Update	**Notes**	D Crossan			67
4.4	Investment and Performance – Older Persons Services, Community Pharmacy, Primary Heath Organisations, and Community Dental Services	**Notes**	R Haggerty			73
5 INFORMATION						
5.1	Pacific Update	**Notes**	T Fagaloa			83
6 OTHER						
6.1	Resolution to Exclude	**Agree**	F Wilde			88

DATE OF NEXT MEETING 15 MAY – LEVEL 11, BOARD ROOM GRACE NEILL BLOCK WELLINGTON REGIONAL HOSPITAL

HEALTH SYSTEM COMMITTEE

Interest Register

UPDATED AS AT APRIL 2019

Name	Interest
Dame Fran Wilde *Chairperson*	• Ambassador Cancer Society Hope Fellowship • Chief Crown Negotiator Ngati Mutunga and Moriori Treaty of Waitangi Claims • Chair, Remuneration Authority • Chair Wellington Lifelines Group • Chair National Military Heritage Trust • Deputy Chair, Capital & Coast District Health Board • Director Museum of NZ Te Papa Tongarewa • Director Frequency Projects Ltd • Chair, Kiwi Can Do Ltd
Mr Andrew Blair *Member*	• Chair, Capital & Coast District Health Board • Chair, Hutt Valley District Health Board • Chair, Hutt Valley DHB Hospital Advisory Committee • Chair, Queenstown Lakes Community Housing Trust • Member, State Services Commission Advisory Group on Crown Entity Chief Executive Remuneration • Member of the Governing Board for the Health Finance, Procurement and Information Management System business case • Member, Hutt Valley DHB combined Disability Support Advisory Committee • Member, Hutt Valley DHB Community and Public Health Advisory Committee • Member, Capital & Coast DHB Finance, Risk and Audit Committee • Member, Capital & Coast Health Systems Committee • Owner and Director of Andrew Blair Consulting Limited, a Company which from time to time provides governance and advisory services to various businesses and organisations, include those in the health sector • Former Member of the Hawkes Bay District Health Board (2013-2016) • Former Chair, Cancer Control (2014-2015) • Former CEO Acurity Health Group Limited • Advisor to Southern Cross Hospitals Limited and Central Lakes Trust to establish an independent short stay surgical hospital in the Queenstown Lakes region • Advisor to the Board of Breastscreen Auckland Limited • Advisor to the Board of St Marks Women's Health (Remuera) Limited
Ms Sue Kedgley *Member*	• Member, Capital & Coast District Health Board • Member, CCDHB CPHAC/DSAC • Member, Greater Wellington Regional Council • Member, Consumer New Zealand Board • Deputy Chair, Consumer New Zealand • Environment spokesperson and Chair of Environment committee, Wellington Regional Council

Name	Interest
	• Step son works in middle management of Fletcher Steel
Dr Roger Blakeley *Member*	• Member of Capital and Coast District Health Board • Deputy Chair, Wellington Regional Strategy Committee • Councillor, Greater Wellington Regional Council • Director, Port Investments Ltd • Director, Greater Wellington Rail Ltd • Economic Development and Infrastructure Portfolio Lead, Greater Wellington Regional Council • Member, Harkness Fellowships Trust Board • Independent Consultant • 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 • Member of the Wesley Community Action Board • Member of the Regional Steering Group, Warm Healthy Homes
Ms ‘Ana Coffey *Member*	• Member of Capital & Coast District Health Board • Councillor, Porirua City Council • Director, Dunstan Lake District Limited • Trustee, Whitireia Foundation • Brother is Team Coach for Pathways and Real Youth Counties Manukau District Health Board • Father is Acting Director in the Office for Disability Issues, Ministry of Social Development
Ms Eileen Brown *Member*	• Member of Capital & Coast District Health Board • Board member (until Feb. 2017), Newtown Union Health Service Board • Employee of New Zealand Council of Trade Unions • Senior Policy Analyst at the Council of Trade Unions (CTU). CTU affiliated members include NZNO, PSA, E tū, ASMS, MERAS and First Union • Executive Committee Member of Healthcare Aotearoa • Executive Member of Health Benefits of Good Work • Nephew on temporary CCDHB ICT employment contract
Ms Sue Driver *Member*	• Community representative, Australian and NZ College of Anaesthetists • Board Member of Kaibosh • Daughter, Policy Advisor, College of Physicians • Former Chair, Robinson Seismic (Base isolators, Wgtn Hospital) • Advisor to various NGOs
Mr Fa’amatuainu Tino Pereira *Member*	• Managing Director Niu Vision Group Ltd (NVG) • Chair 3DHB Sub-Regional Pacific Strategic Health Group (SPSHG) • Chair Pacific Business Trust • Chair Pacific Advisory Group (PAG) MSD • Chair Central Pacific Group (CPC) • Chair, Pasefika Healthy Home Trust • Establishment Chair Council of Pacific Collectives

Name	Interest
	• Chair, Pacific Panel for Vulnerable Children • Member, 3DHB CPHAC/DSAC
Dr Tristram Ingham *Member*	• Senior Research Fellow, University of Otago Wellington • Member, Capital & Coast DHB Māori Partnership Board • Member, Scientific Advisory Board – Asthma Foundation of NZ • Chair, Te Ao Mārama Māori Disability Advisory Group • Councillor at Large – National Council of the Muscular Dystrophy Association • Member, Executive Committee Wellington Branch MDA NZ, Inc. • Trustee, Neuromuscular Research Foundation Trust • Member, Wellington City Council Accessibility Advisory Group • Member, 3DHB Sub-Regional Disability Advisory Group • Professional Member – Royal Society of New Zealand • Member, Institute of Directors • Member, Health Research Council College of Experts • Member, European Respiratory Society • Member, Te Ohu Rata o Aotearoa (Māori Medical Practitioners Association) • Director, Miramar Enterprises Limited (Property Investment Company) • Wife, Research Fellow, University of Otago Wellington

CAPITAL AND COAST DISTRICT HEALTH BOARD
DRAFT Minutes of the Health System Committee
Held on Wednesday 13 March 2019 at 9am
Board Room, Level 11, Grace Neill Block, Wellington Regional Hospital

PUBLIC SECTION

PRESENT

COMMITTEE:	Dame Fran Wilde (Chair) Ms Sue Kedgley Dr Roger Blakeley Ms Eileen Brown Ms Ana Coffey (9.15am) Ms Sue Driver Mr Tino Fa'amatuainu Pereira Dr Tristram Ingham (arrived 9.06am)
STAFF:	Ms Rachel Haggerty, Director, Strategy Innovation and Performance Mrs Robyn Fitzgerald, Committee Secretary Ms Wikke Bargh-Koopmans, Senior Advisor Accountability Team Ms Wendy Page, Business Support Manager Ms Taima Fagaloa, Director Pacific People Health Ms Julie Patterson, Interim CEO, CCDHB (arrived Ms Astuti Balram, ICC Programme Manager Ms Sandy Blake, General Manager, Quality Improvement & Patient Safety Mr Thomas Davis, General Manager, Corporate Services Mr Arish Naresh, Executive Director, Allied Health Scientific
PRESENTERS:	Dr Ken Greer, Clinical Lead Pathway (Item 2.1) Ms Carey Virtue, Executive Director, Operations Medicine Cancer & Community (Item 4.3) Ms Delwyn Hunter, Executive Director, Operations
GENERAL PUBLIC:	Dr Kathryn Adams, Capital & Coast District Health Board member; a member of the public arrived at the meeting at 9.04am.

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1 PROCEDURAL BUSINESS

1.1 PROCEDURAL

Tino Pereira opened the meeting with a prayer and blessing. Dame Fran Wilde, welcomed members of the public and DHB staff.

1.2 APOLOGIES

Apologies received from Sue Emirali, Bob Francis and Andrew Blair.

1.3 INTERESTS

1.3.1 Interest Register

No changes received. Eileen Brown informed the Committee that should industrial issues arise during the meeting that she will remove herself from the meeting until discussions have been completed.

1.4 CONFIRMATION OF PREVIOUS MINUTES

The minutes of the CCDHB Health System Committee held on 13 February 2019, taken with public present, were confirmed as a true and correct record.

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

1.5 MATTERS ARISING

1.6 ACTION LIST

The reporting timeframes on the other open action items were **noted**.

1.7 ANNUAL WORK PROGRAMME

The Committee:

(a) **Noted** that an update will be provided to the Committee on Dementia Services and Aged Residential Care in April;

(b) **Noted** that a meeting with the School of Medicine is scheduled for March as the Dean is currently on leave.

Note the agenda items are presented in the order that the Committee considered them.

4 DISCUSSION

4.3 HOSPITAL & HEALTHCARE SERVICES (HHS) BI-MONTHLY PERFORMANCE REPORT

The paper was taken as **read**.

The Committee:

(a) **Noted** the impact on service provision that has resulted from the RMO industrial action and the anticipated effect of the other planned strikes;

(b) **Noted** the work underway to ensure standards of instrument sterility continue to be met;

(c) **Noted** the outsourcing of some pharmaceutical manufacture as a result of machine failure in pharmacy;

(d) **Noted** the work underway with Hutt Valley to develop options for managing dialysis capacity for the region;

(e) **Noted** the preparations being made for the implementation of the National Bowel Screening Programme at CCDHB in March 2020 ;

(f) **Noted** the continued growth of the regional Cardiology service;

(g) **Noted** the higher access rates for Māori and Pacific peoples for cataract surgery.

(h) **Noted** the potential for significant impact on health care delivery with the expansion of genomic medicine;

(i) **Noted** the Key Performance and health target results;

HSC recommends the Board:

(a) **Note** the paper.

Actions:

1. Management to provide an update to the Board on what CCDHB is doing in relation to the Holidays Act at the next Board meeting;
2. Management to provide more details on the new protocols being developed in the Emergency Department on Equity for Māori.

2 PRESENTATION

2.1 3DHB FALLS AND FRACTURE PREVENTION PROJECT

The Committee:

(a) **Noted** and thanked Dr Greer for his informative presentation.

Action:

3. Management to make the presentation available to the general public.

3 DECISION

3.1 FIRST DRAFT ANNUAL PLAN 2019/20 INCLUDING STATEMENT OF INTENT (SOI) AND STATEMENT OF PERFORMANCE EXPECTATIONS (SPE)

The paper was taken as **read**.

The Committee:

(a) **Noted** the Minister of Health's Letter of Expectations, outlining Government priorities;

(b) **Noted** that the Ministry of Health has provided the Annual Plan 2019/20 Guidance;

(c) **Noted** that the proposed Service changes must be submitted to the Ministry of Health by 8 March;

(d) **Noted** that the first draft Annual Plan 2019/20 will be presented at the March Board meeting;

(e) **Approved** the first draft Annual Plan 2018/19 for inclusion in the 27 March Board papers;

(f) **Noted** that the first draft Annual Plan 2019/20 must be submitted to the Ministry of Health by 8 April;

(g) **Delegated Authority** to the Director SIP to make any changes to the Annual Plan that ELT may require;

(h) **Provided feedback** on the changes to the Annual Plan to Chief Executive and Director, SIP by close of business Tuesday 19 March prior to presentation of the first draft Annual Plan to the Board;

(i) **Noted** that the Sub Regional Pacific Strategic Advisory Group will provide feedback of the Annual Plan to the Ministry of Health's Pacific Group;

(j) **Noted** that FRAC will discuss the financial aspects of the Annual Plan on 27 March.

HSC recommends the Board:

(a) **Note** the paper.

Actions:

4. Management to include a diagram and context, including achieving equity, in the Chair or CEO's report of what CCDHB are doing in the Annual Plan and Statement of Intent.
5. Management to discuss draft with both internal Pacific and Maori Health groups in CCDHB.

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

3.2 GIVING TRACTION TO CAPITAL & COAST DISTRICT HEALTH BOARD'S (CCDHB) EQUITY ASPIRATIONS

The paper was taken as **read**.

The Committee:

(a) **Endorses** the report and its recommendations;

(b) **Agreed** to a programme of work that delivers;

I. A clear CCDHB equity goal and direction

II. An agreed set of equity principles

III. An operational framework that translates principles into practice

IV. A performance framework to monitor and guide progress

(c) **Agreed** to target staged implementation commencing 1 July 2019;

(d) **Noted** that the paper does not include the Pacific or Disability lens. The Pacific Group will be recommending that the Pacific Action Plan be established as an equity tool and compliment this plan;

(e) **Noted** that the two principles of the plan will be included in the recommendations;

(f) **Noted** that the implementation plan will include Pacific and Māori action plans in the area of supporting equity.

HSC recommends the Board:

(a) **Note** the paper.

Action:

6. Management to provide a presentation of this programme to the Board and information on CCDHB's response to WAI2575.

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

4 DISCUSSION

4.1 ANNUAL BUDGET AND SERVICE PROPOSAL — UPDATE

The paper was taken as **read**.

The Committee:

(a) **Noted** that the Annual Budget and Service Proposal process is underway;

(b) **Noted** that the Board strategic direction workshop informs this planning process;

(c) **Noted** that the Executive Leadership Team is taking a whole of DHB approach and including the Integrated Care Collaborative, DHB senior leaders and clinical leaders in the prioritisation process;

(d) **Noted** that the first whole of system senior leaders workshop was held on 4 March;

(e) **Noted** that the Maori Partnership Board, Subregional Pacific Advisory Group and Subregional Disability Advisory Group will provide a critical equity lens to the process.

(f) **Noted** that the Committee will receive a detailed presentation at the Committee meeting.

(g) **Provided** feedback and guidance on the key pressures and priority areas;

(h) **Noted** the Model of Care programme will focus on disability;

(i) **Noted** the funding of disability services is funded by the Ministry of Health.

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

4.2 STATEGY INNOVATION AND PERFORMANCE REPORT JANUARY-FEBRUARY 2019

The paper was taken as **read**.

The Committee:

(a) **Noted** the contents of the update.

HSC recommends the Board:

(a) **Notes** the Board should put a submission into the Heather Simpson Review based on the workshop outcomes.

Actions:

7. Management to provide a 1 page summary to the Board of the submission to the review;
8. Management to recirculate the Terms of Reference of the review and include it in the paper;
9. Management to provide a link to the Heather Simpson Review.

4.4 LOCAL RESPONSE TO AN OUTBREAK OF INFLUENZA AND NOTIFICATION THERE HAVE BEEN NO CONFIRMED CASES OF MEASLES IN OUR COMMUNITY

The paper was taken as **read**.

The Committee:

(a) **Noted** there are currently cases of H1N1 influenza in the Hawkes Bay and measles in Canterbury;

(b) **Noted** last week there was a local outbreak of influenza, with the majority of cases seen by Victoria University Student Health and Wellington Accident and Medical Centre. None of the cases have been identified as the H1N1 strain and presentations appear to be tapering off;

(c) **Noted** there have not been any confirmed cases of measles in CCDHB;

(d) **Noted** that general practice are experiencing an increase in people requesting immunisations or information about their immunisation status. Isolation protocols are being followed for anyone presenting with a high fever and/or rash;

(e) **Noted** the importance of annual influenza vaccination programmes.

HSC recommends the Board:

(a) **Notes** and supports the Model of Care for the Arlington Road multi-agency initiative of Te Whare Okioki;
(b) **Notes** that the Arlington Road initiative will be announced to the general public on Thursday 14 March 2019.

Action:
10. Management to notify the Chair of the Arlington Project.

*Meeting closed at 11.45pm***.**

5 DATE OF NEXT MEETING

17 April 2019, 9am, Board Room, Level 11, Grace Neill Block, Wellington Regional Hospital.

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

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

Fran Wilde
Health System Committee Chair

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

SCHEDULE OF ACTION POINTS – HEALTH SYSTEM COMMITTEE (HSC)

AP No:	Item No.	Topic	Action:	Responsible:	How Dealt With:	Delivery Date:
HSC Public Meeting 13 March 2019						
P015	**4.2**	**Strategy Innovation and Performance Report January-February 2019**	1. Management to provide a 1-page summary to the Board of the submission (closes 31 May 2019) to the Heather Simpson Review; 2. Management to recirculate the Terms of Reference of the review and include it in the paper to the Board; 3. Management to provide a link to the Heather Simpson Review.	Dir SIP	Paper Email Email	May
P014	**3.2**	**Giving traction to CCDHB's equity aspirations**	Management to provide a presentation of this programme to the Board and information on CCDHB's response to WAI2575.	Dir SIP	Presentation	May
P013	**3.1**	**First draft Annual Plan 2019/20 including Statement of Intent (SOI) and Statement of Performance Expectations (SoE)**	1. Management to include a diagram and context, including achieving equity, in the Chair or CEO's report of what CCDHB are doing in the Annual Plan and Statement of Intent. 2. Management to discuss draft with both internal Pacific and Māori Health groups in CCDHB.	Dir SIP	Report Discussion	May
P011	**4.3**	**Hospital and Healthcare Services (HHS) Bi-monthly Performance Report**	Management to provide more details on the new protocols being developed in the Emergency Department on Equity for Māori.	Executive Director, Operations, Medicine Cancer & Community	Verbal	April
HSC Public Meeting 13 February 2019						
P002	**2.3**	**Primary Birthing Facility Feasibility Review**	Management to provide an update to HSC of the role of the midwives in a birthing unit.	Dir Sip	Report	July
HSC Public Meeting 28 November 2018						

	1.6	**Action List**	SIP to follow up HSC membership with Wellington School of Medicine in 2019.	Dir SIP	Verbal	April
HSC Public Meeting 24 October 2018						
	2.3	**Porirua — Supporting Equity and Outcomes**	1. Report to the Board on the progress of Community Health Network in Porirua at a future meeting. 2. Staff to present the localities work to the Porirua City Council following invitation by 'Ana Coffey.	Dir SIP	Report Invitation from PCC	May
	3.3	**Maternity Quality Report**	Staff to discuss the Maternity Quality Report with the Maori Partnership Board and the Sub Regional Pacific Health Advisory Board	SIP	Presentations	In Progress
	3.4	**Investment and Performance — PHOs, Older Persons Services and Community Pharmacies**	To work with the DHBs to request from the Ministry the information on the qualification levels and hours of the aged residential care and support workforce.	SIP	Report	In Progress

Closed since last meeting – 17 April 2019

AP No:	Item No.	Topic	Action:	Responsible:	How Dealt With:	Delivery Date:
HSC Public Meeting 13 March 2019						
P012	**2.1**	**3DHB Falls and fraction prevention project**	Management to make the presentation available to the general public.	Dir SIP	Released on CCDHB website	March
P016	**4.4**	**Local response to an outbreak of influenza and notification there have been no confirmed cases of measles in our community**	Management to notify the CCDHB Chair of the Arlington Project.	Dir SIP/HSC Chair	Telephone	March
HSC Public Meeting 13 February 2019						

P008	**3.2**	**Cancer Services Review**	Management to provide an update on what is happening locally, regionally and nationally and to include addressing cancer outcomes by population group.	Exec Dir Operations and MCC	Paper to be discussed in the April meeting	April
P005	**2.4**	**Citizens Health Council**	Management to provide advice about membership of Citizen's Council member representation on HSC.	Dir Sip	Paper to be discussed in the April meeting	April
P003	**2.1**	**Porirua Children's Skin Project**	Management to bring back to the committee information regarding the schools that did not have hot water for students, in order to ascertain reasons. Depending on responses and reasons, HSC might consider taking the matter further with the appropriate minister (Hon Jenny Salesa), noting the fundamental importance of services such as hot water supply and resources such as soap and hand drying facilities.	Dir Sip	Paper to be discussed in the April meeting	April

Draft Health System Committee Workplan 2019

Regular HSC items: (Public) HSC Report and Minutes; Resolution to Exclude (Public Excluded):

Month		13 February	13 March	17 April	15 May	12 June	17 July	14 August	11 September	16 October	13 November
Location		CCDHB	CCDHB	CCDHB	CCDHB	CCDHB	CCDHB	CCDHB	Porirua	Kenepuru	Paraparaumu
Strategy and Planning	**DECISION**	Porirua Children's Skin Project Pacific Nurse-led Neighbourhood Service in Porirua Primary Birthing Facility Feasibility Review Citizens Health Council Update	Draft Annual Planning Investment and Prioritisation Update Pro-Equity	Investment and Prioritisation Update Acute Planning National Contracts Update Maori Health Strategy and Action Plan AOD Model of Care Draft SOI	Draft Regional Services Plan NZHPL Accountability Final Draft Annual Plan 2019/20 LTIP update	Māori Health Action Plan Investment and Prioritisation Update Citizens Health Council Update	Final LTIP Investment and Prioritisation Update Draft Pacific Plan	2020 Joint Board Schedule and workplan Final Draft Regional Services Plan 2019/20 Final Annual Plan and Capital Budget 2019/20 Investment and Prioritisation Update Citizens Health Council Update	Draft Financials Annual Report Investment and Prioritisation Update	Final Annual Report 2018/19 Draft Annual Plan 2019/20 Investment and Prioritisation Update Citizens Health Council Update	Investment and Prioritisation Update
				Even Better Health Care	Progress update – Regional Services 18/19	Update for implementing the Health System Plan				Investment Plan Update	Progress update – Regional Services 18/19
Regular Reporting	**DISCUSSION**	Access to Psychological therapies for 18 to 25 year olds Cancer Services Review Localities Diagram	System Innovation and Performance Update Hospital and Health Services Update Quarter 2 Performance Report	3DHB ICT Update SOI Draft DASHBOARDS Citizens Health Council Update	Hospital Network Planning System Innovation and Performance Update Hospital and Health Services Update Summary of Heather Simpson Review Submission 3DHB DSAC Report Pacific Nurse-led service update	Quarter 3 Performance Report Pro-Equity Implementation Plan	System Innovation and Performance Update Hospital and Health Services Update 3DHB MHAIDS update 3DHB ICT Update Birthing Facility Feasibility Update	Hospital Network Planning	Quarter 4 Performance Report System Innovation and Performance Update Hospital and Health Services Update 3DHB DSAC Report	3DHB MHAIDS update 3DHB ICT Update	Hospital Network Planning System Innovation and Performance Update Hospital and Health Services Update
	INFORMATION	Population Health (Regional Public Health Report)		Pacific Health Update Porirua Skin Project Update	3DHB MHAIDS update	Dementia Services Aged Residential Care	Pacific Health Update Māori Health Update	Population Health (Regional Public Health Report)		Pacific Health Update Māori Health Update	

V3

ACUTE DEMAND & BED CAPACITY PROGRAMME 2019

Capital & Coast District Health Board
Ūpoko ki te uru hauora

Problem

- Quality of care will be hindered with higher hospital occupancy
- ED is at capacity and hospital occupancy continues to be high
- Hospital occupancy of the last two years is less seasonal, with occupancy over summer remaining high
- Stress on staff across the sector to manage winter demand

Key Principles

- Strengthen how we work together to facilitate improved patient flow.
- Maximise the impact of existing resources (eg. AH, discharge coordination)
- Rapid service development and implementation will require Steering Group to champion and direct changes
- Supporting Māori, Pacific and complex patients with the streamlined care
- Safe, patient centred, effective care delivered to all people without unnecessary waits, delays and duplications
- Providing more care in the community – closer to where patients live

Benefits

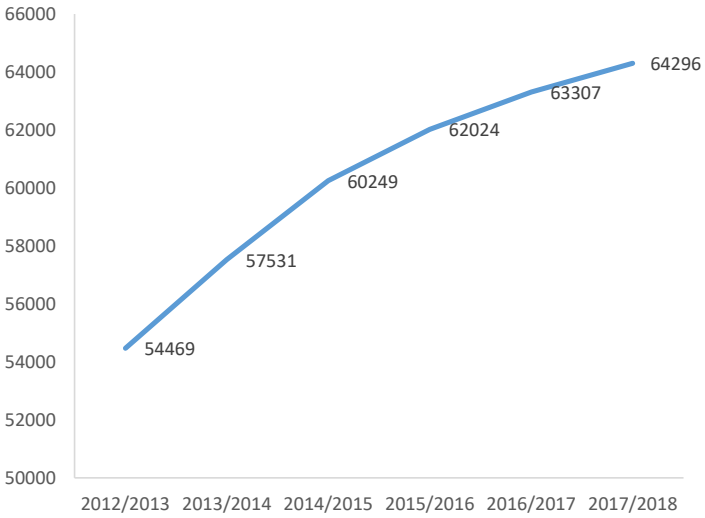
- Patients who present to the hospital will receive better quality care during winter
- Manage patient flow during winter periods when occupancy is expected to be worse
- Increased support for Māori, Pacific and vulnerable patients who may be impacted more when hospital services are gridlocked
- Staff are supported to provide the best care they can during times of peak workloads
- Reduce the number of beds that need to be opened in the hospital.

WHAT THE DATA TELLS US

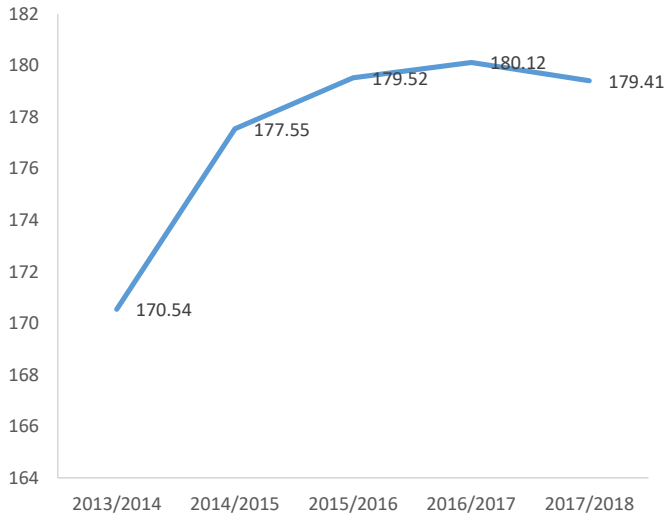
Capital & Coast District Health Board
Ūpoko ki te uru hauora

ED demand is increasing but at a slower rate

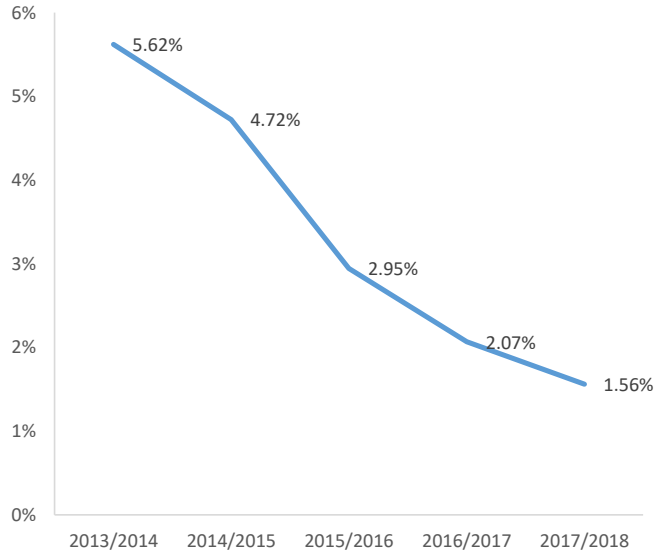
Total ED Presentations to Wellington Hospital ED



Presentation Rate per 1000 population to Wellington Hospital ED



% change year-on-year

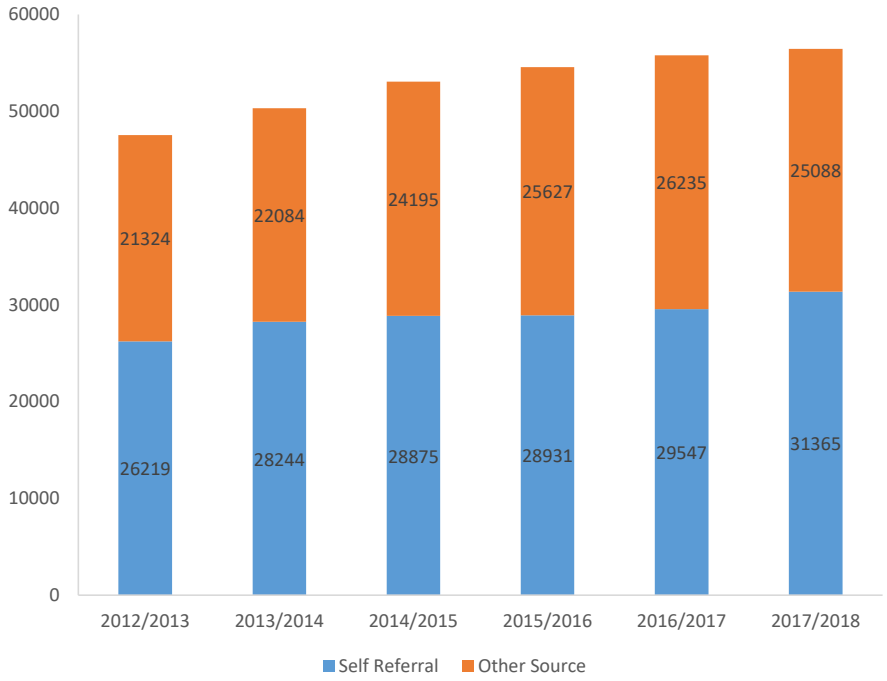


Capital & Coast District Health Board
Ūpoko ki te uru hauora

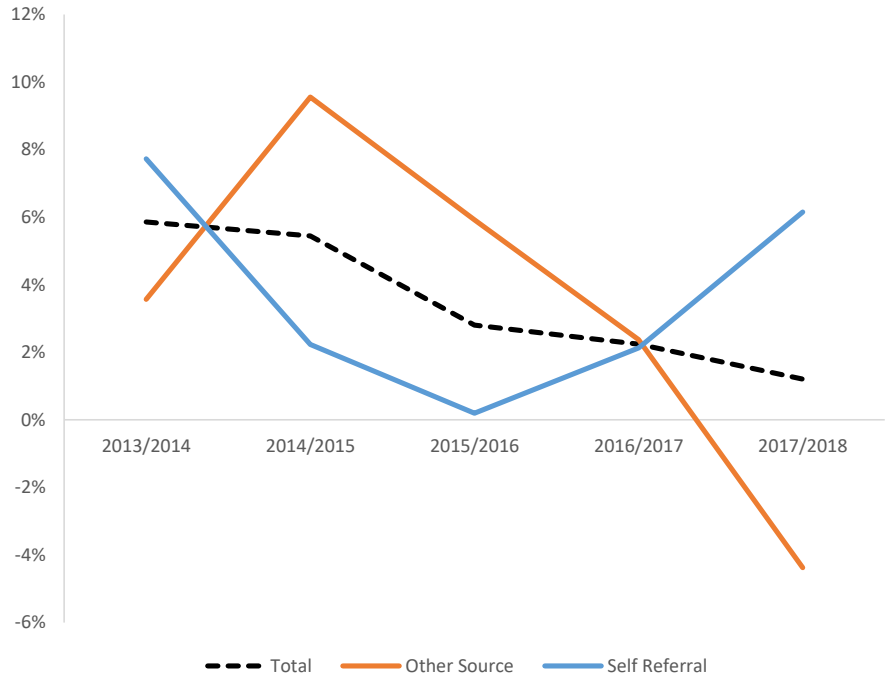
Source: Business Intelligence & Analytics, CCDHB

General Practitioners & Wellington Free Ambulance are managing patients in the community

Total Number and Type of Referrals to ED (CCDHB only)



Year-on-Year Referral Type % Change (CCDHB only)



Capital & Coast District Health Board
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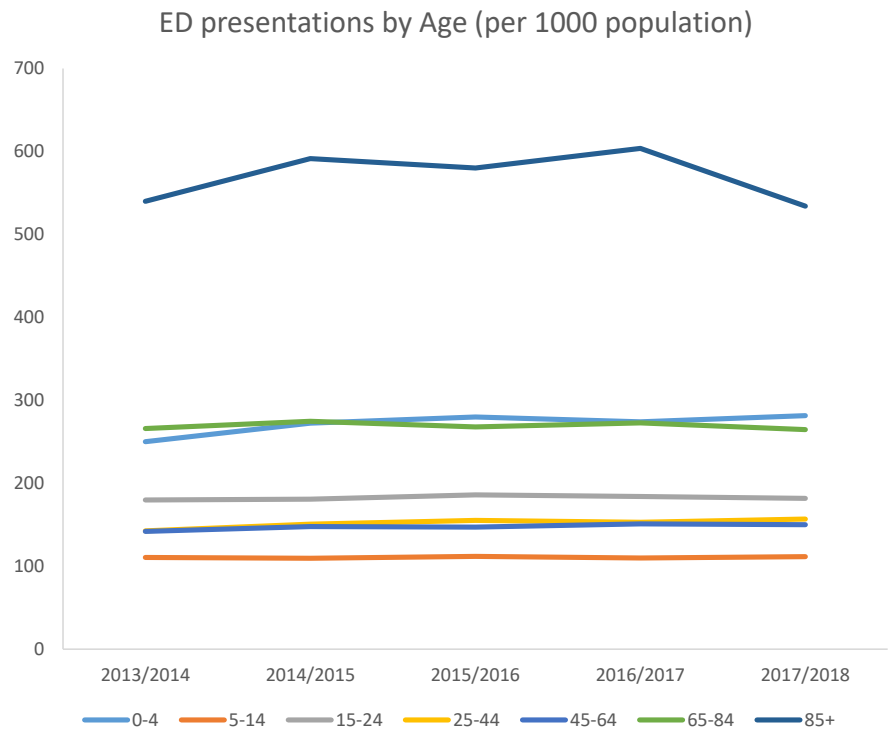
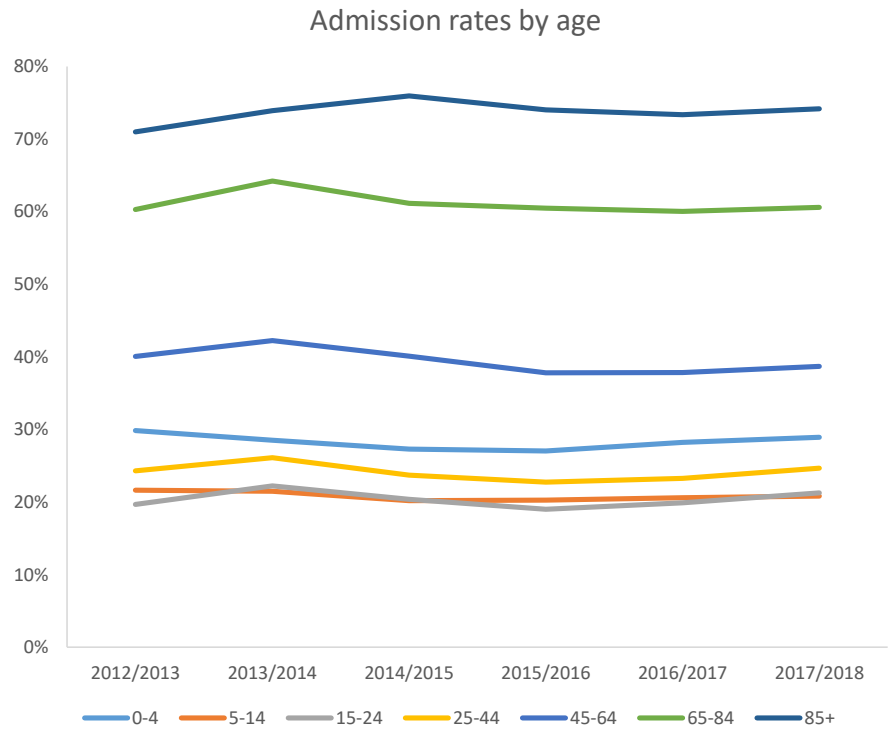
Source: Business Intelligence & Analytics, CCDHB

Young children (0-4 years) and older people (65+ years) are most likely to present to ED

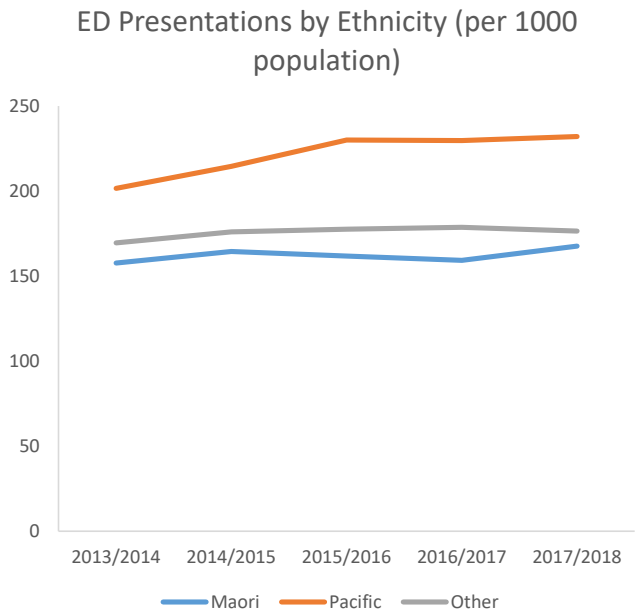


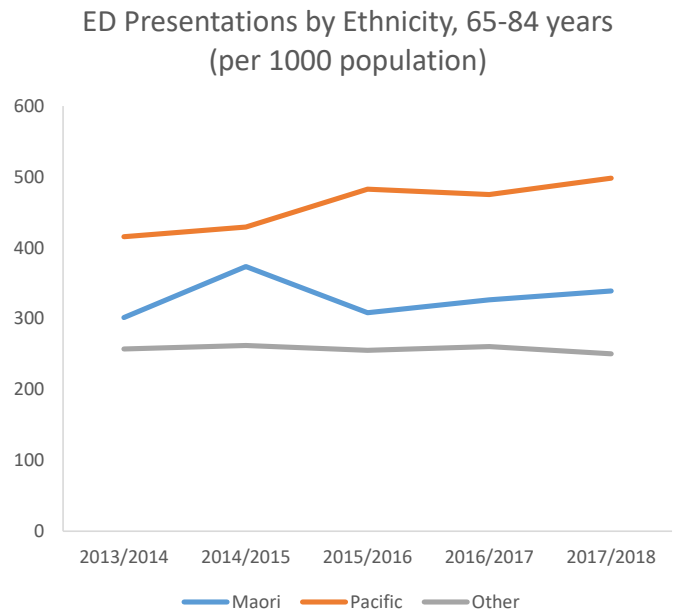
Source: Business Intelligence & Analytics, CCDHB

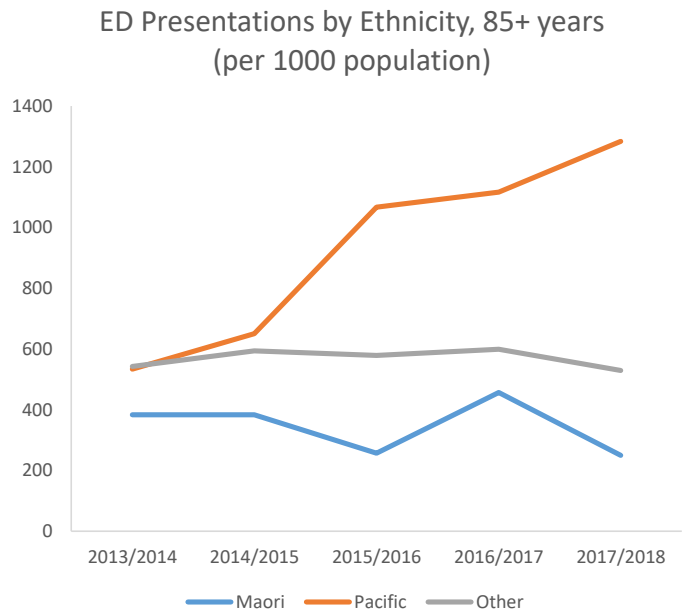
Adults (45-64 years) and older adults (65+ years) are more likely to be admitted from ED



Ethnicity – ED presentation rates for Pacific peoples are increasing, but remain static for Maori and Other ethnic groups. This is particularly true for the older Pacific population (although coming from a small base).



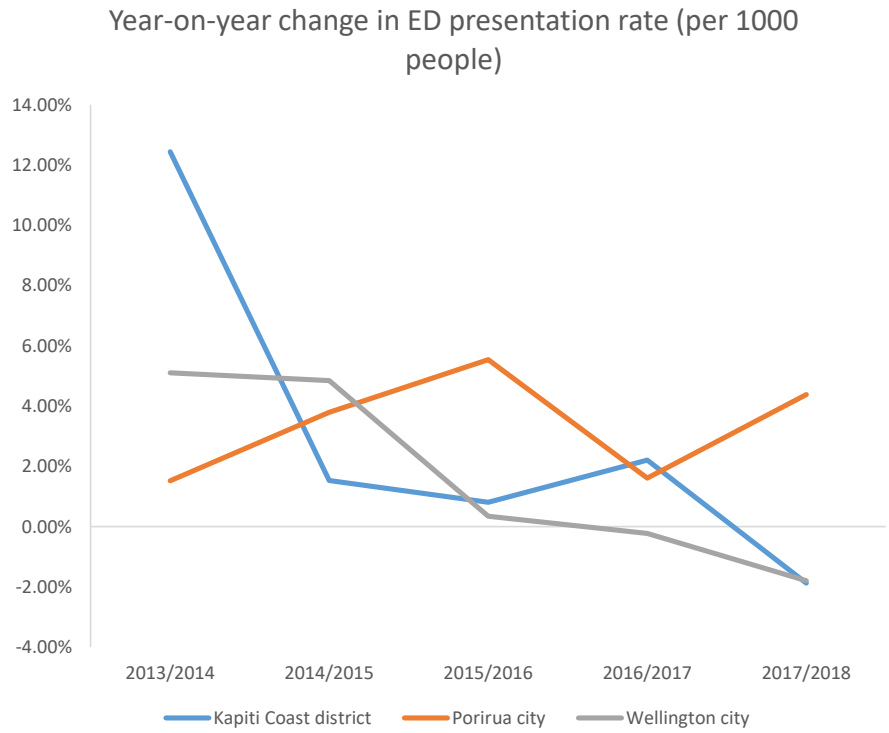




Capital & Coast District Health Board
Ūpoko ki te uru hauora

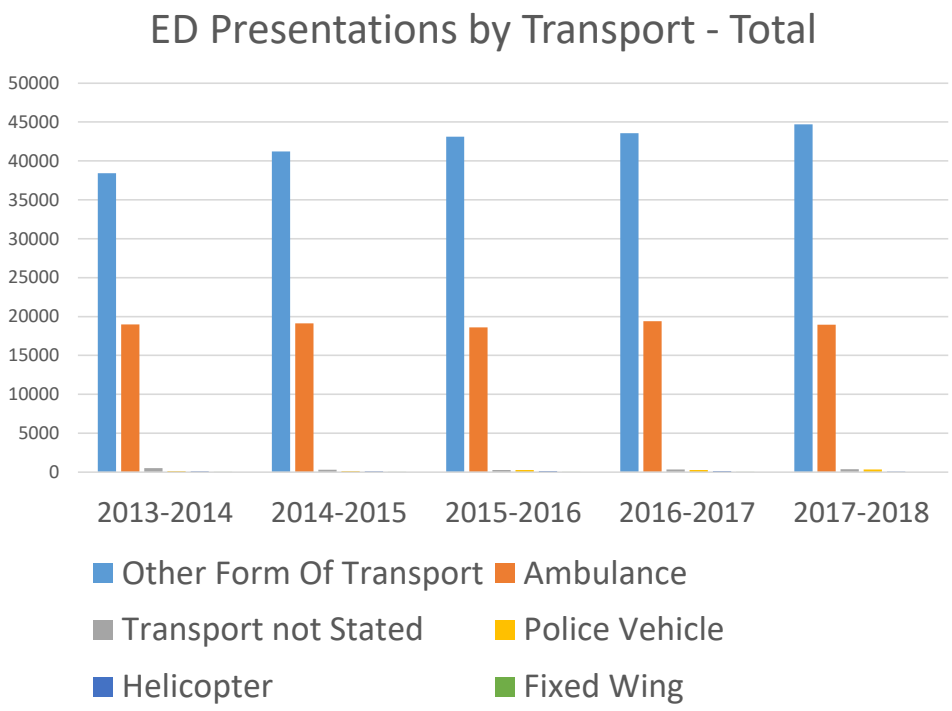
Source: Business Intelligence & Analytics, CCDHB

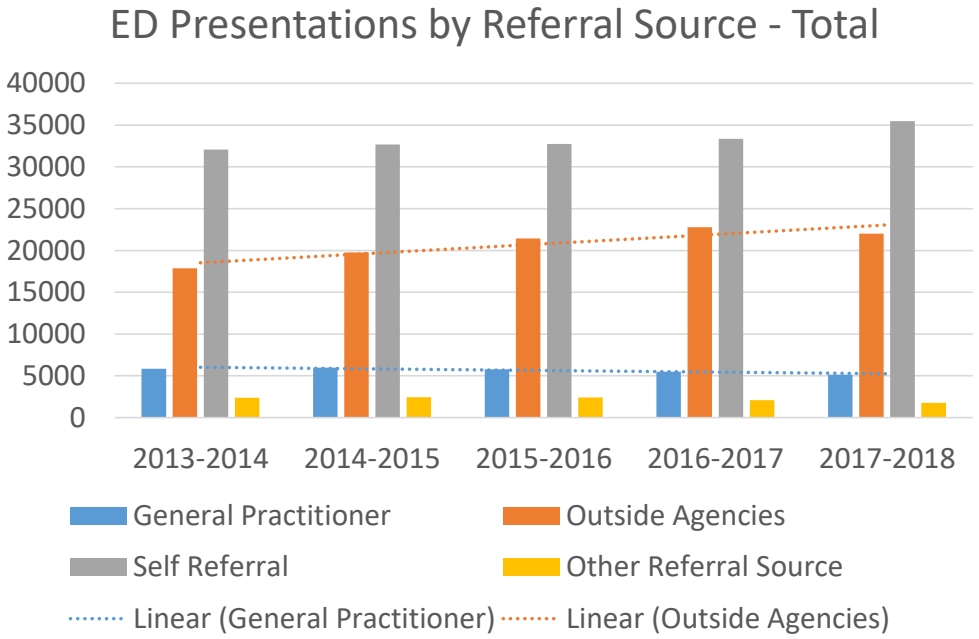
ED presentation rates are decreasing each year for people in Kapiti and Wellington but not Porirua



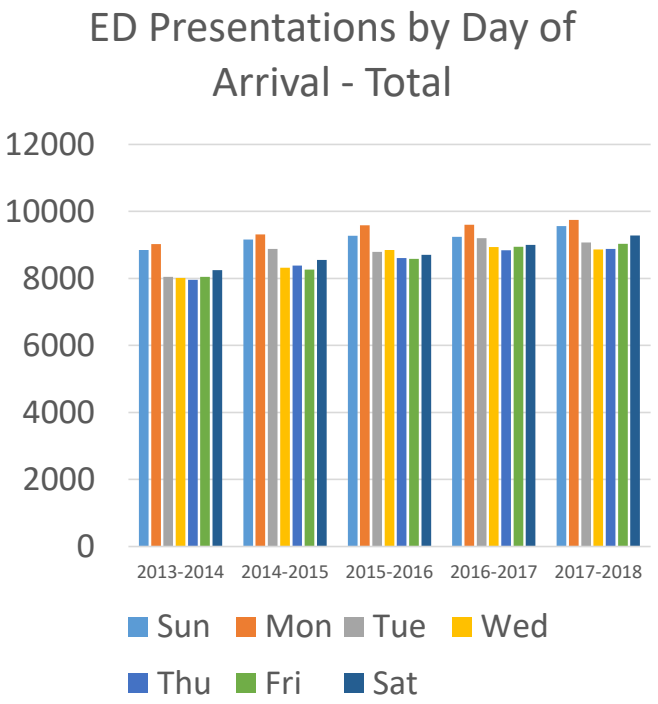
Source: Business Intelligence & Analytics, CCDHB

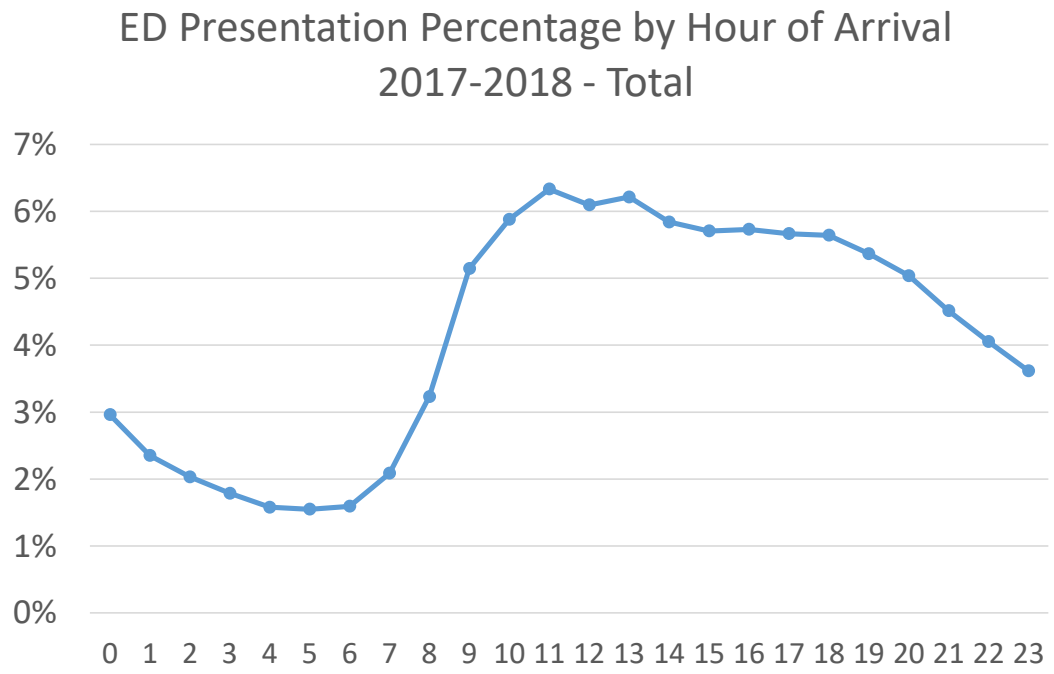
ED Presentations: How do they get here? Where do they come from?





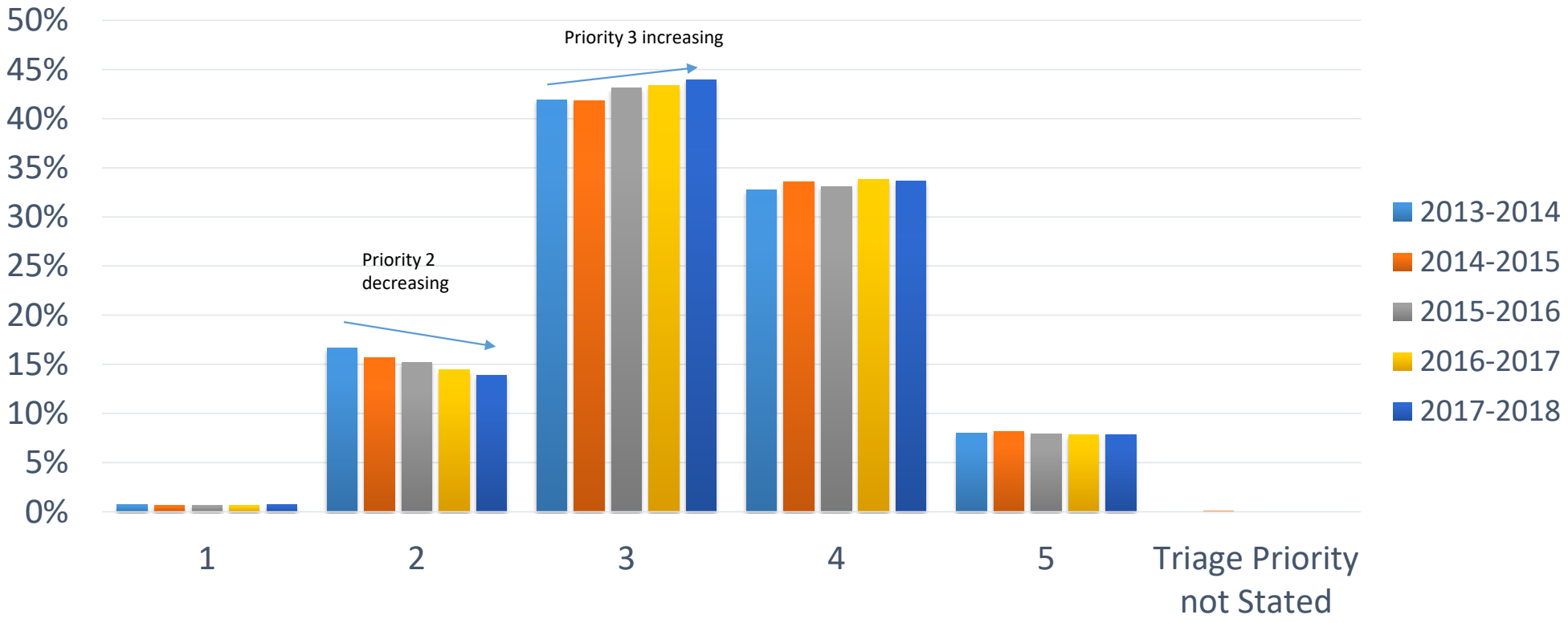
When do people arrive?





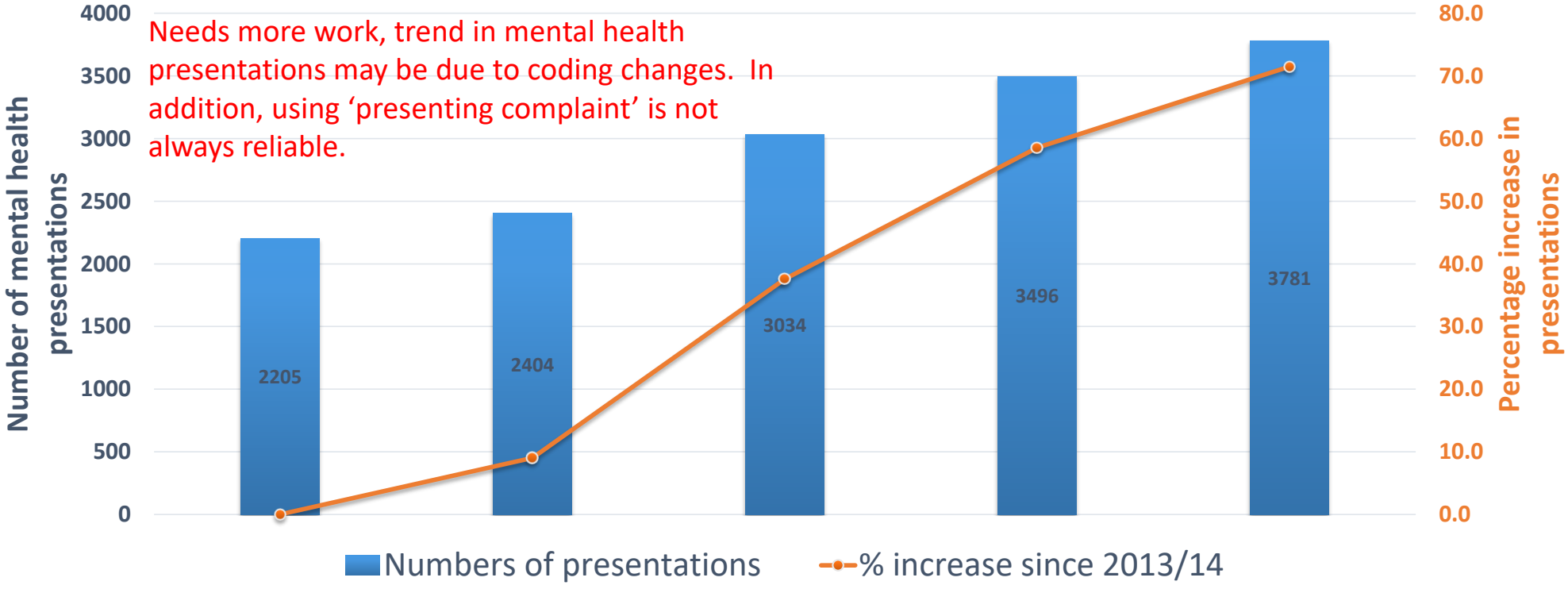
Admissions by triage priority

2013/14 to 2017/18

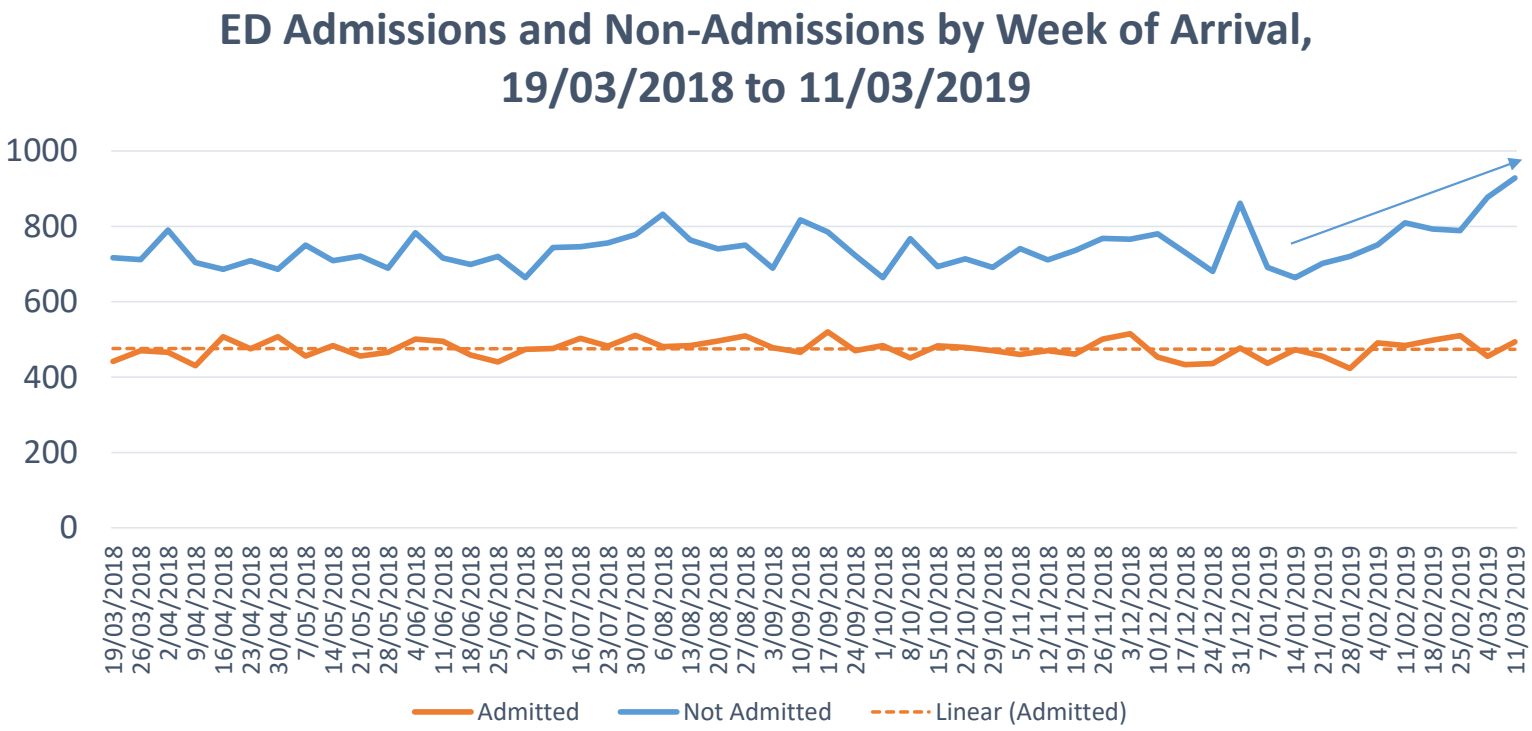


Estimated numbers of mental health presentations and % increase since 2013/14 - Wellington ED

(using ICD10 diagnosis code, or if unavailable, presenting complaint)



Admissions by week of ED presentation

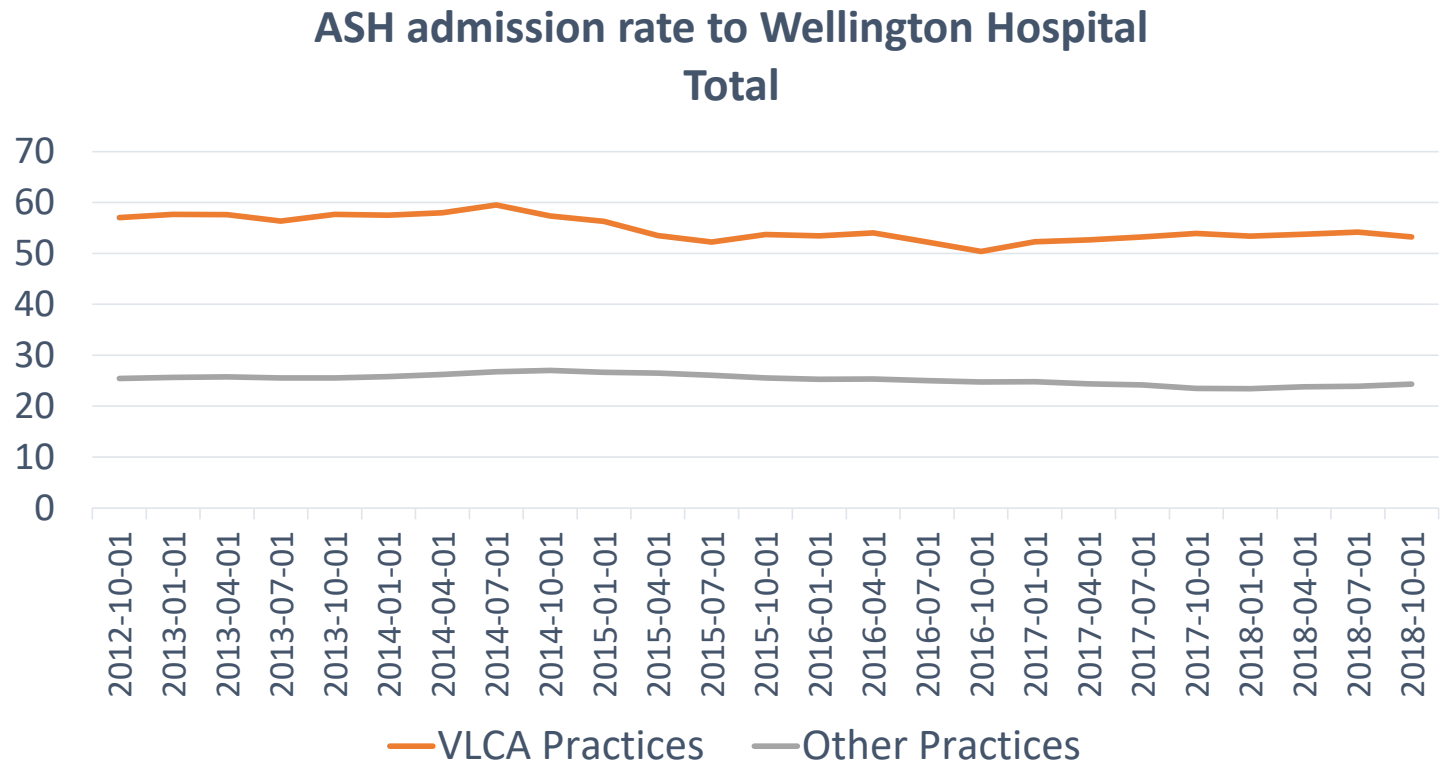


There has been an increase in non-admission presentations to ED since January, while admission presentations have remained constant.

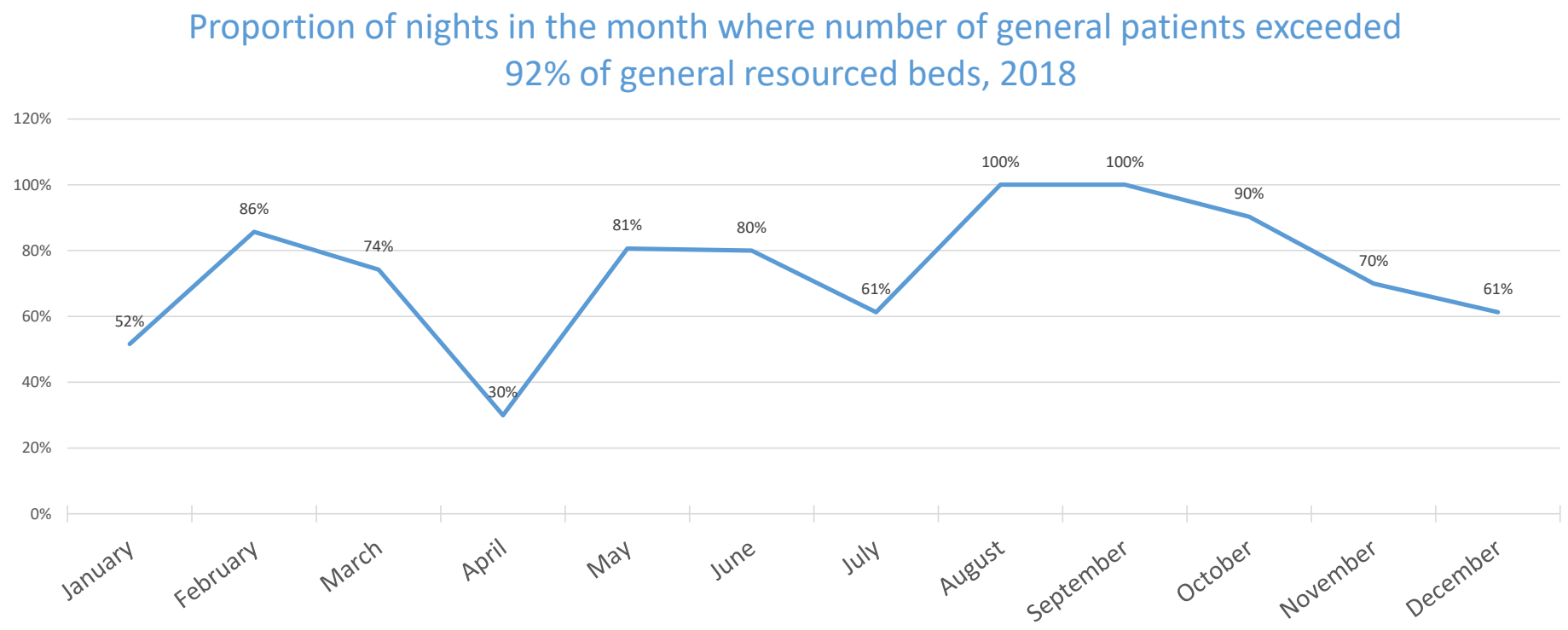
This may be a function of bed availability rather than changes in patient severity.

ASH admission rate to Wellington Hospital

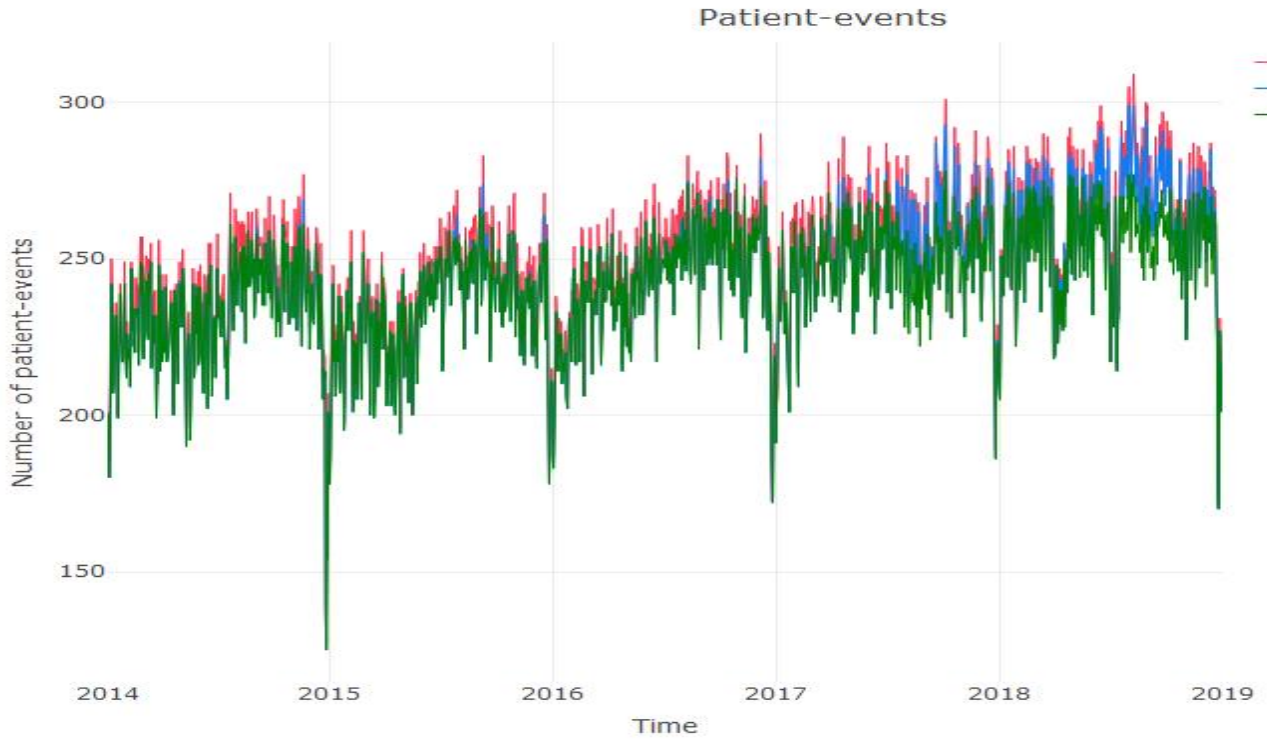
12 month rolling totals; 1 January 2012 - 31 December 2018



In 2018, most months saw the number of “general adult patients” exceed 92% of resourced “general adult beds” on most nights. In August and September, this happened every night.

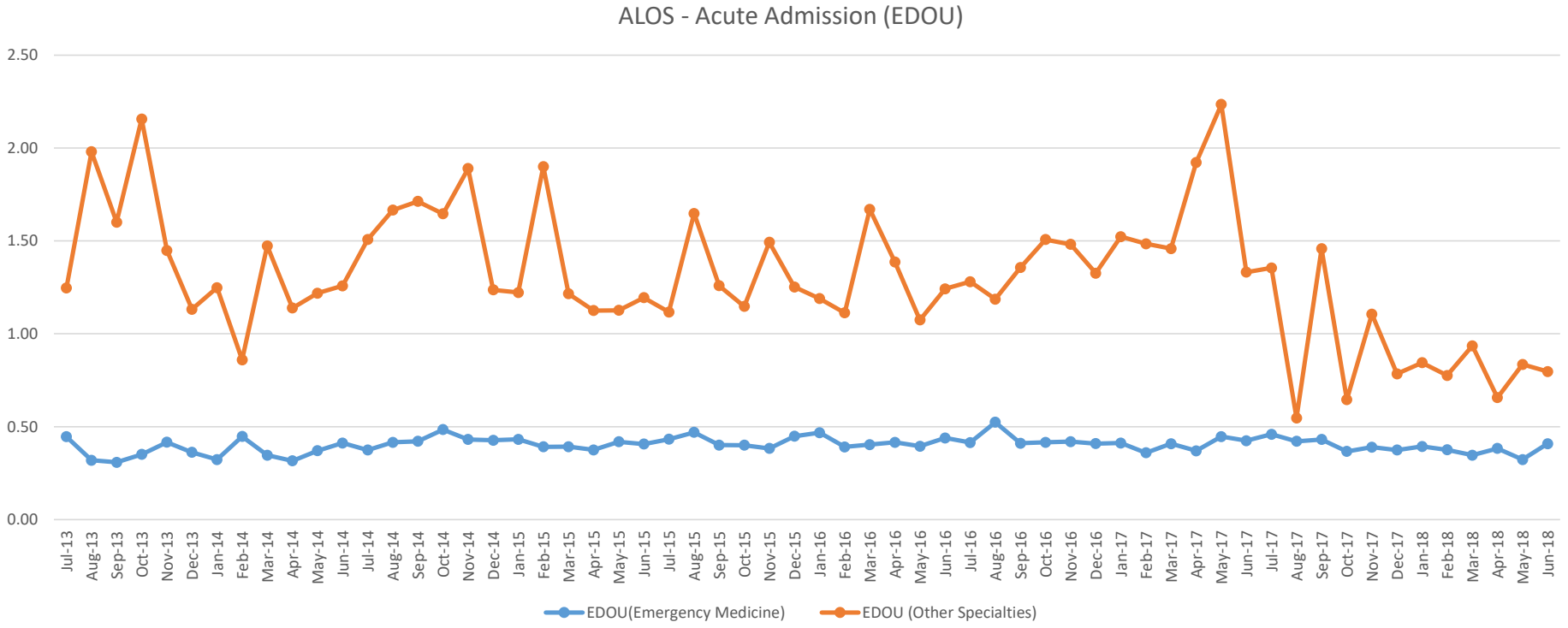


Overflows have been increasing with the number of “general adult inpatients” on the midnight census. Overflows into EDOU have been common but increasing overflows to IRW and Ward 3 have been observed mainly in the last two years.

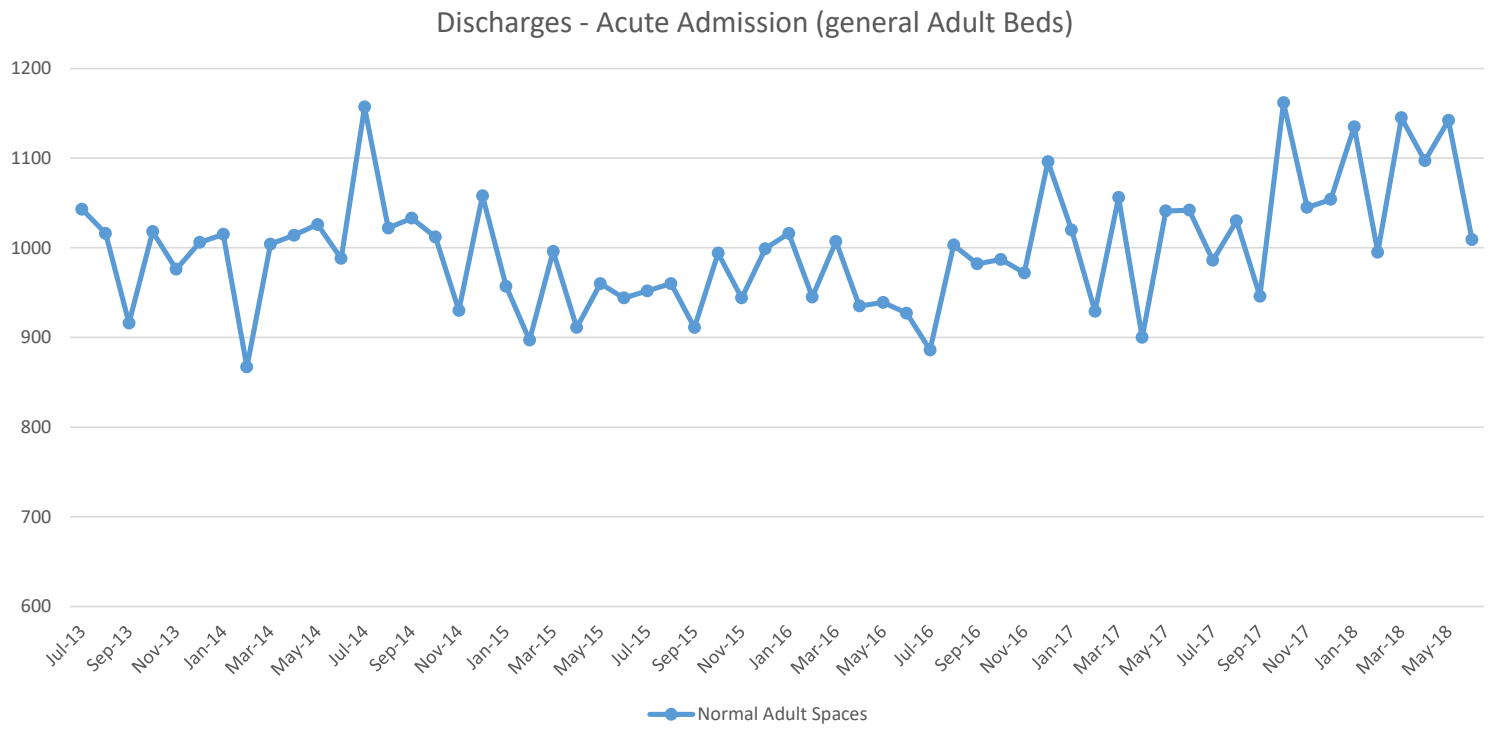


Work being undertaken to asses the midday census.

Increased use of IRW and Ward 3 have significantly reduced the ALoS for acute admissions under other specialties in EDOU. However, these patients still stay longer in EDOU than patients under an ED SMO.



Monthly discharges of acute admissions from “general adult wards” have been rising for the last two years.



A 'WHOLE OF SYSTEM RESPONSE'

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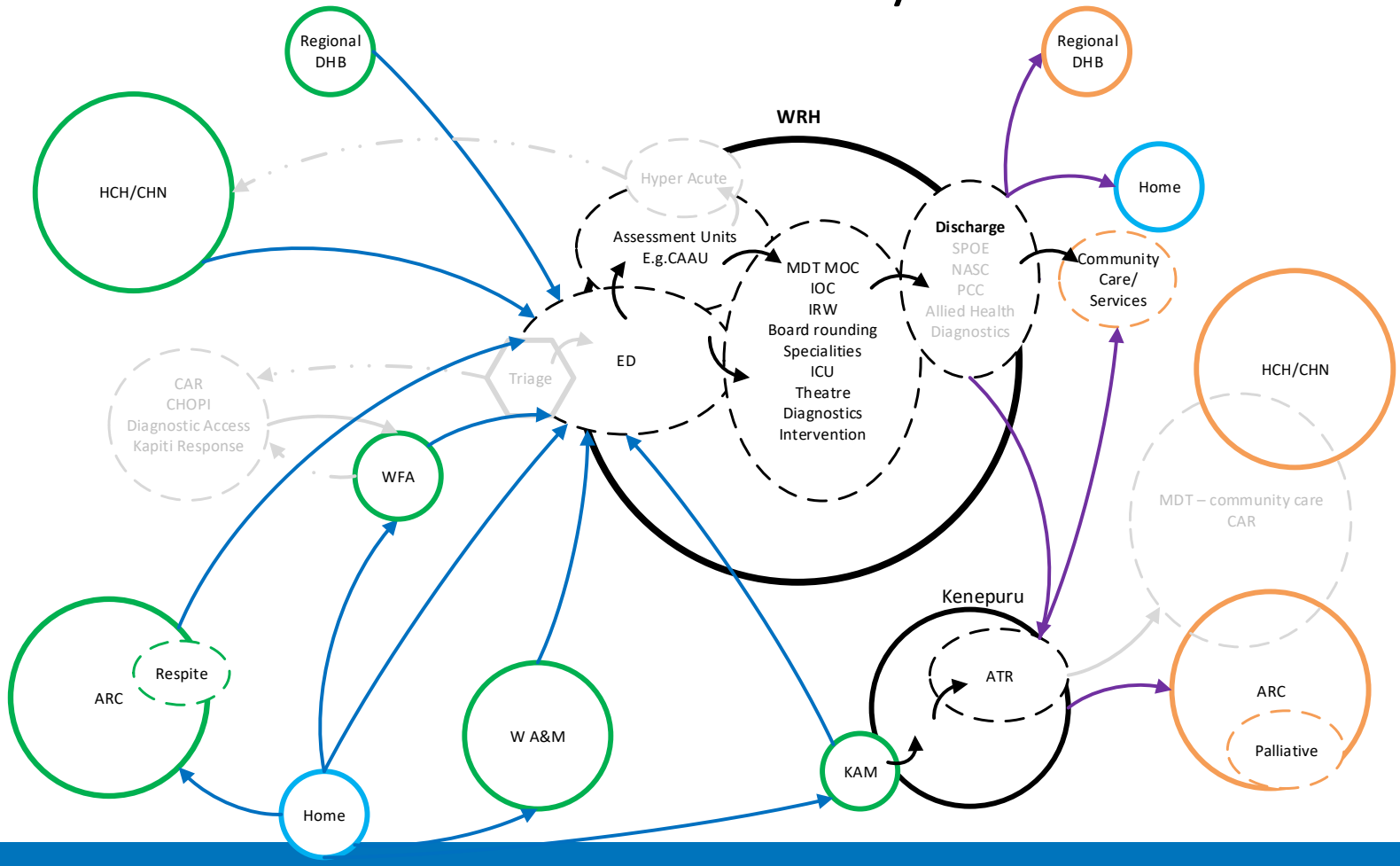
Current Acute System



Lots of Ideas

Community Acute Response Package for Primary Care to use to prevent ED presentation/admission; additional subsidy for Māori & Pacific	Community Rapid Response team incl Allied Health & District Nursing - work in with Primary Care . AH available to work in ambulance	ED -MSK Physiotherapist (during weekend) and SW available in in ED	Boost the coordination support for complex case discharges (fall between funding streams)	Clinical leadership to support all wards to implement MDT Board round across the hospital	Older People Allied Health discharge service - *linked with Community Rapid Response team*
Establish "virtual ward" capacity in geographies (Kapiti) supported with rapid response team (above).	Community Acute Response Package for ambulance to divert patient to HCH/virtual ward and provide ambulatory care	Nurse Triage in ED to support people to primary as appropriate	Support complex patient discharge - role of PCC, discharge coordinator in Kenepuru, Access support role	Clinical audit resource to support acute flow work and quality across directorates	Utilise "virtual ward" capacity in geographies (Kapiti) supported with rapid response team (above).
Network of HOP NPs & AH staff to work with Geriatrician - available for frail elderly proactive, responsive and acute care.	Access to community radiology to support acute response teams/virutal ward. If feasible in Kapiti, Porirua	Dementia care - understand population health need and understand gap in community support service and beds. Early SW input in PPPR process.	Decision/information support to identify complex patients early on admission - to initiate discharge planning & identify dependencies - all wards	Complex discharge Network - agreed accountability mechanisms/improvement processes for services involved	Implement easy e-communications in hospital- Smart Page (currently only afterhours) across MDT
Remove one point entry via CCC for District Nurse & ORA reponsiveness... and release Liaison Nurses to work with HOP community team	Increased social workers in HCH teams to support complex patients and align care coordinators from CCC with HCH	Palliative care - understand population health need and understand gap in community support service and beds	Increase discharge to assess - Shift the point of assessment for facility placement to home/community	Timely repatriation of patients to their DHBs	

Proposed Solutions

Patient rather than bed management, considers the management of the patient journey which requires a multi-disciplinary approach to care management and a dynamic discharge process that includes access to diagnostics, appropriate assessment, alignment of medical and therapeutic care; home when ready, discharge in the morning, transfer care back to the GP.

Focus areas

- Reduce ED presentation
- Improve assessment/triage – ED/Speciality
- Rapid discharge from ED/assessment units
- Prevent older person attendance and/or admission to WRH
- Supporting complex patient discharges
- Streamline discharges from Kenepuru

Underway

To be implemented

In

Community Acute Response

Package for Primary Care to prevent ED presentation; additional subsidy for Māori & Pacific

CHOPI -

Network of HOP NPs & AH staff to work with Geriatrician - available for frail elderly proactive, responsive and acute care.

Nurse Triage in ED

support people to primary as appropriate

Community Rapid Response team

Allied Health & District Nursing - work in with Primary Care .

AH available to work in ambulance

Kapiti Response-

Access WFA diversion support acute response teams/virutal ward Linked to ESD

CAREFUL Team

Optimal Hospital Flow

IRW Extended Hours

Flow improvements

-Clinical leadership

-Board round

-Clinical audit resource

-Smart page use within normal hours

Child Aute Assesment Unit

↑ ICU Bed Resourcing

ED -MSK Physiotherapist (during weekend) and SW available in in ED

Inpatient transfer from WRH to Kene

Out

Discharge Process Redesign

-Interai assessment

-PCC

-SPOE

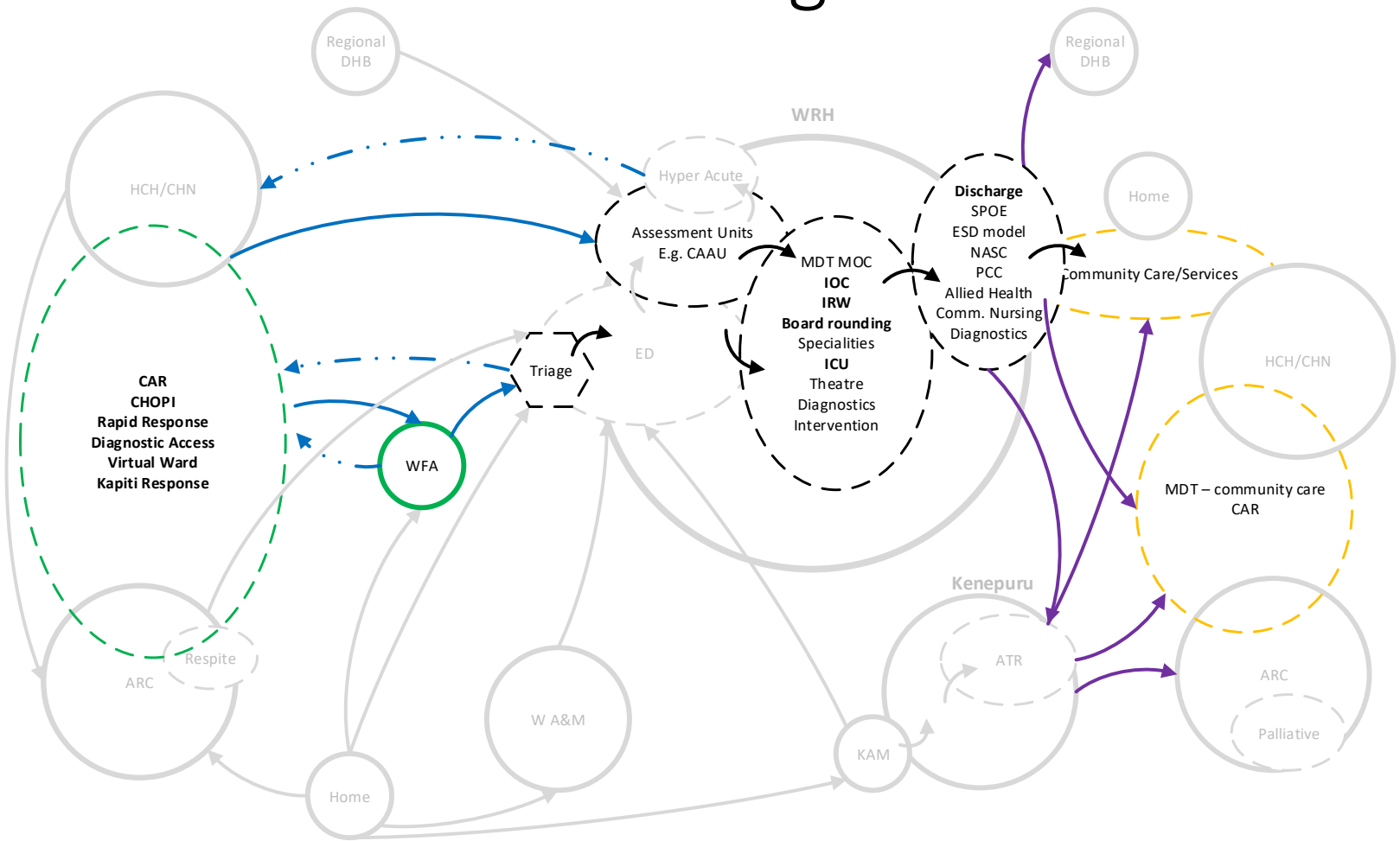
-Complex patient coordination process

-Kene discharge process

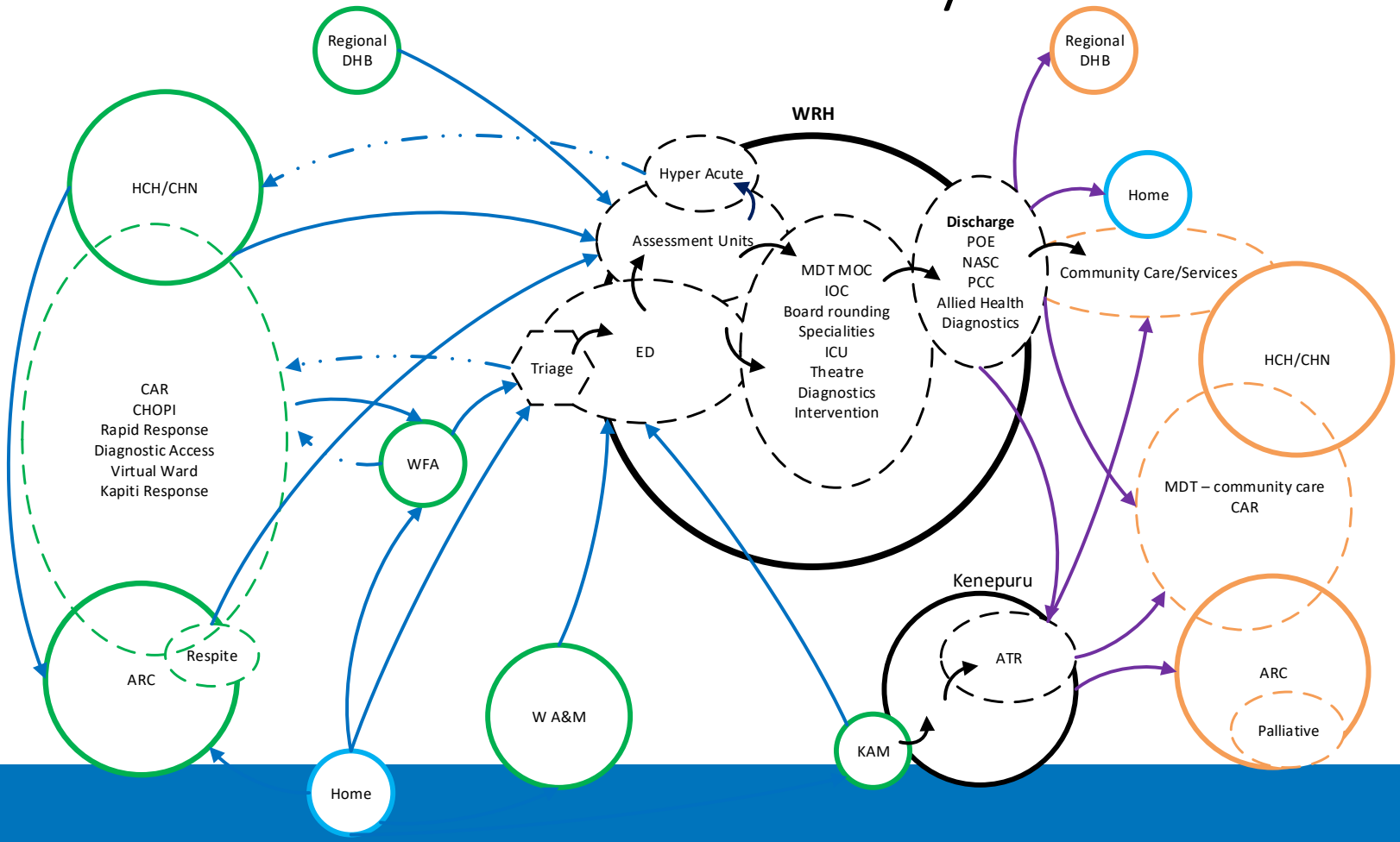
Early Supported Discharge -AH

Timely repatriation of patients to their DHBs

Acute Flow Programme



Future Acute Flow System



STRATEGICALLY LINKED

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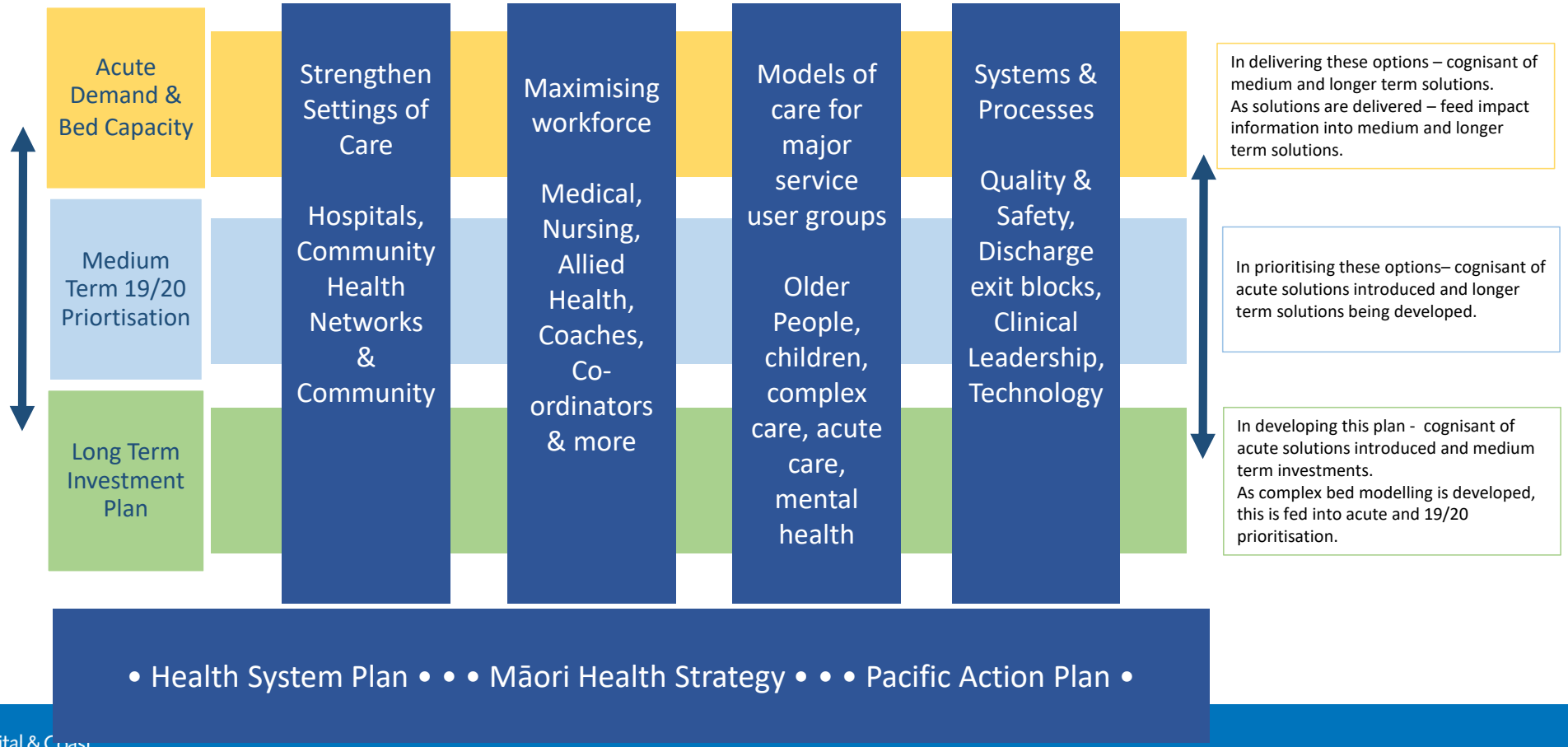
Improving System Flow and Outcomes – Now, Next Year & in the Future



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Date: 10 April 2019	**HEALTH SYSTEM COMMITTEE INFORMATION**
Author	Arianna Rangi, Population Health Advisor
Endorsed by	Justine Thorpe, General Manager Practice Services and Population Health Rachel Haggerty, Executive Director, Strategy Innovation & Performance, CCDHB
Subject	**FOLLOW-UP SURVEY REGARDING ACCESSIBILITY TO HOT/WARM WATER IN PRIMARY SCHOOLS IN THE PORIRUA REGION**

RECOMMENDATIONS

It is **recommended** that the Health System Committee:

(a) **Notes** that 11 primary schools in the Porirua region have been sent a follow up survey to identify barriers to accessing hot/warm water for children.

(b) **Notes** that the key barriers identified to date preventing the installation of hot//warm water in the primary schools are the infrastructural changes required and the associated costs.

(c) **Notes** that Tū Ora Compass Health is developing a submission to send to the Ministry of Education regarding this issue.

(d) **Notes** that the primary care schools, in general, are supportive of advocacy in this area.

(e) **Considers** if the Committee would like the submission to the Ministry of Education to be joint between the CCDHB and Tū Ora Compass Health.

APPENDIX

1. Results from Survey.

Health System Plan Outcomes		**Stewardship**	
Wellbeing Strengthen our communities, families and whānau so they can be well	**X**	**Quality & Safety** Quality & safety of service delivery	
People Centred Make it easier for people to manage their own health needs		**Service Performance** Report on service performance.	
Equity Support equal health outcomes for all communities	**X**	**Health System Performance** Report on health system performance	
Prevention Delay the onset, and reduce the duration and complexity, of long-term health conditions		**Planning Processes and Compliance** Planning processes and compliance with legislation or policy.	
Specialist Services Ensure expert specialist services are available to help improve people's health		**Government Priority** Equity; Child Wellbeing; Mental Health; Primary Care; Water Safety	

1. INTRODUCTION

1.1 Purpose

The purpose of this report is to update the Health System Committee on the results of the Porirua Skin Project primary school follow up survey regarding access to hot/warm water for children. This paper also requests the Committee to consider a joint submission to the Ministry of Education on this issue.

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2. BACKGROUND

The Porirua Skin Project undertaken my Tū Ora Compass Health (Tū Ora) Māori and Population Health Team in the Porirua region identified that some schools do not have access to hot/warm water for children. A report on this project and the outcomes was provided to the February Health Systems Committee meeting.

The project, which was conducted late last year, focused on raising awareness on the prevention of skin infections. As part of this project, we carried out a survey at 19 primary schools – enquiring accessibility to hot/warm water for children. Of the 19 schools involved in this project, 11 schools self-identified as either: "not having access to hot/warm water for children", "staff having access to hot/warm water but not students", or "unsure".

2.1 Project Follow Up Survey

As a follow up to this project, a further survey has been conducted to identify the reasons why some schools in the Porirua region do not have access to hot/warm water for children in Primary Schools. This survey was sent to the schools who self-identified as either "not having access to hot/warm water for children", "staff having access to hot/warm water but not students", or "unsure".

The purpose of this follow-up survey was to:

- gain a better understanding of why schools do not have access to hot/warm water
- identify the key barriers preventing schools from installing hot/warm water in children's bathrooms
- get a better picture of how we can support schools with hot/warm water access and hand hygiene/sanitation.

We were hoping to gain the schools' support and use these findings from the survey to advocate to the Ministry of Health and Ministry of Education to encourage greater government support in the installation of warm/hot water to reduce these current inequalities/inequities.

2.2 Survey Method

From the previous survey 11 schools were self-identified as either "not having access to hot/warm water for children", "staff having access to hot/warm water but not students", or "unsure".

These 11 schools were sent an email containing a follow-up survey. Each of these schools were offered $500 funding to go towards hygiene products in their schools for filling in this survey. The questions in the survey were:

1. Does your school have access to hot water in general?
2. Do the students at your school have access to hot/warm water in the toilets to wash their hands?
3. If you answered "No" to question 2, what are the key barriers preventing you from installing hot/warm water for children?
4. If you answered "No" to question 2, if you were given the necessary support/resourcing would you install hot/warm water for children in your school?
5. Can you tell us what the necessary support/resources are that you require?
6. Do you think that the installation of hot/warm water would be beneficial for the health and wellbeing of your children?

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7. If we were to write a submission to the Ministry of Health and Ministry of Education around gaining government support to address hot/warm water access for children in schools would you support this submission?
8. Is there anything else you would also like us to support you with, regarding accessibility to water and skin hygiene?
9. What is the name of your school?

In addition to this, an email was sent out to each of the leaders from the Kahui Ako (Communities of Learning) to give them context regarding this follow-up survey and to ask them if they have any feedback.

The results from the survey were collected and summarised. These results are provided as appendix 1 to this report.

3. CONCLUSION

Of the schools who responded to the survey, the key barriers preventing installation of hot/warm water are the infrastructural changes required and the associated costs. Those schools who have a large population of high needs children indicated cost as a key barrier. It may be that the funding with a large high needs population are distributed differently due to other priorities. A funding stream, or additional funding, separate from other school budgets for infrastructural changes which impact on the health and wellbeing of children is one option to address this. This would help reduce inequities in accessibility to resources, which are beneficial to the health and wellbeing of children.

Other studies around accessibility to hot/warm water in primary schools have been carried out in other parts of the country. The Ministry of Education includes hot/warm water in toilet hand basins as a recommendation for Primary and Secondary School Toilets. The Ministry of Health also includes hot/warm water in its effective hand washing instructions. Links to these resources are below. To meet the requirements specified by the Ministry of Education and Ministry of Health, extra financial assistance from the government is necessary to reduce the inequities in accessibility to resources beneficial for the health and wellbeing of our tamariki.

Resources:

- Reference for the research paper from a study done in the South Island - https://www.ncbi.nlm.nih.gov/pubmed/22490432
- Reference designs for School Toilets in New Zealand – guidelines and requirements for new buildings and where suitable existing buildings being remodelled - https://www.education.govt.nz/assets/Documents/Primary-Secondary/Property/School-property-design/Design-guidance/ToiletReferenceDesignsV2.0.pdf
- Reference for hand washing by the Ministry of Health - https://www.health.govt.nz/your-health/healthy-living/good-hygiene/hand-washing

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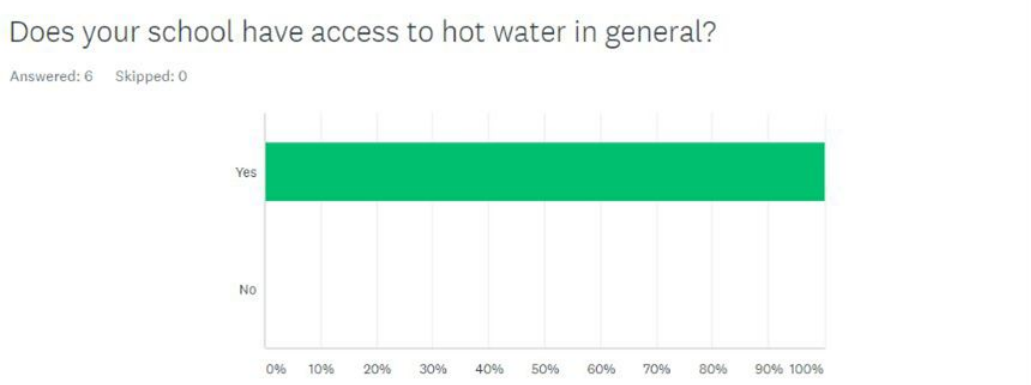
Appendix 1 – Results from Survey

Please find below the questions which were asked in the survey and the answers from the schools. Please note that 6 of the 11 schools have responded so far, but the survey is still open, so we will continue to gather this information.

Question 1 - Does your school have access to hot water in general?

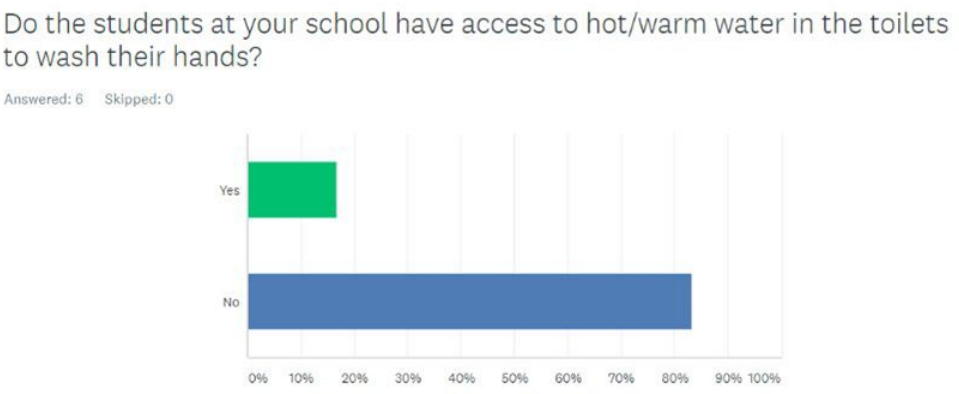
All six schools have access to hot/warm water in general.



ANSWER CHOICES	RESPONSES	
Yes	100.00%	6
No	0.00%	0
TOTAL		6

Question 2 - Do the students at your school have access to hot/warm water in the toilets to wash their hands?

Five schools do not have access to hot/warm water for children to wash their hands. One school does have access to hot/warm water for children.



ANSWER CHOICES	RESPONSES	
Yes	16.67%	1
No	83.33%	5
TOTAL		6

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Question 3 - If you answered "No" to question 2, what are the key barriers preventing you from installing hot/warm water for children?

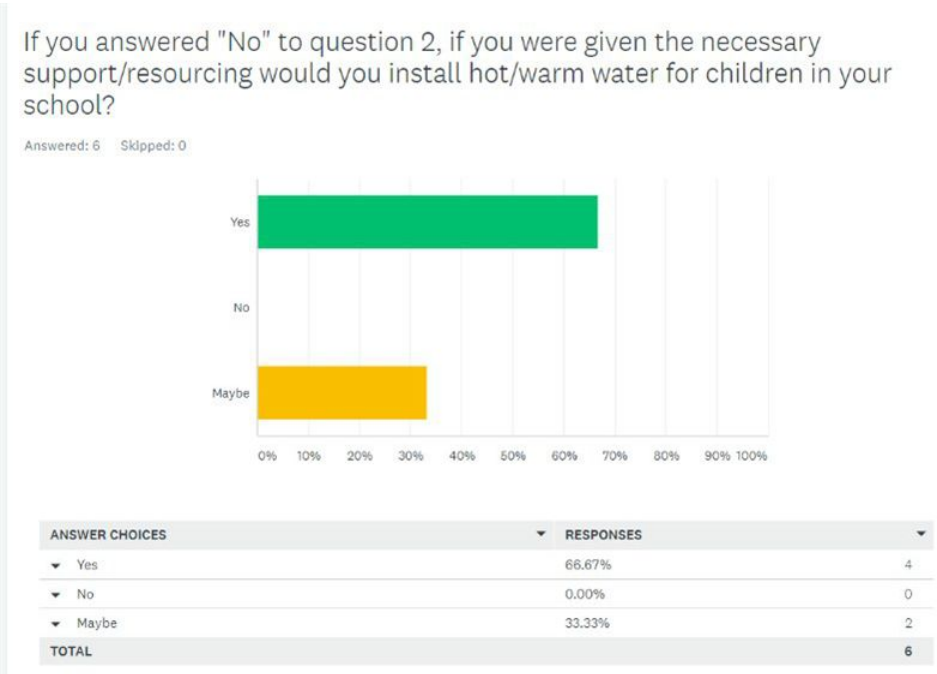
The key barriers that seemed to be a common theme were:

- Cost of installation and on-going cost of hot/warm water.
- Infrastructural changes, e.g. plumbing, hot water cylinders, and the cost associated with that.
- Priorities – e.g. the installation may be in their 5YPP (5 Year Plan), however if other priorities pop up they will take priority.

One school also mentioned that they were concerned about the safety of the children due to hot water causing burns. However, there are measures that can be put in place to mitigate this risk.

Question 4 - If you answered "No" to question 2, if you were given the necessary support/resourcing would you install hot/warm water for children in your school?

Four of the schools said that they would install hot/warm water if they were given the necessary support/resourcing. Two of the schools said they would maybe install hot/warm water if given the necessary support/resourcing.



ANSWER CHOICES	RESPONSES	
Yes	66.67%	4
No	0.00%	0
Maybe	33.33%	2
TOTAL		6

Question 5 - Can you tell us what the necessary support/resources are that you require?

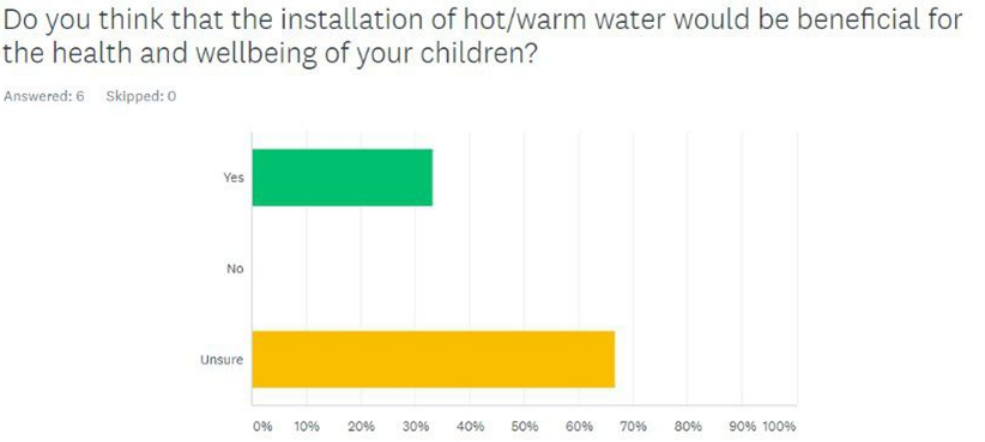
The key support/resources that seemed to be similar between schools were:

- Cost/funding for the installation of the hot/warm water and the on-going cost, e.g. one school identified that it would be beneficial if the installation of hot/warm water was funded separately to the 5YPP.

- Infrastructural changes, for example the plumbing, installation of hot water cylinders/solar panels etc.
- Monitoring of hot/warm water, for example setting the hot/warm to a set temperature and educating children around using warm water.

Question 6 - Do you think that the installation of hot/warm water would be beneficial for the health and wellbeing of your children?

Two of the schools said "Yes", while the other four said they were "Unsure" of the health and wellbeing benefits for children.



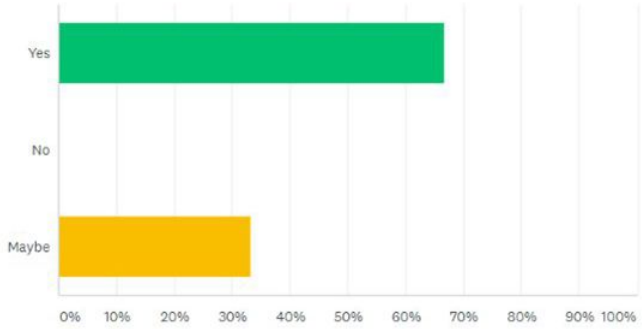
ANSWER CHOICES	RESPONSES	
Yes	33.33%	2
No	0.00%	0
Unsure	66.67%	4
TOTAL		6

Question 7 - If we were to write a submission to the Ministry of Health and Ministry of Education around gaining government support to address hot/warm water access for children in schools would you support this submission?

Four of the schools said they would support this submission. 2 of these schools said they might support this submission.

If we were to write a submission to the Ministry of Health and Ministry of Education around gaining government support to address hot/warm water access for children in schools, would you support this submission?

Answered: 6 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	66.67%	4
No	0.00%	0
Maybe	33.33%	2
TOTAL		6

Question 8 - Is there anything else you would also like us to support you with, regarding accessibility to water and skin hygiene?

In general, the schools did not have many other requests in terms of support. However, a couple of the schools requested some advice in terms of what they should, what options were available and what would be the 'best' way to install hot/warm water. One school also stated that they had a few children with boils, which they think would benefit from the installation of warm/hot water.

In addition to this survey emails were sent to each of the leaders from the Kahui Ako (Communities of Learning) across Porirua. One leader responded stating that it was interesting that some schools still did not have access to hot/warm water. They went on to say that this could be due to the inequalities in the way schools are funded for Property. This, in turn, can prevent schools from installing hot water as money has been re-directed elsewhere. They also said that as the Ministry of Education has identified hot water in toilets a health and safety priority, they would anticipate more schools being able to provide hot water to students.

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Date 9 April 2019	**HEALTH SYSTEM COMMITTEE DISCUSSION**
Author	Anna Nelson, Senior System Development Lead, Mental Health and Addiction, Strategy Innovation and Performance, CCDHB
Endorsed by	Rachel Haggerty, Director, Strategy, Innovation and Performance, CCDHB
Subject	**3 DHB ALCOHOL AND OTHER DRUG (AOD) MODEL OF CARE**

RECOMMENDATIONS

It is **recommended** that the Health Systems Committee:

(a) Note the progress of the 3 DHB AOD Model of Care work;

(b) Note the next steps in the 3 DHB AOD Model of Care work.

APPENDICES

1. Stakeholder Engagement Map;
2. AOD Full Time Equivalent (FTE) Visualisation Map;
3. AOD Kaupapa Māori (FTE) Visualisation Map;
4. Opportunities And Themes From The Stocktake Interviews

Health System Plan Outcomes		**Stewardship**	
Wellbeing Strengthen our communities, families and whānau so they can be well	**X**	**Quality & Safety** Quality & safety of service delivery	
People Centred Make it easier for people to manage their own health needs	**X**	**Service Performance** Report on service performance.	
Equity Support equal health outcomes for all communities	**X**	**Health System Performance** Report on health system performance	
Prevention Delay the onset, and reduce the duration and complexity, of long-term health conditions		**Planning Processes and Compliance** Planning processes and compliance with legislation or policy.	**X**
Specialist Services Ensure expert specialist services are available to help improve people's health	**X**	**Government Priority** Equity; Child Wellbeing; Mental Health; Primary Care; Water Safety	**X**

1. INTRODUCTION

1.1 Purpose

This paper informs the Health System Committee (HSC) about the progress of the 3DHB Alcohol and Other Drug (AOD) Model of Care project being led by CCDHB on behalf of the three sub-regional DHBs.

1.2 Previous Board Discussions/Decisions

The HSC was previously advised of this project on 28 November 2018.

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2. BACKGROUND

Alcohol and other drug (AOD) use is embedded in many of our social and cultural customs, norms and practices. The majority of people who use these substances will do so with little harm to themselves or others. Unfortunately, the problematic use of substances can affect personal, emotional, spiritual and psychological wellbeing; relationships with partners, families and whānau; and the community.

The Law Commission's papers on the reform of New Zealand's liquor laws and its review of the Misuse of Drugs Act 1975 identify that the problematic use of alcohol and other drugs impacts negatively on health, education, police, courts, prison and welfare expenditure through illness, accidents, lost productivity, violence, poor educational performance, arrests and convictions (Law Commission, 2009[1], 2011[2]). Alcohol is New Zealand's most harmful substance and alcohol-related harm in New Zealand has been estimated to cost $5.3 billion per year (Slack, Nana, & Webster, 2009[3]). The New Zealand Drug Harm Index 2016, estimates that the social cost of drug-related harms and intervention costs in 2014/15 was NZ$1.8 billion (McFadden Consultancy, 2016[4]). In New Zealand, problematic use of alcohol and other drugs is also the sixth highest contributor to the burden of disease (National Committee for Addiction Treatment (NCAT), 2011[5]).

There is also a significant relationship between mental health and AOD use, with over 70% of people who attend AOD services having co-existing mental health conditions, and over 50% of mental health service users having co-existing substance use problems (Government Inquiry into Mental Health and Addiction, 2018[6]).

Serious alcohol and drug problems affect 3.5% of the total population (NCAT, 2011), which is approximately 157,000 New Zealanders and 18,000 people who reside in the 3 DHB sub-region, based on current census figures (Statistics New Zealand, 2017[7]). Of these, however, only approximately 4100 receive some form of intervention from an AOD service in the 3 DHB sub region. Based on these figures we know that approximately 13,900 people likely to require AOD services in the 3 DHB sub-region are not accessing them. This may be for a number of reasons including difficulty accessing services, lack of knowledge about what services are available and/or shame.

While serious alcohol and other drug problems can affect people from all parts of the community, some people are more at risk. A range of social determinants are risk factors for substance use related harm: poverty, lack of affordable housing, unemployment and low-paid work, abuse and neglect, family violence

[1] Law Commission. (2011). *Controlling and regulating drugs: A review of the misuse of drugs act 1975*. (Report No. 122). Wellington, New Zealand: Law Commission

[2] Slack, A., Nana, G., & Webster, M. (2009). *Costs of harmful alcohol and other drug use. Final report to the ministry of health and ACC.* (Report prepared by BERL for the Ministry of Health and ACC). Wellington, New Zealand: BERL

[3] Slack, A., Nana, G., & Webster, M. (2009). *Costs of harmful alcohol and other drug use. Final report to the ministry of health and ACC.* (Report prepared by BERL for the Ministry of Health and ACC). Wellington, New Zealand: BERL

[4] McFadden Consultancy. (2016). *The New Zealand drug harm index 2016* (2nd Edition). (Research report). Wellington, New Zealand: Ministry of Health

[5] National Committee for Addiction Treatment (NCAT). (2011). *Addiction treatment is everybody's business*. Wellington, New Zealand: NCAT.

[6] Government Inquiry into Mental health and Addiction. (2018). He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction Retrieved 9 April 2019 https://mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf

[7] Statistics New Zealand. (2017). *Population clock*. Retrieved 21 December, 2017, from http://www.stats.govt.nz/tools_and_services/population_clock.aspx

and other trauma, loneliness and social isolation (especially for older people and rural populations) and, for Māori, deprivation and cultural alienation (Government Inquiry into Mental Health and Addiction, 2018: 8).

Currently the 3 DHB sub-region funds a variety of AOD services (across the continuum from harmful use to severe dependence) including counselling, detoxification and withdrawal services, residential treatment, information services, health promotion, harm reduction and opioid substitution (for example methadone). A recovery model underpins current treatment services with community-based services working in tandem with health, disability, social and justice sectors. There is however, no clearly articulated and agreed locality based AOD model of care across the 3DHB sub-region.

This project reviews current service configuration, identifies gaps, and/ or duplication of services, and will develop a new AOD model of care and integrated client pathway across the 3 DHB sub-region. This work is especially important in relation to the recommendations in *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction, which* focusses on alcohol and other drugs as one of the key areas where change in the current system is required.

2.1 Project Objectives

The key objectives of this project are to:

- determine what the current AOD model of care and client pathways looks like across the 3DHBs
- analyse current locality based need, demand for service, and current resource levels
- identify immediate deliverables to address current need for each locality
- develop an integrated locality based AOD model of care and integrated client pathway to meet current and future demand across the life course
- develop an implementation approach for the new model of care and integrated pathways

2.1.1 Expected benefit

When the project objectives are met, we will see:

- increased options available to support people with AOD issues and their family and whānau across the 3 DHB sub-region
- an agreed but locality based model of care and integrated client pathway across the 3 DHB's
- service gaps being identified and filled
- equitable access to services
- intensified support for those with the greatest need

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DISCUSSION

2.2 Progress to date

2.2.1 Steering group

The Steering Group has been established to oversee and direct the project. The membership includes PHOs, NGOs, MHAIDS, Kaupapa Māori and Pasifika Services as well as Lived Experience Advisory Group (LEAG) members.

2.2.2 AOD Stocktake

A stocktake of current AOD services available across the 3 DHB sub-region is now complete. The stocktake looked at DHB funded and non-funded services. It included services within primary care, NGOs and MHAIDS, as well as peer and non-funded community services that provide support across the life span and across the substance use harm continuum (from harmful use to severe addiction). In total 30 interviews were undertaken that covered 61 different services. Further web-based research took the total number of services included in the stocktake to 70.

We are currently analysing stocktake data to help us identify gaps in service delivery, capacity and workforce, as well as identify where and how to better configure the current system to work more effectively. For example, Appendix 2 shows the number of AOD specific FTE's per population. We can see very low capacity across the sub-region and a lack of equitable coverage of capacity across the DHB areas. This appears to be particularly evident in Kapiti and Upper Hutt. Similarly, Appendix 3 shows Kaupapa Māori FTE per Māori population, and again we can see low capacity across the sub-region with Wellington particularly showing inequitable access for Māori wanting to use Kaupapa services.

The stocktake analysis has provided a strong rationale to support opportunities for immediate investment that are currently being explored. Please see Appendix 4, which shows the opportunities and themes that emerged from the stocktake interviews.

2.2.3 AOD Model of Care

A workshop with AOD Model of Care Steering Group members agreed a number of outcome priorities for the Model of Care. These were:

- Equity of access and outcomes
- A harm reduction focus
- Quality and safety
- A responsive high quality sector
- Effective use of resources
- Simple navigation
- Evidence and culturally informed best practice
- Improved wellbeing for clients, family and whānau.
- A thriving and skilled workforce

The Steering Group also considered the definition of 'addiction' and agreed use the term 'substance use harm,' to convey that substance use harm can impact individuals, family, whānau and communities. It also conveys that there is a continuum of substance use harm (from harmful use to severe dependence) where interventions might range from harm reduction to abstinence focused.

At this time the Steering Group chose not to include other types of 'addiction' for example gambling is excluded.

3. NEXT STEPS

3.1 Stakeholder engagement

A consumer engagement (lived experience of addiction) stakeholder workshop will be held to focus on consumer experience of the current AOD system of service delivery, and hear views on their ideal AOD model of care. This will be completed by June 2019, but there will also be ongoing engagement with the participants.

Other stakeholder groups will also be consulted once a draft Model of Care has been developed and agreed by the Steering Group.

3.2 Data analysis

Analysis of the stocktake data will continue in relation to population and ethnicity data for each part of the sub-region. Data can be analysed by AOD severity, geography, age group, delivery model, and FTE to help understand service gaps. This will be completed by July 2019.

3.3 AOD Model of Care

The overall AOD Model of Care will continue to be developed, underpinned by the already agreed outcome priorities. Our next priority is to agree principles, objectives and outcome measures for the AOD Model of Care with the Steering Group. This will be completed by October 2019. The agreed Model of Care will provide the framework for the integrated client pathways (below).

3.4 Integrated client pathways

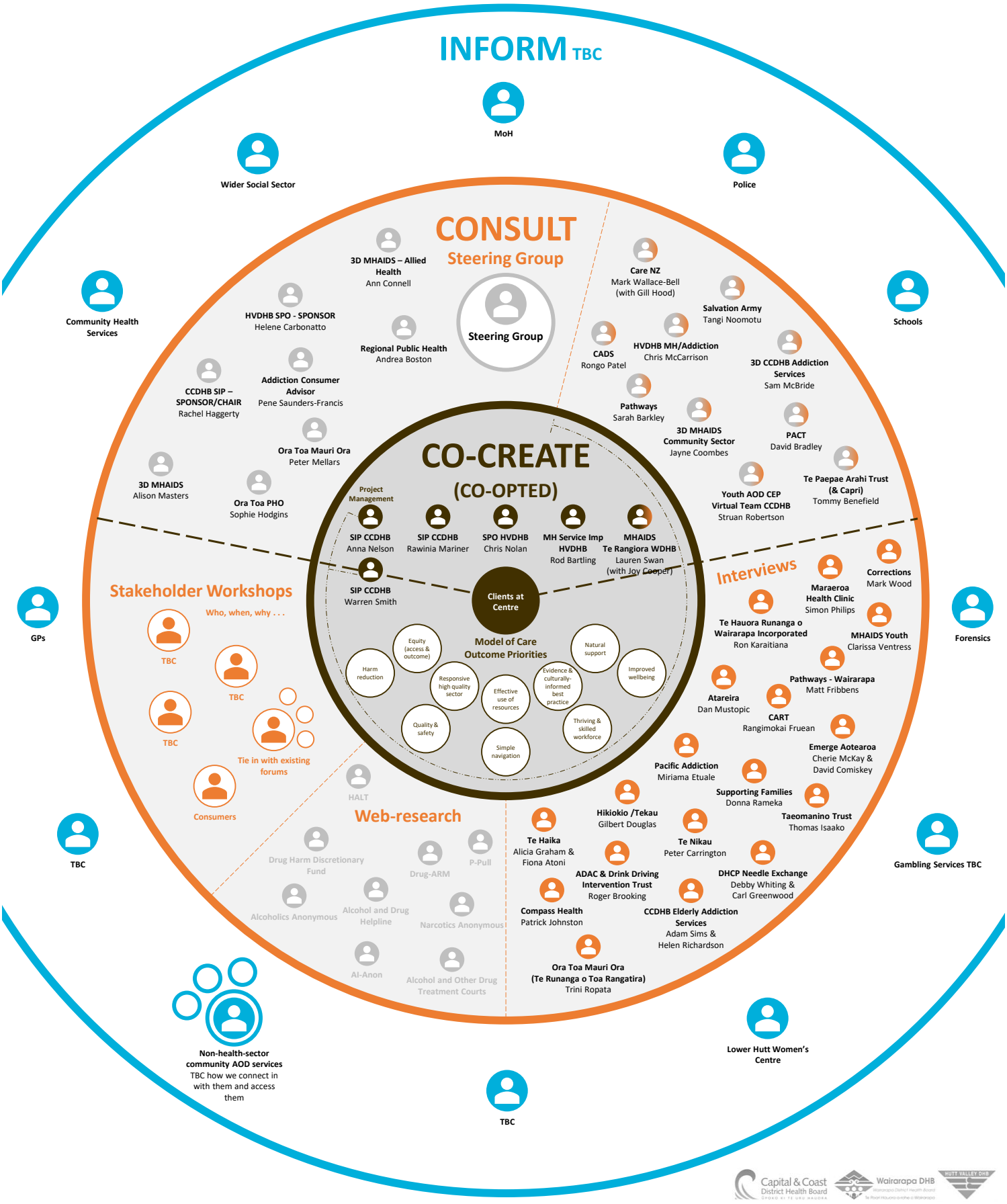
Future state focussed client pathways will be developed and agreed with the Steering Group and other stakeholders. These will be client focussed, putting clients and their family/whānau at the centre of service delivery and map out ideal pathways through an optimal AOD integrated client pathway. This will be completed by October 2019. This will be underpinned by the AOD Model of Care framework, and informed by the stocktake data analysis. For example, the stocktake data so far is showing that the system of AOD service delivery is not effective or efficient with many services not knowing about other services, what they can provide, and/or how to refer to them. A focus on system visibility, partnership and collaboration across the sub-region has already been recognised as an important next step in the development of the model of care.

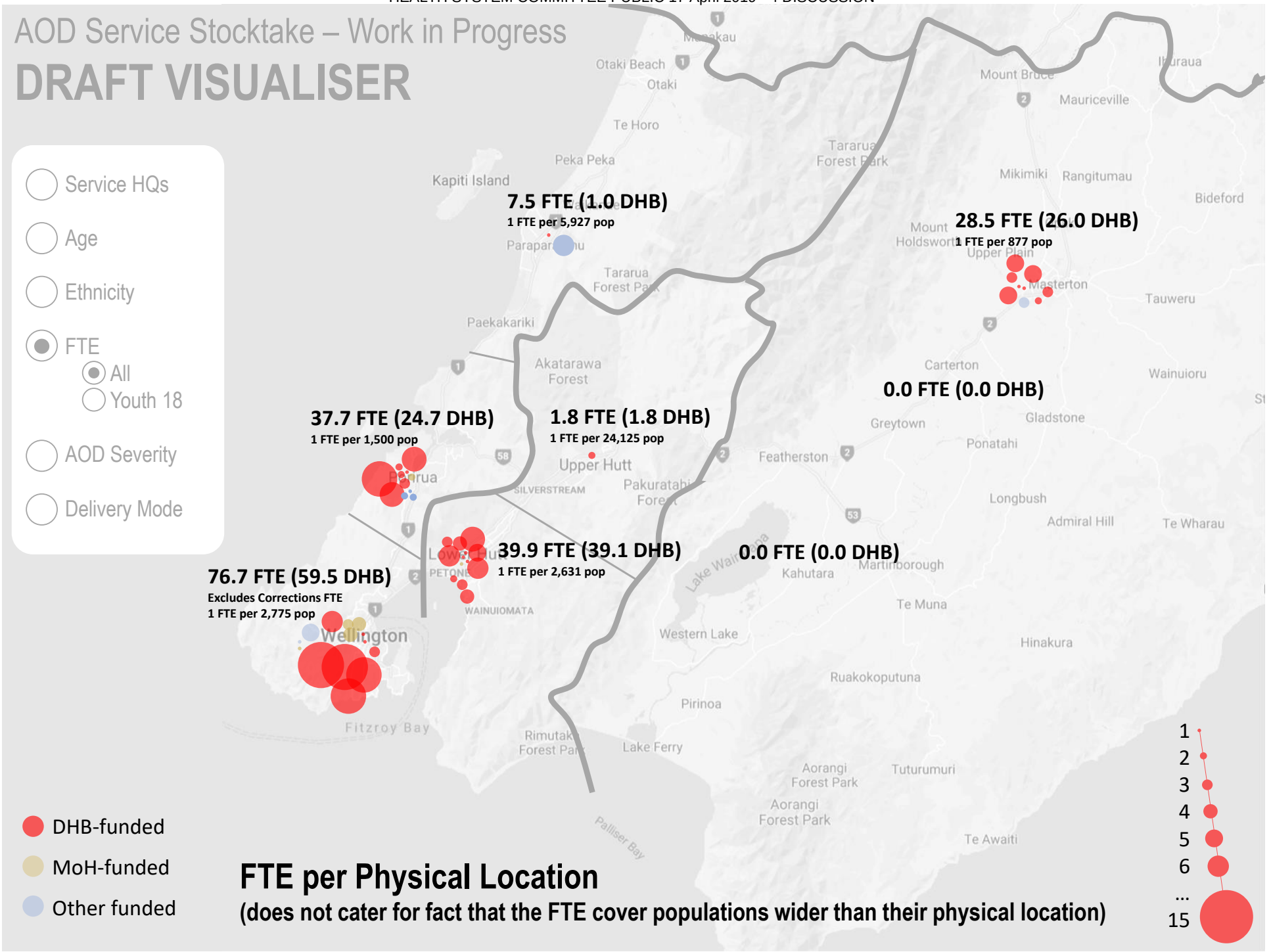
Once the AOD Model of Care and integrated client pathways have been developed and agreed, stage two of this project will look at commissioning opportunities to deliver the new model and pathways. New services will be commissioned by July 2020.

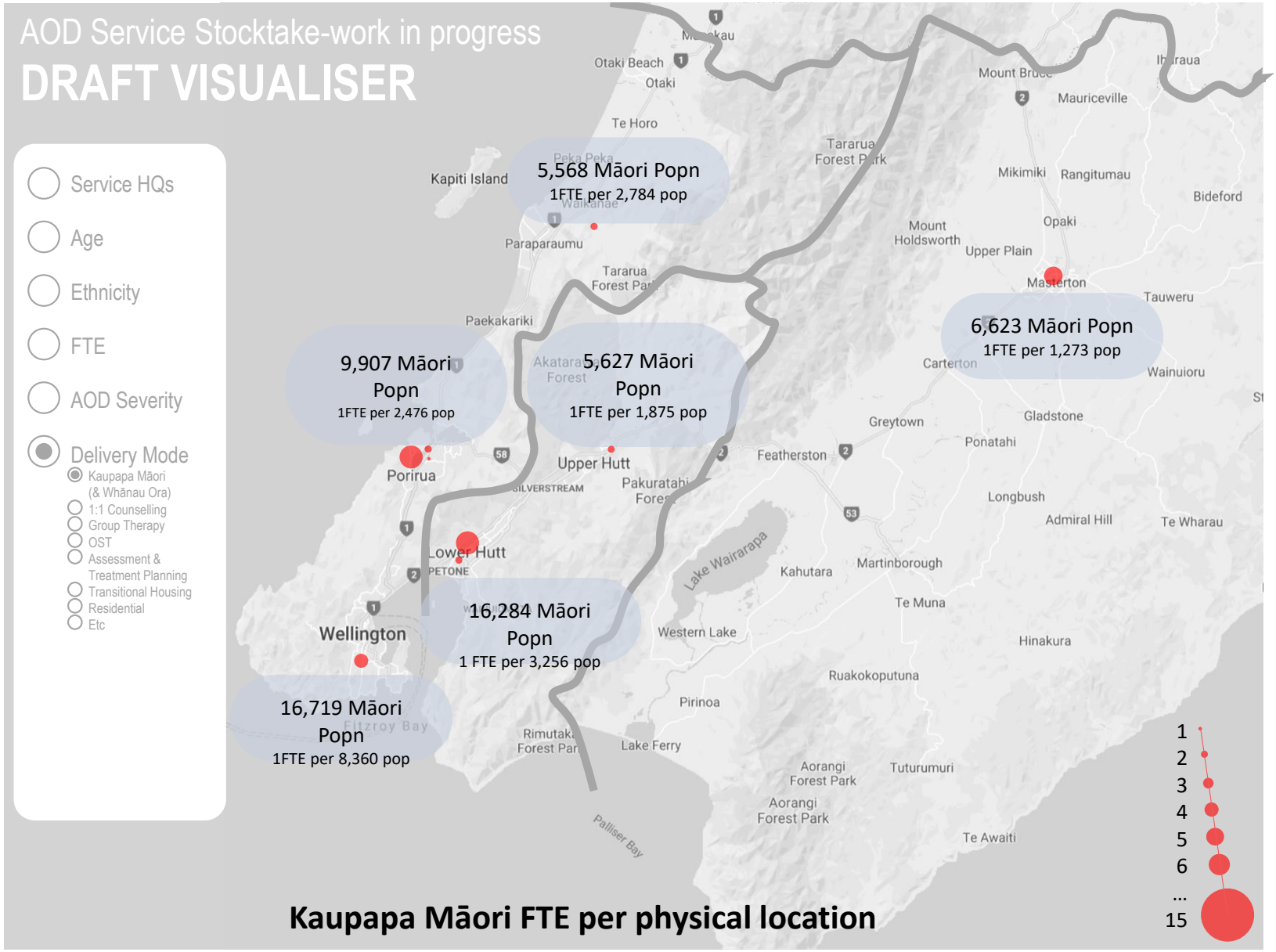
AOD MODEL OF CARE PROJECT

V5

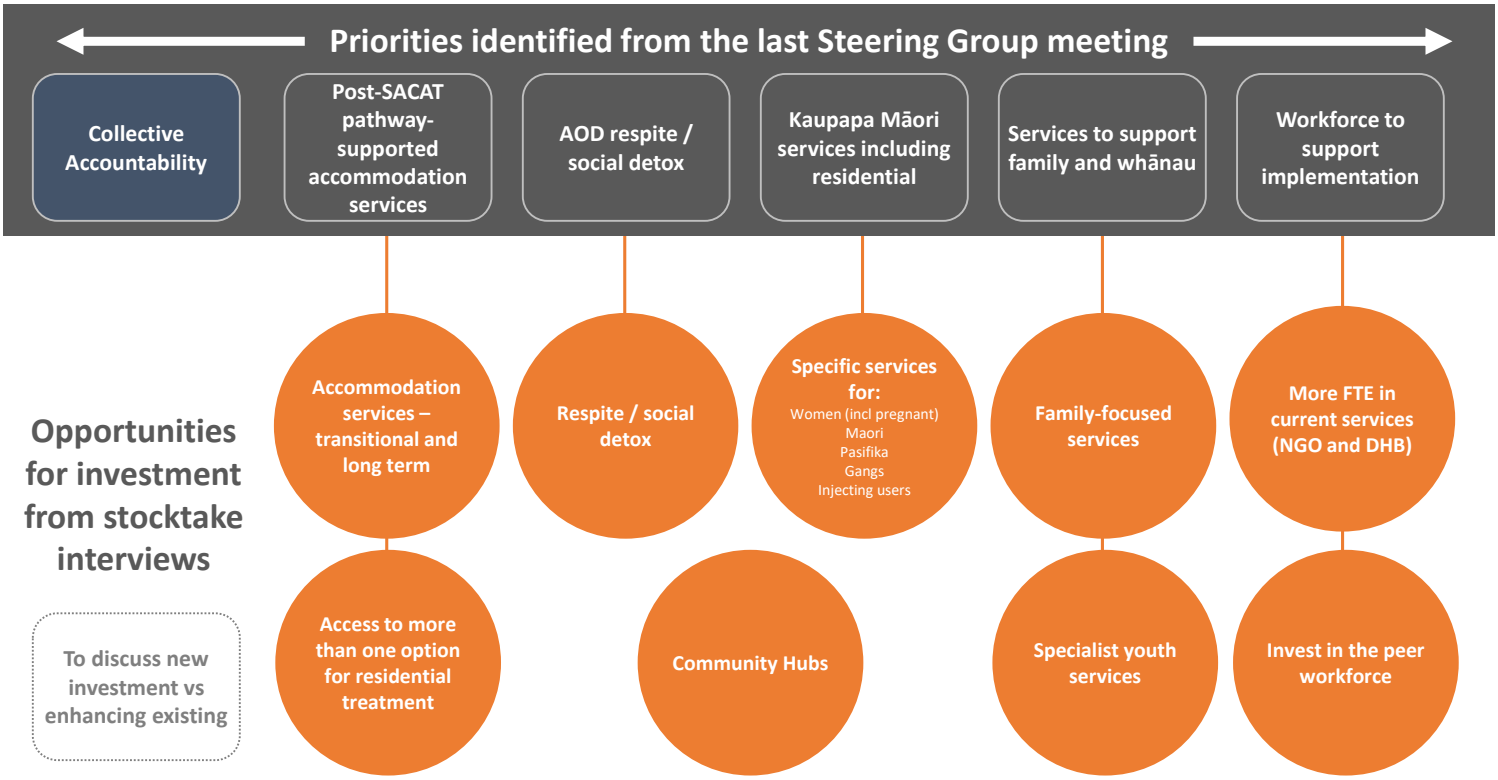
STAKEHOLDER ENGAGEMENT MAP

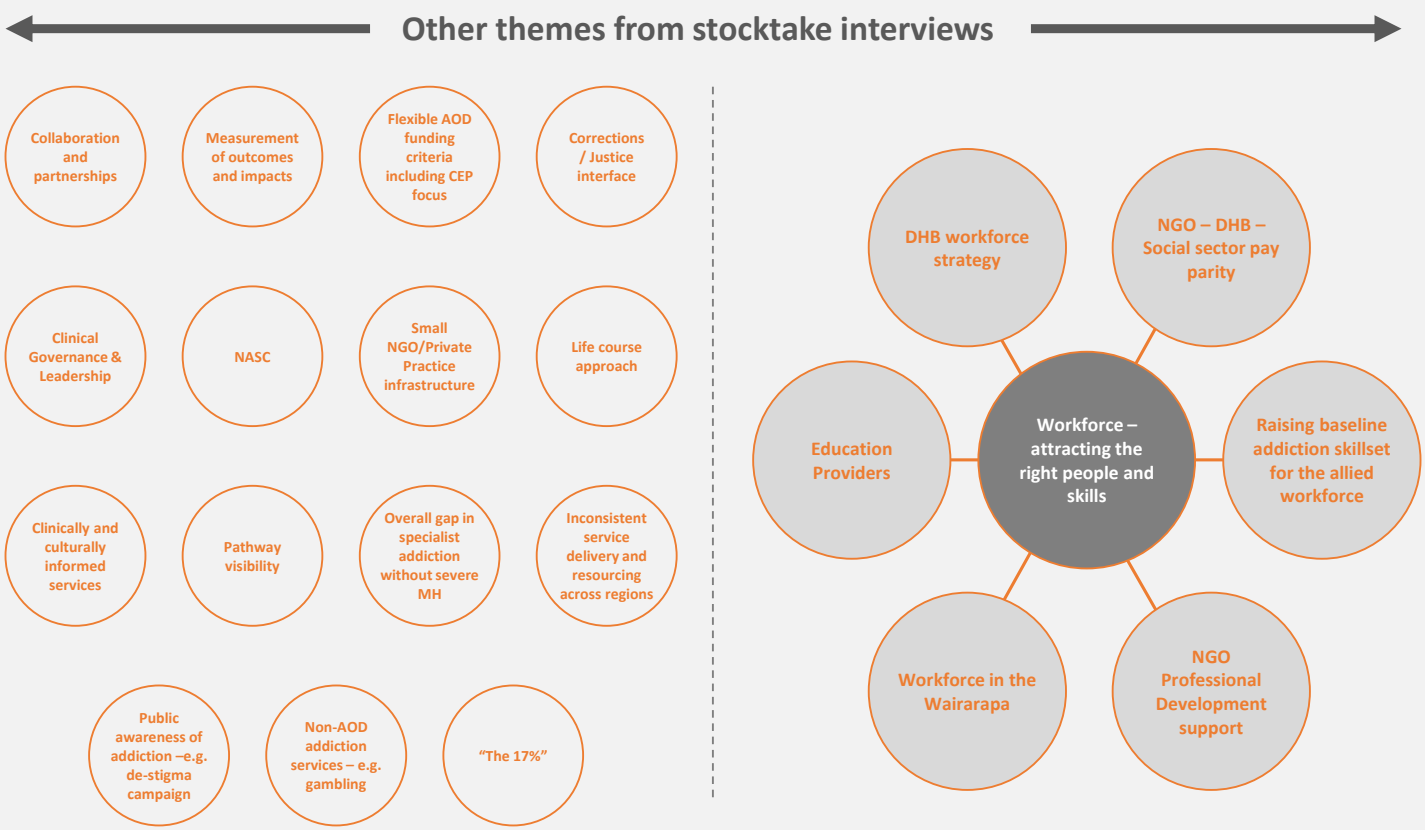



AOD Service Stocktake – Work in Progress
DRAFT VISUALISER
Service HQs
Age
Ethnicity
FTE
All
Youth 18
AOD Severity
Delivery Mode
7.5 FTE (1.0 DHB)
1 FTE per 5,927 pop
28.5 FTE (26.0 DHB)
1 FTE per 877 pop
0.0 FTE (0.0 DHB)
37.7 FTE (24.7 DHB)
1 FTE per 1,500 pop
1.8 FTE (1.8 DHB)
1 FTE per 24,125 pop
39.9 FTE (39.1 DHB)
1 FTE per 2,631 pop
0.0 FTE (0.0 DHB)
76.7 FTE (59.5 DHB)
Excludes Corrections FTE
1 FTE per 2,775 pop
DHB-funded
MoH-funded
Other funded
1
2
3
4
5
6
...
15
FTE per Physical Location
(does not cater for fact that the FTE cover populations wider than their physical location)


AOD Service Stocktake-work in progress
DRAFT VISUALISER
Service HQs
Age
Ethnicity
FTE
AOD Severity
Delivery Mode
Kaupapa Māori (& Whānau Ora)
1:1 Counselling
Group Therapy
OST
Assessment & Treatment Planning
Transitional Housing
Residential
Etc
5,568 Māori Popn
1FTE per 2,784 pop
9,907 Māori Popn
1FTE per 2,476 pop
5,627 Māori Popn
1FTE per 1,875 pop
6,623 Māori Popn
1FTE per 1,273 pop
16,284 Māori Popn
1 FTE per 3,256 pop
16,719 Māori Popn
1FTE per 8,360 pop
Kapiti Island
Paraparaumu
Paekakariki
Porirua
Upper Hutt
Lower Hutt
Wellington
Otaki Beach
Otaki
Te Horo
Mauriceville
Mikimiki
Rangitumau
Bideford
Opaki
Masterton
Tauweru
Carterton
Wainuioru
Gladstone
Greytown
Ponatahi
Featherston
Longbush
Admiral Hill
Te Wharau
Martinborough
Kahutara
Te Muna
Hinakura
Ruakokoputuna
Pirinoa
Western Lake
Lake Ferry
Tuturumuri
Te Awaiti
Lake Wairarapa
Palliser Bay
1
2
3
4
5
6
...
15
Kaupapa Māori FTE per physical location

AOD Model of Care
Investment Opportunities
To inform 2019/2020 investment discussions





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Date 11 APRIL 2019	**HEALTH SYSTEM COMMITTEE DISCUSSION**
Author	Rommel Anthony, 3DHB ICT Planning Manager
Endorsed by	Julie Patterson, CCDHB Chief Executive
Subject	**3DHB ICT Initiatives Contributing to Digital Health**

RECOMMENDATIONS

It is **recommended** that the Health System Committee:

(a) **NOTES** this report.

APPENDICES

1. **ICT SYSTEMS RESILIENCE PROGRAMME SUMMARY**

Health System Plan Outcomes		**Stewardship**	
Wellbeing Strengthen our communities, families and whānau so they can be well		**Quality & Safety** Quality & safety of service delivery	**X**
People Centred Make it easier for people to manage their own health needs		**Service Performance** Report on service performance.	**X**
Equity Support equal health outcomes for all communities		**Health System Performance** Report on health system performance	
Prevention Delay the onset, and reduce the duration and complexity, of long-term health conditions		**Planning Processes and Compliance** Planning processes and compliance with legislation or policy.	
Specialist Services Ensure expert specialist services are available to help improve people's health		**Government Priority** Equity; Child Wellbeing; Mental Health; Primary Care; Water Safety	

1 INTRODUCTION

1.1 Purpose

This paper reports on 3DHB ICT's progress towards a digital health future that supports the Health System Plan. It provides an overview of the key technology investment clusters and a summary of current and future ICT initiatives that are linked to these clusters.

1.2 Previous Board Discussions/Decisions

The paper was requested by the Health System Committee meeting in February 2019.

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2 STRATEGIC INVESTMENT AREAS

Our vision for digital technology to support improved health outcomes is:

> *A technology enabled health system will improve patient experience, quality of care, free up the workforce and support integration across health professionals. It will speed up care, make high quality care more consistent, and will contribute to services being taken out of the confines of the hospital walls. It will improve self-management capability and ultimately allow people and whānau to drive their own care. It will allow better individualised tailored care.*

Our strategic priorities for getting to "technology enabled" and "fully connected information" include:

1. Patient health information that is available whenever and wherever it is needed – any device, anywhere, any time.
2. Digitally-enabled models of care that improve accessibility, equity, quality, safety, efficiency and service experience, targeting as a priority the enablers for improved workflow, a mobilised workforce, care closer to home, continuity of care, coordination of care and services, planning care and better tracking of care, prompting of care.
3. Increased availability of information and tools that support people and whānau to stay well, allows the patient, and those involved in the care of that patient, to manage their care, to share information and care plans.
4. Use of data to gain insights to drive people focused services and individualised care, and service improvement, including intersectoral.
5. A workforce and people / whānau confidently using digital health technologies.
6. Implement key building blocks and practices that enable adaptive and rapid cycle service improvement.
7. A sustainable, fit for purpose operating model for supporting and enhancing ICT including effective decision making and prioritisation (and investment choices).
8. We are recognised as an exemplar for digital health innovation, specifically integrated ways of working across primary, community and secondary care, delivering care close to home and proactive data-driven interventions.

In the short to medium term we have identified five investment clusters that will establish the platform to drive changes in our ability to create and operate models of care that fundamentally shift our organisational paths. These clusters are:

- **Digital & Mobile Inpatient Care**: Optimising workflow and care coordination within and across wards using digital and mobile solutions such as Electronic Orders, Task Management, Patient/Equipment Tracking.
- **Mobility in the Community** : Enabling staff who work in the community to provide efficient closer to home care, spend more time with their patients and be safe in practice, and to help build our community health networks. Examples Mobile Patient Notes, Community Health Resource Scheduling, Telehealth & Remote Monitoring
- **Integrating Whole System of Care**: Smoother, safer more informed patient journeys, optimising workflow and care coordination with and across services, and creating a system of understanding of patient status in our health system. Examples Smart Referrals, Referrals of Advice, GP Patient Activity Dashboard, Shared Care Records and Plans.

- **People & Business Enablement**: Fit for purpose management systems for People & Capability, Workforce, Finance, Procumbent & Supply Chain, Digital Workplace experience, Data/Analytics for operational and population management and service improvement.
- **The Engine (ICT Platforms & Delivery Model)**: Investment in technology, delivery model and resources (business and ICT) to enable rapid and continuous delivery to the business needs. Secure, stable, responsive ICT systems and services with resilient ICT infrastructure including Disaster Recovery capability.

The Engine represents the areas of investment that are ICT's core business for which we have direct responsibility for managing and planning. Action within the other four clusters is determined based on organisational priorities as identified by the services who will own and use the technology and subject to decision at ELT and Board level as per usual investment decision-making processes. These initiatives see ICT working in partnership with services to deliver products that support change and new ways of working. They are not "ICT projects". Investment in digital technology is a critical feature of safe, high quality health services and its success needs to be built on strong relationships with the health workforce.

3 CURRENT INITIATIVES

There are a number of initiatives underway within each of the five investment clusters. Successful implementation of these projects will have an impact on health outcomes through improved patient safety, maintaining business continuity, and improved clinical effectiveness. The table overleaf summarises these projects.

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Name	Investment Cluster	Description	Benefit	Target Completion	Status Comments
Labs e-Ordering System	Digital & Mobile Hospital Care	Implementation of electronic ordering for laboratory tests	Improved patient safety through elimination of illegible lab forms and the tracking of tests	2020	Analysis & Design completed. Business case approved at CCDHB, awaiting signoff at HVDHB and WrDHB.
3DHB Allied Health Mobile Application Development	Digital & Mobile Hospital Care	Development of a mobile application to record Allied Health patient activity	Improved efficiency and data accuracy through electronic, real time capture of patient activity	May 2019	Minimum Viable Product is being piloted.
Mobile Patient Observations	Digital & Mobile Hospital Care	Electronic patient observations and Early Warning Score solution	Improved patient safety from early detection of deteriorating patients	2020	RFI completed, preparing for RFP
Electronic Whiteboards	Digital & Mobile Hospital Care	Electronic Ward and Service Whiteboards to track patients, key activities, discharges status	Improved patient flow through better visibility of patient status and required activities	June 2018	Progressing as planned
CCDHB ePharmacy	Digital & Mobile Hospital Care	Replacement of the unsupported pharmacy application Windose to the e-pharmacy product, including custom build compounding module	Business continuity through replacement of an unsupported critical system.	September 2019	Post go live issue rectification plan approved
CCDHB Cath Lab System Replacement (Synapse)	Digital & Mobile Hospital Care	Replacement of Catheter Laboratory Information Management System (XCELERA/XIMS) with Synapse software	Business continuity through replacement of an unsupported critical systems	September 2019	Contracts negotiations underway
CCDHB Vmax Replacement	Digital & Mobile Hospital Care	Implementation of diagnostic testing software supporting functions of the respiratory service	Maintaining business continuity through replacement of an unsupported critical systems	March 2019	Slight delays

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Name	Investment Cluster	Description	Benefit	Target Completion	Status Comments
CCDHB Medicines Fridge Monitoring Solution	Digital & Mobile Hospital Care	Continuous monitoring and alerting tool - notifications of issues sent before fridge content is compromised	Improved patient safety through better monitoring of medicines refrigeration temperature ranges	April 2019	Implemented and being handed over to business as usual operations.
CCDHB Regional Clinical Portal Transition	Integrating the Whole System of Care	Replicate local clinical record data to the Regional Clinical Portal	Improved quality and safety through a shared hospital record across the region	December 2019	Some delays but good progress now being made
CCDHB Regional RIS	Integrating the Whole System of Care	Transition for the local Radiology Information System (RIS) to the Regional system	Improved sharing of radiologist and radiology resources across the region to support the Regional Radiology Strategy	June/July 2019	Re-planning due to regional RIS upgrade delays
CCDHB ICU Databases	Digital & Mobile Hospital Care	Transition of three critical ICU systems to a supported platform	Maintaining business continuity	March 2019	Completed
CCDHB MOSAIQ Implementation (IOMS)	Digital & Mobile Hospital Care	Implementation of an oncology information management system (MOSAIQ)	Improved patient safety through electronic prescribing, and the ability to share notes throughout the care team	October 2019	Progressing to a revised plan. Some business resourcing challenges
CCDHB Faster Cancer Treatment	Digital & Mobile Hospital Care	Implementation of a case management system to support Faster Cancer Treatment tracking	Improved patient safety through better monitoring and tracking of patients to ensure key diagnostics and follow-ups occur in accordance to their pathways	Dec 2019	Analysis & Design underway

In addition to these clinical IT projects, progress has been made to improve the resilience of our systems to withstand a disaster. A list of the current projects aimed at improving the DHB's resilience is presented in Appendix 1.

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4 FUTURE INITIATIVES

The ICT Investment Plan for 2019/20 is currently going through prioritisation and will not be finalised until May 2019. Opportunities for investment are summarised below:

Investment Cluster	Key Proposed Investments
Digital & Mobile Hospital Care	ECG Imaging and Reporting to improve quality of care through timely sharing of electronic ECG scans Clinical Photography and Care Team communications on Smart Devices Digital Radiography for Hospital Dental Service Hospital ePrescribing and Administration Bowels Screening System Electronic & Voice Recognition Clinical Transcription
Mobile in the Community	Electronic Mobile Patient Notes District Nurse and Allied Health Scheduling Mobile Dictation and Transcription
Integrating the Whole System of Care	Smart Referrals that will improve the exchange of information as part of a referral for specialist care Shared Care Planning – Implementation of Advanced Care Plans and Health Passports Mental Health Client Record Improvements

5 APPOINTMENT OF CCIO

ICT has also recently appointed a 3DHB Chief Clinical Information Officer. Dr Steve Earnshaw was the Chief Medical Officer at Southern DHB and has good experience leading clinical ICT through his work implementing electronic medications for South Canterbury and his work with the South Island equivalent of the Regional Digital Health Service (previously known as RHIP or CRISP). The CCIO will :

- Establish clinical leadership and governance networks across the 3DHB;
- Provide clinical direction on key projects including regional programmes; and
- Aid the Chief Information Officer in the development of ICT Strategy and Action plans.

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Appendix 1: ICT Systems Resilience & Business Continuance

Steady progress is being made towards improving the resilience of the DHB's ICT infrastructure. This includes:

Component	Status	Target Completion
Firewall Replacement	The Business case has been approved. There have been vendor delays. The target date is now Q4 2018/19.	Quarter four 2018/19
Citrix Upgrade	The new Citrix environments are now live and in production. There are a few outstanding actions before the project is closed.	Quarter three 2018/19
Storage Area Network	COMPLETED. The new storage infrastructure has been implemented and tested.	Quarter two 2018/19
3D Wide Area Network	A Request for Proposal has been developed and will be released to the market in Jan/Feb 2019. It is expected that we would have completed our transition to new resilient network services by June 2019.	Quarter four 2018/19
Office 365	Phase 1 (Identity) is underway and will establish a Cloud copy of the DHB's identity and authentication system (Active Directory). A business case for Email in the Cloud (Exchange Online) is being developed and will be presented to the Board for signoff in May. A roadmap for full rollout of Office 365 is being developed.	Quarter four 2018/19
Backup Replacement	The backup strategy and approach completed. Analysis and design for a replacement backup and recovery platform has been initiated and is due to be completed by Q1 2019/20.	Quarter one 2019/20

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Date 4 April	**HEALTH SYSTEM COMMITTEE DISCUSSION**
Author	Taulalo Fiso, Director Community Partnerships, Child Youth & Localities
Endorsed by	Diana Crossan, Chairperson, Citizens Health Council Rachel Haggerty, Director, Strategy Innovation and Performance
Subject	Citizens Health Council (The Council), Citizens Engagements Update

RECOMMENDATIONS

It is **recommended** that the Health System Committee:

(a) **Notes** the content of this paper

(b) **Notes** the paper will be supported by an update by the Citizens Health Council Chairperson

APPENDICES

1. **THE CITIZENS ENGAGEMENT THEMES**
2. **CITIZENS ENGAGEMENT RESOURCE KIT**

Health System Plan Outcomes		**Stewardship**	
Wellbeing Strengthen our communities, families and whānau so they can be well		**Quality & Safety** Quality & safety of service delivery	
People Centred Make it easier for people to manage their own health needs		**Service Performance** Report on service performance.	
Equity Support equal health outcomes for all communities		**Health System Performance** Report on health system performance	
Prevention Delay the onset, and reduce the duration and complexity, of long-term health conditions		**Planning Processes and Compliance** Planning processes and compliance with legislation or policy.	**X**
Specialist Services Ensure expert specialist services are available to help improve people's health		**Government Priority** Equity; Child Wellbeing; Mental Health; Primary Care; Water Safety	**X**

1 INTRODUCTION

1.1 Purpose

The purpose of this paper is to provide an update to the Health System Committee on the recently completed Citizen's Health Council (The Council) engagements with citizens between March and April 2019.

The paper outlines the Council's initial approach to engaging with citizens in Porirua, Kapiti and Wellington as one method being trialled, with further discussion on how other methods will complement or provide an alternative as the next step in planning future engagements.

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2 BACKGROUND

2.1 The purpose of the Citizens Health Council, is to provide "a strategic forum for discussion and advice on critical public health issues facing local health services and where relevant regional services. The Council will facilitate deliberative discussion between citizens, community leaders, board members, district health board managers and staff."

2.2 To operate effectively the Council will:

- remain focused on the concept of citizenship – rights and responsibilities – and strategic direction and voice
- maintain its focus on agreed, defined values, particularly equity
- have access to timely and robust data from CCDHB and regular discussion and inclusion on strategic thinking and direction.

2.3 The following objectives guide the Council:

- to facilitate a mechanism for joint deliberation between communities of interest, the board and executive management team
- to provide a high - profile framework of citizen champions known to, respected by and experienced in their community
- to champion the presentation on behalf of communities and alongside board members an understanding of the impact of policy on a range of stakeholders
- to manage and present on behalf of citizens multiple lenses and the inherent tensions in decisions about prioritisation of development and resource allocation.

It is important to note the approach adopted for the first series of engagements is only one method trialled (as a process of continuous improvement) on citizen's right to participate in the design and delivery of health services that affect them.

3 THE CITIZENS ENGAGEMENT HUI / FONO

3.1 The Citizens Health Council established a series of hui / fono engagements to a diverse range of citizens as an opportunity to listen to citizens and report how useful the method of engagement on trial were conducted, to consider learnings to improve methods of engaging citizens. It is envisaged that further engagements will take place following the initial phase of completed engagements and a review that will inform future methods and models of citizen's engagement.

4 DISCUSSION

4.1 While the council had established an initial trial approach to engaging citizens, feedback provided by participants will be collated and worked through between the council and the communications manager followed by an update by the council to the participants, health systems committee and other identified groups.

4.2 From the initial series of engagements, the council after some reflection and review noted the following:

- Consideration of other mechanisms for asking questions and engaging citizens.
- Whether specific questions and methods needed to be developed with groups of interest.
- How other platforms of engagement might be used, for example social media.
- Who to extend the coverage for engagement so more diverse citizens are engaged.
- How do you talk to the diverse population and ensure the method is useful.
- How useful and meaningful was the approach.

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4.3 Feedback from participants acknowledged the value of having their voices heard through the method implemented by the Council. The opportunity to discuss and consider with further in-depth insights similar to section 4.2 will support the development of future citizen's engagement planning. However it is important to note in informing the health systems committee of the citizens responses and awareness of the issues for health and wellbeing, that feedback from participants provided a strong sense health in a wider context than health service delivery alone (but inclusive other social determinants e.g. housing, social service and education).

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Appendix 1

THE CITIZENS ENGAGEMENT THEMES

Feedback provided by 191 participants from 5 diverse groups across Porirua, Kapiti and Wellington were engaged in this process. It is important to note the valuable and diverse feedback from the participants and the futures thinking and considerations identified. The feedback has been collated and worked through between the council and the communications manager, with a series of communication updates by the council to the participants, health systems committee and other identified groups. The following are not an exhaustive list of what was said but based on some key themes worth noting as follows:

What does good health mean to you?

- Access to services is improved, through improved awareness & affordability
- When health and social determinants work as one
- Where services are culturally competent
- Early prevention and intervention
- Improve GP and health professionals understanding and engagement with youth
- When Maori & Pacific health is good and they are living longer
- A service similar to the Australian Medicare Scheme
- When we self-manage -make better choices and take ownership

What are the barriers to good healthcare?

- Poor Communication: unclear, unfriendly, & doesn't build relationships
- Access: Affordability Availability Accessibility Acceptability
- Lack of understanding of LGBTQI, Pacific & Maori
- Low level of Health Literacy
- Some services and organisations not fully committed
- Health treat symptoms not cause
- Services act alone with little collaboration
- Need to understand individual / family issues are wider than health

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Whose needs aren't being met?

- Equity Groups
- People with addictions & Mental Health
- Sex industry and others with no voice
- Basic needs not being met

What are the issues on the horizon of most interest?

- A communications plan for all that is clear, open and builds sustainable relationships
- Mental health provision that is timely and resourced appropriately
- Community Partnerships with a difference that is not lip service but a solution
- A more responsive health system that is wider than health
- Cost & Affordability
- Equity, health literacy and self-management
- Engaging and responding to youth who will be senior citizens in the future
- Access to health and non-health services as a holistic approach

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Appendix 2

CITIZENS ENGAGEMENT RESOURCE KIT

Together with the CCDHB communications team a communications tool kit with information material was developed to support facilitators inclusive of:

- A letter from Citizens Health Council to meet with citizens
- A one-page information sheet explaining what the council is which would accompany invite letter.
- A PowerPoint presentation with key questions to facilitate and share with its citizens:

1. What does good health mean to you?
2. What are the barriers to good healthcare?
3. Whose needs aren't being met?
4. What are the issues on the horizon of most interest?

Citizens Meeting Schedule:

CITIZENS GROUP	DATE	COUNCIL MEMBERS ATTENDING
Pacific Men's Group Porirua	6 March 2019	Brad Olsen Greg Coyle Taulalo Fiso
1st Year Maori Nursing Students, Whitireia Community Polytechnic	7 March 2019	Brad Olsen Ria Earp Taulalo Fiso
Youth and Others at Kapiti Youth Service	14 March 2019	Jenny Rowan Brad Olsen Taulalo Fiso
4th Year Bachelor of Social work students, Whitireia Community Polytechnic	21 March 2019	Greg Coyle Ria Earp Taulalo Fiso
Wellington Probus Wesley Church	4 April 2019	Diana Crossan Jenny Rowan Taulalo Fiso
Thursday 8am Group of Passionate Citizens Porirua (Postponed)	8 May 2019	The Council Taulalo Fiso
Attendees	March–April 2019	191

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Date 17 April 2019	**HEALTH SYSTEM COMMITTEE DISCUSSION**
Authors	Russell Cooke, Senior System Development Manager Julia Jones, System Development Manager Jan Marment, Senior System Development Manager Lisa Smith, System Development Manager
Endorsed by	Rachel Haggerty, Director of Strategy, Innovation & Performance
Subject	**INVESTMENT AND PERFORMANCE – OLDER PERSONS SERVICES, COMMUNITY PHARMACY, PRIMARY HEALTH ORGANISATIONS, AND COMMUNITY DENTAL SERVICES**

RECOMMENDATIONS

It is **recommended** that the Health System Committee:

(a) **Notes** in 2018/19 CCDHB will invest $228 million in nationally negotiated agreements for aged residential care (ARC), community pharmacy services (ICPSA), primary health organisations (PHOs), and community dental services (CDA).

(b) **Notes** there is a forecast 3% growth in spend on community pharmacy due to cost and volume changes. We are mindful not to assume growth in medicines use is always problematic, and are investing in pharmacy facilitators to ensure medicines are used appropriately in our communities and medicines therapy is optimised.

(c) **Notes** there has been a planned decrease in performance of PHOs across a number of areas: more heart and diabetes checks, and brief advice for smokers to quit in primary care. We are working with our PHO partners to revise our measures in this area and focus on impact and outcome. We are transitioning this reporting to measures such as 'reduction in smokers'.

(d) **Notes** that immunisation rates have fallen and we are working with our PHOs to investing in outreach immunisation services.

(e) **Notes** Māori and Pacific peoples access ARC at lower rates than other populations. In contrast, the number of Māori and Pacific peoples receiving HCSS is in line with population percentage for Māori and but lower for Pacific peoples. This may reflect the natural supports of families in different communities and is being considered in developing an equity response.

(f) **Notes** in 2018 we provided care to 13,465 young people under the community dental services agreement.

(g) **Notes** this reporting is part of our process of improving our understanding of how our investments in the national agreements are working for our population including equity (or not) of access to health services and outcomes achieved.

APPENDICES

1. **HEALTH OF OLDER PEOPLE INVESTMENT DASHBOARD**
2. **PRIMARY HEALTH ORGANISATION PERFORMANCE DASHBOARD**

Health System Plan Outcomes		**Stewardship**	
Wellbeing Strengthen our communities, families and whānau so they can be well		**Quality & Safety** Quality & safety of service delivery	
People Centred Make it easier for people to manage their own health needs		**Service Performance** Report on service performance.	x
Equity Support equal health outcomes for all communities	x	**Health System Performance** Report on health system performance	X
Prevention		**Planning Processes and Compliance**	

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Delay the onset, and reduce the duration and complexity, of long-term health conditions		Planning processes and compliance with legislation or policy.	
Specialist Services Ensure expert specialist services are available to help improve people's health		**Government Priority** Equity; Child Wellbeing; Mental Health; Primary Care; Water Safety	**x**

1. PURPOSE

The purpose of this paper is to update the Health System Committee (HSC) on key national processes, local highlights and the performance of investments in services provided for the CCDBH population under nationally negotiated agreements: Aged Residential Care (ARC), community pharmacy services (ICPSA), primary health organisation services (PHOs), and community dental services (CDA).

In 2018/19, CCDHB will invest $228 million in local providers under these nationally negotiated agreements. The following sections detail performance against those contracts and are presented as sections on older person's services, community pharmacy, PHO primary care services, and community dental services.

2. OLDER PERSONS SERVICES

In 2018/19, CCDHB will invest $72 million in local providers under the nationally negotiated Aged Residential Care Agreements for service that include rest home, continuing care, dementia, and psychogeriatric services. This section provides an update on performance of older person's services, the annual contract review process, ARC funding model review, nursing MECA effects, pay equity impacts, and home and community support services.

2.1 Older person service performance dashboard

The dashboard and commentary provides a snapshot of the performance of our investment in older person services (see Appendix 1). The dashboard includes a selection of performance measures for the more widely used services accessed by the older person within CCDHB. The dashboard continues to show trends in line with the previous dashboards.

Investment and Activity

DHB Investment and ARC activity

DHB investment in ARC and Home and Community Support Services (HCSS) is forecast to remain within budget for 2018/19. The number of clients in aged residential care (ARC) has consistently reduced from 2016. We have added a ratio comparison of the people supported at home compared with those in ARC because this is a broad indication of the DHBs ability to enable people to age in place and stay at home longer. Most DHBs are around the 60 (home): 40 (ARC) ratio. CCDHB is within the target with 59 % supported with HCSS and 41% living in ARC.

For the first time we are including in the dashboard the number of Māori and Pacific people in aged residential care or receiving home and community support services as a percentage of their ethnic group. Although there are less Māori and Pacific people in our older population, they access Home and Community Support services (HCSS) broadly in line with their population size. Given Māori and Pacific people access ARC services at lower rates than our 'other' population we may have expected them to access higher levels of HCSS. However, the natural supports of families may reduce the need for some home and community support options. With the expectation that we will see more Māori and Pacifica in our older population our Health Aging Investment Planning will be considering how our services can better meet the needs of Māori and Pacifica.

System Level Performance

Audit and Compliance

Four-year certifications are an indicator that the ARC facilities are providing good quality services. There has been an increase in the number of four-year certifications from 15 to 19, 61% of 31 eligible ARC facilities. We have one facility with a one-year certification, this is a standard certification for any new

facility or facility that has changed ownership. The facility with a 2 year certification has made significant changes; the clinical and facility managers are new and a broad quality improvement plan is in place.

Complaints
There were fewer complaints about Home and Community Support in the previous 3 months. There are approximately 12,500 cares rostered per week by Access Home Health for approximately 2000 clients. This equates to an average 0.1% rate for both complaints and incidents.

Acute Flow from ARC Facilities
ED presentations and acute admissions of ARC residents are within the historical range.

Impact Measures

Individual Impact
We use the InterRAI assessment to capture a snapshot of a person's needs. These measures show that the *carers' feelings of stress* measure has been rising. We have been working with the NASC to allocate more services that provide respite for carers. The impact of this is reflected in the increased expenditure on day programmes. Other measures show a positive trend; there are more advance care plans being completed and more Enduring Power of Attorneys in place.

System Impact
The non-admitted ED rates (per 1000) for Māori and Pacifica aged 65+ are higher than 'other' aged 75+. However the acute admission rate for Māori is slightly below the 75+ year old 'other'. The acute bed day rate per 1000 for Māori aged 65+ is also below that for 'other' and Pacifica.

The rate for Pacifica is highest for both ED presentations and admissions. The Pacific Neighbourhood Nurse-Led service based in Porirua, supporting Pacific families, individuals with management of complex care is a step towards supporting our Pacific families.

2.2 Aged Residential Care Funding and Contract Reviews

The annual general review of Aged Residential Care Agreements is underway for 2019. This review occurs each year under the terms of the agreement with ARC service providers and covers both services and price. The ARC funding review report prepared by Ernst & Young is with the Ministry of Health. There are around 24 recommendations. The report will be initially released to the Funding Model Review Steering group in April 2019 and then for wider release and comment. This work is considering how funding models may reflect different levels of care intensity.

2.3 Pay Equity and Nursing MECA Impacts

Nationally, the General Managers of Planning and Funding have agreed a payment to ARC as a contribution towards offsetting the effect of the MECA on the nursing workforce in ARC. From 1 July 2019 the payment will increase will be incorporated into any price increase that is agreed for 2019/20. Impacts on two non-ARC providers are being negotiated individually.

2.4 Pay equity Impacts

The Cabinet have directed that Pay Equity is devolved to funders from July 2019 as pay equity funding for ARC for 2019-20 is now a part of the annual contract price setting process. Pay equity funding will be included in DHB funding envelopes for 2019/20. The Ministry has agreed to work with DHBs to best manage the financial risks to DHBs post devolution.

2.5 Home and Community Support service

The revised service with two providers instead of one went live on the 1st of April 2019. The service changes impacts over 3,000 people and 780 support workers across CCDHB and HVDHB. To minimise disruption the DHBs and provider agreed principles for allocating clients.

There are a small but steady number of people wanting to change their designated provider. The DHBs agreed several principles to maximise the success of the transition by minimising the number of changes

as the service went live. These included whether the person is with the most logical provider, can the person's need be met by the assigned provider, and considering the impact on rosters if the person is transferred. Clients will have the option to choose to change their provider, if they wish, after May 2019.

Since the new service started Access are reporting business as usual. Nurse Maude have experienced difficulty in recruiting support workers and have vacancies particularly in the Wellington city area. They have bought staff from Christchurch and Nelson/Marlborough to help with the shortfall, they continue to advertise and have approached several staffing agencies.

3. COMMUNITY PHARMACY

In 2018/19, CCDHB will invest $88 million in local providers under the nationally negotiated Integrated Community Pharmacy Services Agreement (ICPSA) for services including dispensing and other services provided by community pharmacies as well as reimbursement for the costs of the subsidised pharmaceuticals dispensed.

3.1 Growth in Pharmacy costs and dispensing

Current advice from the TAS pharmacy group indicates growth in both the costs and volumes of medicines dispensed at CCDHB, along with the associated dispensing fees. Our growth is 3.0% which is less than the national growth rate of 4.3%. This is a similar pattern to previous years. The increase in medicine dispensing costs and volumes does not take account of population growth or demographic change. We are mindful not to assume growth in medicine use is always problematic.

We want to ensure medicines are used appropriately in our communities and medicines therapy is optimised. This may mean increasing or decreasing use depending on population need. Two pharmacy facilitators whose key task is to reduce polypharmacy in the elderly have been recruited in primary care. This will have some impact on managing growth in medicines volumes. We are also exploring opportunities for pharmacists to work in communities where under-prescribing may be occurring (see section 3.3).

3.2 Zoom Health - Pharmacy

We have accepted an application for a community pharmacy contract from Zoom Health. Zoom is an internet company based in Auckland that dispenses medicines remotely and delivers by courier to the patient's address. The Zoom model ensures pharmacists deliver the critical advice component of the dispensing process through the App they provide as well as telephone or email where needed. This signals one of the future directions that community pharmacies will take and aligns with our Health System Plan "simplify" strategy.

3.3 Local Commissioning

Under the ICPSA agreement, DHBs have the ability to fund local services. We have chosen a community pharmacy based Gout service where pharmacists will have the ability to increase anti-gout medication until the serum urate levels fall beneath the accepted critical level for initial focus. This proposal has been through a consultation process and the final process is being designed.

4. PRIMARY HEALTH ORGANISATIONS

The performance of primary health organisations is a critical element of ensuring performance of the health system. We have three PHOs in CCDHB, providing services at 59 general practices and in community settings across Wellington, Porirua, and Kāpiti. In 2018/19, CCDHB will invest $66 million in services under the nationally negotiated PHO Services Agreement. This section provides information on the switch to National Enrolment Service-based capitation funding and performance of PHO services provided under the PHO Services Agreement.

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4.1 PHO Performance dashboard

The dashboard (Appendix 2) and commentary provides a snapshot of the performance of our investment in Primary Health Organisations (PHOs), focusing on services provided under the PHO Services Agreement.

Funding

In 2018/19, our investment in PHOs has increased above demographic growth due to implementation of two Government led primary care initiatives. These were free general practice visits for 13 year old children and low cost visits for people with a Community Services Card. This increased our expenditure in 2018/19 to a forecasted $66.2 million, offset by $3.7million in Government funding.

Activity

The rate of nurse's visits per enrolled person shows a sharp increase for Pacific peoples. This is a data error, resulting from the merger of Compass Health and Well Health Trust on 1 July 2017. There was a corresponding decrease when the organisations merged and the information from Q4 2018/19 represents the true access rate for Pacific peoples. The rate of doctor's visits has remained steady.

Engagement

Māori and Pacific people under 25 years of age are less likely to have visited a general practice in the last 12 months. Positive engagement at these ages is important for good health in older years. A large proportion of young Māori and Pacific people live in Porirua. We are working with the local community on how we can provide young people in Porirua with additional options for accessing primary health care services.

System Level Performance

Immunisation – 8 months, 24 months and 5 years

Immunisation rates are below the 95% target across all ethnicities and age groups except 8 month immunisations for non-Māori non-Pacific children.

Immunisation coverage									
	8 months			24 months			5 years		
	Māori	Pacific	Other	Māori	Pacific	Other	Māori	Pacific	Other
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
2018/19 Q2	86.4%	93.9%	95.9%	90.3%	93.7%	94.3%	83.7%	90.5%	90.6%
Change from Q4 2017/18	-9.1%	+3.8%	+0.7%	-2.3%	-4.0%	-2.0%	-4.4%	-5.0%	-1.4%

To increase immunisation rates primary care is focusing on ensuring all proactive immunisation activities are ongoing. A cross system working group has convened to better understand the factors influencing increasing decline rates, particularly for Māori children and whanau (who decline at a relatively high and increasing rate). From early 2019, we have increased funding to the Porirua-based outreach immunisation team as part of our work to ensure providers are paid equitably. This will increase resourcing to those not accessing immunisation through mainstream primary care providers in clinic, including Māori, Pacific and families living in quintile 4&5 areas.

Better Help for Smokers to Quit – Primary Care

The percentage of current smokers offered brief advice to quit in primary care has decreased for all ethnicities in the last six months.

Better Help for Smokers to Quit – Primary Care			
	Māori	Pacific	Other
Target	90.0%	90.0%	90.0%
2018/19 Q2	86.6%	85.2%	89.7%
Change from Q4 2017/18	-2.4%	-2.9%	-0.7%

This indicator is a count of the number of current smokers who are offered a brief intervention. A more meaningful indicator for our people would be the number of current smokers, or smoking rate. This would measure the efficacy of brief interventions and subsequent smoking cessation support. Success in this

indicator would be directly measurable as a decreasing number of current smokers. We are gathering the data for this indicator and it will be included in the next dashboard presented to the Committee.

More Heart and Diabetes Checks

The number of checks are currently below the target of 90%, for all populations. In 2018/19, we have implemented the 2018 updated Guidelines for Cardiovascular Risk assessment. Under these guidelines the starting age for risk assessments has been lowered by five years, increasing the number of people eligible. This reflects the need to screen people earlier to offer opportunities to intervene and prevent development of cardiovascular disease. In addition, the follow up period for low risk people has been increased to every 10 years rather than 5 years. Our PHOs are focusing on the younger people and with the increased cohort of people the performance overall has decreased. The data reported below does not include the increased age range or adjust for the 10 year period, it reports performance under the current (old guidelines) Ministry of Health definition.

More Heart and Diabetes Checks			
	Māori	Pacific	Other
Target	90.0%	90.0%	90.0%
2018/19 Q2	82.2%	83.2%	82.0%
Change from Q4 2017/18	-1.1%	-1.4%	-1.4%

From 1 July 2019, we will report the percentage of eligible people who have received a risk assessment over the 10 year interval, in line with the 2018 guidelines. We are currently gathering the data for this change and it will be included in the next dashboard presented to the Committee.

Cervical Screening

Cervical screening rates for all ethnicities are below the target of 80% but coverage has increased for Māori women. A system-wide working group has been focusing on cervical screening coverage for Māori women for the past nine months. We have increased the linkages and collaboration across outreach providers, promoted activities widely, and shared approaches to conversations with women to promote understanding of why cervical screening is important. This initiative has seen an increase in the screening coverage (shown below). Over the same period coverage for Pacific women decreased, highlighting the need for multiple concurrent approaches to improve coverage for all population groups.

Cervical Screening coverage			
	Māori	Pacific	Other
Target	80.0%	80.0%	80.0%
2018/19 Q2	63.2%	66.0%	79.1%
Change from Q4 2017/18	+1.7%	+0.1%	+0.1%

Impact Measures

System Impact

This dashboard presents for the first time system impact measures broken down into performance for children aged 0-4 years and for all ages (age-standardised).

Both sets of indicators show that we are not achieving equitable rates for Māori and Pacific peoples. ED presentation rates overall are slowing compared with population growth, but are increasing for Māori and Pacific peoples. The increase is observed for ambulatory sensitive hospitalisation (ASH) rates and acute medical admissions. We must intensify support for Māori and Pacific peoples of all ages through programmes like the Pacific neighbourhood nurse-led service and other localities-based approaches.

Person Impact measures

Previously we have included the Primary care scores on the Health Quality and Safety Commission Patient Experience survey as person impact measures. However, due to the ongoing low response numbers particularly for Māori and Pacific people we have removed the indicators while we work to identify more meaningful measures for our populations.

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4.2 Switching to National Enrolment Service-based capitation funding

The National Enrolment Service (NES) is the national register of patients enrolled with a primary health organisation. From 1 April 2019, NES will be the single source of truth for primary care enrolment and capitation based funding allocated through the PHO Services Agreement will be paid against this register, replacing the quarterly registers submitted by PHOs.

The use of NES allows PHOs and general practices to check the enrolment status of a person in real-time and enrol them if they are not currently enrolled, identify whether a person has a current community services card and are therefore eligible for reduced fees, and validates addresses to ensure accurate assignment of deprivation-based funding.

5. COMMUNITY DENTAL SERVICES

Dental health is an important contributor to overall health. CCDHB holds a Combined Dental Agreement (CDA) with 44 private dental clinics in its district to enable free access to oral health care for children and people up to their 18th birthday. The agreement design allows for intensification of services for those in greater need and eliminates a key barrier to care for young people in low-income households. Our investment for CDA services in 2018/19 is forecast to be $2.2 million.

We are not presenting a dashboard outlining performance in services provided under the CDA in this paper. The Ministry of Health provides the DHB with a dashboard for CDA services and we are working with them to improve the indicators presented and breakdown of performance for key populations, including views by ethnicity and locality.

5.1 People Served

The Ministry population estimates calculate that there are 16,390 young people who are eligible for CDA services in our district, of whom 17% are Māori, 10% Pacific and 73% Other. In 2018 our coverage was 77% of eligible young people had received services under this agreement. Coverage has been trending upwards toward the target of 85%, although improvement has slowed.

Primary Cohort (Age 5 to 12 & 50% Age 13)				Adolescent Cohort (50% Age 13 & Age 14 to 17) eligible for CDA service			
Total	Māori	Pacific	Other	Total	Māori	Pacific	Other
32,370	6,245	3,360	22,765	16,390	2,815	1,720	11,855
	19%	10%	71%		17%	10%	73%

5.2 Service Activity

In 2018 there were 34,851 service episodes provided to 13,465 young people (2.6 treatments per young person) under the CDA. The top 5 most commonly claimed services are highlighted below and account for 88.4% of all services claimed. Most notably, the number of bitewing x-rays has markedly increased from 4% to 15% of the total service provided. Periapical x-rays are also in the top ten most commonly claimed services.

Treatment	Treatment Description	Number Provided in 2018	As a proportion of services provided
Completion - Decile 7-10	Package of care for adolescents who attends a decile 7-10 school (least deprived). All treatment required (if anything) has been completed.	10,293	30%
Other preventive treatment	e.g. Scale and polish of teeth	6,738	19%
Bitewing radiograph	The most common x-ray taken to diagnose caries.	5,275	15%
Completion - Decile 4-6	Package of care for adolescents who attends a decile 4-6 school. All treatment required (if anything) has been completed.	1,895	5%

Two surface (approximo-occlusal) restorations in posterior teeth	This is a posterior filling which involves two surfaces. Commonly it will involve the interproximal tooth structure and is usually diagnosed from bitewing x-rays.	1,465	4%

5.3 CDA Review

The CDA underwent a substantial review in 2016. The three-year agreement is due to expire on 30 June 2019 and is being reviewed to ensure that it best meets the needs of patients, contract holders, and DHBs. This is being coordinated through TAS and the OHG. A further update will be provided once the changes have been approved.

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APPENDIX 1. HEALTH OF OLDER PERSONS INVESTMENT DASHBOARD

HEALTH OF OLDER PEOPLE INVESTMENT DASHBOARD

Structural Measures

Funding

DHB Investment

Age Residential Care (Year to date – December 2018)

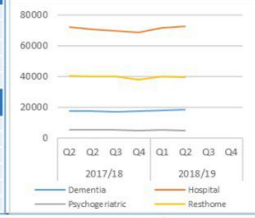
	Budget	Actual	Variance
Hospital level & Psychogeriatric	$22.78m	$20.66m	$2.12m
Rest Home & Dementia	$10.90m	$11.06m	-$0.16m
Physical Disability	$0.25m	$0.19m	$0.06m
Total	$33.93m	$31.91m	$2.02m

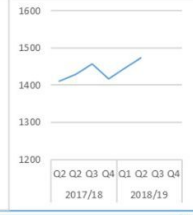
Home and Community Support (Year to date – December 2018)

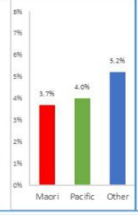
	Budget	Actual	Variance
Home-based Support	$6.09m	$6.24m	-$0.1m
Carer Support	$0.37m	$0.36m	$0.0m
Day Programme	$0.58m	$0.64m	-$0.06m
Respite Care	$0.99m	$0.80m	$0.2m
Total	$8.05m	$8.04m	$0.0m

Activities

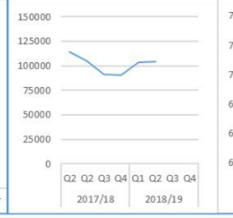
65+ People in Subsidised Age Residential Care

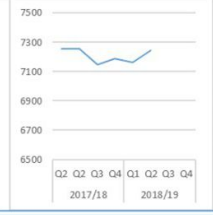


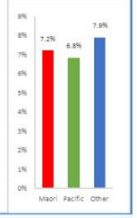




65+ People Receiving Home & Community Support in Own Home



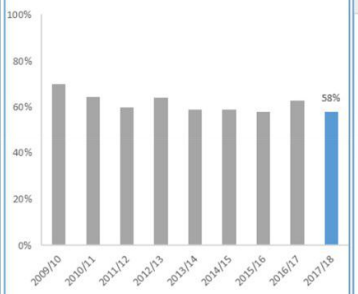




System Level Performance

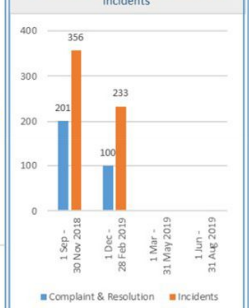
Older Persons Supported to Live at Home

Proportion of 65+ People who received DHB Funded Support to live in own home



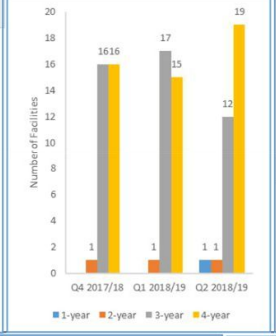
Home & Community Support Services

Number of Complaints and Reported Incidents



Audit and Compliance

ARC Facility Certification



Acute Flow from ARC Facilities

Acute Admissions from CCDHB ARC facilities

Acute bed days for patients from CCDHB ARC facilities

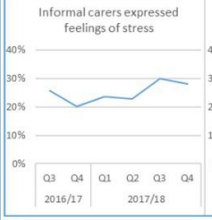
Acute ALOS for patients from CCDHB ARC facilities

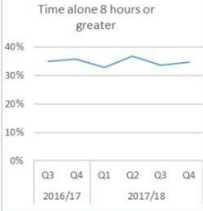
ED presentations not admitted from CCDHB ARC facilities

Impact Measures

Individual Impact

From InterRAI Assessments during the quarter

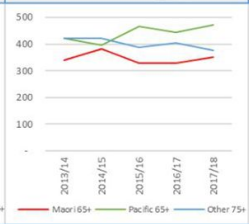




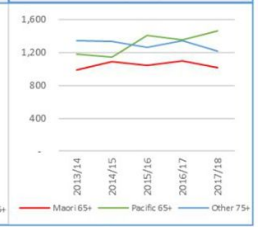
System Impact

Non-admitted ED presentations per 1,000

Acute admission rate per 1,000



Acute bed day rate per 1,000



Performance Highlights	Performance Issues	Key
		Achieved Partially achieved Not achieved

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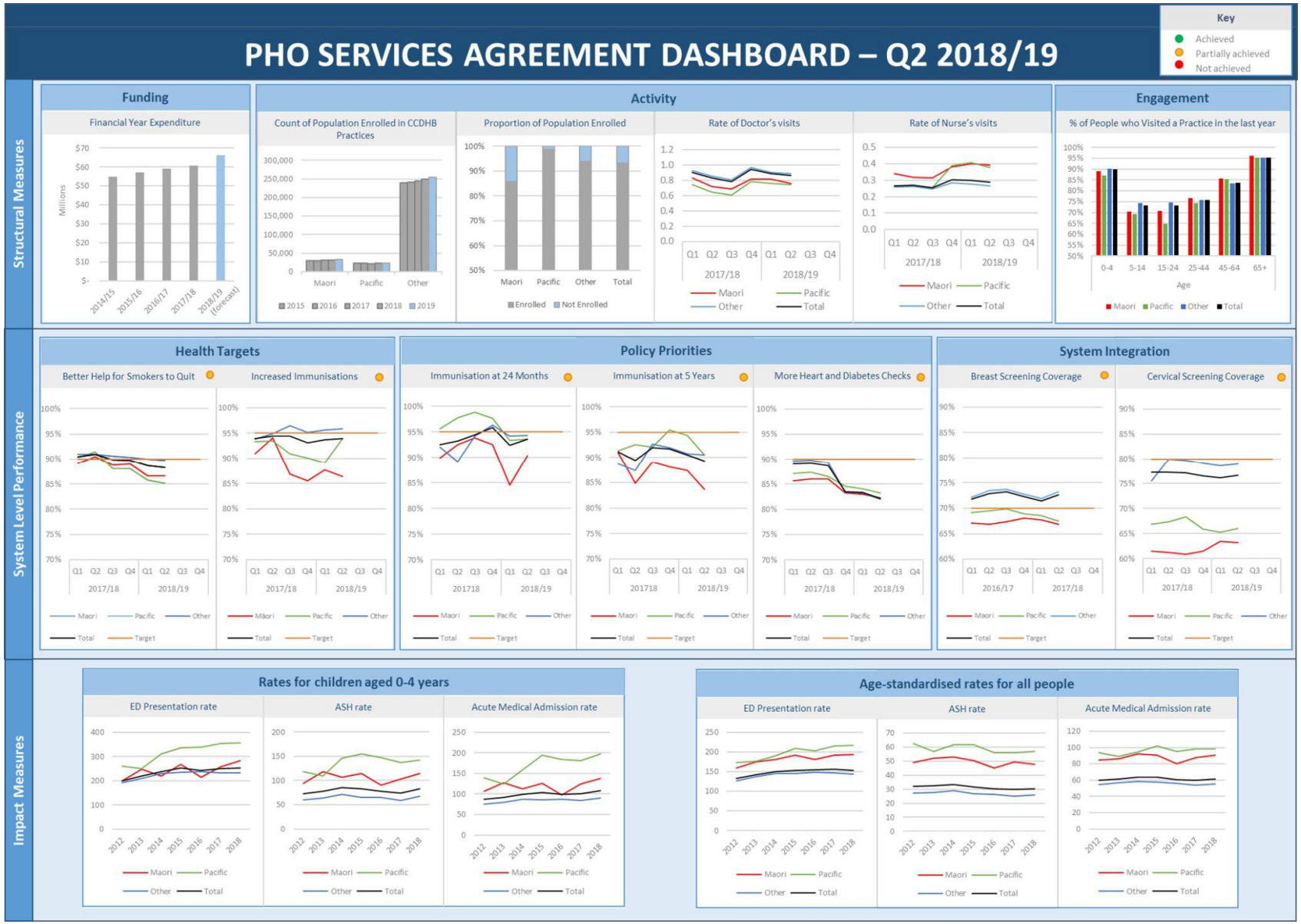
APPENDIX 2. PRIMARY HEALTH ORGANISATIONS PERFORMANCE DASHBOARD



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Date: 8 April 2019	**HEALTH SYSTEM COMMITTEE INFORMATION**
Author	Taima Fagaloa, Director, Pacific Peoples Health Directorate
Endorsed by	Rachel Haggerty, Director, Strategy, Innovation and Planning
Subject	**PACIFIC UPDATE REPORT**

RECOMMENDATION

It is **recommended** that the Health System Committee:

(a) **Notes** the approach being taken to refresh the Subregional Pacific Strategy.

(b) **Notes** the focus on working with families, youth, Pacific providers and Pacific staff.

Health System Plan Outcomes		**Stewardship**	
Wellbeing Strengthen our communities, families and whānau so they can be well		**Quality & Safety** Quality & safety of service delivery	
People Centred Make it easier for people to manage their own health needs		**Service Performance** Report on service performance.	
Equity Support equal health outcomes for all communities	**X**	**Health System Performance** Report on health system performance	
Prevention Delay the onset, and reduce the duration and complexity, of long-term health conditions		**Planning Processes and Compliance** Planning processes and compliance with legislation or policy.	
Specialist Services Ensure expert specialist services are available to help improve people's health		**Government Priority** Equity; Child Wellbeing; Mental Health; Primary Care; Water Safety	**X**

1 INTRODUCTION

1.1 Purpose

The purpose of this paper is to inform the Health System Committee of the 3DHB Pacific Engagement programme that will contribute to the development of the 3DHB Pacific Action Plan.

1.2 Previous Board Discussions/Decisions

The paper responds to the decision made by the Joint 2DHB Board meeting held in February 2019 The Board endorsed the recommendation made by the Sub Regional Pacific Advisory Group to develop a 3DHB Pacific Action Plan for Capital and Coast, Hutt Valley and Wairarapa DHB.

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2 BACKGROUND

At the March 2019 Joint board meeting for Capital and Coast, and Hutt Valley DHB, the Boards approved the approach to develop one Pacific plan across both DHBs. An approach will be made to Wairarapa DHB by the HVDHB Pacific Directorate to ensure the focus for Pacific people in Wairarapa is integrated into a 3DHB plan. This will result in a collaborative approach across Hutt Valley, Wellington, Porirua, Kapiti and Wairarapa with key stakeholders being engaged to co-produce a strategy that will signal the need to boldly re-shape health service design reflecting the aspirations, needs of the 11,680 Pacific people in the Hutt Valley, 1000 people in Wairarapa and 22,600 Pacific people in the Capital and Coast DHB for the next four years.

The Plan will also outline the evolving demographics and the current range of services provided to the Pacific communities. The refreshed Pacific Plan will be a 'single plan' encompassing the stakeholders who are service providers across the 3DHBs including Te Awa Kairangi Health Network PHO, Compass Heath PHO, Regional Public Health, Pacific Providers, mainstream providers and of course the community.

The process is underpinned by a strengths based approach in that whilst local barriers to access and needs of Pacific people will be identified or in some cases re-affirmed. It is also important to utilize the strengths and resilience of the Pacific people to co-partner with the health sector to fully identify and build on what is working well and how we can transfer learnings to improve the system and sector.

3 METHODOLOGY

Critical to the success of the strategy is the need to engage with Pacific people. The Indicative timeframe to meet the August 2019 Joint Board meeting deadline with the first draft, will be built around the current connectivity and pre-established relationships with Pacific communities. Pacific engagement will be established across the four main centres Hutt Valley, Wellington, Porirua and Wairarapa.

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4 ASSESSMENT OF CCDHBS CURRENT PACIFIC PLAN

The Hutt Valley and Wairarapa DHB Plan expired in 2019. Hutt Valley performance review has been undertaken with appropriate visual presentations ready for dissemination to the Pacific communities across Hutt Valley and Wairarapa DHBs.

The CCDHB Plan is due to expire in 2020. CCDHB will undertake a quick assessment on performance and prepare appropriate presentations.

The Ministry for Pacific Peoples' Pacific Policy Analysis Tool – Kapasa will be utilised to add value to the public policy development process. It encourages a strengths-based approach to policy development that draws upon the worldview and lived experiences, strengths and values of Pacific families and communities.

5 ENGAGEMENT

The Ministry of Pacific Peoples has developed the Yavu – Foundations of Pacific Engagement to assist agencies to engage with Pacific peoples. Effective engagement with Pacific peoples and/or service providers is an important element throughout all the phases of the Kapasa. Good engagement amongst Pacific peoples involves creating and maintaining relationships. Take the time to observe protocols and practices that uphold spirituality through prayers, recognition of church and community leaders.

5.1 Pacific families

Capital and Coast, Hutt Valley and Wairarapa DHBs will utilise previous sector engagement approaches. CCDHB has a contract with Catalyst Pacific, a communication specialist providing radio and face to face fono (meeting) with Pacific communities living in Wellington, Porirua and Kapiti.

Catalyst Pacific will lead, set up and facilitate fono in Wellington and Porirua. CCDHBs role will provide context so communities are informed of the challenges we face and how they view solutions that will best fit their communities.

Hutt Valley have a systemised approach to working within and connecting with their communities that is based on sound relationships and that will be established to communicate key health themes for their population. Catalyst Pacific will provide key radio messages across all 3 DHBs ensuring there is consistency in terms of purpose, objectives and deliverables.

5.2 Pacific Youth

Youth engagement takes a different approach from the traditional forms of engagement with older Pacific populations. Consideration is being given to how young Pacific people across the DHBs will be engaged. Both DHB Pacific Directorates agree that the youth focus will be driven by Pacific young people. A small working group will be established with the two youth who have been appointed to the Sub Regional Pacific Strategic Health Group, two Bachelor in Nursing Pacific students who are currently on placement at CCDHB and a Pacific youth representative who is a member of the CCDHB Youth Steering Group. This forum will be run by Pacific young people for Pacific young people with CCDHB and HVDHB staff providing resourcing and information support to tell the Pacific youth story.

A short stocktake of Pacific youth engagement in the Hutt Valley has revealed initiatives conducted with Youth in Hutt Valley by Pacific Health Services Hutt Valley, a local Pacific NGO and Innovate Change, a social change agency that used creative and participatory approaches to build social connectedness. Below are excerpts of the feedback provided by young people in the Hutt Valley. Pacific young people were asked what they thought of health and social services available for Pacific people.

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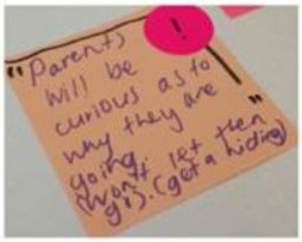
Idea feedback

Barriers to accessing health and social care services…

- x Feeling ashamed, in particular, to talk about mental health, sexual and reproductive health, gender and sexual identity.
- x Not knowing what support exists.
- x Not having the confidence to ask for help.
- x Fear of privacy being breached by Pacific health providers.
- x Fear of running in to someone they know at a health service.
- x Fear of parents finding out from Pacific health providers.
- x Not having transport to get to services that aren't local.
- x Not understanding many services are free, perceiving cost as a barrier.
- x Parents not acknowledging there is a problem or need and refusing to make an appointment.



"Won't go if a relative works there"

"Being scared the nurses will tell my parents or family… seeing someone I know in the waiting room"

"There is no advertising of services"

"In families… some refuse to acknowledge un-wellness"

"It's not okay to talk about mental health"

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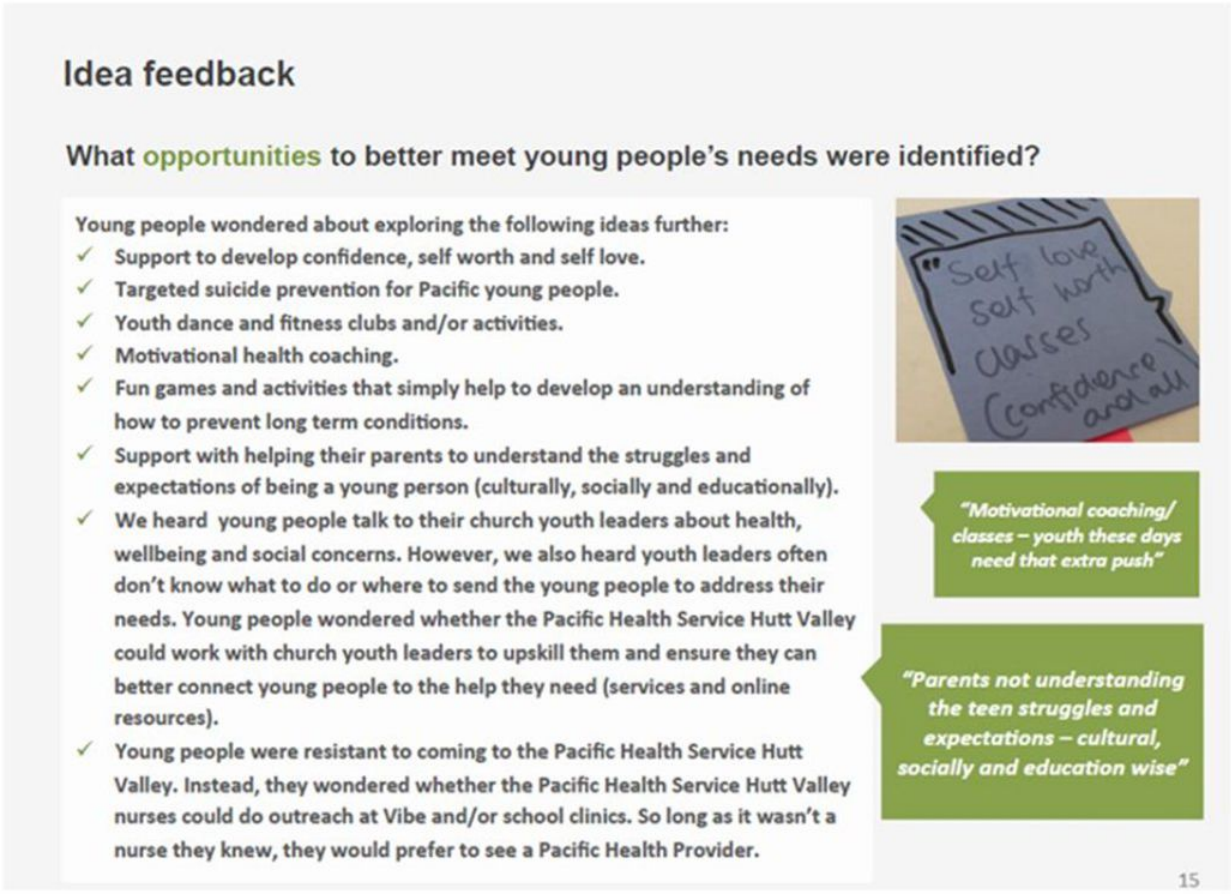

The MOH Pacific team and the Childrens' Commissioners Office Pacific advisor has confirmed their intentions to consult with Pacific youth across our sub-region. This information has provided an opportunity to consider a joined-up youth initiative which will be developed with all three agencies and Pacific youth in mind.

5.3 Pacific Provider Sector and DHB staff

The Pacific provider sector group is a critical sector to engage. Both DHBs have agreed to cater for a sub-regional provider's forum. Consideration of non-Pacific staff consultation is being considered and may be undertaken via an e-survey.

5.4 Facilitation

For engaging with Pacific communities we will utilise the leadership of the Sub Regional Pacific Strategic Health Group (SRPSHG) given their community mandate as well as the Chief Executive and members of the Executive Leadership team who will be invited to meet with Pacific communities for the initial stage of the discussions. The Sub Regional Pacific Advisory Groups' intention is to invite 3DHB Board members. The themes for each forum are yet to be finalised but will cater for the audience to ensure appropriate language is used to inform and engage Pacific people.

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Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**HEALTH SYSTEM COMMITTEE DECISION**
	Date: 4 April 2019
Author	Fran Wilde, Health System Committee Chair
Subject	**RESOLUTION TO EXCLUDE THE PUBLIC**

RECOMMENDATION

It is **recommended** that the Health System Committee:

(a) **Agrees** that as provided by Clause 32(a), of Schedule 3 of the New Zealand Public Health and Disability Act 2000, the public are excluded from the meeting for the following reasons:

SUBJECT	REASON	REFERENCE
Māori Health Strategy Paper and Action Plan Options to Manage Increasing Dialysis Demand in the Sub Region	Papers contain information and advice that is likely to prejudice or disadvantage commercial activities and/or disadvantage negotiations	9(2)(b)(i)(j)

* Official Information Act 1982.