CAPITAL & COAST DISTRICT HEALTH BOARD

Health System Committee

Public Agenda

14 AUGUST 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**	Fran Wilde			
1.3	Continuous Disclosure – Interest Register	**Accepts**	Fran Wilde			2
1.4	Confirmation of Draft Minutes 17 July 2019	**Approves**	Fran Wilde			5
1.5	Matters Arising	**Note**	Fran Wilde			
1.6	Action List	**Notes**	Fran Wilde			11
1.7	Annual Work Programme	**Approves**	Rachel Haggerty			12
2 PRESENTATION						
2.1	Citizens Health Council 2.1.1 Citizens Survey and Engagement Questions	**Notes**	Diana Crossan		11am	13 25
3 DECISION						
3.1	Final draft Regional Services Plan 2019/20 3.1.1 Regional Services Plan 2019/20	**Approves**	Rachel Haggerty			26 29
4 DISCUSSION						
4.1	Pro-Equity Update	**Notes**	Rachel Haggerty			78
4.2	Maternal, Child and Youth Investment and Performance 4.2.1 Child and Youth Intervention and Dashboard Measures 4.2.2 Maternal & Child NGO Investment Dashboard 4.2.3 HSC Investment Dashboard	**Notes**	Gerardine Clifford-Lidstone			81 87 88 89
4.3	AOD Model of Care 4.3.1 Model of Care Design 4.3.2 Substance Use Harm 4.3.3 Unmet Demand Modelling 4.3.4 LEAG – Emerging Themes	**Notes**	Rawinia Mariner			90 95 96 97 99
4.4	Board Champions – Role and Responsibility	**Notes**	Rachel Haggerty			100
5 OTHER						
5.1	Resolution to Exclude	**Approves**	Fran Wilde			104
DATE OF NEXT MEETING 11 SEPTEMBER – KENEPURU EDUCATION CENTRE, KENEPURU COMMUNITY HOSPITAL, RAIHA STREET, PORIRUA						

HEALTH SYSTEM COMMITTEE

Interest Register

UPDATED AS AT AUGUST 2019

Name	Interest
Dame Fran Wilde *Chairperson*	• Deputy Chair, Capital & Coast District Health Board • Chair, CCDHB Health System Committee • Member CCDHB FRAC • Chair CCDHB 3DHB DSAC • Chair Remuneration Authority • Chair, Te Papa Tongarewa Museum of New Zealand • Chief Crown Negotiator Moriori and Ngati Mutunga Treaty of Waitangi Claims • Chair Kiwi Can Do Ltd • Chair Wellington Lifelines Group • Director Frequency Projects Ltd • Ambassador Cancer Society Hope Fellowship • Trustee, Asia New Zealand Foundation
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

Name	Interest
	• Environment spokesperson and Chair of Environment committee, Wellington Regional Council • 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 • Member, Harkness Fellowships Trust Board • Member of the Wesley Community Action Board • Director, Port Investments Ltd • Director, Greater Wellington Rail Ltd • Economic Development and Infrastructure Portfolio Lead, Greater Wellington Regional Council • 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
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

Name	Interest
	• Establishment Chair Council of Pacific Collectives • Chair, Pacific Panel for Vulnerable Children • Member, 3DHB CPHAC/DSAC
Dr Tristram Ingham *Member*	• Senior Research Fellow, University of Otago Wellington • Chair, Independent Monitoring Mechanism to the UN on the UNCRPD • Member, Disabled Persons Organisation Coalition • Member, Capital & Coast DHB Māori Partnership Board • Member, Scientific Advisory Board – Asthma Foundation of NZ • Chair, Te Ao Mārama Māori Disability Advisory Group • Vice Chairperson – National Council of the Muscular Dystrophy Association • Chairperson, Executive Committee Central Region MDA • Trustee, Neuromuscular Research Foundation Trust • Co-Chair, 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 • Director, Foundation for Equity & Research New Zealand
Sue Emirali *Member*	• Interim Chair, Sub Regional Disability Advisory Group 3DHB • Chair, KCDC Disability Advisory Group • President Retina NZ (Low Vision support organisation) • Member of Eye Health Coalition • Member Kapiti Health Advocacy Group • Board Member of Wellable (Wellington and Districts Disability Centres)
Diane Crossan *Member*	• Chair, CCDHB Citizens Health Council • Chair, International Advisory Board for the Global Centre • Chair, Centre for Finance Education — Massey University • Chair, Retirement Income Group Ltd • Board member, Kaibosh

CAPITAL AND COAST DISTRICT HEALTH BOARD
DRAFT Minutes of the Health System Committee
Held on Wednesday 17 July 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
Ms Sue Driver
Mr Tino Fa'amatuainu Pereira
Dr Tristram Ingham (left meeting 10.50am)
Ms Sue Emirali

STAFF:
Ms Fionnagh Dougan, Chief Executive Officer
Ms Rachel Haggerty, Executive Director, Strategy Innovation and Performance
Mrs Robyn Fitzgerald, Committee Secretary
Mr John Tait, Chief Medical Officer
Mr Thomas Davis, Executive Director, Corporate Services
Ms Emma Hickson, Chief Nursing Officer
Ms Carey Virtue, Executive Director, Medicine, Cancer and Community
Ms Justine Plunkett, Acting Executive Director, Surgery, Women & Children
Mr Michael McCarthy, Chief Financial Officer
Ms Taima Fagaloa, Executive Director Pacific Peoples
Mr Nigel Fairley, General Manager MHIADS 3 DHB
Ms Rachel Nobel, General Manager 3DHB Disability Services
Mr Peter Gush, Regional Public Health
Ms Anna Nelson, Senior System Development Manager
Ms Rachel Pearce, Senior System Development Manager
Ms Geraldine Clifford-Lidstone, General Manager, Child Youth and Localities
Mr Sam McLean, Senior Analyst
Ms Shar Carlini, Senior Communications Advisor
Ms Jennifer Langton, Principal Advisor
Mr Peter Guthrie, Manager Planning and Performance
Dr James Entwisle, Radiologist
Ms Sandy Blake, Executive Director Quality Improvement and Patient Safety
Ms Rachel Pearce, Senior System Development Manager
Ms Wendy Page, Senior Business Advisor
Ms Gerardine Clifford-Lidstone, General Manager Child, Youth & Localities

BOARD MEMBERS Dr Kathryn Adams

PRESENTERS:
Ms Astuti Balram, ICC Programme Manager (Item 2.1)
Dr Brian Betty, Chair ICC and General Practitioner (Item 2.1)
Ms Melissa Simpson, Healthcare Home Lead, Tu Ora Compass Health (Item 2.1)
Lisa Smith, System Development Advisory (Item 3.2)

GENERAL PUBLIC: A member of the public
Dame Diana Crossan, Chair Citizens Health Council.

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1 PROCEDURAL BUSINESS

1.1 PROCEDURAL

Tristram opened the meeting with a karakia and blessing. Dame Fran Wilde, welcomed members of the public, DHB staff and new CEO Fionnagh Dougan.

The Committee was advised that the Citizens Health Council will be meeting after this meeting and HSC members were invited to visit after this meeting.

1.2 APOLOGIES

Apologies received from Andrew Blair.

1.3 INTERESTS

1.3.1 Interest Register

Tino Pereira confirmed that he had accepted the recent appointment as Wing representative with NZ Police. Dr Tristram Ingham provided changes to the interest register. No other changes were received.

1.4 CONFIRMATION OF PREVIOUS MINUTES

The minutes of the CCDHB Health System Committee held on 12 June 2019, taken with public present, were confirmed as a true and correct record.

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

1.5 MATTERS ARISING

Nil.

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 the scheduled 3DHB ICT report has been transferred to the next combined Board meeting as there is an item of discussion that will be of national interest.

(b) **Approved** the appointment of **'Ana Coffey** as Board champion on the Pro-Equity Group.

Action:

1. Management to draft a paper describing what a Board champion is – their role and responsibility and present to the next Health System Committee meeting.

1.9 COMMUNICATIONS UPDATE

The Committee:

(a) **Noted** the information updates;

(b) **Noted** that the detailed information update should be made available in the Resource Centre to committee members and that future items that are presented to the committee should be strategically focussed.

Action:

2. Management to provide committee members with communication updates outside of the meeting.

2 PRESENTATION

2.1 HEALTHCARE HOME PERFORMANCE UPDATE

The presentation was noted.

The Committee:

(a) **Noted** and thanked the presenters for their presentation and update on the Healthcare Home programme;

(b) **Noted** that the Healthcare Home programme will be undergoing an evaluation of its effectiveness and other groups will be involved during consultation;

(c) **Noted** the CCDHB HCH model has reached 80% of the CCDHB population with the final practices of Tranche 3 going live in April 2019

(d) **Noted** Tranche 1 and Tranche 2 HCH's have progressed will in the delivery of services that encompass acute, proactive and preventative care

(e) **Noted** Tranche 1 and Tranche 2 HCH's have achieved a positive change in acute demand measure performance.

(f) **Noted** the HCH model continues to evolve that are broadening the HCH practice new, introducing new service delivery mechanisms and improving patient engagement.

(g) **Noted** the HCH development provides a strong base on which to build further system improvements, such as Community Health Networks. A change programme to implement Community Health Networks can be a significant lever for further health improvements.

Actions:

3. Committee Secretary to place presentation in the Resource Centre;
4. The Chair to send a letter to the Ministry of Social Development registering their disappointment of increasing costs for online translator services.

3 DISCUSSION

3.1 NON-FINANCIAL PERFORMANCE MONITORING – QUARTER 3

The paper was taken as **read**.

The Committee:

(a) **Noted** this report is the first report on non-financial monitoring that includes equity. It highlights our persistent ethnic disparities as well as evidence of success and challenges in achieving health targets;

(b) **Noted** that of the six core health targets we have achieved the Faster Cancer Treatment Target.

(c) **Noted** we received a Partially Achieved status on:

i. Increased Immunisation;
ii. Shorter Stays in Emergency Departments;
iii. Raising Healthy Kids;

and a Not Achieved status on:

i. Better Help for Smokers to Quit – Maternity; and,
ii. Better Help for Smokers to Quit – Primary.

(d) **Noted** that on the 42 non-financial performance indicators reported to MoH in quarter 3 2018/19 we achieved and partially achieved 39 indicators and failed on two.

HSC recommends the Board:

(a) **Notes** the paper.

3.2 WAI 2575 UPDATE

The paper was taken as **read**.

The Committee:

(a) **Noted** the Waitangi Tribunal publicly released its findings (the Hauora report) from stage one of the Health Services and Outcomes Kaupapa Inquiry (Wai 2575), focused on the legislative and policy framework for primary health care.

(b) **Noted** the Hauora report has deliberately been delivered within a timeframe that enables its analysis, findings and recommendations to be considered in the Government's Health and Disability System Review.

(c) **Noted** CCDHBs commitment to achieving equity as supported by the Māori Partnership Board and articulated in Taurite Ora and the Pro-Equity work plan.

(d) **Noted** that our focus on equity for Māori needs to continue to be strengthened.

HSC recommends the Board:

(a) **Notes** the paper.

3.3 END OF LIFE BILL: RAMIFICATIONS FOR CCDHB

The paper was taken as **read**.

The Committee:

(a) **Noted** that the End of Life Choice Bill will be scheduled in due course for a third reading and final vote by Parliament;

(b) **Noted** that the Bill aims to legalise voluntary euthanasia in certain circumstances;

(c) **Noted** that if the Bill is passed there are professional, personal and ethical implications for CCDHB staff;

(d) **Noted** that if the Bill is passed there are potential implications for CCDHB services, policy, and education.

HSC recommends the Board:

(a) **Notes** the paper.

4 INFORMATION

4.1 STRATEGY INNOVATION AND PERFORMANCE UPDATE

The paper was taken as **read**.

The Committee:

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

HSC recommends the Board:

(a) **Note** the paper.

4.2 HOSPITAL AND HEALTHCARE SERVICES (HHS) BI-MONTHLY PERFORMANCE

The paper was taken as **read**.

The Committee:

(a) **Noted** the implementation of plans to manage winter pressures;

(b) **Noted** the continued rollout of Care Capacity Demand Management (CCDM) and the interest in its implementation from other DHBs across New Zealand;

(c) **Noted** the outcomes of a recent internal audit within Sterile Services;

(d) **Noted** the low radiation therapy intervention rates for prostate cancer;

(e) **Noted** the key performance and health target results.

4.3 PACIFIC HEALTH UPDATE

The paper was taken as **read**.

The Committee:

(a) **Noted** the adoption of the service name and progress update for the Pacific Nurse Led Neighbourhood Service known as Vaka Atafaga;

(b) **Noted** the first draft of the 3DHB Pacific Action Plan is due to the Health System Committee (HSC)s at the September HSC meeting;

(c) **Noted** the recommendations from the Tokelau Health Report commissioned by Massey University;

(d) **Noted** advanced care planning project being delivered by ATAMU Incorporated and the perspectives of Pacific participants.

4.4 3 DHB MAIDS UPDATE

The paper was taken as **read**.

The Committee:

(a) **Noted** that repair work is on track in Te Whare o Matairangi (TWOM) for the significant fire damage in February, with a completion date scheduled for August 31 2019;

(b) **Noted** that the TrendCare project is progressing well, with most of the MHAIDS inpatient units now up-and-running with the software. It is expected that all units will be operational by September 2019.

Action:

5. Management to liaise with community probation about Mental Health interventions in the community.

5 OTHER

5.1 RESOLUTION TO EXCLUDE

The paper was taken as **read**.

The Committee:

(a) **Agreed** 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
Long Term Investment Plan	Subject to Ministerial approval	9(2)(f)(v)
Birthing Facility Feasibility Update	Papers contain information and advice that is likely to prejudice or disadvantage commercial activities and/or disadvantage negotiations	9(2)(b)(i)(j)
Patient Safety and Clinical Governance	Subject to sections, 6,7,10 and 18, this section applies to protect the privacy of natural persons, including that of deceased natural persons.	9(2)(a)

* Official Information Act 1982.

Moved: Fran Wilde **Seconded**: Roger Blakeley **CARRIED**

The Committee:

(a) **Agreed** to the attendance of Diana Crossan to the Public Excluded session following the Public only meeting.

Public Meeting closed at 10.50am.

6 DATE OF NEXT MEETING

14 August 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:
P038	**4.4**	**3DHB MHAIDS Update**	Management to liaise with community probation about Mental Health interventions in the community.	GM 3DHB MHAIDS	Discussions	August
P037	**2.1**	**Healthcare Home Performance Update**	1. Place presentation into Resource Centre. 2. Write to Ministry of Social Development registering disappointment of increasing costs for online translator services.	Committee Sec. Exec Director, SIP	Resource Centre Management to provide a verbal update	August
P036	**1.9**	**Communications Update**	Management to provide committee members with communication updates outside of meeting.	Comms	Email	August
P035	**1.7**	**Annual Work Programme**	Management to draft a paper describing what a Board champion is — their role and responsibility and present to the next Health System Committee meeting.		Paper	August
HSC 17 July 2019						
P032	**3.1**	**Dementia in our Community**	Disability Sub Regional Group to provide advice to be included in the Investment Plan to be presented to HSC in December 2019.	Exec Director, SIP	Investment Plan	December
HSC Meeting 12 June 2019						
P024	**2.4**	**Hospital and Health Services Update**	Management to provide regular updates or dashboard on specific issues	Exec Director, MCC	Paper	November
HSC Meeting 15 May 2019						

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	LTIP update	Investment and Prioritisation Update	Final LTIP Investment and Prioritisation Update	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 2020 Joint Board Schedule and workplan
	DISCUSSION			Even Better Health Care		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	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	Pro-Equity Implementation Plan	System Innovation and Performance Update Hospital and Health Services Update Birthing Facility Feasibility Update Quarter 3 Performance Report	Hospital Network Planning AOD Model of Care	Quarter 4 Performance Report System Innovation and Performance Update Hospital and Health Services Update 3DHB DSAC Report		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	Health and Safety standards of Beauty and Nail Salons	Dementia Services Aged Residential Care	Pacific Health Update	Population Health (Regional Public Health Report)	Maori Health Action Plan Māori Health Update	Pacific Health Update	

V3

Citizens Health Council

Keeping our communities healthy and well

Presentation of Work Programme 2019

Why are we here today?

- The Citizens Health Council is here to support and enable our communities to input into the design and delivery of future health services in the greater Wellington region.
- We do this by listening to a range of voices and then reporting back to CCDHB and its Board.
- We're information gatherers, not employees of the DHB.
- We are future focused – that means we're looking at how we should design for the next decade and beyond. CCDHB's health service planning is guided by the **Health System Plan which is the roadmap for our healthcare planning until 2030**

Our objectives are:

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

Our Principles

- Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
- The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition.
- The health of all peoples is fundamental to the attainment of peace and security and is dependent on the fullest co-operation of individuals and States.
- The achievement of any State in the promotion and protection of health is of value to all.
- Unequal development in different countries in the promotion of health and control of diseases, especially communicable disease, is a common danger.
- Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.
- The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.
- Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people.
- Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.

Who are the Citizens Health Council?

The Citizens Health Council is here to support and enable our communities to input into the design and delivery of health services in the greater Wellington region.

Current Members:	
Diana Crossan (Chairperson)	Taulalo Fiso (CCDHB Staff)
Ria Earp	Debbie Leyland
Brad Olsen	Mae Tobin-Tapasu
Jenny Rowan	Dr Greg Coyle

Capital & Coast District Health Board

The first year was about

- *Learning about Futures Thinking / Planning*
- *Membership*
- *Trialling Questions*

This year is about

- *Citizens Engagement*
- *Information Gathering*
- *Looking Ahead*
- *Future Focused*
- *Listening to the Voices CCDHB Doesn't Hear*
- *Feedback to CCDHB*
- *Health Responses*
- *The younger voice*
- *Climate Change*

Capital & Coast District Health Board

The Council is:

- *Aligned to the Health System Plan and Citizens of Interest:*
  - Maternity and Children, young people and their families and whanau
  - Young people (15-24 Years)
  - Long term conditions including cancer
  - The frail and pre-frail elderly
  - End of life services

- *Acknowledging groups and citizens engaged to date, and next steps to prioritising future groups of citizens to be engaged.*

Citizens Survey & Engagements:

- *The first round of community engagement questions, focused on the 'here and now' and their own experience of the health system.*
- *The developing survey is being modified as appropriate and then distributed as widely as possible using as many means as we have available, including social media, group meetings, public forums where appropriate, and other avenues identified by the Council (to support future citizen engagements).*
- *The second round is asking questions in such a way as to focus attention on the future.*
- *The next round of survey & engagement results presented to the Health System Committee.*

Work Programme 2019

External

ENGAGE CITIZENS I

CITIZENS ENGAGEMENT SERIES I

- Pacific Men's Group Porirua
- 1st Year Maori Nursing Students, Whitireia Community Polytechnic
- Youth and Others at Kapiti Youth Service
- 4th Year Bachelor of Social Work Students, Whitireia Community Polytechnic
- Wellington Probus
- Thursday 8am Group of Porirua
- Report Back

SURVEY

CITIZENS SURVEYS

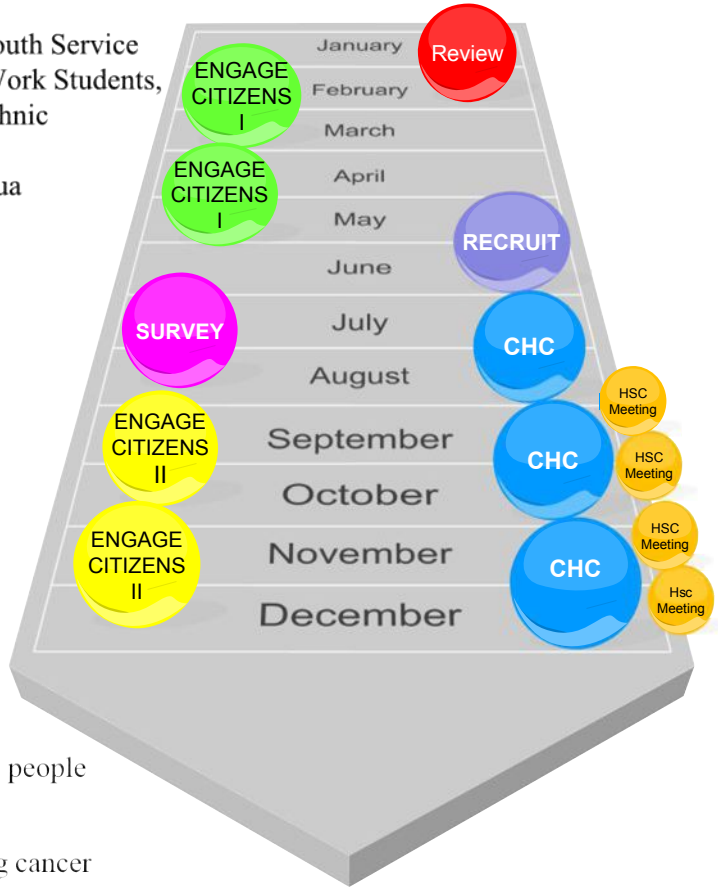
- Questions will be trialled by a controlled survey
- 10 minutes
- Results to inform Citizens engagement presented to HSC in December

ENGAGE CITIZENS II

CITIZENS ENGAGEMENT SERIES II

Questions will focus on the future Align to Heath Systems Plan and Citizens of Interest:

- Maternity and Children, young people and their families and whanau
- Young people (15-24 Years)
- Long term conditions including cancer
- The frail and pre-frail elderly
- End of life services



Internal

REVIEW

Review & Confirm ToR

provide "a strategic forum for discussion and advice on critical public health issues facing local health services and where relevant regional services

RECRUIT

RECRUITMENT

Recruit to full complement of 12 members including locality, age, gender, ethnicity (vulnerable populations) & disabilities.

CHC

MEETINGS

Citizens Health Council
14 Aug (HSC)
4 September
9 October
7 November
4 December TBC

HSC

MEETINGS

Health Systems Committee
14 Aug
11 September
16 October
13 November
Provides advice to the Board and on CCDHB Strategic Framework

Providing Input into Strategy

The Citizens Health Council:

- Provides input and advice to the Board
- Reviews key presentations and papers contributing to the CCDHB Strategic Framework:
  - Health System Plan 2030
  - Maori Strategy
  - Pacific Strategy
  - Disabilities Strategy
  - Mental Health Strategy
  - Equity Strategy

If you have any questions, please email CitizensHealthCouncil@ccdhb.org.nz

Citizens Survey and Engagement Questions

It has been identified from the first round of community engagement questions, that people tend to focus their answers on the 'here and now' and their own experience of the health system.

The second round will address this by asking questions in such a way as to focus attention on the future.

Example questions:

Thinking of your own child or a child you know, … how would you want maternity and child health services to look for them when they become parents.

Thinking of your own child or a child you know, … what facilities would you want to see for them as teenagers, or as the parent of teenagers.

Thinking of your own child or a child you know, … if they are diagnosed with a long term, chronic illness in the future, what would you want to see available for them.

Thinking of your own child or a child you know, … when they become elderly what health services will be important for them.

Thinking of your own child or a child you know, … what would you like their end of life to be like.

These questions will be trialled by a controlled survey. Initially, each CHC member will distribute the survey to 20 people within their own contact circle as diverse as possible.

Respondents will be given 10 days. The survey should not take more than 10 minutes.

Responses will be collated and analysed as to how simple it was for the respondent, whether the information gives the future picture in a way that is useful, and how effective it is in getting people to focus on the future possibilities rather than merely addressing what they see as the existing shortcomings.

The survey will be modified as appropriate and then distributed as widely as possible using as many means as we have available, including social media, group meetings, public forums where appropriate, and other avenues identified by CHC.

The aim is to have the next round of survey results presented to HSC in December 2019.

PUBLIC

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**HEALTH SYSTEM COMMITTEE DECISION**
	Date: 14 August 2019

Author	Peter Guthrie, General Manager Planning and Performance, SIP Sam McLean, Senior Advisor Accountability, SIP
Endorsed by	Rachel Haggerty, Executive Director Strategy Innovation and Performance
Subject	**FINAL DRAFT REGIONAL SERVICE PLAN 2019/20**

RECOMMENDATIONS

It is **recommended** that the Committee:

(a) **Recommend that** the Board Chairs and Deputy Chairs sign the final draft Regional Services Plan 2019/20, subject to feedback from the Ministry and Boards being incorporated;

(b) **Notes** that the Central Region CEs and senior leadership teams have worked closely with TAS to ensure the work programmes, and plan reflect the priorities of the six DHBs, and the Ministry of Health;

(c) **Notes** the final draft Central Region Regional Services Plan 2019/20 submitted by Central Technical Advisory Services (TAS) to the Ministry of Health on 21 June 2019;

(d) **Notes** that TAS incorporated initial feedback from the Boards on the draft Central Regional Services Plan 2019/20 before submitting a final draft to the Ministry of Health on 21 June 2019.

(e) **Notes** the Ministry of Health will consider the final draft Regional Services Plan 2019/20 and advise DHBs when their plans can be signed and sent to the Minister of Health.

APPENDIX

1. Final Draft Central Region Regional Services Plan 2019/20.

1. PURPOSE

This paper provides information to enable Health System Committee (HSC) to recommend that the CCDHB Board Chair and Deputy Chair to sign the final draft Regional Services Plan 2019/20, subject to any further changes requested by the Ministry of Health.

2. THE REGIONAL SERVICES PLAN DOCUMENTS DHBS REGIONAL COLLABORATION EFFORTS

DHBs work together at a regional level to make the best use of available resources, strengthen clinical and financial sustainability and increase access to services. The Regional Services Plan (RSP) provides a mechanism for the Central Region DHBs to document their regional collaboration efforts and align service and capacity planning in a deliberate way. The RSPs include national, regional and local priorities, and outline how DHBs intend to plan, fund and implement these services regionally or sub-regionally.

Central TAS developed the Regional Service Plan 2019/20 on behalf of the six Central Region DHBs. It reflects the work programme agreed across the region. The first draft Central Region RSP was presented at the Joint Board meeting on 30 May 2019 for feedback. Board feedback was included in the final draft Regional Services Plan 2019/20.

PUBLIC

3. REGIONAL SERVICES PLAN GUIDANCE FOR 2019/20 OUTLINED PRIORITIES AND FOCUS AREAS

3.1 Planning Priorities

The RSP planning guidance indicates DHBs plans must reflect their region's locally determined priorities and activities that will benefit most from a regional approach. The regional priorities are:

- Improving equity of outcomes;
- A digitally enabled health system;
- A clinically and financially sustainable health system; and,
- An enabled and capable workforce

Our plan is to prioritise investment in areas with clear opportunities for a regional approach which includes:

- cancer
- cardiac
- radiology
- regional care arrangements
- planned care.

Specific expectations have been set out related to national work programmes that will benefit from regional collaboration, including

- healthy ageing
- hepatitis C
- mental health and addictions
- regional digital health services
- regional workforce.
- trauma

In addition to these requirements, regions are expected to demonstrate regional commitment to engage in the newly established collective improvement work programme, provide regional insights, lead regionally focused improvement activity resulting from the programme, and report on progress during the year. The Ministry will provide more guidance on what this planning priority entails in due course.

3.2 Financial Sustainability

The Ministry expects the RSP to show a strong regional collaboration to support financial sustainability of the DHBs in the region. The final draft RSP reflects this expectation.

3.3 Equity

DHBs must also ensure that the RSP is in line with the legislative obligations of DHBs as Treaty partners and the DHBs obligation in improving Māori health. Improving health outcomes for Māori and Pacific peoples and making measurable progress towards achieving equity of health outcomes and reducing the equity gap is expected to underpin regional activity. TAS has developed, with the Regional Equity Framework. This will be implemented across regional programmes.

3.4 Governance

The regional Chief Executives and Executive Leadership Teams have been working to strengthen regional governance and working relationships. This work is underpinned by a commitment to strengthen DHB participation on the Board of TAS, and driving focus for TAS on a smaller number of agreed work programmes with clear deliverables.

PUBLIC

4. NEXT STEPS

The Ministry will consider the final draft Regional Services Plan 2019/20 and advise DHBs if their plans can be finalised and presented to the Minister of Health. HSC is asked to recommend that the Board Chair and Deputy Chair sign the Regional Services Plan 2019/20, subject to approval by the Ministry.

TAS
Kahui tuitui tangata

REGIONAL
SERVICES PROGRAMME

Central Region
Regional Services Plan 2019/2020

Capital & Coast District Health Board
Whanganui District Health Board
Hutt Valley DHB
MidCentral District Health Board
Hawke's Bay District Health Board
Wairarapa DHB

Prepared by:
Central Region District Health Boards

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2018/19 highlights

Implementation of STEMI Pathway

The New Zealand Out-of-Hospital ST elevation myocardial infarction (STEMI) pathway was launched in the Central Region in March 2019. It is a result of a collaboration with the NZ Cardiac Network, St John, Wellington Free Ambulance and endorsed by the Cardiac Society. The aim is to have a nationally consistent out of hospital pathway being adopted across the country, that will reduce time to treatment, increase equity and improve outcomes for patients.

The STEMI pathway will mean that patients living in or south of Otaki area who have an acute myocardial infarction will now be flown directly to Wellington for primary intervention.

There is also direct transfer of patients who have an acute myocardial infarction to a PCI (percutaneous coronary intervention) capable hospital from the field following fibrinolysis whenever it is feasible and safe.

Implementation of regional stroke clot retrieval service

A regional clot retrieval service was implemented in April 2019, which now provides consistent and equitable access to highly effective emergency therapy that reverses acute stroke symptoms and dramatically reduces the risk of severe long-term disability post-stroke. There is strong evidence that this procedure directly prevents avoidable costs in acute medical care, neurosurgical procedures, rehabilitation for stroke patients and aged residential care, both reducing the total cost of care and improving outcomes for patients.

Regional equity framework

During 2018/19, our region developed a regional equity framework which provides guidance on strengthening actions that will achieve equity across the region. Additional guidance is being planned to provide advice to DHBs on actions that will meet Treaty of Waitangi obligations.

Foreword

In 2017/18 the Central Region district health boards (DHBs) developed a strategy that emphasises a genuine regional approach to service improvement that benefits the whole region's population. This strategy will continue to be implemented in 2019/20.

The strategy is our key accountability document for regional collaboration and has been developed in conjunction with the region's clinical networks, DHBs, and regional governance groups.

A plan for the next year

This *Central Region Regional Services Plan* for 2019/20 articulates our region's strategic direction and provides a high-level overview of the Central Region DHBs' planned actions for the year. Through these actions we will continue to focus on the strategy's three objectives:

- a digitally enabled health system
- a clinically and financially sustainable health system
- an enabled and capable workforce.

Our plan is to prioritise investment in areas with clear opportunities for a regional approach which includes:

- cancer
- cardiac
- radiology
- regional care arrangements
- planned care.

We believe that this more targeted approach will have a vital role in improving the health outcomes of the people in our region.

We will also focus on equity across the region, and in particular achieving better outcomes for Māori through reducing the variations in disease rates and health outcomes among this population. Our work to develop a regional equity framework has progressed considerably over 2018/19 and is aligned closely with *He Korowai Oranga: Māori Health Strategy* and the Government's priorities, as well as our obligation to identify inequities and develop actions to improve outcomes.

Work on our existing regional programmes will also continue to cover national priority areas, where a regional approach has been agreed by the DHBs. This includes:

- healthy ageing
- hepatitis C
- mental health and addictions
- regional digital health services
- regional workforce.
- trauma

- stroke.

Working together for good

This plan explains our approach to improving equity of access, patient experience and outcomes, and has been led by the Central Region DHB Chief Operating Officers, General Managers Planning and Funding, and General Managers Māori and Pacific to provide assurance that time and effort are being invested in the most appropriate way to address the priority areas.

The plan is underpinned by a region-wide understanding that the diverse nature of our population requires us to take a coordinated, regional approach that allows for flexible implementation to meet the needs of individual communities. Through working regionally, we address our shared challenges, and as individual DHBs we provide services to our own populations, which allows for flexibility to tailor service provision.

Reflecting this, this *Central Region Regional Services Plan* does not include work programmes in palliative care, health quality and safety, sudden unexpected death in infancy (SUDI), and Well Child Tamariki Ora Quality Improvement programmes, which are managed at local and/or sub-regional levels; or at a national level. A review of the programmes and our population's needs has identified that this remains the best approach for our region.

A commitment to wellbeing

Together, the six Central Region DHBs are dedicated to offering a sustainable health system that is focused on keeping people well and providing equitable and timely access to safe, effective, high-quality services that are as close to people's homes as possible. In the coming years we will deliver this through a combination of work programmes, regional clinical networks and a commitment to identifying and responding to emerging national priorities.

Our investment focus means that we can allocate funding and effort to programmes that provide the greatest health benefits for our population and the greatest value for the DHBs. We look forward to implementing the plan and building on its actions in years to come.

Andrew Blair
Chair, Capital & Coast DHB

Fionnagh Dougan
Chief Executive, Capital & Coast DHB

Andrew Blair
Chair, Hutt Valley DHB

Fionnagh Dougan
Chief Executive, Hutt Valley DHB

Sir Paul Collins
Chair, Wairarapa DHB

Dale Oliff
Chief Executive, Wairarapa DHB

Dot McKinnon
Chair, MidCentral DHB

Kathryn Cook
Chief Executive MidCentral DHB

Kevin Atkinson
Chair, Hawke's Bay DHB

Vacant
Chief Executive, Hawke's Bay DHB

Dot McKinnon
Chair, Whanganui DHB

Russell Simpson
Chief Executive, Whanganui DHB

Oriana Paewai
Chair, Te Whiti ki Te Uru
Central Region Māori Managers' Forum

5

Letter from the Minister

6

Contents

The Central Region vision and values

The Central Region's vision is:

'Central Region DHBs leading together to achieve New Zealand's healthiest communities'.

*To realise this vision, as **partners** we will:*

*Strive for **excellence***

*Act with **integrity***

*Be **courageous***

***Inspire** each other*

Mahi ngātahi – Partnership

We all share responsibility for this kaupapa
We actively support our partners and colleagues
We understand and take ownership of our role

Kounga – Excellence

We strive for best practice in everything we do

We are patient and whānau centred

We constantly drive improvements

Whai mana – Integrity

We demonstrate understanding, honesty and openness
We build trust by turning our words into actions
We embody respect with the way we treat others

Māia – Courage

We don't shy away from hard decisions or difficult conversations

We are not afraid to take calculated risks when the benefits warrant it

We are prepared to challenge the accepted wisdom

Whakaohooho – Inspire

We celebrate and share success
We are role models by living our values
We proactively develop our teams and our successors

1. Introduction

1.1 The Central Region: context

The Central Region's six district health boards (DHBs) – Hawke's Bay, Whanganui, MidCentral, Wairarapa, Hutt Valley and Capital & Coast – are responsible for delivering health services to a population of **914,000**, which represents about 19% of New Zealand's total population.

Together, we know that regional collaboration is essential if we are to achieve equity of outcomes for this population.

During 2017/18 the DHBs developed a vision and values for the Central Region and a strategy for achieving that vision in the next three to five years, as well as agreed regional values, behavioural statements, roles and responsibilities for governance groups, clinical networks, DHBs and TAS, and a decision-making framework for regional planning and prioritisation.

The strategy reflects and responds to the evolving strategic environment for health care nationally. It aims to balance the emerging priorities for primary care, mental health and integrated models of service delivery with the needs of the communities in our region.

In 2019/20, the Central Region DHBs will continue to focus on the strategy's three strategic objectives:

- a digitally enabled health system
- a clinically and financially sustainable health system
- an enabled and capable workforce.

This *Central Region Regional Services Plan* outlines the steps we plan to take in implementing the strategy. It focuses on five priority areas:

- cancer
- cardiac
- radiology
- regional care arrangements
- planned care.

In developing the *Regional Services Plan*, the six DHBs recognised and acknowledged:

- the Minister's Letter of Expectations
- the evolving nature of the health sector
- the challenges we face in improving outcomes for our population.

To guide progress in achieving our objectives, the DHBs have developed six key principles for regional programmes:

- deliver positive outcomes that can be measured
- include equity measures to work towards better outcomes for Māori

- prioritise the development of IT (information technology) enablers and integrated electronic records
- integrate with regional clinical networks in developing clinical pathways and protocols
- have clear primary care expectations
- be linked to a wellbeing approach across the lifespan.

1.2 About this plan

This *Regional Services Plan* outlines our strategy and priorities for the Central Region DHBs' services in 2019/20. It has been developed by the six DHBs in collaboration with the TAS Regional Planning Team and Regional Programme Managers. It supports the *Central Region Outcomes Framework* (see section 2) and is governed by the DHBs' governance and decision-making frameworks (see section 2.5).

The plan builds on our successes and provides a foundation for achieving our long-term goal of having the healthiest communities possible. It reflects our commitment to working together to deliver services for our population that are clinically and financially sustainable and provide the best quality of care.

1.3 The Central Region

The Central Region's population is forecast to grow by 7% in the next 20 years, with an 84% increase in people aged over 70 years. Our health workforce is ageing too, with a forecasted decrease in health professionals aged 50-59 years.

Our communities are expected to become more diverse, with more Māori, Asian and Pacific people. The number who identify as Māori is forecast to increase by 36%, while the Asian population is expected to grow by 70% and the number of Pacific people by 22%.

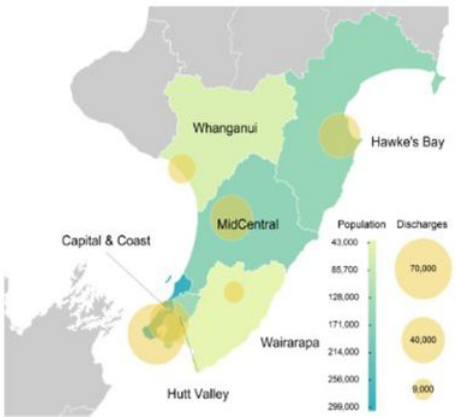
The region has pockets of relatively high socio-economic deprivation and the people who live in those areas have limited access to transport, employment, quality housing and other basic determinants of wellbeing. Approximately 89,500 people, or 10% of our population, live in our most deprived areas.

Māori have higher rates of disease and mortality than non-Māori, are over-represented in areas of high deprivation, have poorer health outcomes and higher rates of premature death. In New Zealand, inequalities between Māori and non-Māori are the most consistent and compelling inequities in health. These differences are not random, they exist because of institutional racism[1] and the impact of colonisation and its continuing processes[2]. Achieving equity for Māori is a priority, as the health gaps across the life-course are significant for Māori.

[1] Jones C. 2000. Levels of racism: a theoretical framework and a gardener's tale. American Journal of Public Health 90: 1212–15.

[2] Ministry of Health. 2018. "Achieving Equity in Health Outcomes: Highlights of important national and international papers".

Figure 1: Central Region population distribution across DHBs



12%	Of our population live in the two smallest DHB regions: Whanganui and Wairarapa.
54%	Of our population live in our two largest DHB regions: MidCentral and Capital & Coast.

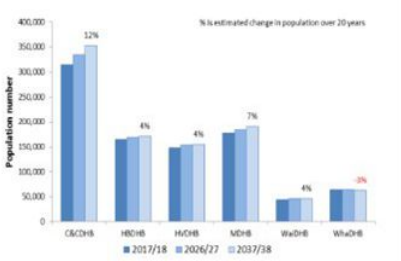
The Central Region's population is **914,000** (19% of the New Zealand total).

In the next 20 years the region's population is expected to increase to **978,000.**

85,000 more people will be aged 70+.

The Central Region's estimated population growth won't be evenly distributed across the six DHB regions: Capital & Coast DHB is expected to see the greatest increase, while Whanganui DHB's population is expected to decrease[3].

Figure 2: Central Region population estimates and changes



DHB	% change in population
Capital & Coast DHB	
MidCentral DHB	
Hawke's Bay DHB	
Hutt Valley DHB	
Wairarapa DHB	
Whanganui DHB	

= 1%

[3] Statistics New Zealand. 2013. Census of Population and Dwellings Survey. Available at www.stats.govt.nz

2. Strategic position

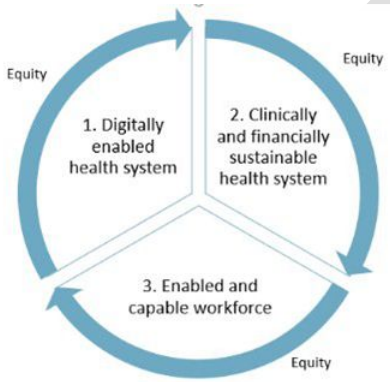
2.1 Regional strategic approach

Our Central Region DHBs are committed to working together to ensure we provide high quality efficient services that keep people in our region well and support innovative approaches and are responsive to the challenges that will impact on health in the coming years.

The changing make-up of the Central Region population, together with the challenges for service providers in ensuring equity of access for geographically dispersed populations while maintaining economies of scale, is placing increasing pressure on, and demand for, new models of care for health services.

To address these challenges, our focus is on ensuring equity of access and outcomes for all our population, in ways that make best use of advances in technology and are both clinically and financially sustainable. Figure 3 shows the three strategic objectives that we identified in 2017/18 and will continue striving to achieve through this *Regional Services Plan 2019/20*.

Figure 3: The Central Region strategic objectives



Supporting this work, we have developed priority areas for focus as well as clear outcomes and outputs for 2019/20. This means that, while the Central Region DHBs will continue with existing regional work programmes, we will prioritise our investment in:

- cardiac
- cancer
- radiology
- regional care arrangements
- planned care.

Figure 4 illustrates the resulting *Central Region Outcomes Framework*, which includes our six outcomes (the results for people and the system) and the three strategic objectives (what we will achieve through our collaborative efforts), and the priority areas of our regional approach.

Figure 4: Central Region Outcomes Framework

Note: BAU = business as usual (our regional work programme); RCA = Regional Care Arrangements

2.2 Equity

During 2018/19, the Central Region has made considerable progress developing an equity framework which provides guidance on strengthening equity across all of our regional activities.

In the Central Region, equity in health is based on the WHO definition of equity – the absence of avoidable or remediable difference among groups of people. The concept acknowledges that these differences in health status are unfair and unjust but are also the result of structural issues as well as differential access to the resources necessary for people to lead healthy lives.

People who are poor, have chronic conditions/diseases, live with disabilities, live rurally and are of Māori ethnicity, are likely to have poorer health, greater exposure to health risks and poorer access to health services. [4] These variables are unlikely to exist in isolation, they are deeply interwoven, and this concept of intersectionality is vital to take into account when exploring the fundamental causes of inequity.

In New Zealand, inequalities between Māori and non-Māori are the most consistent and compelling inequities in health. These differences are not random, they exist because of racism[5] and the impact of colonization and its continuing processes[6]. Achieving equity for Māori is a priority, as the health gaps across the life-course are significant for Māori.

[4] Ministry of Health.2002. "Reducing Inequalities in Health" downloaded at https://www.health.govt.nz/system/files/documents/publications/reducineqal.pdf. . on 5 December 2018.

[5] Jones C. 2000. Levels of racism: a theoretical framework and a gardener's tale. American Journal of Public Health 90: 1212–15.

[6] Howden-Chapman P, Blakely T, Blaiklock A et al. 2000. Closing the health gap. New Zealand Medical Journal 113: 301–2.

The Treaty of Waitangi was signed to protect the interests of Māori and it is not in the interest of Māori to be disadvantaged in any measure of social or economic wellbeing. [7] A companion Treaty of Waitangi document is being developed to sit alongside the regional equity framework to provide direction to the Central Region District Health Boards on meeting their Treaty of Waitangi obligations.

During 2019/20, our region will implement its regional equity framework across our regional programmes. The framework has been approved by our regional DHB Chief Executives (CEs) and regional governance groups and a plan for implementation is being developed for adoption in quarter 1 of 2019/20.

2.3 Linkages

At the highest level, all DHBs are guided by the New Zealand Public Health and Disability Act 2000. Other important strategic guidance includes:

- *Equity of Health Care for Māori: A Framework*
- *'Ala Mo'ui – Pathways to Pacific Health and Wellbeing 2014–2018*
- the *Healthy Ageing Strategy* (2016)
- the *Primary Health Care Strategy* (2001)
- *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017*
- *He Korowai Oranga: Māori Health Strategy* (2014).

This 2019/20 *Regional Services Plan* reflects a focus on facilitating behaviour shifts at a system level, from:

- treatment to prevention and support for independence
- service-centred delivery to people-centred services
- competition to trust, cohesion and collaboration
- fragmented health sector silos to integrated social responses.

These shifts in focus, which challenge traditional, established ways of working in health and care, also challenge the Central Region's collaboration and planning processes. They are the driving force for our commitment to improving collective decision-making processes and ensuring strong, shared responsibilities and accountabilities. We also acknowledge the importance of sharing lessons learned and being able to adopt/ adapt and implement ideas rapidly, and we plan to create opportunities to enable these across the region.

Alongside these longer-term goals and commitments, the Minister of Health's Annual Letter of Expectations outlines annual priorities for the health sector. For 2019/20, the Government has signalled a higher priority for non-communicable diseases including cancer and cardiovascular disease, primary care and a strong focus on improving equity in health outcomes. Accordingly, the Central Region DHBs have strengthened a focus in these areas for 2019/20.

2.4 Regional Governance and Leadership

The Central Region DHBs are committed to ensuring that each DHB benefits from our investment in collaborative regional work.

As a fundamental operating principle, all regional work in the Central Region is led by clinicians and is overseen by a governance structure that supports them through planning, scoping and estimating the funding required and the regional value of new initiatives. The DHB boards (the Regional Governance Group) meet biannually to provide oversight, review the regional priorities against performance, and determine new priorities that may emerge with a changing landscape.

[7] Te Puni Kokiri 2000. "Progress towards Closing Social and Economic Gaps between Māori and non- Māori" in Ministry of Health.2002. "Reducing Inequalities in Health" downloaded at https://www.health.govt.nz/system/files/documents/publications/reducineqal.pdf. . on 5 December 2018.

The Central Region DHBs' General Managers Māori and Pacific are members of the Central Region Service Planning Forum (CRSPF)[8]. This:

- provides a valuable opportunity at governance level to ensure that there is input into planning activity that works to address issues of differential access and outcomes and strengthens our equity actions
- demonstrates our focus on equity of health outcomes for Māori and Pacific peoples
- provides an accountability mechanism for ensuring that our programmes have a strong equity focus.
- differences in health status are unfair and unjust but are also the result of differential access to the resources necessary for people to lead healthy lives.

Te Whiti ki te Uru, the collective group of Central Region DHB Māori relationship boards engages with our regional DHB Boards as part of the governance process.

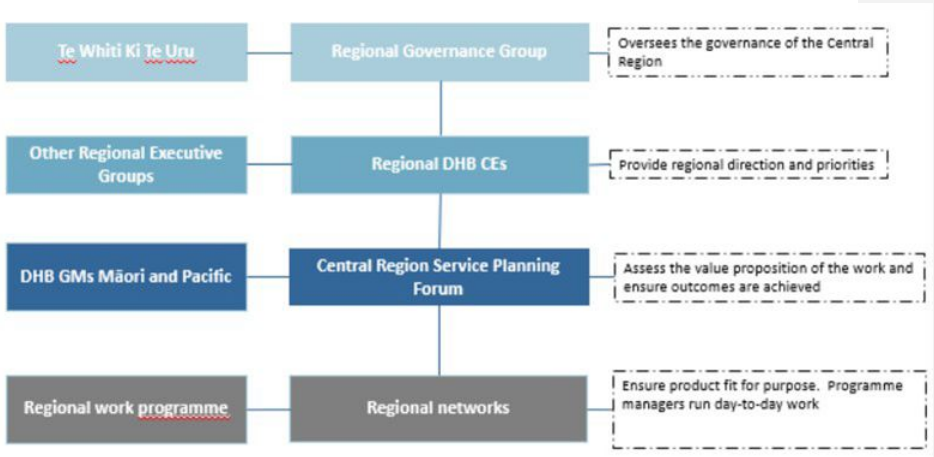
Each regional programme has an assigned lead Regional DHB Chief Executive (CE) and CRSPF sponsor to provide governance and support. The sponsors also help to manage risks and provide a point of escalation to resolve issues where necessary. Governance arrangements are a key factor in developing improvements in our regional decision-making processes.

The Central Region has several established, operationally focused and clinically led regional programmes that support the achievement of our three strategic objectives in our cancer, cardiac, radiology, planned care services, as well as across the regional work programme - healthy ageing, hepatitis C, mental health and addiction, regional trauma, stroke and workforce programmes.

The Central Region DHBs regularly review existing clinical networks and regional programmes, having recognised the need for flexibility to respond to changing needs and advances in technology (for example). During 2019/20 we will broaden the scope of our existing networks and potentially introduce new ones to develop and implement expert responses to new service configurations, changing models of care and opportunities to review the use of existing capacity.

Figure 5 shows the governance structure for the Central Region.

Figure 5: Central Region governance structure



[8] Previously the regional DHB COOs and GMs P&F group.

The escalation pathway is as follows:

- Regional networks to CRSPF
- CRSPF to regional DHB CEs
- Regional DHB CEs to the Regional Governance Group (regional DHB chairs)
- Regional Governance Group to shareholding Minister.

2.5 Regional decision-making framework

The Central Region's approach to making decisions and prioritising regional work is a two-stage process.

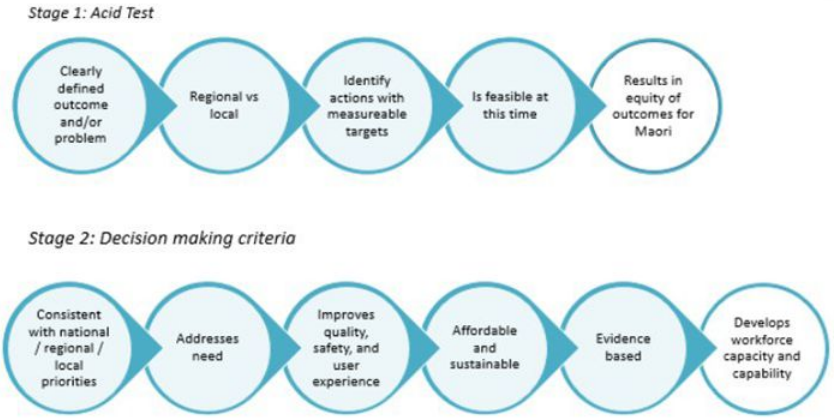
Stage 1, the Acid Test, assesses a work proposal according to whether it:

- aims to resolve a clearly defined problem or achieve a clearly defined outcome
- is regional work
- has measurable targets
- has a feasible timeframe
- ensures equity of health outcomes.

Proposals that meet the Acid Test criteria move on to stage 2, which assesses:

- the work's fit with local, regional and national priorities
- the health needs of the population
- the work's role in improving quality, safety and the user experience
- the work's affordability and sustainability
- the basis of best practice and evidence
- the work's ability to build workforce capacity and capability.

Figure 6: Decision-making process for regional work



2.6 Financial sustainability / costing

Central Region DHBs are working together to deliver a health system that is clinically and financially sustainable, where safe and effective services are provided as close to people's homes as possible. Efficiently allocating public health system resources can occur in a variety of ways.

For highly specialised clinical services, Central Region DHBs work together to ensure that patients are transported in a timely manner to the hospital that performs complex services sufficiently frequently to provide safe and effective services. The region is acutely aware of the fiscal constraints impacting health services and the need to focus on innovation, service integration, improved efficiency and reduced waste to

support provision of high-quality care. Proposals for regional activity must clearly identify the value proposition for patients and/or the system. As the workplans are developed and endorsed, any resource requirements are identified through a business case process with the Central Region Service Planning Forum. Any regional resourcing requests will be prioritised against national, regional and local priorities. Regional activity that needs project or capital funding for Information Service and other capital investments involves discussions with Central Region Chief Executives and Chief Financial Officers.

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3. Locally determined priorities for the region

In 2019/20, our locally determined regional work programme will focus on four areas as a priority: cancer, cardiac, radiology, and regional care arrangements (planned care / electives) with regional programmes continuing for healthy ageing, hepatitis C, mental health and addiction, stroke, regional trauma, technology and digital services, and workforce. Note that further information about our programmes of work for national regional requirements (data and digital, workforce, hepatitis C, healthy ageing, and stroke) are included in Section 4 – nationally-consistent regional requirements.

3.1 Cancer

The Central Region has identified cancer as one of the regional service priorities for 2019/20. Cancer networks work across boundaries and the whole continuum of care to improve outcomes for patients and their families by reducing the:

- incidence of cancer
- impact of cancer
- inequities in cancer

Cancer: key achievements in 2018/19

CCN worked with EY and DHBs to develop and agree a single system of care operating model for the region which will be implemented in 2019/20

CCN improved outcomes in Faster Cancer Treatment (FCT), multidisciplinary meetings (MDMs), variation in radiation oncology, CT/MRI protocols and diagnostic and staging pathways

CCN strengthened referral pathways across primary and secondary care including implementing the prostate cancer decision support tool.

The Central Cancer Network (CCN) is committed to significantly reducing the many cancer health inequities that exist in the region especially within our Māori and Pacific populations. CCN will achieve this by introducing health equity commissioning, delivering health equity leadership and actions across the whole cancer continuum of care and enabler areas, standardising models of care and strengthening collaboration between regional cancer stakeholders under a single system of care. This program of work will be driven by an improved analytics framework. Note that CCN also covers Taranaki DHB for the purpose of regional cancer services.

In 2019/20, CCN will take a focus on implementing the outcomes of the single system of cancer care review including implementing a regional commissioning plan, analytics framework to address variation and a tumour stream approach. A Regional Cancer detailed analysis will also be completed with the overall aim of developing a Long-Term Regional Cancer Plan (2020-2025) for how CCN will provide leadership and actions across the whole cancer continuum of care and enabler areas. Health equity leadership and actions will also be delivered across the whole cancer continuum of care and enabler areas.

3.2 Cardiac

The Central Region DHBs are taking a whole-of-system approach to heart health through an evidence-based *Cardiac Health System Plan*. The plan's development included research into the prevalence of different disease groups, as well as a literature review on health promotion, disease prevention and early intervention, and treatment strategies.

Cardiac: key achievements in 2018/19

The New Zealand Out-of-Hospital ST elevation myocardial infarction (STEMI) pathway was launched in the Central Region in March 2019.

The Central Region was the creator of an echocardiography dataset template that is now being implemented nationally, and DHBs commenced the collection of data on the 1st of March 2019.

A review of heart failure referral protocols and clinical pathways across the region was completed.

The Echocardiography Workforce Plan is being progressively implemented and Whanganui DHB has been successful in recruiting a qualified echo sonographer.

Comprehensive Cardiology Service development business cases are being developed with Hawke's Bay having commenced the development of their business case during 2018/19.

The plan aims to enhance the primary care detection and management of heart failure and atrial fibrillation. This reflects the strong evidence that stroke morbidity and mortality can be reduced through cost-effective approaches, such as:

- screening and medically managing atrial fibrillation
- improving heart health by dispensing heart medications
- having good access to echocardiography for heart failure diagnosis.

The work to develop the echocardiography workforce is important in supporting this.

The *Cardiac Health System Plan* builds on the National Expected Standards for common cardiac conditions, which were developed in the Central Region then rolled out nationwide. Its implementation will require us to work with Alliance Leadership Teams, primary health organisations and DHB planning and funding specialists throughout the region. It includes a focus on testing plans for addressing Māori equity issues by using the Ministry of Health's *Equity of Health Care for Māori: A Framework* (2014) in collaboration with General Managers Māori and Central Region Māori Relationship Boards (Te Whiti Ki Te Uru).

3.3 Radiology

During 2018/19, work has progressed to identify a clear strategy and regional model of care for radiology for our region. A reinvigorated Regional Radiology Steering/Governance Group aims to provide regional governance and decision-making on behalf of the Central Region DHBs to deliver on the Regional Radiology Strategic Plan.

The Regional Radiology Strategic Plan expresses the central region's commitment to implementing a model of care that proposes service changes that will address current and future challenges. These priorities include:

1. A stocktake of service delivery to understand who is doing what
2. Designing and agreeing a model of care that considers other options.
3. Investigating opportunities to use a regional commissioning approach e.g. best use of the private sector.

Regional radiology: key achievements in 2018/19

The completion of a Radiology Strategy workshop. The workshop participants agreed that a new governance group should be established to replace the existing Regional Radiology Steering Group to drive and lead the work programme and short/long term strategy.

An inaugural RRIS/PACS Governance Group meeting has been held and schedule for regular meetings established.

Work commenced on a regional workforce action plan.

Cancer CT protocols have been reviewed by the region and will be implemented soon by DHBs.

3.4 Planned Care

The Central Region is taking a regional approach to improving elective services by developing regional collaboration and information-sharing mechanisms and working with key stakeholders to identify opportunities to maximise regional resources and capacity. The aim is to improve equity of access and quality of care for patients through developing better systems and processes.

In 2019/20 the regional elective services programme will focus on:

- continue to implement a regional model of care for vascular services with a focus on a stocktake of the workforce, and implementing regional multidisciplinary team meetings (MDM) processes
- continuing work to support regional implementation of national pathways and guidelines for aged related macular degeneration and glaucoma through the regional ophthalmology network
- developing a regional and sub-regional approach to the delivery of planned care in line with the Ministry's National Planned Care Strategy.

3.5 Regional Care Arrangements

The purpose of the regional care arrangements programme is to ensure that regional services are arranged, and service models are managed in ways that improve:

- equity of outcomes for those who use the services
- service sustainability and productivity
- cross-sector integration
- financial viability.

Regional care arrangements work includes all care arrangements across the region (acute, and urgent) which will reflect planned care decisions.

Regional care arrangements: key achievements in 2018/19

Completion of a comprehensive stocktake which collected information and data on regional care and financial arrangements.

Development of a tool to provide DHBs with the results of the stocktake which identifies regional care arrangements and patient flow across the region.

A key challenge is to implement a regional planning and decision-making process in which challenges are resolved collectively rather than locally by individual DHBs. To date there has not been a strong focus on regional transparency and agreement in making patients' clinical care arrangements.

The 2019/20 work programme aims to ensure that Central Region DHBs have care arrangements that:

- ensure equity among our populations and across our region
- deliver care closer to home where possible and centralised where necessary
- are sustainable across the region
- represent the best use of regional resources to deliver outcomes for our communities.

We expect arrangements and models of care to change as our health services evolve to meet the needs of our communities, improve equity and respond to financial and resource-allocation pressures. As a result, the region will be better able to manage service development and changes to existing services.

Initially the region will test regional gynaecology and orthopaedics specialties before identifying and testing other options as they emerge.

3.6 Mental health and addiction

All of New Zealand's DHBs agree that mental health and addictions is a priority area. During 2018/19, the region has been working to determine the regional activity that can be delivered to provide the best outcome for our populations. The regional focus for mental health and addiction in 2019/20 will include monitoring of

the 13 regional services being managed and delivered by CCDHB on behalf of the region; organising biannual regional mental health and addiction forums for stakeholders and to disseminate best practice and implementing any regional activities that may arise as a result of the pending mental health inquiry.

3.7 Regional trauma

The key purpose of the central region major trauma work-stream is to support the work of the Major Trauma National Clinical Network (MTNCN) in implementing a contemporary trauma system across New Zealand. Severely injured patients stand the best chance of making a good recovery if the trauma system performs well. The performance of the trauma system can be measured using information on the incidence of injury (where prevention has a role), the severity of injury, and death resulting from injury (where the process of care is important).

In New Zealand, injury is the leading cause of lost years of life in people under aged 45 years, mostly due to road-related incidents (52%), followed by falls (26%) and assaults (9%).[1] There are marked regional differences in cause of injury with falls (34%) and assaults (10%) featuring predominantly in the Central Region with a higher proportion of resultant Serious Traumatic Brain Injuries (sTBI) than the national average.[1]

Regional Trauma: key achievements in 2018/19

Reported elements of the National Minimum Dataset for major trauma patients to the New Zealand Major Trauma Registry

Annual Central Region Trauma Symposium

In collaboration with the Midland Trauma System coordinating and hosting an Abbreviated Injury Scoring (AIS) course and NZ-MTR training in Wellington to improve access for other regions

Increased nursing trauma education and training in the region enabled by the ACC Incentive Fund. Through this funding nurses have attended the AIS coding course and NZ-MTR training, both necessary to input data into the NZ-MTR

Case Fatality Rate (CFR) is a key marker of a trauma system and there is a strong relationship between sTBI, falls (which account for 46% of all deaths) and CFRs.[1] When compared to mortality rates of all causes, the risk of death is much higher in the falls group than it is by any other cause (probably as a result of the age of those suffering falls). With the Central region having the highest unadjusted hospital CFR than any other region (11%), delivering optimal trauma care across the central region is essential.

The major trauma work programme, overseen by the Central Region Trauma Network (CRTN), has been hindered by inadequate resourcing within all six regional DHBs over the past 12 months. There has been very limited capacity to deliver the MTNCN's mandated requirements with current resources. In view of the above statistics resourcing needs to be a key focus to improve trauma care and processes, achieve efficiencies across the health system with reductions in trauma mortality, improvements in the long-term disability outcomes, cost savings, and importantly reduce the equity gap for trauma patients in the Central region.

4. Ministry of Health regional requirements

The Central region acknowledges the expectation to demonstrate regional commitment to engage in the newly established collective improvement work programme, provide regional insights, lead regionally focused improvement activity resulting from the programme, and report on progress during the year. The collective work programme is a joint quality improvement programme involving TAS, the Ministry of Health, Treasury and the Health Quality Safety Commission. Since the concept is still being discussed and scoped, we will provide further detail about our activities to demonstrate regional commitment when we receive advice from the Ministry.

This section provides further detail about the national regional requirements relating to data and digital, workforce, hepatitis C, stroke services, and healthy ageing.

4.1 Data and digital – regional investment portfolio

The Central Region DHBs are working to eliminate their reliance on legacy solutions by deploying more modern and integrated technological and digital solutions. This will:

- enable regional information-sharing
- ensure the best possible use of scarce clinical resources
- allow new models and processes of care to be supported.

With this foundation, it is expected that, in the next four years, this work will support the Central Region's drive to digitise provider, patient and consumer interactions in support of the move to care in the home and self-care. End-to-end processes will also be digitised to enable electronic referrals, a smoother workflow and shared care and service coordination across and within care environments.

4.2 Workforce

The Central Region DHBs are committed to ensuring that regional workforce development aligns with service and population demands, while remaining focused on improving the way we recruit, retain and position health professionals. We acknowledge that, as practice evolves and models of care develop in response to population need and innovations in health and care, the role and scope of practice of health professionals and the wider workforce must also change.

Workforce: key achievements in 2018/19

Development of an agreed set of actions to increase Maori participation in the region

Support for the GMs Pacific on a workforce development plan to increase Pacific participation in the workforce

Provision of workforce information and support for key workforce groups to support workforce planning including radiology, mental health and cardiac physiology.

The Central Region Workforce Development Hub (the Hub) is a collective body providing advice and support to the Central Region Clinical and Professional Networks about workforce development across all disciplines.

Working collaboratively, the Hub will support consistency of practice throughout the region and will enable best practice to be shared and adopted. It will also encourage the best use of resources to ensure our workforce is suitably prepared to provide the best possible care in a modern healthcare system.
As well as supporting the needs of the region the Hub will also support alignment with the national workforce initiatives.

Workforce initiatives for 2019/20 will further build on the alliance formed between the six regional DHBs, the National Strategic Workforce Team and the Ministry. They will be focused on building capability and capacity, improving the diversity of the workforce, supporting leadership and talent development and enabling workforce wellbeing. Where regional work programmes identify workforce issues, these will be addressed

through a collaborative planning process that uses regional and national data and networks to create innovative and flexible regional solutions. Work will also be undertaken to improve and share workforce information and use it for regional decision making.

Our regional workforce programme will continue to strengthen support for vulnerable workforces while building on existing recruitment and retention strategies. It will also align with changing scopes of practice and emerging models of care.

4.3 Hepatitis C

The major change over the 2018-19 period was PHARMAC's funding of Maviret, a pan-genotypic medication that cures almost all cases of Hepatitis C. Given the medication has significantly fewer side-effects and can be used for all new patients, its use in primary-care is encouraged and made easier. The national and regional focus for 2019-20 is to identify acute cases of Hepatitis C as well as those who may have been infected by the virus many years ago so that these populations can be treated successfully. Region actions that will achieve this include:

- enhancing the clinical leadership of the team
- focused promotion of the new Hepatitis C medication
- increasing the number of treatments performed by the primary services
- increasing the testing for Hepatitis C
- Increasing the use of Point of Care Hepatitis testing to detect acute infections.

Hepatitis C: key achievements in 2018/19

Providing information and support to PHO's to enable general practice teams to provide optimal hepatitis C virus care

Raising community and general practice team awareness of, and education on, the hepatitis C virus and risk factors for infection

Promoting nationally and regionally developed resources and activities

Extending primary and secondary care services to provide improved assessment and follow up services for people with hepatitis C, including community-based Liver Elastography Scanning

Progress on secondary health care support of hepatitis C assessment and increasing treatment and follow up in primary health care

Introduction of point of care testing for hepatitis C in needle exchange clinics

4.4 Stroke services

The Central Region Stroke Network was set up to drive a regional approach to implementing the *New Zealand Clinical Guidelines for Stroke Management (2010)*. Its priorities are to ensure that:

- all stroke patients are admitted to acute stroke units or organised stroke pathways
- acute stroke reperfusion therapy is accessible for all patients 24/7
- rehabilitation and community-based services are as accessible for stroke patients under 65 as they are for those over 65
- health practitioners receive training and support in delivering stroke care.

In 2019/20 the Central Region Stroke Network will continue to focus on implementing the guidelines. In particular, the work programme will include:

Stroke: key achievements in 2018/19

Implementation of a regional stroke clot retrieval service

Facilitation of a regional stroke study day at Hutt Valley DHB for regional stroke workforce

Stronger engagement with primary care and allied health through the appointment of additional representatives on regional stroke network

Engagement with BPAC and Health Pathways to better understand the utilisation of diagnostic tools in primary care.

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- developing protocols and pathways to support the implementation of a regional endovascular clot service
- assessing equity of access to support early discharge and rehabilitation
- continuing to work with primary, community and secondary health services on improving primary stroke prevention and promoting the TIA (transient ischaemic attack) diagnostic tool in primary care.

4.5 Healthy ageing

The purpose of the Health of Older People (HOP) work programme is to support the region to carry out key priorities identified in the Healthy Ageing Strategy Implementation Plan 2016 -2019[9] through the delivery of relevant work streams.

Healthy ageing: key achievements in 2018/19

Created collaboration and sharing of model of care innovations by hosting Canterbury, Lakes and Northern DHBs for a surgical liaison and frailty forum

Supported four Clinical Nurse Specialists / Nurse Practitioner Candidates to attend the Australian & NZ Society for Geriatric Medicine Annual Scientific Meeting with their geriatrician leads, resulting in the development of new geriatric liaison approaches to peri-operative care to be investigated locally and shared regionally

Showed clinical leadership in the development of a visualisation tool from interRAI HomeCare data through meetings and collaboration with Canterbury DHB

Contributed subject matter expertise on the Health Quality and Safety Commission's National Advance Care Planning Steering Group, ensuring local, regional and national dialogue which supports equitable access by communities to advance care planning

Influenced and collaborated regionally to improve outcomes for carers of those with dementia, those with young onset dementia and intellectual disability (and dementia) through supporting the NZ Dementia Collaboration and the initiation of new pathways of care for people and their whānau

Raised awareness of the characteristics of older people through the publication of four infographics including an equity infographic for Māori, which was an innovation replicated nationally

The work programme is overseen by the Central Region HOP Network. The programme collaborates with other agencies such as ACC, Health Quality and Safety Commission, Ministry of Health and sectors such as Dementia Wellington and Auckland University's Old Age Psychiatry to influence early, demonstrate clinical leadership and ensure the regional programme has alignment to national programmes, policies and innovations.

The Healthy Ageing Programme is underpinned by the principle of choosing to work together to ensure equity of access to healthy ageing services and finding new and better ways of organising, funding, delivering and continuously improving services for the benefit of older people in the region.

The planned programme of work for 2019/20 is closely aligned to the *The Healthy Ageing Strategy 2016* vision of older people 'living well, ageing well, and having a respectful end of life in age-friendly communities'. The programme will recognise the guidance and actions outlined in the *New Zealand Dementia Framework* and *Improving the Lives of people with Dementia*.

The focus for 2019/20 is to collaborate regionally and nationally to deliver equitable person and whanau centred outcomes for our population by:

- prioritising and implementing relevant regional priorities which arise out of the NZ Dementia Framework Stocktake
- developing pathways of care for people and their whanau to support the early diagnosis and management of young onset dementia
- using the interRAI data to drive insights on the characteristics of older people in our region including a focus on Māori.

[9] Healthy Ageing Strategy Implementation Plan 2017-2019; Ministry of Health; 1 July 2017

- contributing to national and regional forums and processes to ensure that the health sector is able to appropriately respond to a person's advance care plan.

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Appendices: Regional Work Programmes 2019/20

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Cancer

CE Lead: Vacant

CRSPF Sponsor: Rachel Haggerty (Director, Strategy, Innovation and Performance, Capital and Coast DHB)

Key area of focus	Actions to deliver	Measures	Timeframe	Accountable roles
Regional priorities				
1.0 System and Leadership	1.1 Implement the agreed recommendations of the Single System of Cancer Care (SSoC) Review 1.2 Develop Regional Cancer Commissioning Plan and Functions 1.3 Establish a Cancer Clinical Network reporting to the Cancer Governance Group 1.4 Implement a Tumour Stream approach that provides strong clinical leadership	1.1 SSoC Outcomes Implemented 1.2 Commissioning Plan and Functions Developed 1.3 Clinical Network established 1.4 Tumour Streams active and functioning	Q4 Q4 Q4 Q4	Central Cancer Network
2.0 Regional Deep Dive	2.1 Complete a Regional Cancer Deep Dive investigation across the whole Cancer Continuum of Care 2.2 Develop a long-term Regional Cancer Plan across the whole Cancer Continuum of Care and Enabler areas (2020-2025)	2.1 Deep Dive developed and completed in Partnership with National, Regional and Local Cancer stakeholders 2.2 LT Plan developed and completed in Partnership with National, Regional and Local Cancer stakeholders	Q3 Q4	Central Cancer Network
3.0 Prevention	3.1 Support Stakeholder Health Promotion activities to improve Cancer Health Literacy 3.2 Support Stakeholder activities to improve Cancer outcomes in Primary and Community Care	3.1 Health Promotion Activities Supported 3.2 Primary and Community Care Activities Supported	Q1 – Q4 Q1 – Q4	Central Cancer Network
4.0 Screening and Detection	4.1 Implement the Early Detection of Lung Cancer Project 4.2 Monitor Cancer Screening Data and Performance	4.1 Early Detection Project implemented 4.2 Screening Data and Performance Monitored	Q1 – Q4 Q4	Central Cancer Network
5.0 Diagnosis and Treatment	5.1 Address variation issues as identified by tumour stream Quality Performance Indicator (QPI) reports	5.1 QPI Variation issues addressed	Q1 – Q4	Central Cancer Network

Key area of focus	Actions to deliver	Measures	Timeframe	Accountable roles
	5.2 Undertake evaluation of Regional CT/MRI protocols and diagnostic pathways 5.3 Monitor FCT performance and timeliness at a population and service delivery level	5.2 Evaluation completed 5.3 FCT performance and timeliness monitored	Q3 Q1 – Q4	
6.0 Survivorship and Palliative Care	6.1 Implement and monitor a Cancer Supportive Care Framework 6.2 Support Cancer Survivorship and Palliative Care programs	6.1 Supportive Care Framework implemented and monitored 6.2 Survivorship and Palliative Care Programs supported	Q4 Q1 – Q4	Central Cancer Network
Enablers				
7.0 Health Equity	7.1 Deliver Health Equity Leadership and Actions across the whole cancer continuum of care and enabler areas.	7.1 Health Equity Actions developed and delivered in partnership with Māori and Pacific stakeholders	Q1 – Q4	Central Cancer Network
8.0 Workforce	8.1 Support Stakeholders to deliver Cancer Workforce Activities 8.2 Implement the Regional Palliative Care Workforce Plan	8.1 Workforce Activities Supported 8.2 Workforce Plan Implemented	Q1 – Q4 Q4	Central Cancer Network
9.0 Data and Digital	9.1 Develop ICT infrastructure to support Regional Multi-Disciplinary Meetings (MDM's) 9.2 Support DHBs to improve their collection and reporting of cancer staging data 9.3 Investigate and pilot Telehealth enabled service delivery models	9.1 ICT infrastructure implemented for MDM's 9.2 Staging collection and reporting processes implemented 9.3 Telehealth delivery models piloted	Q1 – Q4 Q1 – Q4 Q4	Central Cancer Network
10.0 Research and Quality	10.1 Partner with the Cancer and Chronic Conditions (C3) Research group to pilot a cancer co-morbidity model of care 10.2 Work with the Health and Quality Safety Commission (HQSC) to deliver a Co-design project in the Region	10.1 Co-morbidity Pilot completed 10.2 Co-design Project delivered	Q4 Q4	Central Cancer Network

Cardiac

CE Lead: Russell Simpson (CE, Whanganui DHB)

CRSPF Sponsor: Craig Johnston (General Manager, Strategy, Planning and Performance, MidCentral DHB)

Clinical Lead: Nick Fisher (Medical Director, Nelson Marlborough DHB)

Key area of focus	Actions to deliver	Measures	Timeframe	Accountable roles
Regional priorities				
Atrial Fibrillation and Heart Failure programmes	Implement clinical pathway review findings to reduce variation and inconsistent use of pathways across the region (where deemed appropriate)	Percentage of referrals from primary care to secondary care are accepted.	Q4	Cardiac Network / DHB clinical leads
	Identify strategies that reduce inequalities for Māori and Pacific	Pharmac data shows reduction in inequity	Q4	
Echocardiography data and workforce	Continue to collect echocardiography data	DHBs collect echo data. Quarterly reporting on echos	Q2	Cardiac Network
Comprehensive Cardiology Services	The Network will continue to collaborate, provide support and monitor progress as cardiology services are re- established.	The Network is actively involved in the recruitment and assists to maintain clinical competencies of Clinical Leads in Hawke's Bay and MidCentral DHBs. The Network has a structure in place to support and monitor progress of the development of comprehensive cardiology services.	Q4	Cardiac Network
Recalibration of Networks	Identify opportunities to deliver equitable services across the region through the formation of sub regional networks.	Sub-regional networks are established		Cardiac Network
Equity	Include key equity data into the quarterly Cardiac KPI report	Key ethnicity data is reported.		
National priorities				

Key area of focus	Actions to deliver	Measures	Timeframe	Accountable roles
ANZACS QI Indicators and Targets	**<u>Indicator 1:</u> Door to cath** - Door to cath within 3 days for ≥ 70% of ACS patients undergoing coronary angiogram **<u>Indicator 2:</u> Registry completion-** ≥ 95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days of discharge *and* ≥ *99% within 3 months.* **<u>Indicator 3:</u> ACS LVEF assessment-** ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (ie have had an echocardiogram or LVgram) **<u>Indicator 4:</u> Composite Post ACS Secondary Prevention Medication Indicator** - in the absence of a documented contraindication/intolerance ≥ 85% **<u>Central Region's data</u>** • Time to PCI for non-Nelson /Wellington Patients • Report of ECHO data sets • Report of number of patients on white board /day / month • Stemi data from St John			Cardiac Network

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Radiology[10]

CE Lead: Vacant

CRSPF Sponsor: Craig Johnston (General Manager, Strategy, Planning and Performance, MidCentral DHB)

Clinical Lead: Vacant

Key area of focus	Actions to deliver	Measures	Timeframe	Accountable roles
Regional priorities				
Radiology Strategic Plan	Finalise a Radiology Strategic Plan: • Complete a stocktake of service delivery across the region • Design and agree a regional model of delivery for radiology services	Strategic Plan agreed and signed off Model of delivery options considered, and the preferred model agreed	Q1 – Q2	Regional Radiology Steering Group
Workforce	Develop a regional training plan and business case to address trainee gaps across the region. • Identify the training gap for technical and RMO workforces. • Develop MOUs between DHBs to maximise trainees and trainers in the region	A regional training plan and DHB business cases are completed	Q3 – Q4	Radiology Workforce Group

[10] Note that the radiology work programme is still being refined following the CRSPF meeting on 19 June 2019

Key area of focus	Actions to deliver	Measures	Timeframe	Accountable roles
	Pilot Sonographer reporting in two DHBs (CCDHB and MidCentral) in the region.	Report on pilot outcomes and lessons learnt.	Q3	
	Identify the key issues that impact on skills attraction and recruitment and develop strategies to address these.	Prioritise key actions to address the skills attraction and recruitment	Q4	
Digital Enablers	Develop a RRIS data report using Whanganui and MidCentral DHB data.	Identify indicators available in RRIS that will better inform DHB performance.	Q4	Regional Radiology Steering Group
Equity, Quality and Capability	Identify and review equity measures using existing national indicators	Report and communicate equity indicators for the region	Q1 - Q4	Regional Radiology Steering Group
	Review regional DNA policy and collate data Set up a working group that includes Maori and Pacific representation to assist with determining what are the contributing factors that prevent Maori and Pacific people from accessing diagnostic services.	Regional DNA equity data is reported. Identify and prioritise actions that can be implemented locally or regionally to improve equitable health outcomes for Māori and Pacific	Q3 – Q4	
National/Regional priorities				
CT and MR Indicators and targets	Report on quarterly MR & CT waiting time indicators	MR & CT waiting time indicators reported on quarterly	Q1-4	Regional Radiology Steering Group

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Key area of focus	Actions to deliver	Measures	Timeframe	Accountable roles
Enablers/Linkages				
RRIS	Continue to support the onboarding of RRIS and the defined upgrade path so that all DHBs are utilising the same RRIS	Continue to monitor the onboarding of RRIS and escalate any risks/issues	Q1-Q4	
Stroke Network	Support the development of hyperacute/stroke imaging scanning to identify patients for clot retrieval.	Consistent access in place for diagnostics required for stroke clot retrieval	Q1-Q4	Regional Radiology Steering Group / Regional Stroke Network
Cancer Network	Support the review and development of business cases for the Northern Region PET criteria.		Q4	Regional Radiology Steering Group
NRAG	Continue to support and work with NRAG as part of a national work programme	Central region provides secretariat and coordination resources	Q1 – Q4	TAS / Regional Radiology Steering Group / Central Region DHBs
	Participate in the development of a DHB/MOH Collaborative work programme	Radiology representatives actively participate	Q1 – Q4	

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Planned Care

CE Lead/s: Kath Cook (Chief Executive, MidCentral DHB)

CRSPF Sponsor: Delwyn Hunter (Executive Director Operations, Capital and Coast DHB) – Planned Care
Lyn Horgan – Elective Services (Operations Director, Hospital Services, MidCentral DHB)

Clinical Lead: Kes Wicks – Vascular (Vascular Surgeon, Capital and Coast DHB)
John Ah Chan / Neil Aburn – Ophthalmology (Ophthalmologist, Capital and Coast DHB)

Key area of focus	Actions to deliver	Measures	Timeframe	Accountable roles
Regional priorities				
National Planned Care Strategy	Develop a regional approach for responding to the Ministry of Health's National Planned Care Strategy	Regional approach for planned care developed and agreed and clear actions identified	Q2	TBC
Equity	All planned care projects and activities including ophthalmology and vascular services work to implement the regional equity framework to identify appropriate equity actions	Equity actions in place, measured and reported on quarterly	Q1 – 4	Regional networks associated with the planned care work programme
Ophthalmology				
Contribute to national work conducted by the Ophthalmology Quality Improvement Collaboration, in relation to models of care for aged-related macular degeneration (AMD) and Glaucoma.	• Participate in Ministry workshops. • Work with the CR DHB's to understand and identify regional components of work. • Scope and plan the regional Ophthalmology quality Improvement work	Regional implementation plan developed.	Q4	Central Region Ophthalmology Network
Data and monitoring	• Source and analyse data	Data is analysed, and models and trends are available to make informed decisions for improvement. Track wait time data for improvement.	Q4	Central Region Ophthalmology Network
Workforce readiness for improved and sustainable	• Identify workforce status against data.	Recommendations are reported and approval sort for implementation of the changes.	Q4	Central Region Ophthalmology Network

Key area of focus	Actions to deliver	Measures	Timeframe	Accountable roles
central regional ophthalmology services.	• Using the data analysis build models and trends for the service. • Recommend workforce gaps and requirements.			
Vascular services				
Integration of services	Implement a structured, regular regional MDM	Regional MDM implemented and modified as appropriate for implementation in CCDHB.		Central Region Vascular Services Network
Pathways	Assess vascular services pathways and identify opportunities for regionalising these pathways	Pathways identified and regionalised as appropriate	Q4	Central Region Vascular Services Network
	Review pathways on Health Pathways and update as required	Pathways defined appropriate to the DHB level of vascular service provision	Q1-4	
Optimise prevention and detection	Collect and monitor data on vascular activity to identify opportunities for service planning	Data collected, monitored and reported on quarterly	Q1-4	Central Region Vascular Services Network

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Regional Care Arrangements

CE Lead/s: **TBA**

CRSPF Sponsor: Rachel Haggerty (Director, Strategy, Innovation and Performance, Capital and Coast DHB)– Regional Care Arrangements

Clinical Lead: TBA

Key area of focus	Actions to deliver	Measures	Timeframe	Accountable roles
Regional priorities				
Identify and document regional care arrangements	Develop methodology for documenting regional care arrangements for specialties identified and agreed by the Central Region Service Planning Forum	Regional care arrangements for orthopaedics and gynaecology documented	Q1-2	TAS and Orthopaedic and Gynaecology Sprint Teams
		A decision-making framework is used to prioritise and chart the next services for regional care arrangements	Q2-3	Central Region Service Planning Forum
		Regional care arrangements for prioritised services are documented	Q3-4	TAS and relevant sprint teams

Mental health and addiction

CE Lead: Russell Simpson (CE, Whanganui DHB)

CRSPF Sponsor: Chris Ash (Executive Director, Primary Care, Hawkes Bay DHB)

Clinical Lead: Vanessa Caldwell (Operations Executive, MidCentral DHB)

Key area of focus	Actions to deliver	Measures	Timeframe	Accountable roles
Regional priorities				
Regional mental health and addiction services	Management and monitoring of Central Region mental health and addiction services		Q1 - 4	Regional Mental Health Portfolio Manager, CCDHB
Equity	All regional mental health and addiction activity to implement the regional equity framework to identify appropriate equity actions	Equity actions in place, measured and reported on quarterly	Q1 – 4	Regional Mental Health Portfolio Manager, CCDHB
Regional engagement	Organise six-monthly forums to unite regional mental health and addiction stakeholders and provide an opportunity for sharing best practice	Six monthly regional mental health and addiction forums take place and are reported on.	Q2 / Q4	Regional Mental Health Portfolio Manager, CCDHB
National priorities				
Inquiry into mental health and addiction	Respond to recommendations arising as a result of the inquiry taking a regional approach	Plan for responding to inquiry recommendations developed and implemented	Q2-4	To be determined

Regional Trauma[11]

CE Lead: N/A

CRSPF Sponsor: Lyn Horgan (Operations Director, Hospital Services, MidCentral DHB)

Clinical Lead: James Moore (Intensive Care Specialist and Clinical Leader, Trauma, Capital and Coast DHB)

Key area of focus	Actions to deliver	Measures	Timeframe	Accountable roles
Regional priorities				
Delivery of trauma services in the Central Region	Conduct a review of major trauma hospitals in the Central Region and develop recommendations for regional DHB CEs	Agreed actions are implemented so that a regional trauma service is in place that ensures appropriate staging and transfer of patients to hospitals best able to meet the needs of trauma patients to support improved clinical outcomes	Q4	Regional DHB CE and CRSPF leads and sponsors Regional Trauma Network TAS
Identify opportunities for quality improvement	1. Analysis of regional trauma data to identify and demonstrate the burden of trauma in the region and identify opportunities for quality improvement activities 2. Publish a Central region major trauma annual report	Quality improvement initiatives identified and implemented Central Regional trauma annual report published	Quarterly Q3	TAS / Regional Trauma Network
Trauma pathways and regionally focused major trauma clinical guidelines	Continue to develop and implement regional major trauma and imaging guidelines	Trauma guidelines developed, agreed and implemented in Central Region DHBs	Q1-4	Central Region Trauma Network / Central Region DHBs
National priorities				
Improve the MTNCN's KPIs including: 1. time to CT **2.** trauma specific blood	1. Improved percentage of patients receiving radiological imaging within 2 hours of presentation 2. Increased collection rate in trauma specific blood test makers	1. All DHBs report the elements of the NMDS for major trauma onto the NZ-MTR no more than 30 days after patient discharge 2. Data reported to the MTNCN via arrangement with Midland Trauma System will confirm data entry	Q1-Q4	Clinical and nurse leads for trauma in each central region DHB Midland Trauma System

[11] Regional Trauma work programme still in development

test markers [blood alcohol, venous base excess and INR] 3. NZ-MTR 30-day data entry	3. Improved number of patients entered onto the NZ-MTR within 30-days	3. Quarterly data report from TAS to be provided at each CRTN meeting 4. Nationally consistent data collection and reporting supports improved service delivery for major trauma patients		TAS
Improve equity of outcomes for Maori	Embed equity measures within regular reporting to the regional trauma network and DHBs	Central region major trauma annual report will inform and identify initiatives to improve equity for Maori major trauma patients in the Central region.	Q2-Q4	Central Region Trauma Network TAS

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Regional Digital Health Services

CE Lead: Russell Simpson (Chief Executive, Whanganui DHB)

Key area of focus	Actions to deliver	Measures	Timeframe	Accountable roles
Single electronic record	Regional support provided to the national programme	Regional engagement with national programme	Q1-4	Central Region DHBs
Digital hospital	DHB implementation and use of regional solutions: • WebPAS • RRIS • Enhancement	DHB implementation and use of regional solutions	Q4	Central Region DHBs
Shared clinical information	Continue implementation of regional clinical portal	Regional clinical portal implemented	Q4	Central Region DHBs
National programmes	Identification of regionally based activities to support national programmes including engagement with the Digital Health Strategy and national digital programmes	Regional engagement with national programmes	Q1-Q4	Central Region DHBs

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Regional Workforce

CE Lead: Vacant

Sponsor: Regional DHB GMs HR

Key area of focus	Actions to deliver	Measures	Timeframe	Accountable roles
Regional priorities				
1. Workforce data and intelligence	A Regional Workforce dashboard is developed that each DHB uses for Board reports.	Dashboard is developed and signed off by CEs	Q1	GMsHR & RDoWD
	Improve the ethnicity data in the region	Proactive actions are occurring to increase ethnicity reporting Levels of reported ethnicity are increased Data is monitored quarterly	Q4	GMsHR, RDOWD & Workforce Hub
	Work with Kia Ora Hauora to utilise their database (Subject to privacy agreements) and contacts to increase the number of Māori taking up health careers.	Potential & incoming students are identified by DHB and area of interest.	Q1	GMsHR, RDoWD, Workforce Hub
		An engagement strategy developed (for example, DHB visits, connections with health professionals).	Q4	
		Current students identified by profession and information provided on how they can progress their careers with a focus on recruitment within the Central Region	Q3	
		Information produced on the graduates from Kia Ora Hauora to determine the employment levels within the Central Region with a goal to reproduce this annually.	Q4	
	Partner with National Workforce Team to develop a vulnerable workforce planning tool and dashboard	Tool and dashboard are developed and tested in the Central Region.	Q3	RDoWD

Key area of focus	Actions to deliver	Measures	Timeframe	Accountable roles
2. Increasing Māori participation in the workforce	DHBs will work collaboratively on initiatives to increase Māori participation in the workforce in the three focus areas developed by the national Workforce Strategy Group and Tumu Whakarae	A set of actions is underway which: • Increases the proportion of Māori in the workforce overall and by occupational grouping • Meaningfully realise cultural competence • Positively impact on the recruitment and retention of Māori in DHBs	Q4	GMsHR RDoWD
3. Increasing Pacific participation in the workforce	Implement the Pacific workforce development plan developed in 2018/19	Dashboard is developed that provides key data on the recruitment and retention of Pacifica in the region/ DHB and is provided quarterly	Q1	GMs Pacific & RDoWD
		Best practice information on recruitment and retention of Pacific people is collected and made into a guide	Q3	GMs Pacific & RDoWD
		Information on the careers of successful Pacifica staff is collated and shared	Q4	GMs Pacific & RDoWD
	Develop policy that any Pacific applicant who meets minimum eligibility criteria for a role be interviewed for that role.	Policy developed and agreed by CEs	Q3	GMsHR, RDoWD, Workforce Hub
4. Building health literacy	Develop a health literacy implementation plan for the relationship centred approach to health literacy across the region.	Engagement to develop and refine a plan to meets the needs of the region.	Q1	GMsHR
	Develop health literacy train the trainer modules, pilot and evaluate.		Q2	
	Establish as an ongoing health literacy programme	Ongoing targets are developed for the region	Q4	
5. Building cultural competence	Build on the work done to date on building cultural competence by increasing the number trained in each DHB in engaging effectively with Māori (see 2. above)	Stats collected on numbers trained quarterly.	Q2	GMsHR
	To develop a programme(s) for engaging effectively with Pacific people	Pacific cultural competence programme(s) implementation is underway	Q4	GMsHR & GMs Pacific
6. Leadership and talent development	Finalise analysis of it the central region talent pilot as part of the national	CE endorsement of the approach	Q1	GMsHR

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Key area of focus	Actions to deliver	Measures	Timeframe	Accountable roles
	programme and implementation of the SSC Leadership framework.			
	Present a finalised regional approach to CEs for final approval			
	Implement a regional career board	Plan developed, and first meeting held	Q2	
	Develop frontline leaders' programme for the Central Region	Draft programme developed	Q3	
	Investigate the development of a common panel of providers for Executive Leadership development	Information collected, regional discussions and consultation with SSC held.	Q4	
7. Workforce wellbeing	Support the workforce to be healthy, resilient and safe by: • Implementing the chosen family violence workforce support programme.	Regional Governance approach is in place	Q1	GMsHR
		Local working group structure is in place.	Q1	
		Implementation plans developed	Q2	
		Implementation is underway in all DHBs	Q3	
	• Developing a shared approach for the prevention of occupational violence	Approach is developed and approved but the CEs	Q4	GMsHR
8. Skill sharing programme	Support the further development of skill sharing in the region by developing the Calderdale infrastructure and project support tools and resources.	A post project evaluation report developed and is in use to be used six months following the end of Calderdale project to report on long term sustainability of Calderdale activities.	Q2	DAHs
		Two fully endorsed Calderdale Practitioners and local governance groups in each region.	Q3	DAHs
		Clinical task indicators signed off and six Foundation Day training workshops delivered.	Q4	DAHs

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Hepatitis C

Lead CE: Fionnagh Dougan, CE, Capital and Coast / Hutt Valley DHB

CRSPF Sponsor: Vacant

Clinical Lead: Compass Health

Key area of focus	Actions to deliver	Measures	Timeframe	Accountable roles
Regional objectives				
Assessment and treatment	Implement integrated hepatitis C assessment and treatment services across community, primary and secondary care services in the region	Year on year increase in testing for hepatitis C	Q1 - 4	Central Region Community Hepatitis C Programme / Compass Health
		Year on year increase in the number of Liver Elastography scans Report on elastography numbers by age and ethnicity	Q1 - 4	
Primary care prescribing	Increase hepatitis C treatment uptake and primary care prescribing	Increase in the number of people with hepatitis C receiving antiviral treatment Report on new hepatitis C diagnosis by age	Q1 - 4	
Diagnose those undiagnosed and lost to follow up	Encourage primary health requesters to request more hepatitis C tests particularly in the "baby boomer" generation	Report on number of hepatitis C antibody tests are requested	Q1-4	
Regional pathways	Implement and publicise new regional pathways for hepatitis C	New regional pathways implemented	Q4	

Stroke

CE Lead: Vacant

Sponsor: Craig Johnston (General Manager, Strategy, Planning and Performance, MidCentral DHB)

Clinical lead: Anna Ranta (Executive Clinical Director, Capital and Coast DHB)

Key area of focus	Actions to deliver	Measures	Timeframe	Accountable roles
Regional priorities				
Regional Stroke Clot Retrieval Service	Address barriers that prevent implementation of a 24/7 service	Implementation of a regional 24/7 service progresses	Q4	Central Region Stroke Network / Central Region DHBs
Stroke prevention	Develop a strategy to optimise stroke prevention in the Central Region in collaboration with primary care.	Strategy completed. Implementation work to begin 2020/21	Q4	Central Region Stroke Network
Telestroke	Evaluation of regional telestroke to date	Evaluation completed, and recommendations developed	Q2	Central Region Stroke Network
	Implement recommendations from evaluation (where feasible)	Implementation plan completed	Q4	Central Region Stroke Network / Central Region DHBs
Stroke Rehabilitation	Support establishment of early supported discharge models of care at Central Region DHBs	Feasibility assessment of ESD services and implementation strategy where feasible completed for each Central Region DHB	Q4	Central Region Stroke Network / Central Region DHBs
	Identify opportunities for a regional telemedicine approach for community-based rehabilitation to improve equity of access and outcomes for stroke patients in our region	A potential pilot site to trial rehabilitation telemedicine service identified and draft project plan completed	Q4	Central Region Stroke Network
Workforce Development	Central Region Stroke teams are supported to attend stroke education programmes	Annual study day hosted by a DHB in the Central Region and stroke teams are encouraged and supported to attend	Q3	Central Region Stroke Network / Central Region DHBs
		Central Region Stroke teams are supported to attend the National Stroke Rehabilitation Quality Meeting		

Key area of focus	Actions to deliver	Measures	Timeframe	Accountable roles
Ensuring consistent and equitable access to acute stroke services, inpatient and community rehabilitation.	Central Region Stroke Network to ensure accurate and timely capture of stroke data, and regularly review outcomes including equity of access.	12%[12] or more of potentially eligible stroke patients thrombolysed 24/7 (include ethnicity breakdown)	Q1 – Q4	Central Region Stroke Network
		80% of patients with acute stroke are admitted to a stroke unit or an organised stroke service with a demonstrated stroke pathway (include ethnicity breakdown)	Q1 – Q4	
		80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation are transferred within 7 days of acute admissions (include ethnicity breakdown)	Q1 – Q4	
		60% of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge (include ethnicity breakdown)	Q1-Q4	
	Complete audit to identify ethnic and geographic disparity and potential solutions	Audit (REGIONS Care Project) completed	Q3	Central Region Stroke Network / Central Region DHBs
	Draft a Central Region stroke specific equity strategy in line with the regional equity framework based on audit results	Strategy drafts initiated.	Q4	Central Region Stroke Network

Commented [SN1]: Is this correct

[12] The Ministry of Health's target for regional thrombolysis is 10%, however, the region is aiming to achieve a higher rate.

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Healthy Ageing

CE Lead: Vacant

CRSPF Sponsor: Kieran McCann (Executive Leader, Operations, Wairarapa DHB)

Clinical Lead: Dr Teresa Thompson (Geriatrician, Hutt Valley DHB)

Key area of focus	Actions to deliver	Measures	Timeframe	Accountable roles
Regional priorities				
Equity of outcomes for Māori and Pacific	Publish a comparative infographic that highlights access by Māori to interRAI HomeCare assessments and key risks or issues in this group of older people	Identify indicators available in the interRAI data that highlights equity of outcomes for Māori	Q4	Regional Benchmarking
	Review the implementation of the recommendations from the 2012 Report 'Supporting Older Māori and Pacific Peoples'	Complete a stocktake against the 'Supporting Older Māori and Pacific Peoples' report	Q2	HOP Network, GMs Māori and Pacific, HOP Portfolio Managers
		Identify and prioritise actions that can be implemented locally or regionally to improve outcomes for Māori and Pacific	Q4	HOP Network, GMs Māori and Pacific, HOP Portfolio Managers
Healthy Ageing Strategy	Demonstrate support for the DHB delivery of Actions as identified in the Healthy Ageing Strategy 2016 and the subsequent two year review of actions	Contribute subject matter expertise on the Health Quality and Safety Commission's National Advance Care Planning Steering Group	Q1-Q4	Regional Advance Care Planning Reference Group
		Contribute to the development of advance care planning training and resources for Māori	Q3	Regional Advance Care Planning Reference Group

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Key area of focus	Actions to deliver	Measures	Timeframe	Accountable roles
Dementia framework	Demonstrate best practice through the implementation of regional priorities from the New Zealand Dementia Framework	Provide advice to the Ministry of Health on the template to deliver a comprehensive regional stocktake of dementia services	Q1	Regional Dementia Reference Group
		Complete a regional stocktake against the New Zealand Dementia Framework	Q2	Regional Dementia Reference Group & Local DHBs
		Prioritise and begin implementation of relevant regional priorities which arise out of the NZ Dementia Framework stocktake including collaborating with other regions to identify opportunities for efficiency.	Q3 - Q4	Regional Dementia Reference Group
		Report on work to progress the implementation of the New Zealand Framework for Dementia Care	Q3 – Q4	Regional Dementia Reference Group
	Based on best practice guidelines, deliver a regional pathway for improving access to the assessment and diagnosis of young onset dementia	Review existing dementia pathways of care and ensure relevant linkages and integration occurs with the young onset dementia pathway	Q3	Regional Medical Leads
		Undertake relevant promotion of the pathway with primary care, geriatricians, psycho-geriatricians and regional neurologists	Q3-4	Regional Dementia Reference Group

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Appendix 2 Glossary of Acronyms

Acronym	Definition
ACS	Acute Coronary Syndrome
ACC	Accident Compensation Corporation
AIS	Abbreviation injury score
AMD	Age related macular degeneration
BAU	Business as Usual
BPAC	Best practice advocacy centre
C3	Cancer and chronic condition
CCDHB	Capital Coast District Health Board
CCN	Central Cancer Network
CEO	Chief Executive Officer
CFR	Case Fatality Rate
CNS	Clinical Nurse Specialist
COO	Chief Operating Officer
CRSPF	Central Regional Service Planning Forum
CRTN	Central Region Trauma Network
CT	Computed Tomography
DHB	District Health Board
DON	Director of Nursing
DNA	Deoxyribonucleic acid
Echos	Echocardiograph
EY	Ernst and Young
ESD	Early Supported Discharge
FCT	Faster Cancer Treatment
FTE	Full-Time Equivalent
GMsHR	General Managers Human Resources
HBDHB	Hawke's Bay District Health Board
HOP	Health of Older People
HQSC	Health Quality and Safety Commission
HVDHB	Hutt Valley District Health Board
ICT	Information and Communications Technology

IT	Information Technology
KPI	Key Performance Indicator
LOS	Length of stay
MDM	Multi-disciplinary Meeting
MTNCN	Major Trauma National Clinical Network
MoU	Memorandum of Understanding
NRAC	National Radiology Access Criteria
NZMTD	New Zealand Major Trauma Dataset
NZ-MTR	New Zealand major Trauma Registry
PACS	Picture, Archiving and Communication System
PCI	Percutaneous coronary intervention
PET	Positron Emission Tomography
PHO	Primary Health Organisation
QPI	Quality Performance Indicator
RACPRG	Regional ACP Reference Group
RDoW	Regional Director of Workforce
RRIS	Radiology Information System
RMO	Resident Medical Officer
RSP	Regional Services Plan
SMO	Senior Medical Officer
STBI	Serious Trauma Injuries
STEMI - ST	Elevation myocardial Infraction
SSoC	Single System of Cancer Care
SSC	State Services Commission
SUDI	Sudden unexpected death in infancy TAS Technical Advisory Services
WaiDHB	Wairarapa District Health Board
WDHB	Whanganui District Health Board

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

PUBLIC

Date: 6 August 2019	**HEALTH SYSTEM COMMITTEE DISCUSSION**
Author	Chad Paraone, Consultant
Endorsed by	Rachel Haggerty, Executive Director Strategy, Innovation and Performance
Subject	**PRO-EQUITY WORK PLAN - UPDATE**

RECOMMENDATION

It is **recommended** that the Committee:

(a) **Notes** the update on progress in relation to the pro-equity work plan.

(b) **Notes** the purpose of the pro-equity work plan is to deliver a clear CCDHB equity goal and direction with an agreed set of equity principles; an operational framework that translates these principles into practice; and a performance framework to monitor and guide equity progress.

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 (HSC) of progress to date in relation to the pro-equity work plan.

1.2 Previous Board Discussions/Decisions

The paper follows up on an earlier decision made at the HSC's meeting on 12 June 2019 to endorse the proposed Equity work plan, to approve the Terms of Reference for an Equity Leadership Group, and to request that the Board provide a member of the Board be appointed as a champion of this plan.

2. BACKGROUND

2.1 Planned Milestones

Key milestones for the first 6 months of the plan included delivery of:

(a) a high-level steering group to provide ongoing leadership to the Equity programme;

(b) an approved CCDHB Equity Goal and guiding Principles;

(c) options for embedding equity in decision-making processes for Board and Executive Team;

(d) advanced workings for a Strategy Innovation & Performance (SIP) pro-equity commissioning framework; and

(e) outline of a workplan to develop a Provider Arm operational equity framework.

3. DISCUSSION

3.1 Extending Equity Work Plan timeframes

Executive Leadership Team (ELT) reviewed the Equity work plan in late June and agreed that the proposed timeframes were too tight and needed extending. The following outline indicates the updated timeframes.

Phase 1:	Project Initiation	Complete
Phase 2:	Information collation and exploration	Underway
Phase 3:	Develop Equity Goal(s) and Principles	August/Sept
Phase 4:	Develop Operational Equity Framework – Board, Executive, SIP	September
Phase 5:	Develop approach and work plans for design of tailored Operational Equity Frameworks (for Provider Arm, Corporate, People & Capability, Allied Health)	Jan/March
Phase 6:	Develop Performance and Accountability approach	Jan/March
Phase 7:	Implementation of Equity frameworks - Board, Executive, SIP	Jan/March
	Implementation of work plans for Operational Equity Frameworks - Provider Arm, Corporate, People & Capability, Allied Health	2020

3.2 Getting Underway - Awareness Raising

Ruth De Souza, an expert in the field of Diversity and Equity who is deeply familiar with the NZ health system, was engaged to deliver a series of talks and presentations to staff and management in June 2019. This presentation was focused on raising awareness of the issues relating to diversity and equity in health care, and at providing an opportunity for staff and management to enquire and to engage in open dialogue on both matters.

Over 17 and 18 June, this included the following sessions:

- Developing Child, Youth & Families services to improve equity & outcome
  - Morning workshop - Attended by CCDHB & Hutt Valley DHB – Child & Youth team, Māori Health, Pacific Health & Allied Health
  - Lunch Lecture – Attended by wider CCDHB & HVDHB
- Why we need more than diversity – cultural safety in Health
  - Evening Lecture – Attended by wider CCDHB & HVDHB
- What is Diversity & how we can include this in our work
  - Afternoon workshop – Attended by the Strategy, Innovation & Performance team.

The information, discussion and interest displayed has set the scene for the Equity work plan.

3.3 Setting an Equity Goal and Principles

Work is currently underway on scoping an Equity Goal and set of Principles. This is a significant step, as it sets the foundation for CCDHB's equity aspirations. The goal and principles will both anchor and guide CCDHB towards being a pro-equity organisation.

We are currently in the process of seeking input on goals and principles from the Māori Partnership Board, Sub-Regional Pacific Strategic Advisory Group, Sub-Regional Disability Advisory Group and Citizens Health Council.

This input, coupled with information gleaned from other organisations in the NZ health and other sectors, as well as international literature, will help shape options for a draft Goal and Principles that will go to ELT for deliberation, most likely in September.

The output from the ELT session will be shared with the above stakeholder groups and will be put forward to HSC and the Board for consideration and a decision.

4. NEXT STEPS

The Equity Goal and Principles, once agreed, will inform all subsequent phases of the Equity work plan.

The next stage of the plan is to develop an Operational Equity Framework for the Board, Executive, and for the Strategy Innovation and Performance team (SIP).

This will involve determining how best to apply the equity principles in practice. This will differ according to structure and function. For example:

- Board and Executive: the focus will be on prioritisation and equity-based decision-making as well as organisational performance.
- Provider Arm/Organisation: the focus will be on operational performance, employment practises and the experiences of both workforce, patients and families/whānau.
- SIP/Commissioning: the focus will need to include practical processes relating to prioritisation, service resourcing, approach to commissioning and pro-equity interventions in primary and community care

Consideration will also be given as to how to share this pro-equity approach with Hutt Valley DHB to ensure the organisations are well aligned.

PUBLIC

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**HEALTH SYSTEM COMMITTEE DISCUSSION** **Date:** 14 August 2019

Authors	Gerardine Clifford-Lidstone, GM Commissioning, Child, Youth and Localities Rachel Pearce, Senior Systems Development Manager Julia Jones, System Development Manager
Endorsed By	Rachel Haggerty, Executive Director, Strategy Innovation and Performance
Subject	**MATERNAL, CHILD AND YOUTH INVESTMENT AND PERFORMANCE**

RECOMMENDATIONS

It is **recommended** that the Committee:

(a) **Notes** the intervention logic underpinning current maternal, child and youth health investment in NGO and community settings (Appendix 1);

(b) **Notes** that while CCDHB mothers, babies and youth compare favourably to the national experience against many measures, there are areas of inequitable outcomes for our families/whānau;

(c) **Notes** the work underway to improve the impact of our investment, particularly for Māori, Pacific and other groups.

APPENDICES

1. Child and Youth Intervention and Dashboard Measures;
2. Maternal and Child (0-4 years) NGO Investment Dashboard;
3. HSC Investment Dashboard – Youth (10-25 years).

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	x

PUBLIC

1 PURPOSE

This paper updates the Health System Committee on the approach for commissioning and monitoring performance of services provided for the CCDHB population under locally negotiated NGO agreements for pregnant women, children (tamariki) and young people (rangatahi). To this end, the paper outlines the intervention logic, which demonstrates the link between the child and youth commissioning approach, System Level Measures (SLMs) and other measures against which the Child, Youth and Localities team (CYL) monitors performance. Finally, following assessment of current performance, the paper signals pending changes in the investment approach to better address equity issues.

2 INTRODUCTION

There is substantial evidence that investment in the early years of children's health, development and well-being (including pregnancy) is the most cost-effective means of tackling long-term health conditions and health inequity. Investing in the early years offers the possibility of shifting the trajectory of a person's health over the course of their life and disrupting intergenerational cycles of disadvantage.

Māori and Pacific mothers, tamariki and rangatahi are more likely to experience poor health outcomes and to have specific health needs. This inequity takes on added significance when considering evidence that the disparity in health outcomes experienced in adulthood has a strong association with the adverse health status and risk factors experienced in childhood. It provides increased impetus for investment decisions that improve health outcomes within these communities.

Strategy, Innovation and Performance (SIP) has been developing performance dashboards as a mechanism for monitoring investment. Underpinning each performance dashboard needs to be an intervention framework that provides a direct line of sight between the investment and the impacts and outcomes the CCDHB would like to achieve.

3 INTERVENTION LOGIC (APPENDIX 1)

One of the complexities associated with the CYL investment planning approach is the need to simultaneously consider interventions aimed at influencing the determinants of health/lifestyles to improve health and prevent problems and services which identify, assess and manage concerns or conditions as they arise. Developing the intervention logic addresses these challenges by creating a framework that brings together life course and service delivery approaches based on pathways that are easily understood.

3.1 Aligning the intervention logic to dashboard performance measures

The dashboard methodology demonstrates performance against structural measures, system level performance and system impact measures which is underpinned by the intervention logic. In the intervention logic the dashboard measures are as follows:

Measures	***Child***	***Youth***
Structural Measures	***CHILD*** *DHB Investment* *Pre-school dental examinations* *Outreach Immunisation events* *%WCTO core contact and B4SC* *% of mothers engaging with midwife* *PHO utilisation*	*% PHO enrolment (10-25 years)* *YOSS consultations* *SBHS total contacts* *Green prescription referrals* *HEEAADSSS assessment completed* *Primary care utilisation (10-25)*
System Level Performance	*Breastfeeding coverage at 3 months* *Raising healthy kids target* *Immunisation at 8 months* *Immunisation at 2 years* *Immunisation at 5 years* *Newborn enrolment at 6 weeks*	*STI screening rate* *Mental health and YOSS and SBHS contacts* *SBHS coverage* *%completed green prescription* *% Year 9 completed HEEAADSSS* *%completed dental checks*

Impact Measures	*% babies in smokefree homes* *%caries free at 5 years* *Hāpu ora smoking cessation participants* *ED presentation rate (0-4years)* *Kenepuru A&M presentation rate (0-4 years)* *ASH rate (0-4 years)*	*STI prevalence* *% Year 8 caries free* *Youth suicide (10-25years)* *ED self-harm (10-25 years)* *ED presentation rate (10-25 years)* *ASH rate (10-25 years)*

Attached as Appendix 1 is the intervention logic for the maternal, child and youth investment programme.

4 FUNDING SOURCES

CCDHB receives annual funding from the Ministry of Health via Crown Funding Agreements for a range of national and regional priorities including Sudden Unexpected Death in Infants (SUDI) prevention, rheumatic fever prevention and management, immunisation, contraception services and nutrition and physical activity. SIP continues to review and refine opportunities to deliver on its CFA commitments, in a way that also delivers on local strategies and pressures.

We should include PVS specific to maternal and child health as well as youth; specifically the non-CWD/WIES funding – for example, Programme funding like Pacific Island Breast Feeding.

4.1 Equitable and integrated maternal and child health

Investment in access to safe, high quality and universal pregnancy, childbirth and children's health services is essential for ensuring that all children have the best possible outcomes and developmental trajectory. The provision of integrated high quality antenatal care services, which include maternal support, is a critical part of achieving equitable, person-centred coverage.

2019/20 investment in NGO and community maternal and child health services is as follows. Note: This section does not include investment in mainstream maternal, child and youth primary, secondary and tertiary services and Regional Public Health.

	CFA funding	**CCDHB PBFF funding**	**Total investment**
Increasing access to contraception	$239,019		$239,019
Antenatal and Parenting Education		$91,113	$91,113
Breastfeeding support[#]		$356,236	$356,236
Mātua, Pepi, Tamariki service^		$732,534	$732,534
Sudden Unexpected Death in Infancy (SUDI)	$109,697		$109,697
Well Child Tamariki Ora (WCTO)	$765,517	$193,680	$959,197
Immunisation Coordination and Administration	$60,000		$60,000
Immunisation Outreach Services	$275,427	$146,000	$421,427
B4 School Check (B4SC)*	$511,158		$511,158
B4 School Check – active family	$120,000		$120,000
Total	**$2,080,818.00**	**$1,519,563.00**	**$3,600,381.00**

*Services not yet contracted

^Ongoing funding is $421,000 per annum. Additional funding is provided in 2019/20 to support developmental activities and activities delayed from 2018/19.

[#]This includes funding for pregnancy education classes at Wellington Regional Hospital and Kenepuru Hospital.

In 2019/20, a small portion of the SUDI Prevention and WCTO funding will be used to prototype antenatal education underpinned by cultural frameworks and to support breastfeeding workforce development.

4.2 Equitable and targeted youth health services

2019/20 investment in NGO and community youth health services include:

	CFA funding	CCDHB funding	Total investment
Bee Healthy (dental)		$5,813,611	$5,813,611
Rheumatic fever prevention and management	$124,958	$140,000	$264,958
School Based Health Services		$495,550	$495,550
Combined dental agreement (up to 18 years)		$2,008,501	$2,008,501
Green prescription programmes	$185,113	$619,904	$805,017
Adolescent youth services		$1,164,323	$1,164,323
Integrated Youth Services in Porirua*		$300,000	$300,000
Total	**$310,071.00**	**$10,541,889.00**	**$10,851,960.00**

*Services not yet contracted

SIP funds school based health services in all decile 1-4 schools, as required by the MoH. SIP recognises that there are some higher decile schools that include large cohorts of students requiring more support, and therefore SIP funds six additional schools, over and above the minimum MoH requirements. These schools are Aotea College, Rongotai College, Tawa College, Wellington East Girls' College, Kāpiti College and Paraparaumu College.

Similarly, the MoH has minimum expectations around the availability of nutrition and physical activity programmes for pregnant women, children and adults. CCDHB funds additional in school support for physical activity and nutrition (Project Energize), which is delivered through the Heart Foundation to 30 low decile schools.

5 PERFORMANCE MEASUREMENT

5.1 Dashboards (Appendices 2 and 3)

Using the framework presented in the intervention logic, Appendices 2 and 3 present dashboards demonstrating the impact of CCDHB's investment in maternal and child health and youth health. The intention is to present a selection of indicators that show:

- what our investment purchases (activity);
- how well our population receives the services (engagement with services); and
- the effectiveness and impact of the investment on the system and people.

Dashboard development is ongoing.

5.2 ***Current*** **performance**

In the absence of completed dashboards, this succinct (exception) performance update is provided.

- ***Maternal and child health***

Against many metrics, CCDHB mothers and babies experience good health access and outcomes. CCDHB compares favourably to the national averages for breastfeeding rates, immunisation coverage and SUDI rates:

- 64% of CCDHB mothers are breastfeeding at 3 months, compared to 58% nationally[1].
- 93.4% of CCDHB 8 month olds are fully immunised, compared to 90.7% nationally; 92.4% of CCDHB 2 year olds compared to 90.8% nationally and 89.5% pf 5 year olds compared to 88.5% nationally[2].
- CCDHB's SUDI mortality rate is 0.59 babies per 1,000 births, compared to the national rate of 0.73 per 1,000[3].

However, there are pockets of inequitable outcomes; most commonly for Māori, Pacific and whānau living in areas of high deprivation, particularly in Porirua. For example:

- While 64% of CCDHB mothers are breastfeeding at 3 months, only 48% of Māori mothers and 43% of Pacific mothers are. This gap increases by 6 months.
- While 93.4% of all CCDHB 8 month olds are fully immunised, only 92.2% of Pacific and 87% of Māori 8 months are fully immunised. For 2-year and 5-year milestone, Māori and Pacific children are less likely to be immunised.
- The total CCDHB SUDI mortality rate[3] is 0.59 per 1,000. For Māori the rate is 1.87 per 1,000, compared to 0.27 per 1,000. This means CCDHB Māori babies are at almost 7 times greater risk of SUDI.

- ***Integrated youth services***

CCDHB promotes the growing body of evidence that supports integrated youth specific models of care. There are two YOSS's currently funded by the DHB, Kāpiti Youth Support and Evolve. Demand for these services are greater than capacity, which demonstrates the success of providing wrap around services for young people.

There is a recognised gap in the Porirua community as there is no integrated youth service available. Based on demography, the age, ethnicity and deprivation composition of the Porirua population demonstrates the need for responsive, youth friendly services. Approximately 40% (12,000 people) of Porirua's population is under 25 years of age, of which 65% are Māori and Pacific. Of this total number 29.7% live in the most deprived (decile 10) suburbs.

- ***Oral health***

Oral health utilisation rates (an annual check-up) for 13-18 year olds was 79% in 2018 which is higher than the national average of 69%. While CCDHB results are the fourth highest in the country the result was slightly below the national target of 85%.

6 IMPROVING EQUITY OF OUTCOMES

6.1 Maternal and Child health

Historically, CCDHB's investment in maternal health has been predominantly in secondary and tertiary settings. For the community-based services that are supported, they are often discrete, mainstream programmes. In 2019, CCDHB is reviewing its approach to commissioning maternal and child health services, with a view to shift investment in 2020/21. This process is intended to better target our investment to those who most need it, and create models of care that reflect the clinical and cultural needs and preference of women and families. We want to support services that are trusted by families and provide continuum of care for women, such as hapū wānanga services.

As interim steps, in 2019/20 we are:

- Redistributing funding for pregnancy and parenting services delivered by the HHS to community-based providers.
- Prototyping antenatal education and programmes underpinned by cultural frameworks.

[1] Based on data released in Q3 2018/19. Note: breastfeeding reporting has been delayed.
[2] Based on data as at 30 June 2019.
[3] Based on 2011-2015 data,

- Working in partnership with Ora Toa PHO to establish a Mātua, Pepi, Tamariki service in Porirua.
- Establishing a safe sleep programme across CCDHB, including resources and education for families.

CCDHB is working with Hutt Valley DHB regarding the maternity model and future need across our populations and services. Recommendations regarding birthing models will be presented to the Health System Committee in March 2020.

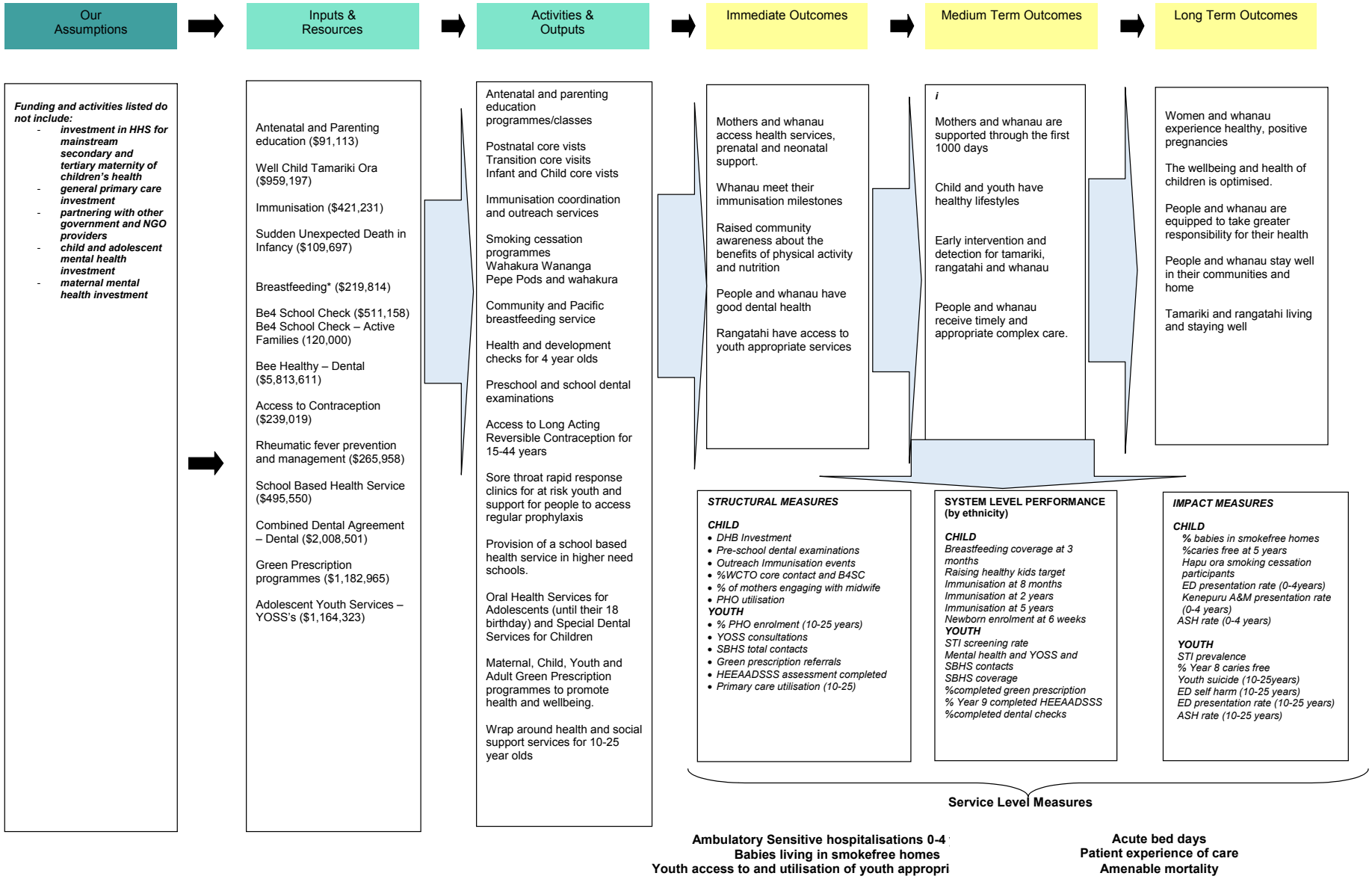
The MoH is currently reviewing the WCTO programme, with a view to implement changes from 1 July 2020. At this stage, there is no indication from the MoH of the future WCTO funding and policy environment. CCDHB continues to participate in regional and national conversations regarding the review.

6.2 Youth health

As outlined above, there is a demonstrated need for youth services in Porirua. CCDHB is currently working in co-design with the rangatahi in Porirua to develop an integrated model of care that will provide more equitable and joined up services for youth in the community to enable better access and a wider range of services for youth by partnering with other agencies.

In 2019/20, we intend to review existing investment in child and youth nutrition and physical activity programmes. This work will review need in the population and the intervention logic of current services. It should be noted that SIP intend to review the package of care across age groups with an equity focus that is being delivering for green prescriptions in 2019.

Appendix One: Child and Youth Intervention Logic



*This currently includes funding for pregnancy education classes at Wellington Regional Hospital and Kenepuru Hospital SIP is working with the Women's Health Service to disinvest from CCDHB delivered education and will shortly look for community based providers.

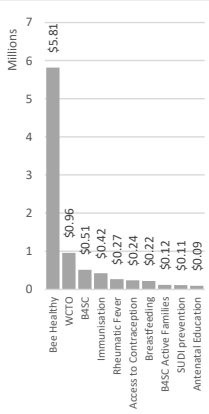
MATERNAL & CHILD (0-4 YEARS) NGO INVESTMENT DASHBOARD

Key
- Achieved
- Partially achieved
- Not achieved

Structural Measures

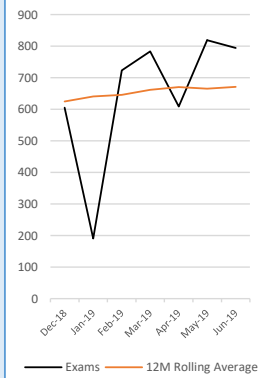
Funding

DHB investment (2019/20)

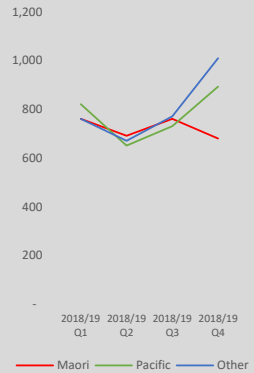


Contracted Activity

Pre-school dental examinations (2-4 years)



Number of infants who receive a WCTO core contact before 50 days

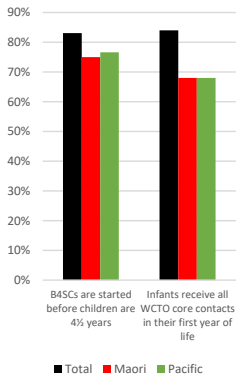


Outreach immunisation events

Developmental Indicator

Engagement with Services

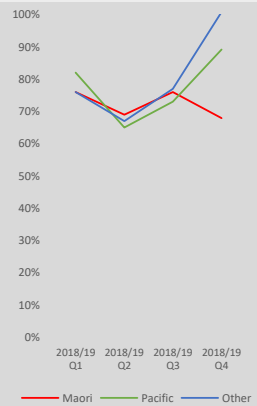
% WCTO core contact and B4SC (2018/19 Q4)



% mothers engaging with midwife in first trimester

Developmental Indicator

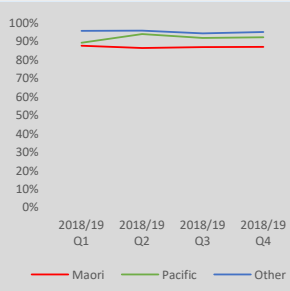
PHO utilisation rates



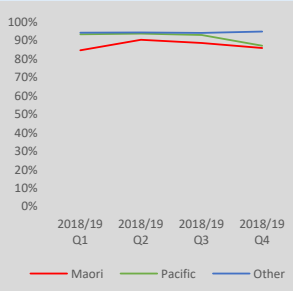
System Level Performance

Policy Priorities

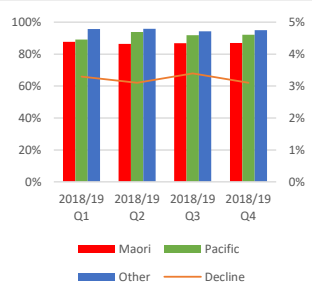
Breastfeeding coverage at 3 months



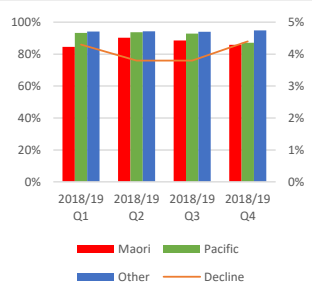
Raising Healthy Kids Target



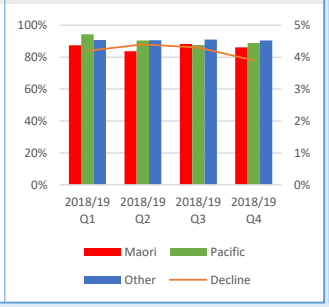
Immunisation coverage at 8 months



Immunisation coverage at 2 years

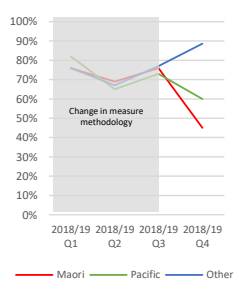


Immunisation coverage at 5 years



System Integration

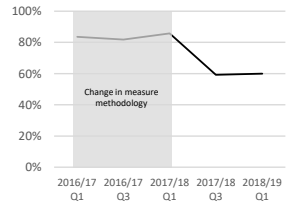
Newborn enrolment at 6 weeks



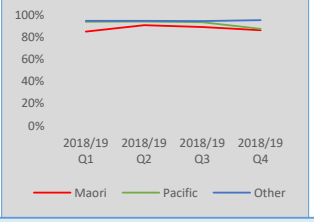
Impact Measures

Person Impact

% babies in smokefree homes



% caries free at 5 years

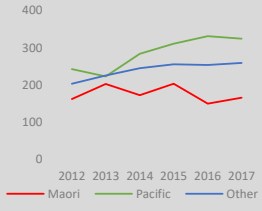


Hapū Ora smoking cessation participants

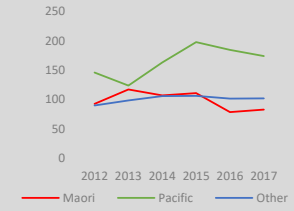
Developmental Indicator

System Impact

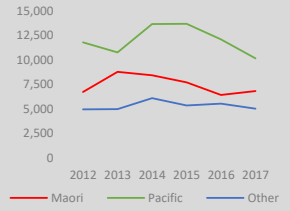
ED presentation rate (0-4 years)



Kenepuru A&M presentation rate (0-4 years)



ASH rate (0-4 years)



***Please note greyed out charts contain placeholder data**

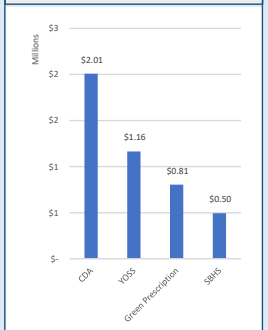
HSC INVESTMENT DASHBOARD – YOUTH (10-25 YEARS)

Key
- Achieved
- Partially achieved
- Not achieved

Structural Measures

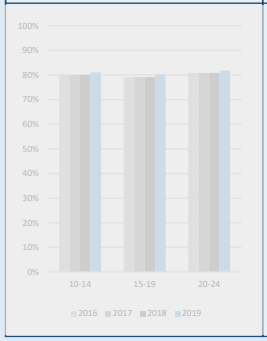
Funding

DHB investment 2019/20

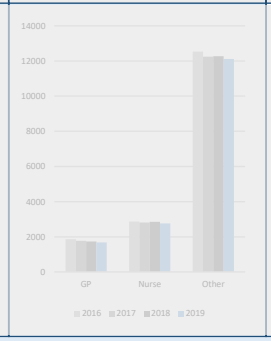


Activity

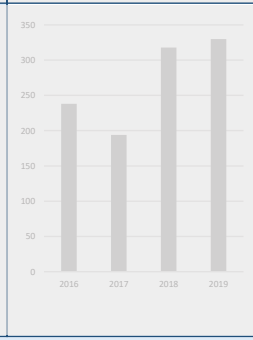
% PHO enrolment (10-25 years)



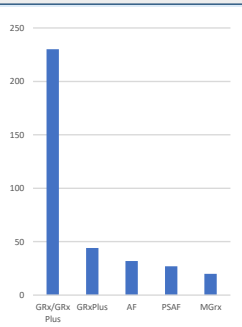
YOSS consultations



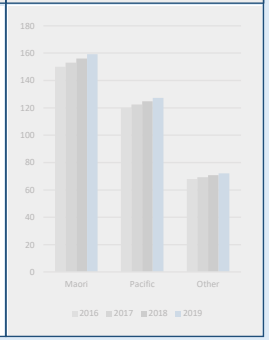
SBHS total contacts



Green Prescription referrals 2019/20 Q4

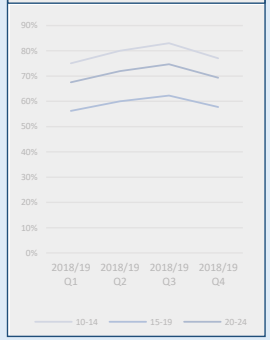


HEEAADSSS assessments completed



Engagement

1° Care utilisation rate (10-25 years)



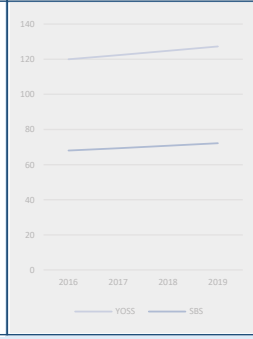
System Level Performance

Population Outcomes

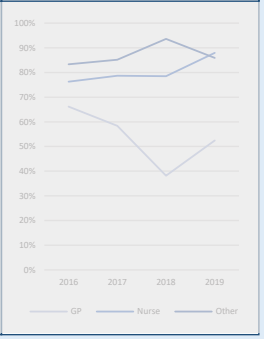
STI screening rate (Chlamydia)

Data to be sourced

Mental Health YOSS and SBHS contacts

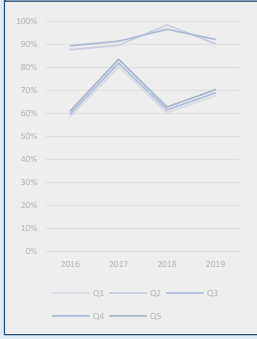


YOSS consultation rate

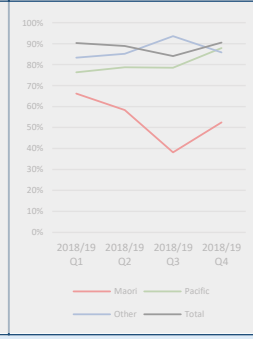


Policy Priorities

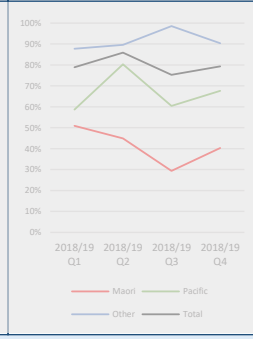
SBHS coverage



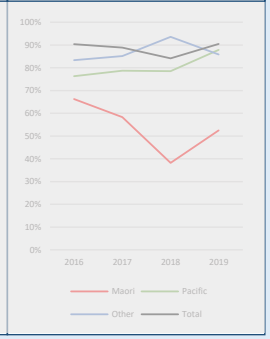
% completed Green Prescription



% Year 9 completed HEEAADSSS



% completed dental checks (13-18 years)



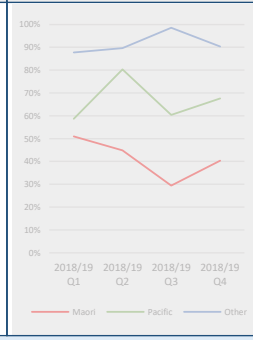
Impact Measures

Person Impact

STI prevalence (Chlamydia)

Data to be sourced

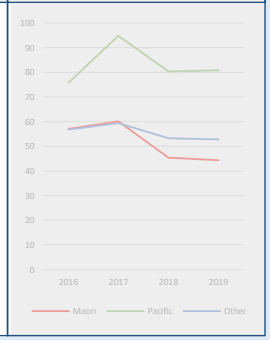
% Year 8 caries free



Youth suicide rate (10-25 years)

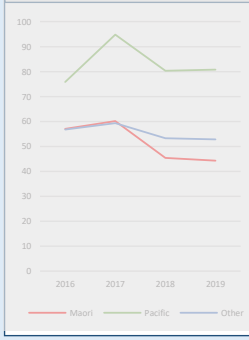
Data to be sourced

ED self-harm rate (10-25 years)

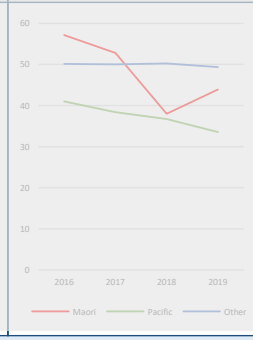


System Impact

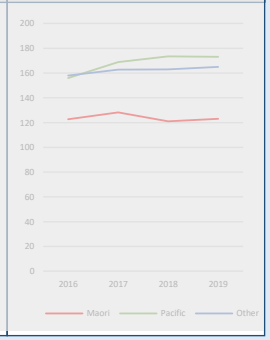
ED presentation rate (10-25 years)



KPH A&M presentation rate (10-25 years)



ASH rate (10-25 years)



*Please note greyed-out charts contain placeholder data

Capital & Coast District Health Board
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PUBLIC

Date 3 August 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, Executive Director, Strategy, Innovation and Performance, CCDHB
Subject	**3 DHB ALCOHOL AND OTHER DRUG (AOD) MODEL OF CARE**

RECOMMENDATIONS

It is **recommended** that the Committee:

(a) **Notes** the progress in relation to the 3 DHB AOD Model of Care work;

(b) **Notes** the next steps in the 3 DHB AOD Model of Care work;

(c) **Notes** that the AOD Model of Care will be presented in December 2019.

APPENDICES

1. AOD Model of Care Draft Visual;
2. Substance Use Harm Definition;
3. Unmet Demand Modelling;
4. Themes from the Lived Experience Engagement Process.

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 in relation to 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 17 April 2019.

Capital & Coast District Health Board
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1.3 Project brief

This project reviews current service configuration, identifies gaps, and/ or duplication of services, and will develop a new AOD model of care and integrated 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.

He Ara Oranga contained 40 recommendations, which apply to health, the wider social sector and society as a whole. The Government has accepted, accepted in principle or agreed to further consideration of 38 of the recommendations, and funding for many new initiatives was announced in the 2019 Wellbeing Budget.

1.4 Wellbeing Budget implications

While there was some money specifically ring-fenced for addiction in the Wellbeing Budget, much of it was for specific initiatives, for example two new pregnancy and parental services, ongoing contribution to *Te Ara Oranga* (a methamphetamine focussed initiative in Northland) and sixty methamphetamine packages of care for residential services. Of these specific initiatives The Salvation Army Bridge Programme based in Wellington received four new methamphetamine packages of care. This equates to four new residential beds in the CCDHB area, however they are able to be accessed nationally.

Other funding that has been ring fenced for AOD includes:

- **Enhancing Specialist AOD Services:** $11m per annum nationally. $44m over four years. This is to ease current pressures and there is no expectation that more people are seen.

- **Enhancing Primary Addiction Responses:** $2m in 2019/20 (nationally) rising by a million each year to $5m in 22/23. $14m over four years.

This effectively gives us very little opportunity to fund the implementation of the 3 DHB Model of Care through central funding initiatives from the Wellbeing Budget in the 2019/2020 year.

The Minitry of Health are going to start work on a National AOD Model of Care to inform investment bids for 2020/21. Anna Nelson is on the working group for this and is working closely with the Ministry in relation to all potential funding opportunities.

2 DISCUSSION

2.1 Progress to date

2.1.1 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.

2.1.2 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.

The gap analysis of the stocktake data showed:

- an invisible, disconnected and disjointed AOD system
- inequitable access to services across the 3 DHB sub-region and within each DHB area, for example services run out of main centres being unable to adequately cover the wider geographical area
- extremely limited AOD focussed services for youth
    - 13 FTE across 5 different services (for under 18 year olds)
    - No access to residential beds for under 18 year olds
- no access to AOD respite facilities in the CCDHB or Hutt Valley area
- no social detox facility in the CCDHB or Hutt Valley areas
- a mix of clinical and non-clinical FTE's for AOD counselling roles
- different rates for clinical and non-clinical FTE within each DHB and across the sub-region
- limited access to services specifically for family and whānau
    - only one service is funded to provide this across mental health and addiction (7 FTE)
- no clear pathway for people being exited from Substance Addiction Act 2017 (SACAAT)
- no funded AOD peer workforce
- highly confusing, and limited capacity clinical governance structure across MHAIDS
- limited AOD specialist workforce
- clinical/cultural paradigm split
- no access to funded Pasifika focussed AOD services in the Hutt and Wairarapa

2.1.3 AOD Model of Care

The 3 DHB AOD Model of Care final draft visual is complete. See Appendix 1. This shows the agreed principles, values and expected outcomes of the AOD Model of Care as agreed by the Steering Group members. This AOD Model of Care shows that individuals, whānau and communities are at the centre of the model and provides the framework for the development of integrated care pathways, implementation and ultimately locally designed and developed service models.

As part of this process a definition of 'substance use harm' has also been agreed. See Appendix 2

2.1.4 Unmet demand modelling

Our draft model of unmet demand has been developed and we are still fine tuning the assumptions that underpin this model. The current model shows utilisation of current services against prevalence rates by age and ethnicity, with an assumption for 'natural recovery' sitting at an agreed 30%. See Appendix 3. The

model has limitations as we do not have current data for the impact of social deprivation on prevalence for example, however the modelling is already showing high unmet demand across the 3 DHB region in most areas even though this is likely to be conservative. Where demand appears to be met, for example for Maori aged 20-64 in south Porirua, we know that this is as a result of access to services through Corrections and implies a mandatory and often brief access into services. The model at present also has a focus on substance use disorder (3.5% of the population) and could be extended in the future to estimate unmet demand for mild to moderate substance use harm, and for future population growth.

We will continue to refine the model with guidance from the Steering Group.

2.1.5 Lived experience engagement

The methodology for engaging with people currently accessing AOD services in the 3 DHB region was agreed and signed off by the Steering Group, which includes 3 members of SIP's Lived Experience Advisory Group (LEAG).

Those with a lived experience of substance use harm have unique experiences, insight and expertise to share, and an essential contribution to make to the design, development, delivery and evolution of initiatives to help people affected by substance use harm. Because of their direct experiences of services, those with a lived experience know better than anyone what works, and what does not.

This process is yet to be completed however Appendix 4 shows the themes that are emerging from this engagement.

3 NEXT STEPS

3.1 Integrated pathway design

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 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, and lived experience engagement.

3.1.1 AOD Collaborative Network

A focus on system visibility, partnership and collaboration across the sub-region has already been recognised as an important next step in the model of care implementation. A proposal in relation to funding and establishing an AOD Collaborative Network is underway.

3.1.2 Model of Care paper

Once the next steps (as above) have been developed and agreed, a paper outlining the entire Model of Care will be written for each of the three DHB boards to approve in December 2019. This will include the work undertaken to inform the process and contain a recommended implementation and outcomes approach.

This paper will then inform the investment required by each DHB to commission locality based services that support the implementation of the agreed Model of Care. This paper will also inform the *Living Life Well* five year investment plan which is due for completion by December 2019, to be presented to each of the three DHB boards by February 2020.

Model of Care Thinking

Work-in-progress draft v1.3
Subject to lived experience engagement

Vision

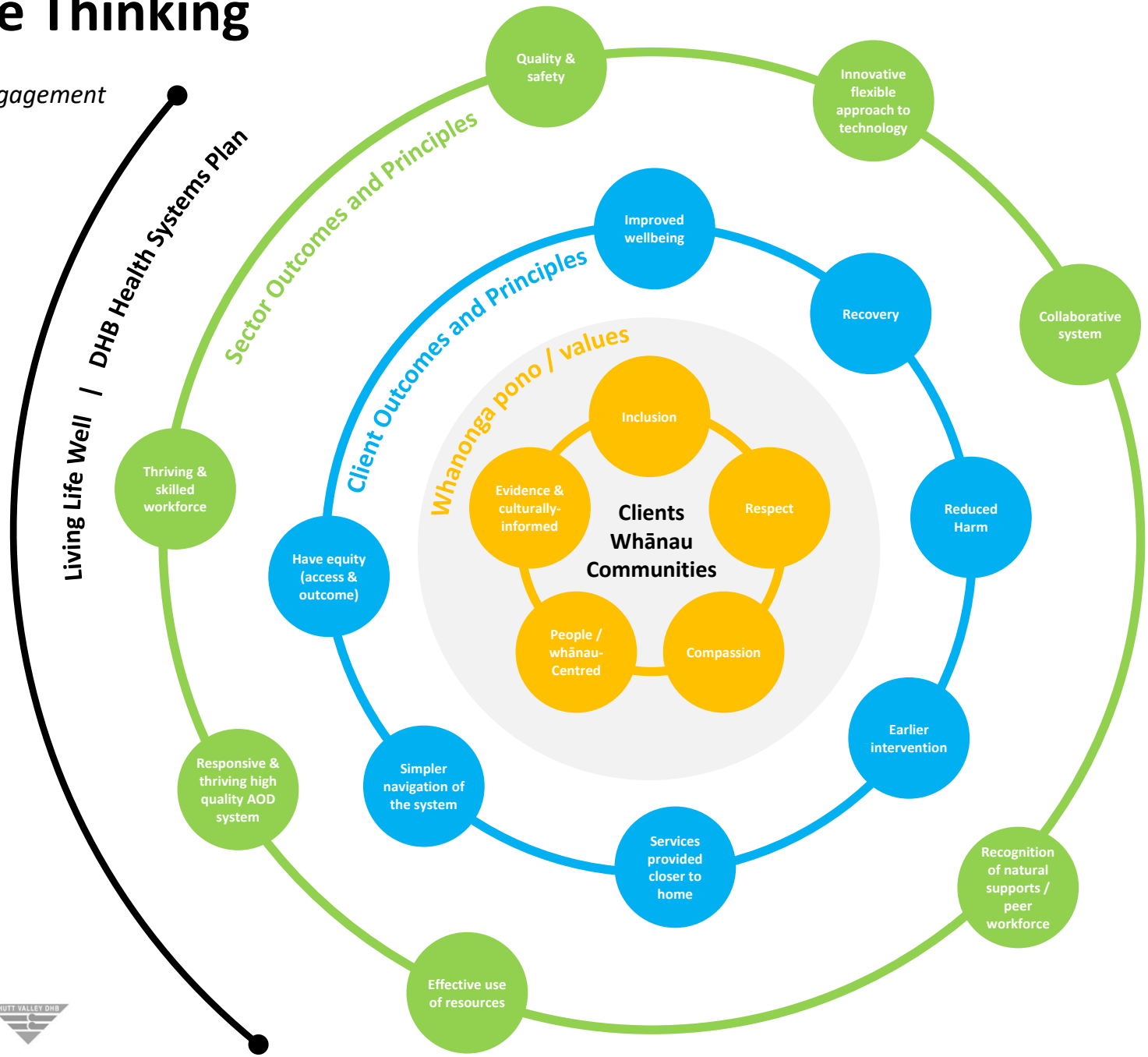
By 2020/21 the 3DHB region will have designed and implemented an enviable locality-based and community-centric AOD Model of Care and practice pathway.

Mission

Sector partners will work inclusively and respectfully to create a client and whānau-centred model using integrated and collaborative practice pathways.

Tangata whai ora, whānau and communities will have substantially improved equity and wellbeing, with reduced AOD harm. Services will be easy to navigate, intervention will be accessible earlier, and closer to home.

The sector will move to a collaborative system, effectively using resources, with an innovative approach to technology-use. Services will be of high quality, and safe services will be based on evidence and culturally-informed best practice. The sector and workforce will be thriving and skilled.



Substance Use Harm

DRAFT DEFINITION

The goal of the AOD system of care is to minimise substance use harm across the 3 DHB sub-region for individuals, whānau and communities.

Substance use harm is any pattern of psychoactive substance use (including alcohol use) that causes harm to individuals, family, whānau and communities.

Harm can manifest in a variety of ways, and might include:

Physical	**Mental**	**Emotional**	**Social**	**Spiritual**	**Cultural**
Relationship	**Family**	**Whānau**	**Financial**	**Legal**	**Community**

Harm is present when defined and identified by individuals, whānau and communities themselves.

Q: HOW DO WE MEASURE THESE HARMS?

Demand Modelling

			Actual service users	Theoretical Prevalence Users	Proportion served	Natural Recovery	Unmet	GREEN represents service needs met, GREY is natural recovery, RED is unmet needs (as %)
N. Porirua	Youth	Māori 0-19	4	177	2%	30%	68%	
		Pacific 0-19	2	211	1%	30%	69%	
		Other 0-19	8	379	2%	30%	68%	
	Adult	Māori 20-64	15	147	10%	30%	60%	
		Pacific 20-64	3	97	3%	30%	67%	
		Other 20-64	63	293	22%	30%	48%	
	Older	Māori 65+	0	21	0%	30%	70%	
		Pacific 65+	0	16	0%	30%	70%	
		Other 65+	3	93	3%	30%	67%	
S. Porirua	Youth	Māori 0-19	145	255	57%	30%	13%	
		Pacific 0-19	64	303	21%	30%	49%	
		Other 0-19	34	546	6%	30%	64%	
	Adult	Māori 20-64	199	173	115%	30%	0%	
		Pacific 20-64	86	116	74%	30%	0%	
		Other 20-64	114	316	36%	30%	34%	
	Older	Māori 65+	1	18	6%	30%	64%	
		Pacific 65+	1	13	7%	30%	63%	
		Other 65+	5	76	7%	30%	63%	
Kapiti	Youth	Māori 0-19	14	244	6%	30%	64%	
		Pacific 0-19	0	60	0%	30%	70%	
		Other 0-19	29	825	4%	30%	66%	
	Adult	Māori 20-64	82	174	47%	30%	23%	
		Pacific 20-64	6	18	33%	30%	37%	
		Other 20-64	267	576	46%	30%	24%	
	Older	Māori 65+	2	27	7%	30%	63%	
		Pacific 65+	0	3	0%	30%	70%	
		Other 65+	15	329	5%	30%	65%	
Wellington CBD	Youth	Māori 0-19	3	63	5%	30%	65%	
		Pacific 0-19	0	41	0%	30%	70%	
		Other 0-19	2	537	0%	30%	70%	
	Adult	Māori 20-64	37	142	26%	30%	44%	
		Pacific 20-64	9	38	23%	30%	47%	
		Other 20-64	168	773	22%	30%	48%	
	Older	Māori 65+	0	7	0%	30%	70%	
		Pacific 65+	0	3	0%	30%	70%	
		Other 65+	2	91	2%	30%	68%	

Demand Modelling cont . . .

			Actual service users	Theoretical Prevalence Users	Proportion served	Natural Recovery	Unmet	GREEN represents service needs met, GREY is natural recovery, RED is unmet needs (as %)
Upper Hutt	Youth	Māori 0-19	15	218	7%	30%	63%	
		Pacific 0-19	1	79	1%	30%	69%	
		Other 0-19	12	943	1%	30%	69%	
	Adult	Māori 20-64	103	173	60%	30%	10%	
		Pacific 20-64	16	24	65%	30%	5%	
		Other 20-64	185	646	29%	30%	41%	
	Older	Māori 65+	0	14	0%	30%	70%	
		Pacific 65+	0	2	0%	30%	70%	
		Other 65+	3	196	2%	30%	68%	
Lower Hutt	Youth	Māori 0-19	32	633	5%	30%	65%	
		Pacific 0-19	6	414	1%	30%	69%	
		Other 0-19	29	2024	1%	30%	69%	
	Adult	Māori 20-64	319	516	62%	30%	8%	
		Pacific 20-64	46	170	27%	30%	43%	
		Other 20-64	403	1438	28%	30%	42%	
	Older	Māori 65+	3	43	7%	30%	63%	
		Pacific 65+	0	16	0%	30%	70%	
		Other 65+	6	415	1%	30%	69%	
Wairarapa (combo)	Youth	Māori 0-19	30	275	11%	30%	59%	
		Pacific 0-19	1	49	2%	30%	68%	
		Other 0-19	12	904	1%	30%	69%	
	Adult	Māori 20-64	214	184	116%	30%	0%	
		Pacific 20-64	18	10	174%	30%	0%	
		Other 20-64	346	609	57%	30%	13%	
	Older	Māori 65+	1	22	5%	30%	65%	
		Pacific 65+	0	0	0%	30%	70%	
		Other 65+	10	272	4%	30%	66%	

LEAG – Emerging Themes for the AOD Model of Care

Te Paepae Arahi 20/6	Bridge Programme 4/7	PACT/Care NZ 24/7	TBC Taeaomanino	TBC Wairarapa	Online Survey
6 Participants	16 Participants	9 Participants			21 Respondents

Bullet points in BOLD are the most frequently raised, Green positive, Red negative

What it is like

What has it been like getting help for your AOD use?

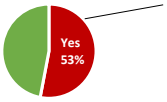
- Excellent
- Easy

VS

- **Difficult/hard**
- **Slow admittance**
- Scary
- Fruitless
- Didn't know who to turn to

Barriers

Were there any barriers to getting help?

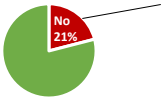


- **Waitlists**
- Stigma
- Limited resources
- Anonymity concerns
- Not taken seriously

- Judgemental
- **No information or support while waiting**
- Element of luck
- **Criminal stigma**

Traditional service access

Did you access 'traditional funded services'? e.g. community alcohol and drug services, counselling or residential services



- Didn't know who to turn to
- Felt judged
- Didn't need to
- Embarrassed

- Wait times too long
- **Where to start?**
- Not enough beds
- Couldn't access
- No follow-up

Most useful

What has been most useful when you have accessed services or got support for your AOD use?

- **Counselling**
- **Sharing with fellow addicts**
- **12 step programme**
- Acceptance
- Being listened to
- No judgement
- Online groups

Difference made

What difference did accessing services or support make to your life?

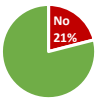
- **Huge difference**
- **Made life worth living**
- **Brought back family and children**
- **Stay on path to recovery**
- Sense of community

VS

- Not much
- Hard – wait time

Wider wellbeing

Did the service(s) you accessed for support give you information or support for non-health related matters to support your wellbeing?



Least useful

What has been the least useful when you have accessed services or received support for your AOD use?

- **Wait times**
- **Counsellors not having understanding/lived experience**
- High threshold
- Not understanding indigenous needs
- **No peer support**
- Lack of programme awareness by GPs
- No support for unplanned discharges

If only . . .

What would have made your experiences better?

- **Earlier/faster access**
- **Kaupapa Māori focused**
- Staff related to addiction
- **More staff and money**
- Marketing normalising sobriety
- **Better communications and awareness about programmes**
- Alignment between health, legal, education sectors – communication and work together
- Physiotherapy offering

Ideal AOD service

What would the ideal AOD service look like?

- **Wait list reduction**
- Treated with hope
- Shift to a recovery model
- Earlier access
- Alternative medicines
- **Recognise successes**
- Fully subsidised
- Free counselling
- **Community focus**
- **Clearer access visibility**
- Hub approach
- Open environment
- **Continuity of aftercare**
- Personalisation
- **Peer support**

Overall improvements

How do you think things could be improved overall?

- **Recognise successes**
- **More funding and staff**
- Not treated like a criminal
- Community promotion
- Proper training
- Normalise living alcohol free
- Marae programmes
- REAL counsellors with lived experience
- Assistance with study

PUBLIC

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**HEALTH SYSTEM COMMITTEE DISCUSSION**
	Date: 14 August 2019

Author	Peter Guthrie, General Manager Planning & Performance Sam McLean, Senior Advisor Accountability
Endorsed by	Rachel Haggerty, Executive Director, Strategy, Innovation & Performance
Subject	**BOARD CHAMPIONS – ROLE AND RESPONSIBILITY**

RECOMMENDATIONS

It is **recommended** that the Committee:

(a) **Notes and discusses** the evidence presented here with a view to agreeing what they believe to be the core functions of a Board Champion;

(b) **Endorses** management to develop this feedback into a role description, outlining scope and responsibilities, to present to the CCDHB Board for endorsement.

1. PURPOSE

This paper describes the generic role and responsibility of a Board champion and seeks the Health System Committee (HSC) input into where we might want to emphasise particular aspects of a Board Champion to reflect the CCDHB environment.

2. BACKGROUND

At the last HSC meeting (17 July 2019), Board Champions were appointed in priority areas for the DHB. HSC requested that in order to ensure maximum value was gained from the role that management describe the role and responsibility of a Board Champion.

3. BOARD CHAMPIONS

Internationally, the appointment of Board Champions is becoming common practice, particularly within the NHS. In the NHS, Board Champions engender a Board level commitment and focus around strategic priorities or key areas of service development or delivery (NHS Wales).

The introduction of Board Champions requires a clear definition of the role and responsibilities to support the intention of the appointment. From experience in the NHS, we know that the absence of a clear description of roles and responsibilities for Board Champions results in blurred accountabilities and role confusion. Care is required to describe the role in a way which ensures Board Champions are enabled to function strategically and maintain focus on the priority or key area they are responsible for.

4. ROLES AND RESPONSIBILITIES OF CHAMPIONS

The following summary of the role and responsibilities of Champions has been adapted from the Ministry for the Environment's appointment of an Urban Design Champion.

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4.1 What is a Champion?

A Champion is a senior, influential person who can promote their championed area in all areas of the organisation. They are critical in making the championed area successful through increasing awareness and demonstrating the values of the organisation.

4.2 Why are Champions important?

Success does not just happen by chance. It requires good planning based on a long-term vision and co-ordinated implementation. To be successful, the focus area needs to be an integral part of the everyday actions of your organisation, not just something reserved for visible, glossy, front page projects. Champions at a senior level within an organisation are an effective mechanism for embedding this focus in the organisation and achieving success.

4.3 What do Champions contribute?

Champions strengthen the focus of a particular organisational priority by providing the strong leadership needed to put and keep the focus area on the agenda. An important role of Champions and their success is raising awareness of the benefits and challenging of existing approaches where they do not result in the intended outcomes. Champions communicate the expectations of the organisation to all relevant staff. Champions should promote their focus area within the organisation, and ensure their focus area is are considered in all relevant decisions. This could include:

- identifying opportunities and encouraging proactive action to improve outcomes
- promoting specific values
- persuading and influencing key decision-makers
- sharing knowledge and learning across the organisation and with other partners
- helping build a common vision for the projects or programmes and how they see the quality of these projects improving the organisation's actions
- ensuring the implications of any strategy, policy or project are considered at an early stage
- developing an approach across professions, departments, teams or groups within your organisation
- working jointly with other organisations and sectors to improve outcomes
- encouraging early and pro-active consultation on major projects
- ensuring access to sufficient skills within the organisation
- becoming a visible central point of contact both within and outside of the organisation
- developing ways to encourage innovation and creativity within the organisation
- developing 'partnering' approaches with other organisations.

4.4 Who should be a Champion?

A Champion should be a senior and influential person within the organisation, someone with responsibility to oversee many of your organisation's key functions. It is not necessary for the Champion to have technical skills. However, they will need a reasonable understanding of the issues, and be willing to learn. In addition, they will need to be supported by professionals either inside or outside of the organisation. A champion needs to be:

- passionate about achieving a success
- able to influence people to make changes within your organisation
- respected for their opinion
- a good communicator with links inside and outside the organisation
- able to call upon technical and professional support from within or outside the organisation
- prepared to promote the long term picture and develop a vision within your organisation.

5. STRATEGIC CHAMPIONS VS. OPERATIONAL CHAMPIONS

Shaw et al. (2012) identify two types of champions: project champions and organizational champions. Core competencies of both types of champions include:

- Actively and enthusiastically promoting their area;
- Making connections between different people in the organization;
- Able to mobilise resources;
- Navigating the socio-political environment inside and outside of the organization;
- Building support for the initiative by expressing a compelling vision and boosting organizational members' skills and confidence;
- Ensuring that change is implemented in the face of organizational inertia or resistance.

Project Champion	**Organisational Change Champion**
Has or is given authority to drive forward a project-based innovation	Has authority to cultivate an environment for ongoing practice improvement/organisation learning
Effectively communicates the purpose and scope of work for the project-based innovation	Has a clear vision for the larger organisation and effectively communicates how the project-based innovation fits into that vision
Time-delimited role as established by the project	Ongoing role
Actively and enthusiastically promotes a project-based innovation	Actively and enthusiastically promotes both the specific project as well as ongoing practice improvement
Mobilises resources (internal/external) for a project-based innovation	Mobilises resources (internal/external) for ongoing practice improvement
Navigates the socio-political environment for a project-based innovation	Navigates the social-political environment for ongoing practice improvement
Provides leadership for a project-based innovation	Provides leadership for ongoing practice improvement

While both types of champions do many of the same activities, what differentiates the two is the focus and boundaries of the change championed. Generally, project champions drive quality improvement projects across their team or organisation. In contrast, organisational champions oversee the work of project champions in the context of a wider vision of system transformation and ensuring projects support long-term organisational goals.

Shaw et al. (2012) indicate that change achieved by project champions is sustainable when a complementary organisational champion that provides leadership, authority, and a vision for the 'bigger picture'. That is, system transformation requires sustained improvement efforts guided by a larger vision and assurance that individual change projects fit together into a meaningful whole. Organisations that have both types of champions are best able to implement and sustain successful change.

6. DIRECTION FROM BOARD MEMBERS

Board members have provided some feedback on what a Board Champion means to them:

- A Board Champion is a governance centred role.
- The Board Champion will evaluate Board papers through their focus area lens and ensure that Board discussions and decisions maintains a focus on that lens.
- A secondary role is to be a point of contact for ELT on equity issues.

- A commissioner of a "state of the nation" report to the Board and ELT on how we are doing and opportunities for improvement on a reporting cycle appropriate to the focus area.

This means the Champion needs to be:

- versed or knowledgeable about what success looks like in terms of the area of focus
- clear about the values to be reflected and approaches/outcomes to be achieved (in the wider social system but more specifically within the health system)
- have a strategic focus
- a good communicator and able to bring their governance colleagues along with them on the journey
- an acceptable point of contact for ELT, and people within the organisation (i.e. the Champion is an internally focused role)
- An advocate and source of knowledge at both governance level and with ELT.

7. NEXT STEPS - DEVELOPING A DESCRIPTION OF ROLES AND RESPONSIBILITIES FOR CCDHB

The HSC is asked to review the evidence presented here and discuss, with a view to agreeing, what they believe to be the core functions of a Board Champion. We will then develop this feedback into a brief role description, outlining scope and responsibilities, to present to the CCDHB Board for endorsement.

We are also seeking advice from MOH and other Government agencies, including Pharmac and State Services Commission, who use Champions to support change.

PUBLIC

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**HEALTH SYSTEM COMMITTEE DECISION**
	Date: 14 August 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
Joint Hospital Network Planning Update Joint Health System Committee Proposal	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.