CAPITAL & COAST DISTRICT HEALTH BOARD

Health System Committee

Public Agenda

12 JUNE 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 15 May 2019	**Approves**	Fran Wilde			5
1.5	Matters Arising	**Notes**	Fran Wilde			
1.6	Action List	**Notes**	Fran Wilde			
1.7	Annual Work Programme	**Approves**	Rachel Haggerty			10
2 DECISION						
2.1	Pro-Equity Work Plan 2.1.1 Project Plan 2.1.2 Proposed Terms of Reference – Leadership Group 2.1.3 Central Region Equity Framework	**Approves**	Rachel Haggerty			11 14 16 19
3 DISCUSSION						
3.1	Dementia in our Community – Prevalence, Impacts and Planning for the Future	**Notes**	Rachel Haggerty			26
3.2	Update on Integration of Youth Services in Porirua Project	**Notes**	Gerardine Clifford-Lidstone			43
4. Presentation						
4.1	Sustainability and Investment Choices	**Notes**	Rachel Haggerty			

DATE OF NEXT MEETING 17 JULY 2019 – LEVEL 11, BOARD ROOM GRACE NEILL BLOCK WELLINGTON REGIONAL HOSPITAL

HEALTH SYSTEM COMMITTEE

Interest Register

UPDATED AS AT JUNE 2019

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

Name	Interest
	• Step son works in middle management of Fletcher Steel
Dr Roger Blakeley *Member*	• Member of Capital and Coast District Health Board • Deputy Chair, Wellington Regional Strategy Committee • Councillor, Greater Wellington Regional Council • 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 • Establishment Chair Council of Pacific Collectives • Chair, Pacific Panel for Vulnerable Children

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

CAPITAL AND COAST DISTRICT HEALTH BOARD
DRAFT Minutes of the Health System Committee
Held on Wednesday 15 May 2019 at 9am
Board Room, Level 11, Grace Neill Block, Wellington Regional Hospital

PUBLIC SECTION

PRESENT

COMMITTEE:	Ms Sue Driver (Acting Chair) Dr Roger Blakeley Ms Eileen Brown Ms Ana Coffey Ms Sue Driver Mr Tino Fa'amatuainu Pereira (arrived 9.25am) Dr Tristram Ingham Ms Bernadette Jones Mr Andrew Blair (Teleconference)
BOARD:	Dr Kathryn Adams
STAFF:	Ms Rachel Haggerty, Director, Strategy Innovation and Performance Mrs Robyn Fitzgerald, Committee Secretary Ms Julie Patterson, Interim CEO (arrived 9.34am) Ms Emma Hickson, Chief Nursing Officer Mr Thomas Davis, General Manager, Corporate Services Ms Arawhetu Gray, Director Māori Health Team Ms Emma Hickson, Chief Nursing Officer Mr Nigel Fairley, General Manager, 3DHB MHAIDS Ms Sandy Blake, General Manager, Quality Improvement & Patient Safety Mr Michael McCarthy, Chief Financial Officer Ms Rachel Nobel, General Manager 3DHB Disability Services Mr Peter Guthrie, Manager Planning and Performance Ms Jennifer Langton, Principal Advisor Ms Wikke Bargh-Koopmans, Senior Advisor Ms Koskwa Shoniwa, Service Development Manager
PRESENTERS:	Ms Carey Virtue, Executive Director, Medicine, Cancer and Community (Items 2.2 and 2.4) Ms Delwyn Hunter, Executive Director, Surgery, Women and Children (Items 2.2 and 2.4) Mr Peter Gush, Regional Public Health (Item 3.1) Ms Lisa Smith, System Development Advisor (Item 3.2)
GENERAL PUBLIC:	A member of the public.

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1 PROCEDURAL BUSINESS

1.1 PROCEDURAL

Tristram Ingham opened the meeting with a karakia and blessing. Sue Driver welcomed members of the public and DHB staff.

1.2 APOLOGIES

Apologies received from Dame Fran Wilde, and Sue Emirali.

1.3 INTERESTS

1.3.1 Interest Register

No changes received.

1.4 CONFIRMATION OF PREVIOUS MINUTES

The minutes of the CCDHB Health System Committee held on 17 April 2019, taken with public present, were confirmed as a true and correct record with one amendment as listed below.

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

1.5 MATTERS ARISING

The Committee noted that they will be meeting with the Citizens Council in July. They will discuss with the Council the appointment of a member onto the Health Systems Committee.

Management to follow up with academic institutions with the potential to do research with CCDHB.

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 work programme.

2 PRESENTATION

2.1 UPDATE ON THE ANNUAL PLAN 2019/20 AND STATEMENT OF INTENT, INCORPORATING THE STATEMENT OF PERFORMANCE EXPECTATIONS

The paper was taken as **read.**

The Committee:

(a) **Noted** that a first draft Annual Plan was presented to the Health System Committee on 18 March and the Board on 27 March. The first draft Annual Plan was submitted to the Ministry on 5 April;

(b) **Noted** there are no updates to report against the Annual Plan. Informal feedback on the first draft Annual Plan is expected from the Ministry on 17 May;

(c) **Noted** feedback from advisory committees and the Ministry, including updated guidance, will be incorporated into the final draft of the Annual Plan 2019/20;

(d) **Noted** the final draft Annual Plan will be presented to the Board on 30 May for approval to submit to the Ministry.

(e) **Noted** that a first draft Statement of Intent, incorporating the Statement of Performance Expectations is attached in Appendix One;

(f) **Noted** that no financial information has been included in the first draft SOI. The Financial Performance section will be included when the budget is finalised;

(g) **Reviewed and provided feedback** on the content of the SOI, incorporating the SPE, to Director SIP;

(h) **Delegated authority** to the Director SIP to make any changes that HSC may require;

(i) **Approved** the first draft SOI, incorporating the SPE to be submitted to the Ministry of Health on 16 May.

Moved: Tristram Ingham **Seconded:** Bernadette Jones **CARRIED**

Actions:

1. Management to arrange a workshop for Board members to review the budget in June.
2. Management to ensure copies of plan are distributed to Minister, Ministry of Health and other District Health Boards.
3. Management to ensure draft plan to be distributed early to advisory groups so that they may provide timely feedback during the development of the Annual Plan.

2.2 HOSPITAL OCCURANCY AND CAPACITY PLANNING

The paper was taken as **read.**

The Committee:

(a) **Noted** the current inpatient occupancy issues at CCDHB, and the impact of this on patient services;

(b) **Noted** the Acute Demand and Bed Capacity programme which has been established to provide a whole of system response to acute demand growth and will have some impact on bed day reductions;

(c) **Noted** further investment bed capacity will be required as this programme will not deliver sufficient bed-day savings to stop the inpatient use of beds in the Emergency Department Observation Unit (EDOU), the Interventional Radiology Day Ward (IRW), the Research Unit, and at the same time provide capacity for decanting if required for copper pipe remediation.

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

2.3 SYSTEM INNOVATION AND PERFORMANCE UPDATE

The paper was taken as **read.**

The Committee:

(a) **Noted** the contents of the report;

(b) **Recommended** that the Board notes the update.

Moved: Eileen Brown **Seconded:** Bernadette Jones **CARRIED**

2.4 HOSPITAL AND HEALTH SERVICES UPDATE

The paper was taken as **read.**

The Committee:

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

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

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

(d) **Noted** the capacity issues in ophthalmology following up waiting times.

Action:

4. Management to provide regular updates or dashboard on specific issues like waiting times and other items not meeting targets.

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3 INFORMATION

3.1 HEALTH AND SAFETY STANDARDS OF BEAUTY AND NAIL SALONS

The paper was taken as **read**.

The Committee:

(a) **Notes** the report;

(b) **Endorses** a joint submission from Capital & Coast District Health Board and Regional Public Health to Wellington City Council.

Moved: Sue Driver **Seconded**: 'Ana Coffey **CARRIED**

3.2 UPDATE ON THE RESPONSE TO MEASLES IN OUR COMMUNITY AND, MORE BROADLY, IMMUNISATION COVERAGE ACROSS CCDHB

The paper was taken as **read**.

The Committee:

(a) **Notes** there have been two confirmed cases of measles in the Wellington region;

(b) **Notes** Regional Public Health have advised that there is low risk of community spread;

(c) **Notes** CCDHB coverage of MMR vaccination is 94% for 15-month olds and 92% for 4 year olds, as at 31 December 2018;

(d) **Notes** childhood immunisation coverage is below the 95% target across all milestone age groups.

(e) **Notes** in all age groups except 24 months, immunisation coverage is lower for Māori and Pacific children, and those living in low socioeconomic areas;

(f) **Notes** the rate of people declining to immunise their children or opting-off the National Immunisation Register is increasing, although remains below the national average;

(g) **Notes** we are working with our partners across the system to improve immunisation coverage;

(h) **Recommended** that the Board notes the update.

Moved: Sue Driver **Seconded**: 'Ana Coffey **CARRIED**

Action:

5. Management to forward paper to ICC.

4 OTHER

4.1 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 Update Health System Review – Draft Response	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.

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

*Public Meeting closed at 11.00am***.**

7 DATE OF NEXT MEETING

12 June 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

Sue Driver
Health System Committee, Acting Chair

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	~~Final Draft Annual Plan 2019/20~~ LTIP update	Māori Health Action Plan Investment and Prioritisation Update Citizens Health Council Update	Final LTIP Investment and Prioritisation Update Draft Pacific Plan	2020 Joint Board Schedule and workplan Final Draft Regional Services Plan 2019/20 Final Annual Plan and Capital Budget 2019/20 Investment and Prioritisation Update Citizens Health Council Update	Draft Financials Annual Report Investment and Prioritisation Update	Final Annual Report 2018/19 Draft Annual Plan 2019/20 Investment and Prioritisation Update Citizens Health Council Update	Investment and Prioritisation Update
	DISCUSSION			Even Better Health Care	~~Progress update – Regional Services 18/19~~	Update for implementing the Health System Plan				Investment Plan Update	Progress update – Regional Services 18/19
Regular Reporting	**DISCUSSION**	Access to Psychological therapies for 18 to 25 year olds Cancer Services Review Localities Diagram	System Innovation and Performance Update Hospital and Health Services Update Quarter 2 Performance Report	3DHB ICT Update SOI Draft DASHBOARDS Citizens Health Council Update	Hospital Network Planning System Innovation and Performance Update Hospital and Health Services Update Summary of Heather Simpson Review Submission ~~3DHB DSAC Report~~ ~~Pacific Nurse-led service update~~	Quarter 3 Performance Report Pro-Equity Implementation Plan	System Innovation and Performance Update Hospital and Health Services Update 3DHB MHAIDS update 3DHB ICT Update Birthing Facility Feasibility Update	Hospital Network Planning	Quarter 4 Performance Report System Innovation and Performance Update Hospital and Health Services Update 3DHB DSAC Report	3DHB MHAIDS update 3DHB ICT Update	Hospital Network Planning System Innovation and Performance Update Hospital and Health Services Update
	INFORMATION	Population Health (Regional Public Health Report)		Pacific Health Update Porirua Skin Project Update	~~3DHB MHAIDS update~~ Health and Safety standards of Beauty and Nail Salons	Dementia Services Aged Residential Care	Pacific Health Update Māori Health Update	Population Health (Regional Public Health Report)		Pacific Health Update Māori Health Update	

V3

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**HEALTH SYSTEM COMMITTEE DECISION** **Date**: 12 June 2019
Authors	Chad Paraone, Consultant
Endorsed By	Arawhetu Gray, Executive Director, Māori Health Taima Fagaloga, Executive Director, Pacific Health Rachel Haggerty, Director Strategy, Innovation and Performance
Subject	**PRO-EQUITY WORK PLAN**

RECOMMENDATIONS

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

(a) **Endorses** the proposed Equity work plan, through to December 2019;

(b) **Approves** the draft Terms of Reference for an Equity Leadership Group, including membership;

(c) **Notes** that the Health System Committee will receive quarterly updates on progress towards a pro-equity organisation.

APPENDICES

1. Project Plan;
2. Proposed Terms of Reference – Leadership Group;
3. Central Region Equity Framework.

1 Background

In March 2019 the Health System Committee received a Pro-Equity check-up report prepared by Baker Jones. The Committee was advised that an Implementation Plan would be presented to the Board in June 2019.

In addition, over the last six months the Central region DHBs have been developing an Equity Framework for use by all DHBs to adopt a pro-equity approach. This framework is attached as Appendix 3. This framework is being workshopped across DHBs to determine how it may be implemented. This work will inform CCDHBs implementation of equity.

It also worthwhile noting that the Central Region has also commissioned the development of a Treaty Partnership framework. The region has recognised that equity and Treaty Partnership are complementary but require different responses from our organisations. This conversation is currently underway.

2 PURPOSE

In March this year, the Health System Committee agreed to commit to a programme of work that delivers:

- a clear CCDHB equity goal and direction, with an agreed set of equity principles
- an operational framework that translates these principles into practice

- a performance framework to monitor and guide progress.

The aim is to target staged implementation commencing from July 2019. Building on discussions to date, this paper sets out a staged approach to developing a pro-equity framework to support CCDHB in decision-making, service commissioning and service provision. Also, included is a draft Terms of Reference or an Equity Leadership Group. This group will provide operational oversight and connections for the Equity work plan, reporting back to ELT on a regular basis.

3 KEY DELIVERABLES

3.1 Now to August 2019

The short-term objective is to deliver by the end of August:

(a) a 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) a work plan to develop a Provider Arm operational equity framework.

Deliverables d) and e) differ as the SIP work stream is likely to move more rapidly than the Provider Arm, given the latter has a much larger and more complex scope of operations (and headcount), requiring a broader and deeper set of actions across multiple levels of activity.

3.2 August to December 2019

The subsequent work plan will include:

(a) embedding equity factors in Board and Executive functions/decision-making processes,
(b) completing the SIP commissioning framework, and beginning application to SIP activity,
(c) progressing development of an operational equity framework for Provider Arm (Operations),
(d) progressing development of an operational equity framework for Corporate Services, People & Capability, Allied Health, and
(e) developing an Equity Performance & Accountability Framework for CCDHB.

Note that achieving these timelines will require ELT and senior management support for prioritising this activity, including allocating time and resources (as appropriate) in a timely manner to the work programme. This might include access to senior staff, workshop time, agenda slots, allocating project team members and administrative support, and expediting access to/through approval processes.

4 WORK PLAN OUTLINE

4.1 The process through to December 2019 will comprise seven phases, as summarised below:

Phase 1:	Project Initiation	June
Phase 2:	Information collation and exploration	June
Phase 3:	Develop Equity Goal(s) and Principles	July
Phase 4:	Develop Operational Equity Framework – Board, Executive, SIP	August
Phase 5:	Develop approach and work plans for design of tailored Operational Equity Frameworks	

	Provider Arm (MHAIDS, SWC, MCC) (higher level outline)	December
	Corporate	
	People & Capability	
	Allied Health	
Phase 6:	Develop Performance and Accountability approach	September
Phase 7:	Implementation of Equity frameworks	
	Board, Executive, SIP	August–December
	Implementation of work plans to design and implement Operational Equity Frameworks	
	Provider Arm, Corporate, People & Capability, Allied Health	From December

A more detailed outline is provided in Appendix 1.

5 EXECUTIVE LEADERSHIP TEAM AND EQUITY

ELT has a critical role to play in shaping and setting the Equity goal and Principles for the organisation. This extends to then providing leadership, advocacy and support for the equity programme, as it reaches out to different parts of the organisation.

6 MĀORI, PACIFIC AND DISABILITY LEADERSHIP

The Māori Partnership Board, the Sub-Regional Pacific Strategic Advisory Group and the Sub-Regional Disability Advisory group will take a leadership role in the process, as key CCDHB partners with an interest in striving for equity in health access and outcomes. It is important for CCDHB to have their guidance and support around this equity agenda. This includes the development and approval of the CCDHB Equity Goal and Principles.

7 EQUITY LEADERSHIP GROUP

A steering group ('Leadership Group') is being formed with the purpose of providing operational leadership for the design and implementation of a pro-equity framework across the whole of CCDHB, including services both provided and funded.

The core function of the group is to oversee and support the equity work plan. This includes tackling roadblocks and keeping ELT informed on progress and matters that require escalation. The draft Terms of Reference for this group is attached, as Appendix 2.

CCDHB Pro-Equity framework – development and implementation - proposed Project phases

➢ PHASE 1: PROJECT INITIATION	TIMEFRAME
▶ **Establish project structures and initiate project** - Sponsor and Steering Group agreed, and project team appointed - Terms of Reference approved, plus project plan and reporting - Initial meetings held	**June**
PHASE 2: INFORMATION COLLATION	
▶ **Purpose: Develop understanding of current thinking, models and practice** ▶ **Approach:** - Rapid background scan of literature - internal documents and external - Identify exemplar models, systems, processes (in DHBs/other entities) - Initial discussions with key stakeholders and influencers	**June**
PHASE 3: EQUITY GOALS & PRINCIPLES	
▶ **Purpose: Engage leadership, clarify aspirations, agree Goal(s) and Principles** ▶ **Approach: Structured workshops with senior leaders and stakeholders** - **Workshop 1 – Learning session re Equity (Why, What, How)** Invite respected authority to facilitate an exploration among senior leaders of the equity theme in health systems and health leadership, including how this plays out, key factors and examples of actions deployed to address these. - **Workshop 2 (or ELT) – Decision on CCDHB Equity Goal and Principles** Develop and present options for equity goals and principles - for ELT discussion and decision.	**June** **July**
PHASE 4: OPERATIONAL FRAMEWORK – BOARD, EXEC, STRATEGY INNOVATION & PERFORMANCE	
▶ **Purpose: Determine and agree how to apply equity principles in practice** ▶ **Approach: Project team develop draft frameworks, socialise, gain approval** ▶ **Parallel streams:** - **Board and Executive Leadership Team** Develop material. Take to ELT and Board for review and sign-off. *Focus on options for prioritisation and equity-based decision-making.* - **Strategy, Innovation & Performance (SIP)** Develop material. Workshops (2) with SIP team to socialise and refine. Gain approval/sign-off from Executive Director, SIP. *Focus on prioritisation, service resourcing, approach to commissioning services and pro-equity interventions in primary and community care.*	**August** **August**

PHASE 5: OPERATIONAL FRAMEWORK – PROVIDER ARM, CORPORATE, PEOPLE & CAPABILITY (P&C)	
▶ **Purpose: Determine approach to applying equity principles in practice** ▶ **Approach:** - **Project team develop workplan for Provider Arm, Corporate, P&C** - **Workshop series with Provider Arm, Corporate, Allied Health, P&C to** a) engage key leaders and stakeholders, b) introduce the CCDHB equity theme, goals and principles c) develop approach for designing and implementing an operational equity framework for different parts of the Provider Arm (MHAIDS, SWC, MCC), Allied Health, Corporate Services, People & Capability ▶ **Parallel streams:** - **Provider Arm (MHAIDS, SWC, MCC)** *Building commitment, capability and capacity for systemic application.* *Includes a focus on clinical decisions & care support, prioritisation, workforce culture and behaviour, and patient/whānau communication* - **Corporate Services, People & Capability, Allied Health** *Focus on Human Resources, workforce and infrastructure (including facility development, information management, and IT tools).*	**August** **December**
PHASE 6: TRACKING PERFORMANCE & ACCOUNTABILITY	
▶ **Purpose: Determine how to measure and monitor progress / performance** ▶ **Approach: Project team develop draft framework for ELT consideration** ▶ Clarify accountabilities at each level (*Who is accountable for What?*) ▶ Agree implementation milestones for business units (*Are we there?*) ▶ Develop performance measures (*How well are we doing?*)	**September**
PHASE 7: IMPLEMENTATION – BOARD, EXEC, STRATEGY INNOVATION & PERFORMANCE	
▶ **Purpose: Complete and implement approved equity frameworks** ▶ **Approach:** ▶ **Board and Executive Leadership Team** Circulate approved processes and supporting material (templates, etc) to Executive Team and supporting management. Begin use. ▶ **Strategy, Innovation & Performance (SIP)** Develop implementation plan with SIP management. Identify potential barriers/inhibiting factors to successful uptake and develop mitigation options. Prototype equity approach with one service (develop and implement). Review and refine framework and approach, as appropriate. Adopt staged uptake across the wider SIP team and services. ▶ **Provider Arm, Corporate Services, P&C, Allied Health** Develop implementation plans for staged implementation.	**August** **September** **Sept - Dec** **December +** **December +**

CCDHB Equity Leadership Group

TERMS OF REFERENCE

Sponsor	Director - Strategy, Innovation & Performance
Background	Achieving equity in healthcare and health status is a common goal of health systems worldwide, including New Zealand. CCDHB, like other DHBs, has been grappling with health inequity across the populations served. Māori, Pasifika, low-income families and those challenged by mental health and addictions generally feature more prominently in this picture of inequity, encountering greater challenges around access to timely, quality healthcare, which contributes to poorer health status. CCDHB has declared equity a priority focus for the organisation. An independent report was commissioned in late 2018 on how well the organisation is embedding a pro-equity approach into its work. The report findings indicated that there is a high-level commitment to the goal of achieving equity, a general awareness of the key issues, and pockets of strong pro-equity behaviour. It emphasised, however, that this has not translated into a consistent and comprehensive response across the whole of the DHB. More was needed. In February 2019, CCDHB's Executive Leadership Team agreed to commit to a programme of work that delivers **a) a clear CCDHB equity goal and direction,** **b) an agreed set of equity principles,** **c) an operational framework that translates principles into practice, and** **d) a performance framework to monitor and guide progress.** Effective leadership is required to oversee the design and delivery of this organisation-wide commitment. This group is intended to provide that role.
Purpose	The purpose of the Equity Leadership Group is to provide operational leadership for the design and implementation of a pro-equity framework across the whole of CCDHB, including services both provided and funded. The objective is to: • achieve equity in healthcare delivery and health outcomes for the Capital and Coast population, through a deliberate and progressive implementation of pro-equity frameworks and capability across CCDHB. • focus initially on equity for priority populations: Māori, Pasifika, low-income vulnerable families, and those with mental health and addiction challenges • strengthen partnership, trust and relationships between CCDHB and key community partners in the process of achieving equity in healthcare delivery
Functions	The functions of Equity Leadership Group are to: 1. Lead and foster the CCDHB commitment to achieving equity in healthcare delivery and health outcomes, with an emphasis on priority populations

	2. Provide operational guidance and oversight of an agreed CCDHB Equity Transformation agenda through ensuring: a. Development and delivery of an **Equity Transformation work plan**, based on progressive implementation across the whole of CCDHB b. Organisational commitment to the plan, including prioritisation of resources to support implementation c. Proactive consideration of strategic opportunities to advance equity for priority populations d. Effective prioritisation of attention and effort e. Appropriate collaboration with community and strategic partners f. Consistency with the Taurite Ora, the emerging CCDHB Māori Health strategy, and other key CCDHB strategies 3. Monitor and support work plan implementation, taking action where required 4. Help address barriers, roadblocks and impediments to progress 5. Ensure the work plan, and resulting pro-equity frameworks, are embedded in CCDHB planning and decision-making processes 6. Provide advice to the CCDHB Executive Leadership Team and Health System Committee on strategies, policies, processes and decisions to maximise the impact of the Equity Transformation work plan 7. Report to the CCDHB Executive Leadership Team and Health System Committee on implementation of the Equity Transformation work plan, including progress on reducing health disparities for the identified priority populations
Membership	The Equity Leadership Group will report to the Executive Leadership Team. It will comprise the following members: - Executive Director, Māori Health (CHAIR) - Executive Director, Pacific People's Health - General Manager, Mental Health & Additions - General Manager, Disability - Clinical Champion (medical) - Clinical Champion (nursing) - Clinical Champion (allied health, professional and technical) - Clinical Director, Strategy Innovation & Performance - Provider Arm Leader, Health & Hospital Services - Provider Arm Leader, Mental Health, Addictions and Intellectual Disability - Māori Partnership Board *(as Treaty partner)* - Chair, Integrated Care Collective representative
Meetings	Meetings will initially be 2-3, through to August 2019. Thereafter, meetings will be monthly through to December 2019. If additional meetings are required, they will be agreed and scheduled accordingly. A quorum will comprise a majority of members
Reporting	1. A brief Progress Report will be prepared for Equity Leadership Group meetings, on performance against the work plan and objectives. This report will include

	a. progress against key milestones b. risks, issues and barriers to successful implementation of the work plan c. recommendations for consideration 2. The Progress Report will inform a. monthly reporting to the CCDHB Executive Leadership Team b. quarterly reporting to the CCDHB Health System Committee
Term	The Equity Leadership Group runs to December 2020, at which time the need for the group will be reviewed. The Terms of Reference will be reviewed in December 2019. If required, an earlier review of the Terms of Reference may be undertaken.

Prepared by TAS
Kahui tuitui tangata

REGIONAL
SERVICES PROGRAMME

Central Region Service Planning Forum (CRSPF)

Equity Framework

April 2019

Capital & Coast District Health Board ŌPOKO KI TE URU HAUORA
HUTT VALLEY DHB
HAWKE'S BAY District Health Board Whakawātea Tia
MidCentral District Health Board Te Poe Hauora o Ruahine o Tararua
Wairarapa DHB Wairarapa District Health Board
Whanganui District Health Board

The CRSPF Equity Framework

The Central Region Service Planning Forum (CRSPF) commission health and disability services that aim to improve health outcomes and achieve equity for all populations living in the central region district health board areas. This framework[1], provides guidance to the CRSPF on strengthening their commissioning to achieve equity within activities identified within the Central regions, Regional Services Plan (RSP).

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 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 different ethnicities, will have poorer health, greater exposure to health risks and poorer access to health services[2]. These variables are unlikely to exist in isolation, they are deeply interwoven, 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. The Central Region Chief Executives and the Central Region Māori General Managers hold the view that these differences are not random, they exist because of institutional racism[3] and the impact of colonization and its continuing processes[4]. Achieving equity for Māori is a priority, as the health gaps across the life-course are significant for Māori.

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[5]. A companion Treaty of Waitangi document will be developed, with the purpose of providing direction to the Central Region District Health Boards on what they need to do to meet their Treaty of Waitangi obligations.

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[1] Australian Government Department of Health and PricewaterhouseCoopers (PwC). 2016. "Planning in a commissioning environment – a Guide" downloaded at www.health.gov.au/internet/main/publihsing.nsf/Content/5FB77FB5E6BO7121CA25 on 12 November 2018.
[2] 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.
[3] Jones C. 2000. Levels of racism: a theoretical framework and a gardener's tale. American Journal of Public Health 90: 1212–15.
[4] Ministry of Health. 2018. "Achieving Equity in Health Outcomes: Highlights of important national and international papers".
[5] Te Puni Kokiri 2000. "Progress towards Closing Social and Economic Gaps between Maori and non-Maori" 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 CRSPF Equity Framework

Adapted from the "Planning in a Commissioning Environment – A Guide" developed by the Australian Government Department of Health and PricewaterhouseCoopers (PwC) 2016.

Central Region Services Planning Forum (CRSPF) Equity Framework

Role	Leadership	Knowledge	Commitment
Capability	Establish recruitment, retention and training targets that increase equity capacity and capability in the Central Region District Health Board (DHB) organisations.	Ensure all people have the skills or are supported to gain the skills in equity planning methodologies and approaches to inform design implementation.	Increase the number of people employed in the Central Region DHB organisations with the capacity and understanding of what to do to achieve equity.
	Set expectations that all health practitioners, managers and contracted organisations are focused on actions to achieve equity outcomes for all people.	Support all staff employed by the Central Region DHBs to keep abreast of the latest information on what works to achieve equity.	Disseminate the latest equity literature, information and data, and establish forums focused on sharing what is working.
	Make transparent Central Region DHBs' accountabilities and responsibilities	Develop processes to ensure that all Central Region DHBs are able to improve their cross region working.	Increase the focus on integration of the health system to achieve equity.
		Increase health leaders' awareness on how "in-equity" is acting at all levels of the system.	Commit to eliminating inequity at all levels of the system.
Strategic Planning	Initiate a systematic process to determine the equity gap for a given condition / disease of interest for a defined population (health needs assessment).	Gather all the relevant data and information available.	Allocate the resources needed to complete an equity focused health needs assessment.
	Set an expectation that the right people will be involved in the process, particularly Māori and service users.	Gather all the people who: • Know about the issue • Care about the issue • Can make change happen.	Establish administrative systems and information that make it easier for those who should participate to do so.

Role	Leadership	Knowledge	Commitment
Strategic Planning	Set timelines for the delivery of a strategic plan complete with equity objectives and tasks using appropriate planning methodologies.	Use the planning tools most appropriate to achieve the outcomes being sought, like the Health Equity Assessment (HEAT Tool)[6] Whānau Ora Health Impact Assessment (WoHIA)[7], and keep abreast of new equity tools as they are developed.	Ensure the plan is based on the equity needs, opportunities, priorities and options identified in the health needs assessment.
	Set expectations that strategic plans and actions are based on what people feel and need, rather than an imposition of planners' thinking.		Allocate appropriate resources to ensure that General Managers Māori and Pacific Peoples are involved in all work that is focused on equity for Māori and Pacific Peoples.
	Focus all policy and accountability levers and mechanisms available to funders and planners on achieving equity.	Build funders' and planners' knowledge about the use of policy, accountability levers and mechanisms and how they can be used to progress equity.	Demonstrate a genuine commitment to decentralising power and decision-making.

[6] Ministry of Health. 2008. "The Health Equity Assessment Tool – A User's Guide", downloaded at https://www.health.govt.nz/system/files/documents/publications/health-equity-assessment-tool-guide.pdf, on 13 November 2018.
[7] Ministry of Health. 2007. "Whānau Ora Health Impact Assessment", downloaded at https://www.health.govt.nz/system/files/documents/publications/whanau-ora-hia-2007.pdf, on 13 November 2018.

Role	Leadership	Knowledge	Commitment
Procuring Services	Establish a process for determining whether the procuring of equity services will be a purchasing or a commissioning process.	Ensure that procurement decisions are based on evidence that existing services are able to deliver these equity services or there is a need to design new services.	Make transparent to relevant stakeholders the process for deciding on purchasing or commissioning as the preferred procurement process.
	Ensure in procuring services, that all the relevant stakeholders: communities, clinicians, service providers are involved in the design or co-design of new services.	Make sure that the design or co-design process is acceptable to stakeholders, informed by evidence, incorporates an equity lens and is consistent with agreed standards of quality and clinical safety.	Establish transparent decision-making processes that are directed at increasing equity outcomes, and agreed and known by all the participants in the procuring process.
	Establish transparent processes for identifying the most appropriate delivery mechanisms.	Develop and support health practitioners and health provider organisations who are best placed to provide culturally and clinically safe services to the population identified.	All investment decisions are transparent and directed at increasing equity of outcome.
	Promote an environment in which it is safe to ask the question 'how is racism acting here?'	Encourage staff to keep abreast of the latest literature on institutional racism and use that to inform the way in which services are designed.	Put in place policies, practices and programmes that are focused on abolishing institutional racism.
	Make reducing the health literacy burden imposed on individuals and their whanau and families by health organisations, services and practitioners a core requirement in the design of new services.	Ensure health service design that enables individuals, whanau and families to obtain, process and understand basic health information and services needed to make informed and appropriate health decisions.	Imbed the guide 'Becoming a health literate organisation'[8]. into the procuring and design of services.

[8] Ministry of Health. 2015. "Health Literacy Review – A Guide", downloaded at https://www.health.govt.nz/system/files/documents/publications/health-literacy-review-a-guide-may15-v2.pdf on 13 November 2018.

Role	Leadership	Knowledge	Commitment
Procuring Services	Prioritise investment decisions that are focused on achieving equity ensuring that they are applying a 'simplify and intensify' approach.	Build knowledge and understanding about the concept of 'simplify and intensify' as a New Zealand model of 'universal proportionalism'[9].	Establish ways for the Central Region Service Planning Forum to disseminate knowledge, evidence and information how these concepts have been used, can be used.
	Ensure that investment decisions reflect what people feel and want.	Establish processes for identifying people's wishes about service provision.	Establish gold standard guidelines for appropriate consultation processes.
Monitoring and evaluation	Ensure the collection of high quality, complete and consistent equity and ethnicity data.	Require all performance data to be stratified and analysed by ethnicity, deprivation, age, gender, disability and location.	Ensure that any equity report comparing differences between two populations compares the population of interest with the rest of the population.
	Agree co-designed performance improvement and monitoring/evaluation methods.	Invest in building knowledge about validated tools and methodologies that support the evaluation of service changes focused on achieving equity.	Set an expectation of having appropriate resources to implement quality evaluation.
	Contribute to the development of specific co-designed health equity measures that can educate, influence, and accelerate improvements to achieve improved health equity for everyone.	Gather all relevant evaluation material, including the voice of defined population, service providers, and planners.	Ensure that the person and whānau voices are captured in evaluation methodologies, particularly Māori and service users.

[9] European portal for Action on Health Inequalities – Marmot Reviews. http://www.health-inequalities.eu/resources/marmot-reviews/ downloaded on 14 November 2018.

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Date 12 June 2019	**HEALTH SYSTEM COMMITTEE DISCUSSION**
Author	Jan Marment, Senior System Development Manager, Older Persons Services
Endorsed by	Rachel Haggerty, Director of Strategy, Innovation and Performance
Subject	**DEMENTIA IN OUR COMMUNITY – PREVALENCE, IMPACTS AND PLANNING FOR THE FUTURE**

RECOMMENDATIONS

It is **recommended** that the Committee:

(a) **Notes** 80% of people receiving Health of the Older Person funded services have some form of cognitive impairment

(b) **Notes** All funded services for the elderly have clients with cognitive impairment

(c) **Notes** An integrated approach that includes both health and social aspects of care will maximise wellbeing and independence

(d) **Notes** that as our population ages more of our patients in hospital and mental health care will have dementia.

(e) **Notes** we are working with our partners to develop dementia friendly communities – including government agencies, NGO's, councils.

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

1. PURPOSE

The purpose of this paper is to inform the Health System Committee of the prevalence and impact of dementia in our community and our planning for the future with our ageing population.

The paper will:

- Provide a definition
- Explore the prevalence of dementia within CCDHB

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- Set out how people with dementia and their whanau are supported
- Analyse the impact of dementia on our services now and in the future
- Outline a framework to support our response and the response of the community

2. DEFINITION OF DEMENTIA

Dementia is an irreversible, progressive deterioration in cognition defined by the presence of:

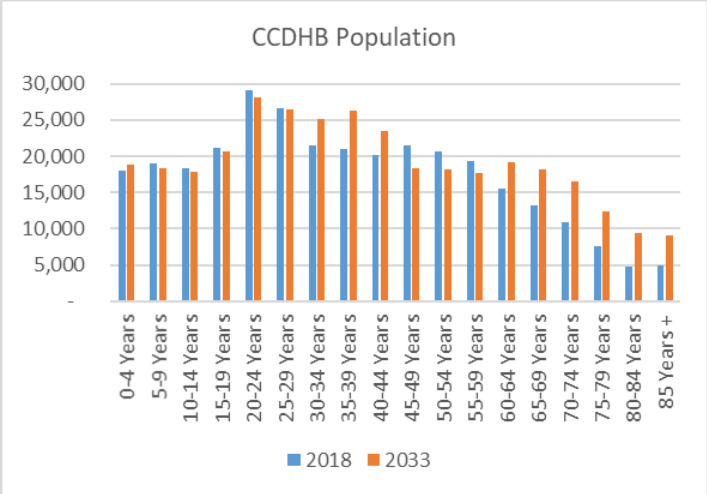
- A short term memory problem **and**
- trouble with at least one cognitive function (e.g. abstract thought, judgement, orientation, behaviour) **and**
- these troubles have an impact on the performance of daily life activities.

The most common form of dementia is Alzheimers disease; other forms include vascular and fronto-temporal dementias. This paper will consider all forms of dementia together.

3. DEMENTIA AFFECTS PEOPLE, COMMUNITIES, AND THE HEALTH SYSTEM

3.1 Prevalence

It is difficult to determine the prevalence of dementia as the disease is progressive and early diagnosis remains a challenge. We do know that the greatest risk for the development of dementia is age and our older population is growing. There are currently 5,000 people living in the CCDHB area who are over 85 years old, and by 2033 there will be over 9,000. It is important that all services provided for the frail elderly have expertise in the care and support of those with dementia.



Alzheimers New Zealand estimates that as many as 40% of people over the age of 85 develop dementia. However, recent research[1] in the USA shows the prevalence of dementia in the United States has declined significantly from 11.6% of those 65 and older in 2000 to 8.8% in 2012. There is more research needed to be confident of prevalence data.

A cohort of people we can identify with reliability are those who receive health of the older person funded supports (aged residential care, home and community support, carer support) all of whom must have an interRAI assessment before the service is provided. These are the frail elderly who currently receive services; in 2018, this was 4,566 people, 11% of the population over 65 years of age.

1. [1] A Comparison of the Prevalence of Dementia in the United States in 2000 and 2012

Kenneth M. Langa, MD, PhD1,2,3,4; Eric B. Larson, MD, MPH5; Eileen M. Crimmins, PhD6; et alJessica D. Faul, PhD3; Deborah A. Levine, MD, MPH1,2,4,7; Mohammed U. Kabeto, MS1,2; David R. Weir, PhD3

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The data derived from the InterRAI assessment captures the level of cognitive impairment. We can examine this group by: ethnicity, age and where they live – in the community or in aged care.

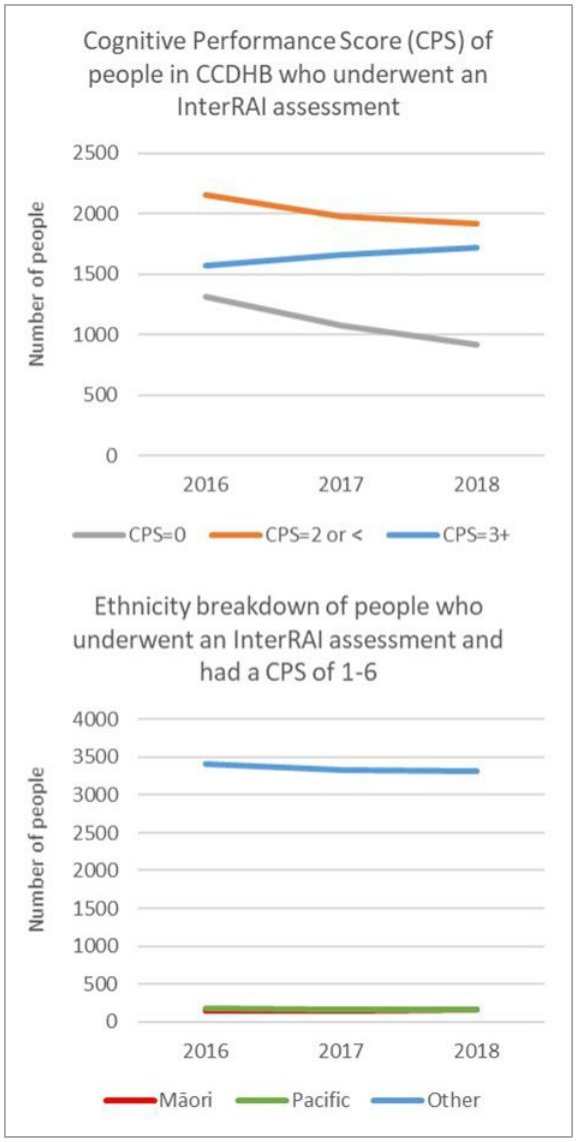
3.2 InterRAI data

The InterRAI assessment contains Cognitive Performance questions, which alert the assessor to a problem with cognitive functioning and provide a Cognitive Performance Score (CPS). A score of two or less means the person has or is at risk of having a form of dementia, a Mini Mental State Exam (MMSE) result of 19+. A score of three or more shows significant cognitive decline, a MMSE score less than 19. A score of '0' indicates no cognitive impairment.

The figure on the right shows the prevalence of people (interRAI assessed) who have mild and significant cognitive impairment over three years.

There are 149 more people assessed with significant decline in 2018 than 2016 and 240 fewer people with mild decline in the same time. The prevalence for Maori and Pacific is stable over 2016 – 2018. From this small data sample taken from interRAI it is likely that the prevalence of dementia is in line with the ageing population.

Data from Tū Ora Compass Health shows that over a four year time period (2015 – 2019) there are just 3% (330 people) who have a diagnosis of dementia who have not had an interRAI assessment. This is reassuring that most people with a diagnosis are receiving services. It does not include the number of people who may have dementia but have not yet been diagnosed.



3.3 Investment in services

We invest $71.5 million per annum in residential care, community support services and in support for carers for all eligible older people. Using the population projection for 2033 if we spend the same amount per person as in 2018 the investment required would be $141 million per annum. It is not possible to determine the proportion of this spend that is specific to dementia however we can estimate that approximately 80% of these people have some cognitive impairment.

The $71.5 million investment does not include the cost of outpatient visits, hospital admissions and pharmaceuticals for people over the age of 65. All funded services for the elderly have clients with dementia.

Not all community services are funded by the DHB. MSD, grants, donations provide funding for many of the community agencies.

4. SUPPORTING PEOPLE WITH DEMENTIA AND THEIR WHANAU

We are guided by the National Framework for Dementia Care (2013) and the New Zealand Healthy Ageing Strategy (2016).

The emotional, social and economic costs of dementia are significant and require planning as the population ages and more people live into their mid-80's and beyond.

People living with dementia and those who support them require:

1. Timely diagnosis and access to specialist care when needed
2. Good information and advice
3. To be able to participate in community life/environments that enhance wellbeing and independence
4. A dignified death

4.1 Timely diagnosis and access to specialist care when needed

Most experts agree that accurate and early diagnosis is important to enable people to adjust to the diagnosis, modify its impact and plan for the future

How we do this now

GPs diagnose and treat people with uncomplicated dementia. HealthPathways 'Cognitive Impairment and Dementia' Pathway is the most used pathway in CCDHB. Dementia Wellington provides education for GPs on the pathway particularly focusing on the benefit of early diagnosis.

Supporting the generalist workforce to diagnose, treat and support people with dementia and their whanau enables the specialist teams to concentrate their work with those who require the expertise of medical specialists and multi-disciplinary teams. Specialist intervention is likely required for those who are younger, those with atypical/complicated dementia, with complicating comorbidities.

4.2 Good information and advice is readily available to make it easier for people with dementia to self-manage and to support carers at the various stages of the illness.

Our aim is to help the person and their whanau navigate through the health and social support system, to enable good decision-making and to maximise their abilities and independence.

How this happens now

Health navigator gives information and links to relevant services.

Services in our community include:

Dementia Wellington, who provide:

- written information
- one on one advice and support for both the person living with dementia and their whanau

- group sessions on Living well with a Cognitive Impairment, Navigating Dementia, Dementia Essentials Mid-Stage, Dementia Essentials Late-Stage
- living well activities, Cog Cafes and supporter meetings.

Seniorline which is a national information service to help older people and their whanau navigate the health system. This is funded by all DHBs and provides telephone and email assistance Mon – Friday 8-4pm.

Eldernet an online resource for the older person including the printed "Where to from here" booklet (personalised to geographic regions) with the aim to give information needed to make informed decisions.

Age Concern, a nationwide service with branches in Wellington city and Kapiti providing information, advocacy, educational programmes and the opportunity for people to meet.

Advanced Care Planning - Several NGO's including Dementia Wgtn, Stroke Central, Wellelder, Age Concern have received funding to enable them to promote advance care planning. Significant work across the 3DHBs is raising awareness and promoting the benefits of completing these plans. Advance care planning within Aged Care has seen increasing numbers of staff having completed the training.

4.3 Able to participate in community life – Living well

How this happens now

- The workforce receive dementia training which focuses on how best to interact with the person with dementia.
- Training is available to community groups –for example golf clubs and banks are recent examples of organisations investing in training their staff to be responsive to those with dementia.
- Age friendly community initiatives - Super Seniors (run by the Office for Seniors) offer grants and support for communities.
- Specialist advice is available to GPs, aged care facilities, home and community support services - this enables people to remain in the least restrictive environment.
- Support for carers – respite, in its various forms, gives both the carer and the person being cared for a break.
- WellElder provide specialist counselling for the older person.

Like many other disabilities, the environment is key to independence and well-being.

How this happens now

- Ministry of Health published guidelines - Secure Dementia Care Home Design to support those involved in the development of major reconfiguration of secure dementia homes. The design principles are relevant to all people living with dementia in both secure and non-secure homes.
- Technology solutions: GPS tracking devices in case of wandering, automatic shutoff devices on electrical and gas appliances, personal alarms.

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4.4 A dignified Death

Aged residential care is the most likely place of death for people with dementia. Dementia is a progressive and terminal disease.

A dignified death for a person with dementia means: dying pain free, with minimal disruption (moving from one place to another), without prolonged suffering, with whanau and in a place where your needs are met.

How this happens now

Hospice programme:

- link nurse training - nurses from aged residential care undertake intensive training course with Mary Potter.
- Hospice employ ARC partnership nurses – supports transition into aged residential care, mentoring of ARC staff through bedside mentoring, case reviews and debriefing. Recent increased FTE.
- Hospice has more consultants and nurses providing care in the community.
- Enhanced Maori and Pacifica support (increased resource provided for navigation for families and community liaison)

Community Services

- GP's funded to create an anticipatory palliative care plan. "Living Well, Dying Well' Strategy is progressively being implemented.
- 72 Hour funding – a nurse or care assistant provides, mostly overnight care, in the last days of life to give carers respite and enable the dying person to stay at home until death or for as long as possible.

Hospital based Palliative Care Team

- Consultative service for patients in the hospital

The following table shows days in aged residential care, hospital or hospice in the last years of life.

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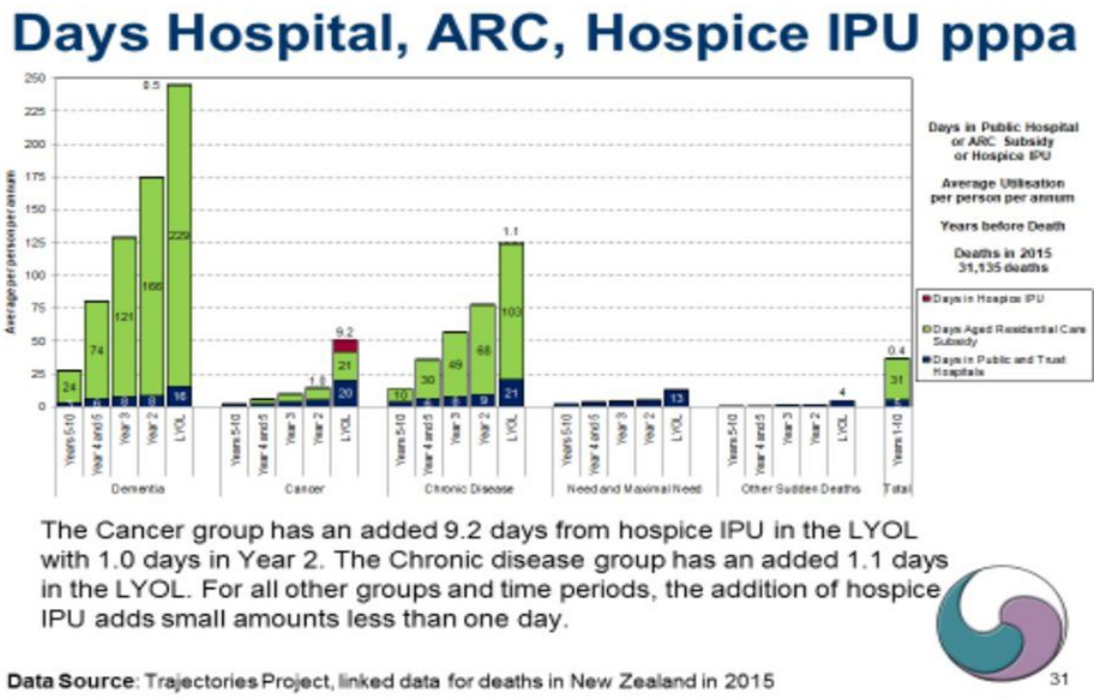

4.5 Dementia and impacts for Maori and Pacific

A 2018 study published in the International Journal of Geriatric Psychiatry found Māori and Pacific peoples with dementia presented to a NZ memory service at a younger age than NZ Europeans, and Pacific peoples presented with more advanced dementia. Whanau may normalise dementia symptoms as a normal part of ageing or the inevitable consequence of poor health. While this maintains the person's identity and avoids stigma, it delays future planning and receiving support.

Proportionally fewer Maori and Pacific people entered residential care. This reflects the culture that whanau prefer to care for their elders at home. Townsend and New (2011) investigated contemporary Māori views of dementia resulting from both spiritual and traditional beliefs. They noted that approaches to dementia care for Māori needed to be more holistic; the exclusion of Māori cultural values and understandings from service provision was detrimental to the wellbeing of older Māori.

Townsend and New recommended enabling Māori to care for their older people within the home environment, in accordance with traditional values, and noted that health service delivery should be based in whānau, hapū or iwi structures.

<u>How we do this now</u>
Carer support is a reimbursement of some of the costs associated with hiring a person to provide respite. This can be whanau, friends, neighbours or support workers. This type of respite does fit with traditional values.

The Home and Community Support Providers are able to employ family and friends to provide the support that would otherwise be provided by another support worker. This is particularly useful if English is a second language or there are cultural requirements that are hard to meet with the regular workforce.

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4.6 People with specific needs

Intellectual disability

We are not yet able to determine the number of people with intellectual disability and who have a diagnosis of dementia. People with Down's syndrome experience premature ageing and an increased risk for dementia compared with the general population. For those in supported community housing, their ability to continue living in their homes is fundamental to living well.

Early –Onset Dementia

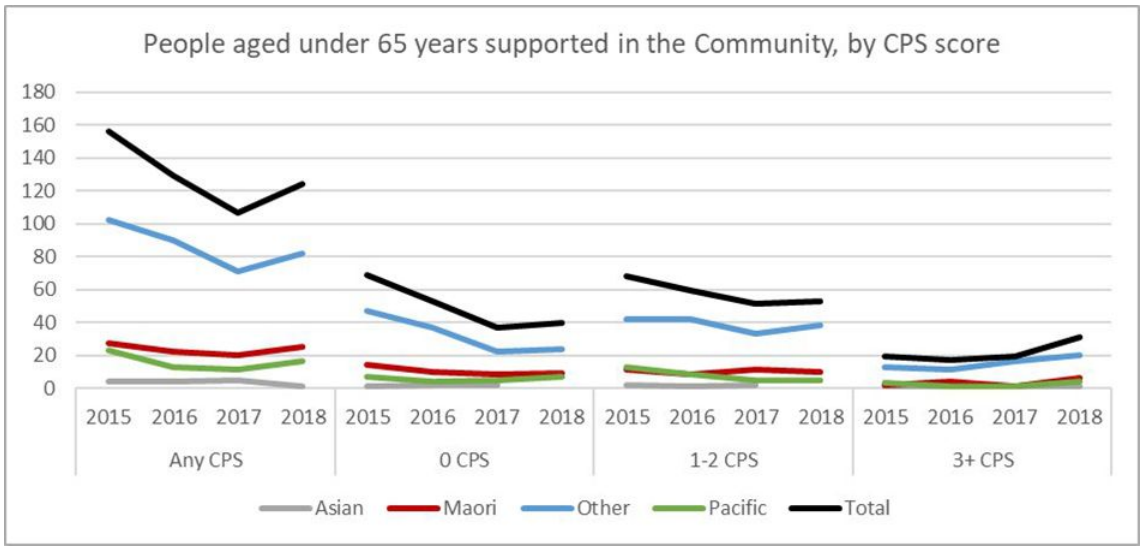
This usually occurs between a person's 30s to mid-60s and is rare. These people face different issues to those with later onset dementia such as dealing with disability at work, raising children and finding the right support. Currently we provide packages of care to support the person in the home for as long as possible. The packages are flexible and comprehensive to avoid admission to aged residential care.

The number of people diagnosed with younger onset dementia are small however the impact is significant.

4.7 Cognitive Impairment Scores of those under 65years

The graphs below show the numbers of people who are under 65 years of year receiving community support or residential care, by their cognitive score. The number reflects the people receiving community support. The presence of cognitive impairment is now well understood.

0 CPS = no cognitive impairment
1-2 CPS = mild cognitive impairment
3+ CPS = severe cognitive impairment



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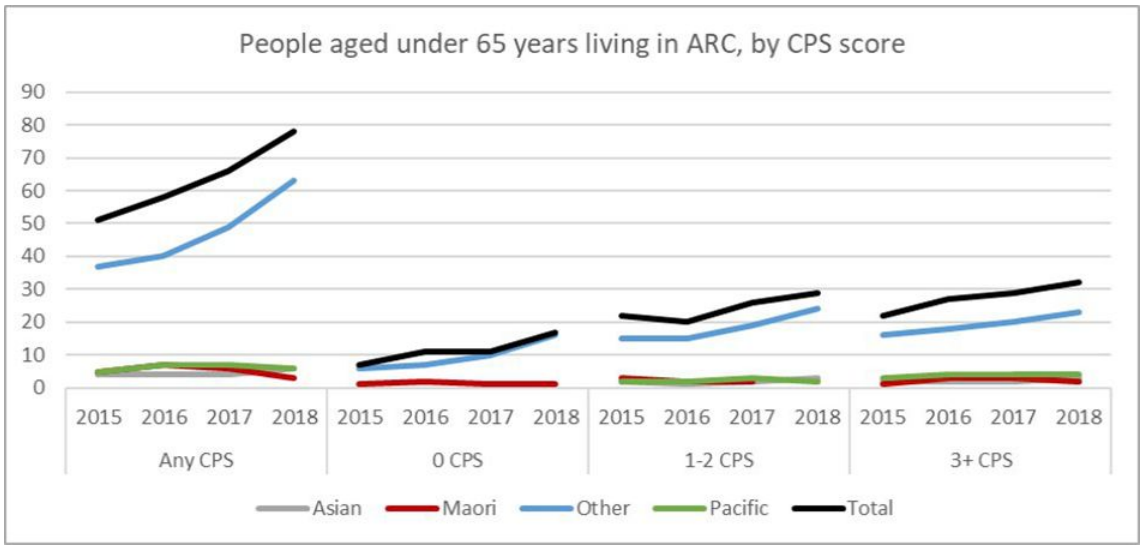

5. IMPACT OF DEMENTIA ON HEALTH SERVICES

The Dementia contribution to overall health system demand is not fully recognised.

5.1 Aged Residential Care

Entry to residential care is demand driven and requires an assessment for eligibility and it is income and asset tested. CCDHB has a higher percentage of residents, compared with other DHBs, who are private paying up to the maximum contribution level. The maximum contribution amount is the maximum amount that any person in residential care must pay per week. The Ministry of Health sets it annually. For those at rest home level of care, if they do not qualify for subsidy, they fully fund their care. The DHB does not contribute.

The maximum contribution amount is set below the bed day price for dementia or hospital level of care. This means that for those people who have assets and income above the subsidy threshold and are in a dementia unit or at hospital level of care they will receive a top up subsidy from the DHB.

The principle of least restrictive care is an opportunity to enable people to enter residential care at rest home level and remain at that level for as long as possible. If the environment, staffing and overall security of the facility take into account the needs of a person with dementia, the need for a secure unit diminishes. The difficult behaviours associated with dementia can be the result of the environment not meeting their needs.

Most people who have a diagnosis of dementia in residential care do not require a secure unit; they are able to stay at rest home level until their physical health determines they require hospital level (many are unable to mobilise). However, people with dementia have a longer length of stay in residential care. The requirement for constant surveillance and inability to manage incontinence are the main drivers for entry to residential care. In contrast, older people with physical limitations remain at home longer because, despite their high level of need, they are able to be alone.

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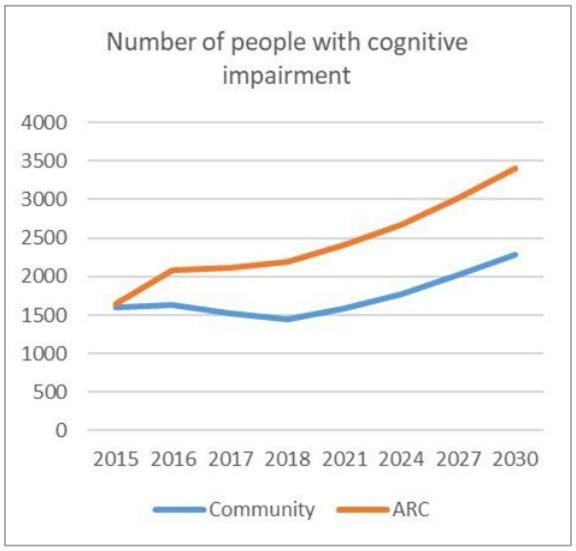
Investment in the education of aged residential care staff and a physical environment that takes account of the needs of a person with dementia will result in fewer admissions to a secure unit. The Ministry of Health published the Secure Dementia Care Home Design in 2016. The aim of the resource is to support people in the development or major reconfiguration of secure dementia care homes, and to enhance the quality of life of people living in them. It approaches these aims from a person-centred perspective.

The projection to the right shows the impact for aged residential care and for those in the community. It uses the count of people in 2018 with some cognitive impairment currently receiving services and projects to 2030.



Aged Residential Care Beds

CCDHB is experiencing a high occupancy rate within aged care following the closure of Johnsonvale (60 beds) and the dementia unit at Eldon.

Type of bed	Dedicated rest home beds	Dedicated Hospital beds	Hospital or rest home (Dual Occupancy)	Dementia beds	Psychogeriatric beds	LTO Units
Number	420	491	679	232	73	244
Occupancy May 2019	94%	91%	94%	90%	92%	

In May 2019, of the 1943 people in aged care

- 11% in a dementia bed
- 76% in a rest home or hospital bed
- 3% in a psychogeriatric bed
- 9% in a serviced licenced to occupy (LTO) apartment

There have been a number of new ARC developments signalled to the DHB.

Company	Suburb	Configuration	Opening Date
Millvale	Lindale	14 psychogeriatric beds	September 2019
Summerset	Kenepuru	43 dual purpose + 20 licence to occupy dementia beds	2021
Ryman	Karori	120 beds (likely 40 rest home, 40 hospital, 40 dementia)	Not before 2022

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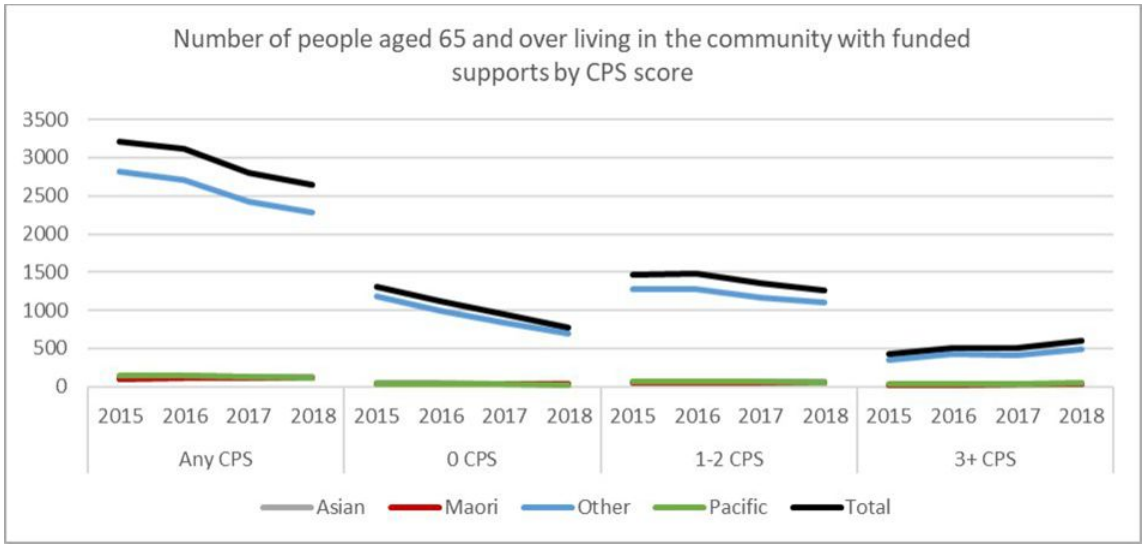
5.2 Home and Community Support



There are more people with cognitive impairment supported in the community than without. Training for support workers and consideration of how we communicate with this group will improve their experience of care.

The impact of increased demand on the small day activity programmes means most already have waiting lists for their programmes. These providers are not able to 'flex' numbers up as they are restrained by the size of their premises.

Carers – particularly spouses, provide care 24/7. Supporting these carers, who are also elderly, is challenging. When cognitive impairment is 'in the mix' carers can find it difficult to use the established respite options as their spouse does not want to be away from home or the familiar faces of their family.

Retirement villages are offering those who have the ability to purchase a villa a supportive, safer environment where carers can offer support to each other.

5.3 Hospital services

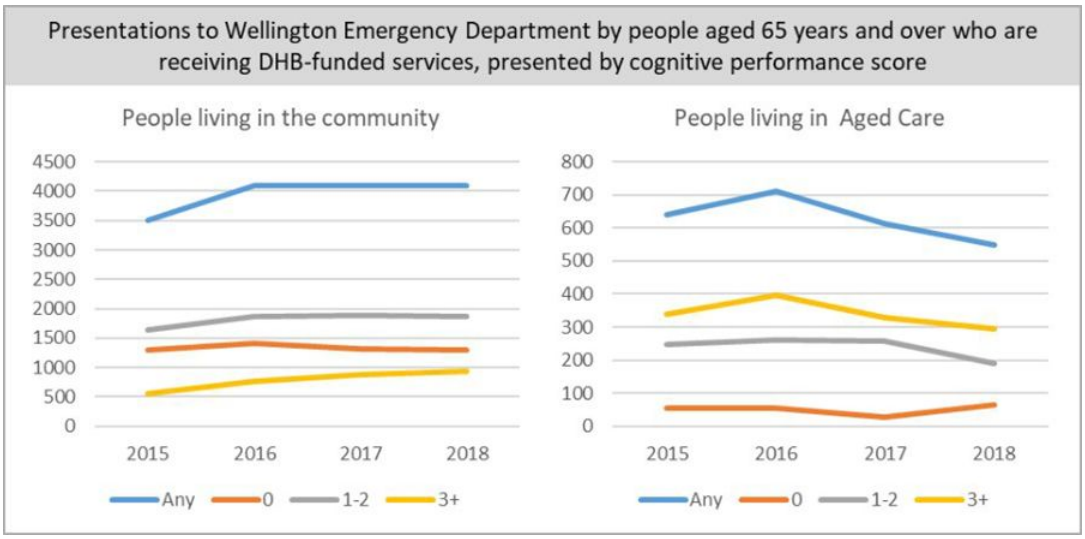
The following graphs show the impact on services using information from the data set above. These are **only people who are currently already receiving services (who have had an interRAI assessment)**.

Number of unique people by year with highest CPS score

Number of people	CPS=3+	CPS=2 or <	CPS=0	Total
2015	1266	2007	1457	4730
2016	1577	2159	1315	5051
2017	1663	1984	1078	4725
2018	1726	1919	921	4566

0 = no cognitive impairment
1-2 = mild cognitive impairment
3+ = severe cognitive impairment

Presentations to Emergency Department (ED) (not admitted)



The total number of people living in the community presenting to ED is stable, but there is an increase in those with significant impairment presenting. This is unsurprising given that these people are living in the community with significant impairment. In contrast, of the approx. 1900 people in aged care there has been a slight decline in total ED presentations since 2015. This also reflects the reduction in people entering residential care in the previous three years.

Inpatient Admissions Wellington Hospital

Dementia does not require a hospital admission for either diagnosis or treatment. Most people with dementia generally enter hospital for other reasons – for example broken bones, delirium, complex behaviour and medical emergencies.

People with dementia in a hospital setting respond to calm, quiet environments with minimal transfers. This is difficult to achieve in a busy medical or surgical ward. Ensuring that admissions are essential, as

short as possible, staff have appropriate training and a hospital environment that helps to orientate can improve the person's experience.

While the total inpatient admissions are stable, the number with significant impairment is increasing. This reflects the increases in the number of people with significant impairment living in the community and the challenges this presents.

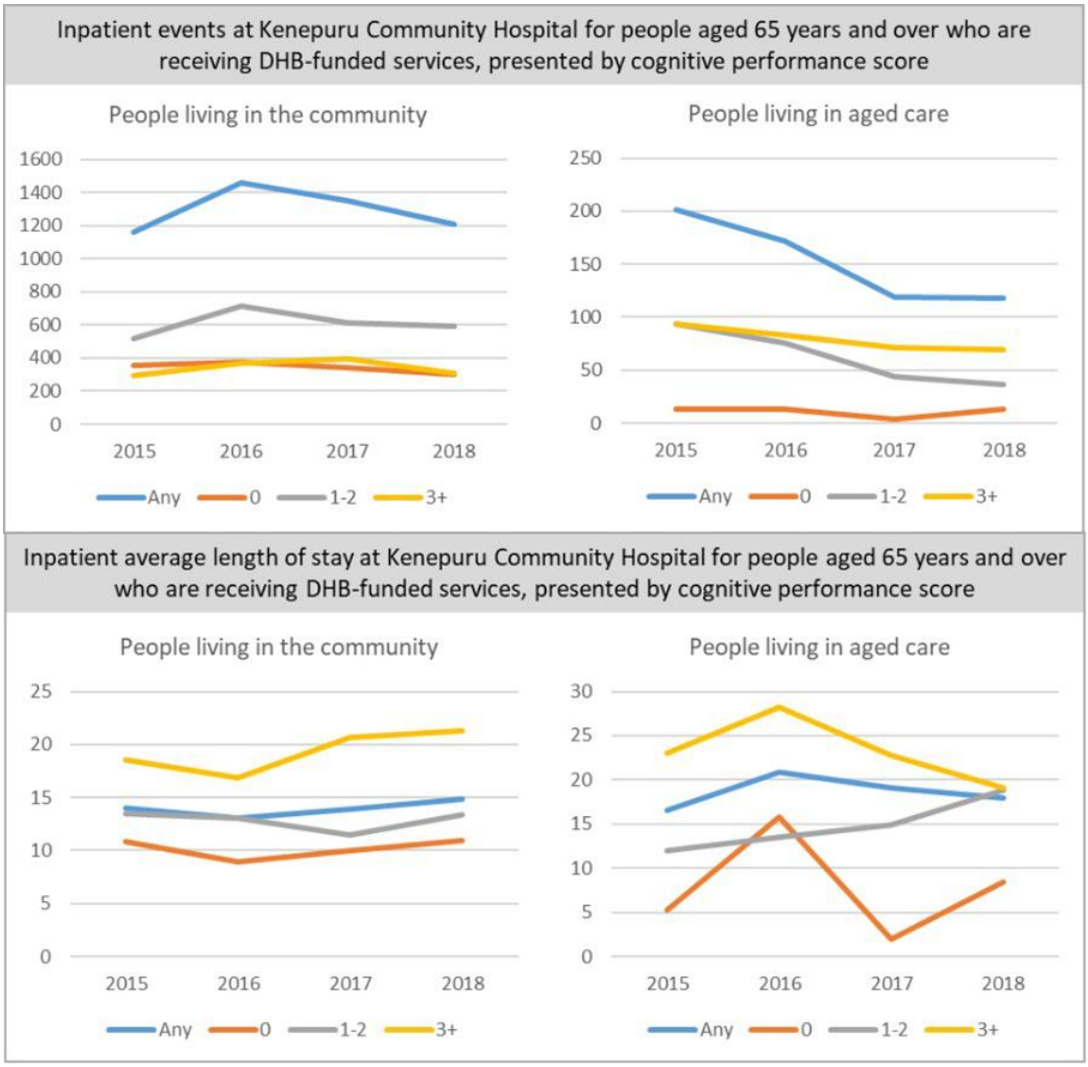
For those in aged residential care the increase in IP admissions is for those without cognitive impairment. The total number from aged care admitted to Wellington hospital is stable over the previous 4 years. There is a reduction in the number admitted with cognitive impairment – this is an expected result of effective advance care planning and palliative care principles applied.

The length of stay is slightly increasing; unsurprisingly those with a significant impairment living in the community stay longer. A hospital admission can be a catalyst for entry to residential care. Incapacity to make decisions can lengthen hospital stay.

Opportunities exist to ensure that the process for transfer to residential care is timely. There has been an increase in the FTE of staff responsible for coordinating discharge this alongside other initiatives will improve the LOS. The length of stay in hospital for those admitted from aged care is increasing. The procedure for changing level of care must minimise delays.

Inpatient admissions – Kenepuru Hospital

The length of stay for Kenepuru hospital for those people who came from residential care is increasing for those with no cognitive impairment and those with mild impairment. Further work is underway to understand the reasons for this.



Visits to Out Patient Clinics

Visits to outpatient clinics by people who currently receive services and who live in the community or from people in aged residential care. Outpatient visits for those people with cognitive impairment are stable. There has been a reduction in the total numbers from aged care.

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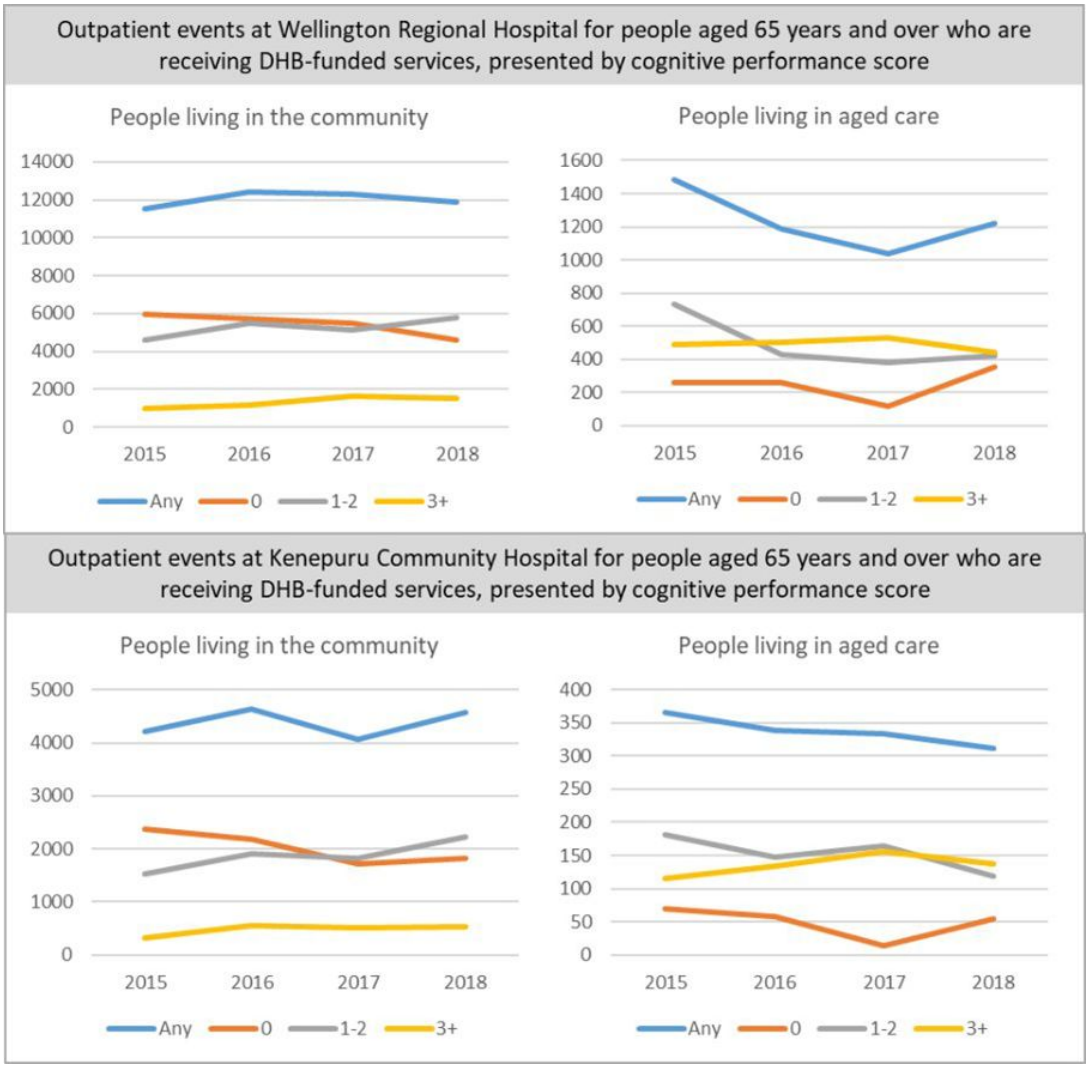

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6. HOW CAN WE RESPOND TO THESE DEMANDS

Our response to these demands requires us to respect, value and partner with people with dementia and their whanau.

The national framework for dementia care sets us the principles:

- Following a person centred approach
- Providing accessible, proactive and integrated services that are flexible to meet a variety of needs
- Developing the highest possible standard of care

The Ageing Well Strategy defines actions required of the DHB, MoH, councils, other government departments and the community. These actions include:

- Promote the concept of age friendly communities
- improve health literacy, including uptake of technology, particularly among Maori, Pacific and those with poorer health status
- promote volunteering
- increase awareness of advance care plans
- improve recruitment, retention and training of the workforce
- build the resilience and capability of family and whanau, volunteer groups that support older people

Our framework requires

- Awareness and risk reduction
- Early diagnosis, Intervention and ongoing support
- Living well – live in the community with a sense of purpose and confidence
- Meeting challenges to maximise wellbeing
- Supported end of life

Matthew Croucher (2019, Healthy Ageing Services conference, Auckland) outlined new future needs for services for people with dementia:

- Unacceptability of pure medical model / demand for person-centred care
- Unacceptability of custodial nursing care models
- Demand for culturally-appropriate services
- Demand for new treatments and the diagnostic tools that support them

We are working with our partners in communities and in the health and social sector to support people living with dementia and their whanau. The table over the page summarises activities underway and initiatives planned for the future.

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	Happening Now	Future Work
Timely diagnosis & access to specialist care when needed	Health Pathway Education and support for GPs.	Increased FTE geriatrician, nurse practitioner and pharmacist in the community supporting GP's.
Good information and advice	Health Navigator Dementia Wellington – groups, 1:1 support, navigation, Health Pathway education Seniorline, Age Concern	Increased Advance Care Planning initiatives within community NGO's Digital Seniors
Living Well - To be able to participate in community life/environments that enhance wellbeing and independence	Age friendly community initiatives – councils, Super Seniors. Respite for carers. Training – career force. Health Care Home (HCH) – for those with more complex needs and integration between services. Elder Abuse services. Specialist counselling for older people. Hospital focused on shortening length of stay. Specific training for hospital based staff on delirium. Frailty awareness week – promoting recognising frailty and minimising further harm.	Increased access to day programmes in the local community – Porirua. Refinement of the "living with Risk" tool. Community services - understand and respond to the needs of people with dementia. Increased coverage of HCH. New buildings – follow good practice guidelines. Minimise LOS in hospital for people with dementia to prevent deconditioning and maintain independence.
A dignified death	Hospice programmes: training for residential care RNs, specialists in the community, Pacifica and Maori support – navigation for families. GPs - anticipatory palliative care plan. 72 hour funding – last days of life. Early Advance Care planning - Advance planning promoted given dementia is progressive and a terminal illness.	Implement Te Ara Whakapiri into the community and aged residential care. Review the model for 72 funding.

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Date: 12 June 2019	**HEALTH SYSTEM COMMITTEE DISCUSSION**
Author	Julia Jones, System Development Manager
Endorsed by	Gerardine Clifford-Lidstone, General Manager, Child, Youth and Localities
Subject	**UPDATE ON INTEGRATION OF YOUTH SERVICES IN PORIRUA PROJECT**

RECOMMENDATIONS

It is **recommended** that the Committee:

(a) **Notes** the contents of the paper.

(b) **Endorses** the co-design workshop and planned next steps.

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

1. INTRODUCTION

1.1 Purpose

The purpose of this paper is to inform you of progress on the project to integrate youth services in Porirua which was endorsed by ELT after a successful investment bid process in 2018/19.

1.2 Previous Board Discussions

The paper follows up on an earlier paper at the HSC's meeting on South Porirua Integration Priorities, Youth Health Services for Porirua in October 2018.

2. BACKGROUND

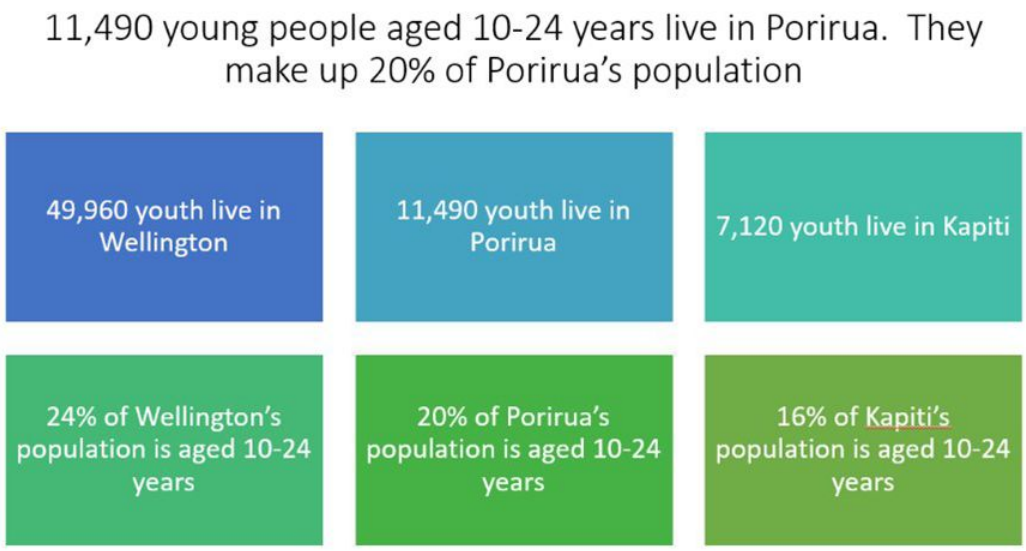
In 2018 the Board approved ongoing funding to support an integrated youth service in Porirua with a specific focus on providing equitable outcomes for young people in the CCDHB catchment.

CCDHB currently provide funding to two successful youth one stop shop services. These are located in Kapiti (Kapiti Youth Support) and Wellington City (Evolve Youth Services). There is no specialist integrated youth service in Porirua, despite the fact that in comparison to Kapiti and Wellington City, Porirua youth experience inequitable and fragmented health and social services, cost barriers, transport difficulties,

access issues and barriers that are recognised in the current service provision. Porirua has a high concentration of families living in deprivation which is a proven contributing factor to poor health and wellbeing outcomes.

In mid-2015 the Porirua Social Sector Trial (now Tumai Hauora ki Porirua) was commissioned by the 3DHB's and Porirua City Council to look at improving outcomes for young people in Porirua. One of the seven recommendations was to *provide a cohesive youth service and fill service gaps*. This integration of youth services in Porirua project continues this work and the model of care will be driven by co-design with youth and the wider Porirua community to work toward more equitable access and improved health outcomes for youth with the highest need by linking and building on existing services.

2.1 Young people in Porirua



2.2 Young people in Porirua by ethnicity

Ethnicity	# People	% Population
Asian	610	5%
Maori	2388	21%
Other	5340	46%
Pacific peoples	3148	28%
Total	11,486	100%

3. PROJECT UPDATE

A contractor has been engaged since January 2019 to review existing recommendations that have been made for youth services in Porirua and engage and collate further information from stakeholders and

stakeholder groups within the Porirua community so that SIP can provide a clear set of recommendations around a proposed model of care for integrated youth services in Porirua.

SIP have engaged with key stakeholders in Porirua and the feedback continues to be consistent with previous consultation and is supported by DHB analytics which identifies poorer health outcomes for Porirua rangatahi, particularly for those living in the Porirua South/East area.

A working group has been established to ensure the DHB are on track and well informed by community representatives. Members of the Working Group are younger people from the community, and representatives from the Youth ICC Steering Group, the Tumai Hauora Alliance, an established YOSS and a member from the Porirua City Council.

A member of the working group who has specific expertise engaging and leading young people has been contracted as the Youth Lead and will support, coordinate and co-lead the youth membership and administration of the project. There will be a dedicated youth panel consisting of eight members that will continue to support the implementation of the project over the next twelve months.

A co-design workshop with a group of rangatahi that represent the specific Porirua community is being planned for 18 and 19 June 2019.

The literature from the Tumai Hauora report, NZ evidence and the wider international picture for integrated youth services has shown that the model for rangatahi in Porirua should ensure that they are able to access health care and be supported to have good health outcomes whether they are in or out of school or work, whatever their ethnicity or health needs and wherever they live.

Five areas have been identified for specific focus to improve outcomes for rangatahi in Porirua. These are:

- An overarching vision to work together to support young people and support better health and social outcomes.
- That youth appropriate general practices are made available.
- The provision of a community based youth hub, with satellite/outreach services to meet the needs of the community.
- That the school based health services remain in all secondary schools, teen parent unit and alternative education facilities and are needs tested on an ongoing basis.
- The development of an online service to enable young people to better understand the health system and where to access services.

As well as the health focus on integrated youth services for Porirua the DHB have commenced engagement at a local level with key agencies including the Porirua City Council, Oranga Tamariki, Police and the Ministry of Social Development with initial indications of strong commitment to the establishment of a service in Porirua where a range of services in a safe and confidential environment are made available for young people.

Underpinning this project and the wider scope of the potential for a holistic multi agency approach to a rangatahi service is meaningful engagement with Iwi as Treaty partners.

Feedback from stakeholders combined with the need to escalate progress towards improved outcomes for young people in the Porirua indicate that a stepped approach to the establishment of the integrated youth service is required.

A stepped approach is required because CCDHB has allocated establishment funds for the 2019/2020 financial year and it is therefore in a position to lead the establishment of the service by designing the integrated model of care and kick starting the health component of the model of care.

4. RISKS

To ensure the continued success of a community based hub for rangatahi sufficient funding needs to be available to provide for services particularly as Porirua is an area of recognised higher need. SIP will consider additional funding opportunities as part of the development of the model of care.

While engagement with other key agencies at a local level is has indicated positive support, engagement from a policy, planning and investment perspective is still being progressed and would benefit from greater buy in at a senior level to develop the *integrated* aspect of the service, and associated funding/service contribution.

5. NEXT STEPS

The current focus of the project is the co-design workshop and the establishment of a youth panel to consult and engage with rangatahi to discuss the ongoing needs for them in the community and develop the detailed service design.

The working group includes four younger people who have a range of connections with rangatahi in the Porirua community and they have collectively provided a good depth and insight to the DHB project team.

Our youth lead is working with community leaders to recruit up to 60 young people to participate in the co-design workshop. The workshop will be held on 18 June and 19 June 2019 at Maraeroa Marae in Cannons Creek, Porirua which has been identified as the most appropriate venue to hold the workshop to engage with rangatahi.

Two facilitators have been contracted to run the service design workshop which will cover the following themes/questions:

- What services currently exist for young people?
- What are the perceived gap?
- What is a great service and why?
- What are the barriers to accessing services?
- What is the ideal support service for Porirua?
- Support in learning to pitch and explain the ideas and process to the stakeholder group.

It is anticipated that the design phase of the project will be completed by 31 July 2019. The design phase will provide clear service specifications which will inform an RFP process to establish a service to deliver the proposed model of care.