CAPITAL & COAST DISTRICT HEALTH BOARD

Health System Committee

Public Agenda

15 MAY 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**	S Driver			
1.3	Continuous Disclosure – Interest Register	**Accepts**	S Driver			2
1.4	Confirmation of Draft Minutes 17 April 2019	**Approves**	S Driver			5
1.5	Matters Arising	**Notes**	S Driver			
1.6	Action List	**Notes**	S Driver			10
1.7	Annual Work Programme	**Approves**	R Haggerty			12
2 DISCUSSION						
2.1	Update on the Annual Plan 2019/20 and Statement of Intent, incorporating the Statement of Performance Expectations Item 2.1.1 First draft Statement of Intent incorporating the Statement of Performance Expectations 2019/20	**Approves**	R Haggerty			13 17
2.2	Hospital Occupancy and Capacity Planning Item 2.2.1 Appendix 1	**Notes**	C Virtue			37 44
2.3	System Innovation and Performance Update	**Late Paper**	R Haggerty			47
2.4	Hospital and Health Services Update	**Notes**	C Virtue			51
3 INFORMATION						
3.1	Health and Safety standards of Beauty and Nail Salons Item 3.1.1 Survey of Knowledge and Infection Control Practices in Salons Offering Nail Services	**Notes**	P Gush			58 60
3.2	Update on the response to Measles in our community and, more broadly, immunisation coverage across CCDHB	**Notes**	L Smith			102
4 OTHER						
4.1	Resolution to Exclude	**Agree**	S Driver			107

DATE OF NEXT MEETING 12 JUNE 2019 – LEVEL 11, BOARD ROOM GRACE NEILL BLOCK WELLINGTON REGIONAL HOSPITAL

HEALTH SYSTEM COMMITTEE

Interest Register

UPDATED AS AT MAY 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 17 April 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 (arrived 9.25am)
Dr Tristram Ingham

STAFF:
Ms Rachel Haggerty, Director, Strategy Innovation and Performance
Mrs Robyn Fitzgerald, Committee Secretary
Ms Julie Patterson, Interim CEO (arrived 9.34am)
Mr John Tait, Chief Medical Officer
Mr Thomas Davis, General Manager, Corporate Services
Ms Arawhetu Gray, Director Māori Health Team
Ms Emma Hickson, Chief Nursing Officer
Ms Carey Virtue, Executive Director,
Mr Michael McCarthy, Chief Financial Officer
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 Taulalo Fiso, Director Community Partnership
Mr Peter Guthrie, Manager Planning and Performance

PRESENTERS:
Jamie Duncan, System Development Manager (Item 2.1)
Nicky McGeorge, Service Development Manager (Item 4.1)
Rawinia Mariner, Manager Mental Health & Addictions (Item 4.1)
Dianne Crossan, Chair Citizen's Health Council (Item 4.3)
Brad Olsen (Item 4.3)
Debbie Leyland (Item 4.3)
Lisa Smith, System Development Advisory (Item 4.4)
Sipaia Kupa, Senior Service Development Adviser (Item 5.1)

GENERAL PUBLIC: A member of the public.

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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 and DHB staff.

1.2 APOLOGIES

Apologies received from Sue Emirali and Andrew Blair.

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 13 March 2019, taken with public present, were confirmed as a true and correct record with one amendment as listed below.

Reword Item 1.3.1 sentence to read as follows 'Eileen Brown informed the Committee that should confidential industrial issues arise during the meeting that she will remove herself from the meeting until discussions have been completed.'

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

1.5 MATTERS ARISING

Action:

1. Committee Chair to follow up with Board Chair on meeting of 20-21 May re attendees.

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 Dean of the Otago School of Medicine will attend HSC meetings when relevant items are discussed;

(b) **Noted** that consideration should be given to growing closer ties with academia with interns being invited to work with CCDHB

Action:

2. Management to discuss working relationships with academic institutions.

2 PRESENTATION

2.1 ACUTE PLANNING

The presentation was noted.

The Committee:

(a) **Noted** and thanked Jamie Duncan and the SIP team for their presentation;

(b) **Noted** the benefits and design objectives of the programme.

3 DECISION

3.1 PORIRUA SKIN PROJECT UPDATE

The paper was taken as **read**.

The Committee:

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

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

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

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

(e) **Agreed** that the submission to the Ministry of Education be joint between the CCDHB and Tū Ora Compass Health and copied to the Ministry of Health;

(f) **Noted** the collaborative work with the Regional Public Health.

HSC recommends the Board:

(a) **Noted** the paper.

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

Action:

3. Management to discuss 'support' from Porirua City Council.

4 DISCUSSION

4.1 ALCOHOL AND OTHER DRUGS MODEL OF CARE

The paper was taken as **read**.

The Committee:

(a) **Noted** the progress of the 3DHB Alcohol and other Drugs (AOD) Model of Care work;

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

(c) **Noted** that Domestic Family Violence with a Pacific focus should also be included.

HSC recommends the Board:

(a) **Note** the paper.

Action:

4. Management to provide regular updates.

4.2 3DHB ICT STRATEGY

The paper was taken as **read**.

The Committee:

(a) **Noted** the report.

Actions:

5. Management to include in the next update a copy of the National ICT strategy and where CCDHB's ICT plan aligns with this strategy, the regional plan and compares with other DHBs and how CCDHB are building accessibility standards into the system.
6. Management to circulate to Committee members a copy of the presentation presented at TAS by the TAS Intelligence Officer.

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

4.4 INVESTMENT AND PERFORMANCE — OLDER PERSONS SERVICES, COMMUNITY PHARMACY, PRIMARY HEALTH ORGANISATIONS, AND COMMUNITY DENTAL SERVICES

The paper was taken as **read**.

The Committee:

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

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

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

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

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

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

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

Moved: Tristram Ingham **Seconded**: Eileen Brown **CONFIRMED**

5 INFORMATION

5.1 PACIFIC UPDATE

The paper was taken as **read**.

The Committee:

(a) **Noted** the approach being taken to refresh the Subregional Pacific Strategy;

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

Moved: Tino Pereira **Seconded**: Roger Blakeley **CARRIED**

6 OTHER

6.1 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
Māori Health Strategy Paper and Action Plan Options to Manage Increasing Dialysis Demand in the Sub Region	Papers contain information and advice that is likely to prejudice or disadvantage commercial activities and/or disadvantage negotiations	9(2)(b)(i)(j)

* Official Information Act 1982.

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

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

7 DATE OF NEXT MEETING

15 May 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:
P022	**4.2**	**3DHB ICT Strategy**	Management to circulate to Committee members a copy of the presentation presented at TAS by the TAS Intelligence officer.	Dir SIP/CIO	Email	May
P021	**4.2**	**3DHB ICT Strategy**	Management to include in the next update a copy of the National ICT strategy and where CCDHB's ICT plan aligns with this strategy, the regional plan and compares with other DHBs and how CCDHB are building accessibility standards into the system.	CIO	Paper	~~June~~ July
P020	**4.1**	**Alcohol and Other Drugs Model of Care Project**	Management to provide regular updates	Dir SIP	Quarterly reports	August
P019	**3.1**	**Porirua Skin Project**	Management to discuss 'support' with Porirua City Council.	Dir SIP	Meeting	June
P018	**1.7**	**Annual Work Programme**	Management to discuss working relationships with academic institutions.	Dir SIP	Meeting	June
P017	**1.5**	**Matters Arising**	Committee Chair to follow up with Board Chair on Meeting of 21-21 May re attendees.	Chair	Email/Phone	May
HSC Meeting 17 April 2019						
P015	**4.2**	**Strategy Innovation and Performance Report January-February 2019**	1. Management to provide a submission to the Heather Simpson Review; 2. Management to recirculate the Terms of Reference of the review and include it in the paper to the Board; 3. Management to provide a link to the Heather Simpson Review.	Dir SIP	Paper Email Email	May Closed Closed
P014	**3.2**	**Giving traction to**	Management to provide a presentation of this programme to the Board.	Dir SIP	Presentation	~~May~~

		CCDHB's equity aspirations	Provide information on CCDHB's response to WAI2575.			June
P013	**3.1**	**First draft Annual Plan 2019/20 including Statement of Intent (SOI) and Statement of Performance Expectations (SoE)**	1. Management to include a diagram and context, including achieving equity, in the Chair or CEO's report of what CCDHB are doing in the Annual Plan and Statement of Intent. 2. Management to discuss draft with both internal Pacific and Māori Health groups in CCDHB.	Dir SIP	Report Discussion	~~April~~ ~~May~~ June
P011	**4.3**	**Hospital and Healthcare Services (HHS) Bi-monthly Performance Report**	Management to provide more details on the new protocols being developed in the Emergency Department on Equity for Māori.	Executive Director, Operations, Medicine Cancer & Community	Paper	May
HSC Meeting 13 March 2019						
P002	**2.3**	**Primary Birthing Facility Feasibility Review**	Management to provide an update to HSC of the role of the midwives in a birthing unit.	Dir Sip	Report	July
HSC Public Meeting 13 February 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	~~Final Draft Annual Plan 2019/20~~ LTIP update	Māori Health Action Plan Investment and Prioritisation Update Citizens Health Council Update	Final LTIP Investment and Prioritisation Update Draft Pacific Plan	2020 Joint Board Schedule and workplan Final Draft Regional Services Plan 2019/20 Final Annual Plan and Capital Budget 2019/20 Investment and Prioritisation Update Citizens Health Council Update	Draft Financials Annual Report Investment and Prioritisation Update	Final Annual Report 2018/19 Draft Annual Plan 2019/20 Investment and Prioritisation Update Citizens Health Council Update	Investment and Prioritisation Update
				Even Better Health Care	~~Progress update – Regional Services 18/19~~	Update for implementing the Health System Plan				Investment Plan Update	Progress update – Regional Services 18/19
Regular Reporting	**DISCUSSION**	Access to Psychological therapies for 18 to 25 year olds Cancer Services Review Localities Diagram	System Innovation and Performance Update Hospital and Health Services Update Quarter 2 Performance Report	3DHB ICT Update SOI Draft DASHBOARDS Citizens Health Council Update	Hospital Network Planning System Innovation and Performance Update Hospital and Health Services Update Summary of Heather Simpson Review Submission ~~3DHB DSAC Report~~ ~~Pacific Nurse-led service update~~	Quarter 3 Performance Report Pro-Equity Implementation Plan	System Innovation and Performance Update Hospital and Health Services Update 3DHB MHAIDS update 3DHB ICT Update Birthing Facility Feasibility Update	Hospital Network Planning	Quarter 4 Performance Report System Innovation and Performance Update Hospital and Health Services Update 3DHB DSAC Report	3DHB MHAIDS update 3DHB ICT Update	Hospital Network Planning System Innovation and Performance Update Hospital and Health Services Update
	INFORMATION	Population Health (Regional Public Health Report)		Pacific Health Update Porirua Skin Project Update	~~3DHB MHAIDS update~~ 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

PUBLIC

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**HSC DECISION** **Date:** 15 May 2019
Author	Rachel Haggerty, Director - Strategy, Innovation & Performance
Endorsed by	Julie Patterson, Interim Chief Executive
Subject	**UPDATE ON THE ANNUAL PLAN 2019/20 AND STATEMENT OF INTENT, INCORPORATING THE STATEMENT OF PERFORMANCE EXPECTATIONS**

RECOMMENDATIONS

It is recommended that the Health System Committee:

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

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

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

(f) **Notes** 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) **Reviews and provides feedback** on the content of the SOI, incorporating the SPE, to Director SIP;

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

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

CONSULTATION

The Annual Plan has been reviewed by:

- Subregional Pacific Advisory Group
- Subregional Disability Advisory group
- Maori Partnership Board
- Clinical Council

APPENDIX

1. First draft Statement of Intent incorporating the Statement of Performance Expectations 2019/20.

PUBLIC

Health System Plan Outcomes		Stewardship	
Wellbeing Strengthen our communities, families and whanau 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	**X**	**Planning Processes and Compliance** Planning processes and compliance with legislation or policy	**X**
Specialist Services Ensure expert specialist services are available to help improve people's health		**Government Priority** Equity; Child Wellbeing; Mental Health; Primary Care; Water Safety	**X**

1. PURPOSE

This paper provides an update on the Annual Plan 2019/20 and outlines the content of the first draft Statement of Intent (SOI) for Capital & Coast DHB (CCDHB).

The HSC has been asked to review and provide feedback on this first draft SOI. The HSC has also been asked to approve the first draft SOI to be submitted to the Ministry of Health on 16 May. The Financial Performance section will be included when the budget has been finalised.

2. MINISTERS EXPECTATIONS

The Minister's Letter of Expectations outlines the Government's priorities for health to ensure that our public health system is:

- Strong and equitable;
- Performing well; and,
- Focused on the right things to make all New Zealanders' lives better.

The priorities outlined in the Minister's Letter of Expectations for 2019/20 include:

- Achieving Equity;
- Strong and Equitable Public Health and Disability System;
- Mental Health and Addiction Care;
- Child Wellbeing;
- Primary Health Care;
- Non-Communicable Disease (NCD) Prevention and Management;
- Public Health and the Environment; and,
- Fiscal Responsibility.

3. ANNUAL PLANNING ACTIVITY TO DATE

The first draft Annual Plan was presented to the HSC on 18 March and the Board on 27 March. The first draft Annual Plan was submitted to the Ministry on 5 April. The first draft SOI was not included in the draft Annual Plan, the draft SPE was included as an appendix.

The first draft Annual Plan has been presented to the Sub-Regional Pacific Strategic Advisory Group on 3 April for review; will be presented to Clinical Council for review on 16 May; and circulated electronically to Māori Partnership Board and Disability Services Advisory Group for review and feedback.

The HSC has asked to note that as a result of early sector consultation there are no updates to report against the first draft Annual Plan. Informal feedback on the first draft Annual Plan is expected from the Ministry on 10 May, with formal feedback expected on 17 May.

Feedback from advisory committees and the Ministry, including updated guidance, will be incorporated into the final draft of the Annual Plan 2019/20 and a final draft presented to the Board on 30 May for approval to submit to the Ministry.

The Statement of Intent (SOI), incorporating the Statement of Performance Expectations (SPE) is part of the Ministry of Health's Annual Plan; a placeholder was in place for the Statement of Intent (SOI) in the first draft Annual Plan. As per the Ministry Guidance (received 29 March), the SOI must incorporate the Statement of Performance Expectations (SPE), including Financial Performance.

Further planning guidance was received from the Ministry on 29 March, including requirements for the SOI and SPE. The updated requirements outlined that the SOI, incorporating the SPE and the financial performance will be presented as Part B of the Annual Plan.

4. DEVELOPMENT OF THE STATEMENT OF INTENT, INCORPORATING THE STATEMENT OF PERFORMANCE EXPECTATIONS

Each DHB has a statutory responsibility to prepare an SOI and an SPE, providing financial accountability to Parliament and the public triennially and annually respectively. The Ministry of Health Annual Planning guidance for 2019/20 indicates that the SOI must include the following information:

1. Strategic Direction;
2. Managing our Business;
3. Statement of Performance Expectations (SPE);
4. Financial Performance.

4.1 Strategic Direction

CCDHBs strategic direction is outlined in part 1 *'who we are and what do we do'* and part 2 *'what are we trying to achieve?'* An overview of our local population and how this population is changing is presented in part 1. We also provide details on the services we provide (local, sub-regional and tertiary services) and the key challenges we are facing.

Our strategic direction is included in part 2 of the document. This part also includes the National, Regional and Sub-Regional Strategic Direction, focus for 2019/20 and key programmes and initiatives for 2019/20. Finally, sections on Health and Safety and Workforce are included in this part of the document.

4.2 Managing our Business

Part 3 'how we manage our business' describes the arrangements and systems CCDHB has in place to manage our core functions and deliver planned services. The content of this section is also included in the Stewardship section of the Annual Plan.

4.3 Statement of Performance Expectations (SPE)

The SPE enables the Minister to participate in setting annual performance expectations, to inform the House of Representatives and to provide a base against which annual performance can be assessed. The SPE will be audited by Audit NZ and CCDHB reports against the measures in the Annual Report.

For 2019/20, we have reviewed the performance measures in the SPE so that they reflect the priorities of the Government, the Ministry and CCDHB. This has also included a deliberate move to shift indicators from a focus on Outputs (i.e. activity) towards Outcomes (i.e. how well did we do it) and Impact (i.e. what difference did we make). Again, we have worked to ensure the decisions made in the Board's January workshop are reflected in the first draft Annual Plan.

4.4 Financial performance

This section contains forecast financial statements for the forecast year prepared under generally accepted accounting practice. DHBs must submit to the Ministry financial templates supporting the Annual Plan that comply with monthly/quarterly financial reporting requirements. DHBs must provide all necessary information in the financial templates to meet Crown Financial Information Systems reporting requirements. The Financial Performance section will be included when the budget is finalised.

5. NEXT STEPS

The HSC has been asked to review and provide feedback on the first draft Statement of Intent, Incorporating the Statement of Performance Expectations (SPE). Further work will be done on the Annual Plan and Statement of intent as further guidance is expected as we receive feedback from our advisory groups. The timeline for the Annual Planning process for 2019/20 is:

Activity	Timeline/Date
HSC to Review Draft Annual Plan 2019/20	*13 March*
Board to Approve submission of first draft Annual Plan 2019/20 to MoH	*28 March*
Draft Annual Plan 2019/20 Presented to the SRPHSG	*3 April*
First draft Annual Plan 2019/20 Submitted to MoH	*5 April*
Production plans 2019/20 Submitted to MoH	*12 April*
Planning Priority Forums to Discuss Draft Annual Plan	*April – May*
Draft Annual Plan 2019/20 presented to the Māori Partnership Board, Disability Support Advisory Committee, Sub-Regional Pacific Strategic Advisory Group and Clinical Council for review and feedback	*May*
HSC to review the first draft SOI, incorporating the SPE	15 May
First draft SOI submitted to MoH	16 May
Board to Approve Final Draft Annual Plan 2019/20 (including final SOI, incorporating the SPE)	30 May
CFO to Provide the Financial Performance Sections to SIP	By 20 June
Final Draft Plans Submitted to MoH	21 June

CAPITAL & COAST DISTRICT HEALTH BOARD

Statement of Intent

2019/20 - 2021/22

MA TINI, MA MANO, KA RAPA TE WHAI
BY JOINING TOGETHER WE WILL SUCCEED

Capital & Coast
District Health Board
ŌPOKO KI TE URU HAUORA

Foreword from Chair and Chief Executive

I am delighted to present Capital & Coast District Health Board's Statement of Intent, which sets out our strategic intentions for the next three years.

We have a strong focus on achieving equity of access to health services and equitable health outcomes for our communities, particularly for Māori, Pacific Peoples and communities experiencing high deprivation. This renewed equity focus is essential for CCDHB to deliver improved health outcomes, meet its statutory responsibilities and reach its medium term goals for a clinically and financially sustainable local health system.

At CCDHB, we are deliberate in our investment choices to deliver better care and outcomes for our communities. We work collaboratively with our strategic partners including our Māori Partnership Board, community and primary care partners to inform these choices. We will also continue to support our DHB partners in the central region as a tertiary provider.

Knowing that the services we deliver are achieving the outcomes we want, in a sustainable way, is a top priority for me. Oversight of high quality performance monitoring is an integral role for the Board. As a Board, we have set a strong expectation that CCDHB measures and reports on the right things – including equity and quality - clearly and consistently.

We also expect the DHB to respond appropriately to safety, quality and performance issues in a timely way. The DHB is building its capability to use data and evidence in smarter ways to support this focus. I anticipate further improvements over the coming year in our ability to use information and insights to respond to the challenges we face.

We know our workforce matters. Our people and their capability is critical to our success. We continue to strengthen our commitment to the safety and development of our workforce.

We are actively engaged in meeting the expectations of the Minister of Health, which our own long term vision for our health system is well aligned with. We continue to emphasise action to improve the wellbeing of our tamariki and rangatahi, enhance the capacity of primary care, improve mental health outcomes, support older people to live well and maintain strong publicly delivered health services.

I am pleased to present Capital & Coast District Health Board's Statement of Intent. This plan outlines clear priorities for CCDHB to allocate our resources and focus our efforts on elevating performance to meet the needs of key groups within our population.

It reflects a strong relationship between the wider factors influencing health and the leadership role we must take to build partnerships with other agencies, services and communities to build resilience and improve health and social wellbeing.

The life course focus we are taking to ensure services are equipped to meet peoples' needs throughout every stage of life is critical for optimising health outcomes for our communities.

Our key actions across the life course include:

- Equitable outcomes, particularly for Māori, Pacific peoples, those with socio-economic deprivation, and those experiencing disabilities
- Mental Health and Addictions services
- Primary Care services
- Child Wellbeing
- The strength of our publically funded health system

CCDHB will continue to partner with Hutt Valley DHB and Wairarapa DHB where it best serves our communities and makes the best use of resources. CCDHB will also continue to partner with our Central Region DHBs.

We have started to develop and apply new ways of working and have established some sound building blocks including the development of a long-term strategic plan (HSP2030), integrated support services key projects and Even Better Health Care.

We continue to strengthen our commitment to the safety and development of our workforce including implementing Care Capacity Demand Management (CCDM). Continuing to build our clinical governance will further strengthen our focus on the quality and safety of the services we deliver.

These new ways of leveraging the existing strengths in our organisation including our strong relationships within and across our communities, a committed and involved clinical workforce, and our equity focus will be key to deliver on the ambitious targets we have set ourselves for the next three years.

Andrew Blair
Board Chair

Julie Patterson
Interim Chief Executive

PART 1: Who we are and what we do

Capital & Coast DHB (CCDHB) is one of 20 DHBs established under the New Zealand Public Health and Disability Act (2000). We are the Government's funder and provider of health services to the residents living in the Kāpiti Coast District, Porirua City and Wellington City.

Who we are

The CCDHB region is diverse. Our communities reflect many cultures, ethnicities and abilities as well as geographic settings. In 2018, an estimated 318,000 people called the region home. This is projected to grow by 28,500 people by 2030; a 9% increase.

Infographic of growing population

In 2018, 106,400 people under 25 years of age made up 33% of the region's population. Most people, 58%, were aged 25-69 years (183,000). The remaining 9%were people over 70 years; 29,000 people.

In 2018, Wellington had a large proportion of people in the younger working age group of 20–44 years (90,500 people), while nearly one-quarter (23%) of the Porirua population were aged under 15 years (13,000 people). Just over one-quarter (26%) of the Kāpiti Coast population were aged over 65 years; 11,500 people.

Infographic of population age distribution

The region is ethnically diverse. In 2018, 28,500 people identified as Māori (11% of the population), 21,000 identified as Pacific peoples (7%) and 35,500 identified as Asian (15%); 67 percent of the population identified in the 'Other' ethnic category (228,000).

Porirua had a larger proportion of Māori (16% or 9,000 people) and Pacific peoples (21% or 12,000 people), while 89 percent of the Kāpiti Coast population identified in the 'Other' ethnic category (70,800 people).

Our Māori and Pacific populations tend to be younger, with 29% of the region's Māori (10,600) and 27% of the region's Pacific people (6,000) aged under 15 years in 2018.

Infographic of diverse population

According to the New Zealand Disability Survey 2013 there were 72,200 people with a disability living in the CCDHB region. This is expected to increase to 84,500 by 2030. The growing rates of disability partially reflects our ageing population.

A changing population

The CCDHB population is changing: the population is growing, ageing and becoming more diverse.

The majority of the population increase is predicted to be in our Māori and Asian communities. For Māori, we expect growth of 20% or 7,300 people. Our Asian population is predicted to grow by 43% or 20,300 people. Pacific peoples and 'Other' populations are expected to grow much more slowly and even decline in some younger age groups.

There will be significant growth in the number of older people in the region, as our large baby boomer generation shifts into older age brackets. The largest growth is expected be in the 70-79 and 80+ age groups; as our population is living to reach much older ages.

The health of our population

Compared to New Zealand as a whole, we are relatively 'healthy and wealthy'. We have a high life expectancy at 82 years, rates of premature deaths from conditions amenable to healthcare have declined by 45% between 2000 and 2015, and the majority of our population (62%) live in areas of low deprivation.

However, we also have groups who experience inequitable health outcomes; in particular, Māori, Pacific

peoples, those experiencing disabilities and those who live in highly deprived areas, concentrated in Porirua.

What we do

CCDHB is responsible for improving, promoting and protecting the health of the people, whānau and communities in our region. These expectations are reflected in our vision:

"Keeping our Community Healthy and Well."

The objectives of DHBs are outlined within the Health and Disability Act (2000). These objectives include:

- Improve, promote, and protect the health of communities
- Reduce inequalities in health status
- Integrate health services, especially primary and hospital services
- Promote effective care or support of people needing personal health services or disability support

DHBs act as 'planners', 'funders' and 'providers' of health services as well as owners of Crown assets.

Local Services

CCDHB provides community and hospital services throughout the region.

CCDHB has a range of contract with community providers, such as primary health organisations, pharmacies, laboratory, and community NGOs.

CCDHB operates two hospitals: Wellington Regional Hospital in Newtown and Kenepuru Community Hospital in Porirua. We also operate the Kapiti Health Centre in Paraparaumu, and Rātonga-Rua-O-Porirua, a large mental health campus based in Porirua.

We provide a range of specialist services in the community including district nursing, rehabilitation services, social work, alcohol and drug services, and home support services. CCDHB also provides sub-regional, regional and tertiary services for other DHBs.

CCDHB employs around 5,700 staff and has an annual budget of $1.*XX* billion in 2019/20.

Sub-Regional Services

CCDHB provides services to the people of Hutt Valley DHB and Wairarapa DHB under 2DHB (CCDHB and Hutt Valley DHB) and 3DHB models.

CCDHB and Hutt Valley DHB serve populations that are geographically co-located. CCDHB provides more services to the Hutt Valley DHB population than any other DHB. There are also DHB services provided to both populations, either at CCDHB or at Hutt Valley DHB.

In 2018, an estimated 150,000 people lived in Hutt Valley DHB. Hutt Valley's population has greater ethnic diversity and is slightly younger compared to CCDHB. Hutt Valley's population is predicted to grow by 4% or 6,500 people by 2030.

A further 45,500 people live in Wairarapa DHB. The population in the Wairarapa is projected to grow by 2,600 people (6%) by 2030.

Tertiary Services

CCDHB is the complex care provider for the Central region. The central region includes Hawkes Bay, MidCentral, Whanganui, Wairarapa, Hutt Valley and Capital & Coast DHBs.

In 2018, the Central Region population was 922,855 people. This represents 19 percent of the total New Zealand population and is projected to grow by 6 percent by 2030 to just under one million people (978,900)[1].

Map of Central Region DHBs

CCDHB is also a provider of some tertiary services outside the central region (for example Taranaki DHB and Nelson Marlborough DHB) as well as national services.

Achieving health equity in CCDHB

Improving equity performance is a priority for CCDHB. This focus is on ultimately achieving equity amongst our populations. We know that we don't do as well for Māori and Pacific Peoples in our district, as well as those who have low socio-economic status, an enduring mental illness and/or addiction, or a disability. CCDHB is committed to improving health outcomes and achieving equity for our communities.

CCDHB's strategic direction, to reduce and ultimately eliminate inequities, is driven by:

- Taurite Ora, Māori Health Strategy 2018-2030
- CCDHB Pro-Equity Implementation Plan
- Toe Timata Le Upega, Pacific Action Plan 2017-2020
- Sub-Regional Disability Strategy 2017-2022

The key challenges we are facing

Our health system is generally performing well: New Zealanders are living longer and experiencing better health. From 2000 to 2012, New Zealand's amenable mortality rate decreased across all age groups, though ethnic and gender disparities persist.

Even though New Zealanders are living longer in better health, there are a number of challenges as a provider and funder of health services:

Health Inequities - The inequity present in some communities is fuelling health needs. As in most other countries, there are poorer health outcomes across the socioeconomic hierarchy. Inequalities in health begin to appear very early in life, accumulate over the life course, and are reflected in most common causes of death, injury or hospitalisation.

Child Wellbeing - Giving every child the best start in life is crucial to reducing health inequities across the life course. The Children's Commissioner identified that children who experience poverty will have both a forward liability for the health sector and a cross-sector liability, representing a productivity cost to individuals, businesses, and the nation.

Long-Term Conditions - The impact of long-term conditions is growing. Although we are living longer, and living longer in good health, some people are living longer in poor health. The New Zealand Burden of Disease study found that 88 percent of health loss in this country is caused by long-term mental and physical conditions. Alongside this, disability now accounts for over half of the total health loss experienced by the population as a whole.

Mental Health and Addictions - CCDHB is facing a growing need for mental health and addiction services. There are about 40,000 people with mental health needs currently living in the CCDHB region. This figure is expected to rise to 44,000 people by 2030. Not all these people will require the support of mental health services, but some people, particularly those with moderate or severe mental health needs, are likely to require additional support to manage and maintain their health and wellbeing.

Aging Population - The demand on our healthcare system continues to increase as the population is growing and ageing. Improvements in health will not necessarily reduce spending on healthcare. The number of people aged over 70 years is expected to increase significantly. Forecasts suggest that by 2030 at least one in six people will be aged 70 years or over, and the population aged over 80 will increase by over 80 percent.

Sustainability of Specialised Services - We see growing complexity in the people we do care for. The purpose of Wellington and Kenepuru Community hospitals is to provide acute care and to ensure access to planned (non-acute) services, birthing services, and a comprehensive range of subspecialties. Wellington Hospital is a tertiary service centre that serves the people of the central region, with the greatest level of support being provided to Hutt Valley DHB.

Financial sustainable - The demand trends for health services, together with projected expenditure trends, mean that the cost of the current model of healthcare is unaffordable and unsustainable.

The HSP outlines the strategic direction that will allow Capital and Coast's health system to respond more effectively to the growing and changing needs of its people and populations, reduce inequalities and enable communities to better sustain their own health and well-being over time.

Part 2: What are we trying to achieve?

Our Strategic Direction

To deliver on the vision ***"Keeping our Community Healthy and Well"***, CCDHB is implementing a health system that organises service delivery in the most appropriate setting, for our people and communities that makes the best use of resources to achieve positive health outcomes and equity amongst our population.

We recognise the role of many in our success; our communities, our families, our workforce, our provider partners, our Ministry and our social service partners. At the heart of this approach is enabling people and their whānau to take the lead in their own health and wellbeing.

The HSP outlines CCDHB's strategy to improve the performance of our healthcare system to support people to have better health and wellbeing throughout their lives and ensure equity amongst our communities.

The plan will enable us to respond to the growing demand for healthcare, and increasing complexity with a system design that will improve outcomes and equity for the people of the Capital and Coast district, and the wider central region. The Health System Plan is supported by this whakataukī:

"Ma Tini, Ma Mano, Ka Rapa, Te Whai

By Joining Together We Will Succeed"

Good health and wellbeing are central to every person's ability to live a satisfying life and contribute both socially and economically to the community they live in.

Our health system will keep our community healthy by:

- Promoting health and wellbeing
- Preventing the onset and development of avoidable illness
- Improving health outcomes
- Supporting people to live better lives
- Supporting the end of life with dignity

Improving the health and wellbeing of communities requires a more broad approach than the traditional boundaries of health and social services.

Partnership with Councils, Government Agencies, NGOs from other sectors and community organisations) is required to better respond to the social determinants of health. These partnerships are being developed through locality based approaches working in partnership with our communities of Wellington, Porirua and Kāpiti.

The HSP is designed to support people and whānau-led wellbeing with the system organised around the two elements: 'People' and 'Place'.

People

We are committed to developing people-focused service delivery models. The HSP outlines three broad service delivery models for the main users of our health services:

- **Core health care service users** (those who require any form of urgent and planned care –the health system will be acting early to prevent illness and disability and save lives)
- **Maternity services users and children, young people, and their families and whānau** (the health system will be providing support in these key life transitions, with a strong focus on children and young people where early action has benefits across the life course)
- **People with complex care needs who require system coordination** (including those who have long-term conditions, are becoming frail or are at the end of their life. These are people who have multiple needs from the health system and require the system to be easily and effectively navigated to enable them to lead their own health care).

Recognising those who need more help include: the socially & economic vulnerable; those with mental illness and addiction; those with disability; and Māori, Pacific and Refugees.

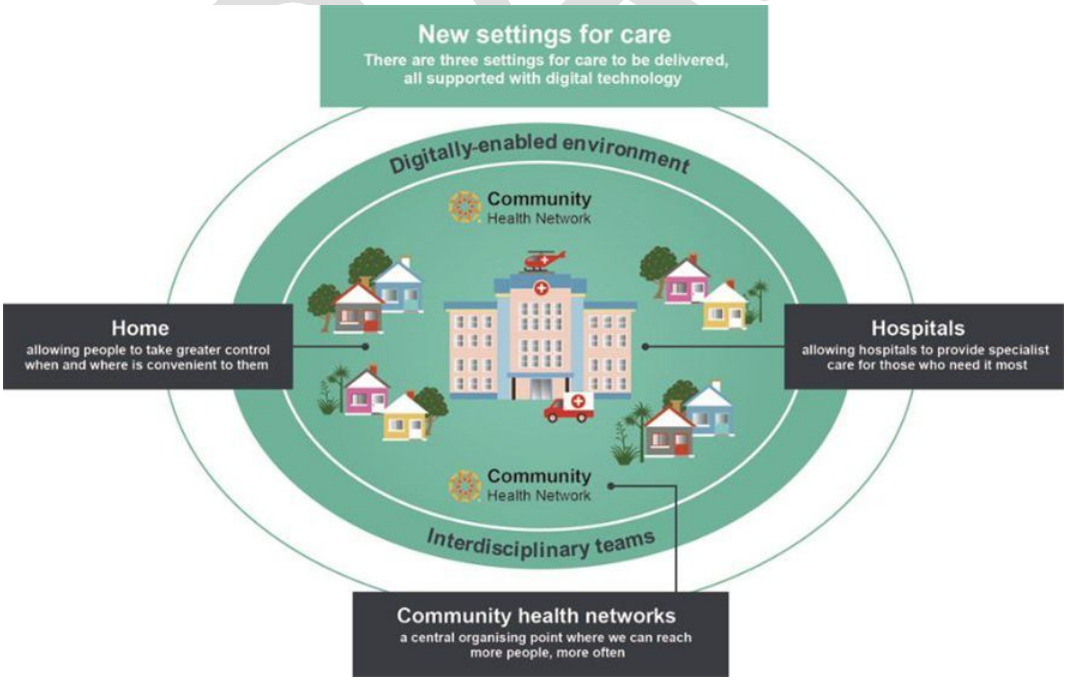
Place

Using 'place' as the basis for health and social supports creates immediate links to a community's strengths; it makes it easier to recognise and value community diversity, while organising a consistent system across many groups. Better information about the characteristics of the people being served, shared among those delivering services, is central to succeeding with this approach. It has the potential to reduce health care costs over time as communities increasingly support their own health and wellbeing.

Health care has always been delivered in a variety of settings. The places where care is organised and delivered, together with increased access to better and cheaper technologies, provide the platform for a comprehensive system of care.

The plan centres on the following three core care settings.

- People's homes and residential care facilities
- Community Health Networks (CHN), including the Health Care Home (and the Kāpiti Health Centre)
- Wellington and Kenepuru Community hospitals providing specialist care for the CCDHB region.



National, Regional and Sub-Regional Strategic Direction

National

The Minister's Letter of Expectations sets out the Government's expectations for district health boards (DHBs) and their subsidiary entities.

The priorities for 2019/20 include:

- Strong and Equitable Public Health and Disability System
- Mental Health and Addiction Care
- Child Wellbeing
- Primary Health Care
- Fiscal Responsibility

Regional

CCDHB is a complex tertiary provider for the Central Region, as well as a specialist provider for its own communities. CCDHB is committed to improving regional care arrangements with our partner DHBs in the Central Region.

The central region's priorities and activities are outlined in the Regional Services Plan. An implementation programme has been developed focussed on the key regional strategic priorities:

- Equity
- Tertiary Services Strategy
- Radiology
- Cardiology
- Cancer

Sub-Regional

CCDHB and Hutt Valley DHB share a Chief Executive and a Board Chair. Our Boards hold joint quarterly meetings which allows further collaboration and a more integrated and aligned approach to planning and delivery of health services across the two DHBs.

Hospital Network Planning – In 2018, CCDHB and Hutt Valley DHB (HVDHB) entered into a joint sub-regional clinical planning process. A joined up approach offers the opportunity for joint provision of key services and to strengthen the network of hospitals in the greater Wellington region.

CCDHB and HVDHB serve populations that are geographically co-located. A greater proportion of the Hutt Valley population receive services at CCDHB, than any other population as there are a large number of services that are provided by CCDHB for the Hutt Valley population as well as services where there is collaboration across the two DHBs.

There are very few services that are jointly provided. They include advanced care planning and the disability strategy. The most significant clinical service is Mental Health and Addiction Services (MHAIDS) which is provided across the three DHBs (including Wairarapa DHB).

CCDHB has strong relationships with its two PHOs and the NGO sector. The partners work together for system improvement through the local Alliance Leadership Team, the Integrated Care Collaborative (ICC).

Focus for 2019/20

Our focus is on delivering on the HSP. The HSP is underpinned by knowing the major drivers of demand for health care, and the potential opportunities offered by increasingly affordable, reliable, and sophisticated technologies.

The HSP presents three key strategies for developing our approach to 'people' as an organising system for health care:

- **Simplifying care** for those who have good health literacy and resources
- **Intensifying care** for those who have less resources and experience the greatest levels of avoidable poor health
- Strengthening investment in **acting early to prevent avoidable costs** around health care over a lifetime.

The HSP also outlines four key strategies for developing our approach to 'place' as an organising system for health care:

- **Working with and in communities** to develop location-specific approaches to health care for local populations
- Using health resources effectively by **organising their use around settings of care**
- Developing **interdisciplinary health teams** who work together to support safe and effective health care Strengthening **innovation, using technologies** to improve knowledge, choice, and access to health care.

Key programmes and initiatives in 2019/20

Equity - CCDHB is investing to sustainably implement equity, with a focus on those where inequitable outcomes have the greatest negative impact. The development of the CCDHB **Pro-Equity Strategy** puts in place the building blocks for CCDHB to advance as a pro-equity organisation.

Taurite Ora - CCDHB has developed a new Māori health strategy, Taurite Ora: CCDHB's Māori Health Strategy and Action Plan 2019-2030. This strategy will guide activity to achieve equitable Māori health outcomes in the CCDHB district by 2025 with a broader goal of 'pae ora', (health futures for Māori) by 2030.

Hospital Network Planning - CCDHB and Hutt Valley DHB have entered into a joint sub-regional clinical planning process. The joint hospital network planning work programme is an input into CCDHB's Long Term Investment Plan for 2019, and will inform the joint LTIP in 2020.

Children's Hospital - The build of a new Children's Hospital is underway with the support of Treasury and MoH.

Primary Care - The Healthcare Home is a key priority for CCDHB, as we move to develop our Community Health Networks. The emphasis in year-three of this programme is on equity and ensuring models of service delivery are effective for all of our communities.

Tertiary Services Strategy - Delivering quality and clinically sustainable specialised care at Wellington Hospital requires building on existing clinical care arrangements. CCDHB is committed to improving regional care arrangements with our partner DHBs in the Central Region. A separate tertiary services strategy will be developed in 2019/20.

Mental Health and Addictions - CCDHB has a comprehensive programme of work to improve mental health and wellbeing and ensure we effectively implement the recommendations of the Mental Health Inquiry.

Health and safety

At CCDHB the health and safety of all workers, patients and all others utilising our facilities and services is paramount.

CDHB is committed to the development and maintenance of a positive health and safety culture, providing safe and secure facilities, having well trained, instructed and supervised workers, to ensure their and others safety.

Workforce

CCDHB strives to be a good employer and is aware of our legal and ethical obligations. We are aware that good employment practices are critical to attracting and retaining top health professionals and support staff who embody our values and culture in their practice and contribution to organisational life.

We recognise the aims, aspirations, cultural differences and employment requirements of Māori, Pacific Peoples, people from other ethnic or minority groups and those experiencing disabilities. We will prioritise a range of strategies with a particular focus on the recruitment and retention of Māori and Pacific staff. We will provide opportunities for individual employee development and career advancement, including cultural competency training.

CCDHB's People Strategy has the following principles:

PART 3: How we manage our business

Organisational performance management

CCDHB's performance is assessed on both financial and non-financial measures. Internally, performance is presented to the Executive Leadership Team (ELT), Clinical Council, Māori Partnership Board (MPB), Sub-Regional Pacific Strategic Health Group (SRPSHG), Sub-Regional Disability Advisory Group (SRDAG), the Health System Committee (HSC), 3DHB Disability Support Advisory Group (DSAC), Finance and Risk Assessment Committee (FRAC), and the Board. CCDHB reports to the Ministry on a quarterly, six-monthly or annual basis.

Funding and financial management

CCDHB's key financial indicators are spend against budget and budget against deficit. These are assessed against and reported through CCDHB's performance management process to the ELT and the Finance and Risk Assessment Committee (FRAC).

Key high-level figures/assumptions to be included when available

Investment and asset management

CCDHB is committed to a sustainability pathway that emphasises cross-organisation and system governance of financial and service delivery performance. It is supported by an Investment Approach that considers all investments across the health system, and determines their impact on the optimisation of the system. Part of the work programme is the development of whole of system investment plans, capital investment, infrastructure development and service investment strategies as reflected in the Long Term Investment Plan (LTIP) currently being updated.

CCDHB and Hutt Valley DHB have entered into a joint sub-regional clinical planning process. CCDHB will deliver an LTIP by July 2019 to meet Treasury requirements, with a joint LTIP (CCDHB and HVDHB) to be delivered by July 2020. The joint hospital network planning work programme is an input into CCDHB's LTIP for 2019, and will inform the joint LTIP in 2020. The LTIP will inform 'what' investments are needed to implement the strategic vision and associated strategies of CCDHB and HVDHB. These investments have to deliver on ensuring the safety and quality of our services, the impact on equity and outcomes amongst our populations and the sustainability of our health system.

Shared service arrangements and ownership interests

CCDHB has a part ownership interest in Central Region Technical Advisory Service (CRTAS), the Regional Health Information Partnership (RHIP), Allied Linen Services Ltd (ALSL) and New Zealand Health Partnerships (NZHP). The DHB does not intend to acquire interests in companies, trusts or partnerships.

Risk management

The CCDHB Risk Management Framework provides principles and process to ensure CCDHB is operating in accordance with the 2008 Health and Disability Service Standards, the AS/NZS ISO 31000:2009 standard for Risk Management and the Health and Safety at Work Act 2015 and associated regulations.

Health and Safety (H&S) is a particular focus across the DHB. Accountability for H&S is the responsibility of every manager and employee. Systems for managing H&S risk are deployed across the organisation.

The Finance, Risk & Audit Committee (FRAC) of the CCDHB Board has oversight of internal controls (including risk management) and is focussed on financial and contractual matters of significance.

The DHB has established external and internal Audit functions which provide independent professional assessments of key risks, the accuracy and integrity of CCDHB financial reports and the adequacy of internal controls. We are progressing improvement plans for the Treasury Investor Confidence Rating.

Quality assurance and improvement

Clinical Governance is the system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks, and fostering an environment of excellence in care for consumers/patients/residents.1 A shared commitment is required from all clinical and non-clinical staff to provide high quality and safe care, and organisational support from board to the ward.

[1] National model Clinical Governance Framework. Australian Commission on safety and Quality in Healthcare. Nov 2017

The CCDHB Clinical Governance Framework has recently been updated. This framework aims to bring individual elements together to strengthen and sustain ongoing improvement around the six dimensions of quality; safe, timely, equitable, effective, efficient and people centred (STEEEP).

CCDHB's clinical governance framework has four components2. These are:

- consumer engagement and participation
- clinical effectiveness
- quality improvement and patient safety
- engaged effective workforce

They provide a structure to implement strategies to improve and enhance the quality of care.

[2] Clinical Governance Guidance for Health and Disability Providers. Health Quality and safety Commission. Feb 2017

PART 4: How we measure our performance
Statement of Performance Expectations including Financial Performance

This section must be tabled in Parliament. All components of this section are mandatory (section 149C of the Crown Entities Act 2004)

As both the major funder and provider of health services in the Capital & Coast DHB region, the decisions we make and the way in which we deliver services have a significant impact on the health and wellbeing our population and communities.

Having a limited resource pool and growing demand for health services, we are strongly motivated to ensure we are delivering the most effective and efficient services possible.

On an annual basis, we evaluate our performance by providing a forecast of the services we plan to deliver and the standards we expect to meet. The results are then presented in our Annual Report at year end.

The following section presents Capital & Coast DHB's Statement of Performance Expectations for 2019/20.

Interpreting Our Performance

As it would be overwhelming to measure every service delivered, the services we deliver have been grouped into four services classes. These are common to all DHBs and reflect the types of services provided across the full health and wellbeing continuum:

- Prevention services
- Early detection and management services
- Intensive assessment and treatment services
- Rehabilitation and support services

Under each service class, we have identified a mix of service measures that we believe are important to our community and stakeholders, and provide a fair indication of how well the DHB is performing.

Setting Standards

In setting performance standards, we consider the changing demography of our population, areas of increasing demand and the assumption that resources and funding growth will be limited.

Our performance standards reflect the outcomes the DHB is wanting to achieve:

- Strengthen our communities and families so they can be well;
- It is easier for people to manage their own health needs;
- We have equal health outcomes for all communities;
- Long term health conditions and complexity occur later in life and for shorter duration; and,
- Expert specialist services are available to improve health gain.

We also seek to improve the experience of people in our care and public confidence in our health system.

While targeted intervention can reduce service demand in some areas, there will always be some demand the DHB cannot influence, such as demand for maternity services and palliative care services. It is not appropriate to set targets for these services, however they are an important part of the picture of health need and service delivery in our region.

In health, the number of people who receive a service can be less important than whether enough of the right people received the service, or whether the service was delivered at the right time. To ensure a balanced, well rounded picture, the mix of measures identified in our Statement of Performance Expectations address four key aspects of service performance:

Access	How well are people accessing services, is access equitable, are we engaging with all of our population?
Timeliness	How long are people waiting to be seen or treated, are we meeting expectations?
Quality	How effective is the service, are we delivering the desired health outcomes?
Experience	How satisfied are people with the service they receive, do they have confidence in us?

With a growing diversity and persistent inequities across our population, achieving equity of outcomes is an overarching priority for the DHB. All of our targets are universal, with the aim of reducing disparities between population groups.

Where does the money go?

In 2019/20, the DHB will receive approximately $*XXX* billion dollars with which to purchase and provide the services required to meet the needs of our population.

The table below represents a summary of our anticipated financial split for 2019/20 by service class.

	2019/20
Revenue	**Total $'000**
Prevention	
Early detection & management	
Intensive assessment & treatment	
Rehabilitation & support	
Total Revenue - $'000	
Expenditure	
Prevention	
Early detection & management	
Intensive assessment & treatment	
Rehabilitation & support	
Total Expenditure - $'000	
Surplus/(Deficit) - $'000	

Prevention Services

Why are these services significant?

Prevention services are publically funded services that promote and protect the health of the whole population or targeted populations. These services seek to address individual behaviours by targeting physical and social environments and norms that can influence and support people to make healthier choices and are, in this way, distinct from treatment services.

The four leading long-term conditions; cancer, cardiovascular disease, diabetes, and respiratory disease—make up 80% of the disease burden for our population. By supporting people to make healthier choices we can reduce the risk factors that contribute to these conditions. High-need population groups are also more likely to engage in risky behaviours, or live in environments less conducive to making healthier choices. Prevention services are therefore one of our foremost opportunities to target improvements in the health of high-need populations and reduce inequities in health status and health outcomes. Prevention services are designed to spread consistent messages to a large number of people and can therefore be a very cost-effective health intervention.

How will we demonstrate our success?

Immunisation Services				
These services reduce the transmission and impact of vaccine-preventable diseases, both routinely and in response to specific risk. Engagement in programmes and high coverage rates are indicative of a well-coordinated, successful service	Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
% of eight month olds fully vaccinated	Māori	96%	86%	≥95%
	Pacific	90%	94%	
	Other	95%	96%	
	Total	93%	94%	
% of two year olds fully immunised	Māori	93%	90%	≥95%
	Pacific	98%	94%	
	Other	96%	94%	
	Total	96%	94%	
% of five year olds fully immunised	Māori	88%	84%	≥95%
	Pacific	96%	91%	
	Other	92%	91%	
	Total	92%	89%	
% of Year 7 children provided Boostrix vaccination in schools	Māori	80%	80%	≥70%
	Pacific	82%	82%	
	Other	*TBC*	*TBC*	
	Total	68%	68%	
% of Year 8 girls vaccinated against HPV in schools	Māori	64%	64%	≥75%
	Pacific	75%	75%	
	Other	*TBC*	*TBC*	
	Total	64%	64%	

Health Promotion Services				
These services inform people about risk, and support them to make healthy choices. Success is evident through increased engagement, which leads over time to more positive behaviour choices and a healthier population.	Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
% of infants fully or exclusively breastfed at 3 months	Māori	52%	50%	≥60%
	Pacific	44%	54%	
	Other	68%	69%	
	Total	63%	65%	
% of four year olds identified as obese at their B4 School Check referred for family based nutrition, activity and lifestyle intervention	Māori	96%	97%	≥95%
	Pacific	97%	97%	
	Other	91%	100%	
	Total	95%	95%	
% of PHO-enrolled patients who have quit smoking in the last 12 months	Māori	9%	8%	*TBC*
	Pacific	9%	8%	
	Other	15%	14%	
	Total	13%	12%	

Population-based Screening Services				
These services help to identify people at risk of developing a long-term condition and support earlier intervention and treatment. Success is reflected by engagement in programmes and high coverage rates across the population.	Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
% of eligible children receiving a B4 School Check	Māori	82%	84%	≥90%
	Pacific	81%	90%	
	Other	94%	92%	
	Total	90%	90%	
% of youth who have a HEEADSS assessment in DHB funded school based health services	Māori	*TBC*	*TBC*	≥95%

	Pacific	*TBC*	*TBC*	
	Other	*TBC*	*TBC*	
	Total	*TBC*	*TBC*	
% of eligible women (25-69 years old) having cervical screening in the last 3 years	Māori	61%	63%	≥80%
	Pacific	68%	66%	
	Other	79%	79%	
	Total	77%	77%	
% of eligible women (50-69 years old) having breast cancer screening in the last 2 years	Māori	67%	68%	≥70%
	Pacific	70%	69%	
	Other	73%	72%	
	Total	73%	72%	

Public Health Services				
These services address aspects of the physical, social and built environment in order to protect health and improve health outcomes.	Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
Number of disease notifications investigated	Māori	109	109	*TBC*
	Pacific	92	92	*TBC*
	Other	*TBC*	*TBC*	*TBC*
	Total	1,291	1,291	*TBC*
Number of new referrals to Public Health Nurses in primary/intermediate schools	Māori	756	756	*TBC*
	Pacific	707	707	*TBC*
	Other	*TBC*	*TBC*	*TBC*
	Total	1,887	1,887	*TBC*
Number of submissions providing strategic public health input and expert advice to inform policy and public health programming in the sub-region	Total	*TBC*	*TBC*	*TBC*
Number of environmental health investigations	Total	727	727	*TBC*
Number of premises visited for alcohol controlled purchase operations	Total	70	70	*TBC*
Number of premises visited for tobacco controlled purchase operations	Total	17	17	*TBC*
Number of assessments related to requirements of the Drinking-Water Standards	Total	*TBC*	*TBC*	*TBC*

Early Detection and Management Services

Why are these services significant?

The New Zealand health system is experiencing an increasing prevalence of long-term conditions; so-called because once diagnosed, people usually have them for the rest of their lives. Some population groups suffer from these conditions more than others and prevalence increases with age.

Our Health System Plan is designed to support people and whānau-le wellbeing with the system organised around two elements: People and Place. For most people, their general practice team is their first point of contact with health services and is vital as a point of continuity in improving the management of care for people with long-term conditions. By promoting regular engagement with primary and community services we are better able to support people to stay well, identify issues earlier, and reduce complications, acute illness and unnecessary hospital admissions. Our approach will be particularly effective where people have multiple conditions requiring ongoing intervention or support.

How will we demonstrate our success?

Oral Health Services				
These services help people maintain healthy teeth and gums and support lifelong health and wellbeing. High levels of enrolment and timely access to treatment are indicative of an accessible and efficient service.	Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
% of children under 5 years enrolled in DHB-funded dental services	Māori	67%	*TBC*	≥95%
	Pacific	80%	*TBC*	
	Other	103%	*TBC*	
	Total	94%	*TBC*	
% of children caries free at 5 years	Māori	51%	*TBC*	≥69%
	Pacific	39%	*TBC*	
	Other	77%	*TBC*	
	Total	70%	*TBC*	
Ratio of mean decayed, missing, filled teeth (DMFT) at year 8	Māori	0.79	*TBC*	≤0.49
	Pacific	0.97	*TBC*	
	Other	0.41	*TBC*	
	Total	0.51	*TBC*	
% of children (0-12) enrolled in DHB oral health services examined according to planned recall	Māori	14%	*TBC*	≤10%
	Pacific	14%	*TBC*	
	Other	12%	*TBC*	
	Total	12%	*TBC*	
% of adolescents accessing DHB-funded dental services	Māori	*TBC*	*TBC*	≥85%
	Pacific	*TBC*	*TBC*	
	Other	*TBC*	*TBC*	
	Total	80%	*TBC*	

Primary Care Services				
These services support people to maintain and manage their health and wellbeing and avoid unnecessary hospital admissions. High levels of enrolment and engagement with general practice are indicative of an accessible and responsive service.	Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
% of the DHB-domiciled population that is enrolled in a PHO	Māori	86%	85%	≥94%
	Pacific	*TBC*	*TBC*	
	Other	*TBC*	*TBC*	
	Total	*TBC*	*TBC*	
% of the eligible population assessed for CVD risk in the last five (ten) years	Māori	83%	82%	≥90%
	Pacific	85%	83%	
	Other	83%	82%	
	Total	83%	82%	
% of people with diabetes aged 15-74 years enrolled with a PHO who latest HbA1c in the last 12 months was <=64 mmol/mol	Māori	61%	61%	≥70%
	Pacific	51%	56%	
	Other	70%	69%	
	Total	66%	66%	
Avoidable hospital admission rate for children aged 0-4 (per 100,000 people)	Māori	7,330	8,143	*TBC*
	Pacific	10,100	10,297	
	Other	5,039	5,700	
	Total	6,038	6,685	
Avoidable hospital admission rate for adults aged 45-64 (per 100,000 people)	Māori	6,163	6,070	*TBC*
	Pacific	6,636	7,893	
	Other	2,387	2,537	
	Total	2,943	3,140	
Primary Care Patient Experience scores	Communication	8.5	8.4	*TBC*

	Partnership	7.6	7.5	
	Physical & Emotional Needs	7.8	7.8	
	Coordination	8.4	8.5	

Pharmacy Services				
These are services which a health professional uses to help diagnose or monitor a health condition. While largely demand driven, timely access to services enables improved clinical decision-making and reduces unnecessary delays in treatment, and is therefore indicative of a successful service.	Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
% of the DHB-domiciled population that were dispensed at least one prescription item	Māori	*TBC*	*TBC*	*TBC*
	Pacific	*TBC*	*TBC*	
	Other	*TBC*	*TBC*	
	Total	78%	*TBC*	
Number of people registered with a Long Term Conditions programme in a pharmacy	Māori	*TBC*	*TBC*	*TBC*
	Pacific	*TBC*	*TBC*	
	Other	*TBC*	*TBC*	
	Total	6,823	*TBC*	
Number of people participating in a Community Pharmacy Anticoagulant Management service in a pharmacy	Māori	*TBC*	*TBC*	*TBC*
	Pacific	*TBC*	*TBC*	
	Other	*TBC*	*TBC*	
	Total	225	*TBC*	
% of people receiving five or more long-term medications	Māori	*TBC*	*TBC*	*TBC*
	Pacific	*TBC*	*TBC*	
	Other	*TBC*	*TBC*	
	Total	*TBC*	*TBC*	

Intensive Assessment and Treatment Services

Why are these services significant?

Intensive assessment and treatment services are more complex services provided by specialists and health professionals working closely together. They are usually provided in hospital settings, which enables the co-location of expertise and equipment. A proportion of these services are delivered in response to acute events; others are planned, and access is determined by clinical triage, capacity, treatment thresholds and national service coverage agreements.

Timely access to intensive assessment and treatment can significantly improve people's quality of life through corrective action and is crucial to improving survival rates for complex illness such as cancer. Responsive services and timely access to treatment also enable people to establish more stable lives, and result in improved confidence in the health system.

As a provider of specialist services, the DHB is committed to ensuring the quality of its service provision. Adverse events and delays in treatment, as well as causing harm to patients, drive unnecessary costs. Improved processes will support patient safety, reduce the number of events causing injury or harm, and improve health outcomes for our population.

How will we demonstrate our success?

Maternity Services				
These services are provided to women and their families through pre-conception, pregnancy, childbirth and the early months of a baby's life. Demand driven, service utilisation is monitored to ensure services are accessible and responsive to need.	Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
% of maternity deliveries made in Primary Birthing Units	Māori	21%	*TBC*	≥9%
	Pacific	22%	*TBC*	
	Other	8%	*TBC*	
	Total	11%	11%	

Acute and Urgent Services				
These are services delivered in response to accidents or illnesses that have an abrupt onset or progress rapidly. While largely demand driven, not all acute events require hospital treatment. Because early intervention can reduce the impact of the event, multiple options and shorter waiting times are indicative of a responsive system.	Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
Number of acute demand packages of care provided in community settings	Total	*TBC*	*TBC*	*TBC*
Number of extended hours	Total	*TBC*	*TBC*	*TBC*
Age-standardised ED presentation rate per 1,000 population	Māori	196	198	*TBC*
	Pacific	250	243	
	Other	158	152	
	Total	166	161	
% of patients admitted, discharged or transferred from ED within 6 hours	Māori	89%	86%	≥95%
	Pacific	90%	85%	
	Other	90%	87%	
	Total	90%	87%	
Standardised inpatient average length of stay (ALOS) in days	Total	2.24	2.25	*TBC*

Elective & Arranged Services				
These are medical and surgical services provided for people who do not need immediate hospital treatment, where their assessment or treatment is booked or arranged. Maintaining access while reducing waiting times is indicative of an efficient service.	Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
Number of surgical elective discharges	Māori	11,341	*TBC*	*TBC*
	Pacific		*TBC*	
	Other		*TBC*	
	Total		*TBC*	
Standardised inpatient average length of stay (ALOS) in days, Elective	Total	1.55	1.56	*TBC*
% of patients given a commitment to treatment but not treated within four months	Total	*TBC*	*TBC*	0%
% of "DNA" (did not attend) appointments for outpatient appointments	Māori	15%	*TBC*	*TBC*
	Pacific	17%	*TBC*	
	Other	*TBC*	*TBC*	
	Total	8%	*TBC*	
% of patients waiting longer than four months for their first specialist assessment	Total	*TBC*	*TBC*	0%
% of patients with a high suspicion of cancer and a need to be seen within two weeks that received their first cancer treatment (or other management) within 62 days of being referred	Māori	*TBC*	*TBC*	≥90%
	Pacific	*TBC*	*TBC*	
	Other	*TBC*	*TBC*	
	Total	90%	88%	

Mental health, addictions and wellbeing services					
These are services for those most severely affected by mental illness and/or addictions who require specialist intervention and treatment. Reducing waiting times, while meeting an increasing demand for services, is indicative of a responsive and efficient service.		Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
% of population accessing community mental health services		Māori	*TBC*	*TBC*	*TBC*
		Pacific	*TBC*	*TBC*	
		Other	*TBC*	*TBC*	
		Total	*TBC*	*TBC*	
% of population accessing secondary mental health services		Māori	*TBC*	*TBC*	*TBC*
		Pacific	*TBC*	*TBC*	
		Other	*TBC*	*TBC*	
		Total	*TBC*	*TBC*	
% of patients 0-19 referred to non-urgent child & adolescent services that were seen within eight weeks:	Mental health services	Māori	*TBC*	*TBC*	≥95%
		Pacific	*TBC*	*TBC*	
		Other	*TBC*	*TBC*	
		Total	89%	92%	
	Addiction services	Māori	*TBC*	*TBC*	
		Pacific	*TBC*	*TBC*	
		Other	*TBC*	*TBC*	
		Total	92%	98%	
% of people admitted to an acute mental health inpatient service that were seen by mental health community team:	7 days prior to the day of admission	Māori	*TBC*	*TBC*	≥75%
		Pacific	*TBC*	*TBC*	
		Other	*TBC*	*TBC*	
		Total	62%	*TBC*	
	7 days following the day of discharge	Māori	*TBC*	*TBC*	≥90%
		Pacific	*TBC*	*TBC*	
		Other	*TBC*	*TBC*	
		Total	73%	*TBC*	
Rate of Māori under the Mental Health Act: Section 29 community treatment orders		Māori	520	482	*TBC*
		Non- Māori	139	139	*TBC*

Quality, safety and patient experience				
These quality and patient safety measures are national markers championed and monitored by the NZ Health Quality & Safety Commission. High compliance levels indicate quality processes and strong clinical engagement.	Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
Rate of identified opioid medication errors causing harm, per 1,000 bed days	Māori	*TBC*	*TBC*	≤5
	Pacific	*TBC*	*TBC*	
	Other	*TBC*	*TBC*	
	Total	*TBC*	*TBC*	
Rate of Hospital Acquired Pressure Injuries, per 1,000 bed days	Māori	*TBC*	*TBC*	≤0.3
	Pacific	*TBC*	*TBC*	
	Other	*TBC*	*TBC*	
	Total	0.2	*TBC*	
Rate of inpatient falls causing harm per 1,000 bed days	Māori	*TBC*	*TBC*	≤0.2
	Pacific	*TBC*	*TBC*	
	Other	*TBC*	*TBC*	
	Total	0.5	*TBC*	
Number of in-hospital cardiopulmonary arrests in adult inpatient wards	Māori	*TBC*	*TBC*	35
	Pacific	*TBC*	*TBC*	
	Other	*TBC*	*TBC*	
	Total	*TBC*	*TBC*	
The weighted average score in the Inpatient Experience Survey by domain	Communication	8.5	8.5	8.4 - 8.6
	Partnership	8.7	8.5	
	Physical & Emotional Needs	8.7	8.6	
	Coordination	8.4	8.1	

Rehabilitation and Support Services

Why are these services significant?

Rehabilitation and support services provide people with the assistance they need to live safely and independently in their own homes or regain functional ability after a health related event. These services are considered to provide people with a much higher quality of life as a result of people being able to stay active and positively connected to their communities. This is evidenced by less dependence on hospital and residential services and a reduction in acute illness, crisis or deterioration leading to acute admission or readmission into our hospitals.

Even when returning to full health is not possible, timely access to responsive support services enables people to maximise their independence. In preventing deterioration, acute illness or crisis, these services have a major impact on the sustainability of our health system by reducing acute demand, unnecessary ED presentations and the need for more complex interventions. These services also support patient flow by enabling people to go home from hospital earlier.

Support services also include palliative care for people who have end-of-life conditions. It is important that they and their families are appropriately supported, so that the person is able to live comfortably and have their needs met in a holistic and respectful way, without undue pain and suffering.

How will we demonstrate our success?

Disability Support Services				
These services support people with disabilities to find solutions to support their engagement in health services. Success is measured by responsive services that support people with disabilities and consumer-clinician partnership.	Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
Number of CCDHB Disability Forums	Total	0	*TBC*	1
Number of sub-regional Disability Forums	Total	0	*TBC*	1
% of hospital staff that have completed the Disability Responsiveness eLearning Module	Total	18%	*TBC*	*TBC*
Number of people with a Disability Alert	Total	8,357	*TBC*	*TBC*
% of the Disability Alert Population who are Māori or Pacific	Māori	*TBC*	*TBC*	*TBC*
	Pacific	*TBC*	*TBC*	*TBC*
	Other	*TBC*	*TBC*	*TBC*
	Total	*TBC*	*TBC*	*TBC*

Home-based and Community Support Services				
These services aim to restore or maximise people's health or functional ability, following a health-related event such as a fall, heart attack or stroke. Largely demand-driven, success is measured through appropriate service referral following an event.	Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
% of people 65+ receiving DHB-funded HOP support who are being supported to live at home	Māori	*TBC*	*TBC*	≥63%
	Pacific	*TBC*	*TBC*	
	Other	*TBC*	*TBC*	
	Total	62%	*TBC*	
% of people 65+ who have received long term home support services in the last three months who have had a comprehensive clinical (interRAI) assessment and a completed care plan	Māori	100%	100%	≥98%
	Pacific	100%	100%	
	Other	100%	100%	
	Total	100%	100%	
% of people who have had an interRAI assessment with an Advance Care Plan	Total	4.1%	4.2%	*TBC*
Rate of hip (neck of femur) fractures due to a fall per 1,000 people 50+	Māori	*TBC*	0.6	*TBC*
	Pacific	*TBC*	--	*TBC*
	Other	*TBC*	1.8	*TBC*
	Total	2.6	2.5	*TBC*
Number of older people accessing respite services	Total	*TBC*	*TBC*	*TBC*

Aged Residential Care Services				
With an ageing population, demand for aged related care (ARC) is expected to increase, but a reduction in demand for lower-level residential care is indicative of more people being successfully supported for longer in their own homes. The DHB subsidises ARC for people who meet the national thresholds for care.	Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
Rate of ED presentations from aged residential care facilities that are not admitted per 1,000 population in aged residential care	Māori	*TBC*	*TBC*	*TBC*
	Pacific			
	Other			
	Total			
% of residential care providers meeting four year certification standards	Total	53%	*TBC*	*TBC*

Financial Performance

(Placeholder for Financial Performance Tables – pending release of the Funding Envelope)

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**HEALTH SYSTEM COMMITTEE DISCUSSION**
	Date 15 May 2019

Prepared by	Carey Virtue, Executive Director Medicine, Cancer & Community Delwyn Hunter, Executive Director Surgery Women and Children
Endorsed by	Julie Patterson, Interim Chief Executive Officer
Subject	**HOSPITAL OCCUPANCY AND ACUTE DEMAND**

RECOMMENDATIONS

It is **recommended** that the Committee:

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

(b) **Notes** 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) **Notes** 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.

APPENDIX

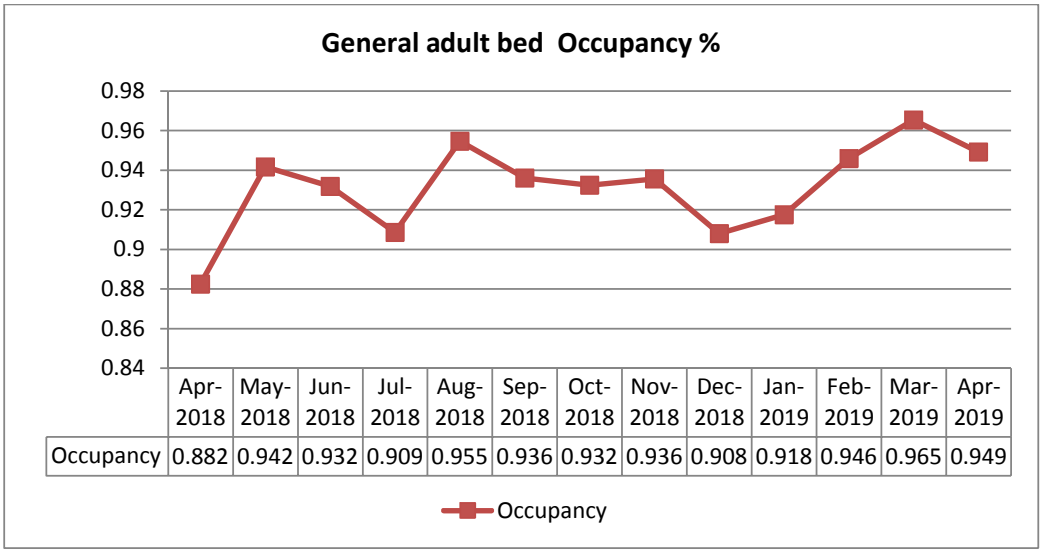
1. MOH report on Shorter Stays in Emergency Department.

1. INTRODUCTION

The purpose of this paper is to highlight for the Health System Committee (HSC) the current inpatient occupancy issues at CCDHB, the impact of this on patient services, and the work that is underway to manage this in the short and longer term. Attached to the paper is a report by the MoH following a visit to CCDHB to review our performance and provide advice on areas for further improvement (**Appendix 1**).

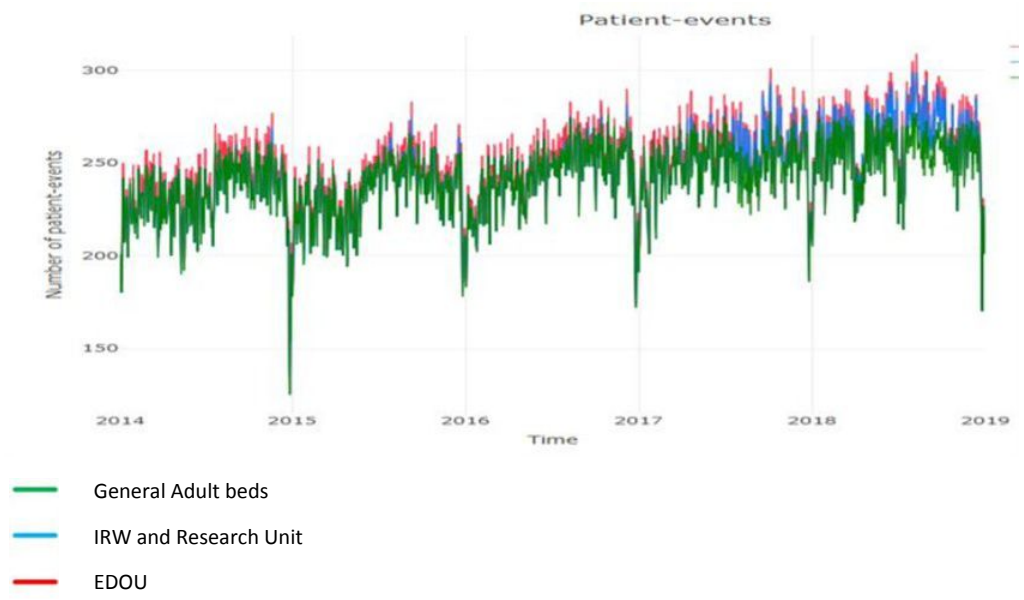
2. BACKGROUND

A combination of rising demand for services and constrained bed capacity continues to have an impact on safe hospital flow. Hospital occupancy has been rising within the adult bed cohort at Wellington Regional Hospital (WRH); average occupancy is consistently over 92% placing real constraints on patient movement.



	Apr-2018	May-2018	Jun-2018	Jul-2018	Aug-2018	Sep-2018	Oct-2018	Nov-2018	Dec-2018	Jan-2019	Feb-2019	Mar-2019	Apr-2019
Occupancy	0.882	0.942	0.932	0.909	0.955	0.936	0.932	0.936	0.908	0.918	0.946	0.965	0.949

Included within the occupancy figures there are up to 16 beds in use that are overflow beds and not designed for use as inpatient beds. The graph below demonstrates the increasing use of beds that are not designed or appropriate for inpatient use. Green represents utilisation of our "general adult beds", red represents inpatient use of beds in the Emergency Department Observation Unit (EDOU), and blue represents use of beds in the research unit and overnight use of the interventional day ward.

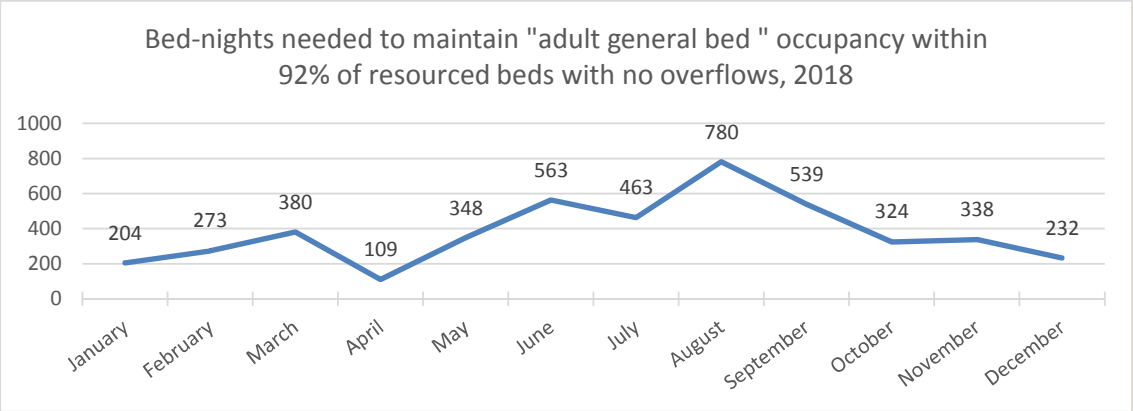


The volume of acute admissions to "general adult wards" have been rising for the last two years whilst the average length of stay remains relatively stable resulting in higher occupancy and increasing bed block. The unavailability of hospital beds has a direct impact on how long patients have to wait in ED before being admitted to hospital. The occupancy reported is midnight census and occupancy is even higher during the day.

In 2018, most months saw the number of general adult inpatients [1] exceed 92% of resourced "adult beds" on most nights. In August and September of 2018, this happened every night.

[1] Includes general adult beds in Wellington regional beds and excludes MHAIDS, NICU , Maternity and Kenepuru

To have accommodated all these general adult inpatients in resourced and appropriate beds at an occupancy no greater than 92% would have required between 109 and 780 additional 'bed nights' per month or between 3.6 and 25.6 additional beds.



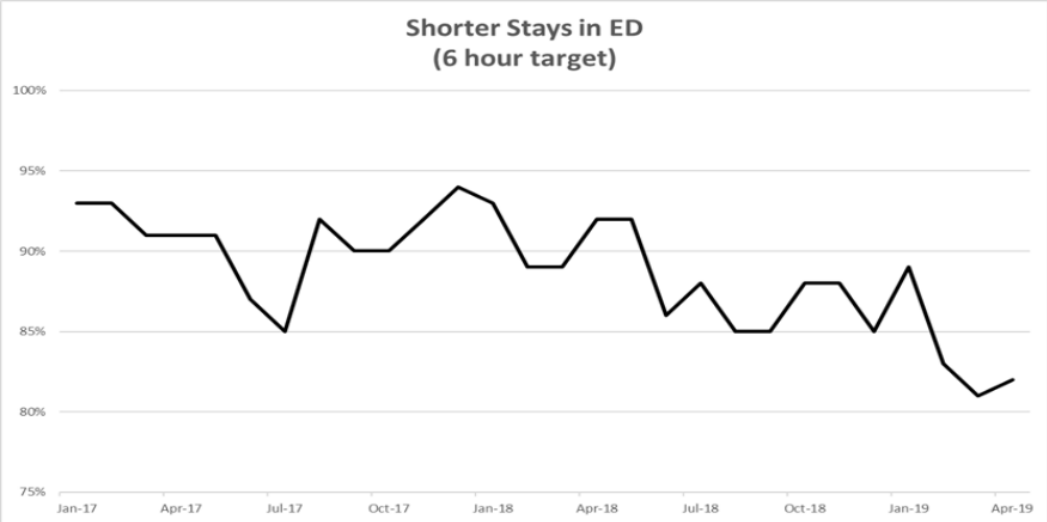
3. QUALITY AND SAFETY IMPACT

Despite improvements in length of stay over time and success in implementing strategies to manage acute demand, the overall demand for beds including elective and acute services in Wellington during peak winter periods exceeds available capacity and creates patient and staff safety risks.

High levels of occupancy can make it difficult to manage patient flow through the hospital, with consequences for operational performance, elective surgical cancellations and delays in admission from ED. There is ongoing debate about the optimum level of bed occupancy. Some NHS providers have argued that occupancy should not exceed 85 per cent. This, however, is not realistic within the New Zealand context and most would agree that we should avoid occupancy exceeding 92 per cent in order to maintain patient flow.

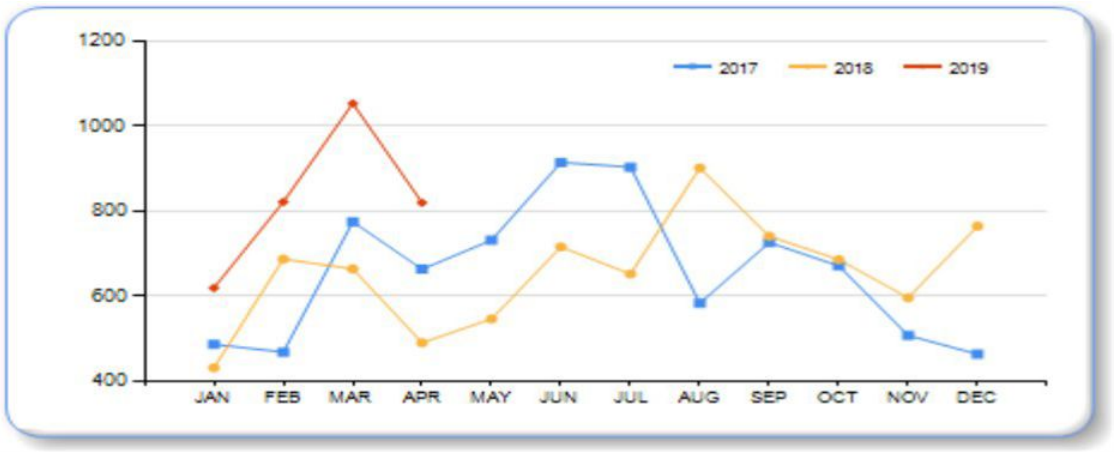
The NHS Kings fund have identified that hospitals with average bed-occupancy levels above 85 per cent can expect to have regular bed shortages, periodic bed crises and increased numbers of health care-acquired infections. A relationship between high bed-occupancy levels and increased infection rates has also been identified. Furthermore, routinely exceeding bed occupancy rates of 92 per cent can make it more difficult to contain flu outbreaks or vomiting bugs such as norovirus.

Increasing presentations, higher acuity, very high hospital occupancy and longer stays in ED have led to a steady decline in CCDHB performance against the Shorter Stays in ED (SSIED) target (95% patients out of ED within 6 hours) with compliance reaching the very low levels of 2011. In March 1,100 patients waited > 6 hours in ED (35 patients per day).



Because of high occupancy and minimal acute flow, admitted patients remain in ED for long periods, often blocking cubicles and preventing the assessment of new ED patients. Due to the limited space in ED, patients are moved to corridors to empty some cubicles for assessment. March has seen the highest number of patient ending up in a corridor in recent history. Corridors are not acceptable as patient areas as there is no privacy, call bell or support utilities.

Numbers of patients cared for in corridors



This graph highlights by month the numbers of patients cared for in corridors. March is a good predictor for winter activity. This March was the highest on record. Despite many community and hospital strategies seeking to reduce demand on ED, the demand on the Hospital continues to increase.

4. CCDHB BED CAPACITY

The current shortfall of general adult beds is around 16-24 beds and there is a projected challenge in the next few years of 12-24 more if we are to provide beds for decanting for the copper pipe replacement.

It was recognised when the Wellington Regional Hospital (WRH) was commissioned that the bed numbers would not be adequate for future need. With the opening of the Wellington Regional Hospital (WRH),

there were 306 resourced adult inpatient beds. In 2012, a capacity assessment carried out by John Bissett[2] indicated that WRH had a shortfall of around 29 physical beds. At this time, 12 "flexi beds" were resourced to provide additional capacity and were utilised by general medicine.

In 2013 in response to an identified need for more adult bed space at WRH, an additional 14 beds were created on the Wellington campus in the north end wards. At the time it was identified there was a requirement for a further increase within 18 months. This was a short-term strategy to enable better management of local and regional demand, to support service improvement, enable the development of surgical and medical assessment units as well as the relocation of high dependency facilities and to better support acute patient flow from ED.

At that time there was agreement to establish a Surgical Assessment and Planning Unit (SAPU) and the flexi pod of 12 beds was transferred to surgical services to establish the unit near the surgical wards.

A programme of service improvement was also commenced to reduce demand on inpatient beds, which did deliver significant reductions in bed days. While this had significant benefits for flow, despite ongoing improvements in length of stay, occupancy has continued to increase.

In 2016 Renal offices and allied health gym spaces were converted to a new ward (6 East) adding 12 new beds for general medical services.

Over the last two years, the organisation has been compelled to repurpose overflow beds in order to manage the ongoing increase in demand. This includes 8 beds in IRW (an internal day ward space within Radiology and 8 beds in the clinical trials unit (within the WSB block remote from other clinical areas), both of which are not ideal or ongoing or efficient inpatient bed use.

The DHB has also been required to utilise the ED observation unit for inpatient overflow (restricting the capacity for ED) and increase occupancy to 6 beds in many of the older adult wards over winter at Kenepuru.

Frequently treatment rooms on the inpatient wards are used as additional bed spaces. This comes at the cost of losing space created to provide treatment to patients in privacy, which now means procedures are undertaken in multi-bedded cubicles if the treatment room is occupied.

A recent analysis of in General Medicine activity has shown that length of stay (LOS) for patients less than 10 days remains at historically low levels, but overall acuity is rising and the bed days utilised by the complex (greater than 10 day stay) patients has almost doubled. Whilst these patients can be medically complex, there is a growing cohort of socially complex patients that present significant barriers to discharge.

We are now at the point where there are no further bed spaces available to manage our increasing demand. There is little ability to expand within the current ward configuration. Any further development offering isolated beds on an ad hoc basis and in multiple locations would lead to further operational inefficiencies. Medium to long term planning is now underway to look at realistic options for future growth including expanding the Interventional recovery ward (IRW), developing spaces within Ward Support Block (WSB) and development of an acute assessment unit at the front door.

In addition, with the impending replacement of copper pipes in the regional hospital it has been signalled that a further 12-24 bed may be required in order to support decanting of clinical areas.

[2] Australasian Hospital Capacity Planner Consultant

Master Site planning, initiated in 2017, is now incorporated as part of the Long Term Investment Programme (LTIP). With the exception of developing IRW, no other options will provide additional beds within the next 12 months. This project is being considered as part of the capex prioritisation process for 2019 / 2020

5. STRATEGIES TO MANAGE CAPACITY GOING FORWARD

The Acute Demand and Bed Capacity Steering group has been established to provide a whole of system response to acute demand growth. The group is led by the executive leadership team and includes cross sector leaders from the hospital and primary care, with the CCDHB professional heads taking a key lead.

This programme builds on previous acute flow work in the DHB and is specifically targeting initiatives that will manage capacity through reducing the presentations to the emergency department, managing the flow through the hospital and supporting early discharge back into the community.

To date analysis, data modelling and clinical expertise has identified areas for targeted initiatives. The focus is on solutions that can support the capacity issues for this winter. Based on the analysis completed and clinical input the areas of focus for the whole of system acute flow programme include:

- early supported discharge through new models of care of allied health
- community acute response service through primary care and acute nursing
- supporting increased ward resourcing to optimise flow in the emergency department observation unit
- focus on older people who present to the hospital with earlier assessment
- supporting children to flow out of the Emergency Department to more appropriate care setting
- supporting increase capacity for discharge coordination and improvements in the discharge processes.

There is alignment with this whole of system acute demand programme of work with investment planning for 2019/20 and with the LTIP.

The investment planning process had already highlighted initiatives that would deliver improved services close to the door of the hospital, and support further care in the community and improve flow through the hospital system. The proposals related to these investments have been considered through a leadership group with representation from across the DHB and community. These initiatives, where the impact analysis identifies clear benefits, are being pulled through into the whole of system acute flow programme for more rapid implementation with support from the steering group and ELT. The LTIP process will provide the DHB with an investment road map to ensure there is sufficient hospital capacity to deal with demand over the next ten years. This take into account the changes to the system described within the Health System Plan 2030.

The whole of system acute flow programme is developing a monitoring framework to provide regular and timely oversight of the capacity pressure on the hospital. As initiatives are implemented active, monitoring of the impact to ensure that benefits are maximised will be incorporated as initiatives go live.

It should be noted, however, that despite these initiatives there will be a significant shortfall of beds if we are to replace the beds in EDOU, IRW and the Research Unit with appropriate general adult beds, make a provision of 12-24 beds for decanting for the copper pipe replacement, and achieve overall occupancy below 92%. This planning will be included as part of the LTIP process.

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2 May 2019

Julie Patterson
Acting Chief Executive
Capital & Coast District Health Board
Wellington Regional Hospital
Private Bag 7902
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Dear Julie

Shorter stays in Emergency Department performance measure visit – 11 April 2019

Firstly, I would like to thank your team for hosting Sophia Faure and I on our recent visit to Capital & Coast District Health Board (CCDHB). We appreciated the willingness of your team to engage constructively about performance.

Capital & Coast District Health Board has not achieved the Shorter Stays in emergency department (ED) measure since Quarter 4, 2014/2015. The DHB has worked hard to make improvements to patient flow but has been unable to achieve the measure. Capital & Coast District Health Board requested a visit from the Ministry of Health Emergency Department team to provide them with some suggestions on where to focus their efforts to achieve improvements.

In the data provided by CCDHB, the overall performance against the ED measure in the most recent quarter is 87 percent. When the performance is split between discharged and admitted patients, the performance for those discharged from the ED is 93 percent. For patients requiring admission, the performance is averaging below 80 percent. The data suggests the main reason the DHB is not meeting the measure is due to the delay in admitting patients, known as access block. Access block is a sign of an acute system that is not working optimally, and is associated with worse outcomes for all patients.

Despite CCDHB needing to improve on their admission processes, I want to acknowledge the hard work that has happened over the past few years to build relationships across the organisation and improve care for patients. Without this work I believe access to acute care at the DHB would be significantly worse. It was encouraging to see the level of understanding and engagement from the clinicians and managers we met in medicine, surgery and orthopaedics. The ability and willingness of the clinical leaders in these services to analyse their own data and identify areas for improvement should be applauded. This is a marked change from my experience visiting the CCDHB ED in 2011.

The level of engagement and understanding of how to improve access to care for acute patients demonstrated by your clinicians and managers was very impressive. This culture of cooperation and collegiality throughout the organisation will put the DHB in good stead for continued service improvement projects.

Opportunities

During our visit we heard of successful strategies that have been adopted as well as some challenges the DHB is facing that impact adversely on patient care. Some suggestions for improvements are provided below:

- Hospital occupancy was consistently very high (more than 90 percent) and over 100 percent in the cardiac wards. This occupancy clearly impacts on the DHB's ability to move patients from the ED and intensive care unit (ICU) to the wards, and also receive inter-district transfers. This is partly due to the increased complexity and age of the admitted patients. Data shows that as full-time equivalent (FTE) staff available to help plan discharges for complex patients has fallen, the bed-days per month, for patients with stays longer than 10 days, has increased. The data showed from near zero bed-days with three FTE, to over 300 per month with the current one FTE. Discharge planning resource may be an area that you could consider focusing on to help avert hospital gridlock over the coming months. Better access to allied health, especially social workers may also help with discharging complex patients earlier.

- It was interesting to hear that the transit lounge for patients waiting for discharge is only used for approximately 15 percent of discharges. Stable patients awaiting discharge should not be occupying an acute hospital bed while they wait for paperwork to be completed. There may also be opportunities for quick wins by ensuring that wards do not unnecessarily delay receiving new patients once beds are available. Ensuring bed spaces are cleaned as soon as patients are discharged (or moved to the transit lounge) and that there are no delays waiting for orderlies to take patients to the wards will improve throughput.

- Prioritisation of patients for discharge on morning rounds is another way of creating capacity. However implementing this process without delaying review of new admissions and those who are most unwell is an ongoing challenge for your medical and surgical teams.

- The timely availability of ambulance services to transport patients to their home DHB or Kenepuru Hospital should also be reviewed. The DHB could consider how the ambulances that are providing these services, are not the same ambulances tasked with meeting acute calls in the community as the stable hospital patients will be correctly prioritised lower than the emergency calls.

- It was pleasing to hear that there has been a gradual improvement in the use of the ED observation unit, with ED having ownership over most of the beds, most of the time. However to hear that the placement of patients in corridors for care in the ED is common, and reportedly increasing is of concern. Corridors are not appropriate treatment areas and their use suggests that your ED does not have sufficient treatment spaces to appropriately care for the volume of patients seen.

- We were unable to meet with any of the paediatric team on our visit, but from the tour of the ED, apart from the waiting room, there is no separate space for children. This falls below the standard of care expected in a modern ED. Clinical staff commented the current Children's Assessment Unit is under-resourced and under-utilised. Given the opportunity presented by the rebuilding of the children's wards that is under way, if possible, I highly recommend ensuring a specific paediatric ED be planned for this development.

Timely access for mental health patients

Timely access to assessment for mental health patients was identified by staff as an area for improvement. It is encouraging to hear that there will soon be Crisis Response Team members based in ED. It was also encouraging to hear that a review of the Te Haika telephone triage service is underway, as this has been identified regionally as not meeting the needs for timely assessment of patients, as it places increased workload on the service, which then outstrips the available resources. It is concerning that the inpatient mental health unit is running at more than 100 percent occupancy, and that for many years there has been no increase in the number of acute beds for mental health. The ED is not an appropriate area for care of mental health patients beyond the first few hours for initial assessment. Long stays in ED for mental health patients places those patients, other patients and the ED staff at risk of preventable harm.

Health of Older People

I was surprised to hear about the limited availability of specialists in older people's health during Monday to Friday 'office hours' and that there were no inpatient beds in Wellington Regional Hospital specifically for older people's health. With a broader view, the provision of aged care in the community and expectations of acute care for those at the end of their life is something that the DHB could consider reviewing. Specifically, the value of a transfer to the acute hospital for patients at or near the end of life from home or an aged care facility should be questioned.

Final Words

I hope you find my comments helpful and I look forward to hearing the outcomes of the changes in models of care we heard about. Please do not hesitate to get in touch if you have any questions, or if I or my colleagues at the Ministry can provide further support on any of the above recommendations. Please also extend this offer of support to your staff.

Yours sincerely

Dr Peter G Jones
Shorter Stays in Emergency Departments Performance Champion

cc Carey Virtue, Executive Director Operations, Capital & Coast DHB
John Tait, Chief Medical Officer, Capital & Coast DHB
Andre Cromhout, ED Clinical Director, Capital & Coast DHB
Peter Jane, Manager for DHB Relations, Ministry of Health

PUBLIC

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**HEALTH SYSTEM COMMITTEE DISCUSSION**
	Date: 12 May 2019
Author	Rachel Haggerty, Director, Strategy Innovation and Performance
Endorsed by	Rachel Haggerty, Director, Strategy Innovation and Performance
Subject	**STRATEGY INNOVATION AND PERFORMANCE REPORT MARCH-APRIL 2019**

RECOMMENDATIONS

It is **recommended** that the Committee:

(a) **Notes** the contents of this update;

(b) **Recommends** to the Board that it **notes** this update.

1. PURPOSE

This paper updates the Health System Committee on the Strategy Innovation and Performance (SIP) areas of focus during March and April 2019.

SIP has focused effort on initiatives that respond to Board, Organisational and Government priorities such as mental health and addictions, child wellbeing and equity.

A key priority is the prioritisation process for the 2019/20 financial year and acute flow planning to improve the management of acute bed demand across Wellington Regional Hospital and Kenepuru Hospital.

2. MENTAL HEALTH AND ADDICTIONS

The development of the implementation plan for the Mental Health and Addictions Strategy 2019-2025, "Living Life Well" was a strong focus. This was endorsed by the Disability Advisory Committee on 6 May 2019. Work is underway to develop priorities.

Work is continuing on the 3DHB Addiction model of care, suicide prevention and postvention and the development of integrated service model for Porirua.

It is also a year since the Porirua community suicide cluster. The team are working with schools and the community to ensure there is support at this significant time post this cluster of events.

The Te Ara Pai review has commenced with the stakeholder. Recommendations are expected in June 2019.

2.1 Integrated Care in Porirua

Mental Health and Addictions services have been experiencing increased pressure on all areas with increased referrals for both urgent and non-urgent response. For people trying to get help, it can seem that there are many barriers access and that in order to be seen or to have a family member seen quickly they need to have reached a severe level of distress. When people are in crisis and need an urgent response but are unable to access the appropriate services they can be in primary care or calling emergency services. Establish a prototype for community mental health care. The model would be integrated with primary care and MHAIDS services and may change the demand profile for Te Haika, crisis services, MHAIDS community teams, and the Emergency Department.

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3. CHILD AND YOUTH

3.1 2019/20 Sudden Unexpected Death in Infants Prevention Plan

The Sudden Unexpected Death in Infants (SUDI) Prevention Crown Funding Agreement (CFA) aims to reduce the incidence of SUDI to 0.1 in 1,000 infants by 2025 (CCDHB's rate from 2012 – 2016 was 0.61 per 1,000) and was developed largely in response to the marked inequity experienced by Māori and Pacific people in relation to SUDI.

Current Status

The 2018-19 SUDI Prevention Plan, in partnership with CentralTAS, identified key strategies:

- provision of safe sleeping devices to high risk mothers/whānau;
- development of community based programme/s, particularly wahakura programmes; and
- promotion of smokefree homes, initiatives and incentives.

The programme for 2019/2020 builds on these key strategies. It strengthens the focus on Māori and Pacific communities.The key elements of this plan are:

- Distribution of safe sleep devices to mothers and babies who fit risk criteria
- Funding for wahakura wānanga programmes
- Hāpu mama smoking cessation incentives programme
- Maternal and Child Wellbeing Coordination Services, to support the establishment of a CCDHB safe sleep programme, wahakura wānanga and coordinate stakeholder hui
- Additional breastfeeding resource (peer support counsellors and/or kaiāwhina kaiāwhina)

3.2 Long Acting Reversible Contraceptive (LARC) investment

As previously advised, in New Zealand, more than 40 percent of births are unplanned, but some groups of women experience higher rates of unplanned pregnancies. The highest rates of unplanned pregnancies are in young women (80%), Māori (70%) and Pacific women (60%). There are almost double (57%) the number of births from unplanned pregnancies to women living in NZ Dep quintile 5, compared to 29% for women living in quintiles 1-3.

There is a 31 percent increased risk of pre-term birth and a 36 percent increased risk of low birth weight babies, in unplanned pregnancies, which can result in ongoing functional disability, including cerebral palsy, cognitive, motor and language delay. There is also a higher risk of foetal alcohol spectrum disorder and persistently poorer mental health outcomes for mothers.

New Zealand and international data shows that cost is one of the critical factors in contraceptive access. Access to contraception gives autonomy to girls, women and couples to choose the timing of their pregnancies and pursue other priorities, such as education, financial, personal, family or work goals. This improves long term health and wellbeing for women, children and families.

An additional 458 free LARC will be funded through our PHOs from 1 July 2019 – 30 June 2020. The intention is review the impact and effectiveness of this funding allocation before renewing/varying in 2020/21. Funding and activity targets will be distributed across our PHOs based on the proportion of their population in the CFA's prescribed 'risk groups' (women aged 15 – 55, who live in quintile 5 areas or with a CSC or at high risk). Locally, we will apply a weighting to the available funding and activity targets, to prioritise redressing the known equity gaps for Māori and Pacific.

This additional access in the community will support the existing access to LARCs through our provider arm. Our HHS has an existing policy to support timely, safe, effective use of LARCs in women at risk of unplanned pregnancy post termination and immediately postpartum. Approximately 300 Jadelles and

650 copper intrauterine devices (IUDs) are inserted through Women's Health Services each year. These devices are funded through the pharmacy budget. The extension of this service to primary care will enhance service provision.

4. 3DHB DISABILITIES SERVICES

4.1 Disability Forum

The Disability Forum is scheduled for 21 June 2019. The Forum is co-facilitated and all Board members are invited to attend. The theme of the Forum is "Enabling Partnerships: *Collaboration for effective access to health services".* There are four focus areas:

- Leadership
- Inclusion and Support
- Access
- Health.

4.2 Accessibility

CCDHB is exploring the actions and resources required to implement 'The Accessibility Charter'.

The Accessibility Charter documents a statement of commitment after considering Article 9 – Accessibility of the United Convention of the Rights of People. The Chief Executives of the Disability Forum are committed to ensuring that the public sector is accessible for everyone.

Committing to the Accessibility Charter requires the Chief Executive, and Communications and IT managers sign the charter, which endorses their organisation's commitment to accessibility and mandates staff to work towards an accessible environment.

The recommendation will be presented to the Disability Services Advisory Committee in August 2019.

5. COMMUNITY SERVICES

5.1 Gout and Pharmacies

Gout is a serious long term condition which affects Māori and Pacifica to a greater extent than other groups. Within CCDHB the prevalence is 6.1% for Māori, 12.7% for Pacifica while for the remainder it is 3.3%. Most of the ethnic variations are based on genetic factors. Gout is caused by uric acid deposition in joints and can be controlled by uric acid lowering drugs such as Allopurinol.

As part of the settlement of the Community Pharmacy contract last year, each DHB has been allocated some PBF- based funding to spend on Community Pharmacy based services covering their population. CCDHB has chosen to invest in a Pharmacy based gout service. The service will not be open to all pharmacies, rather to those pharmacies where the majority of their users are Māori and Pacifica and where they already dispense Allopurinol to high numbers of users.

Once a patient presents to one of selected pharmacies with a prescription for Allopurinol, the medicine is dispensed and the patient is asked to come back in a month. When they return a finger-prick test to measure uric acid is performed by the pharmacy and the dose of Allopurinol is adjusted. The aim is to increase the medication until the uric acid concentration is less than 0.36, which is considered the level where uric acid deposition ceases.

This proposal has been to consultation and we are now seeking expressions of interest from pharmacies that meet the criteria mentioned above. We hope to begin the service in June.

6. PRO-EQUITY

The development of the pro-equity work programme is progressing and includes:

- a high-level strategic steering group to provide ongoing leadership to the Equity programme;
- an approved CCDHB Equity Goal and guiding Principles;

- options for embedding equity in decision-making processes for Board and Executive Team;
- advanced workings for a Planning & Funding pro-equity commissioning framework; and
- outline of the work plan to develop a Provider Arm operational equity framework.

7. CITIZENS HEALTH COUNCIL

The Citizens Health Council had a strategic workshop with key members to explore the next steps in engaging with wider Citizens. The workshop focused on linkages with communities and citizens through a series of value based questions that can be formed and shared with the community to explore health in our communities. The shaping of the questions is now being completed by a Communications Advisor.

PUBLIC

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**HSC DISCUSSION**
	Date: 15 May 2019

Authors	Delwyn Hunter, Executive Director Surgery, Women & Children's Carey Virtue, Executive Director Medicine, Cancer & Community
Endorsed by	Julie Patterson, Interim Chief Executive
Subject	**HOSPITAL & HEALTHCARE SERVICES (HHS) BI-MONTHLY PERFORMANCE REPORT**

RECOMMENDATIONS

It is **recommended** that the Committee:

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

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

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

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

1 INTRODUCTION

Purpose

The purpose of this paper is to inform the Health System Committee of key activities and priorities being progressed through the Hospital and Healthcare Services of CCDHB.

2 KEY ISSUES / PRIORITIES

2.1 Equity

2.1.1 The 'Equity for Māori in the Emergency Department (ED)' programme

The 'Equity for Māori in ED' programme, launched to coincide with Waitangi Day, has embarked on a programme of work looking at activity and outcomes for Māori in ED.
To date the team have reviewed the ED guidance documents on 'Death and Dying', 'Managing Taonga While Treating Patients', 'Hauora Māori guidelines for ED based on Tikanga principles' and 'How Tapu principles should guide head examination'.

The team have also removed culturally inappropriate signage from the department. The programme intends to align with existing approaches and work with the Māori Development Unit to help develop organisational wide guidance where appropriate.

A particular programme goal is to develop an evidence base to help identify how the department is responding to the needs of its Māori patients guided by the principle of cultural safety. Initial activity involves collecting information about patients choosing not to use the service, those who choose not to wait in ED and those who do not follow the advice and recommendations given following a consultation in ED.

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2.1.2 Waiting times for Cataract and Hip Surgery (follow up from last report)

Cataract procedures and total hip procedures are two of the more common procedures undertaken by CCDHB for our local population. The table below shows [average?] wait times in days from being given certainty of treatment to discharge, by ethnic group.

Cataracts wait time days (from certainty of treatment to discharge)

Year	Asian	Maori	Other	Pacific	Average
2014	68	65	65	63	65
2015	60	64	60	57	60
2016	52	59	58	57	58
2017	57	51	57	55	57
2018	71	70	70	68	70

For cataract surgery there appears to be no significant variation in waiting times for patients across all ethnic groups.

Total Hip Replacement wait time days from certainty to discharge

Year	Asian	Maori	Other	Pacific	Average
2014	114	92	89	59	89
2015	49	64	50	64	52
2016	40	63	51	55	52
2017	35	58	62	63	61
2018	68	72	69	67	69

For total hip replacements there appears to be some variation in wait time between the different ethnic groups between years for total hip replacements. This is due to treatment being provided at both Wellington and Kenepuru Hospitals and the different access criteria. Those patients with more complex health issues can only be treated at Wellington Hospital and are more likely to have to wait longer to access surgery. Surgery at Wellington Hospital can be disrupted by acute cases, which is not the case at Kenepuru.

2.2 Industrial Action

2.2.1 Resident Doctors Association (RDA) industrial action

During the months of March and April the Resident Doctors Association (RDA) issued two strike notices. The first strike notice was for the period commencing Monday 15 April at 0800 hrs through to Thursday 18 April at 2300 hrs. The strike notice was withdrawn by the union prior to the strike commencing but planning was well advanced and surgical activity was impacted. The second strike notice was for a period of 5 workings days from Monday 29 April at 0800 hrs through to Saturday 4 May at 0800 hrs. For this period 56% of CCDHB's RMOs went on strike, which was a high rate compared to all other tertiary regions. During the strike period we relied on Senior Medical Officer workforce, supplemented by non-striking junior medical staff, to provide services normally provided by junior medical staff. This had a significant impact on elective activity both in the outpatient and inpatient areas. The impact on elective surgery was significant. While there were no reported significant clinical safety impacts on individual patients during the strike period, there is no doubt that the strike action has significant impact on hundreds of patients who had their treatment delayed or rescheduled.

The RDA and DHBs have now agreed to attend facilitation planned for early May.

2.2.2 MERAS industrial action – Midwives

No further industrial action occurred during this period. MERAs and the DHBs have reached a settlement which was ratified mid-April. Payroll will be processing the MECA increases in May with two payments backdated to June and August 2018.

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2.2.3 APEX industrial action - Medical Physicists

The strike action by the Medical Physicists continues involving two periods of strike action for seven days between March 12 and March 25 and a period of five days from 10 to 16 April. Further action was planned for 6 to 19 of May but this has been lifted following the recommencement of bargaining on 2 May. Planning has been effective in minimizing the impact of the strike on patients, there have been very few patient treatment deferrals during the strike, however the strike action has impacted on the regular service quality activities that are normally scheduled to take place at the times that were impacted by the strike.

2.2.4 Response to Christchurch Terrorist Attack

Mid-afternoon on Friday 15 March we became aware of the Christchurch terrorist attacks. Initial information was through social media and the number of casualties were increasing with subsequent reports. There were some informal conversations between surgeons from Christchurch District Health Board (CDHB) and CCDHB colleagues asking about capacity to provide assistance if they needed to transfer patients. The Emergency Operations Centre (EOC) was activated to co-ordinate any support that CDHB may require.

The Intensive Care network throughout New Zealand initiated assessment of all units' capacity to take patients. Patients (in CCDHB) were assessed for transfer to wards and beds cleared in anticipation of possible transfers. A teleconference was held at 4 pm and at that time CDHB confirmed they had 9 ventilated patients from the terrorist attack and were coping with the workload. All DHB's confirmed the availability of ICU beds if transfers required. At CCDHB the Flight Service went on standby in case of emergency retrievals. They were available to be immediately deployed and had access to two aircraft and flight teams.

Over the weekend CDHB requested 4 patient transfers to create capacity within their unit which were accepted and retrieved. None of the transfers were shooting victims. Accepting these patients had some flow on impact for CCDHB elective surgical patients requiring access to ICU and resulted in at least a couple of patients having their surgery deferred on the basis of no ICU bed.

2.3 TrendCare and Care Capacity Demand Management (CCDM)

Further partnership training has been undertaken for CCDM Council members and those heavily involved with the programme to strengthen the existing partnership and orientate new Council members. This provided the opportunity to acknowledge challenges and successes as the programme progresses with FTE calculations and variance response management.

TrendCare timing studies have commenced in maternity to address the national concerns regarding the reflection of acuity on evening and night shifts. Focus continues on the use of the allocate staff screen, ensuring appropriate selection of patient types, discharge analysis and inter rater reliability (IRR) testing to ensure accuracy and compliance with the tool. Implementation into mental health and forensic areas is on schedule. Further input and improvement is required for Te Whare o Maitarangi to attain TrendCare compliance and accuracy. A plan for the same is in development.

The core data set is now implemented in QLIK through the CCDM dashboard, which enables ease of access and transparency for the local data and CCDM Councils. A national webinar was held in conjunction with Acumen with 70 plus attendees interested in how CCDHB has developed and implemented the core data set. We are the first DHB to achieve this level of visibility with the core data set. Local data council implementation continues with emphasis on education and data interpretation. This will be supported with the data literacy project which is currently under development.

FTE calculations are complete for the first 6 areas within the Surgery, Women and Children's Directorate with the report endorsed by the CCDM Council. This will proceed to business cases for each area.
The FTE calculation report for Neonatal Intensive Care Unit (NICU) and 7 North has not been endorsed due to data concerns. NICU will now undergo further data investigation to understand the issues more in depth. FTE reports for MAPU, 6 East, 5 North and 5 South are almost complete.

Variance response management continues with Emergency Department, Maternity and Intensive Care escalation plans and associated standard operating procedures.

Consideration is now being given to re-development of Capacity at a Glance (CaaG) screens to include variance indicator scoring and TrendCare acuity.

Ministry of Health, CCDM Governance and bi-monthly staff reporting is on schedule.

The current nursing personnel vacancy rate is 5.9% (137.5 FTE).

2.6 Sterile Services

A follow up teleconference has been held with the MoH and DHBs in relation to the incident at Hawkes Bay DHB when unsterilized instruments were used on patients due to a failure of process. While the final report has not been shared at the time of writing this report, a summary of issues and recommendations was discussed.

The MoH has requested that all DHBs:

- Confirm they have taken into account the learnings from the external review and is confident in the robustness of its sterilising policies and procedures
- Advise whether audits against the Australia and New Zealand Sterilisation Standard (2014) AS/NZS 4187:2014 are done and what challenges, if any, they experience in complying with the standard.

As a result of the learnings and our own assessment to date we will:

- Undertake a self-audit against the standards and report and correct any areas of non-compliance – the Ministry has now provided the audit tool.
- Audit fast tracked instruments and identify if more instruments need to be purchased
- Progress a capex application to secure the unit to mitigate the risk of instruments being removed before all quality checks are complete.

The Ministry recommends that each DHB consider, as part of the organisation's wider resourcing prioritisation, the implementation of a robust tracking system for surgical instruments. We are progressing our capex application for implementation of a track and trace system that tracks instruments to the individual level. Report due to Ministry by 17 May 2019.

3 KEY PERFORMANCE INDICATORS

3.1 Planned Care

There is still limited information available on the MOH's definition and strategy in relation to planned care. There is indication that planned care will incorporate an equivalent measure to the current elective discharge target, some of the current ESPI measures, access to cardiology procedures and diagnostics such as MRI and CT, and waiting times for specified follow up appointments such as ophthalmology.

2.2 Elective Discharge Target

The elective discharge target is 11,208 discharges for the current year, and this also includes arranged surgical procedures and work undertaken by other DHBs for our population. Currently we are reporting 313 procedures behind our in-house year to date target of 5,889. The key driver for our adverse position continues to be industrial action undertaken by the RDA and also the stretch target built into in-house production. The forecast shortfall is 500 procedures due to RDA industrial action this year. This volume includes IDF but there will be proportionately more local than IDF patients.

Work continues on ensuring we utilise all available theatre sessions in-house and outsource appropriate patients to our private providers.

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2.3 Elective Service Patient Flow Indicators (ESPIs)

Our ESPI 2 (First Specialist Assessment - FSA) and ESPI 5 (elective treatment) remain non-complaint with too many patients waiting outside the 120 day timeframe. Key drivers of our non-compliance relate to an increase in the volume of patients meeting threshold for acceptance onto the waiting lists. This has resulted in growth of the waiting lists and has been made worse by lower than normal activity in our FSA and treatment volumes as a result of industrial action. Major surgery cases were rescheduled in the days leading up to strike to ensure the hospital was at manageable capacity and inpatients could be cared for safely. The planned industrial action which was withdrawn in mid-April also contributed to this negative position as theatre sessions were not able to be fully rebooked. In addition SMO vacancy in orthopaedics impacts our ability to backfill lists at Kenepuru when the allocated surgeon is on leave. We have been unable to recruit for two years. The vacancy impact is on total case performance and Kenepuru utilisation.

The current level of ESPI noncompliance is outlined in the table below. May numbers are a forecast only and may change. We continue to work on accessing additional outpatient clinics and theatre sessions to treat patients waiting longer than 120 days. All DHBs are in a similar position in relation to ESPI noncompliance.

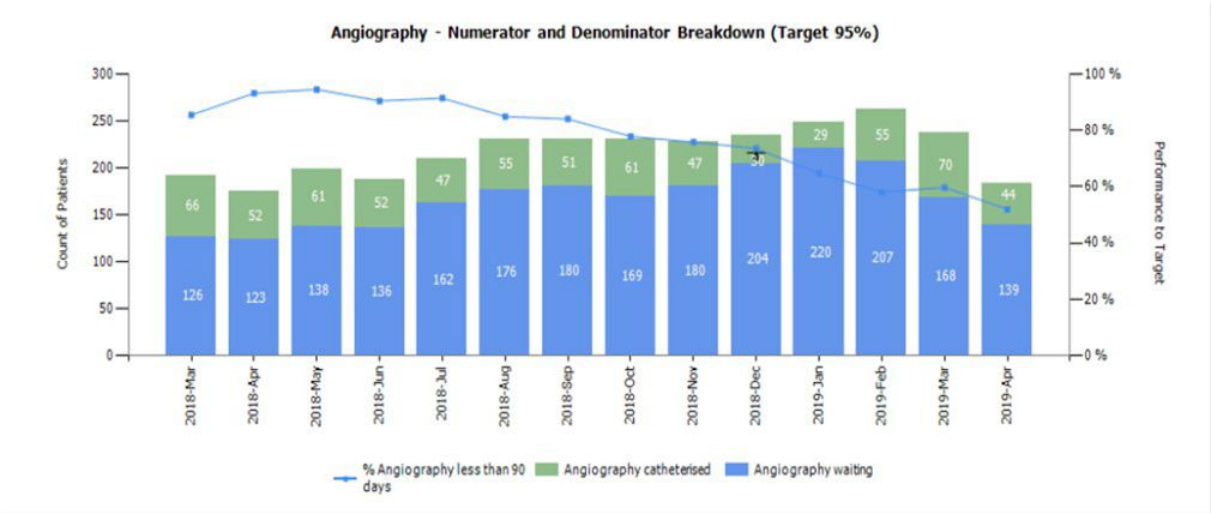
ESPI 2 and 5 Results as at End of March 2019

	Oct	Nov	Dec	Jan	Feb	March	April	May*
ESPI 2	18	16	40	208	72	151	136	138
ESPI 5	22	22	61	137	143	152	168	148

**Forecast*

2.4 Coronary Angiography

There continue to be challenges for CCDHB and the central region to meet the target for elective coronary angiography within 90 days of a referral being accepted. The service has seen a further reduction in the number of patients undergoing the procedure within the 90 day target. Only 52% of procedures met this target in April. A recovery plan has been provided to the Ministry of Health proposing two additional weekly sessions for which staff are currently being recruited, and outsourcing a number of these procedures to Nelson DHB and private providers. All patients waiting over 120 days are reviewed by the responsible SMO, assigned a priority and given a procedure date for either in-house or outsourced provision.



2.5 Access to Diagnostics – Radiology

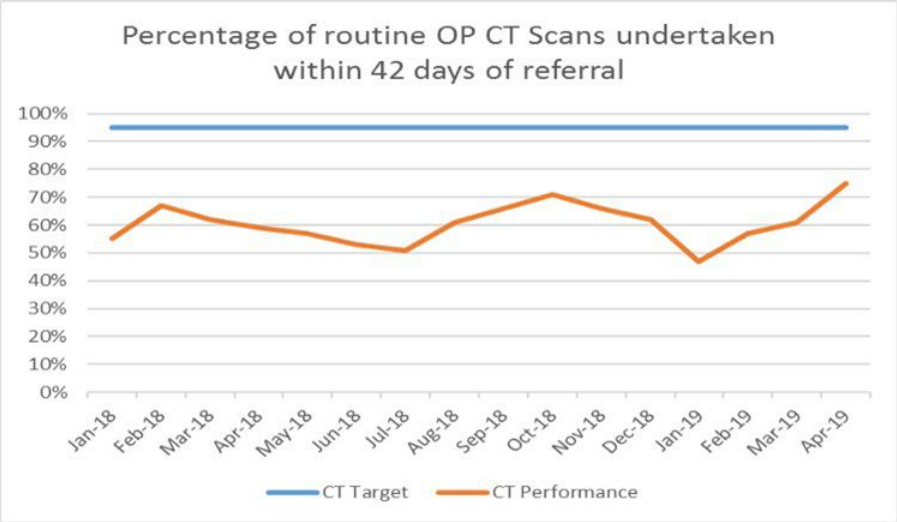
Performance against the CT and MRI MOH indicator for non-urgent referrals continues to be a challenge for the service however, both CT and MRI have improved through March and April.

CT Scanning

PUBLIC

The service continues to work with staff and unions with a draft workforce development plan which will enable the CT service to extend the hours across all 7 days a week. Training continues and elective lists are run most Saturday mornings contributing to increased capacity in conjunction with outsourcing.

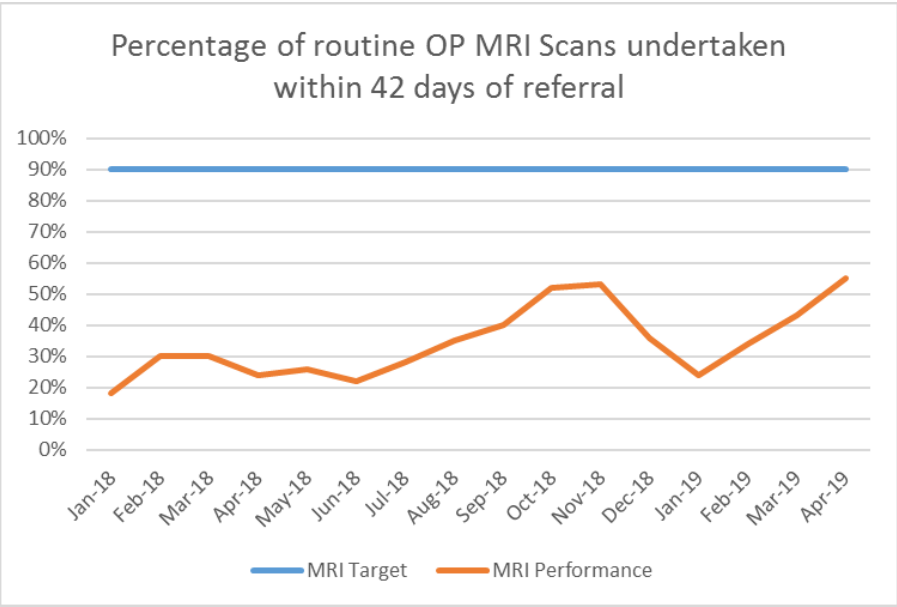
The service had planned to increase outsourcing volumes to reduce the number of scans requiring rescheduling as a result of the planned Medical Physicists strike. This plan is being reviewed in the light of the decision not to go ahead with this strike.



MRI Scanning

The service continues to outsource scans when there is provider capacity and has begun to run ad hoc elective MRI lists and weekend lists as staffing allows.

As part of the workforce development plan, the service has increased the number of trainees by training Medical Radiation Technologists (MRTs) to become MRI MRTs (2 current positions) which has helped support weekend elective lists. However there continues to be a local and national shortage of qualified staff.



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2.4 Colonoscopies

The Gastroenterology service have experienced a 60% increase in endoscopy procedures over the last two years that has put significant pressure on the service. In response the service has prioritised the urgent and non-urgent colonoscopies. This pattern mirrors that seen nationally. The result has been that only 53% of surveillance colonoscopies are undertaken within 84 days against a target of 70%. This equates to approximately 200 patients waiting in excess of the intended timeframe.

To manage this the service has increased capacity through outsourcing and additional colonoscopy sessions. The service plans to develop and utilize the facilities at Kenepuru that have been identified for bowel screening by opening this unit in October 2019, earlier than anticipated, to help reduce the number of patients waiting. However, this is contingent on securing an additional gastroenterologist which is proving to be a challenge. Consequently, we are investigating alternative options include increasing our outsourcing volumes if there is capacity to support this.

The CCDHB recently received a letter from the National Bowel Cancer Screening Unit re-emphasising the need for all colonoscopy waiting time targets to be achieved before commencement of the bowel screening programming and highlighting a number of changes to the way the Unit operates in support of DHBs to manage their colonoscopy waiting times.

2.5 Ophthalmology Follow Ups

A quality improvement project to address the issue of patients waiting for follow up longer than clinically appropriate has been in place for some time. Although there has been significant improvement over time, of the 8,095 patients currently awaiting follow up appointments, 865 have been waiting longer then clinically indicated and 62 of those have been waiting for twice the expected waiting time.

The service has reached a point where there is limited capacity to make further improvements in the number waiting past their follow up timeframe within available resources. We have requested additional resources as part of the 2019-20 budget process.

We continue to hold additional locum clinics and we have short term contracts in place for two SMOs which have been funded from vacancy in orthopaedics. We have initiated further nurse led clinics, including acute triage clinics and will be managing some oculoplastic clinics through virtual review. We are training a further two Registered Nurses to do intraocular injections.

There is also ongoing work with central TAS and the central regional services exploring how we can work more effectively from a regional perspective. Each ophthalmology centre is experiencing similar problems to us although we are having fewer problems attracting ophthalmic staff compared to the regional centres.

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Date: 10 May 2019	**HEALTH SYSTEM COMMITTEE INFORMATION**
Author	Peter Gush, Service Manager, Regional Public Health
Subject	**NAIL BAR REPORT**

RECOMMENDATIONS

It is **recommended** that the Committee:

(a) **Notes** the report;

(b) **Considers** a joint submission to Wellington City Council.

APPENDIX

1. Survey of Knowledge & Infection Control Practices in Salons Offering Nail Services.

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 the Health System Committee of the issues raised through the Nail Bar report and seek support for a joint submission to Wellington City Council.

2. BACKGROUND

In the absence of local bylaws there is no national regulation or oversight of tattooing or beauty or nail services. These services can result in injuries, or infections (Hepatitis B, C HIV, fungal or bacterial infections) if staff do not clean the equipment properly.

A survey conducted by RPH of 57 salons that offer nail and pedicure services in the Hutt Valley, Wellington, Porirua and Kapiti found;

There is limited understanding of blood-borne viruses and other infections and how they are spread or controlled.

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- Only 12% of nail and beauty salons who participated in the survey adequately disinfect, sterilise and store equipment used on customers.
- 46% do not routinely ask customers about health conditions (e.g. diabetes, circulation problems, cancer treatments) that could put the person had high risk of infection or slow healing following a skin cut.
- 31% did not have a separate equipment cleaning sink.
- Some salons continue to use heel blades to remove calluses or hard skin, which is associated with a high risk of cutting the underlying tissue and bleeding
- 93% of salons in the survey were supportive of a local bylaw.

There was high media and public interest in this issue with coverage by TV1 News RadioNZ Wellington-nail-salons-lack-of-hygiene-highlighted-in-report Newshub The Herald and Stuff.

In the greater Wellington region only Masterton and South Wairarapa District Councils have a bylaw requiring registration and annual inspection for nail, beauty and tattooing services. Hutt City Council is currently consulting on a proposed bylaw. Wellington City Council (WCC) is currently seeking public feedback on whether a bylaw is an appropriate response for these industries.

Regional Public Health would recommend a joint submission to Wellington City Council in support of a bylaw that includes all commercial services that risk cutting/piercing or burning the skin e.g. beauty or nails salons, tattoo, body and skin piercing studios. This would be consistent with similar bylaws from other regions in NZ (Auckland Unitary Authority, Napier City, Dunedin City, Timaru, Stratford, Ruapehu District Councils).

Wellington City Council will consider feedback at the Council's City Strategy Committee in June, and the Council will make a final decision in June 2019. Submissions are due by 5pm Friday 24th May.

Regional Public Health
HAUORA Ā IWI KI TE ŪPOKO O TE IKA A MĀUI
Better health for the greater Wellington region

SURVEY OF KNOWLEDGE AND INFECTION CONTROL PRACTICES IN SALONS OFFERING NAIL SERVICES

Regional Public Health

This report was prepared by Helen van Mil and Annette Nesdale, on behalf of the project team: Helen van Mil, Annette Nesdale, Jonathan Lambert, and Barbara Eddie.

Disclaimer

Citation: Regional Public Health. 2018. *Survey of Knowledge and Infection Control Practices in Salons Offering Nail Services.* Wellington. Regional Public Health.

Regional Public Health (2018)

www.rph.org.nz

ACKNOWLEDGEMENTS

The project team would like to thank the following organisations for their assistance with the development and implementation of the project:

- Porirua City Council
- Hutt City Council
- Masterton District Council
- New Zealand Association for Registered Beauty Therapists
- Podiatry New Zealand
- Nail and beauty salon owners and managers in the greater Wellington region.

EXECUTIVE SUMMARY

- A survey of 57 nail and beauty salons in the Wellington region was undertaken between January and July 2017 to assess the knowledge and infection prevention and control procedures within the nail industry
- A lack of recognised formal qualifications was observed in over half of the salons visited. Many staff are trained on the job, or by nail polish companies
- Nail or beauty salons with an adequate number of trained staff were twice as likely to ask clients about pre-existing health conditions
- There is limited understanding about blood borne viruses and other infections and how they are spread/controlled
- There was limited understanding about protection from hepatitis B infection. Staff are often not vaccinated, or their immunity status is unknown
- Some salons continue to use heel blades to remove calluses or hard skin, which is associated with a high risk of cutting the underlying tissue and bleeding
- There is a lack of understanding about cleaning, disinfecting, sterilising and hygienically storing instruments
- The large majority of salons have no written infection control protocols for staff to follow, or cleaning schedules
- Nail and beauty salons visited in the Wellington region are overwhelmingly supportive of some form of regulation to improve standards within the industry
- There is both a need and interest within the industry, for education and resources to be provided regarding infection control practices in nail and beauty salons that provide nail treatments.

TABLE OF CONTENTS

INTRODUCTION

Recent years have seen an increase in the popularity of pedicures, manicures and application of acrylic nails with a subsequent increase in the number of salons providing these services. In particular, there has been an increase in 'drop-in' nail salons offering lower priced services. However, many staff (1),(2)and clients have low awareness of the potential risks that these nail treatments can pose.

There is a high risk of infection from manicures and pedicures if the skin is cut or broken and there are inadequate infection control measures in place. Viral hepatitis (3),(4) bacteria (5), *mycobacterium* (6),(7),(8) and fungi can be transmitted directly to or from clients, operators and the environment via dirty hands, cuts or sores or inadequately cleaned, disinfected and sterilised equipment (9).

The full extent of harm from manicures and pedicures is not well known or researched. Infections are likely to be under recognised, under reported and infrequently come to the attention of health professionals. In addition, doctors may not ask about possible causes of infections or injuries to the hands and feet and there is no requirement for concerns to be reported to public health or other agencies. Accident Compensation Corporation (ACC) data from 2012-2017 shows only a handful of claims associated with nail salons are made each year(10). A magazine article (11) in 2013 reported ACC accepted 52 claims for accidents in nail bars and beauty salons in the previous year. The main injuries were punctures, lacerations, heel cuts and nail infections. These figures are likely to be an underrepresentation of harm from nail treatments, as many clients and possibly doctors may not be aware that some nail treatment injuries can be lodged as a claim with ACC. The ACC data is also limited. Although there are some mandatory fields in the claim form (accident date, and if the accident occurred at work) it is optional for the claimant to include a description of how the accident occurred. Nevertheless, international evidence suggests moderate to serious harm is occurring as a result of nail treatments. A case report from the UK details a manicure leading to gangrene and amputation of fingers.(12) At least two deaths have been reported in the United States.(13) Two cases of acute hepatitis B were investigated by the Dutch Municipal Health Service identifying the most probable source of infection was a piercing salon that both had visited on the same day (14). An outbreak of nine cases of acute hepatitis B in the USA were linked to podiatric care.(3) More recent reviews from the United States(15) confirm the risk for HBV/HCV transmission in nail salons cannot be excluded. Boils and skin infections due to *mycobacterium* are also occurring internationally. An outbreak of over 100 cases of *mycobacterium furunculosis* associated with footbaths was identified in a nail salon in California.(8) Environmental sampling of a variety of nail salons indicated the presence of pathogens, a buildup of organic debris and hair behind the filters in foot spas.(7),(8) Dissatisfied clients also report their experiences in the media(11) (16) and to the NZ Association of Registered Beauty Therapists (NZARBT).

Unlike many Canadian provinces and territories, (17) there are no national regulations, minimum requirements or standards for nail and beauty salons in NZ. No formal training or qualification is required to set up and operate as a nail technician in NZ unless there is a local bylaw.

Some areas in New Zealand (NZ) have local bylaws that provide for a minimum standard and annual registration of the salons and staff training. The bylaws vary, but in general cover beauty therapy treatments, tattooing, skin piercing, tanning and /or hair removal.

In 2013 The Masterton and South Wairarapa District Councils' Consolidated Bylaw 2012 was introduced. It requires the registration of beauty therapists, solarium operators, nail technicians, tattooists and skin piercers. This bylaw requires all practitioners to be trained to a recognised standard; sets out minimum physical standards for the premises and equipment, and sterilisation and disinfection be carried out using accepted methods. There is no bylaw in Wellington City, Porirua, Kāpiti Coast, Lower Hutt or Upper Hutt. Environmental Health Managers in these local councils indicate that they would be supportive of a bylaw to reduce risk to the public health but that there would need to be evidence of the risk in order to provide Councillors with justification to enact a new bylaw.

To establish a new bylaw the Local Government Act 2002 (s 155 (1)) requires a council to determine that the issue is significant and that a bylaw is the most appropriate way to address the problem. Currently the Auckland Unitary Authority, Napier City, Dunedin City, Masterton, South Wairarapa, Stratford, Ruapehu and Timaru District Councils all have a bylaw that includes licencing and inspection of beauticians, tattooists, body piercers and nail technicians. The last two bylaws were enacted in January and April 2018 respectively.

There is variation across NZ regarding other council inclination to pursue bylaws for tattooing and beauty services. Nelson City Council and Marlborough District Council chose not to pursue bylaws for beauty therapy, tattooing and skin piercings in recent years. Their reasons were that there was insufficient local evidence regarding health problems or unhygienic premises and preferring national legislation over local bylaws.

There are no local bylaws in the Wellington region, meaning baseline data on operating standards from annual registration visits does not exist.

This survey provides baseline information about infection prevention and control measures in nail and beauty salons in the Wellington region and highlights the potential benefits of regulation. Regulation of the industry would see a reduction in infection risks associated with nail services offered by nail and beauty salons. Ideally, national regulation applying across the country, would ensure consistency and efficiency. In the absence of national regulation, each council will have to introduce their own bylaw to ensure the support of safe practices within their district.

Regulations need to be supported by education and guidance on how to provide a safe service. The NZARBT has produced Health and Hygiene Guidelines which are consistent with best international practice. However, membership to NZARBT is limited to people who have a formal beauty therapy qualification and membership is voluntary.

OBJECTIVES

1. Assess infection control knowledge and practices of the nail and beauty salon operators/ managers across the region
2. Support managers/ owners to deliver services in line with best practice
3. Gather data to inform local councils, and the Ministry of Health regarding the need for a comprehensive system to protect public health
4. Assist RPH staff to understand how nail and beauty salons operate, their current infection control practices and the environmental factors that either support or hinder best practice.

SCOPE

The project scope was defined as follows.

- Nail salons and beauty salons offering nail treatments, manicures and pedicures in the greater Wellington region were invited to participate in the survey
- Owners or managers of salons were interviewed
- Education and advice was offered at the time of the inspection, particularly if any serious issues were identified.
- Participation in the survey was voluntary

GLOSSARY OF TERMS AND ABBREVIATIONS

NZARBT	New Zealand Association of Registered Beauty Therapists
RPH	Regional Public Health
TLA	Territorial Local Authority
EHO	Environmental Health Officer
MDC	Masterton District Council
FTE	Full Time Equivalent

METHODS

Project team

A project team was developed to undertake the planning of the project, comprising of:

- Helen van Mil, Health Protection Officer
- Annette Nesdale, Medical Officer of Health
- Jonathan Lambert, Health Protection Officer
- Barbara Eddie, Public Health Nurse

Ethical review

The project team were advised by the National Health and Disability Ethics Committee that the project did not require their review. Throughout the project, the interviewers emphasised that participation in the survey was voluntary. The interviewers were respectful and discrete when visiting salons; particularly if clients were present.

Capacity development

A workshop was developed for Healthy Environments and Disease Control (HEDC) staff from Regional Public Health (RPH) and local authority Environmental Health Officers (EHOs) who had expressed interest in assisting with undertaking survey visits. The workshop covered expected infection prevention and control measures for manicures, pedicures and other nail treatments, how to conduct a visit, and an introduction to the Masterton District Council (MDC) bylaw. It included speakers from RPH, MDC, and Podiatry New Zealand. A copy of the programme can be found in Appendix 1.

Survey development

A questionnaire was developed in consultation with Julie Martin, formerly of NZARBT, and an EHO from Masterton District Council. A copy of the questionnaire can be found in Appendix 2.

Visits

As nail and beauty salons are unregulated in the Wellington region, there is no list of registered premises. A search using regional telephone books and the internet identified 127 nail and beauty salons who offer nail services. Salons were contacted initially by telephone to introduce the survey and arrange a suitable appointment time. At least three attempts were made to contact each salon, including telephone and email. Salon staff were informed that the visit was voluntary. A letter outlining the survey was sent to salons by email if telephone contact could not be made.
At the visit, the manager or owner of each salon was interviewed and the salons facilities equipment and cleaning procedures were reviewed. Each participating salon was provided with a copy of the NZARBT Health and Hygiene Guidelines (the Guidelines). (18) Verbal feedback was provided at the time of the visit if any issues were identified.

The visits were undertaken between January and July 2017. Visits were performed in pairs by staff from RPH, Hutt City Council, and Porirua City Council. 127 salons were identified. 57 salons were assessed, representing 45 % of the identified salons offering nail services in the greater Wellington region. Reasons for not being able to visit were:

- 10 % (13 salons) no longer operating
- 11 % (14 salons) declined to take part (or cancelled appointment)
- 21 % (27 salons) unable to make contact (or no response).

Following the visit a thank you letter was sent and further recommendations regarding disinfection and sterilisation were included (Appendix 4).

Data collection and analysis

Data was collected on a hard copy questionnaire and entered into the EpiInfo7 programme for analysis. Proportions were compared using a chi square test with the significance set at $p < 0.05$. A two tail Mantel-Haenszel was used for p values.
The following definitions were used in the analysis.

- Salons were defined as either 'nail only' or 'full beauty services'. Full beauty services included salons which provided nail services as well as facials, hair removal, hair dressing, tanning and or make up etc.
- Training qualifications were categorised into two groups;
    - Salon with adequate number of trained staff; defined as at least 75% of staff at the salon have a formal qualification (may include some staff members with more than one formal qualification). A formal qualification is the equivalent of an internationally recognised one year diploma, two year certificate, or World Standard e.g. CIDESCO (Comite International d'Esthetique et de Cosmetology).
    - Salon with inadequate number of trained staff; defined as less than 75% of staff have a formal qualification. Informal qualifications include shorter duration courses, unrecognised qualifications, and supplier training (e.g. nail polish manufacturer)
- 'Don't know' or 'no on-going training' includes salons which couldn't sufficiently describe on-going training
- Lower price salons was defined as $40 or less for a manicure
- Adequate instrument sterilisation must include all of the following steps;
    - Wash in hot soapy water
    - Scrub or ultrasonic cleaner
    - Soak in disinfectant for required time (as specified in the manufacturer's instructions). The disinfectant also had to be within its stated use by date
    - Sterilise with a glass bead steriliser or autoclave
    - A separate note is made of those salons who then store the sterilised instruments in a suitable manner (i.e. UV cabinet, clean unused food grade plastic bag), as this is required in order to maintain the sterility
- Adequate cleaning of towels is considered as either a commercial laundry service or hot wash at 60^0 C or higher

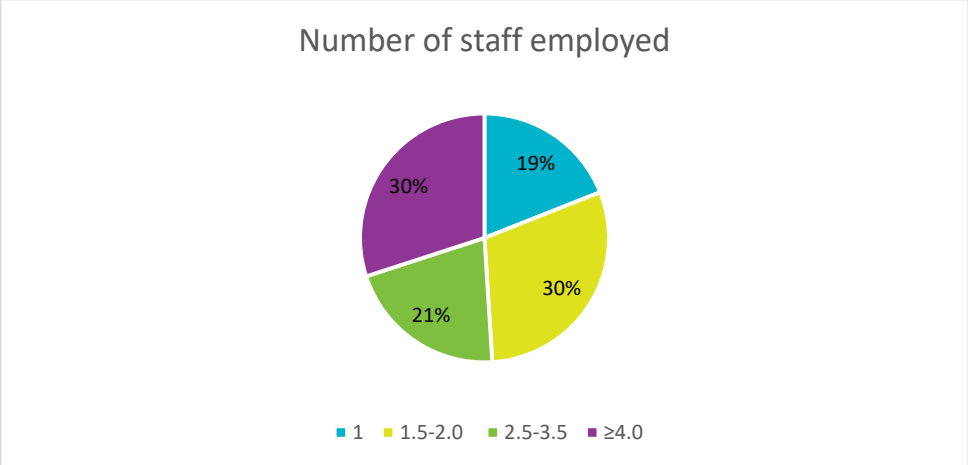
- Adequate cleaning of client areas was defined as cleaning with a suitable disinfectant, change paper/towels
- Owners/managers were asked if they used equipment that needed to be sterilised. Their response has been categorised as either 'yes' or 'no' or 'don't know'
- Adequately aware of transferrable conditions is considered as knowing about fungal, bacterial, and blood borne viral infections rather than one or two of these categories
- Suitable disinfectant solutions were defined as those capable of killing viruses and bacteria (e.g. hospital grade disinfectants), used at the correct concentration, correct contact time and within the stated use by date.

RESULTS/DATA ANALYSIS

Salon and operator characteristics

The number of staff (FTE) per salon is displayed in figure1. The FTE per salon ranged from one to 10.5, with 19% having just one staff member. A further 30% had between 1.5 and 2.0 full time equivalent staff members, 21 % employed between 2.5 and 3.5, while 30% employed more than four staff members.

Figure 1: Number of full time equivalent staff in visited salons



The combined number of pedicures and manicures performed per week (figure 2) by each salon varied from one to 245, with a median of 20 and average of 47. There were 17% of salons doing 100 or more manicures/ pedicures per week. The cost of a manicure ranged from $23 to $96 and a pedicure from $35 to $96. The average price for a manicure was $46 and a pedicure $54.

Figure 2: Average number of manicures/pedicures in visited salons

79% (45) of businesses offered full beauty services and 21% (12) were nail salons only.
Over half of salons interviewed (32) served predominantly pre-booked clients, while 37% (21) dealt mainly with casual, 'walk-in', clients and the remaining 4% (7) had a mix of custom.

41% (29) of businesses had been operating for less than five years, with one business having only been open one month. Overall 32% (18) of salons were members of the NZARBT, while 5% (3) had never heard of the association.

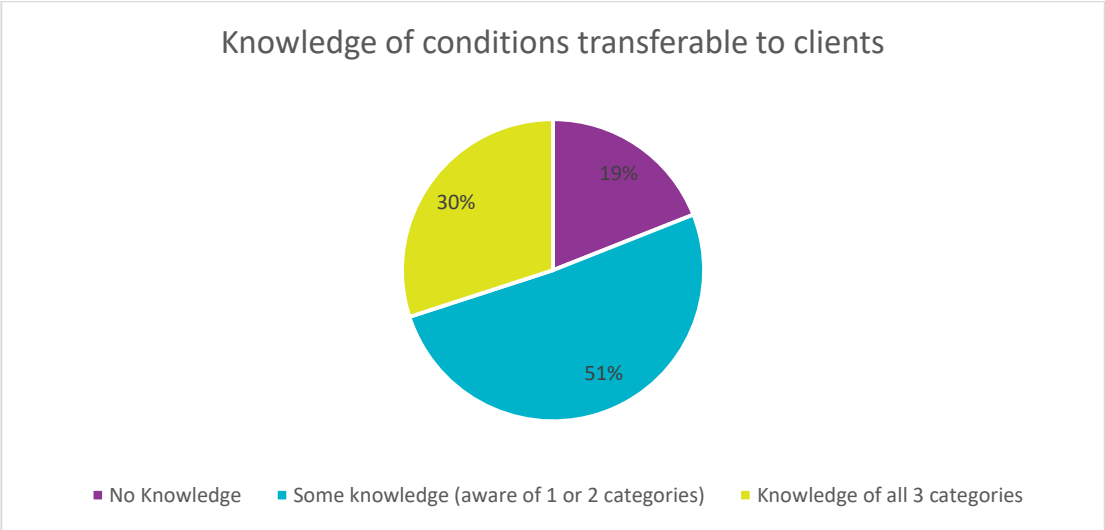
Knowledge/understanding

Owners/managers were questioned as to whether they ask clients any health questions. 68% (39) responded that they obtained health information in a variety of ways ranging from requesting clients to complete health questionnaires, visual inspection of the hands/feet, or relying on the clients to provide information if they considered it necessary. 54% (31) reported they routinely ask clients about their health conditions. Of these, 49% (28) asked about infections, 33 % (19) allergies, 30% (17) problems with previous treatments, and 23% (13) about medications the client is taking. Salons with an adequate number of trained staff were almost twice as likely to ask clients health questions prior to treatment (71% compared with 38%).

Respondents reported they would not provide the manicure/pedicure if they observed the client had an infection in 39% (22) of salons. The same number reported discontinuing treatment if a client began to bleed during treatment. 16 % (9) of salons commented that they were using styptic pens or other haemostatic solutions to stop superficial bleeding. The likelihood of discontinuing treatment due to infection or bleeding did not alter significantly based on having adequately trained staff, pre-booked custom, or how long the salon had been in business. However, lower priced salons were significantly less likely (approximately 2.5 times) to halt treatment than higher priced salons (21 % compared with 53%).

Several questions assessed the owner/managers knowledge of the risk of infection transmission between staff and clients or between clients via inadequately cleaned instruments or equipment (e.g. foot spa). Assessment was based on knowledge of three categories of conditions; bacterial infections (skin infection/boil/abscess), viral infections (hepatitis B/hepatitis C/HIV/blood borne viruses), and fungal infections (fungus/tinea). When asked about conditions that could be transferred to clients, 19% (11) of respondents had no knowledge, 25 % (14) were aware of one condition, 26% (15) of two, and 30% (17) were aware of all three categories (see figure 3). With regard to conditions that staff could acquire either from clients or equipment, 16% (9) had no knowledge, 23% (13) were aware of one, 21% (12) of two, and 40% (23) were aware of all three categories.

Figure 3: Knowledge of conditions (bacterial, viral, fungal) transferable to clients



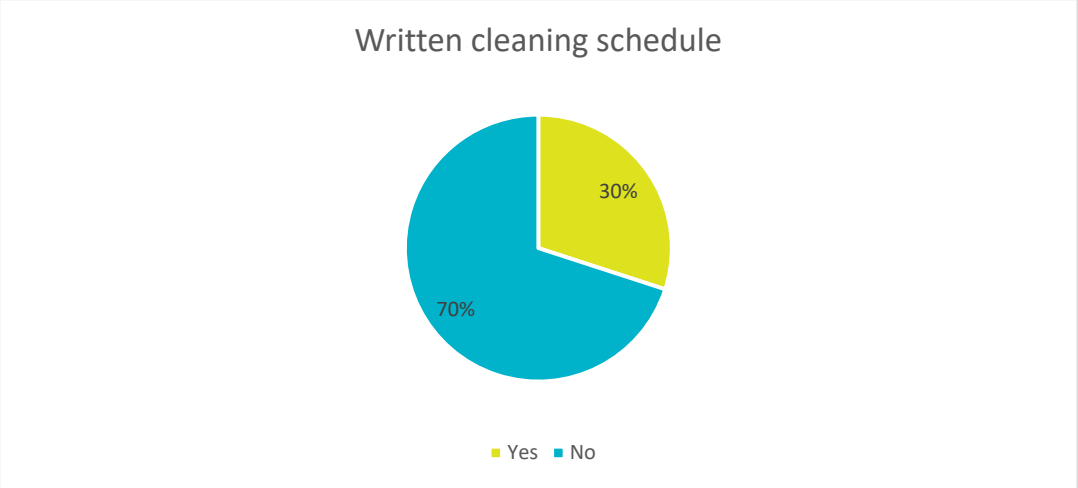
Respondents from salons with adequately trained staff were almost twice as likely to be aware of all conditions transferable to staff but no more likely than others to be aware of conditions transferable to clients.

Only 16% (9) of salons reported that staff were fully vaccinated for Hepatitis B. When asked how they knew all their staff were vaccinated; some operators weren't able to provide an answer, one salon operator said this is an immigration requirement other responses included that staff were all vaccinated in Vietnam or that the staff member has told them they are vaccinated or sole operator who knew their own status. Less than 5% (2) said they encourage staff to have these vaccinations. No salons were paying for staff to be vaccinated. This did not vary based on training, client base, length of time in business, or average price of a manicure.

Practices

Only 30% of salons had a written cleaning schedule (see figure 4). Salons with an adequate number of trained staff were three times more likely to have a written schedule than those without an adequate number of trained staff. In keeping with lower price salons being more likely to have inadequately trained staff, these salons were also five times less likely to operate with a written cleaning schedule.

Figure 4: Premises with a written cleaning schedule



All salons had separate staff hand basins, but only 69% had separate equipment cleaning sinks. The remainder using kitchen or treatment area sinks for equipment cleaning. Hand sanitiser was available at all workstations in 61% (35) of salons.

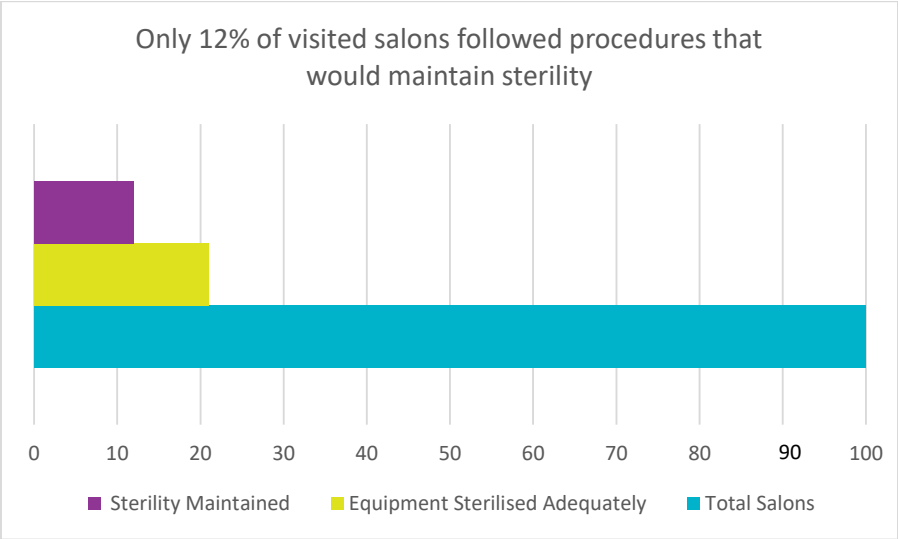
75% (43) of nail salons visited have staff uniforms. However, less than half of these were washing uniforms daily. The remaining salons either did not state the frequency of uniform washing or reported uniform washing every two days or twice a week.

40% (23) of salons assessed could not adequately describe how they wash their towels and/or uniforms (e.g. don't know what temperature or staff wash at home as required).
Adequate cleaning of client areas (e.g. fresh paper/towels, work stations wiped down with appropriate disinfecting product) was recorded in 90% (51) of salons.

Suitable disinfectants, defined as those capable of killing both viruses and bacteria, at the right concertation and contact time, and within the use by date, were used by 86% (49) of salons. Of the 14 % (8) of salons not using appropriate disinfectant, one was using an unknown chemical in an unlabelled bottle and three were using household cleaners such as 'Spray and Wipe' and three had no expiry date. One of these salons was using disinfectant at a significantly lower concentration than required by the manufacturer's instructions (this salon was also using a solution past its expiry date).

21% (12) of salons were adequately disinfecting and sterilising equipment, however, almost half (5) of these salons then failed to store or treat the equipment in such a way as to prevent recontamination (i.e. in a UV cabinet/zip lock bag). This means only 12% of salons surveyed were adequately disinfecting and maintaining the sterility of their equipment (see figure 5). Salons with trained staff were slightly more likely to have appropriate disinfection procedures, but due to the small number of salons adequately disinfecting, this is not statistically significant. Salons with mostly 'walk-in' custom were over five times less likely to be adequately disinfecting equipment than those salons with mostly pre-booked clients.

Figure 5: Disinfection and Sterilisation Procedures in Premises

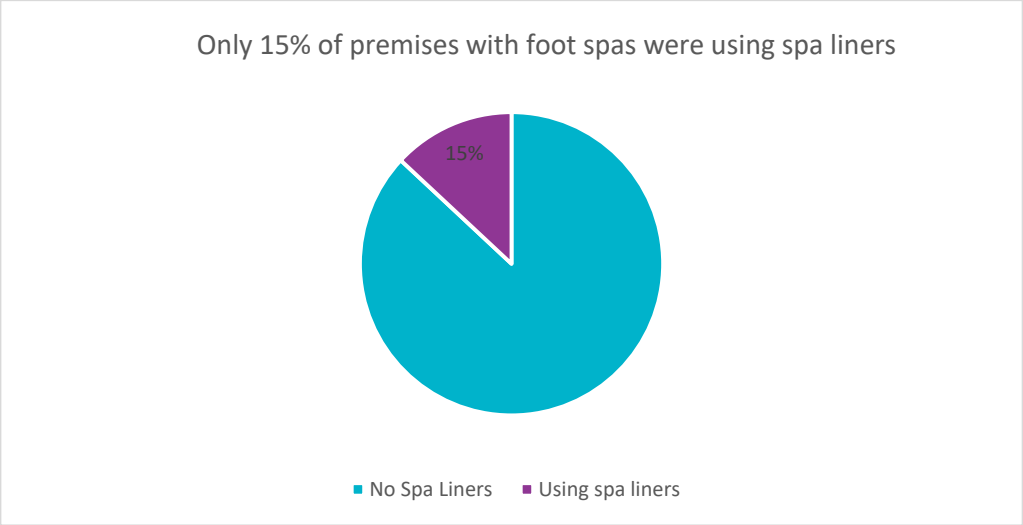


All respondent's confirmed they had equipment that required sterilising, including cuticle/nail clipper (75%), scissors (54%), any equipment that cuts or pierces the skin (26%), and 'other' equipment (32%). Only one salon was sterilising their equipment using the preferred method of an autoclave. Glass bead sterilisers were used in 14 salons, and for this study this was considered acceptable. Several operators/ managers incorrectly thought that their UV cabinet or other device such a hot air oven (temperature and time not specified) sterilised instruments.

Overgrown cuticles were pushed back with a metal cuticle pusher (72%), cut (47%), or pushed back with a rubber hoof stick instrument (16%). One operator could not describe what action was taken to deal with cuticles. These results did not vary significantly by training, client base, and length of time in business, or average cost of services.

Foot spas were used in 61% (34) of salons surveyed, but only 15% (5) of these were using spa liners (see figure 6). The remaining salons were cleaning foot spas between clients with hot soapy water, spray disinfectant, and/or scrubbing around the jets.

Figure 6: Premises using spa liners in foot spas



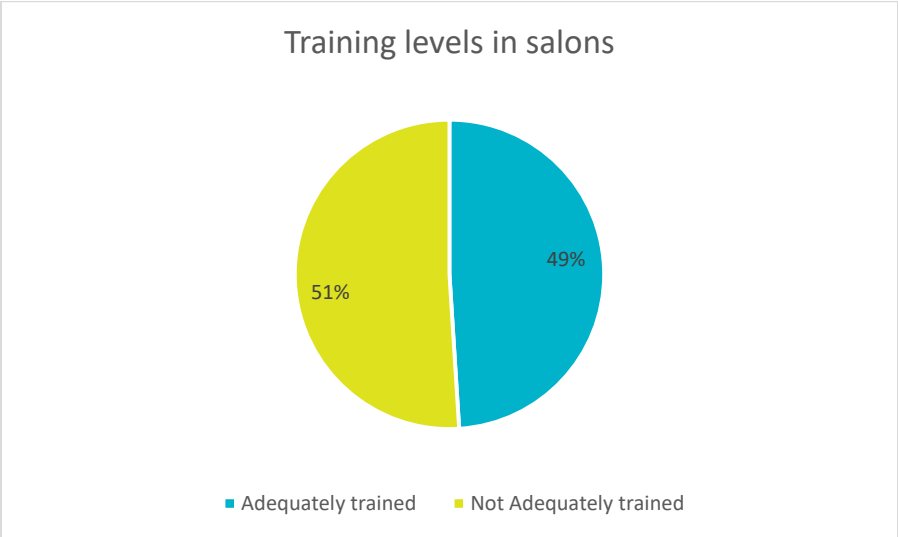
Heel blades to shave calluses and dry skin from feet were used in 14% (8) of salons. While an additional salon said they did not use heel blades, several were observed in the UV cabinet while officers were at the salon. None of these salons were members of the NZARBT, and were six times more likely to have staff that were not adequately trained. Salons with mostly 'walk-in' custom were eight times more likely to be using heels blades. Each of these salons was advised that heel blades should not be used by nail technicians due to the risk of infection and injury by removing too much skin. Clients with significant callus should be referred to a registered podiatrist who has the appropriate training to safely use a heel blade if required.

92% (51) salons had a first aid kit, four salons did not have a kit and there was no data for two salons. Inspecting the first aid kit was not part of the survey but some visits did review the kits. The contents of kits varied from basic, with only band aids, to a more comprehensive kit. The NZARBT recommends all salons have a first aid kit and have at least one person with a current first aid certificate on the premises at all times.

Training

47% (25) of salons were displaying staff qualifications where they could be viewed by clients, although these were not necessarily formal qualifications. In assessing training and qualifications, it was considered that slightly less than half (49%) of salons had an adequate number of trained staff (see figure 7).

Figure 7: Adequate number of trained staff in salons visited



Respondents were asked about on-going training undertaken by their staff. A third reported on-going training was in-house only (32%), while 21% (12) said their staff had none, didn't know, or were unable to satisfactorily describe any on-going training.

Lower priced salons, charging an average of $40 or less for a manicure were over three times more likely to have an inadequate number of trained staff than those charging more than $40. The number of years in operation (i.e. more than, or less than, five years) had no significance on the likelihood of having an adequate number of trained staff. Salons operating on a mostly 'walk-in' basis had a higher number of untrained staff, but this was not statistically significant.

Attitudes to education and regulation

Most nail salons (70%) were aware that some other regions in New Zealand have bylaws requiring the registration and inspection of nail/ beauty salons. An overwhelming 93% were supportive of a similar bylaw in the Wellington region. This figure did not vary significantly by qualification level of staff, type of salon (i.e. full beauty services versus nails only), average price, or how long the salons had been in operation. Just 5% of salons (3) expressed concern about the potential cost of regulation.

A large majority of salons stated they were interested in receiving education sessions arranged by RPH. In addition, salons were asked if they would be interested in resources being developed for nail salon staff. 89 % expressed an interest and the majority had a preference for resources to be written in English (84%). Other significant preferences included Vietnamese (25%) and Cambodian (7%).

Summary results from surveys

Table 1. Participating salons as a proportion of all salons in the specific geographic area

SALONS ASSESSED BY GEOGRAPHIC AREA	NO OF SALONS ASSESSED	% OF ALL SALONS IN AREA ASSESSED
Wellington city	27	45
Hutt city	10	30
Upper Hutt city	8	73
Porirua city	6	67
Kāpiti Coast	6	43
Total	**57**	**N/A**

Table 2. Salon and operator characteristics

SALON AND OPERATOR CHARACTERISTICS	NO OF SALONS	%
Number of staff		
• 0 - 1.0	11	19
• 1.5 – 2.0	17	30
• 2.5 – 3.5	12	21
• > 4.0	17	30
Number of manicures and pedicures combined per week		
• <5	13	25
• 5-20	14	27
• 21-99	16	31
• 100+	9	17
Average price of manicure		
• <$30	6	11
• $30- $45	23	43
• >$45	25	46
• Not recorded	3	N/A
Average price of pedicure		
• <$30	0	0
• $30- $45	23	44
• >$45	29	56
• Not recorded	5	N/A
Full beauty services are available at the salon	45	79
Custom		
• Mostly pre-booked	32	56
• Walk-in	21	37
• Mix of pre-booked and walk-in	4	7
Salons operating for less than 5 years	22	41
Member of NZARBT	18	32

Table 3. Characteristics assessed

CHARACTERISTIC OR SURVEY ITEM	NO OF SALONS	%
Health and understanding of transmissible infections		
Staff ask clients about		
• Health conditions	31	54
• Infections	28	49
• Allergies	19	33
• Problems with previous treatments	17	30
• Medications	13	23
• Other	39	68
Staff do not do a nail treatment if an infection is observed	22	39
Staff awareness of conditions transferable to clients (category 1 = Bacterial infections, category 2 = viral blood borne infections, category 3 = fungal infections)		
Knowledge of		
• None of the categories	11	19
• 1 of the above categories	14	25
• 2 of the above categories	15	26
• All 3 categories	17	30
Adequately aware of conditions transferable to staff (category 1 = Bacterial infections, category 2 = viral blood borne infections, category 3 = fungal infections)		
Knowledge of		
• None of the categories	9	16
• 1 of the above categories	13	23
• 2 of the above categories	12	21
• All 3 categories	23	40
Nail technician stops the treatment if the client bleeds	22	39
Staff are known to be fully vaccinated (hepatitis B)	9	16
Practices		
A written cleaning schedule is used	17	30
There is a separate staff hand basin	57	100
The salon has a separate sink to clean equipment sink	38	69
Hand sanitiser is available at all workstations	35	61
Staff wear a uniform/apron and it is washed daily	20	35
Towels are adequately cleaned	34	60
Adequate cleaning of client areas (i.e. fresh paper, wiped down, or adequate other)	51	90
Adequate instrument cleaning/disinfection/sterilisation	12	21
Instruments are stored or treated to prevent contamination **after** adequate disinfection/sterilisation.	7/12*	12 (7/57)

Disinfecting solution for equipment		
• Suitable disinfectant solution is used	49	86
• No expiry date on solution	3	5
• Incorrect concentration	1	2
• Unlabelled chemical in bottle (don't know)	1	2
• Other solution (not suitable) is used	3	6
Equipment identified by operator that needs to be sterilised	57	100
• Cuticle/nail clippers	43	75
• Scissors	31	54
• Any equipment that cuts or pierces skin	15	26
• Other	32	56
Salons use a foot spa	34	61
Salon who use a foot spa and a spa liner used	5	15
Staff deal with overgrown cuticles by		
• Pushing the skin back with metal instrument	41	72
• Cutting with scissors or cuticle clippers	27	47
• Pushing the skin back with rubber instrument	9	16
• Don't know	1	2
Staff deal with rough skin in feet by		
• pumice	19	33
• metal file	13	23
• Heel blade	8	14
Training		
Qualifications displayed on wall	25	47
Adequate number of trained staff		
• Yes	28	49
• No	29	51
On-going training		
• No on-going training	12	21
• In-house training only	18	32
Attitudes to education and regulation		
Salon manager has heard of bylaws in other regions	40	70
Supportive of bylaw	52	93
Worried about cost of bylaw	3	5
Interested in education sessions	49	89

Table 4. Characteristics assessed compared with level of staff training

CHARACTERISTIC OR SURVEY ITEM	ADEQUATELY TRAINED STAFF				
	Yes(n = 28)		No (n = 29)		P value
	Number	%	Number	%	
Average price of manicure* • <=$40 (Low Price) • $40 * for 3 salons price not recorded	5 21	18 75	19 9	66 31	0.0013
Knowledge/understanding					
Ask health questions	20	71	11	38	0.011
Ask about infections	15	54	13	45	0.51
Treatment not done if infection observed	18	49	19	51	0.9
Adequately aware of conditions transferable to clients	11	39	6	21	0.12
Adequately aware of conditions transferable to staff	15	54	8	29	0.046
Do they stop treatment if client bleeds	13	46	9	31	0.23
Staff are fully vaccinated	4	14	5	17	0.76
Practices					
Written cleaning schedule	13	46	4	14	0.007
Adequate instrument cleaning (including correct solution)	7	25	5	17	0.47
How deal with overgrown cuticle - cut	11	39	16	55	0.23
How deal with rough skin - use heel blade	1	4	7	24	0.02

Table 5. Characteristics assessed compared with booking style of salon

CHARACTERISTIC OR SURVEY ITEM	CLIENTS MOSTLY PREBOOK				
	Yes n=32		No n=21		P value
Knowledge/understanding	Number	%	Number	%	
Ask health questions	21	66	9	43	0.10
Ask about infections	20	63	7	33	0.4
Staff are fully vaccinated	5	16	3	14	0.89
Practices					
Written cleaning schedule	10	31	6	29	0.84
Adequate instrument cleaning	9	28	1	5	0.03
How deal with overgrown cuticle -Cut	14	44	10	47	0.78
How deal with rough skin – Heel blade	1	3	5	24	0.02
Do they stop treatment if client bleeds	14	44	7	33	0.45
Don't do if infection	22	69	11	52	0.23
Training					
Adequate training	20	63	8	38	0.08

Table 6. Characteristics assessed compared with the number of years salon has been in operation

CHARACTERISTIC OR SURVEY ITEM	SALONS IN BUSINESS MORE THAN 5 YEARS				
	Yes n=32		No=25		P value
Knowledge/understanding	Number	%	Number	%	
Ask health questions	19	59	12	48	0.39
Ask about infections	13	41	15	60	**0.04**
Staff are fully vaccinated	3	9	6	25	0.13
Practices					
Written cleaning schedule	10	31	7	28	0.79
Adequate instrument cleaning	7	22	5	20	0.86
How deal with overgrown cuticle -Cut	12	38	15	60	0.09
How deal with rough skin – Heel blade	2	6	6	24	0.06
Stop if bleed	12	38	10	40	0.85
Don't do if infection	19	59	18	72	0.32
Training					
Adequate training	16	50	12	48	0.88

Table 7. Characteristics assessed compared with average price salons charge

CHARACTERISTIC OR SURVEY ITEM	LOW PRICE SALONS (I.E. <=$40 FOR MANICURE)				
	Yes n = 24		No n = 30		P value
Knowledge/understanding	Number	%	Number	%	
Ask health questions	10	42	20	67	0.07
Ask about infections	11	46	15	50	0.76
Staff are fully vaccinated	4	17	4	13	0.73
Practices					
Written cleaning schedule	2	8	14	47	0.002
Adequate instrument disinfection	4	17	8	27	0.38
Suitable disinfectant solution	21	88	27	90	0.77
How deal with overgrown cuticle - Cut	12	50	14	47	0.81
How deal with rough skin – heel blade	5	21	2	7	0.13
Do they stop treatment if client bleeds	**5**	**21**	**16**	**53**	**0.02**
Don't do if infection	16	67	19	63	0.80
Training					
Adequate training	5	21	21	70	0.0003

DISCUSSION

Assessment of knowledge and infection prevention and control practices in commercial nail and beauty salons in the Wellington region has not occurred previously. To our knowledge this is also the first assessment of this kind in New Zealand.

The main outcome is the identification of baseline data on infection control practices of salons in the Wellington region. The dataset also provides a benchmark of current practices in the industry, which can then be compared with other regions where regulation occurs through bylaws. The immediate value of the salon visits was that RPH staff provided feedback on any unsafe practices and other areas for improvement.

While the NZARBT has developed guidelines for the industry, only 32% of the salons visited were members of this organisation. Those salons who do not have a staff member with a qualification recognised by NZARB, are unable to join the association or access resources the association provides. There are national guidelines for the safe piercing of skin(19) used by tattooist and skin piercers, but there is not a similar resource for other commercial beauty and personal services that can break the skin.

While many operators indicated that staff received some form of on-going training, this was often in the form of 'in-house' training, provided by nail product companies or other staff (32%). A further 21% of salons had no on-going training at all.

The results of the survey clearly indicate a need for more accessible ongoing education in the sector.

While 89% of salons interviewed expressed an interest in education sessions arranged by RPH, a significant number (19%) of salons surveyed were sole operators, meaning taking time off to attend training sessions may present difficulties. Education and support for nail salon workers has been found to be effective at improving compliance with infection control practices(20).

A lot of salons were getting some of the basic infection prevention measures wrong, with 60% reporting they would continue a treatment even if the client started bleeding.

Only 64% of salons would advise a client that a treatment could not be done that day due to a hand/foot infection in the treatment area. Both these practices put clients at high risk of infection. A lack of understanding about the potential impact of the clients existing health conditions is reflected by 46% of salons not asking clients about pre-existing health conditions. Conditions such as diabetes, some cancers or cancer treatments and poor vascular circulation put the client at higher risk of serious infection and delayed healing following an unintended cut or abrasion. With an aging population and increase in health conditions it is important that salons routinely ask about these conditions and adjust what services they offer to people at higher risk.

Responses to the cleaning of facilities, uniforms and equipment were variable. Nearly all the salons (90%) described adequate process for cleaning client areas and work stations. However, to ensure all areas are consistently cleaned every time requires a written cleaning schedule, particularly where

there are multiple staff. Salons offering lower cost manicures were five times less likely to have a written cleaning schedule. The survey did not ask if all staff are involved in salon cleaning, or if cleaning was done by a particular person or contracted to an external company. Owner / manager knowledge and practices for uniform and towel washing was not as good as it could be. Fungi like *Tinea pedis* ('Athletes Foot') and *Staphylococcus* can be spread to clients and staff through inadequate laundered towels. All salon owners or managers should understand the importance of effective laundering and have appropriate oversight within their salon.

Of greatest concern is an apparent lack of understanding of the steps required to adequately process tools that may pierce or cut the skin (e.g. nail clippers,) prior to use for the next client.

Nail clippers and scissors are considered semi-critical instruments and require a wash in soapy water, immersion in hospital grade disinfectant for required time, and then sterilisation. An autoclave is the preferred method. Only one salon was using an autoclave and 14 were using glass bead sterilisers. Adequate sterilisation is a challenge for salons; in particular the cost, ease of use and requirement for a rapid turnaround time. Glass bead sterilisers use a high temperature and offer a relatively short sterilising time and are considered acceptable for sterilisation by the NZARBT. Potential issues with glass bead sterilisers include difficulty monitoring their effectiveness, inconsistent heating resulting in cold spots, and the potential for air trapped between the beads to affect the sterilisation process. Satisfactory performance of the glass bead steriliser is dependent on the operator; allowing adequate time for the beads to reach the operating temperature, inserting instruments in to the body of the beads (not the sides where temperatures are lower), limiting number of instruments per load and allowing beads to come back to temperature before the next load(21).

Adequate processing of semi critical instruments is dependent on staff following all the required steps (washing, disinfecting, sterilising and storage). Some salons were doing the first three steps well, then storing instruments in a way that they could get contaminated e.g. stored on an open shelf near a hand basin. Only 12% of participating salons were adequately following all the steps of washing, disinfecting, sterilising and storing their equipment. Inadequate disinfection and sterilisation of equipment was seen across all types of salons, including those with suitably trained staff. Anecdotally, salon managers often believed they were following best practice and strived to achieve this, however in the absence of any minimum standards, managers don't always have the information required to achieve this. This issue is not unique to NZ, with a similar gap in knowledge and a lack of adequate infection control measures found in a Canadian survey of manicure and pedicure establishments.(1)

Almost half of salons were cutting cuticles with scissors or clippers, and this did not alter based on any of the variables considered. This increases the risk of infection through cuts and possible transference of blood borne pathogens between clients, especially in an environment where equipment may not have been adequately sterilised. The NZARBT recommends the use of a rubber hoof stick to push back cuticles rather than cutting or clipping.

Further unsafe practices, such as the use of heel blades or shavers, were observed in a significant number of salons. This can lead to permanent damage and increases the risk of infection still

further. The NZARBT explicitly bans the use of shavers by beauty therapists in its Guidelines. None of these salons were members of the NZARBT, and were six times more likely to have staff that were not adequately trained, and eight times more likely to have mostly 'walk-in' clients.

While the use of styptic pens to stop bleeding was not specifically queried, 16 % (9) of salons commented that they were using these. Styptic pens may present an infection risk from previous clients, especially if applied directly to a wound. In addition, the presence of these, and similar solutions, implies that bleeding during a treatment is of sufficient likelihood to require stock to be held onsite.

The Guidelines also require pedicure basins to be lined with a single use disposable plastic basin liner for each client and pipes to be regularly disinfected. While disinfection of pipes was not explored, only 15% of those using foot spas were using spa liners which can help reduce the risk of the spread of infection. Fungal nail and foot infections are common in the community and the whirlpool footbaths are extremely difficult to clean properly. Outbreak investigations of boils and skin infections associated with pedicures have identified mycobacterium, visible debris, slime (7) hair and skin debris (8) in the screens and pipes of footbaths.

Although not specifically queried we did not identify any salons offering fish pedicures. Internationally use of Garra Rufa fish to nibble on the dead skin on feet has been associated with infection risks. Fish pedicures are banned in several states in the United States (22) and although rated as low risk in the UK the Health Protection Agency has developed very detailed guidance on the requirements to offer a safe service (23)

That salons without adequately trained staff (51%) represent an elevated infection risk to clients is demonstrated by the comparison with those salons who do have adequately trained staff. These salons were three times less likely to have written cleaning schedules, almost half as likely to ask health questions before a treatment, and had less awareness of transmissible infections. Salons at the cheaper end of the market were more than three times more likely to have untrained staff, suggesting that lower price salons also presented an elevated infection risk.

Overall there was very poor knowledge about the risk of infection to either staff or patients. 19% of operators were not able to name any conditions that clients could get from a nail treatment and only 30% were able to identify that bacteria, viruses, or fungi could be acquired during a treatment. In answering the question operators did not have to use these specific terms. Words such as boil, infection or abscess were counted as bacterial infection, similarly hepatitis B or C, HIV were accepted for viral infections and *tinea*, athletes foot, etc were counted for fungal infections. There also seemed to be limited understanding that staff could get infections from equipment or clients if the appropriate safe guards were not in place. This lack of knowledge about transmissible pathogens may well be a contributing factor to poor instrument processing.

Hepatitis B virus infection (HBV) is highly infectious and preventable by vaccination. However only 16% of salons reported that all their staff were fully vaccinated, only 5% encourage staff to be vaccinated and no salons pay for staff to be vaccinated. NZ staff born before 1974 will not routinely have been immunised and those born between 1974 - 1988 may not have received all the required

doses through the HBV school catch up programme. Staff from overseas may or may not be protected from HBV. Overall there seemed to be a somewhat passive approach to knowing or ensuring that staff are protected from HBV. From a health and safety perspective a more active approach to assess their staffs' protection against HBV and recommending vaccination (if susceptible) is a practicable step that operators can take to protect their staff and their clients. Both the NZARBT(18) and the NZ Immunisation Handbook(24) recommend HBV vaccination (if susceptible) for staff who perform procedures where skin penetration may occur.

Clients are potentially at risk of HBV infection from equipment that has been inadequately cleaned after exposure to blood from a staff member or prior client who is a carrier of HBV. HBV can survive on work surfaces or equipment even in the absence of visible blood contamination for more than a week. Podiatric care was the most likely cause of an outbreak of HBV in the United States. Five people developed acute HBV with the same HBV sequence as person who was had chronic HBV after all attending the same clinic on the same day (3).

There is support within the industry for regulation with an overwhelming 93% of survey participants stating they were supportive. Support for regulation across the wider appearance and personal services industry is consistent with the position of the NZARBT (25) and also members of allied industries such as tattooing (26-28). Only 5% of operators in the survey were concerned about the possible costs associated with regulation. The general feeling is that regulation would increase standards and decrease the number of cut price operators. Within the industry there is a perception that it is only cut price salons that require regulation to improve their safety. This survey identifies room for improvement in salons across the price spectrum. Just because a salon has a very professional or upmarket appearance this does not mean they are adequately cleaning their salon and equipment. Informally we are aware that the public often think that nail and beauty salons and tattoo studios are already regulated and are surprised to hear they are not. Educational resources to raise client awareness and assist customers to ask key questions about how a salon clean their instruments might be useful. This approach of the empowered customer has been used to help people chose a tattooist (29) in New Zealand and to choose a safe nail salon in the United States (30). The main limitations to this being effective for nail services are that; unlike tattoos they are perceived by the public as minimal or no risk, they are used more frequently, in addition a client may feel asking their nail technician questions about cleaning equipment could get in the way of the relaxing experience. In addition it can be difficult for clients to adequately assess the information given by the operator. The empowered customer approach would be useful to support but not replace regulation and industry education.

It is recognised that some salons surveyed would be unable to meet standards if a local bylaw had criteria similar to others currently operating in New Zealand e.g. separate equipment sink (69%). However this type of infrastructure cost should be factored into the business model when opening a salon.

The survey identified there is high turnover of salons, with a significant number (10%) ceasing to operate between being identified through the telephone directory or social media, and being contacted. An additional 41% of salons had been operating for less than 5 years. This further points

to the benefit of regulation in the industry. With new operators entering the market regularly measurable improvements could occur in relatively short space of time.

LIMITATIONS

- New Zealand does not have a national guideline for safe practice and infection prevention for manicures and pedicures. The NZARBT Health and Hygiene Guidelines, although not widely used in the industry, was used as 'best practice' in this survey.

- There was some difficulty in developing a complete list of salons in the region. Salons were identified using internet and telephone directory searches, however this may not identify all salons, particularly given the high turnover rate in the industry. Some additional salons were identified during the visits and these were included in the survey.

- Participation in the survey was voluntary and a portion of salons declined to be visited. It is unclear whether these salons would differ significantly in their knowledge and practices. However salons that are not confident in their infection prevention practices may be more likely to decline the visit.

- Several salons had staff where English was a second language. While interpreters were offered only one operator requested an interpreter. This may have introduced a comprehension issue when asking or answering questions.

- All surveys were conducted with the manager or owner of the salon. In salons which are not sole operators, there may be some variation in processes by other staff which has not been accounted for.

- This survey did not look at other potential risks to staff from exposure to solvents, lacquers, adhesives or dust.

- This survey did not look at other potential risks in the wider appearance and personal services industry.

Conclusions

This project demonstrated that a lack of knowledge and inadequate infection control is prevalent amongst the nail industry, with only 12% reporting adequate disinfection, sterilisation and storage of equipment. A significant portion of salons hire staff that have no formal qualifications, and on-going training is not the norm.

Salon operators were provided with recommendations at the visit. However the survey shows there is both a need and interest within the industry, for education sessions and resources to be provided regarding infection control practices in nail salons.

Education of staff alone is unlikely to be sufficient to bring about the required knowledge and behavioural changes, particularly given the proportion of staff without formal training and high

turnover of staff. National regulation could provide for regular inspections a legal infrastructure for corrective actions and could see minimum standards applied throughout the industry. In the absence of national regulation, local councils should pursue local bylaws to reduce risk in their communities.

These findings raise wider issues related to other unregulated areas of the beauty and appearance industry which are of higher risk and more invasive. In particular the use of laser devices, skin micro needling, eyebrow micro blading and waxing.

Recommendations

Ongoing infection prevention training and resources

- RPH to scope the potential to host an education workshop for salon managers and staff.
- RPH to explore with the NZABRT the provision of on-going training (cost-recovery) for salons with staff not able to join the NZARBT
- RPH to explore with the Ministry of Health and NZABRT the development of resources for staff in languages other than English (e.g. Vietnamese) , to reflect the language preferences within the industry

Dissemination of the survey findings

- RPH to present the survey findings at a Health Protection Forum in 2018
- RPH to share the survey results with the local council to inform consideration of local bylaws to regulate nail and beauty salons in the region
- RPH to share with the Ministry of Health the results identifying inadequate infection control procedures in many salons
- RPH to share the results with WorkSafe New Zealand with regard to worker knowledge and safety
- RPH to continue to work closely with allied partners e.g. Podiatry NZ, NZABRT, and local councils to look at long term solutions
- RPH to develop information on risks associated with manicures, pedicures and nail services to increase awareness with local health professionals

Further research

RPH to conduct the same survey in Masterton and South Wairarapa regions in 2019 to allow comparison of knowledge and practices in the industry in an area subject to bylaw regulation.

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Appendix 1

Infection Prevention and Control in Nail Bars Workshop
22 Nov 2016 1pm – 4.00pm

ITEM	DESCRIPTION	TIME
1	Introduction, Purpose of the Workshop.	1.00pm
2	Infection risk associated with nail bars, prevention and control	1.10pm
3	The podiatrists view	2.00pm
4	Afternoon tea	2.20pm
5	Implementation of Masterton District Council Bylaw	2.40pm
6	Survey format and questionnaire	3.15pm
7	Use of interpreters	3.35pm
8	Summary	3.50pm

Appendix 2. Questionnaire

Nail Manicure/ Pedicure questionnaire

Salons name:	
Address:	**TLA:**
Owner/Manager:	**Telephone:**
Name of interviewer(s)	**Date of interview**
Procedures done at this salon: *(circle all answers provided)* Manicure Pedicure Application of false nails Nail augmentation Gel nails Acrylic nails Shellac Tanning Hair dressing Other beauty services e.g. Waxing Makeup Facials	

At the start of the interview;

- Confirm that this is a convenient time to do the questionnaire.
- Advise the questionnaire will take approx. 60 minutes.
- Advise that we are doing questionnaires with a lot of nail and beauty salons across the greater Wellington region.
- The purpose of the questionnaire is too find out about knowledge and practices to keep customers and staff healthy and assess if a bylaw to regulate salons will be useful in our region.
- Advise that all their answers are confidential and only information that doesn't identify salons will be used.
- Advise that the visit may identify some things that they can change and increase customer and staff safety.
- Advise that you will give them some education information and feedback at the end of the questionnaire.
- If the owner / manager has requested an interpreter, check that this is still OK.
- Ask if they have any questions before the questionnaire starts.
- If a participant decides not to continue – thank them for their time and provide the education resources.

General			
How many staff (full time equivalent) do you have that do nail manicures, nail applications and pedicures?			
Approximately how many manicures _____ and pedicures _____does your salon do per day/week?			
How long has this salon been operating? _____			
What is the standard price for a pedicure?_____Manicure?_____ Do you offer specials(e.g. grab one)?_____			
How do you receive your customer? Mostly pre-booked (telephone or on-line) Mostly 'walk-ins' Mixture Other_____			
Do you own/ manage any other salons that offer nail/ manicure/ pedicure services? Yes or No *If yes specify*_____			
Training education and qualifications			
What qualifications do you and your staff have? *Enter number of staff for each category* Don't know _____ No formal training _____ On the job training _____ NZ 1 yr certificate in beauty therapy _____ 2 yr diploma in beauty therapy _____ CIDESCO (World stnd)_____ Other (e.g. trained by supplier i.e. ProfessioNail or Creative Nails NZ.)_____			
How do you and staff keep your knowledge and training up to date? (Circle all answers provided) Don't know or no on-going training Attend training courses In house training Other _____			
Are staff qualifications displayed where clients can see them (e.g. on wall)?	**NO**	**YES**	**N/A**
Salon and equipment cleaning			
	NO	**YES**	**N/A**
Do you have a written cleaning schedule? *If yes ask to see it and see if it outlines what must be cleaned, how often, products to be used and who is responsible)*			
Can you show me the hand basin staff use to wash their hands *(circle which of the following apply)* Is it located close to work station and supplied with			

liquid soap warm and cold water Single use towels or hand dryer			
Do you have a separate equipment cleaning sink*? If yes circle which of the following apply* Sink located away from client area Brush available for cleaning			
	NO	**YES**	**N/A**
Do you have hand sanitiser available for staff? *If yes, circle below where it is located* At front desk At all work stations At some work stations Other _____			
Do staff wear gloves for any nail/ manicure or pedicure treatments/ *If yes, which treatments*_____			
Do staff wear a uniform or apron? *If yes* how often are these washed? _____			
How are towels cleaned?*(circle all answers provided)* Professional/ commercial laundry service Machine washed on site (temp >60C) _____ Other;_____			
How are client areas cleaned between clients? Don't know, no cleaning done Fresh paper put on chairs Chairs/ tables wiped down with appropriate solution Other _____			
Do staff have their own instruments (e.g. scissors, clippers, files) *If yes* How many sets does each person have_____ If salon supplies the instruments How many sets of instruments does the salon have? _____			
Do you have any equipment that is used for one client and then thrown out? *(Circle all answers provided)* Gloves Cardboard nail files Other _____			

Can you tell me how you clean your scissors and nail clippers *(Circle all answers provided)* Wash in hot soapy water Scrub with a brush Ultrasonic cleaner Rinse with running water Soak in disinfectant (usually 20-30 mins) Sterilise with glass bead steriliser, autoclave Store in UV cabinet Other _____			
What disinfecting solution do you use for equipment? *(Circle all answers provided)* None, don't know Unlabelled chemical in bottle Hospital grade disinfectant Chlorine/ bleach solution Other_____			
What equipment that you use needs to be sterilised? *(Circle all answers provided)* None or don't know Any equipment that cuts or pierces the skin Cuticle clippers, nail clippers Scissors Other_____			
	NO	**YES**	**N/A**
Do you use foot spas? *If yes* – Do you use disposable liners in the foot spa			
If you don't use disposable foot spa liner how do you clean the foot spa and disinfect the jets? (*Circle all answers provided)* Don't know Not cleaned Scrub with brush Scrub around the jets Washed with hot soapy water Flushed with disinfectant solution Rinsed with water Other _____			
Health			

Do you ask clients any health questions before a manicure/ pedicure or nail application?
(*Circle all answers provided)*
Health conditions
Problems with previous treatments
Infections
Allergies
Medications
Other
_____

What do staff do if a clients has a nail/ hand or foot infection? *(Circle all answers provided)*
Don't know
Cover the area and continue the treatment on unaffected areas
Advise person to see GP
Advise that a nail/ pedicure treatment can't be done today
Other
_____

What conditions could customers get from a pedicure, manicure or artificial nails? (*Circle all answers provided)*
Don't know or none
infections, skin infection, bacterial infection, boil, abscess
Viral infection, Hepatitis B ,Hepatitis C, HIV, blood borne virus, BBV
Fungus, fungal infection, tinea, athletes foot
Cuts, damage to nail, damage to cuticle
Other_____

What conditions could you/your staff get from customers (*circle all answers provided)*
Don't know or none
Infections, skin infection, bacterial infection, boil,
Virus infection, Hepatitis B, Hepatitis C, HIV, blood borne viruses
Fungus, fungal infection, tinea,
Other
_____

What do staff do if a clients skin bleeds during a treatment? (*circle all answers provided)*
Stop the treatment,
Put on gloves (if not already on)
Apply pressure with a clean dressing to stop bleeding ,
Apply band aid or similar
If serious, advice person to see GP
Other _____

Do you have a first aid kit on site? YES …. NO
If yes ask to see the first aid kit and record if it contains appropriate supplies e.g. unopened dressings, band aids etc.

How do staff deal with overgrown cuticle skin? (*circle all answers provided)*
Don't know
Push skin back with metal instrument
Push skin back with rubber hoof stick
Cut with scissors or cuticle clippers
Other
_____

How do you deal with hard rough skin or calluses on feet and heels?
Pumice stone
Metal file
Heel blade/ razor to cut skin away (*(if yes, at the end of the questionnaire advise that this should NOT be done due to infection risk*
Other
_____

Do you know if you and your staff have been vaccinated or/are protected against Hepatitis B infection?
(*Circle all answers provided)*
No
Don't know
Yes- all staff protected - *ask how they know this.*
_____
Some staff protected
Encourage all staff to be vaccinated
Pay for staff to be vaccinated

If education resources are developed, what languages would be most useful for you and your staff?
English
Te reo
Samoan, Tongan
Korean
Vietnamese
Filipino
Mandarin
Other
_____

Are you a member of the New Zealand Association for Registered Beauty Therapists (NZARBT)? (*Circle all answers provided)*
Yes
No
Don't know,
I've never heard of it

Are you aware that some Councils in NZ have bylaws so that nail and beauty salons are inspected each year? (*Circle all answers provided)*

Yes No Don't know, I've never heard of it
What are your thoughts on being registered and inspected by the Council each year? (*Circle all answers provided)* Supportive of registration Opposed to registration Neutral or don't know Worried about cost of registration **Other comments**
If education sessions were offered by Public Health or your local Council would you/ your staff be interested in attending? YES NO Comments
Do you have any questions for us?
Overall Comments:

Advise that the questionnaire has now finished and ask if they have any questions or comments

Action points:

☐ **Shown a copy of NZBA Health and Hygiene Guidelines and web address**

☐ **Given feedback about any infection control practices at the salons.**

Appendix 3. Invitation letter to participate in the survey

Regional Public Health
HAUORA Ā IWI KI TE ŪPOKO O TE IKA A MĀUI
Better health for the greater Wellington region

Date

Owner/ manager of
Address

Dear

Preventing infections during manicures and pedicures

Having a manicure or pedicure is popular and can be a relaxing and fun beauty treatment. The majority of the time clients will have a good experience, but very occasionally the client may develop an infection which is could be bad for the client as well as your business.
Regional Public Health, in association with your local council, plans to meet with all operators of pedicure/manicure businesses in the Wellington region.
Your salon has been identified from electronic advertising, and we would like to arrange a suitable day and time to meet with you. The visit will take around 30-60 mins. We would visit at a time when you were not busy. Having a visit is voluntary, though we encourage you to take part, as we want to support you and your staff to provide the best and safest service.
As part of the visit, we would like to do the following:

- Discuss with you how you manage infection prevention and control
- Provide health education materials and answer questions you may have

We will contact you in a few days to check if there is a suitable time for us to visit. We can also arrange an interpreter if needed. If you have any questions, or would like to discuss this further, please feel free to contact _____on 04 570 ____.

Yours sincerely

AC Nesdale

Dr Annette Nesdale
Medical Officer of Health

Regional Public Health, Private Bag 31907, Lower Hutt 5040 | P 04 570 9002 F 04 570 9211 E rph@huttvalleydhb.org.nz | www.rph.org.nz

Appendix 4: Thank you letter for survey participation

Regional Public Health
HAUORA Ā IWI KI TE ŪPOKO O TE IKA A MĀUI
Better health for the greater Wellington region

Dear salon owner/operator,

We would like to express our sincere thanks for your time and for allowing our officers to visit your premises to complete our questionnaire.

We would be grateful if you could please take the time to read the New Zealand Association of Registered Beauty Therapists (NZARBT) Health & Hygiene Guidelines provide to you at the time of our visit.

In order to ensure the safety of your clients when conducting manicures and pedicures, it is very important that you understand how clients can become infected by harmful bacteria, viruses and fungal spores. Therefore, we recommend the following for semi critical instruments:

1. Wash and scrub semi critical instruments (clippers, scissors, cuticle pushers) in hot soapy water (use a clean toothbrush to remove any dirt or debris)
2. Immerse the instruments in a hospital grade disinfectant that is proven to kill pathogens – for example, Viraclean (note: this is low level disinfectant and will not kill spores).
3. Place semi critical instruments into an autoclave to achieve sterilisation.
4. Alternative to 3 – place instruments into a glass bead steriliser as per device manufacturer's instructions
5. Hygienically store your clean instruments either in a UV cabinet or in single use sealable sandwich bags.
6. Ensure that you have enough sets of clean instruments for use between clients as it will take time to effectively clean, disinfect and sterilize the set you have just used.

We would strongly recommend that you consider joining the NZARBT, and have included their contact details as follows: info@beautynz.org.nz or Tel: 09 579-9704.
Please note: if there is enough interest generated from operators, we may organise a workshop on infection prevention and control in nail bar settings, please let us know if you would be interested in this training.

Please don't hesitate to give us a call if you have any questions or queries.

Kind regards

Regional Public Health
Tel: 04-570-9002
Email: healthprotection@huttvalleydhb.org.nz

Regional Public Health, Private Bag 31907, Lower Hutt 5040 | P 04 570 9002 F 04 570 9211 E rph@huttvalleydhb.org.nz | www.rph.org.nz

PUBLIC

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**HEALTH SYSTEM COMMITTEE INFORMATION**
	Date: 15 May 2019

Authors	Lisa Smith, System Development Manager Rachel Pearce, Senior System Development Manager Russell Cooke, Senior System Development Manager Sam McLean, Senior Analyst
Endorsed by	Rachel Haggerty, Director Strategy, Innovation & Performance
Subject	**UPDATE ON THE RESPONSE TO MEASLES IN OUR COMMUNITY AND, MORE BROADLY, IMMUNISATION COVERAGE ACROSS CCDHB**

RECOMMENDATIONS

It is **recommended** that 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.

1. PURPOSE

The purpose of this paper is to update the Health System Committee on the response to measles in our community, and provide information more broadly about DHB immunisation coverage and activities to improve coverage.

2. MEASLES RESPONSE IN THE WELLINGTON REGION

2.1 Confirmed cases

There are two confirmed cases of Measles in the Wellington region, both directly linked to cases in the Bay of Plenty. Regional Public Health (RPH) have advised that there is low risk of community spread in our region as neither of the ill people spent time in public places while infectious.

2.2 Immunisation against measles

The Ministry of Health recommends two doses of the measles vaccine to obtain the most effective protection for individuals, families and communities. The Measles, Mumps and Rubella (MMR) vaccine is recommended and funded for children at 15 months and 4 years of age, under the National

Immunisation Schedule. MMR is also free for those under 50 years of age who have not had 2 documented doses. People aged over 50 years are considered immune.

At 31 December 2018, coverage of MMR vaccination was 94% for 15-month olds and 92% for 4 year olds in Capital & Coast DHB. This data is held in the National Immunisation Register (NIR). Coverage of MMR vaccination in the total population is difficult to estimate as records were historically held in paper form and more recently in individual practice management systems, the NIR was only rolled out in 2005.

2.3 Regional Public Health-led measles preparedness

RPH leads measles preparedness locally. Current activities include:

- Supporting the PHOs and primary care with messaging and advice via teleconferences and RPH webpage;
- Raising community awareness and promoting immunisation via information distributed to all ECC's, schools and councils across the greater Wellington region;
- Reminding primary care about ensuring their staff are protected and that they have effective infection control practices to prevent transmission in medical centres;
- Supporting the localisation of the 3D Measles pathway to support triage, diagnosis and infection control; and
- Ensuring RPH staff are protected from measles.

2.4 Primary Care

General practices remain on alert and are experiencing an increase in people requesting immunisations for themselves or their children, or requesting information about their immunisation status. Isolation protocols are being followed for anyone presenting with a high fever and/or rash.

All practices are receiving the National Health Advisories from Regional Public Health and PHOs are distributing information to staff about how to protect yourself and whānau.

3. CCDHB IMMUNISATION COVERAGE MORE BROADLY AND IMPROVEMENT ACTIVITIES

We are committed to proactively supporting people to access immunisations. Immunisations are available in a range of venues, including general practice and from outreach immunisation teams. Childhood immunisation rates are shown below as an indicator of immunisation trends.

Childhood immunisation coverage in CCDHB is below the 95% target across all age groups (figure 1). However, at a total population level CCDHB performance is higher than the national average.

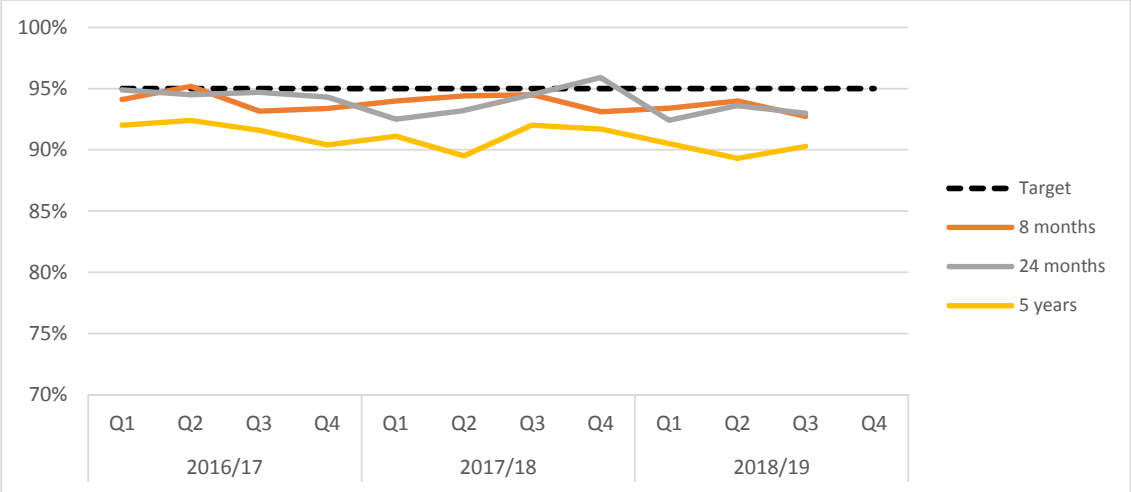

Figure 1. Percentage of CCDHB domiciled children fully immunised at the milestone ages: 8 months, 24 months, and 5 years.

In all age groups except 24 months, immunisation coverage is lower for Māori and Pacific children, and those living in low socioeconomic areas (figure 2).

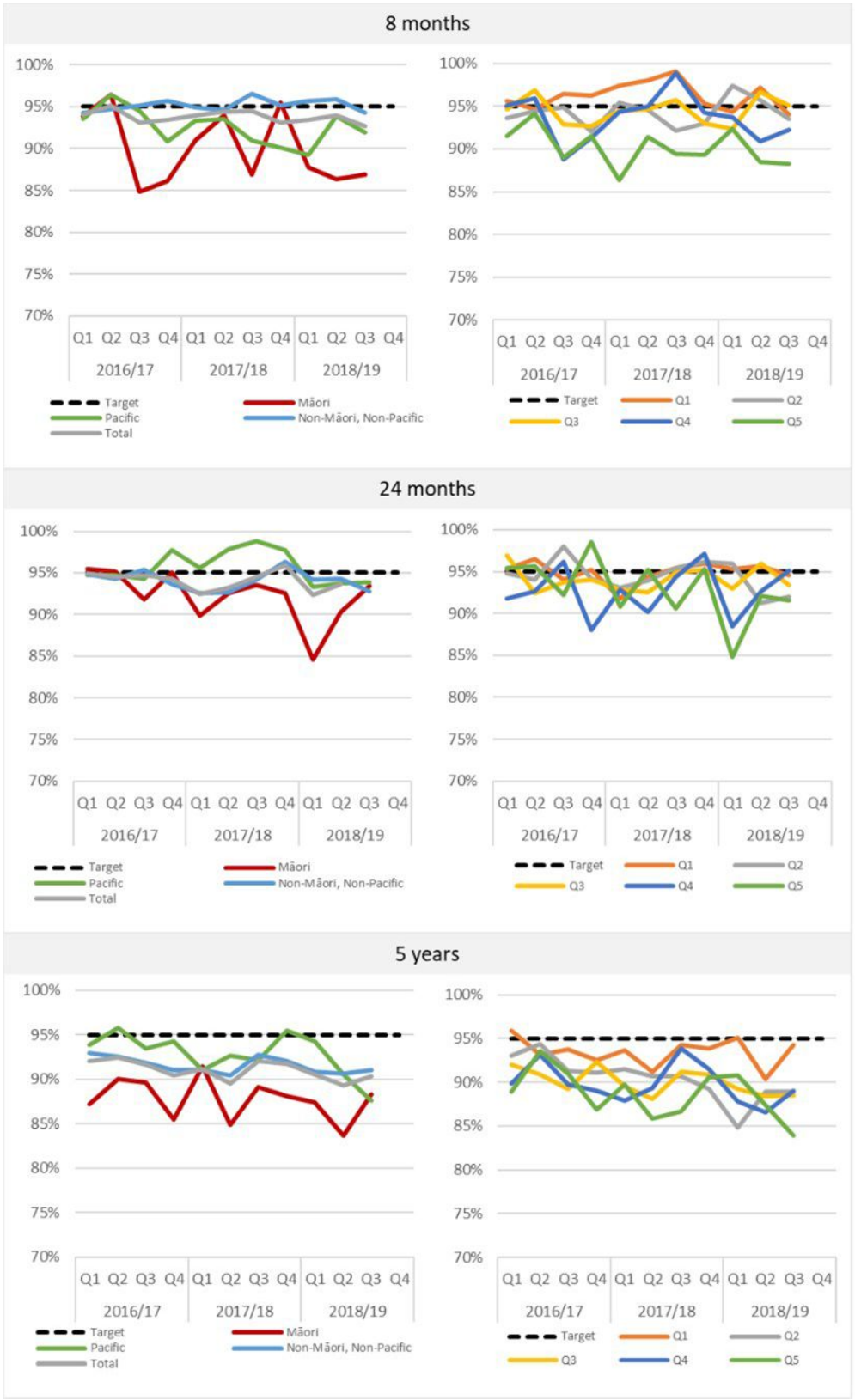

Figure 2. Percentage of CCDHB domiciled children fully immunised at the milestone ages: 8 months, 24 months, and 5 years; by ethnicity and quintile.

PUBLIC

The number (and rate) of people declining to immunise their children or opting-off the NIR is increasing (figure 3), although remains below the national average. The same is true for the children we did not immunise (missed).

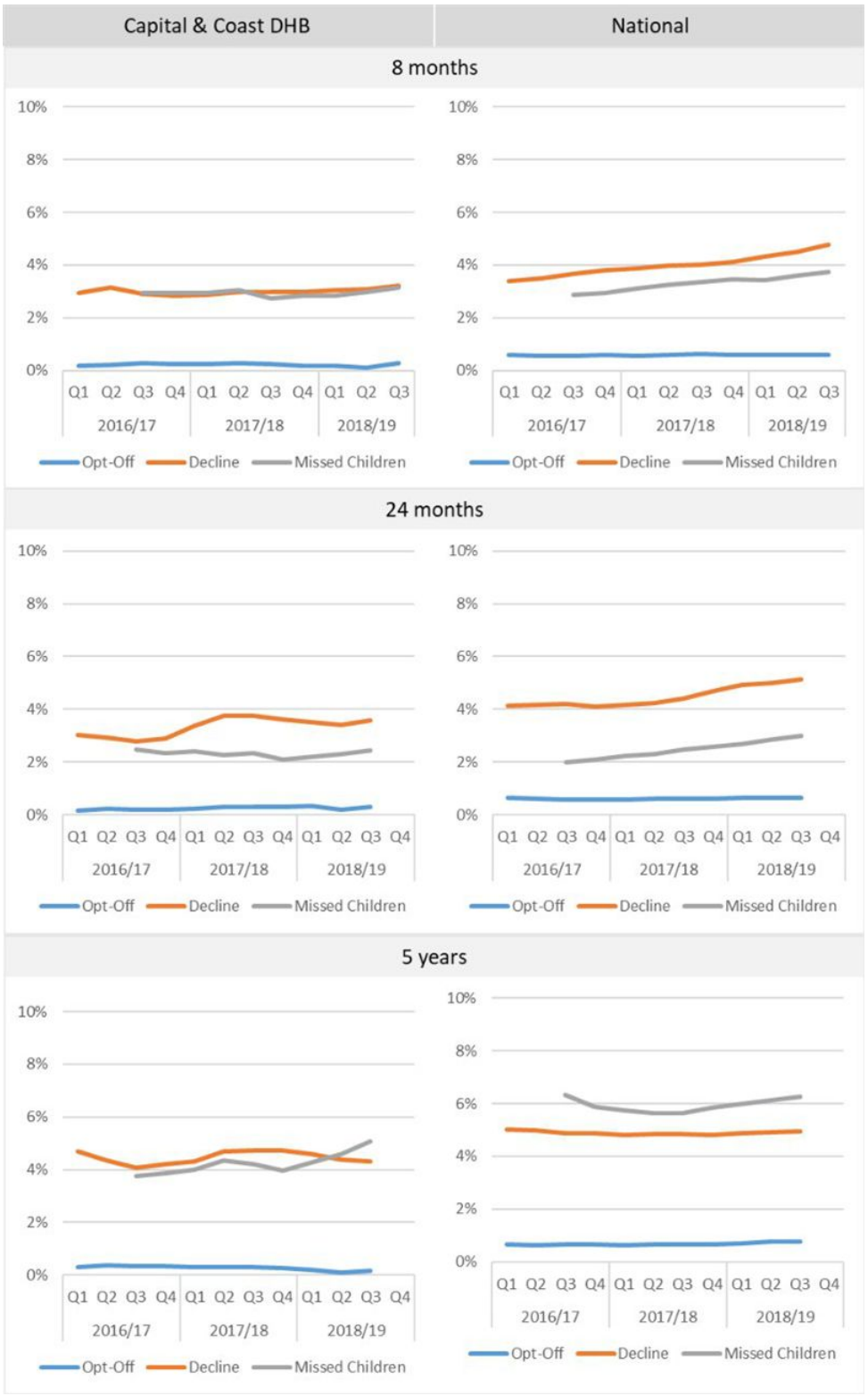

Figure 3. CCDHB and National percentages of children whose families declined immunisation, opted off the National Immunisation Register or were missed from immunisation at the milestone ages: 8 months, 24 months, and 5 years.

We are working collaboratively across the system to improve immunisation coverage, particularly for Māori and Pacific children, and those living in low socioeconomic areas.

At a national level, the Ministry of Health and Health Promotion Agency produced a campaign for Immunisation Week 2019. The videos for this campaign are playing on television nationwide and TVNZ OnDemand, and over the coming weeks our communications department will be boosting the signal of these messages by posting the images and videos on our CCDHB Facebook page.

In the sub-region, Regional Public Health's work programme includes:

- The Early Childhood Centres (ECC) team working closely with ECCs on the importance of immunisation for children and staff and the use of the immunisation register. All ECCs and primary schools are responsible for recording the child immunisation status on their register. Positive promotion of immunisation on entry to an ECC or school is an important tool for prompting parents/ whānau of the importance of immunisation. The school public health nurses have a similar role in primary schools.
- The school based immunisation programme for children in year 7 / (aged 11/12 years) and provides immunisation to protect against whooping cough, diphtheria, tetanus and HPV. This programme has high population coverage. This team also delivers the Year 8 Gardasil vaccine in the school setting.
- The Public Health Nurses and Medical officer of Health support local education sessions on immunisation for primary care. Confident, knowledgeable staff in primary care are key to parental confidence in immunisation.
- The above activities are in addition to the ongoing promotion of immunisation in newsletters to schools/ ECCs and in relation to localised cases or outbreaks. Local outbreaks will often include radio, newspaper and other media coverage.

Locally, we are working at multiple points across the system including:

- With our PHO partners to ensure general practice maintains high visibility of the immunisation targets and performance by ethnicity groups.
- Development and implementation of the Mama, Pepi, Tamariki service in Porirua, focused on supporting whānau in the early years of a child's life.
- Ensuring babies are enrolled in the National Immunisation Register at birth as part of a triple-enrolment form process, this ensures they are followed up at milestone ages by their general practice or outreach immunisation teams.
- Increased investment in the CCDHB National Immunisation Register team who actively identify children who are overdue for immunisations and contact the general practice or outreach immunisation teams for follow-up.
- Increased investment in the Porirua-based outreach immunisation team which will increase follow up of those not accessing immunisation through mainstream primary care providers.
- Identifying opportunistic immunisation scenarios and learning from currently successful programmes like immunisation of the family members of babies in NICU.

PUBLIC

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**HEALTH SYSTEM COMMITTEE DECISION**
	Date: 10 May 2019
Author	Sue Driver, Health System Committee Deputy 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
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.