

COMMUNITY & PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEES

Agenda



6 June 2017 10:00am

Boardroom, Pilmuir House, Hutt Valley District Health Board, Lower Hutt

	ITEM	ACTION	PRESENTER	MIN	TIME	PG
1 PROCEDURAL BUSINESS				15	10:00am	
1.1	Karakia					
1.2	Apologies	RECORD	F Wilde			
1.3	Continuous Disclosure - Conflict of Interest	ACCEPT	F Wilde			2-5
1.4	Confirmation of Minutes 24 March 2017	APPROVE	F Wilde			6-9
1.5	Matters Arising	NOTE	F Wilde			
1.6	Action List	NOTE	F Wilde			10
1.7	Final CPHAC DSAC Terms of Reference	NOTE	F Wilde			11-13
DECISION						
2.1	Mental Health and Wellbeing: <ul style="list-style-type: none">PaperThere will be additional presentations and consumers will be attending.	ENDORSE	R Haggerty A Gray A Culver Consumers	60	10.15	15-22
DISCUSSION						
3.1	Overview of topics <ul style="list-style-type: none">Paper	DISCUSS	R Haggerty N Broome H Carbonatto	15	11.15	23-25
3.2	Quality Assurance – Health of Older People <ul style="list-style-type: none">Paper	DISCUSS	R Haggerty	15	11.30	26-30
3.3	Equity Report <ul style="list-style-type: none">Paper	DISCUSS	R Haggerty N Broome H Carbonatto	15	11.45	31-38
OTHER						
4	General Business <ul style="list-style-type: none">Sub Regional Disability Strategy	NOTE	F Wilde P Boyles	15	12.00	40-42
ADJOURN						
APPENDICES						
3.3.1	Appendix 1 – Equity Dashboard – Capital & Coast DHB					43-45
3.3.2	Appendix 2 – Equity Dashboard – Hutt Valley DHB					46-47
3.3.3	Appendix 3 – Equity Dashboard – Wairarapa DHB					48-50



COMMUNITY & PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEES

Conflicts & Declarations of Interest Register

UPDATED AS AT MAY 2017

Name	Interest
Dame Fran Wilde <i>Chairperson</i>	<ul style="list-style-type: none"> Deputy Chair, Capital & Coast District Health Board Chair, Remuneration Authority Deputy Chair NZ Transport Agency Chair Wellington Lifelines Group Director Museum of NZ Te Papa Tongarewa Member Whitireia-Weltec Council Director Business Mentors NZ Ltd Director Frequency Projects Ltd Chief Crown Negotiator Ngati Mutunga and Moriori Treaty of Waitangi Claims Chair Wellington Culinary Events Trust Chair National Military Heritage Trust
Mr Andrew Blair <i>Member</i>	<ul style="list-style-type: none"> Chair, Southern Partnership Group (appointed jointly by Ministers of Finance and Health to provide governance for the redevelopment of Dunedin Hospital) Member of the Board of Trustees of the Gillies McIndoe Research Institute Chair, Hutt Valley District Health Board (from 5 December 2016) Former Member of the Hawkes Bay District Health Board (2013-2016) Former Chair, Cancer Control (2014-2015) Former CEO Acurity Health Group Limited Director, Breastscreen Auckland Limited Director, St Marks Women's Health (Remuera) Ltd Director, Safer Sleep Ltd Director, Safer Sleep LLC Ltd Advisor to the Board, Forte Health Limited, Christchurch 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
Ms Eileen Brown <i>Member</i>	<ul style="list-style-type: none"> 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.

Wairarapa, Hutt Valley and Capital & Coast District Health Boards

Name	Interest
	<ul style="list-style-type: none"> • God daughter/family friend employed as a solicitor at specialist health law firm, Claro.
Ms Sue Kedgley <i>Member</i>	<ul style="list-style-type: none"> • Member, Capital & Coast District Health Board • Member, CCDHB HAC committee • Member, Greater Wellington Regional Council • Member, Consumer New Zealand Board • Shareholder in Green Cross Health • Step son works in middle management of Fletcher Steel • Deputy Chair, Consumer New Zealand • Environment spokesperson and Chair of Environment committee, Wellington Regional Council
Mr Ronald Karaitiana <i>Member</i>	<ul style="list-style-type: none"> • Member, Wairarapa District Health Board • Member, Wairarapa Te Iwi Kainga Committee • Member, Wairarapa District Health Board, Finance Risk & Audit Committee • Wife Kylie Smith is currently the DHB liaison from Child Youth & Family • Akura Lands Trust Chairman • Advisory Committee for Diabetes New Zealand (24 August 2016) • Contractor to Whaiora and Hauora as a Programme Manager • Contractor to Rangitane as Transition Manager • Director Rangitane ex Officio • Extended family members work in varying roles at DHB
Mr Alan Shirley <i>Member</i>	<ul style="list-style-type: none"> • Member, Wairarapa District Health Board • Member, Wairarapa, Hutt Valley and CCDHB Hospital Advisory Committees • Surgeon at Wairarapa Hospital • Wairarapa Community Health Board Member • Wairarapa Community Health Trust Trustee (15 September 2016)
Kim Smith <i>Member</i>	<ul style="list-style-type: none"> • Employee of Te Puni Kokiri • Chair of Te Oranga o Te Iwi Kainga • Sister, Member of Parliament
Mr Derek Milne <i>Member</i>	<ul style="list-style-type: none"> • Chair, Wairarapa District Health Board • Deputy Chair, Capital & Coast District Health Board • Deputy Chair, Wairarapa, Hutt Valley and CCDHB Hospital Advisory Committees • Member, Hutt Valley and CCDHB Finance Risk & Audit Committees • Ex Officio Member, WDHB Finance Risk & Audit Committee (30 March 2016) • Ex Officio Member, WDHB Hospital Advisory Committee (30 March 2016) • Member, WDHB CPHAC/DSAC (30 March 2016) • Brother-in-law is on the Board of Healthcare Ltd

<p>Fa'amatuainu Tino Pereira <i>Member</i></p>	<ul style="list-style-type: none"> • 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) • Establishment Chair Council of Pacific Collectives • Member CPHAC/DSAC • Member Ministerial Advisory Group – Ministry of Pacific Peoples • Member Advisory Board to Commissioner of Police
<p>Ms Debbie Chin <i>CCDHB Chief Executive Officer</i></p>	<ul style="list-style-type: none"> • Member, Rotary • Member, HBL FPSC Procurement Steering Group (regional Chief Executive representative) • Member, HBL Shared Services Council (regional Chief Executive representative) • Trustee, Wellington Hospitals Foundation • DHB lead CE for sector performance frameworks
<p>Dr Ashley Bloomfield <i>HVDHB Chief Executive Officer</i></p>	<ul style="list-style-type: none"> • Trustee, AR & EL Bloomfield Trusts • Fellow, NZ College of Public Health Medicine • Board Member, Action on Smoking and Health (ASH) • Member, NZ College of Public Health Medicine, Finance, Risk & Audit Committee • Sister is a nurse at Hutt Valley DHB
<p>Rachel Haggerty <i>General Manager, Strategy Innovation & Performance</i></p>	<ul style="list-style-type: none"> • Chair, Takanini Care Ltd • Director, Haggety & Associates
<p>Dr Pauline Boyles <i>Senior Disability Advisor</i></p>	<ul style="list-style-type: none"> • President, Australian and NZ Association of Psychiatry, Psychology and Law • Trustee, Porirua Hospital Museum • Fellow, NZ College of Clinical Psychologists • Director and shareholder, Gerney Limited

Lisa Bridson Member	•
Yvette Grace Member	•
Prue Lamason Member	•
John Terris Member	•
Jane Hopkirk Member	•

Public

**WAIRARAPA, HUTT VALLEY AND CAPITAL & COAST DISTRICT HEALTH BOARDS
COMMUNITY PUBLIC HEALTH ADVISORY AND DISABILITY SUPPORT ADVISORY COMMITTEES
DRAFT MINUTES**

10am Friday, 24 March 2017

Board Room, Pilmuir House, Hutt Valley District Health Board

PRESENT:	IN ATTENDANCE:
Committee	Management & Externals
Fran Wilde (Chair) Alan Shirley (Member) Eileen Brown (Member) Derek Milne (Member) Lisa Bridson (Member) John Terris (Member) Sue Kedgley (Member)	Dr Ashley Bloomfield (CEO, Hutt Valley DHB) Adri Isbister (CEO, Wairarapa DHB) Rachel Haggerty (Executive Director Strategy Innovation and Performance, CCDHB) Dr Pauline Boyles (Senior Disability Advisor, SIDU) Nigel Broom (Executive Leader, Planning & Performance, Wairarapa DHB) Helene Carbonatto (General Manager Strategy, Planning & Outcomes, Hutt Valley DHB) Lisa Congdon (Minute Secretary)
APOLOGIES:	Presenters
Yvette Grace (Member) Jane Hopkirk (Member) Kim Smith (Member) Prue Lamson (Member) Debbie Chin (CEO, Capital & Coast DHB)	Item 2.1 <i>Presentation of the NZ Disability Strategy</i> Bob Francis (Chair, Sub Regional Disability Advisory Group) Bryony
IN ATTENDANCE:	NOT PRESENT:

1.1 PROCEDURAL BUSINESS

Chair Fran Wilde opened the Meeting.

1.2 APOLOGIES

Apologies from Yvette Grace, Jane Hopkirk, Kim Smith, Prue Lamson and Debbie Chin were **RECEIVED**.

Public

1.3 CONFLICTS OF INTEREST:

Conflicts are as noted in the conflicts section in the papers to each Board. These will be collated into one document to be included in papers to this Committee

1.4 CONFIRMATION OF MINUTES:

The Committees **APPROVED** the minutes as read.

Moved: Derek Brown **Seconded:** Alan Shirley **CARRIED**

1.5 MATTERS ARISING

Matters arising: Nil

1.6 MATTERS ARISING AND SCHEDULE OF ACTION POINTS:

Action Points that have been completed will be removed from the Schedule of Action Points going forward

1.6.1 Schedule of action points:

Action point 4.0 : (Meeting 17 July 2015) *"The committee requested that more focus is required on Aged Care..."*

This action has been completed and will be removed from the schedule of action points

Action point 1.3: (Meeting 20 November 2015) *"2. Development of a Maori paper or similar to the Pacific Paper..."*

The Committee was advised that this will be discussed at today's meeting

Action point 2.3: (Meeting 20 May 2016) *"Requested management to bring back to the Committee in the next Equity Report..."*

The Committee was advised that this will be discussed at today's meeting

Action point 2.5: Meeting 20 May 2016) *"Report back on the DHBs role in working with homeless ..."*

The Committee was advised that this is on the work plan and will be discussed at a future Committee meeting

Action point 2.2 (Meeting 16 September 2016) *" Sub Regional Disability Plan implementation update..."*

This action has been completed and will be removed from the schedule of action points

Action point 2.3 (Meeting 16 September 2016) *"Child Health & Youth Update..."*

This action has been completed and will be removed from the schedule of action points

Action point 2.4 (Meeting 16 September 2016) *"Regional Public Health Update..."*

The Committee was advised that this is on the work plan and will be discussed at a future Committee meeting

Action point 2.5 (Meeting 16 September 2016) *"Update on Progress against the regional suicide prevention plan and Porirua Social Sector Trial..."*

This action has been completed and will be removed from the schedule of action points

1.7 APPOINTMENT OF REPRESENTATIVES

Question was raised prior to the meeting if the Chair needed to be formally appointed. Advice was taken and it was confirmed that the appointment of the Chair was confirmed by the Capital & Coast, Hutt Valley and Wairarapa Boards. However it was noted that a Deputy Chair needed to be appointment. Chair advised that Yvette Grace was considered for this and the Chair will discuss this with her. The Deputy Chair will be formally appointed at the next meeting.

Chair moved that the committee endorse the resolution to appoint representatives from the Subregional Disability Advisory Group, Subregional Pacific Advisory Group and the Maori Partnership Board to the Committee.

Moved: Fran Wilde **Seconded:** Eileen Brown **CARRIED**

Public

2.0 DISCUSSION PAPERS**2.1 PROPOSED APPROACH TO CPHAC DSAC**

The Committees **ENDORSED** the appointment of the Chairs of the Sub Regional Disability Advisory Group, the Sub Regional Pacific Advisory Group and an appropriate representative from the Maori Partnership Board to the Committee.

The Committee **AGREED** the terms of Reference pending a wording change on page two of the Terms of Reference to read “to provide advice to each Board on strategies to achieve equity *by focusing on relieving barriers to good health and quality of life* amongst the population...”

Some Committee members who have a particular interest in Health of Older People, currently scheduled for the July meeting that they are unable to attend, asked if the schedule could be changed to ensure their attendance. Health of Older People will now be discussed at the September meeting.

Question was raised on how the Committee will ensure that issues that arise outside of a Committee meeting will have the opportunity to be addressed. The Chair advised that Committee members are welcome to advise both the Chair and Rachel Haggerty if there are any issues that they would like discussed and these will be to the agenda as part of General Business.

The Committee advised that they would like more detail in the Work Programme to include what each topic will cover. Rachel Haggerty will provide a one pager to the Committee providing more detail on each topic and what it will be likely to cover.

The Committee **AGREED** to add to the Terms of Reference that part of the Committee’s mandate is to look for opportunities for collaboration between the three DHBs.

Moved: Sue Kedgley **Seconded:** Lisa Bridson **CARRIED**

The Chair thanked and commended the presenters and their Groups for their work on looking to taking a new approach.

3.1 SUB REGIONAL DISABILITY STRATEGY 2017

Presentation on the New Zealand Disability Strategy was given by Pauline Boyles (Senior Disability Advisor, SIDU), Bob Francis (Chair, Sub Regional Disability Advisory Group), Rachel Nobel (Sub Regional Disability Advisory Group Member), Joanne Witco (New Zealand Sign Language and Health Project), Bryony Murray (Programme Co-ordinator) on the New Zealand Disability Strategy.

A copy of the presentation is attached to these minutes.

The Chair thanked and commended the Sub-Regional Disability Advisory Group Members and Disability Strategy Team for their presentation and advised that the Committee was looking forward to working with the team in the future.

3.2 SUB REGIONAL DISABILITY STRATEGY 2017

The Committee **AGREED** to add the additional recommendation that each DHB will provide a 6 monthly monitoring updates to the committee to inform progress and then **ENDORSED** all recommendations.

The Committee also **AGREED** to have a section in General Business to discuss progress on the NZ Sign Language in Health Project.

The Committee thanked and commended all involved with the work that they have done on the Disability Strategy.

Moved: Lisa Bridson **Seconded:** Derek Milne **CARRIED**

Public

3.3 EQUITY MONITORING INDICATORS

The Committee **AGREED** to add the additional recommendation that Equity Monitoring will become a standing item on the Committee Meeting Agenda

The Committee **NOTED** all recommendations:

The Committee was advised that the Maori Health Plan requirement with the Ministry of Health has been removed with the expectation that equity will be built into annual plans.

The proposed approach is that we look at developing reporting that is boarder and more sophisticated and is an approach that is relative to our communities but also collaborative across the three DHBs on specific approaches.

Concern was raised that in embedding equity in business as usual that focus not be lost on having specific targets but also make sure the targets are the right targets.

Concern raised around Aged Care monitoring and the suggestion was raised for a workshop to be held to address issues and consider options.

Questions raised around measures of deprivation and what the definition of Deprivation is. This will be provided to the Committee.

Moved: Fran Wilde **Seconded:** Derek Milne **CARRIED**

4.0 GENERAL BUSINESS

Question was raised regarding Refugee Health. Where does this sit and should it be a specific focus in our workplan or would it be covered under one of the already noted work plan areas. It was advised that this would span a number of topics, including Public Health and Equity.

The meeting concluded at 12.16 pm.

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

DATED this day of 2016

Fran Wilde
CHAIR



SCHEDULE OF ACTION POINTS - PUBLIC CPHAC-DSAC COMMITTEES

AP No:	Topic:	Action:	Responsible:	How Dealt With:	Delivery Date:
Ex CPHAC-DSAC Public Meeting 20 November 2015					
1.3	Confirmation of Minutes	1. Equity indicators will be reviewed annually. 2. Maori Health Plan to be presented.	Director, SIP Director, Maori Health	1. On agenda for June 2017. 2. To be on agreed	May 2017 March 2017
Ex CPHAC-DSAC Public Meeting 20 May 2016					
2.3	Equity Monitoring Indicators	Requested management to bring back to the Committee in the next Equity Report an outline of the specific actions in the Annual Plan and the Maori Health Plan and advice to the Committee so it could advise the Boards on an equity action plan over a longer time period.	Director, SIP	On work programme for March 2017	June 2017
2.5	Regional Public Health Update Report	Report back on DHBs role in working with the homeless as they often have high health needs and find access to services difficult.		On work programme for March 2017.	March 2017

ITEMS CLOSED SINCE LAST MEETING – 24 MARCH 2017

AP No:	Topic:	Action:	Responsible:	How Dealt With:	Delivery Date:
4.0	General Business	<ol style="list-style-type: none"> 1. H85 – transferred from Hospital Advisory Committee 2. The committee requested that more focus is required on Aged Care in the community and where this fits within the Board / Sub Committee / s responsibilities i.e. a Community Provider Committee. 	Director, SIP	Workshop agenda item in September 2017.	Closed March 2017
Ex CPHAC-DSAC Public Meeting 16 September 2016					
2.2	Sub Regional Disability Implementation Plan Update	The Committees requested management to investigate funding for the plan coordinator to the end of Q4 2016/17.	Director, SIDU	Referred to Management.	Completed March 2017
2.3	Child Health & Youth (including Rheumatic Fever) Update	<ol style="list-style-type: none"> 1. Management is to provide an update in the next report clarifying whether the rheumatic fever hospitalisation rates referred to in the report in relation to how the DHBs are tracking towards the target, is captured by DHB of domicile or by region. 2. Management to provide an update in the next report clarifying the MOH criteria and funding for Sudden Expected Death of an Infant (SUDI) pepipods, and making them (or something similar) more widely available. 	Director, SIDU	It has been confirmed as DHB of Domicile.	Completed March 2017
2.4	Regional Public Health Update	<ol style="list-style-type: none"> 1. Management was requested to bring the Regional Public Health annual plan to a future meeting for discussion. 2. Management was requested to provide an update on the recent visit by Regional Public Health to Wairarapa Iwi Kainga. 	Director, SIDU	<p>On work programme for November 2017.</p> <p>See Director's Report.</p>	<p>Completed</p> <p>Closed.</p>

AP No:	Topic:	Action:	Responsible:	How Dealt With:	Delivery Date:
2.5	Director's Report	1. Management was requested to provide an update in the next report on progress against the regional suicide prevention plan.	Director, SIDU	Next update on work programme for March 2017.	Closed
		2. Management was requested to provide an update in the next report on the Porirua social sector trial hot water hand washing audit.		Awaiting information from Social Sector Trials.	Closed



Terms of Reference

Capital & Coast, Hutt Valley and Wairarapa District Health Board Community and Public Health Advisory Committee and a Disability Support Advisory Committee

1 March 2017

Compliance	<p>In accordance with section 35 of the New Zealand Public Health and Disability Act 2000, the Board shall establish a Community and Public Health Advisory Committee and Disability Advisory Committee (hereinafter called “The Committee”) whose members and chairperson shall be as determined by the Board from time to time.</p> <p>The Committee shall comply with the New Zealand Public Health and Disability Act 2000. The terms of reference of the Committee shall be to do the following in a manner not inconsistent with the New Zealand Health Strategy.</p> <p>The Committee shall comply with the Board’s Standing Orders for Statutory Committees.</p> <p>These Terms of Reference:</p> <ul style="list-style-type: none"> • Are supplementary to the provisions of the Act and Schedule 4 to the Act; • Supersede the previous Terms of Reference dated 30 April 2013; • Are effective from March 2017.
Functions of the Committee	<p>The functions of this Committee is to give the advice to the full Board of each DHB on:</p> <ul style="list-style-type: none"> • The needs, and the factors that may affect the health and disability status, of the residents of the DHB; • The disability support needs of the resident population of the DHB; • Priorities for use of health and disability support funding. <p>The aim of the Committee’s advice is to ensure that each DHB maximizes the overall health gain for the population and promotes the inclusion and participation in society, and maximize the independence of the people with disabilities within the DHB’s resident population through:</p> <ul style="list-style-type: none"> • The range of disability support services the DHB has provided or funded or could provide or fund for those people; • The service interventions the DHB has provided or funded or could provide or fund for the population; • The policies the DHB has adopted or could adopt for those people. <p>The Committee’s advice will be consistent with the New Zealand Health Strategy.</p> <p>The Committee shall present its findings and recommendations to the Board for its consideration.</p>
Objectives and Accountability	<p>The Committee shall:</p> <ul style="list-style-type: none"> • To monitor the health status and health and disability support needs of each DHB resident population providing advice to each Board; • To provide advice to each Board on the implications of health and disability need and status for planning and funding of nation-wide and sector-wide health and disability goals; • To provide advice to each Board on policies, strategies and commissioning (planning and funding) to support improved health and disability outcomes in each district; • To provide advice to each Board on priorities for health improvement and independence as part of the strategic and annual planning process to improve health

	<p>gain and independence within each district;</p> <ul style="list-style-type: none"> • To provide advice to each Board on strategies to achieve equity in modifiable health and disability status amongst the population of each DHB including but not limited to Māori, Pacific, people living in high deprivation, people with mental health and addiction conditions and people with disabilities; • To monitor and advise each Board on the impact of health and disability support services being provided for the resident population of each DHB including the effectiveness of disability support services being provided for the DHB resident population; • To provide advice to each Board on the delivery of health services accessed by people with disabilities including how it can effectively meet its responsibilities towards the government's vision and strategies for people with disabilities. • The Committee may identify issues and opportunities in relation to the provision of health services that the Committee considers may warrant further investigation and advise the Board accordingly. • To identify when "expert" assistance will be required in order for the Committees to fulfill its obligations, and achieve its annual work plan by co-opting experience when required; • To report regularly to each Board on the Committees' findings (generally the minutes of each meeting will be placed on the agenda of the next Board meeting); • To collaborate as required with Committees of other district health boards in the interests of providing optimum, economical and efficient services; • To perform any other functions as directed by the respective DHB Boards.
Authorities and Access	<p>The following authorities are delegated to the Committees:</p> <ul style="list-style-type: none"> • To require the Chief Executive Officers and/or delegated staff to attend its meetings, provide advice, provide information and prepare reports upon request; • To interface with any other Committee(s) that may be formed from time to time.
Meetings	<p>The Committee shall hold no less than five meetings per annum, but may determine to meet more often if considered necessary by the Committee or upon that instruction of the Board.</p>
Quorum	<p>A quorum is a majority of Committee members, and must include at least one member from each Board and at least one co-opted member from each of the other two sub-regional Boards.</p>
Membership	<p>Membership of the Committee shall be as directed by the Boards. The Committee has the ability to co-opt expert advisors as required.</p>
Procedure	<p>Schedule 4 of the New Zealand Public Health and Disability Act will apply to the business and procedure of the Committee.</p>

  		DISCUSSION PAPER
		Date: 6 June 2017
From	Rachel Haggerty, Director – Strategy, Innovation & Performance Helene Carbonatto, General Manager – Strategy, Planning and Outcomes Nigel Broom, Executive Leader – Planning and Performance	
Author	Rachel Haggerty, Director - Strategy, Innovation & Performance	
Endorsed by	Ashley Bloomfield, Chief Executive - HVDHB Adri Isbister, Chief Executive - WDHB Debbie Chin, Chief Executive - CCDHB	
Subject	Mental Health and Wellbeing	
RECOMMENDATIONS		
That having considered the attached paper, and presentations, the CPHAC DSAC Committee:		
<p>a) Notes that in the Budget 2017 investments to improve mental health outcomes were made in Vote Health sector and the budgets of other Government Agencies, including a specific focus on Rangatahi Suicide prevention (TPK¹), integrated employment and mental health initiatives (MSD²) and the development of a social investment fund (SIU³) for new proposals that target mental health.</p> <p>b) Endorses that using intersectoral approaches, social investment models, primary mental health care and early intervention in our communities can improve mental health and wellbeing in our population.</p> <p>c) Endorses improving mental health outcomes through a wide focus on mental health services in our community NGOs, intersectoral partners and primary care is important to improving mental health and wellbeing in our communities.</p> <p>d) Endorses the continued focus on improved quality of MHAIDS and community service delivery.</p> <p>e) Recommends that each DHB strengthens its local mental health and wellbeing approach to address social determinants through social sector forums, wellness plans and locality approaches, working with other sectors.</p> <p>f) Recommends the development of innovative programmes, in partnership with those government agencies that received mental health funding in the budget, to target improved mental health outcomes and reduce suicide and self-harm.</p> <p>g) Recommends that a whole system investment plan is developed for mental health and wellbeing as a critical lever to implement this approach from 2018.</p> <p>h) Notes that the transformation is commencing now and will take several years to implement and realise the change.</p> <p>i) Recommends the development of a youth specific mental health and wellbeing whole system investment plan that includes initiatives that contribute to suicide and self-harm prevention.</p>		

¹ Te Puni Kokiri² Ministry of Social Development³ Social Investment Unit

1. PURPOSE

This paper seeks endorsement on a commissioning whole system approach to transform mental health and wellbeing outcomes in Wairarapa, Hutt Valley and Capital & Coast District Health Boards (3DHB).

2. CONTEXT

Mental health and wellbeing are central to our ability to enjoy life. They enable us to engage in education, employment, family / whānau and social life.

At least 40% of people in New Zealand have experienced poor mental health at some point in their lives. For 20% of people, this experience has occurred within the last year. Furthermore 14% of people will experience issues of substance abuse over their lifetime. Most strikingly, it is estimated that on average, three-quarters of all mental health problems emerge by the time a person is aged 20.

Over the past eight years there has been growing government, consumer, whānau/family calls for a dramatically different approach to how mental health and addiction services support consumers and whānau/family. Such calls have been reinforced by the acknowledgement that current health and social care systems are not sustainable in their current form with increasing demand driving the gap between need and available resources. The pressure on mental health services is of growing concern. Much of our current service emphasis is on managing people with serious mental illness. This is the 3% of the population with the most severe and enduring mental health needs.

There is also now a greater understanding of how social determinants contribute to the incidence of mental illness and addiction. Social and economic disadvantage is associated with higher rates of serious mental health and addiction. The factors below are known to support mental health and wellbeing in people's lives. The absence of these things will contribute to greater levels of mental illness and addiction in our communities.

- Healthy, safe and secure homes
- Financial security and independence
- Employment and education
- Social, cultural and family connection
- Wellbeing, respect and freedom from discrimination
- General health and wellbeing
- Mental health and freedom from addiction

3. A PLAN TO CHANGE

There is evidence showing the need for a considerable shift in the way mental health and addiction care is organised and delivered. It tells us that we need a broad approach that is better able to fulfil consumer and whānau/family preferences for care as they journey through life, rather than through the services that are available.

The shift is to invest in services that prevent avoidable mental illness, intervene earlier in lower cost settings and importantly support people to manage their lives when they have mental illness and addiction. There are many people who experience mental illness and addiction that could be prevented and/or have less of an impact on their ability to live their lives if we change what we do.

PUBLIC

To achieve change we must address the extent to which services are currently set up to work towards their own organisational priorities, and shift the dominance of silos within sectors, providers and professional groups. Our funding and commissioning models are outdated, and support an entrenched insular approach to service purchasing and delivery.

Our new approaches must include the spectrum of health and social service agencies as well as better integration of services from primary to secondary. Change will not be achieved through incremental steps or solely a focus on quality improvement of existing services.

It requires more than a linear service delivery approach. It requires a different approach to commissioning and investment. This is achieved by shifting our planning and service delivery to support mental health and wellbeing.

We need a plan to change.

4. DO WE HAVE THE SUPPORT TO CHANGE?

Creating a change of this scale requires a plan that starts now. Listening to our consumers and communities, meeting Government expectations and improving mental health and addictions service delivery all need to be part of this approach.

4.1 What people in our communities want?

People using Mental Health & Addictions (MHA) services told us they want to see significant change in the services they receive. They want to receive support before they reach a crisis point, and have a more holistic (whole-istic) approach to their treatment and recovery. Service users identified that they wish to see greater emphasis on the things that contribute to the overall wellbeing, with medical prescriptions and treatment being only one component.

In the past two years the Mental Health and Addictions Integrated Leadership, the Consumer Leadership, and SIDU, has worked to co-design an approach to service development which gives greater emphasis to services that meet the following strategic imperatives:

- Intervene earlier (in the course of the illness, in the life course of the consumer, and at key relapse times)
- Integrated and timely responses.
- Be close to home and address local needs.

Our consumers want this change.

4.2 Ministers Expectations

The expectation of the New Zealand Health Strategy (NZHS), and the Minister of Health highlight the importance of achieving 'equitable outcomes for all New Zealanders' by understanding people's needs and providing services that are; integrated across sectors; across the life-course approach and considers factors such as 'home environment and participation in work' as vital to people's wellbeing and health. The NZHS states explicit an expectation that we must change the way we work together, to better understand people's needs and provide effective services that are integrated across sectors.

PUBLIC

Government has translated these expectations into Budget 2017 with an extra \$224 million over four years in mental health services for innovative approaches. Government specifically identified mental health as a social investment priority as it is a major social issue that has a big impact in the employment, housing, health and justice sectors.

The Budget 2017 funding includes:

- \$100 million for a new cross-government social investment fund that will target innovative new proposals to tackle mental health issues (Social Investment Unit).
- \$4.1 million for the Ministry of Social Development to trial integrated employment and mental health services.
- \$11.6 million to help the Department of Corrections better manage and support prisoners at risk of self-harm.
- \$8 million in Vote Maori Development (Te Puni Kokiri) to extend the Rangatahi Suicide Prevention Fund

District Boards, if we are innovative and flexible, can partner with these agencies, and deliver services that contribute to better mental health and wellbeing. In some of the cross sector work that we are currently engaged in, we are now seeing the benefits of these partnerships.

4.3 Service quality improvement is important

Each Board has recently received a detailed update from MHAIDS (Mental health, addiction and intellectual disability services) on the development of services. The Board has also received advice on the response to the mental health service reviews emphasising the importance of safe management of clients, including good documentation and quality handovers so all members of the MHAIDS team can work effectively with the client and their family. This has been further reinforced by an investment request to implement a 3DHB Electronic Client Management System.

The approaches being taken by MHAIDS are supported by the Health Quality & Safety Commission new mental health and addiction quality improvement programme. The programme will take place over an initial five-year term, and aims to improve the quality and safety of mental health and addiction services and the experience of care for consumers. It is funded by district health boards. The Commission's programme beginning 1 July 2017 will focus on five priority areas:

- Minimise restrictive care
- Maximise physical health
- Improve medication management and prescribing
- Improve service transitions
- Learning from serious adverse events and consumer experience

These initiatives are incredibly important alongside a shift to a mental health and wellbeing outcomes, a whole system investment approach and intersectoral collaboration to achieve the change our communities deserve.

5. TRANSFORMING THE SYSTEM

The shift to invest in services that prevent avoidable mental illness, intervening earlier in lower cost settings and importantly supporting people to manage their lives when they have mental illness and addiction

requires four things to occur concurrently. DHBs cannot make this change alone and must work with other sectors. There are four key areas of work:

- Integrated and timely responses
- Working closer to home and addressing local issues
- Whole system investment strategies
- Social investment and working with other sectors
- Focusing on Rangatahi as a priority population

5.1 Integrated and timely responses

Internationally, as well as nationally, there is an increased focus on bring together general and mental health through integrated approaches. In New Zealand and overseas, people with mental health and addiction problems tend to have worse physical health than their counterparts in the general population, and a shorter life expectancy. Diabetes, cardiovascular disease, metabolic syndrome, cancer and oral health issues are more common for this population group.

People who experience serious mental illness and/or addiction die much earlier than their counterparts in the general population, with a two to three times greater risk of premature death. Two-thirds of this premature mortality is due to cardiovascular disease, cancer, and other physical illnesses. Māori who experience mental illness and/or addiction have a one third higher mortality rate than Māori in the general population.

A focus on integrating general and mental health service responses creates a stronger focus on this aspect of integration, which should address four related but distinct challenges:

- Rising levels of multi-morbidity
- Inequalities in life expectancy
- Psychological aspects of physical health
- Medically unexplained symptoms
-

5.1.1 What does this mean?

This means we no longer separate mental health care from general healthcare. Bringing together these services in our communities, in primary care and ensuring that we meet mental health needs in our primary care and hospital settings and equally support general health services for our consumers with mental health and addiction issues to improve their overall health.

5.2 Closer to home and addressing local needs

All of our DHBs are implementing approaches that work in our communities more effectively.

“My issues arise in my community – why am I not looked after in my community?”

By focusing on localities and community based approaches, immediate links are formed with communities; evidence from the United Kingdom found that services integrated across a geographic area resulted in better coordinated services and higher quality care alongside a reduced need for acute care.

Sharing information about the population needs amongst those delivering services in this locality model is central to achieving change, including shifting the cost curve as communities increasingly support their own health and wellbeing over time. Building local intelligence using DHB, primary care and community data will be critical in developing evidence based solutions that improve mental health and wellbeing.

Moving the health system towards locality or place-based care that is more sustainable, effective and affordable requires:

- Shifting from institutions to people and places – leveraging people’s capacity and local resources more effectively
- Shifting from service silos to system outcomes – moving away from vertical silos of ‘health’ and ‘care’ to horizontal place based systems
- Enabling change from national and regional to local – through policy frameworks that creates a long-term environment for placed-base prevention approaches and removes blockages for practitioners

This approach creates the opportunity to move to service delivery models in our communities that:

- Simplify how and when people access services
- Screening, identifying and responding to needs earlier and in a more effective manner
- Reduce duplication of intake and assessment activity and transfer of care duplication
- Addressing multiple and complex mental health and general health needs in a more coordinated way
- Work much more closely with primary care
- Move decision-making closer to consumers and families

5.2.1 What does this mean?

In each DHB we will work locally to through a locality, community or wellness plan approach to:

- work with other sectors to address social determinants for people with mental illness and addictions and for those at risk of poor mental health and wellbeing
- develop integrated service responses across the social, mental and general health needs to create stronger solutions

5.3 WHOLE SYSTEM INVESTMENT

Whole System investment planning is a comprehensive approach to commissioning services in way that improves system performance and outcomes. It is a commissioning tool that enables our DHBs to design and buy services that support people centred design across a continuum of services organised in homes, communities, primary healthcare, mental health NGOs and in our specialist inpatient care services.

The process engages DHB providers, primary care, NGOs and communities in commissioning choices focused on major service users and localities strengthening our ability to development and implement prevention and early intervention programmes and target social investment approaches.

There are components to implementing whole system commissioning to improve system performance and create opportunities to manage and re-prioritise investment to improve health outcomes. These are:

- Analysing current investment and activity for major service users
- Identifying partners and communities who contribute to outcomes for these communities,
- Use big data sources to analyse needs and outcomes informing social investment approaches
- Develop partnership and alliancing mechanisms to bring social service providers and council partners to the commissioning approach

5.3.1 What can whole system investment achieve?

This approach creates the opportunity to move to investment choices that:

- Simplifies service access for those people who live with mental illness and addiction to access the support they need when they need it and where they need it
- Intensifies service delivery for those who have severe illness and addiction or are vulnerable
- Works with communities to improve the health and wellbeing to prevent or delay the onset of mental illness and addiction
- Implements models of care that intervene earlier in lower cost settings
- Organise technology and interdisciplinary teams in homes, communities and inpatient settings to ensure efficient use of resources

5.3.2 What does this mean?

Across the three DHBs we will develop whole system investment plans that reflect the needs of our communities and our investment choices. These plans will be prepared for implementation from the 2018 year and take a medium term view to investment choices that support the change described in this paper. It will also reflect intersectoral and social investment opportunities as outlined below.

5.4 Social Investment And Working With Other Sectors

Social Investment is about improving the lives of New Zealanders by applying rigorous and evidence-based investment practices to social services. It means using information and technology to better understand the people who need public services and what works, and then adjusting services accordingly. What is learnt through this process informs the next set of investment decisions.

Working with people differently to achieve the same outcome is necessary. Different populations experience the social determinants and complex problems that affect mental health, mental illness and addiction differently. For some, the effect of these problems can lead to a cycle of socioeconomic deprivation and poor mental health that reaches across the life course and generations. As a result, the unequal distribution of mental health and wellbeing outcomes can be used to identify disadvantaged or at risk populations who would benefit from innovative approaches and experience better life outcomes.

Much of the focus of social investment is on early investment to achieve better long-term results for people and helping them to become more independent. Social Investment puts the needs of people who rely on public services at the centre of decisions on planning, programmes and resourcing, by:

- Setting clear, measurable goals for helping those people
- Using information and technology to better understand the needs of people who rely on social services and what services they are currently receiving
- Systematically measuring the effectiveness of services, so we know what works well and what doesn't
- Purchasing results rather than specific inputs, and moving funding to the most effective services irrespective of whether they are provided by government or non-government agencies

5.4.1 What does this mean?

The Government has created a social investment fund and the social investment unit will have a \$100m fund to improve mental health. This is only one social investment opportunity as other government agencies, including Justice and Oranga Tamariki, have investment funds for mental health and addiction services. The critical success factor is that these programmes will be focused on life outcomes for e.g. being in employment or reducing offending, rather than only on treatment or health outcomes.

Each DHB will work in partnership with other agencies to develop and propose joint programmes and services that will improve life outcomes, through addressing mental health and addiction challenges. The three DHBs will actively collaborate to use our shared resources to ensure these programmes are of high quality and successful in attracting funding support.

5.5 A focus on Rangatahi (young people)

Our Rangatahi are currently at greatest risk on our system. It is estimated that on average, three-quarters of all mental health problems emerge by the time a person is aged 20. Focusing on Rangatahi, as a priority population has the largest potential for impact in terms of population with mild/moderate mental illness. They are also a group where social investment approaches offer significant benefits with strong political interest.

Rangatahi, aged 15–24, are in major transitions in life; they have opportunity but many of our young people are at risk of not being able to fulfil their potential. The social consequences of not supporting young people are significant as are the risks of supplying medically centric solutions to problems that will respond well to early intervention, prevention and social supports. Some of the key challenges that emerge in young people throughout this time include:

- gender and sexual identity and orientation can generate stress in young people lives especially when they are rejected by their families
- early onset psychoses (mental illness), severe anxiety and depression and suicide and self-harm behaviour
- the impacts of accumulated adversity in young people's lives resulting in conduct and behavioural challenges
- impacts of disability and chronic health conditions on life choices
- impacts of other childhood conditions such autism and ADHD

The consequences for young people of a lack of support and early intervention to support mental health and wellbeing can have significant consequences.

- They will be in our justice system. The rate of mental illness and alcohol and drug dependence among young adults in contact with the justice system is estimated between 40–60%. This rate is highest among those who receive prison sentences. They are also more likely to be Maori
- Young people from disadvantaged backgrounds, and those who experience learning difficulties, behavioural problems and discrimination at school, are more likely to leave school without qualifications
- Young adults who are negotiating their gender identity and sexual orientation are at higher risk of psychosocial problems and suicide, particularly when they feel rejected by their families and culture

5.5.1 We have to act?

We will take a specific youth focus in the mental health and wellbeing investment plans. We will bring together investment in primary health care, communities and specialist services around youth in our communities. Some of the opportunities and issues identified in early work include youth health services, youth alcohol and drug service, gender identity healthcare pathways and the effective suicide and self-harm prevention strategies.

PUBLIC

 <div>Wairarapa DHB Wairarapa District Health Board Te Peori Hauora a-rohe o Wairarapa</div>  <div>HUTT VALLEY DHB</div>  <div>Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA</div>		DISCUSSION PAPER
		Date: 6 June 2017
From	Rachel Haggerty, Director – Strategy, Innovation & Performance Helene Carbonatto, General Manager – Strategy, Planning and Outcomes Nigel Broom, Executive Leader – Planning and Performance	
Author	Rachel Haggerty, Director – Strategy, Innovation & Performance	
Endorsed By	Debbie Chin, Chief Executive, Capital & Coast DHB Ashley Bloomfield, Chief Executive, Hutt Valley DHB Adri Isbister, Chief Executive, Wairarapa DHB	
Subject	TOPIC OVERVIEW	
RECOMMENDATION It is recommended that CPHAC/DSAC: a. DISCUSS the topic overviews for the remaining meetings of 2017.		
ADDENDUMS None		

1. PURPOSE

The members of CPHAC DSAC requested a short overview of the topics to be discussed at each of the CPHAC DSAC meetings. The planned schedule is:

- Monday, 3 July Primary Care and Specialist Complex Care Services
- Friday, 1 Sept Health of Older People/End of Life Care/Advanced Care Planning
- Friday, 17 Nov Public Health, Localities & Social Investment

In addition, there will be regular updates on achievements in equity and the implementation of the Sub-Regional Disability Strategy.

2. PRIMARY CARE, SPECIALIST AND COMPLEX CARE SERVICES

All of our DHBs invest in, and deliver an extensive range of services in primary care (general practise and communities), and in each of our three hospitals. These services are known as personal health services providing urgent and planned healthcare. This is the core of our public health system. Care is delivered in our communities, by community pharmacy, ambulance services, in primary care in general practise and healthcare homes and in our district and specialist hospital services. Planned and urgent healthcare saves lives, prevents illness and disability and is fundamentally important to the health of all people in New Zealand.

Some of the key areas of work in personal health services are:

- Growing acute demand as a consequence of the aging of the population and the greater presence of long term health conditions;
- Acute demand for healthcare and approaches to ensuring people have the access they need to manage their own health and wellbeing;
- Preventing avoidable demand for hospital care and working with primary care to improve;
- Integration of primary care with specialist care through health pathways;
- Elective service targets and access to planned services;
- The delivery of secondary specialist services (e.g. general medicine and paediatrics) in our hospitals and the opportunities and challenges;
- The delivery of complex care services (e.g. cardiothoracic, paediatric surgery) in the Wellington region.

3. HEALTH OF OLDER PEOPLE/END OF LIFE CARE/ADVANCED CARE PLANNING

This meeting will consider three areas which are inter-dependent although they have unique challenges and attributes of their own. It is estimated that 40% of healthcare expenditure is spent on older people. Furthermore, the highest costs of care are incurred in the last year of life particularly when people are younger although often this does not contribute to an extended life.

The Health Needs Assessment and projected population changes over the next 15 years show that the most significant pressure on across the three DHBS will be the significant growth in the population aged over 70 years by 60%, and especially those aged over 80 years. This ageing of the population will have an impact of all types of healthcare including a growing number of older people with frailty.

End of life care enables people to die with dignity and support families and health care support workers to provide the compassionate care required when life is ending. There are opportunities to improve end of life care. A core metric is the proportion of people who die in hospital rather than in their community. Currently, in New Zealand, 34% of deaths occur in hospitals compared with Holland where 20% occur in hospital.

One of the most significant interventions is Advanced Care Planning (ACP) that gives people and their families/whānau the chance to consider what matters should they become unwell. It allows people to think about what treatment they may or may not want and make it easier for families, and health professionals, to support the person. Advance Care Plans are completed by the person (and their family if they wish) as early in life as reasonable and should be accessible by the health professionals caring for them.

There are many complex and important issues in how our DHBs approach the need for complex care in our communities when people are ageing. Our DHBs provide a wide range of services including funding home support and residential services. These three areas are priorities for the Ministry of Health and the DHBs as outlined in our District Annual Plans.

4. PUBLIC HEALTH, LOCALITIES & SOCIAL INVESTMENT

This meeting will consider how we improve health and wellbeing in our communities. Strengthening working with communities in ways that support greater health and wellbeing is the focus. Health is

PUBLIC

influenced by factors that are not about clinical care. Studies estimate that 50% of health outcomes is influenced by social determinants and 50% by healthy behaviours and access to health services. The social determinants of health - the conditions in which people are born, grow, live, learn, work and age - are shaped by our level of education, where we live, what kind of job we have, our income and a range of other environmental factors. Addressing social determinants, to improve health outcomes, creates an opportunity to rethink models of care to be more located in communities and work with people as the experts in their own health, supporting them to stay well.

Public health is a core capability of the DHBs in working with communities. Public health support schools, healthy home approaches and healthy communities. Building on this capability is leveraged through social investment and locality approaches.

Social Investment is defined by Treasury is an approach which seeks to improve the lives of New Zealanders by applying rigorous and evidence-based investment practices to social services. By gaining a clearer understanding of the indicators that are associated with poor outcomes, social sector and community organisations can identify where best to invest early rather than deal with problems after they have emerged. In the Budget announcement the Social Investment Unit becomes an independent Government Agency.

Localities approaches use place as the organising system for health and social services creating immediate links to the capability of communities and improves the ability to recognise and value community diversity, while organising a consistent system across many communities. How services are brought together and where they are located will vary from district to district. It is a mechanism for working more closely with Councils, health and social agencies, and social service providers to develop approaches enabling people and their households and whanau to participate and improve their own health and wellbeing.

 <div>Wairarapa DHB Wairarapa District Health Board Te Pori Hauora a-rohe o Wairarapa</div>  <div>HUTT VALLEY DHB</div>  <div>Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA</div>		CPHAC-DSAC PAPER	INFORMATION
		Date: 12 May 2017	
Author	Jan Marment and Jan Edwards		
From	Sandra Williams, Acting Director, SIDU		
Endorsed by	Debbie Chin, CE Capital & Coast DHB Ashley Bloomfield, CE Hutt Valley DHB Adri Isbister, CE Wairarapa DHB		
Subject	Quality Assurance and Obligations – Health of Older People Services		
RECOMMENDATION			
It is recommended that the CPHAC-DSAC Committee			
a. Note the update;			
b. Note:			
i. All Residential Care providers must be certified by the Ministry of Health before the DHB can contract with them.			
ii. All DHB service contracts include requirements for meeting quality and legislative obligations.			
iii. DHBs monitor the compliance and quality of residential services in partnership with the MoH. The Ministry through HealthCERT are responsible for the administration of the Health and Disability Services (Safety) Act 2001.			
iv. According to advice received by Buddle Findlay, DHBs’ obligations under the Health and Safety at Work Act (2016) are considered to be addressed through the DHB’s “normal contract management and performance of their other statutory obligations.”			
v. Buddle Findlay have also noted that essentially the same obligations which apply to ARC services also apply to HCSS and all other providers contracted by the DHB.			

1 PURPOSE

The purpose of this paper is to inform CPHAC-DSAC about quality assurance mechanisms which are in place for Health of Older People with regard to meeting the Health and Disability Safety Standards and relevant legislation requirements for the Health and Safety at Work Act (2016).

2 SUMMARY

- All Residential Care providers must be certified by the Ministry of health before the DHB can contract with them.
- All DHB service contracts include requirements for meeting quality and legislative obligations.
- DHBs monitor the compliance and quality of residential services in partnership with the MoH. The Ministry through HealthCERT are responsible for the administration of the Health and Disability Services (Safety) Act 2001.
- According to advice received by Buddle Findlay, DHBs' obligations under the Health and Safety at Work Act (2016) are considered to be addressed through the DHB's "normal contract management and performance of their other statutory obligations."
- Buddle Findlay have also noted that essentially the same obligations which apply to ARC services also apply to HCSS and all other providers contracted by the DHB.

3. CERTIFICATION, AUDITING & MONITORING PROCESS IN AGED RESIDENTIAL CARE

3.1 Certification

- All facilities are audited by a Designated Auditing Authority (DAA) for certification.
- All DAA's are internationally accredited.
- Facility certification can be between one and four years.
- Facilities have a surveillance audit half way between their certification periods. This is an unannounced audit. Therefore if a facility has a three year certification they are audited every 18 months.

The audit is based on the Health and Disability Sector Standards and the Aged Residential Services agreement. The standards include: Consumer rights, Organisational Management, Continuum of Service delivery, Safe and Appropriate Environment, Restraint Minimisation and Infection Protection and Control

Without certification a facility would not be able to hold a contract with the DHB.

3.2 Other Types of Audits

3.2.a Provisional

Prospective providers undergo a provisional audit to establish the level of preparedness to provide a health and disability service and conformity prior to a facility being purchased or developed.

3.2.b Partial provisional

This is undertaken to establish the level of preparedness of a certified provider to provide a new health and disability service.

Both provisional and partial provisional audits are for a maximum of one year.

All of the above audits are publically available on the MoH website. File path is:

<https://www.health.govt.nz/your-health/certified-providers/aged-care>

3.2.c Claims Audit

Claims audits are undertaken randomly unless specifically requested by the DHB to assess a provider financial compliance.

There has been one request in the past 12 months for a specific financial audit of an aged care facility following an anonymous call to the DHB.

3.3 Certification periods

As at May 2017 Capital and Coast have 100% of the ARC facilities with three or more years accreditation. The data for the other sub regional DHBs is included for comparison.

The maximum 4 year certification period requires the facility to have none or very few low risk corrective actions and to have been commended for quality and care initiatives. CCDHB has a very high % of facilities with the highest certification period of 4 years.

ARC certification periods in the subregion

Certification Periods Aged Residential Care				
	Months certified			Total
	48	36	24	
HVDHB	3	12	0	15 (excl 1 new facility)
	20%	80%	0	100%
CCDHB	14	19	0	33
	42%	58%	0	100%
Wairarapa	1	8	2	11 (excl 2 new providers)
	9%	73%	18%	100%

3.4 Monitoring Corrective Actions Arising from an Audit

DHBs work with the facilities once an audit has been undertaken agreeing a plan to address all corrective actions and monitor compliance with the plan. This approach works well.

It enables the DHBs to:

- identify those facilities that could gain the most benefit from additional quality improvement inputs such as Nurse Practitioner (or other) led education sessions. Other learning and development opportunities have been developed in each DHB to support ARC facilities. CCDHB employs a PDRP and District Nurses input to support up-skilling within ARC teams. The Older People Nurse Practitioners and the Director of Nursing Community have significant input into ARC facilities.
- Monitor the progress against the corrective actions and share examples of good practice.
- Maintain and strengthen relationship between the facility and the DHB.

4. HEALTH & SAFETY LEGISLATION – AGED CARE SERVICES**4.1 All NGO providers, including NASC**

A letter from Buddle Findlay on 10th January 2016, clarified responsibilities of DHBs with regard to the changes in the Health & Safety legislation. In clauses 7 and 8 of the advice letter (which was also endorsed in August), Buddle Findlay states:

“Clearly what is reasonable and practicable will depend of a number of factors, and the steps that are practicable for the DHB to take when it is the provider of services will not, of course, be the same as the steps that it is practicable for it to undertake as the funder. While the DHBs cannot contract out of their duties (clause 29) they can and should:

- undertake due diligence when selecting providers*
- clearly define the DHB’s and providers’ respective responsibilities;*
- monitor the provider so as to ensure that the provider is doing what is agreed; and*
- address any safety issues that arise.*

These are of course all steps that the DHBs take in the course of their normal contract management, and in the performance of the DHBs’ other statutory responsibilities. In short, we don’t think the responsibilities that the DHBs have potentially under health and safety legislation changes the DHBs’ substantive obligations”

Through the Ministry of Health Sector Services, DHBs use a standard contract format which includes a section on General Safety Obligations:

C29.1 You will protect consumers, visitors and staff from exposure to avoidable/preventable risk and harm.

This section includes contract requirements under:

- Risk management
- Equipment maintenance

- Infection control/environmental and hygiene management
- Security
- Management of internal emergencies and external disasters
- Incident and accident management
- Prevention of abuse and/or neglect

In addition to this contractual requirement, SIDU sent a letter to all contracted providers,

Accompanying this letter was a questionnaire for further discussion with providers as opportunity arose and these discussions are ongoing.

In addition auditing of contracted providers includes consideration of the questions contained in the questionnaire. The DHB will follow up with any corrective actions arising from these audits.

4.2 Aged Residential Care (ARC)

As outlined in Section 2 above, the aged care facilities are audited via the Ministry of Health process which includes audit against the Health and Disability Standards and the contractual obligations under the national Aged Related Residential Care (ARRC) agreement. Although the proposed changes to health and safety legislation were considered in context of the 2016 national agreement review for aged residential care, on advice from Buddle Findlay, no related change to the contract was seen as required.

Standards address workplace safety in sections relating to Quality and Risk Management and human resource management where the standard states:

“Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.”

The DHB contract requires aged care facilities to document and implement policies in relation to:

- occupational health and safety
- infection control
- safe food handling
- safe management and administration of medications
- safe storage and use of chemicals/poisons
- prevention, detection and removal of abuse or neglect of subsidised residents, visitors and/or staff

Facilities are also required to document and implement policies, processes and procedures for:

- identifying key risks to health and safety, evaluating and prioritising these risks
- dealing with the risks
- minimising the impact of internal emergencies and external or environmental disasters
- accident and hazard management that safe guard residents, visitors and staff from avoidable incidents, accidents and hazards.

The facilities must also comply with WorkSafe legislation. This requires them to view the facility as a workplace and all people within that facility therefore are subject to WorkSafe’s regulations.

With regard to the national agreement for ARC a memo was sent from DHB Shared Services to DHBs in February and endorsed in August with regard to the DHBs’ obligations under the Health and Safety at Work Act (April 2016). It was based on the legal advice from Buddle Findlay. The key message was that the current provisions for ARC are seen as appropriate:

In summary, a change to the aged residential care agreement in respect to the proposed changes to health and safety legislation is not seen as required.

The ARC contract already includes a number of provisions relating (or relevant) to health and safety.

In addition, the ARC contract gives DHBs the power to intervene if it has concerns about services being provided, including the power to specify “compliance requirements” following an audit. These are likely to be sufficient for DHBs to have fulfilled their PCBU obligations.

WorkSafe NZ has held education sessions during the provider meeting held with the DHB and Aged Residential Care Managers. These have been well attended.




4.3 Home and Community Support services (HCSS)

DHBs again sought Buddle Findlay advice in August 2016 in a response to a request from Health Care NZ for an amendment to the agreements under which it provides home and community support service.

Buddle Findlay noted that to meet their obligations, DHBs need to ensure that they undertake due diligence in selecting providers, clearly define the DHBs' and providers' respective responsibilities, monitor providers to ensure that they are doing what is agreed (and to ensure so far as is reasonably practicable that health and safety matters are being appropriately resourced, identified, managed and addressed), and address any health and safety concerns with the providers if and when they arise.

Buddle Findlay also noted that essentially the same obligations which apply to ARC services (as described above) also apply to HCSS. *“The above are all matters that the DHBs should be attending to as part of their normal contract management and performance of their other statutory obligations.”*

PUBLIC

  		DISCUSSION PAPER
		Date: 6 June 2017
From	Rachel Haggerty, Director – Strategy, Innovation & Performance Helene Carbonatto, General Manager – Strategy, Planning and Outcomes Nigel Broom, Executive Leader – Planning and Performance	
Author	Sam McLean, Analyst – Strategy, Innovation & Performance, Capital & Coast DHB	
Endorsed By	Debbie Chin, Chief Executive, Capital & Coast DHB Ashley Bloomfield, Chief Executive, Hutt Valley DHB Adri Isbister, Chief Executive, Wairarapa DHB	
Subject	EQUITY: CAPITAL & COAST, HUTT VALLEY AND WAIRARAPA DHBS	
RECOMMENDATION		
It is recommended that CPHAC/DSAC:		
<p>a. NOTES Capital & Coast DHBs’ summary of performance on the 17 equity monitoring indicators where targets have been set (excludes mental health and disability indicators).</p> <ul style="list-style-type: none">• Maori: 5/17 targets achieved• Pacific: 3/17 targets achieved• Other/Total: 11/17 targets achieved• Disability: 3/3 indicators with better outcomes compared to total hospital population.		
<p>b. NOTES Hutt Valley DHB’s summary of performance on the 17 equity monitoring indicators where targets have been set (excludes mental health indicators)</p> <ul style="list-style-type: none">• Maori: 2/17 targets achieved• Pacific: 3/17 targets achieved• Other/Total: 9/17 targets achieved		
<p>c. NOTES Wairarapa DHB’s summary of performance on the 17 equity monitoring indicators where targets have been set (excludes mental health indicators. Pacific is reported where data is available).</p> <ul style="list-style-type: none">• Maori: 5/17 targets achieved• Pacific: 2/7 targets achieved• Other/Total: 12/17 targets achieved		

ADDENDUMS

- EQUITY DASHBOARD: CAPITAL & COAST DHB**
- EQUITY DASHBOARD: HUTT VALLEY DHB**
- EQUITY DASHBOARD: WAIRARAPA DHB**

1. PURPOSE

Wairarapa, Hutt Valley and Capital & Coast DHBs acknowledge their responsibility to design and deliver health services that are accessible and responsive to the needs of its population. This report provides an update to CPHAC-DSAC on current and planned actions to deliver improved and equitable outcomes for our Māori and Pacific population.

2. BACKGROUND

The World Health Organization defines equity as the absence of avoidable or remediable differences among populations or groups defined socially, economically, demographically or geographically. Equity is not a single component, but rather a cross-cutting dimension across multiple social axes and all elements of quality.

In New Zealand, there are recognised health disparities across population groups and communities. These disparities are related to the accessibility of health services, social determinants of health, cultural responsiveness and current models of care. Populations can also find it hard to access the health services they need or know how to manage their health if the services they are accessing are not culturally competent or designed to meet their needs.

3. MINISTRY OF HEALTH APPROACH TO EQUITY

In the Ministry of Health's 2017-18 planning package, DHBs were required to integrate the Māori Health Plan into DHB Annual Plans, strengthen their focus on health equity for priority populations within the Annual Plans and ensure there is an emphasis on "equity of outcomes" for each planning priority area identified by the Ministry.

Wairarapa, Hutt Valley and Capital & Coast DHBs' are working to establish local and shared strategic views of equity and ensure that a medium-to-long term strategy to address equity is explicit in overall DHB Strategies, clinical services planning, service commissioning and investment decisions. A shift towards a medium-to-long term district view of equity and managing local responses to improve equitable outcomes will take time.

4. EQUITY UPDATE: CAPITAL & COAST DHB

Healthy Children

Breast Feeding

We have begun the introduction of Maternal Green Prescriptions, with 50% targets for Māori and Pacific women. In addition, we have continued production and distribution of the resource *Loving Pepe for Life* through the Maternal Green Prescription programme. This resource has key messages of the Health 4 Life Project and is expected to improve breastfeeding rates. Business as usual centres on the CCDHB Women's Health Service Community Lactation Coordinator and the Pacific Breastfeeding Service.

Immunisation

General practice teams, supported by immunisation outreach services, continue to target Māori and Pacific infants to ensure eight months immunisation rates are equitable. The DHB will provide increased support and monitoring to the PHOs from 1 July 2017 due to the PHO merger between Well Health and Compass. The Immunisation Outreach Service, currently contracted to Well Health, will transition to

PUBLIC

Compass and will be monitored to ensure the Service's success amongst Māori remains. The DHB continues to monitor monthly immunisation coverage reporting and reports to PHOs.

Oral Health

Through the at-birth enrolment scheme children (born after 2014) are automatically enrolled in oral health services unless parents opt-out of the scheme. A data-match conducted at end of 2016 between Bee Healthy and PHOs identified children not enrolled in the service and children born before 2014 and moving in or out of the region. The Regional Dental Service is now working collaboratively with CCDHB and their Maori and Pacific Providers to identify children not enrolled for dental care.

We have implemented on-site early childhood centre and Kohanga Reo examinations making it easier for families to get their preschool child examined without time off work or travel costs and we have undertaken a communications drive to ensure stakeholders and people in the community were able to understand the new system and know how to contact the service.

Screening and Early Intervention**Breast and Cervical Screening**

PHO Cervical Data Matching Reports are sent to practices with information on the screening status of all women to assist practices in recalling women, including priority women as well as unscreened and under-screened women. Access to these reports has been made available to the Regional Screening Service (RSS). The RSS has implemented 'Combined Priority Screening Days' for priority women living in the most deprived areas and has contracted a Smear Taker to provide services out of hours, evenings and Saturdays. In addition a breast screening site on Lambton Quay has improved access for women working in the CBD. Mobile clinics provide more access for priority women in Kapiti.

RSS, Recruitment & Retention Advisors and Register Staff are working with three high needs practices in Porirua and phoning NCSP priority women overdue for screening. These women are invited to 'free smear clinics' during the day or after hours. Support and transport are offered to these women to attend services. Women with no phone contact will be home visited. RSS has also run promotions at Pinkilicious Pacific Health Day, CreekFest WINZ Community Link Porirua, Newtown Festival.

Tobacco

We have invested in a Hapū Ora service located in Ora Toa PHO. Hapū Ora works with young Māori women and uses smoking cessation interventions to encourage them to stop smoking. The programme is also available to women who have young tamariki up to five years of age. The Regional Stop Smoking Service has a Quit Coach in two practices. Kokiri Marae Quit Coaches are also providing phone support. There is also an option to be referred to the Pacific Quit Team at Pacific Health Services Porirua.

We have contacted Bay of Plenty DHB for suggestions on how to achieve the target. They have suggested adapting a system that reviews 'missed' events by the coding team and discharging doctor.

Cardiovascular Risk Assessment

Ora Toa runs monthly weekend CVD risk assessment clinics in all their practices to fit with work schedules and improves the overall accessibility of risk assessments. A community nurse runs a weekly clinic in 3 practices and conducts home visits.

PUBLIC

Compass Health have a dashboard that shows CVD risk assessment coverage by practice for Maori, Pacific, High Need population and identifies patients who have not had a CVD risk assessment completed. There remains an equity gap in CVD risk assessment for high needs populations.

Through the Pacific Action Plan we are supporting self-management programmes for Pacific people with long term conditions and are working towards ensuring Pacific people have a CVD risk assessment.

Access and Quality Care**Newborn Enrollment**

Due to on-going discrepancies in data between PHOs and the Ministry of Health, these figures are not reported. There are continued efforts to resolve this issue.

Ambulatory Sensitive Hospitalisation

The Health Care Home model of care is being implemented across the DHB over 4 years, starting 2015/16. Initial roll out of the model has prioritised high needs practices and the Porirua locality.

There are now improved referral processes for children presenting to hospital with respiratory illnesses to Porirua Asthma Services and/or Well Homes and are being promoted by the paediatric department.

We continue to increase the number of people who are being supported with packages of care in the community who may otherwise have presented to the hospital e.g. cellulitis.

The Diabetes Care Improvement Plan is delivering a range integrated services to diabetes management in primary care. Specialist case collaboration and diabetes nurses partnered to practices have been targeted to the priority Māori and Pacific population.

Our Pacific Action Plan has priorities that include encouraging Pacific people to eat healthy and stay active, and supporting Pacific People to actively utilize health services and increase GP and nurse utilization rates in line with population growth

Did Not Attend Rate

Within the Whānau Care Service (WCS) DNA programme we call patients in priority clinics (child health and cardiology) to remind them of appointments and undertake follow up calling.

Mental Health

We are assessing the possibility of the AIMS (text/email) reminder system being implemented at to reduce DNA rates. At Hutt Valley DHB, AIMS has improved DNA rates.

We have begun a project to ensure all clients who did not attend appointments will be discussed in a daily multi-disciplinary team (MDT) forum to consider any required actions to support access.

The focused work that the adult inpatient units are involved with is having a positive impact locally with reduction in seclusion hours across all populations in Te Whare O Matairangi.

A driver of the 28 day readmission rate increase appeared to be the practice of practitioners working in Te Whare O Matairangi who, for several months, placed an emphasis on lower occupancy. This outcome was achieved, possibly at the expense of higher readmission rates. These practitioners have since departed and we will continue to lower occupancy but will be vigilant of the relationship between occupancy, length of stay and readmission.

A local KPI focuses on improving 7 day follow-up rates post discharge and is expected to impact positively on 28 day readmission rates. As work in this area progresses improvements will register in outcomes for Māori, Pacific and the total population.

Disability

We are developing a Dashboard of Indicators, based on unique NHIs with a Disability Alert, to inform future activities for Disability Support Services and undertaking a whole of Life NASC project to blend health and Disability Support Service funding.

5. EQUITY UPDATE: HUTT VALLEY DHB

Healthy Children

Breastfeeding and Oral Health

Lifting the performance of health providers working with children and parents remains a priority, though the complexity of accountabilities, inter-relationships and fragmentation between the various providers involved in the care of children and families remains a major barrier to improvement. Hutt Valley DHB is embarking on a number of integration programmes of work to bring some of these providers closer together to improve their interface and joint accountabilities. Working with Lead Maternity Carers to support the 'right start' for families is more complex, given the different funding and accountability arrangements they hold directly with the Ministry of Health.

Screening and Early Intervention

Cervical Screening

There is opportunity for primary care to improve its performance on the national target for cervical screening coverage. Rates have dropped across all ethnicities this year. Despite continued investment to improve the inequalities that sit within cervical screening rates, improvements remain elusive.

Tobacco

There were improvements in some areas – particularly in the number of people offered brief advice to quit smoking in primary care following a concerted effort by the PHO. This improvement shows the value of concerted, systematic system improvements to support achievement in performance.

Breast Screening

Breast screening coverage also continues to improve across all the ethnicities compare to the previous 12 month period. The national 70% target was very close at 67% for Māori and Pacific women.

Access and Quality Care

Ambulatory Sensitive Hospitalisation

The DHB has a major programme of work underway under the Alliance Leadership Team to improve ASH rates. We are working alongside a number of practices with high Maori and pacific people to improve their management of paediatric respiratory conditions, establishing greater support for these practices via the specialist respiratory service, and have updated the asthma clinical pathways. Significant investment in the Healthy Homes project has been underway since August 2016 which we expect will go some way to help alleviate respiratory conditions. We are also establishing a data

PUBLIC

matching project to share NHI data that will allow us to track patients in the system, and understand where the gaps and duplications in the care of those most at risk are occurring. This will be the first step in improving the integration of services that support high risk families, and ensure a strong interface and referral pathway across providers. Health Care Home, should also make a difference in reducing ASH. The business case for Health Care Home will be presented to the Board for consideration in June 2017.

Did not Attend Rate

Outpatient DNA rates continue to improve for Maori and have levelled off for Pacific people. The Maori and Pacific units continue to support clients and follow up to understand reasons behind DNA.

We will also embark on a Wellness Plan over the next few months that will bring our key providers, local councils and wider community stakeholders together to develop a broad wellness approach across health and wider agencies. We anticipate this plan will have a strong inequalities focus, placing its efforts in the most vulnerable communities. Such a Plan will also support the DHB to consider a wider social investment approach to improving health outcomes amongst Maori and Pacific populations.

6. EQUITY UPDATE: WAIRARAPA DHB**Healthy Children:****Breastfeeding**

To improve breastfeeding rates, work has progressed to develop breastfeeding community support. Regional Public Health (RPH), Parents Centre and Whaiora have provided funding, through which RPH have been able to train two Peer Counsellor Programme Administrators (PCPAs) in Auckland with La Leche League. The Breast Friends drop-in centre has also been in action for several months.

The Health 4 Life Project aims to improve maternal and infant nutrition and physical activity in the Greater Wellington Region. This is achieved through the delivery of simple, common messages to Māori, Pacific, and vulnerable pregnant women and mothers of infants in the first year of life and their whānau. Production of the resource *Loving Pepe for Life* will contribute to improved breastfeeding.

The introduction of Maternal Green prescriptions for targeted women from 1 January 2017 will also contribute to improving equity.

Oral Health

In Wairarapa DHB, the oral health service is working with the two Māori health providers through the Taki Wahi Taki Ora programme focusing on 0-4 year olds. These providers offer assistance in following up families of Māori pre-schoolers who do not attend their appointments along with the Tamariki Ora providers.

New-born oral health information sessions for parents continue to be offered when the child is 8-12 weeks old. These information sessions are a method of engaging early with families, providing good oral health messages and ensuring families understand how to access oral health care for their children when they need it. If a family does not attend an information session, the family is contacted again when their child is 1 year old and invited to attend the dental clinic for an examination.

Screening and Early Intervention:**Breast Screening**

PUBLIC

To improve equity in our breast screening coverage, screening services are using PHO Data Matching Reports to identify women who are not enrolled or under screened to target these women. As the mobile clinic's schedule to visit Wairarapa DHB has changed to an annual visit (previously every two years), the timing of the data matching reports aligns with visits from the mobile clinics to maximise screening coverage. Annual visits from the mobile clinic will ensure the breast screening coverage in Wairarapa DHB is maintained or improved.

Cervical Screening

Key to improving equity in cervical screening is the PHO Cervical Screening Data Matching Reports that were first published in February 2016. PHOs can access these reports electronically via the secure file transfer protocol (EFT account). These reports are sent from PHO's to practices with information on the screening status of all women enrolled in their PHO and can assist practices in recalling women. The PHO Cervical Screening Data Matching Reports ensure timely and accurate information is available each month allowing easier follow-up of women needing to be recalled for screening. As a result this should have a significant impact on equity increasing coverage for National Cervical Screening Programme (NCSP) priority women. Priority women include Māori, Pacific (and Asian for NCSP), as well as unscreened and under-screened women.

Tobacco

The Smoking Cessation Clinical Champion has developed an action plan of activities to support the achievement of the health target by:

- Including practice performance against IPIF indicators as a standing agenda item at quarterly practice visits;
- Actively working with general practices in the Wairarapa to improve data collection and mapping processes and encourage practices to focus on improving their cessation referrals.

The 'Learn on Line' ABC smoking cessation training has been publicised in the hospital communications, Daily Dose and Insite. An audit of those who have completed the training has been completed in the Emergency Department.

Cardiovascular and Diabetes Risk Assessments

The Compass Health Wairarapa population health team are developing a CVDRA incentive programme similar to the Cervical Screening programme. The focus will be on Māori aged between 35 and 44 years. As part of this initiative, Compass Health and the Māori Health Unit have engaged with the Māori Women's Welfare League and Whaiora to discuss how we can work together to follow up with those that do not respond to the invitation.

Access and Quality Care:**Ambulatory Sensitive Hospitalisations (ASH)**

All general practices have Annual Plans that focus on reducing ASH admissions to hospital and joint winter planning with the DHB has been undertaken.

Whaiora have developed two whānau education programmes, "Love the Skin You're in" and "Breathe Easy". Included in the Breathe Easy/Ha Ngawari programme are presentations on asthma and asthma medication, rongoa and mirimiri techniques, Aukati Kaipapa (smoking cessation), Healthy Homes, Nutrition and Exercise, and WINZ entitlements. Included in the "Love the skin you're in" programme are

PUBLIC

presentations on the importance of Healthy Skin, Personal stories, rongoa, nutrition (Kai on a budget), Healthy Homes and Work and Income New Zealand (WINZ) entitlements.

A Respiratory Working Group has been established to discuss the best approach for addressing respiratory presentations to ED and admissions to hospital. The intention of the Respiratory Working Group is to explore and identify improvements in the current delivery of services for respiratory disease with a focus on 0-4 year old children and adults with Chronic Obstructive Pulmonary Disorder (COPD).

Mental Health

To improve DNA rates in the Wairarapa, a project is underway which uses the AIMS (text/email) reminder system. The AIMS system is being used in Hutt Valley DHB and has resulted in a reduction in DNA rates. A second project is also underway to ensure all clients who did not attend an appointment will be discussed in a weekly MDT forum to consider actions to support access to appointments. This includes follow up appointments for all DNA's with notification to their Care Manager.

The Mental Health Service is also working alongside Compass Health with their 'Equally Well Project' that is aimed at managing and improving the physical health of mental health consumers.

7. CONCLUSION

Wairarapa, Hutt Valley and Capital & Coast DHBs continue to develop their approach to improving equity and improving outcomes for all our people. Above we have described the range of activity being undertaken to improve equity of results.

PUBLIC

 <div>Wairarapa DHB Wairarapa District Health Board Te Pori Hauora a-rohe o Wairarapa</div>  <div>HUTT VALLEY DHB</div>  <div>Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA</div>		BOARD DECISION PAPER
		Date: 6 June 2017
Author	Dr Pauline Boyles	
From	Rachel Haggerty: Executive Director of Strategy Innovation and Performance CCDHB	
Endorsed By	Adri Isbister CEO Wairarapa DHB Ashley Bloomfield CEO Hutt Valley DHB Debbie Chin CEO Capital and Coast DHN	
Subject	New Zealand Sign Language Action Plan: Funding award MSD	
RECOMMENDATION It is recommended that the Boards: <div><div>a.</div><div>Note New Zealand Sign Language (NZSL) in Health Research and Action Plan</div></div> <div><div>b.</div><div>Note the funding towards resources for developing improved access to health services for deaf people</div></div>		
Appendix 1: STRATEGIC LINKAGES (WHO FRAMEWORK)		
Appendix 2: KEY NZSL IN HEALTH RESEARCH FINDINGS ON BARRIERS TO HEALTH INFORMATION		

1. Background

The 'NZSL Enquiry' report commissioned in 2013 by the Human Rights Commission¹ recommended DHBs develop comprehensive NZSL interpreting and translation policies, including close consultation with the deaf community². The legislative imperatives for government departments have been in place since 2003³. The New Zealand Sign Language Act led to the inclusion of NZSL policy as one of the operational obligations under the Public Health and Disability Act since 2006.

2. Project Rationale and Framework

The 'New Zealand Sign Language in Health' project was initiated by the Service Integration and Development Unit (SIDU) Wairarapa, Hutt Valley and Capital and Coast District Health Boards (DHBs) to inform the development of a NZSL policy for the sub region. This plan is now an integral part of the Sub Regional Disability Strategy 2017-2022 (**Appendix 1**)

The recently released NZSL Board Action plan (2016-2018) has listed 'Access to services and information in NZSL' as a priority area and will be monitoring the existence of NZSL policies within 'core government information and services' such as DHB's within 2016/2017⁴.

¹ (Human Rights Commission, 2013)

² The Human Rights Commission (2013) "[A New Era in the Right to Sign. His Houhanga Rongo te Tika Ki Te Reo Turi: Report of the New Zealand Sign Language Inquiry.](#)" September 2013).

³ A cabinet paper on the NZSL Bill³ noted NZSL policies for DHB's must be comprehensive, must specify the use of qualified NZSL interpreters and must ensure that DHB services and information are accessible.

⁴ (Office for Disability Issues, 2016) ODI is a business unit of MSD

2.2 Project Framework

A number of goals were identified with the SIDU Management Team and the project working group.⁵ The project was designed to achieve some overall findings in Phase One until March 2016 followed by Phase Two from April 2016 until May 2017. The findings from phase one as documented and presented to CPHAC DSAC in April 2016 contributed to an overall five year action plan. The project leads set up a research steering group to oversee a piece of participatory action research based on appreciative enquiry principles. The project itself continues into phase two drawing on the research findings summarised in 3.5.

The high level project aims were as follows:

- To identify an evidence base of the specific issues and experiences deaf people face when accessing all ⁶secondary services across Wairarapa, Hutt Valley and Capital and Coast District Health Boards.
- To record and document the range of issues and experiences of staff employed within the District health boards when working with deaf clients and patients within a secondary health setting.
- To use the evidence gained as a foundation of a five year New Zealand Sign Language plan for the Wellington sub region⁷.
- To share the findings nationally

An article outlining the findings has been submitted to the NZ Medical Journal and is currently in the peer review process. Plans are also underway for further publishing such as particular issues of interpreting within health services and mitigation strategies.

3 NZSL fund awards awarded by MSD

Based on some key findings documented within the research report regarding barriers to health information (**Appendix 2**), three applications were made to the NZSL fund⁸. All three were successful and a brief summary of each is presented below.

3.1 Health Sector Interpreting: total grant \$7,325.50

This money will be used to facilitate a workshop between the local Wellington deaf community and NZSL interpreters including documenting variations in the use of NZSL for future reference. The goal is to improve access to health information and empower deaf people with their whanau and communities to be more in charge of their health care decisions.

⁵ Consisted of SIDU mental health portfolio lead, Senior Disability advisor and the project expert lead

⁶ Includes general and mental health and addiction services who co led this project

⁷ All DHBS have been obligated to develop a plan since 2006 when NZSL become an official language. There is scant evidence country wide of a specific plan to improve access. Auckland and Wellington have the biggest deaf populations

⁸ New Zealand Sign Language Board working with ODI

3.2 Health Information in NZSL: \$8855.00

This money will be used to scope and research a proposal for the sustainable production and delivery of electronic health information and resources in NZSL. Currently the deaf community has very limited access to health information in NZSL. This is one of the reasons why the health of deaf people is poorer than that of the general population (Edmond, 2015). Increased accessibility to health information in NZSL will allow more informed decisions to be made by the deaf community and their whanau, leading to improved health literacy and health outcomes.

3.3 Website Information: \$34,799.00

This funding will be used to:

1. Ensure the deaf community has access to disability related information and other practical information regarding accessing DHB services, on each DHB website equivalent to the general population.
2. Develop information for staff from the 3DHBs on the intranet in relation to 'effectively communicating and interacting with deaf from the deaf community'.

This will allow both the deaf community and DHB staff to be better informed about how to work together leading to improved confidence on both sides and improved health outcomes.

It is expected that all these resources will be shared nationally with other District Health Boards

A further report will be presented to boards once the resources have been completed.

Appendix 1

Sub Regional Disability Strategy and links to Who Framework

WHO Integrated Framework		
Creating Enabling Environments		
3DHB Disability Implementation Plan	World Health Organisation	Examples of NZSL project integration
Health	Reorienting the model of care	Health literacy and health information
Access	Coordinating Services	Improving access to NZSL interpreters for deaf
Inclusion + Support	Empowering and engaging people	deaf community leadership in education and service co design
Leadership	Strengthening governance and accountability	Community leadership in electronic enablers and system monitoring

Under each of these themes some key feedback is included below and early indicators for an action plan over the next twelve months

Appendix 2

Relevant research findings (Extract from CPHAC DSAC paper April 2016)

Deaf people need full access to their health information

NZSL interpreters are often not being used when a deaf person is accessing health services. Communication strategies such as using pen and paper, gesturing, lip reading or using family/friends to interpret are common strategies, though the risks and limitations of these methods are often not fully understood. Access to health information, including how the DHB presents/relays the information, relates to wider DHB objectives around health literacy.

Improved understanding of health care and needs may result in greater health outcomes.

Many deaf people talked about their plans to discontinue the treatment recommended by their treatment provider. It was clear that the deaf person involved often did not understand why they were required to have these repeated procedures and what the likely consequences could be. Research indicates 'patient comprehension is a pre-requisite for compliance with medical instruction'⁹. A link exists between a lack of understanding of health information and poor adherence to treatment which can result in poorer health outcomes as described in overseas literature¹⁰. One striking example is that of a deaf lady who experienced a stroke due to misunderstanding the need to take her blood pressure medication on an on-going basis. She instead assumed she only needed to take this medication until it ran out, as with antibiotics. As a consequence of the stroke she required significant inpatient and outpatient rehabilitation over a number of years. This example occurred within a GP setting and no interpreter was used and demonstrates an example of the barriers facing deaf people using ordinarily well functioning health services.

⁹ (Harmer, 1999).

¹⁰ (Harmer, 1999).

APPENDIX 1: EQUITY DASHBOARD – CAPITAL & COAST DHB

Performance result	Oral health DMFT result	ASH ratio		
Target achieved	Target achieved	At or below NZ benchmark	▲	Increase since last quarter indicating improved performance
Within 10% of target	Within 0.2 of target mean	101-150% of NZ benchmark	▲	Increase since last quarter indicating reduced performance
10-20% from target	0.2-0.5 from target mean	150-200% of NZ benchmark	▼	Decrease since last quarter indicating improved performance
> 20% from target	> 0.5 from target mean	> 200% of NZ benchmark	▼	Decrease since last quarter indicating reduced performance
			—	No change since last quarter

Domain	Indicator	Target (National/ Local)	Māori		Pacific		Other (or Total)	
Healthy children	Full or exclusive breastfeeding at 6 weeks Data Jan-Jun 2016	75% (National)	53%	▼	57%	▲	73%	▼
	Full or exclusive breastfeeding at 3 months Data Jan-Jun 2016	60% (National)	43%	▼	49%	▲	68%	—
	Any breastfeeding at 6 months Data Jan-Jun 2016	65% (National)	55%	—	58%	▼	79%	▲
	Infants fully immunised at 8 months Data at Mar 2017	95% (National)	96%	▲	95%	▼	93% (Total)	▼
	Pre-school enrolment in dental services Data for 2016	95% (National)	70%	▲	86%	▼	97% (Total)	
	Dental examination arrears rate Data for 2016	15% (National)	9%	▼	12%	—	15% (Total)	▲
	Percentage caries free at 5 years Data for 2016	69% (Local)	50%	▼	39%	▼	73%	▼
	Mean number of decayed, missing, filled teeth at Year 8 Data for 2016	0.60 (Local)	0.80	▲	1.07	▼	0.46	▼
Screening and early intervention	Breast screening 2 year coverage, 50-69 yrs Data at Mar 2017	70% (National)	67%	—	69%	—	73%	▼
	Cervical screening 3 year coverage, 25-69 yrs Data at Mar 2017	80% (National)	61%	▼	67%	▼	80%	▼
	Brief advice to quit smoking offered in primary care Data at Mar 2017	90% (National)	85%	—	84%	—	86%	—
	Brief advice to quit smoking offered to inpatients Data at Mar 2017	95% (National)	91%	▲	91%	—	92%	▲
	Cardiovascular risk assessment completion Data at Mar 2017	90% (National)	87%	—	88%	—	90%	▼
Access and quality care	New-born enrolment in general practice by 3 months	74% (National baseline)	Note data issues					

Domain	Indicator	Target (National/ Local)	Māori		Pacific		Other (or Total)	
	Ambulatory sensitive hospitalisation ratio 0-4 yrs Data to Dec 2016	100% (National)	96%	—	180%	▲	83%	▲
	Ambulatory sensitive hospitalisation ratio 45-64 yrs Data to Dec 2016	100% (National benchmark)	145%	▼	191%	▼	73%	▼
	Outpatient 'did not attend' rate Data at Mar 2017	6% (Local)	14%	▼	15%	▼	6%	▲
Mental health	Long term users of MH&A services seen by a GP in previous 12 months Data YTD 2016/17	-	69%	▼	77%	▼	84%	▼
	MH&A community DNA rate Data YTD 2016/17	-	7%	▼	8%	—	7%	▲
	Acute inpatient unit seclusion hours per 100,000 population Data for 2015/16	-	3,940	▼	478	▼	284	▼
	Acute inpatient 28 day readmission rate Data for 2015/16	-	12.8%	▼	27.8%	▲	17.8%	▲
	Access to specialist MH&A services 0-19 yrs Data YTD 2016/17	3.74% (Local)	5.1%	△	3.1%	△	3.6%	△
	Access to specialist MH&A services 20-64 yrs Data YTD 2016/17	3.36% (Local)	7.0%	▽	3.6%	▽	3.1%	▽
	Access to specialist MH&A services 65+ yrs Data YTD 2016/17	1.30% (Local)	1.5%	▽	1.0%	△	1.1%	▽

Domain	Indicator	Target (National/ Local)	Disability Alert		Total Population	
Disability	Inpatient average length of stay Data at Mar 2017	N/A	2.97	▼	3.09	▲
	Outpatient DNA rate Data at Mar 2017	N/A	4.8%	▲	7%	—
	Inpatient readmission rate Data at Dec 2016	N/A	7%	▼	16%	▲

APPENDIX 2: EQUITY DASHBOARD - HUTT VALLEY DHB

Table 1 contains the equity monitoring performance dashboard with the most recent data available as at the end of Quarter Three 2016/17.

A traffic light system has been applied to each result according to the key below¹. Note that a traffic light rating has not been applied for indicators without a current target. The mental health indicators are new and targets have not yet been developed.

































Performance result	Oral health DMFT result	ASH ratio		
Target achieved	Target achieved	At or below NZ benchmark		Increase since last quarter indicating improved performance
Within 10% of target	Within 0.2 of target mean	101-150% of NZ benchmark		Increase since last quarter indicating reduced performance
10-20% from target	0.2-0.5 from target mean	150-200% of NZ benchmark		Decrease since last quarter indicating improved performance
> 20% from target	> 0.5 from target mean	> 200% of NZ benchmark		Decrease since last quarter indicating reduced performance
				No change since last quarter

Table 1: Hutt Valley DHB equity monitoring performance dashboard

Domain	Indicator	Target (National/ Local)	Māori		Pacific		Other (or Total)	
Healthy children	Full or exclusive breastfeeding at 6 weeks Data Jan-Jun 2016	75% (National)	50%		63%		65%	
	Full or exclusive breastfeeding at 3 months Data Jan-Jun 2016	60% (National)	39%		46%		57%	
	Any breastfeeding at 6 months Data Jan-Jun 2016	65% (National)	44%		64%		70%	
	Infants fully immunised at 8 months Data at Mar 2017	95% (National)	89%		94%		93%	
	Pre-school enrolment in dental services Data for 2016	95% (National)	81%		83%		108%	
	Dental examination arrears rate Data for 2016	13% (local)	13%		11%		12%	
	Percentage caries free at 5 years Data for 2016	70% (Local)	46%		45%		73%	

¹ Two of the indicators (Oral health DMFT and Ambulatory sensitive hospitalisations) are not measured as a percentage out of 100; therefore have a slightly different rating system as described in the key.

Domain	Indicator	Target (National/ Local)	Māori		Pacific		Other (or Total)	
	Mean number of decayed, missing, filled teeth at Year 8 Data for 2016	0.72 (Local)	0.96	▼	1.22	▼	0.60	▲
Screening and early intervention	Breast screening 2 year coverage, 50-69 yrs Data at Mar 2017	70% (National)	69%	▼	72%	▼	76%	▼
	Cervical screening 3 year coverage, 25-69 yrs Data at Mar 2017	80% (National)	67%	▼	71%	▼	79%	▼
	Brief advice to quit smoking offered in primary care Data at Mar 2017	90% (National)	89.5%	▲	89.4%	▲	88%	▲
	Brief advice to quit smoking offered to inpatients Data at Mar 2017	95% (National)	93%	▼	95%	▲	92%	▼
	Cardiovascular risk assessment completion Data at Mar 2017	90% (National)	83%	▼	86%	▼	89%	▼
Access and quality care	Newborn enrolment in general practice by 3 months Data at Sep 2016	77% (National baseline Q4 15/16)	85%	▼	75%	▼	88%	▲
	Ambulatory sensitive hospitalisation ratio 0-4 yrs Data to Dec 2016	100% (National)	138%	▲	192%	▼	122%	▲
	Ambulatory sensitive hospitalisation ratio 45-64 yrs Data to Dec 2016	100% (National benchmark)	178%	▼	207%	▲	93%	▲
	Outpatient 'did not attend' rate Data at Jun 2016	6% (Local)	14%	▼	15%	—	5%	—
Mental health	Long term users of MH&A services seen by a GP in previous 12 months Data at YTD 2016/17	-	72%	▼	81%	▲	83%	▼
	MH&A community DNA rate Data at YTD 2016/17	-	15%	▼	15%	▲	8%	▼
	Acute inpatient unit seclusion hours per 100,000 population Data for 2015/16	-	7,235	▲	442	▼	1,171	▼
	Acute inpatient 28 day readmission rate Data for 2015/16	-	18.3%	▲	12.5%	▲	13.0%	▼
	Access to specialist MH&A services 0-19 yrs Data for 2015/16	4.22% (Local)	4.9%	—	2.5%	△	4.1%	▽

Domain	Indicator	Target (National/ Local)	Māori	Pacific	Other (or Total)
	Access to specialist MH&A services 20-64 yrs Data for YTD 2016/17	4.53% (Local)	9.3% 	4.9% 	4.3% 
	Access to specialist MH&A services 65+ yrs Data for YTD 2016/17	1.97% (Local)	2.4% 	1.2% 	1.8% 

APPENDIX 3: EQUITY DASHBOARD – WAIRARAPA DHB

Table 1 contains the equity monitoring performance dashboard with the most recent data available as at the end of Quarter Three 2016/17.

A traffic light system has been applied to each result according to the key below¹. Note that a traffic light rating has not been applied for indicators without a current target. Most mental health indicators are new and targets have not yet been developed.









Performance result	Oral health DMFT result	ASH ratio		
Target achieved	Target achieved	At or below NZ benchmark	▲	Increase since last quarter indicating improved performance
Within 10% of target	Within 0.2 of target mean	101-150% of NZ benchmark	▲	Increase since last quarter indicating reduced performance
10-20% from target	0.2-0.5 from target mean	150-200% of NZ benchmark	▼	Decrease since last quarter indicating improved performance
> 20% from target	> 0.5 from target mean	> 200% of NZ benchmark	▼	Decrease since last quarter indicating reduced performance
			—	No change since last quarter

Table 1: Wairarapa DHB equity monitoring performance dashboard

Domain	Indicator	Target (National/ Local)	Māori		Pacific		Other (or Total)	
Healthy children	Full or exclusive breastfeeding at 6 weeks Data Jan-Jun 2016	75% (National)	57%	▼	60%	—	71%	—
	Full or exclusive breastfeeding at 3 months Data Jan-Jun 2016	60% (National)	60%	▲	50%	▼	60%	▲
	Any breastfeeding at 6 months Data Jan-Jun 2016	65% (National)	56%	▲	63%	▼	72%	▲
	Infants fully immunised at 8 months Data at Mar 2017	95% (National)	97%	▼	N/A		93%	▼
	Pre-school enrolment in dental services Data for 2016	85% (National)	68%	▼	N/A		92%	▼
	Dental examination arrears rate Data for 2016 Note ethnicity not available	15% (National)	N/A		N/A		12% (Total)	▲

¹ Two of the indicators (Oral health DMFT and Ambulatory sensitive hospitalisations) are not measured as a percentage out of 100; therefore have a slightly different rating system as described in the key.

Domain	Indicator	Target (National/ Local)	Māori		Pacific		Other (or Total)	
	Percentage caries free at 5 years Data for 2016	68% (Local)	53%	▲	N/A		73%	▲
	Mean number of decayed, missing, filled teeth at Year 8 Data for 2016	1.15 (Local)	1.11	▲	N/A		0.76	▲
Screening and early intervention	Breast screening 2 year coverage, 50-69 yrs Data at Dec 2016	70% (National)	70%	▼	75%	▼	76%	▼
	Cervical screening 3 year coverage, 25-69 yrs Data at Mar 2017	80% (National)	72%	▲	90%	▲	79%	▼
	Brief advice to quit smoking offered in primary care Data at Mar 2017	90% (National)	85%	▲	N/A		90%	▲
	Brief advice to quit smoking offered to inpatients Data at Mar 2017	95% (National)	92%	▼	N/A		91% (Total)	—
	Cardiovascular risk assessment completion Data at Mar 2017	90% (National)	83%	▼	84%	▼	91%	▼
Access and quality care	Newborn enrolment in general practice by 3 months Data at Dec 2016	77% (National baseline Q4 15/16)	105%	▲	N/A		76%	—
	Ambulatory sensitive hospitalisation ratio 0-4 yrs Data to Dec 2016	100% (National)	128%	▼	N/A		99%	▼
	Ambulatory sensitive hospitalisation ratio 45-64 yrs Data to Dec 2016	100% (National benchmark)	128%	▼	N/A		89%	▼
	Outpatient 'did not attend' rate Data at Sep 2016	6% (Local)	19%	▲	17%	▲	6%	▼
Mental health	Long term users of MH&A services seen by a GP in previous 12 months Data at Jun 2016	-	79%	▼	78%	▲	84%	▼
	MH&A community DNA rate Data at Jun 2016	-	9%	▲	21%	▲	8%	▼

Domain	Indicator	Target (National/ Local)	Māori	Pacific	Other (or Total)
	Access to specialist MH&A services 0-19 yrs Data for 2015/16	5.49% (Local)	7.1% 	2.3% 	5.5% 
	Access to specialist MH&A services 20-64 yrs Data for 2015/16	5.56% (Local)	10.7% 	6.5% 	5.1% 
	Access to specialist MH&A services 65+ yrs Data for 2015/16	1.02% (Local)	3.6% 	4.4% 	1.1% 