CAPITAL & COAST DISTRICT HEALTH BOARD

Health System Committee

Public Agenda

17 JULY 2019

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

	ITEM	ACTION	PRESENTER	MIN	TIME	PG
1 PROCEDURAL BUSINESS					9am	
1.1	Karakia					
1.2	Apologies	**Records**	Fran Wilde			
1.3	Continuous Disclosure – Interest Register	**Accepts**	Fran Wilde			2
1.4	Confirmation of Draft Minutes 12 June 2019	**Approves**	Fran Wilde			5
1.5	Matters Arising	**Notes**	Fran Wilde			
1.6	Action List	**Notes**	Fran Wilde			10
1.7	Nomination of Sponsor Pro-Equity Plan	**Nominate**	Fran Wilde			
1.8	Annual Work Programme	**Approves**	Rachel Haggerty			12
1.9	Communications Update	**Notes**	Rachel Haggerty			13
2 PRESENTATION						
2.1	Healthcare Home Performance Update	**Approves**	Astuti Balram, Bryan Beatty			
3 DISCUSSION						
3.1	Non-Financial Performance Monitoring Quarter 3	**Notes**	Rachel Haggerty, Carey Virtue, Delwyn Hunter, Nigel Fairley			28
3.2	Wai 2575 Update Item 3.2.1 Appendix 2 Chapter 9 Hauora Report	**Notes**	Rachel Haggerty			44
3.3	End of Life Bill Update	**Notes**	Rachel Haggerty			61
4 INFORMATION						
4.1	Strategy Innovation and Performance Update	**Notes**	Rachel Haggerty			69
4.2	Hospital and Health Services Update	**Notes**	Carey Virtue, Delwyn Hunter			75
4.3	Pacific Health Update	**Notes**	Taima Fagaloa			83
4.4	3DHB MHAIDS Update	**Notes**	Nigel Fairley			89
5 OTHER						
5.1	Resolution to Exclude	**Agree**	Fran Wilde			100

DATE OF NEXT MEETING 14 AUGUST 2019 – LEVEL 11, BOARD ROOM GRACE NEILL BLOCK WELLINGTON REGIONAL HOSPITAL

HEALTH SYSTEM COMMITTEE

Interest Register

UPDATED AS AT JULY 2019

Name	Interest
Dame Fran Wilde *Chairperson*	• Deputy Chair, Capital & Coast District Health Board • Chair, CCDHB Health System Committee • Member CCDHB FRAC • Chair CCDHB 3DHB DSAC • Chair Remuneration Authority • Chair, Te Papa Tongarewa Museum of New Zealand • Chief Crown Negotiator Moriori and Ngati Mutunga Treaty of Waitangi Claims • Chair Kiwi Can Do Ltd • Chair Wellington Lifelines Group • Director Frequency Projects Ltd • Ambassador Cancer Society Hope Fellowship • Trustee, Asia New Zealand Foundation
Mr Andrew Blair *Member*	• Chair, Capital & Coast District Health Board • Chair, Hutt Valley District Health Board • Chair, Hutt Valley DHB Hospital Advisory Committee • Chair, Queenstown Lakes Community Housing Trust • Member, State Services Commission Advisory Group on Crown Entity Chief Executive Remuneration • Member of the Governing Board for the Health Finance, Procurement and Information Management System business case • Member, Hutt Valley DHB combined Disability Support Advisory Committee • Member, Hutt Valley DHB Community and Public Health Advisory Committee • Member, Capital & Coast DHB Finance, Risk and Audit Committee • Member, Capital & Coast Health Systems Committee • Owner and Director of Andrew Blair Consulting Limited, a Company which from time to time provides governance and advisory services to various businesses and organisations, include those in the health sector • Former Member of the Hawkes Bay District Health Board (2013-2016) • Former Chair, Cancer Control (2014-2015) • Former CEO Acurity Health Group Limited • Advisor to Southern Cross Hospitals Limited and Central Lakes Trust to establish an independent short stay surgical hospital in the Queenstown Lakes region • Advisor to the Board of Breastscreen Auckland Limited • Advisor to the Board of St Marks Women's Health (Remuera) Limited
Ms Sue Kedgley *Member*	• Member, Capital & Coast District Health Board • Member, CCDHB CPHAC/DSAC • Member, Greater Wellington Regional Council • Member, Consumer New Zealand Board • Deputy Chair, Consumer New Zealand

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

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

CAPITAL AND COAST DISTRICT HEALTH BOARD
DRAFT Minutes of the Health System Committee
Held on Wednesday 12 June 2019 at 9am
Board Room, Level 11, Grace Neill Block, Wellington Regional Hospital

PUBLIC SECTION

PRESENT

COMMITTEE:	Dame Fran Wilde (Chair) Ms Sue Driver Dr Roger Blakeley Ms Eileen Brown Ms 'Ana Coffey Ms Sue Kedgley Dr Tristram Ingham Ms Sue Emirali Dr Margaret Southwick Mr Andrew Blair (arrived 9.24am)
STAFF:	Ms Rachel Haggerty, Director, Strategy Innovation and Performance Mrs Robyn Fitzgerald, Committee Secretary Ms Emma Hickson, Chief Nursing Officer Mr Thomas Davies, General Manager Corporate Services Ms Anna Chalmers, Manager Communications Ms Rachel Nobel, General Manager 3DHB Disability Services Mr Peter Guthrie, Manager Planning and Performance Mr Peter Gush, Regional Public Health Ms Lisa Smith, System Development Adviser Ms Gerardine Clifford-Lidstone, General Manager, Child Youth and Localities Ms Carey Virtue, Executive Director, Medicine, Cancer and Community Ms Delwyn Hunter, Executive Director, Surgery, Women and Children Ms Jan Marment, Senior System Development Manager Ms Marie
BOARD	Dr Kathryn Adams (arrived 9.26am)
GENERAL PUBLIC:	A member of the public.

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1 PROCEDURAL BUSINESS

1.1 PROCEDURAL

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

1.2 APOLOGIES

Apologies received from Mr Tino Fa'amatuainu Pereira, Julie Patterson and the late arrival of Andrew Blair.

1.3 INTERESTS

1.3.1 Interest Register

Dr Margaret Southwick registered her interests as a member of the Health and Disability Review Panel and as the lead for the Pacific Nurse-led services in Porirua project.

1.4 CONFIRMATION OF PREVIOUS MINUTES

The minutes of the CCDHB Health System Committee held on 15 May 2019, taken with public present, were confirmed as a true and correct record with one amendment as listed below.

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

1.5 MATTERS ARISING

An update was provided to the Committee on Items 3.1 Timeframe for Nail Salons, and 3.2 Measles Report by Peter Gush, Regional Public Health.

Action:

1. Management to ensure all papers that reference other papers should hyperlink these documents for all committee and Board papers.

1.6 **ACTION LIST**

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

Action:

2. Committee to include in discussion with the Citizens Health Council's presentation to the Committee representation of a CHC member on the Health System Committee.

1.7 ANNUAL WORK PROGRAMME

The Committee:

(a) **Noted** that the work programme;

(b) **Noted** that an update on Oranga Tamariki and Maternity Services will be included on the August agenda and workplan.

2 DECISION

2.1 PRO-EQUITY WORK PLAN

The paper was taken as **read.**

The Committee:

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

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

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

(d) **Endorse** to the Board that a member from the Board be appointed as a champion of this plan.

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

Actions:

3. Management to reference the UN Convention in the plan. Disability and other advisory groups to be listed in the Terms of Reference;
4. Management to ensure a 'whole system' view be taken to ensure it is inclusive of all the population;
5. Management to reference Taurite Ora: Māori Health Strategy in the Terms of Reference of the plan.
6. Management to invite members to presentation by Ruth d'Souza on *Diversity and equity of Healthcare*.

2.2 ANNUAL PLAN

The Committee was informed that there had been no changes since the Annual Plan had been presented to the Health System Committee and that delegated authority was given by the Board to the Health System Committee to approve the final draft Annual Plan 2019/20 so that it may be submitted to the Ministry of Health.

The Committee:

(a) **Approved** the final draft Annual Plan 2019/20 to be submitted to the Ministry of Health by 21 June.

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

3 DISCUSSION

3.1 DEMENTIA IN OUR COMMUNITY — PREVALENCE, IMPACTS AND PLANNING FOR THE FUTURE

The paper was taken as **read**.

The Committee:

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

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

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

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

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

Actions:

7. Disability Sub Regional Group to provide advice to be included in the Long Term Investment Plan;
8. Management to bring back a paper to the Committee on elderly and dementia.

3.2 UPDATE ON INTEGRATION OF YOUTH SERVICES IN PORIRUA PROJECT

The paper was taken as **read**.

The Committee:

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

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

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

DRAFT

4 PRESENTATION

4.1 SUSTAINABILITY AND INVESTMENT CHOICES

To be presented at this afternoon's Board workshop.

4.2 WELL BEING PROJECT

Discussion on the Government Well Being Budget specifically for:

- Mental Health Services
- Telehealth
- Suicide prevention
- Mental Health Commission
- Supporting education
- Investing in social determinants
- Family support – training for health workers
- Child development
- Māori Health Workforce package
- Investment in Pacific Health.

Action:

9. Management to arrange for the Dementia paper to be emailed to Dementia Wellington.

*Public Meeting closed at 11.10am***.**

7 DATE OF NEXT MEETING

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

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

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

Fran Wilde
Health System Committee, Chair

DRAFT

Capital & Coast District Health Board
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SCHEDULE OF ACTION POINTS – HEALTH SYSTEM COMMITTEE (HSC)

AP No:	Item No.	Topic	Action:	Responsible:	How Dealt With:	Delivery Date:
P032	**3.1**	**Dementia in our Community**	Disability Sub Regional Group to provide advice to be included in the Investment Plan to be presented to HSC in December 2019.	Dir SIP	Investment Plan	December
HSC Meeting 12 June 2019						
P024	**2.4**	**Hospital and Health Services Update**	Management to provide regular updates or dashboard on specific issues	Exec Director, MCC	Paper	November
HSC Meeting 15 May 2019						
P021	**4.2**	**3DHB ICT Strategy**	Management to include in the next update a copy of the National ICT strategy and show alignment to CCDHB's ICT plan, the regional plan and compares with other DHBs. Include discussion on accessibility standards.	CIO	Paper	~~June~~ ~~July~~ Transferred to Board August
HSC Meeting 17 April 2019						

Action items completed prior to 17 July 2019 Health System Committee meeting

P030	**2.1**	**Pro-Equity Work Plan**	Management to reference Taurite Ora: Māori Health Strategy in the Terms of Reference of the plan.	Dir SIP	Update Plan	Closed
P029	**2.1**	**Pro-Equity Work Plan**	Management to ensure a 'whole system' view be taken to ensure it is inclusive of all the population.	Dir SIP	Update Plan	Closed
P028	**2.1**	**Pro-Equity Work Plan**	Management to reference the UN Convention in the plan. Disability and other advisory groups to be listed in the Terms of Reference.	Dir SIP	Update Plan	Closed
P027	**1.6**	**Action List**	Committee to include in discussion with the Citizens Health Council's presentation to the Committee representation of a CHC member on the Health	Dir SIP	Discussion at August meeting.	Closed
P026	**1.5**	**Matters Arising**	Management to ensure all papers that reference other papers should be hyperlinked to those documents for all committee and Board papers.	ELT	Guidance given to ELT	Closed
P034	**4.2**	**Well Being Project**	Management to arrange for the Dementia paper to be emailed to Dementia Wellington.	Committee Secretary	Email	Closed
P031	**2.1**	**Pro-Equity Work Plan**	Management to invite members to presentation by Ruth DeSouza on *Diversity and equity of Healthcare*.	Dir Sip	Invitation	Closed
HSC Meeting 12 June 2019						

Draft Health System Committee Workplan 2019

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

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

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V3

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PUBLIC

Date: 10 May 2019	**HEALTH SYSTEM COMMITTEE PROCEDURAL**
Author	Shar Carlini, Senior Communications Advisor for SIP
Subject	**COMMUNICATIONS UPDATE**

RECOMMENDATION

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

(a) **Notes** the communication activities in July 2019.

APPENDICES

1. Health Matters Article in the June Issue
2. Winter Wellness Messaging 1,2,3
3. Media Round Up On Forums And New Services for Kapiti
4. General Media Release
5. Articles In NZ Doctor
6. Facebook Post on Kāpiti Urgent and After Hours
7. Facebook Post of Sub Regional Disability Advisory Group Forum
8. Intranet Article on Diversity Featuring Ruth De Souza.

1. ACUTE DEMAND BED CAPACITY (ADBC) PROJECT (OVERALL)

- Health Matters article in June issue outlining the project's objectives (Appendix 1)
- Lift lobby posters for month of July
- Winter wellness messaging through giggle TV channel from Wellington South to Wellington North – in creative production now and due for release August through September (Appendix 2)

2. KĀPITI URGENT & AFTER HOURS PROJECT

- Local media piece rounding up the forums and beginning of new services for Kāpiti (Appendix 3)
- Article in Wellington Free newsletter
- Article in Compass newsletter
- CCDHB website article
- General media release distributed via Voxy (Appendix 4)
- Extended media release with more local content in Kapiti papers to appear week of 15 July
- Two articles in in NZ Doctor – one in free web content, the other for subscribers (Appendix 5)
- Article adapted and updated for Health Matters July
- Facebook post – reach 3873, engagements 525 (Appendix 6)
- Updated Kenepuru shuttle poster and travel information for Kapiti residents
- Updated information for outpatients letters
- Produced ED staff poster specific to earlier discharge of Kapiti residents

3. DISABILITY STRATEGY

- Implemented fortnightly bulletin to key stakeholders from Rachel Nobel getting great feedback
- Facebook post on SRDAG workshop – reach 1175, engagements 41 (Appendix 7)

- Follow up article written to appear in July Health Matters

4. DIVERSITY

- Intranet piece on Ruth de Souza visit (Appendix 8)
- Diversity paragraph in CEO update.

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Appendix 1 – Acute Demand Health Matters Article, June 2019

PROJECT GROUP FOCUSES ON WINTER ED PRESSURE

March 2019. An unexplained spike in ED presentations sounded an alarm for a potential increase in the expected high number of presentations this winter.

What was a seasonal trend seems to be becoming less seasonal and more long-term. ED is already at capacity. High hospital occupancy has the potential to impact quality of care and put extra stress on staff.

Fast forward to June 2019, and a group of thought leaders who've been meeting regularly since March, have picked apart the challenges and opportunities, and tested ideas to ease the winter pressures. They are the Acute Demand Bed Capacity (ADBC) Projects Group – led by Astuti Balram – which reports to a Steering Group made up of SMOs and clinical leaders chaired, and cheered on, by Strategy Innovation and Performance Director Rachel Haggerty.

"Our projects all have a strong focus on facilitating improved patient flow and maximising the impact of existing resources. We're looking at how we support early discharge for complex patients, how we use the transit lounge more effectively, patient flow through the Interventional Recovery Ward, as well as improvements to assessment and triage of people coming into ED."

She says the project teams are also looking at ways to divert people coming through ED who may not need to be there.

"It's all those kinds of improvements that can make life easier for our staff at a time when they're already under a lot of pressure."

Rachel Haggerty says the work is being supported by a dashboard of analytics relevant to the project teams so results can be monitored in real time and modified where appropriate.

"The project teams are working hard to alleviate the pressures before they become too big. They're listening to our staff who are working in the coalface, and putting the resources in place to try and take the dread out of winter."

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Appendix 2 – Winter Wellness Messaging 1, 2, 3

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Appendix 3 – Local media round up on forums and new services for Kāpiti

Post Forum Article – distributed via Kapiti Coast District Council and local papers

Delivering urgent health care services closer to home in Kāpiti has been a priority for the Kāpiti Health Advisory Group (KHAG) which was set up by Mayor Gurunathan almost two years ago. On the 1st of May 2019, KHAG was able to engage with our Kāpiti community to discuss the journey to achieve this and other improvements.

"We welcome the support our community showed at the Forums and the clear endorsement and shared passion for the work KHAG is doing" said Kathy Spiers, Chair of the KHAG.

"By turning out in such numbers it was clear that people are concerned and interested in what is happening with our health care and that more services based in our community will be welcome."

Every year, more than 6500 Kāpiti residents travel to Wellington Hospital Emergency Department seeking treatment. More than half of these people travel by Wellington Free Ambulance (WFA) and fewer than 50% will require hospital admission.

"At the present time, KHAG is working with a wide range of partners to help determine improved pathways for more community based services" said Kathy. "It was clear at the Forums that Kāpiti people would welcome improved care here in the community which would save the stressful and difficult trip to Wellington Hospital, free up resources for the WFA and help reduce the high workload in the Wellington Hospital Emergency Department," said Kathy Spiers, Chair of KHAG.

At the present time KHAG is working to finalise an Annual Plan setting out the issues it will work on to help deliver on the five priorities identified by KHAG which are:

- Better access to services, including transport and delivery closer to home
- Urgent care
- Mental Health
- Care of older persons and people with disabilities
- Children and young persons

"We are currently looking at where we can work with our partners to make a difference in these areas and will be seeking more opportunities to engage with people as we work to deliver better health services in Kāpiti" said Kathy.

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Appendix 4 – General media release distributed via Voxy

News from Capital and Coast District Health Board
Some Kāpiti residents requiring emergency ambulance care and a possible trip to Wellington Hospital now have a treatment option closer to home. Thanks to a joint partnership between local general practice teams, the Kāpiti Health Advisory Group, the Wellington Free Ambulance and the CCDHB, some patients will receive funded treatment by their GP or medical centre.
Now, following clinical assessment, paramedic staff can work with the patient's GP or urgent care centre to establish if funding treatment can be provided at a local centre, without a trip to hospital.

CCDHB Strategy, Innovation and Performance Director Rachel Haggerty says the changes have been welcomed by local GPs and patients.

"This is what locals have been asking for and it's been an excellent collaboration between Wellington Free Ambulance, Tū Ora Compass Health PHO, and ourselves. A key to getting this off the ground has been working with the Kāpiti Health Advisory Group (KHAG) and the Mayor to identify the community's priority needs."

Ms Haggerty says the focus has been on supporting the community, and implementing a system which takes care of all the key players – GPs and their staff, ambulance paramedics, and the patient – to make the process of receiving health care as seamless as possible.

"We want to avoid Kāpiti people having to come in to Emergency Department if at all possible. It's often not the ideal place, wait times can be several hours, and then there's a long haul to get home again. Ambulance services take people to hospital, but can't bring them home again. People often get stranded in Wellington, adding another level of stress to being unwell."

Every year, more than 6200 Kāpiti residents travel to Wellington Hospital Emergency Department seeking treatment outside of normal consulting hours. More than half of people who attend ED travel by ambulance, but fewer than 50% actually end up requiring hospital admission. This places a huge strain on the available resources – both the hospital and the ambulance system – and on families and loved ones.

GP Clinical Lead and member of the establishment group, Dr Herman Van Kradenburg from Waikanae Health, says Kāpiti GPs have a lot of experience in urgent and emergency medicine which, until now, has been very under-utilised by the DHB.

"Over 10,000 patients are treated by the two existing urgent care centres, Waikanae Health and Team Medical, each year. We have the capacity and the skill right here in Kāpiti, so it's a real bonus to our community that the CCDHB are funding an excellent front line health care service in the community where they live."

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Wellington Free Ambulance Relationships Manager and Extended Care Paramedic, Vanessa Simpson, highlights the collaboration between Wellington Free and GPs to seek the most appropriate and timely care for Kāpiti patients.

“Our highly trained clinicians always assess and work with patients to determine the best medical treatment, but this new service allows us to take a more collaborative approach. Being referred by Wellington Free to your GP, being closer to home and avoiding potential long waits in ED can make a big difference to how patients feel during what can be a really distressing time.”

The Kāpiti Health Advisory Group (KHAG), a community organisation advocating for patient needs, has been working towards improved access to urgent care for Kāpiti residents and welcomes the new services. KHAG is chaired by Kathy Spiers and was established with support of Kāpiti Coast Council Mayor Gurunathan who says this is a significant development for the community in terms of a safer and convenient delivery of services closer to home.

“CCDHB’s collaborative approach is a testimony to other government agencies on what can be achieved if they strike a genuine partnership with communities to co-design solutions. On behalf of the community I congratulate Kathy Spiers and her team of dedicated and skilled volunteers who have put in thousands of hours to deliver this outcome. I’m keen to see further collaboration.”

ENDS

Capital & Coast District Health Board
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PUBLIC

Appendix 5 – Articles in NZ Doctor

+NEWS |

DHB adds funding in bid to stem tide of Kāpiti patients to Wellington ED

1

Virginia McMillan
vmcmillan@nzdoctor.co.nz

Tuesday 2 July 2019, 04:31 PM

Wellington Free Ambulance paramedics James Currie and Vanessa Simpson, and Waikanae GP Herman van Kradenburg aim to keep Kāpiti people out of the ED at Wellington Hospital

7/3/2019 DHB adds funding in bid to stem tide of Kāpiti patients to Wellington ED | New Zealand Doctor

https://www.nzdoctor.co.nz/article/news/dhb-adds-funding-bid-stem-tide-kapiti-patients-wellington-ed 2/9

"We have the capacity and the skill right here in Kāpiti, so it's a real bonus to our community that the DHB is funding an excellent front-line healthcare service in the community where they live" Dr Herman van Kradenberg, Waikanae Health Centre

Kāpiti Coast residents' ambulance trips to Wellington may be slashed in the next year, after all nine local general practices signed up to a "redirection" scheme funded by Capital & Coast DHB.

The scheme, begun three weeks ago, funds care for patients who would otherwise be taken from the coast by ambulance to Wellington Hospital's emergency department.

More than 3000 Kāpiti residents a year are driven by ambulance to the hospital ED, but under half of these require a hospital stay.

A journey to avoid if at all possible

Strategy, innovation and performance director Rachel Haggerty says the DHB wants, if at all possible, to avoid Kāpiti people having to go to ED. Ms Haggerty refers to the huge strain on hospital and ambulance service resources, and on families and loved ones.

She says the redirection works by paramedic staff clinically assessing the patient, then working with the patient's GP or urgent care centre to establish whether funded treatment can be provided locally.

Paying practices twice?

New Zealand Doctor asked if the DHB was effectively paying practices twice – via capitation and the new scheme.

In a statement, Ms Haggerty says the financial arrangements recognise the existing funding streams, and support additional service requirements.

The ambulance service is already being funded whether the patient is taken to their local GP, to ED or treated on site, so there is no change to the level of funding.

However, when the patient is taken to one of the two urgent care clinics or treated at their own medical centre, the treating GP receives payment for the additional clinical care required, thereby saving the cost of treating the patient in ED.

"Primary care is providing an appropriate alternative for particular conditions/presentations in the community setting, Ms Haggerty says.

Hours of coverage 8am to 8pm

PHO Tū Ora Compass Health led the scheme's establishment and is managing it. In a statement, Mabli Jones, general manager service development at the PHO, says the Kāpiti practices agreed to take their own patients on ambulance diversion in core hours, 8am to 5pm.

As a backstop, Team Medical in Paraparaumu can take patients 8am to 8pm seven days a week, and Waikanae Health, 8am to 7pm Monday to Friday and Saturday 9am to 4pm.

Wellington Free Ambulance diverts to practices between 8am and 8pm, seven days a week, Ms Jones says.

Strengthened relationships

Team Medical is a general practice and urgent care clinic and is well used to working with paramedics.

Nurse manager Ruth Downs says the scheme has "formalised a lot of what we were already doing" and also strengthened relationships with both the ambulance service and community.

Ms Downs says it is positive that patients do not have to pay, and the scheme is also keeping people out of the ED.

"It's working really well, we're really happy with it," she says.

Urgent care experience under-utilised

Waikanae Health GP Herman Van Kradenburg is clinical lead and member of the scheme's establishment group. Dr Kradenburg says Kāpiti GPs have a lot of experience in urgent and emergency medicine which, until now, has been very under-used by the DHB.

He says Waikanae Health and Team Medical treat more than 10,000 patients a year.

Dr Kradenburg made his comments in a media release, and could not be reached for interview.

In the release he says: “We have the capacity and the skill right here in Kāpiti, so it’s a real bonus to our community that the DHB is funding an excellent front-line healthcare service in the community where they live.”

For Wellington Free Ambulance, relationships manager and extended care paramedic Vanessa Simpson adds that the organisation’s highly trained clinicians always assess and work with patients to determine the best medical treatment, “but this new service allows us to take a more collaborative approach”.

Making a difference for patients

Being referred by Wellington Free to the GP, being closer to home and avoiding potential long waits in ED can make a big difference for patients, Ms Simpson says in the release.

Ms Heggarty says the Tū Ora Compass Health contract covers ambulance redirection and extended “packages of care”, such as gastroenteritis management, asthma management and observation, vertigo, migraine, UTI, cellulitis, and renal colic.

The service also includes supporting people to be discharged earlier from ED, as well as fully funded visits for Māori and Pacific people, and those with a high level of deprivation. The service is an extension of existing Health Care Home and Primary Options for Acute Care services across the DHB “that are together building the strength of primary care”, she says.

The DHB paid for the engagement and design process, and will carry an ongoing cost of about $200,000 a year.

Tū Ora Compass Health’s Ms Jones says the project has been a real collaboration with Wellington Free Ambulance, “and a testament to the practices in that region to mobilise this new service in a matter of weeks, in time for winter pressures”.

Another key player in setting up the scheme was the Kāpiti Health Advisory Group.

Western Bay of Plenty began a similar scheme last year.

ENDS

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+UNDOCTORED

Improved access to after-hours and urgent healthcare for Kāpiti

0

Media release from Capital & Coast DHB
Tuesday 2 July 2019, 03:54 PM

Some Kāpiti residents requiring emergency ambulance care and a possible trip to Wellington Hospital now have a treatment option closer to home.

Thanks to a joint partnership between local general practice teams, the Kāpiti Health Advisory Group, Wellington Free Ambulance and the CCDHB, some patients will receive funded treatment by their GP or medical centre.

Now, following clinical assessment, paramedic staff can work with the patient's GP or urgent care centre to establish if funding treatment can be provided at a local centre, without a trip to hospital.

CCDHB Strategy, Innovation and Performance Director Rachel Haggerty says the changes have been welcomed by local GPs and patients.

"This is what locals have been asking for and it's been an excellent collaboration between Wellington Free Ambulance, Tū Ora Compass Health PHO, and ourselves. A key to getting this off the ground has been working with the Kāpiti Health Advisory Group (KHAG) and the Mayor to identify the community's priority needs."

Ms Haggerty says the focus has been on supporting the community, and implementing a system which takes care of all the key players – GPs and their staff, ambulance paramedics, and the patient – to make the process of receiving health care as seamless as possible.

"We want to avoid Kāpiti people having to come in to Emergency Department if at all possible. It's often not the ideal place, wait times can be several hours, and then there's a long haul to get home again. Ambulance services take people to hospital, but can't bring them home again. People often get stranded in Wellington, adding another level of stress to being unwell."
Every year, more than 6200 Kāpiti residents travel to Wellington Hospital Emergency Department seeking treatment outside of normal consulting hours. More than half of people who attend ED travel by ambulance, but fewer than 50% actually end up requiring hospital admission. This places a huge strain on the available resources – both the hospital and the ambulance system – and on families and loved ones.

GP Clinical Lead and member of the establishment group, Dr Herman Van Kradenburg from Waikanae Health, says Kāpiti GPs have a lot of experience in urgent and emergency medicine which, until now, has been very under-utilised by the DHB.

"Over 10,000 patients are treated by the two existing urgent care centres, Waikanae Health and Team Medical, each year. We have the capacity and the skill right here in Kāpiti, so it's a real bonus to our community that the CCDHB are funding an excellent front line health care service in the community where they live."
Wellington Free Ambulance Relationships Manager and Extended Care Paramedic, Vanessa Simpson, highlights the collaboration between Wellington Free and GPs to seek the most appropriate and timely care for Kāpiti patients.

"Our highly trained clinicians always assess and work with patients to determine the best medical treatment, but this new service allows us to take a more collaborative approach. Being referred by Wellington Free to your GP, being closer to home and avoiding potential long waits in ED can make a big difference to how patients feel during what can be a really distressing time."

The Kāpiti Health Advisory Group (KHAG), a community organisation advocating for patient needs, has been working towards improved access to urgent care for Kāpiti residents and welcomes the new services. KHAG is chaired by Kathy Spiers and was established with support of Kāpiti Coast Council Mayor Gurunathan who says this is a significant development for the community in terms of a safer and convenient delivery of services closer to home.

"CCDHB's collaborative approach is a testimony to other government agencies on what can be achieved if they strike a genuine partnership with communities to co-design solutions. On behalf of the community I congratulate Kathy Spiers and her team of dedicated and skilled volunteers who have put in thousands of hours to deliver this outcome. I'm keen to see further collaboration."

ENDS

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Appendix 6 – Facebook Post on Kāpiti Urgent and After Hours

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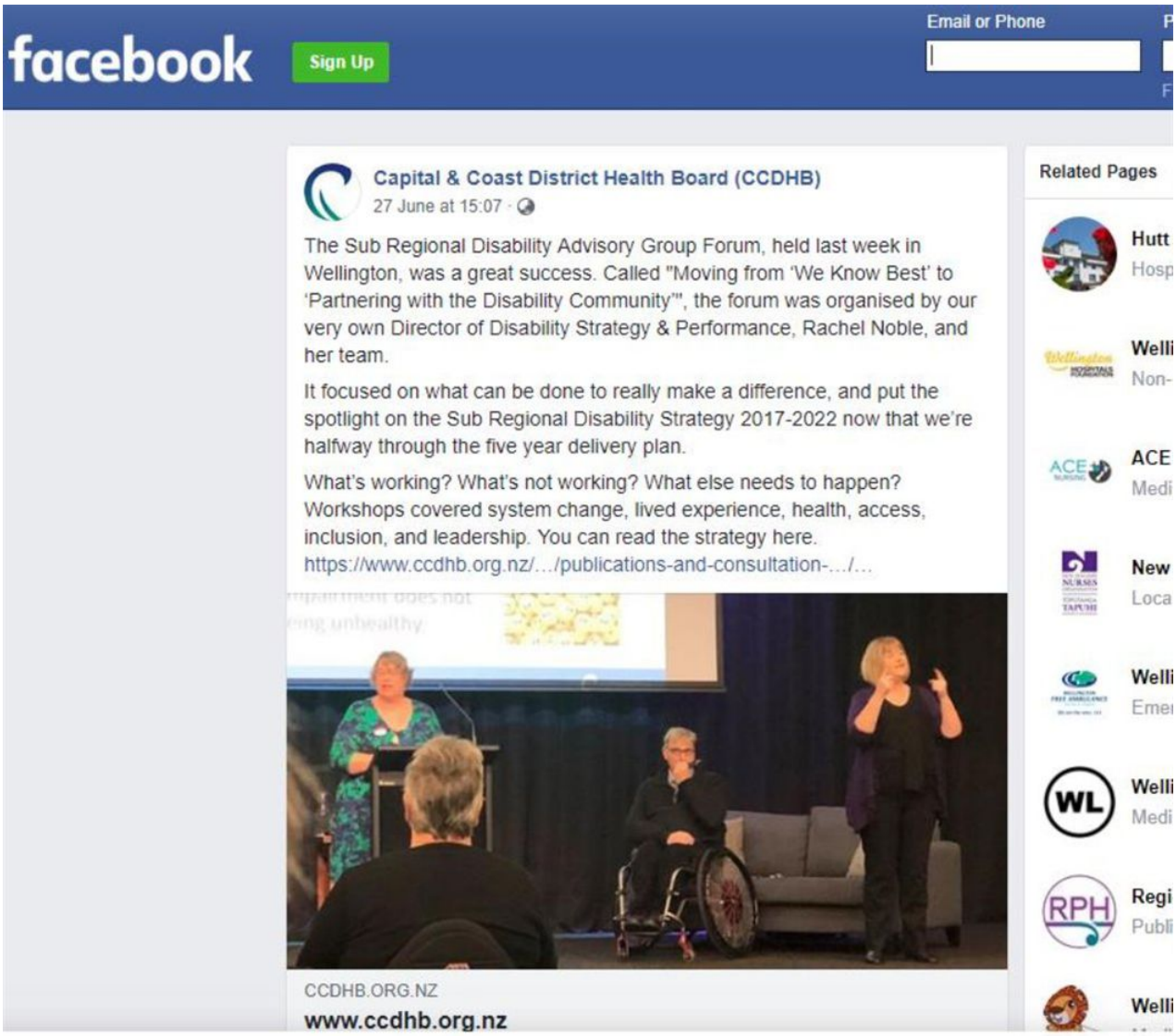
Appendix 7 – Facebook post on Sub-Regional Disability Advisory Group Forum



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Appendix 8 – Intranet article on Diversity featuring Ruth De Souza

Home > Home Page Notices

Colourful Insights Into Diversity And Equity

28.06.2019

What is diversity and equity and how do we make a difference? Everyone has a role in supporting communities and workplaces to be the best they can be. To that end, speaker, writer, researcher and consultant **Ruth de Souza** (pictured right below with Tagaloa Taima Fagaloa, Director of Pacific People's Health) came to CCDHB to share her colourful insights into how we can make a better world.

Ruth's specific professional expertise includes cultural safety, maternity, cultural issues in health, migration and health, social inclusion, and mental health. She has conducted empirical studies and theoretical investigations into sites, like hospitals, where health inequities are found, including refugee, migrant and indigenous communities.

Her five workshop lectures over two days were an interesting mix of listening and participating, sharing and being challenged. She skillfully created a space for participants to talk and discuss concepts, and learn from each other as well as some of the confronting real life examples she shared of migrant mothers experiences in the health system.

As the health system is moving into an interesting area around cultural safety, Rachel asked how, without the Treaty and without partnership, can we support health literacy for iwi and whanau?

From an equity point of view, she says, if we treat people the same we don't necessarily get the same outcomes.

By getting everyone thinking about their own context, history, social standing, privilege, Ruth showed how everyone contributes to the likes of racism, able-ism, stereoptyping.

"You don't see what's there while your privilege is invisible to you. The work you are doing within the health system will open your eyes, so think about those things and how people are being persecuted for being different."

She says warmth, kindness, and caring are how we want health services to be, yet there is inequity. What helps explain the gap?

"It's not because of tyrannical power that there is oppression, it's the everyday things we all do. We aren't asking whose interests are being served. We aren't questioning the rules."

So while the corridors and tea rooms are abuzz with the conversations Ruth has started, it's over to us now to keep it going.

Resources:
- Why cultural safety and equity?
- Developing Child, Youth and Families services to improve quity and outcome
- References from Ruth De Souza's talk

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Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**HEALTH SYSTEM COMMITTEE** **INFORMATION** **Date:** 11 July 2019
Author	Peter Guthrie, GM Planning & Performance, Strategy Innovation & Performance Sam McLean, Analyst, Strategy, Innovation & Performances
Endorsed by	Rachel Haggerty, Executive Director, Strategy, Innovation & Performance
Subject	**MINISTRY OF HEALTH NON-FINANCIAL MONITORING REPORT - QUARTER 3 2018/19**

RECOMMENDATIONS

It is **recommended** that the HSC:

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

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

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

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

(d) and a Not Achieved status on:

(e) Better Help for Smokers to Quit – Maternity; and,
(f) Better Help for Smokers to Quit – Primary.

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

1. PURPOSE

This paper provides an overview of CCDHB's performance against the DHB Non-Financial Monitoring Framework for Quarter 3 2018/19 (Appendix 1). This includes the six core health targets and 41 non-financial measures.

2. BACKGROUND

2.1 DHBs supply the Ministry with quarterly reports on their non-financial performance

The Ministry assesses DHB performance against the DHB non-financial monitoring framework. The DHB non-financial monitoring framework aims to provide a rounded view of performance using a range of performance indicators. All performance indicators link to the New Zealand Health Strategy and a life course group and the Ministry reports DHB performance to the Minister on a quarterly basis.

2.2 The Government directed the Ministry of Health to redesign the performance framework

A redesign of DHB non-financial performance framework has occurred in consultation with DHBs in 2018/19. The redesign aims to emphasise a stronger population view of performance and change the conversation to one of improvement and benefits for people within the context of the existing policies

and levers, including financial sustainability. The objective is to give confidence the decisions are improving health outcomes for New Zealanders.

The revised framework, shifts away from the current four domains (above) to the Government's priorities as a central organising method:

The Ministry will implement the revised non-financial monitoring framework from Quarter 1 2019/20.

2.3 SIP has implemented this quarterly non-financial performance monitoring report

This report is the third in the series SIP has reported to ELT and the first to the Health System Committee. It highlights significant challenges, persistent ethnic disparities as well as evidence of success and progress over a broad range of indicators. The Ministry review of the targets has highlighted that a wider spread of targets is necessary to assess performance. It has also highlighted the persistence of some issues, and the significant ethnic inequities have not been well addressed by the current target method.

CCDHB has achieved and partially achieved four of the six health targets and 39 of the 41 non-financial measures.

3. OVERVIEW OF PERFORMANCE – HEALTH TARGETS

3.1 DHBs continue to report to the Ministry against the current set of Health Targets

In quarter three 2018/19, we received the following results for the priority targets from the MoH:

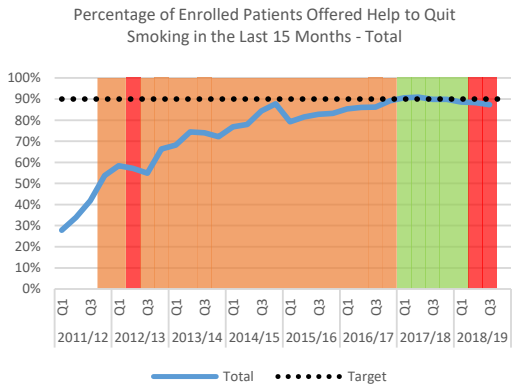
Achievement	Health Target	Performance	Target
Outstanding	N/A	N/A	N/A
Achieved	Faster Cancer Treatment	90%	90%
Partially Achieved	Increased Immunisation	93%	95%
	Shorter Stays in ED	84%	95%
	Raising Healthy Kids	94%	95%
Not Achieved	Better Help for Smokers to Quit – Maternity	86%	90%
	Better Help for Smokers to Quit – Primary Care	87%	90%

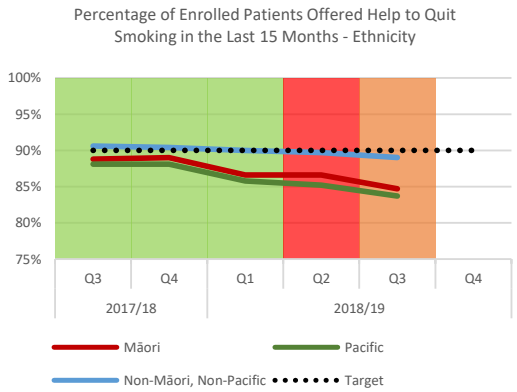
3.2 Better Help for Smoker to Quit – Primary Care

Responsible ELT Member: Rachel Haggerty, Executive Director, Strategy Innovation & Performance

Ministry Requirement: 90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months

Performance to Quarter 3 2018/19: We have achieved 87%. Performance has declined over the previous three quarters. Performance for Māori and Pacific is declining at a faster rate compared to Non-Māori, Non-Pacific.





Action Plan:

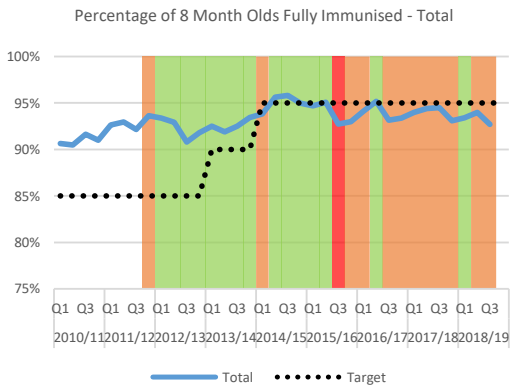
- The new Indici PMS is continuing to be rolled out to CCDHB practices. Introducing a new PMS to practices has challenged practices to identify patients due brief advice to quit smoking. We are working with our PHOs to improve their performance.
- Together with our PHOs, we are also focusing on supporting Mori and Pacific households with current smokers who share the residence with babies or young children. Supporting these families and households to become smoke free will give our children the best start in life and concentrate our effort.

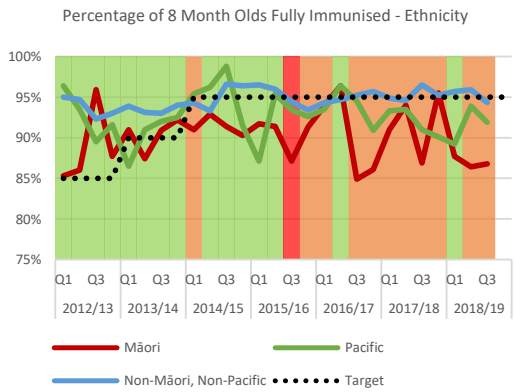
3.3 Increased Immunisation

Responsible ELT Member: Rachel Haggerty, Executive Director, Strategy Innovation & Performance

Ministry Requirement: 95% of eligible children fully immunised at eight months of age

Performance to Quarter 3 2018/19: We have achieved 93%. There are significant variations for Māori and Pacific due to small numbers, as well as embedded inequities.





Action Plan:

- There is nationwide concern regarding achievement of immunisation targets. The Ministry of Health have established a programme of work to consider how to respond to this national decline, and the persistent inequities.
- We are working with PHOs, and our Māori and Pacific partners, to complete a review of new-born enrolment processes, identify opportunities to streamline the process, and strengthen the relationship between children, whānau and primary care;

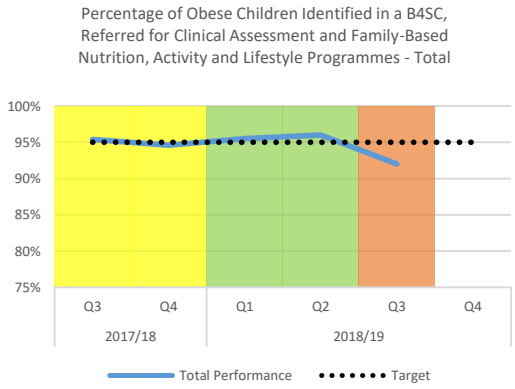
- CCDHB is looking to improve opportunistic immunisations by identifying opportunities to streamline administrative processes and requirements associated with looking up and updating the NIR on the children's wards, NICU, ED and Kenepuru Accident & Medical Clinic.

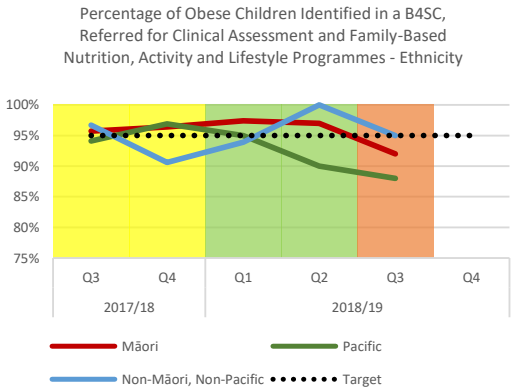
3.4 Raising Healthy Kids

Responsible ELT Member: Rachel Haggerty, Executive Director, Strategy Innovation & Performance

Ministry Requirement: 95% of obese children identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.

Performance to Quarter 3 2018/19: We achieve 94% for the total population. We achieved 92% for Māori and 88% for Pacific children. The decline is in quarter 3.





Action Plan:

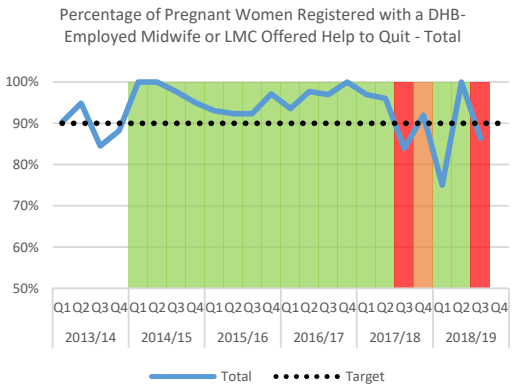
- CCDHB has recently contracted Ora Toa to deliver a weight management programme targeted at families/whānau. This includes a culturally responsive kaiāwhina service and wraparound support to increase healthy behaviours related to diet and physical activity, to manage and prevent chronic conditions such as obesity and early onset diabetes. This will provide a trial to identify how to improve Māori and Pacific results.

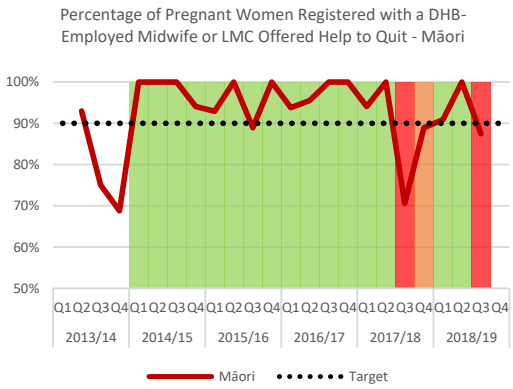
3.5 Better Help for Smoker to Quit – Maternity

Responsible ELT Member: Delwyn Hunter, Executive Director Operations, Surgery Women & Children's

Ministry Requirement: 90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking

Performance to Quarter 3 2018/19: We achieved 87%. The fluctuations reflect very small numbers in this cohort.





Action Plan:

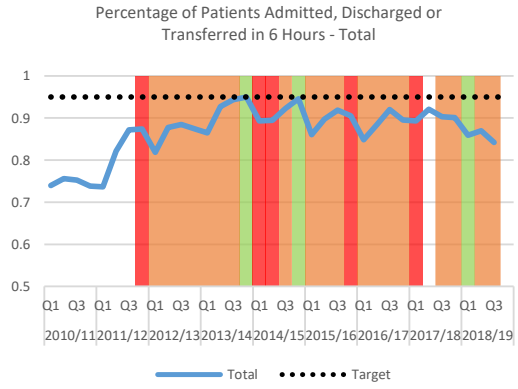
- CCDHB will work with our Maternity Quality and Safety Representative and Lead Maternity Carers (LMCs) to make accurate capture of smoking cessation activity a standard operating procedure;
- Distribute resources to remind LMCs about smoking cessation resources available to them and to refer women and their whānau to the Regional Stop Smoking Service.

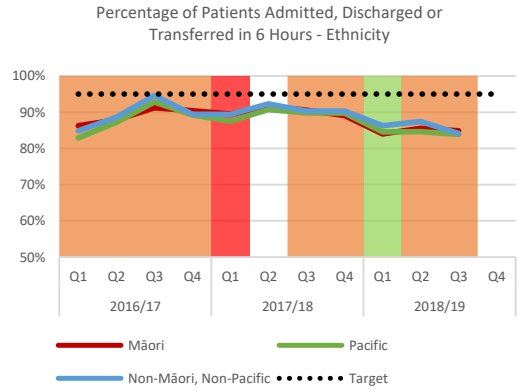
3.6 Shorter Stays in Emergency Departments

Responsible ELT Member: Carey Virtue, Executive Director Operations, Medicine Cancer and Community

Ministry Requirement: 95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours

Performance to Quarter 3 2018/19: We have achieved the 95% target once in nine years. Consistent pressure on acute beds remains the most significant driver of this non-achievement.





Action Plan:

- The Acute Flow Programme that has been presented to the HSC previously is a significant contribution to the achievement of this target;
- Developing a model of care transitioning some bed capacity from the ED Observation Unit to acute presentation & assessment beds for ED;
- Commence initiatives focussed on improved process for complex and early supported discharge.

4. OVERVIEW OF PERFORMANCE – NON-FINANCIAL PERFORMANCE FRAMEWORK

This paper covers the indicators assessed in Quarter 3 of 2018/19 only; some indicators are assessed six-monthly or annually. The report for Quarter 4 of 2018/19 will cover the full suite of indicators.

In the following 23 targets, CCDHB has reached a status of 'achieved' or 'satisfactory':

MoH Descriptor	Indicator
Outputs	Mental Health Output Delivery Against Plan
Ownership	Improving the Quality of Identity Data within the National Health Index (NHI) and Data Submitted to National Collections - Focus Area 1
	Improving the Quality of Identity Data within the National Health Index (NHI) and Data Submitted to National Collections - Focus Area 2a - NBRS Collection has Accurate Dates and Links to NNPAC and NMDS
	Improving the Quality of Identity Data within the National Health Index (NHI) and Data Submitted to National Collections - Focus Area 3 - Improving the Quality of the Programme for the Integration of Mental Health Data
	Inpatient Average Length of Stay (ALOS) – Acute
	Reducing Acute Readmissions to Hospital
Policy Priority	Children Caries Free at 5 Years of Age
	Improved Management for Long Term Conditions - Focus Area 3 - Cardiovascular (CVD) Health
	Improving System Integration and System Level Measures
	Implementing the Healthy Aging Strategy
	Rising to the Challenge: The Mental Health & Addiction Service Development Plan - Focus Area 1 Primary Mental Health
	Rising to the Challenge: The Mental Health & Addiction Service Development Plan - Focus Area 2 District Suicide Prevention and Postvention
	Rising to the Challenge: The Mental Health & Addiction Service Development Plan - Focus Area 3 Improving Crisis Response Services
	Rising to the Challenge: The Mental Health & Addiction Service Development Plan - Focus Area 4 Improve Outcomes for Children
	Rising to the Challenge: The Mental Health & Addiction Service Development Plan - Focus Area 5 Improving Employment and Physical Health Needs of People with Low Prevalence Conditions
	Faster Cancer Treatment - 31 Day Indicator
	Elective surgical discharges (former Health Target)
System Integration	Ensuring Delivery of Service Coverage
Crown Funding Agreement	B4 School Check
	DHB level service component of the National SUDI Prevention Programme
	Disability Support Services Funding Increase
	Well Child/ Tamariki Ora Services
Health Strategy	Supporting Delivery of the New Zealand Health Strategy

For the following 16 targets, CCDHB has reached a partially achieved or further work required status, indicating that 'some aspects still need development/or the DHB is not tracking to target but has an appropriate resolution plan',

MoH Descriptor	Indicator
Ownership	Inpatient Average Length of Stay (ALOS) – Elective
Policy Priorities	Oral Health DMFT Score at Year 8
	Improving the Number of Children Enrolled in DHB Funded Dental Services - Number of Pre-School Children Enrolled in DHB-funded Oral Health Services
	Improved Management for Long Term Conditions - Focus Area 4 - Acute Heart Service
	Improved Management for Long Term Conditions - Focus Area 5 - Stroke Services
	Immunisation Coverage (includes previous health target) Focus Area 1 - 2 Year Old and 5 Year Old Immunisation Coverage
	Prime Minister's Youth Mental Health Project

	Improving Waiting Times for Diagnostic Services – Colonoscopy
	Improving Waiting Times for Diagnostic Services – Coronary Angiography
	Improving Waiting Times for Diagnostic Services – CT/ MRI
	Reduce the rate of Māori under the Mental Health Act section 29 community treatment orders
	Improving Mental Health Services using Transition (Discharge) Planning
	Shorter Waits for non-Urgent Mental Health and Addiction Services for 0-19 Year Olds
System Integration	Delivery of Regional Service Plans
	Elective Services Standardised Intervention Rates
Crown Funding Agreement	Elective Initiative and Ambulatory Initiative

For the following 2 indicators, CCDHB has reached a not achieved status, indicating the 'DHB is not on track to meet the target and does not have an appropriate resolution plan':

MoH Descriptor	Indicator
Policy Priorities	Better Help for Smokers to Quit in Public Hospitals
	Improving Breast Feeding Rates

All 16 Partially Achieved and 2 Not Achieved performance indicators ('Better Help for Smokers to Quit – Hospital' and 'Improving Breast Feeding Rates') have resolution plans in place to ensure an Achieved status is attained.

4.1 We have improved our performance status across some performance indicators

In quarter three 2018/19, CCDHB achieved 23 of the 42 performance indicators reported against to MoH.

Compared to quarter two, we have improved our performance status from Partially Achieved to Achieved in two performance indicators:

- Inpatient average length of stay (ALOS): Acute
- Oral Health: Children caries free at 5 years of age

In quarter three 2018/19, CCDHB has partially achieved 16 of the 42 performance indicators reported.

Compared to quarter two, we have improved our performance status from Not Achieved to Partially Achieved in three performance indicators:

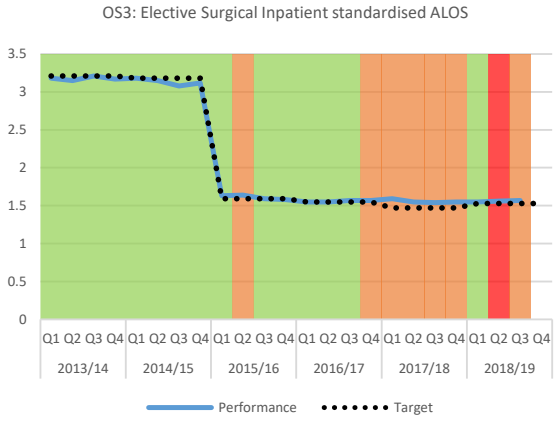
- Inpatient average length of stay (ALOS): Elective
- Immunisation Coverage: 2 year old and 5 year old immunisation coverage
- Reduce the rate of Māori under the Mental Health Act section 29 community treatment orders

Inpatient average length of stay (ALOS): Elective

Responsible ELT Member: Delwyn Hunter, Executive Director Operations, Surgery Women & Children's

Ministry Requirement: Standardised average length of stay for elective inpatients ≤1.53

Performance to Quarter 3 2018/19: We achieved 1.57.



Action Plan to Improve Performance:

The actions to reduce elective patients' ALOS were negatively impacted in quarter three by efforts to manage the RMO industrial action. The focus remains on surgical service improvement including;

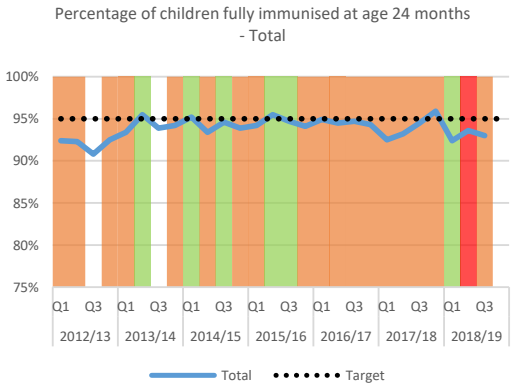
- Board rounding in all wards;
- Criteria led discharges (nursing led discharges); and,
- Increasing Day of Surgery Admissions (DOSA) – particularly for neurosurgery and cardiothoracic patients

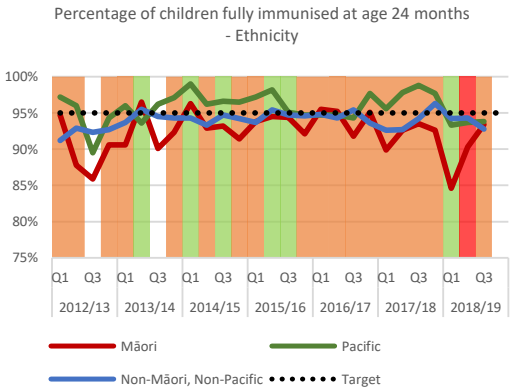
Immunisation Coverage at 24 months and 5 years of age

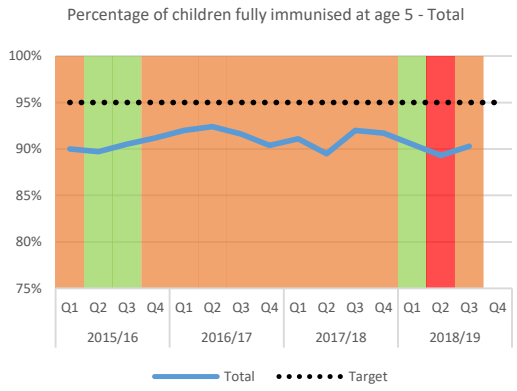
Responsible ELT Member: Rachel Haggerty, Executive Director, Strategy Innovation & Performance

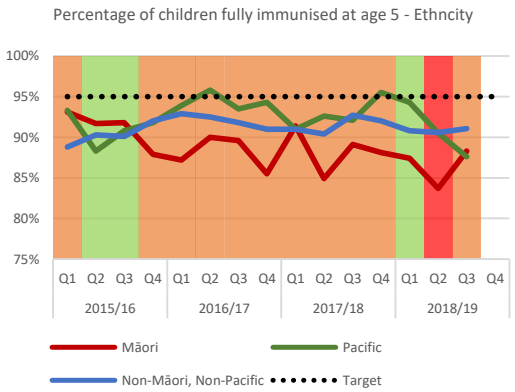
Ministry Requirement: 95% of eligible children fully immunised at 24 months and five years.

Performance to Quarter 3 2018/19: We have achieved 93% target for two years olds and 92% for five year olds.









Action Plan:

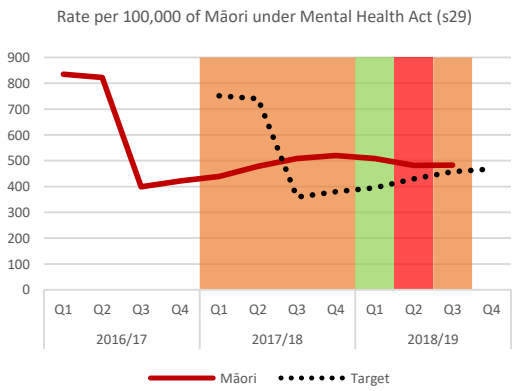
- As stated above there is Ministry response to this area of nationwide concern.
- Additional resource has been deployed for outreach immunisation in Porirua to support and follow up of families declining immunisations.
- Exploring opportunities to streamline administrative processes and requirements associated with looking up and updating the National Immunisation Register (NIR) on the children's wards, NICU, ED and Kenepuru Accident & Medical Clinic.

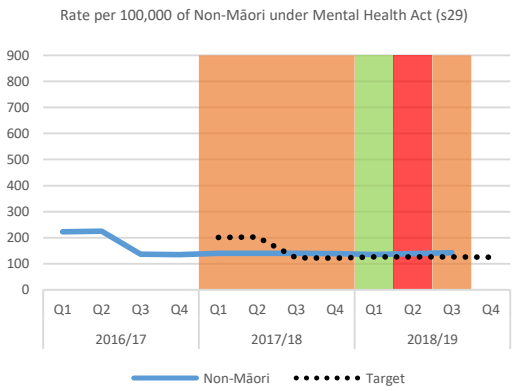
Reduce the rate of Māori under the Mental Health Act section 29 community treatment orders:

Responsible ELT Member: Nigel Fairley, General Manager, 3DHB MHAIDS

Ministry Requirement: DHBs are required to reduce the rate of Māori under s29 of the Mental Health Act by at least 10% by the end of the reporting year

Performance to Quarter 3 2018/19: Performance has improved against target but the disparity is significant with a rate of 458 per 100,000 for Māori and 126 for non-Māori.





Action Plan:

- To address the rate of Māori clients under s29 we have increased awareness across teams and promoting cultural advice and support. MHAIDS will also introduce this as part of their multi-disciplinary team discussions with clients.

- MHAIDS has reported to MoH that current actions are not having a big enough impact on reducing the rate of Māori under s29 of the Mental Health Act and they will bring this matter to ELT to inform a series of strategies to respond appropriately.

4.2 We have deteriorating performance across some performance indicators:

Compared to quarter two, we have deteriorating performance status from Achieved ("A") to Partially Achieved ("P") in three performance indicators.

- Improved Management for Long Term Conditions - Focus Area 4 - Acute Heart Service
- Improved Management for Long Term Conditions - Focus Area 5 - Stroke Services
- Oral Health DMFT Score at Year 8

Improved Management for Long Term Conditions - Focus Area 4 - Acute Heart Service

Responsible ELT Member: Carey Virtue, Executive Director Operations, Medicine Cancer and Community

Performance to Quarter 3 2018/19: CCDHB met 3 of the 5 targets measured by this indicator. We did not meet indicator 3 or 4:

- ≥85% of Acute Coronary Syndrome (ACS) patients who undergo coronary angiogram have pre-discharge assessment of LVEF; and,
- >85% of ACS patients who undergo coronary angiogram should be prescribed at discharge aspirin, a 2nd anti-platelet agent, statin and an ACEI/ARB (4-classes), and LVEF<40% should also be on a beta-blocker (5-classes).

We anticipate performance next quarter to result in an 'Achieved' status.

Improved Management for Long Term Conditions - Focus Area 5 - Stroke Services

Responsible ELT Member: Carey Virtue, Executive Director Operations, Medicine Cancer and Community

Performance to Quarter 3 2018/19: CCDHB met 1 of the 4 targets measured by this indicator. We did not meet:

- 80% of stroke patients admitted to a stroke unit or organised stroke service, with a demonstrated stroke pathway
    - All hyper-acute patients are consistently admitted to the stroke unit, however the total number of patients sometimes exceeds the number of available beds on the stroke unit. All efforts are made to ensure any outlying patients are transferred to the stroke unit in a timely manner
- 80% patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission
    - Our performance is trending towards the target. We are facing significant challenges in timely transfer to inpatient rehabilitation service due to a rise in acute admissions for stroke as well as encountering difficulties accessing aged residential care facilities for younger patients with severe stroke. CCDHB recently approved an Early Supported Discharge service and we anticipate this will support attainment of the 80% target.
- 60% of patients referred for community rehabilitation are seen face to face by a member of the community rehab team within 7 calendar days of hospital discharge

- CCDHB is still not able to meet this target. However, the time for patients to be seen by the community rehabilitation team has reduced for 4 quarters in a row. We are piloting a change process with one community team the results of which are expected to be observed in 2019/20.

Action Plan:

- Two interventional neuroradiologists have started employment and we have moved to a formal regional daytime service and aiming to extend hours in June. This will expand capacity and improve performance.
- Accessing CT and angiography for acute patients remains a barrier and is a current focus of effort.

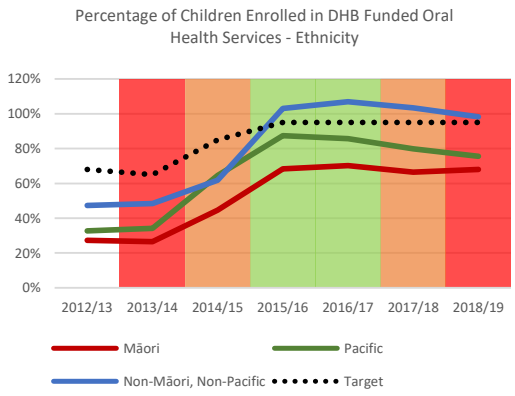
Oral health indicators

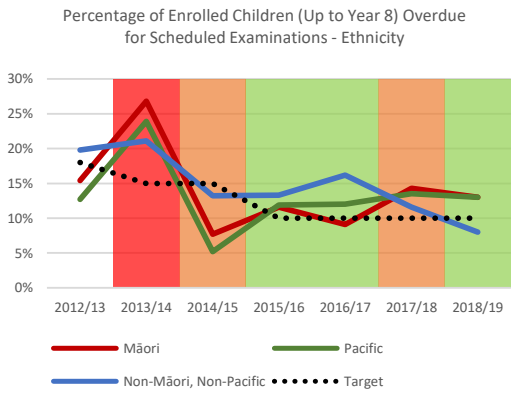
Responsible ELT Member: Rachel Haggerty, Executive Director, Strategy Innovation & Performance delegated to Hutt Valley DHB Oral health Service who are the provider.

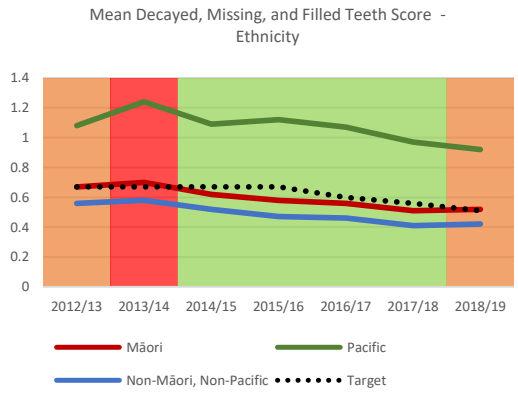
Ministry Requirement:

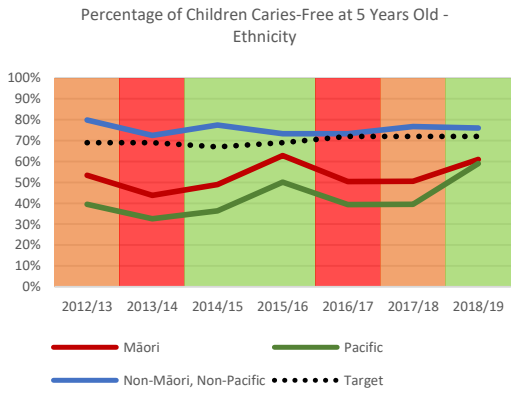
1. 95% of pre-school children are enrolled in DHB-funded oral health services
2. Less than 10% of enrolled pre-school and primary school are overdue for the their scheduled examinations
3. 72% of pre-school children are caries free
4. Primary school children have an average of 0.51 decayed, missing or filled teeth

Performance to Quarter 3 2018/19: There is inconsistent performance in this target with inequities for Māori and Pacific children require a focus.









Action Plan:

- The sub-regional provider at Hutt Valley DHB, Bee Healthy, is progressing initiatives including onsite examinations and prevention visits to high risk early childhood centres.
- Bee Healthy also supports Regional Public Health's water only schools programme by providing data to school Boards as evidence to go adopt a water only policy.
- Bee Healthy is implementing digital radiography in 2019, which is expected to improve patient flow and booking processes. Whānau will have more choice around when their children are seen and should improve accessibility for families with inflexible work and/or transport arrangements.
- Bee Healthy conducts onsite visits to high risk early childhood centres and supports Regional Public Health's water only schools programme.

The impacts of these initiatives, including equitable oral health outcomes, will be realised in the medium to long term.

4.3 Performance in Waiting Times for Diagnostic Services is a priority

Performance in the Improving Waiting Times for Diagnostic Services is challenged as service capacity is pressured.

Improving Waiting Times for Diagnostic Services – CT, MRI and Coronary Angiography

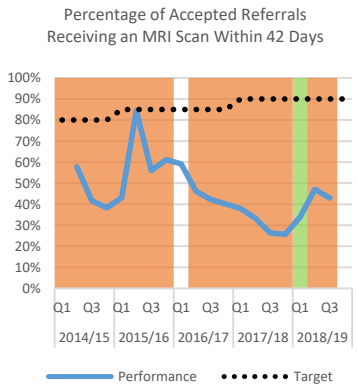
Responsible ELT Member: Carey Virtue, Executive Director Operations, Medicine Cancer and Community

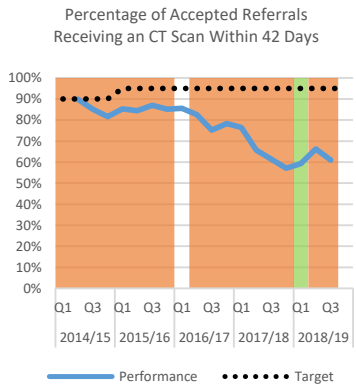
Ministry Requirement:

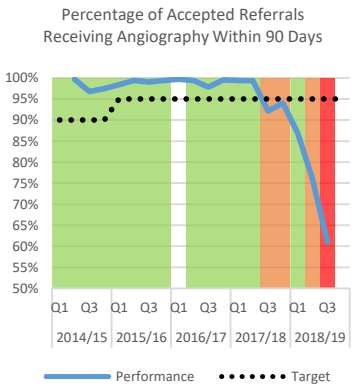
1. ≥95% of accepted referrals receiving CT scan within 42 days
2. ≥90% of accepted referrals receiving MRI scan within 42 day
3. ≥95% of accepted referrals receiving angiography within 90 days

Performance to Quarter 3 2018/19: The declining performance across these targets is of concern, particularly given the Minister's feedback to Board Chairs on wait times.

- CT elective waiting times are holding at approximately 9 weeks post referral date;
- MRI elective waiting times are at 20 weeks (down from approximately 40 weeks).







Action Plan:

- Continued elective CT & MRI weekend lists and outsourcing in order to improve performance.
- For Angiography there is back filling of existing scheduled capacity, outsourcing and recruiting a cardiologist, nurses and physiologists to support sessions being lost to acute cover in the region.

Improving Waiting Times for Diagnostic Services – Colonoscopy

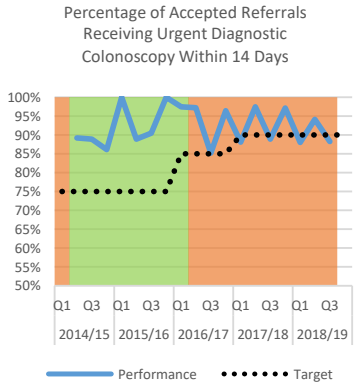
Responsible ELT Member: Carey Virtue, Executive Director Operations, Medicine Cancer and Community

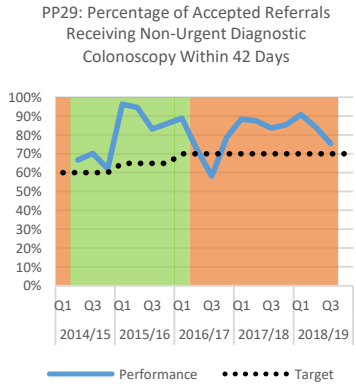
Ministry Requirement:

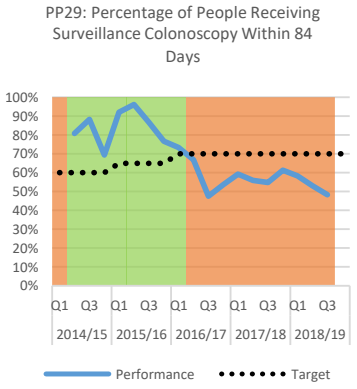
1. ≥90% of accepted referrals receiving urgent diagnostic colonoscopy within 14 days
2. ≥70% of accepted referrals receiving non-urgent diagnostic colonoscopy within 42 days
3. ≥70% of accepted referrals receiving surveillance colonoscopy within 84 days

Performance to Quarter 3 2018/19: While expectations for diagnostic colonoscopies have not changed, the National Bowel Screening Programme target that requires 95% of participants to have received their colonoscopy within 45 working days of their FIT (faecal immunochemical test) result being recorded in the National Bowel Screening Programme information system.

CCDHB will continue to endeavour to ensure colonoscopy wait time indicators are consistently met ahead of implementation of the National Bowel Screening Programme.







Action Plan:

- We are continuing to outsource and have recruited an additional endoscopist, who started in March, and expect our performance to improve.

- We are investigating the provision of colonoscopy services at Kenepuru Community Hospital (to promote Māori and Pacific attendance). This will also enable us to reduce waiting lists.

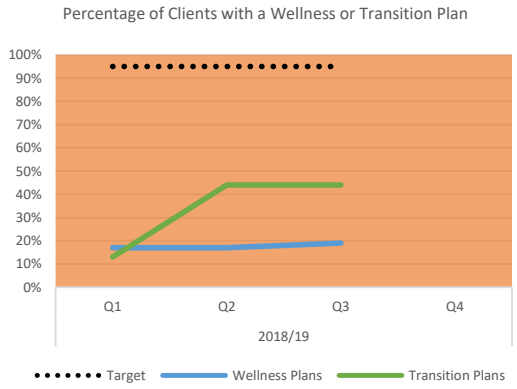
Improving mental health services using wellness and transition (discharge) planning

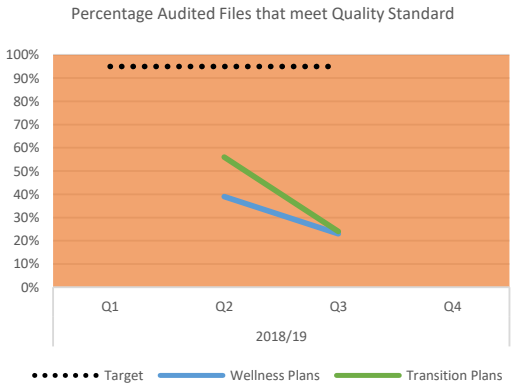
Responsible ELT Member: Nigel Fairley, General Manager, 3DHB MHAIDS

Ministry Requirement:

1. 95% of clients with an open referral to MH&A services of greater than 12 months have a wellness plan
2. 95% of audited files have a wellness plan of acceptable standard
3. 95% of clients discharged from community MH&A services have a transition (discharge) plan
4. 95% of audited files have a transition (discharge) plan of acceptable standard.

Performance to Quarter 3 2018/19: Prior to 2018/19, MHAIDS did not have data systems in place to collect or report information on Wellness or Transition plans. We are not tracking towards to the 95% target for clients with Wellness or Transition Plans and their quality of plans is declining.





Action Plan:

- Of the 55 audits completed on Transition Plans, 24% were of an acceptable standard. 58% of GPs received a clients' Transition Plan while 27% of clients received a copy of their Transition Plan. MHAIDS is working to increase the number of Transition Plans received by both the client and their GP.
- Of the 48 audits completed on Wellness Plans, 23% were of an acceptable standard. 79% of Wellness Plans involved the client in the development while 23% clients were was provided with a copy of their Plan. MHAIDS is working to increase the number of Wellness Plans were the client was involved in the Plan's development and a copy was received by the client.

4.4 Significant challenges are notable in the following measures on smoking advice

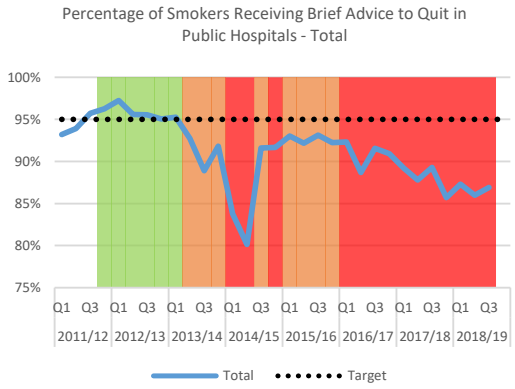
In quarter three 2018/19, CCDHB has Not Achieved ("N") 2 of the 42 performance indicators. These indicators show no signs of progressing towards a partially achieved or achieved in 2018/19.

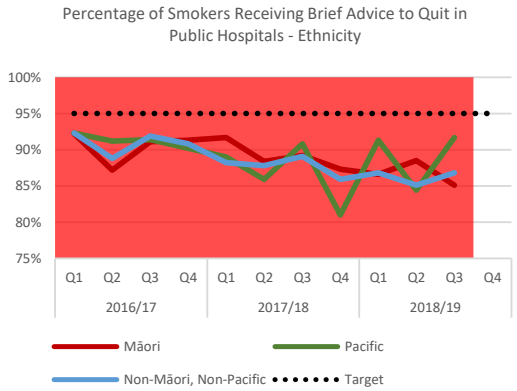
Better Help for Smokers to Quit - Public Hospitals

Responsible ELT Member: Carey Virtue, Executive Director Operations, Medicine Cancer and Community

Ministry Requirement: 95% of hospitalised smokers are offered brief advice to quit smoking

Performance to Quarter 3 2018/19: We have achieved 86.9%. There has been significant challenges with the reporting of this target. This target continues to show a steady decline in performance and inequitable outcomes for Māori and Pacific.





Action Plan:

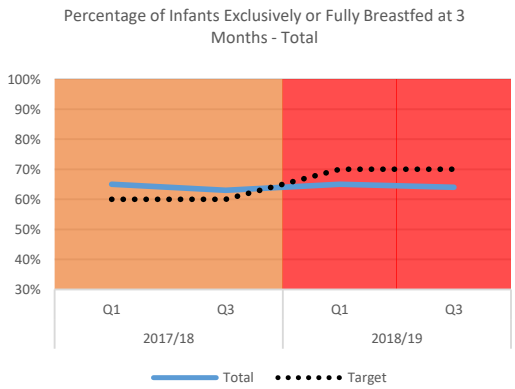
- The Māori Health Development Group continues work to embed sustainable system change in the hospital.
- Ongoing support is provided by the Tākiri Mai Te Ata smoking cessation advisor to bridge the gap between admission and enrolment in cessation support services.
- We have engaged with other DHBs to identify best practice and opportunities to improve our performance, particularly in ED. Based on their feedback, no clear mechanism for improving performance was identified.
- We will complete a further in-depth review next quarter.

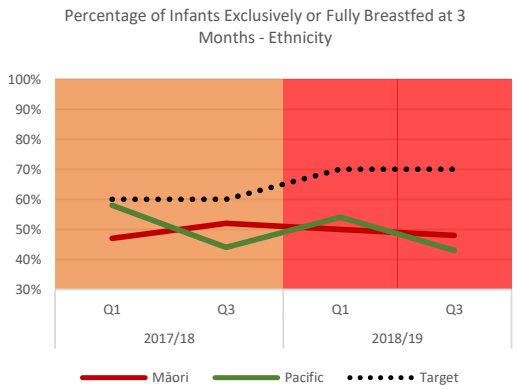
Improving Breast Feeding Rates

Responsible ELT Member: Rachel Haggerty, Executive Director, Strategy Innovation & Performance

Ministry Requirement: 70% of infants are exclusively or fully breastfed at three months.

Performance to Quarter 3 2018/19: We achieved 64% of target. This target continues to perform under the increased target and inequitable outcomes for Māori and Pacific.





Action Plan:

- The Health System Committee received a presentation on breastfeeding services and the approach we are taking to developing Te Ao Māori approaches within our communities.
- We are working with our Iwi led PHO to develop and implement an integrated maternal and child service, which will focus on providing whole-of-whānau support for positive pregnancies. Breastfeeding support will be a key activity promoted through the service. The service will commence from October 2019.

5. NEXT STEPS

There are specific action plans in place to improve performance on the three partially achieved health targets and two not achieved health targets. There are significant challenges for CCDHB to improve equity. The final report for Quarter four will not be available until September 2019. The new measures have not yet been confirmed for 2019/20 by the Ministry of Health.

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

PUBLIC

Date: 17 July 2019	**HEALTH SYSTEM COMMITTEE DISCUSSION**
Author	Lisa Smith, Strategy, Innovation and Performance
Endorsed by	Rachel Haggerty, Director Strategy, Innovation & Performance
Subject	**HAUORA: REPORT ON STAGE ONE OF THE HEALTH SERVICES AND OUTCOMES KAUPAPA INQUIRY**

RECOMMENDATIONS

It is **recommended** that the Committee:

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

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

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

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

APPENDICES

1. Statement of Issues For Stage One Of The Waitangi Tribunal Inquiry Into Māori Health – Wai 2575.
2. Chapter 9 of The Hauora Report: Prejudice And Recommendations.

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

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

PUBLIC

1. PURPOSE

On the 1st of July 2019, the outcomes and recommendations from stage one of the Waitangi Tribunal Health Services and Outcomes Kaupapa Inquiry were made publicly available in **Hauora: Report on stage one of the Health Services and Outcomes Kaupapa Inquiry**[1]**.**

This paper advises the Health System Committee of the recommendations of the report and discusses these in the context of Capital & Coast DHB (CCDHB).

2. HEALTH SERVICES AND OUTCOMES KAUPAPA INQUIRY

The Waitangi Tribunal is a commission of inquiry which hears and makes recommendations on claims brought by Māori that the Crown has breached promises made in Te Tiriti o Waitangi. The Health Services and Outcomes Inquiry, Wai 2575, is hearing grievances related to health services and outcomes of national significance to Māori. The inquiry, is hearing health related issues in three stages according to priority:

- Priority themes that demonstrate system issues (primary care);
- Nationally significant system issues and themes that emerge (mental health, Māori with disabilities, and issues of alcohol, tobacco and substance abuse);
- Remaining themes of national significance, including eligible historical claims.

Stage one has been completed, the findings of which are the focus of this paper. Stage two is in progress and the third stage has not yet commenced.

3. STAGE ONE – THE LEGISLATIVE AND POLICY FRAMEWORK OF PRIMARY HEALTH CARE

In stage one, the Tribunal inquiry focused on the Treaty-compliance of the legislative and policy framework of primary health care, the structures that establish and direct primary health care in New Zealand. Claims were heard from the Māori Primary Health Organisations and Providers (Wai 1315) and National Hauora Coalition (Wai 2687), with participation from interested parties. These claims were made on behalf of individuals and groups, and on behalf of all Māori, and alleged that "the Crown's primary health care framework has failed to achieve Māori health equity, and further, that the framework is not sufficiently fit for that purpose in its current state … they raised concerns about the role of, and resourcing for Māori-led primary health organisations and providers, and broadly argued that Māori were not able to exercise Tino Rangatiratanga in the design and delivery of primary health care to their own people".

All parties involved in the inquiry agreed on the fundamental basis for the inquiry: "that the state of Māori health outcomes indicates persistent, systemic problems in the primary health care sector".

The scope of stage one is outlined in the Statement of Issues (Appendix 1). Broadly, the inquiry examined the compliance with Te Tiriti o Waitangi of the following:

- The New Zealand Public Health and Disability Act 2000
- Funding arrangements for primary health care
- Accountability arrangements for primary health care
- The nature of Treaty partnership arrangements in the primary health care sector.

3.1 Inquiry Findings

Chapter nine of the Hauora report summarises the findings of the inquiry[2] (Appendix 2) and states:

- That the claims of the Māori Primary Health Organisations and Providers (Wai 1315) and the National Hauora Coalition (Wai 2687) are well-founded.

[1] Hauora: Report on stage one of the Health Services and Outcomes Kaupapa Inquiry

[2] Text directly sourced from Chapter 9: Prejudice and Recommendations of the Hauora report.

- The legislative and policy framework of the primary health care system fails to address adequately the severe health inequities experienced by Māori. Further, the Crown failed to lead and direct the primary health care system in a way that adequately supported and resourced Māori to design and provide for their own wellbeing through designing and delivering primary health care to Māori.
- The depth of inequity suffered by Māori, and particularly the fact that it has not measurably improved in the two decades since the framework was put in place, mean that the Crown's failures are serious.

In response to these findings, the report details recommendations for change: overarching recommendations, structural reform, and specific recommendations that pertain to the current primary health care legislative and policy framework.

3.2 Inquiry Recommendations

The recommendations of the Hauora report are outlined below[3].

Overarching recommendations

The Hauora report recommended:

- That the legislative and policy framework of the New Zealand primary health care system recognises and provides for the Treaty of Waitangi and its principles.
- That the commitment to recognise and provide for the Treaty of Waitangi and its principles should not be limited to Māori Health Strategy and any Māori Health action plan. The commitment should be stated expressly in all documents that make up the policy framework of the primary health system: the strategies, the plans and so-called lower level documentation.
- That the following are adopted as the Treaty principles for the primary health care system:
    (a) The guarantee of tino rangatiratanga, which provides for Māori self-determination and mana motuhake in the design, delivery and monitoring of primary health care.
    (b) The principle of equity, which requires the Crown to commit to achieving equitable health outcomes for Māori.
    (c) The principle of active protection, which requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori. This includes ensuring that it, its agents and its Treaty partner are well-informed on the extent, and nature of, both Māori health outcomes and efforts to achieve Māori health equity.
    (d) The principle of options, which requires the Crown to provide for and properly resource kaupapa Māori primary health services. Furthermore, the Crown is obliged to ensure that all primary health care services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
    (e) The principle of partnership, which requires the Crown and Māori to work in partnership in the governance, design, delivery and monitoring of primary health services. Māori must be co-designers, with the Crown, of the primary health system for Māori.
- That the Crown commit itself and the health sector to achieve equitable health outcomes for Māori.

[3] Text directly sourced from Chapter 9: Prejudice and Recommendations of the Hauora report to avoid misinterpretation.

- That:
    (a) section 3 (1)(b) of the New Zealand Public Health and Disability Act 2000 be amended to read as follows : 'to achieve equitable health outcomes for Māori and other population groups'; and
    (b) section 3(2) remain as is[4], to account for prevailing factors.
- That the commitment to achieve equitable health outcomes for Māori is expressly stated in all documents that make up the policy framework of the primary health system: the strategies, the plans and so-called lower level documentation.

Structural reform

The Tribunal panel recognise that the Ministry of Health is the steward of the New Zealand health system and that the health system is complex and resource hungry. However, it finds the Crown must do better in meeting its obligations to Māori arising out of the Treaty relationship.

With this in mind the panel recommends:

- That the Crown commit to exploring the concept of a stand-alone Māori primary health authority.
- This recommendation is interim, and further articulates that:
    (a) Within the next seven months, the Crown and representatives of the Wai 1315 and Wai 2687 claimants design a draft term of reference to explore the possibility of a stand-alone Māori health authority. ... that the Crown and the Wai 1315 and Wai 2687 claimants file a joint memorandum by 20 January 2020 updating the Tribunal on progress. If the parties are unable to agree on filing a joint memorandum they may file separate memoranda.
    (b) The Crown fund the process and provide the necessary secretariat support.

Specific recommendations

Specific recommendations are made for modifications to the existing framework for primary health care and are made in light of the time that may be required for the overarching and structural changes to be implemented. The recommendations are interim to reflect this timeframe and cover funding, accountability, a Treaty-compliant primary health care framework, and acknowledgement.

Funding

With regard to funding of the primary health care system and Māori health providers, the report recommends:

- That within the next seven months, the Crown and representatives of the Wai 1315 and Wai 2687 claimants agree upon a methodology for the assessment of the extent of underfunding of Māori primary health organisations and providers. The methodology should include a means of assessing initial establishment and ongoing resource underfunding since the commencement of the New Zealand Primary Health and Disability Act 2000.
- That the Crown conduct an urgent and thorough review of the funding for primary health care, to better align it with the aim of achieving equitable health outcomes for Māori.

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[4] Section 3 of the New Zealand Public Health and Disability Act 2000:

1) The purpose of this Act is to provide for the public funding and provision of personal health services, public health services, and disability support services, and to establish new publicly-owned health and disability organisations, in order to pursue the following objectives:

b) to reduce health disparities by improving the health outcomes of Maori and other population groups:

2) The objectives stated in subsection (1) are to be pursued to the extent that they are reasonably achievable within the funding provided.

Accountability

With regard to accountability in the health sector for Māori health equity, the recommendations are:

- That the Crown commit to reviewing and strengthening accountability mechanisms and processes in the primary health sector, which impact on Māori.
- That He Korowai Oranga is reviewed considering the content of this report. It, the New Zealand Health Strategy and the Primary Health Care Strategy, and their relevant action plans, need to state expressly how our overarching recommendations are to be integrated across the primary health care sector.
- That section 8(4) of the Act be amended to include a Māori Health Strategy.
- That:
    a) The Crown, in conjunction with Māori health experts, including representatives of the Wai 1315 and Wai 2687 claimants, co-design a primary health research agenda.
    b) The Ministry collect robust quantitative and qualitative primary care data and information relevant to Māori health outcomes. This data and information should be made public and be easily understandable and accessible. To this end, the Crown should, in conjunction with Māori health experts, including representatives of the Wai 1315 and Wai 2687 claimants, co-design measures specific to Māori as a population group.
    c) The Crown ensure that measures relevant to Māori health outcomes are reported on separately. These measures and the reporting against them should be made public and be easily understandable and accessible.
    d) District health boards and primary health organisations prepare, and make publicly available, an annual Māori health plan. The nature and content of these plans should have national minimum requirements that are set and monitored by the Ministry, but should also be co-designed with Māori who are associated with the particular organisation.
    e) All health sector contracting documents should have a reference to the Treaty of Waitangi and its principles …. Health sector contracts should also include a commitment to achieving equitable health outcomes for Māori.
    f) The Crown review, with a view to redesigning, the current arrangements for the monitoring of the Ministry by external agencies, which are intended to ensure the sufficiency of the design and delivery of health services to Māori.

A Treaty-compliant primary health care framework

To ensure that primary health care framework recognises and provides for Māori expertise and viewpoints as guaranteed by the Treaty, the recommendation is:

- That the Crown review, with a view to redesign, its current partnership arrangements across all levels of the primary health care sector. This process should be co-designed with Māori health experts, including representatives from the Wai 1315 and Wai 2687 claimants.

Acknowledgement

Recommend:

- That the Crown acknowledge the overall failure of the legislative and policy framework of the New Zealand primary health system to improve Māori health outcomes since the commencement of the New Zealand Primary Health and Disability Act 2000.

4. SYSTEM CONTEXT

New Zealand Health and Disability System Review

The Hauora report has deliberately been delivered within a timeframe that enables its analysis, findings and recommendations to be considered in the Government's Health and Disability System Review, led by Heather Simpson.

Key dates in this context:

1 July 2019	Hauora report publicly released
August 2019	Interim report from New Zealand Health and Disability System Review expected
20 January 2020	Reports due to tribunal on the interim recommendations for the establishment of a stand-alone Māori primary health authority, and a methodology for the assessment of underfunding of Maori primary health organisations and providers.
31 March 2020	Final report from the New Zealand Health and Disability System Review.

Primary care funding mechanisms including capitation

The responsibility for setting the policies, frameworks and associated funding formulas for primary care sits with the Ministry of Health. A national group, PHO Services Agreement Amendment Protocol (PSAAP), negotiates the annual inputs into the existing formulas. As a DHB we provide local advice to, and our PHOs have representation on, this group.

5. CCDHB CONTEXT - OUR COMMITMENT TO HEALTH EQUITY FOR MĀORI

There are 38,000 people who identify as Māori live in Wellington, Porirua, and Kāpiti. As in the rest of New Zealand, Māori living in CCDHB experience poorer health outcomes than non-Māori:

- Māori tamariki (0-4 years) are more likely to be admitted to hospital for an avoidable (ambulatory sensitive, ASH) hospital event;
- Māori adults are more likely to have at least one long term condition, and it start earlier in life;
- Māori are twice as likely to die early from conditions responsive to healthcare ('amenable mortality') than non-Māori non-Pacific.

Equity is a declared priority area for Capital & Coast DHB and we are committed to becoming a pro-equity organisation, we have a Māori Partnership Board and our Māori Health Plan, Taurite Ora. We are committed to working with our communities and sector partners to achieve health equity. Our focus on equity for Maori needs to continue to be strengthened.

5.1 Māori Partnership Board

There are three iwi within the CCDHB boundaries, Te Ati Awa (Iwi kainga), Ngāti Toa and Ngāti Raukawa. Our Māori Partnership Board comprises representatives from each, as well as Taura Here, descendants of iwi and hapū who have long resided here. At a local level, the Māori Partnership Board is how we give effect to our Treaty of Waitangi obligations, in particular our Crown-Iwi partnership. This relationship is highly valued and membership of the Partnership Board provide guidance and hold us to account for Māori health outcomes.

Current dialogue is focused on our responses to inequities in:

- primary care enrolment, fifteen percent of Māori living in CCDHB are not enrolled with a primary care provider;
- cervical screening coverage for Māori women in the DHB is 20% lower than women of 'other' ethnicities, Māori women aged 25-44 years are three times as likely to be diagnoses with cervical cancer as non-Maori women and twice as likely to die;
- breastfeeding rates for Māori babies at all time points measured after birth and the declining rate accelerates quicker for Māori babies than non-Māori babies.

The above are examples of individual areas of action to improve health outcomes. Taurite Ora, CCDHB's Māori Health Strategy 2019-2030, outlines how we will embed focus and action to achieve health equity for Māori across the DHB. Our Maori Partnership Board was instrumental in the development of Taurite Ora. In Taurite Ora the Challenge of health equity is clear.

5.2 Taurite Ora

Taurite Ora outlines three strategic priorities on the pathway to achieve health equity:

1. Become a Pro-Equity health organisation
2. Grow and empower our workforce
3. Strengthen our commissioned services

5.3 Become a Pro-Equity health organisation

Among the many findings of the 2018 CCDHB-commissioned Pro-equity check-up we identified that:

- To deliver on the Board's expectations there needs to be clearer accountability for equity at every level of the organisation
- There is focus on getting the "right voices around the table" but this puts a lot of pressure on a small number of individual experts. More should be done to grow, embed and realise the benefits of this expertise.
- Racism as a root cause is examined informally or superficially, although there is a groundswell of support from staff for anti-racist activities.

Our Pro-Equity work plan will deliver in August[5] details of:

- A steering group to provide ongoing leadership to the Equity programme;
- An approved CCDHB Equity Goal and guiding Principles;
- Options for embedding equity in decision-making processes for Board and Executive Team;
- Advanced workings for a Strategy, Innovation and Performance (SIP) pro-equity commissioning framework; and
- A work plan to develop a Provider Arm operational equity framework.

[5] As advised in the June 2019 HSC meeting

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CHAPTER 9

PREJUDICE AND RECOMMENDATIONS

Whakataka te hau ki te muri;
Whakataka te hau ki te tonga kia mākinakina ki uta;
Kia mātaratara ki tai kia hiia ake te ātākura, he tio, he huka, he hau-hūnga

9.1 Prejudice

Our task in stage one was to focus on the legislative and policy framework of New Zealand's primary health care system and its alleged flaws, when assessed against the principles of the Treaty of Waitangi. We focused on four specific areas: the Treaty-compliance of the Act and framework; funding; accountability; and the nature of Treaty partnership arrangements in the primary health care sector. In each of these areas, we found that the Crown acted inconsistently with the principles of the Treaty. Thus, we find that the claims of the Māori Primary Health Organisations and Providers (Wai 1315) and the National Hauora Coalition (Wai 2687) are well-founded.

We accept that the primary health care legislative and policy framework broadly cannot address all the determinants of health. We also are aware that this report is the result of stage one of a continuing inquiry process that will investigate the design and provision of health care beyond the scope of what we have covered in this stage one report. Even when taking these factors into account, the legislative and policy framework of the primary health care system fails to address adequately the severe health inequities experienced by Māori. Further, the Crown failed to lead and direct the primary health care system in a way that adequately supported and resourced Māori to design and provide for their own wellbeing through designing and delivering primary health care to Māori. The Crown's failures prejudicially affect the ability of Māori to sustain their health and wellbeing.

The prejudice suffered by Māori because of these Crown failures is extensive. The legislative and policy framework is insufficient in and of itself, and the Crown's renewed, specific commitments to improve Māori health are not enough to negate this insufficiency on their own. However, we are particularly concerned that the evidence before us indicates that some of the framework's provisions, intended to improve Māori health outcomes and give them input into how primary health care is designed and delivered, were not fully implemented, or in some cases ceased to operate entirely. This is unacceptable. We reiterate that the depth of inequity suffered by Māori, and particularly the fact that it has not measurably improved in the two decades since the framework was put in place, mean that the Crown's failures are very serious.

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9.2 Recommendations

Our analysis and findings in this report into the Māori Primary Health Organisations and Providers and National Hauora Coalition claims are final, and this is reflected in our recommendations. However, we have also made several interim recommendations where we have asked the stage one claimants and the Crown to report back to us on certain matters by 20 January 2020. Where the recommendations are interim, we have clearly indicated so. Some of the interim recommendations reflect the fact that a wider discussion is needed involving other Māori stakeholders in the health sector.

In making our recommendations, we are conscious that there are other primary health-related claims that have yet to be heard. Previously, we signalled that we will hear from those other claimants on whether the Health Services and Outcomes Kaupapa Inquiry process we have pursued to date needs to be re-designed to allow for broader inquiry into other primary health-related claims. This will be an agenda item at yet to be held forthcoming judicial conferences, which will address the future planning of the overall inquiry.

Given the scope of stage one of this inquiry, we have exercised caution in making our recommendations. Our expertise is the Crown–Māori Treaty relationship. In this inquiry, that requires an assessment of the Crown's performance as it relates to the primary health care legislative and policy framework. This report outlines the Treaty standards that in our view will make the framework Treaty-compliant. With this in mind, we begin with two overarching recommendations.

9.3 Overarching Recommendations

9.3.1 The Treaty of Waitangi and its principles

In chapter 5, we found that the New Zealand Public Health and Disability Act 2000 does not give proper and full effect to the Treaty or its principles, and is not Treaty-compliant. We found that He Korowai Oranga and its articulation of '"partnership, participation and protection"' does not adequately reflect the Treaty or its principles. We considered that the removal of specific Treaty references from lower-level documents amounted to a concerning omission of the health sector's Treaty obligations. When viewed collectively or individually, these omissions by the Crown constitute breaches of the Treaty principles of partnership, active protection and equity. As such, we are of the view that the relationship between the Crown and Māori in primary health needs in future to provide for an enhanced commitment to the Treaty of Waitangi and its principles.

We recommend that the Crown ensure that the legislative and policy framework of the New Zealand primary health care system recognises and provides for the Treaty of Waitangi and its principles.

Such a commitment starts with the relevant legislation, currently the New Zealand Public Health and Disability Act 2000, section 4. We recommend that section 4 be amended to read as follows:

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4 Treaty of Waitangi and its principles

This Act shall be interpreted and administered so as to give effect to the principles of the Treaty of Waitangi.

In this inquiry, we found that the Crown has failed to ensure that everyone who works in the primary health care system is aware of their Treaty obligations. The Crown's failure to abide by its Treaty obligations and ensure that its agents and the health sector as a whole are doing the same has contributed to the dire state of Māori health outcomes. It cannot continue to evade its obligations. We say this because the health inequities experienced by Māori compel an urgent, and thorough, intervention. The commitment to recognise and provide for the Treaty of Waitangi and its principles must be embedded at all levels of the primary health system and in all the relevant documents that make up the framework.

To this end, we found that the Crown's 'three Ps' articulation of Treaty principles is outdated and needs to be reformed. While the Crown accepts that is the case, it has submitted that updated principles for the health sector should be developed and articulated as part of a draft Māori Health Action Plan.[1] We consider that proposal is unnecessary.

We recommend that the commitment to recognise and provide for the Treaty of Waitangi and its principles should not be limited to a Māori Health Strategy and any Māori health action plan. The commitment should be stated expressly in all documents that make up the policy framework of the primary health system: the strategies, the plans and so-called lower level documentation.

We recommend that the following are adopted as the Treaty principles for the primary health care system:

(a) The guarantee of tino rangatiratanga, which provides for Māori self-determination and mana motuhake in the design, delivery and monitoring of primary health care.
(b) The principle of equity, which requires the Crown to commit to achieving equitable health outcomes for Māori.
(c) The principle of active protection, which requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori. This includes ensuring that it, its agents and its Treaty partner are well-informed on the extent, and nature of, both Māori health outcomes and efforts to achieve Māori health equity.
(d) The principle of options, which requires the Crown to provide for and properly resource kaupapa Māori primary health services. Furthermore, the Crown is obliged to ensure that all primary health care services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
(e) The principle of partnership, which requires the Crown and Māori to work in partnership in the governance, design, delivery and monitoring of

1. Submission 3.3.32, para 58.

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primary health services. Māori must be co-designers, with the Crown, of the primary health system for Māori.

9.3.2 Equity

We found that the dominant language in the legislation and policy framework is 'reducing disparities' or 'reducing inequality', rather than a commitment to achieving equity of health outcomes for Māori. We reiterate that including an expressly stated, stand-alone commitment to achieving health equity should not be controversial. Achieving health equity should be among the ultimate purposes of any just health system.

We recognise that complexities are at play. All parties to this inquiry, including the Crown, are aware of the impact of the social determinants of health and the ongoing impact of colonisation and institutional racism. While the commitment to achieve equitable health outcomes for Māori must be enduring, the contemporary circumstances heighten, under the principles of active protection and equity, the Crown's obligations to act to address these inequities.

We recommend that the Crown commit itself and the health sector to achieve equitable health outcomes for Māori.

That commitment starts with the legislation. We recommend that:

(a) section 3 (1)(b) of the New Zealand Public Health and Disability Act 2000 be amended to read as follows: 'to achieve equitable health outcomes for Māori and other population groups'; and

(b) section 3(2) remain as is, to account for prevailing factors.

We recommend that the commitment to achieve equitable health outcomes for Māori is expressly stated in all documents that make up the policy framework of the primary health system: the strategies, the plans and so-called lower level documentation.

9.4 Structural Reform – an Independent Māori Health Authority

Both claimant groups have said that the Crown has led and controlled the design, structure and resourcing of the primary health system. This system has not addressed Māori health inequities in a Treaty-compliant way, and this failure is in part why Māori health inequities have persisted. In response, the claimants seek recommendations from the Tribunal that an independent Māori health authority be established.

The Māori Primary Health Organisations and Providers claimants led evidence on and sought recommendations that New Zealand adopt a model of health similar to an Alaskan model of indigenous health – the NUKA model. The National Hauora Coalition claimants seek a recommendation that the Crown establish an independent statutory Hauora Authority. Further, they say that this authority should have similar legal status to an autonomous or independent Crown entity under the Crown Entities Act 2004, such as the Accident Compensation Corporation or Pharmac, and carry out a variety of functions including the

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Health System Committee PUBLIC 17 July 2019 - Item 3.2 Wai 2575 Update

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provision of services, commissioning for outcomes, procuring services from providers and policy advice.

The recommendations sought in this respect reflect the evidence we heard for recognition of tino rangatiratanga and mana motuhake in the design, delivery, resourcing and control of Māori primary health.

We observe that the demand for structures and services that are 'by Māori, for Māori' across all sectors of social service design and delivery is a current and future reality that successive governments of the day will face. That demand will not diminish; it will only increase in the years to come. The Tribunal has made clear in its previous reports that co-governance, particularly in social service design and delivery, is an essential part not only of upholding the Treaty relationship, but also essential to the improvement of Māori socio-economic status. The Crown should be making policy decisions with a view to fulfilling this Treaty obligation under the principle of partnership, and to recognise tino rangatiratanga.

In responding to a call from one claimant counsel that it 'should work in partnership with Māori' to come up with and implement reforms to the primary health care framework, the Crown submitted that 'the Health and Disability Review is supported by a Māori Advisory Group', and that its recommendations will 'be discussed between the Treaty partners'.[2] This is certainly part of a partnership process, but is not on its own a reflection of the joint obligations under the principle of partnership. Co-design must be manifested through a more robust engagement between Treaty partners.

We recognise that the Ministry is the steward of the New Zealand health system. It has responsibilities to deliver health services across all levels of the health system, not just primary health and not just for Māori. We understand that the health system is complex and resource hungry, but the Crown must do better in meeting its obligations to Māori arising out of the Treaty relationship.

We make an interim recommendation that the Crown commit to exploring the concept of a stand-alone Māori primary health authority.

The recommendation is an interim one for several reasons. We are conscious that we heard evidence from only two out of the four Māori primary health organisations. We also heard evidence from some Māori providers, but not all. The positions of non-Māori primary health organisations and providers, who deliver most primary health services to Māori, should also be considered. The claimant groups intend this new authority to be involved not just in primary health care, but in all types and levels of health care. We have not heard from all Māori stakeholders in the primary care sector, and certainly have not heard from any stakeholders beyond primary care.

We are also conscious that both claimant groups sought recommendation that either a NUKA-based model or independent Māori health authority have a much wider ambit than primary health and cover both secondary and tertiary health care. We have not gone as far as that yet because the claims before us are focused

2. Submission 3.3.32(a), p 1.

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on the legislative and policy framework of the New Zealand primary health care health system, not the entire health system.

We make further interim recommendations that:

(a) Within the next seven months, the Crown and representatives of the Wai 1315 and Wai 2687 claimants design a draft term of reference to explore the possibility of a stand-alone Māori health authority. We direct that the Crown and the Wai 1315 and Wai 2687 claimants file a joint memorandum by 20 January 2020 updating the Tribunal on progress. If the parties are unable to agree on filing a joint memorandum they may file separate memoranda.

(b) The Crown fund the process and provide the necessary secretariat support.

We reserve the right to review these interim recommendations and make further recommendations depending on the outcome of this process.

Our recommendation only mentions the representatives of the Māori Primary Health Organisations and Providers and the National Hauroa Coalition for the initial seven-month period. This is because they are the groups that undertook the responsibility for the prosecution of these claims. Our reasoning is also pragmatic. The process must start with someone, somewhere. We would not like to see the first step delayed by a failure to agree upon who should be involved in that process.

If a draft term of reference is agreed upon it should then go out for consultation and discussions with the wider Māori primary health sector. Obvious entities to involve would be the two Māori primary health organisations and other Māori providers whom we have not heard from, and mainstream primary health organisations who have a significant number of Māori enrolled patients. Groups who appeared before us as interested parties, such as the Māori Medical Practitioners Association, the Māori nurses and the New Zealand Māori Council, would no doubt wish to be involved. Representative iwi entities may also wish to participate.

To reiterate, we have specified only that the terms of reference should explore the possibility of a stand-alone Māori health authority. As experts in primary health care design and delivery, we are confident that the parties are best placed to formulate the rest of the terms of reference between them.

9.5 Specific Recommendations

What follows are a series of specific recommendations to the existing framework. We make these recommendations based on the assumption that the recommendations outlined earlier may take some time to be fully implemented.

9.5.1 Funding

In chapter 6, we discussed the initial funding of Māori primary health organisations. In broad terms, we found that the funding at the time of establishment of primary health organisations was variable, and as such disadvantaged Māori organisations and Māori patients with high needs. For some Māori primary health organisations, that resulted in severe under funding.

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We make interim recommendations that:

(a) Within the next seven months, the Crown and representatives of the Wai 1315 and Wai 2687 claimants agree upon a methodology for the assessment of the extent of underfunding of Māori primary health organisations and providers. The methodology should include a means of assessing initial establishment and ongoing resource underfunding since the commencement of the New Zealand Primary Health and Disability Act 2000. We direct that the Crown and the Wai 1315 and Wai 2687 claimants file a joint memorandum by 20 January 2020 updating the Tribunal on progress. If the parties are unable to agree on filing a joint memorandum they may file separate memoranda.

(b) The Crown fund the process and provide the necessary secretariat support.

We reserve the right to review these interim recommendations and make further recommendations depending on the outcome of this process.

We recognise that there is a compensatory aspect to this process, in that it responds to acknowledged historic underfunding. However, we make no recommendations at this stage as to the final destination of any such compensation. That is a matter which is complicated by the fact that many of the initial Māori primary health organisations and providers no longer exist. Our initial thinking is that if a final sum can be agreed upon: first, it could be used in part to compensate those Māori primary health organisations and providers still in existence; and, secondly, it could be future-focused, perhaps with a view to supporting the development of additional Māori primary health organisations and providers. That is a matter which we think should form part of the development of the methodology we recommend.

In relation to the capitated funding formulas, we have found that the formulas disadvantage primary health organisations and providers that predominantly service high-needs populations, and particularly impact on Māori-led primary health organisations and providers who predominantly serve these populations. Further, kaupapa Māori models of care are not adequately recognised or resourced by these funding arrangements. The Crown failed to amend adequately or replace those funding formulas despite being well-informed that they were insufficient and that its attempts to fix them were not working to the nature and extent required by the health needs of Māori.

We recommend that the Crown conduct an urgent and thorough review of the funding for primary health care, to better align it with the aim of achieving equitable health outcomes for Māori.

9.5.2 Accountability

In chapter 7, we discussed how the health sector is held to account for pursuing Māori health equity. We discussed the standards and processes used in the planning, measuring and monitoring undertaken by the numerous entities in the primary health sector. The evidence confirmed to us that the existing accountability

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mechanisms are not being used effectively to hold entities to account for insufficient, or no, action in relation to improving Māori health outcomes.

Moreover, we found that the Crown is neither undertaking sufficiently robust assessments of whether the primary health system is performing well for Māori, nor collecting or publishing enough quantitative and qualitative information to make any assessment useful. Further, we concluded that external monitoring of the Ministry appears severely lacking, as exemplified by the minimal monitoring conducted by Te Puni Kōkiri since 2000, particularly their failure to conduct agency reviews.

Strong accountability mechanisms, and robust, public measuring and reporting, are key to the Treaty-compliance of the legislation and policy of the primary health care sector. We find the lack of these mechanisms and measures are inconsistent with the principles of partnership, active protection and equity.

We make a general recommendation that the Crown commit to reviewing and strengthening accountability mechanisms and processes in the primary health sector, which impact on Māori.

We recommend that He Korowai Oranga is reviewed considering the content of this report. It, the New Zealand Health Strategy and the Primary Health Care Strategy, and their relevant action plans, need to state expressly how our overarching recommendations are to be integrated across the primary health care sector. Given the importance of achieving equitable health outcomes for Māori, we recommend that section 8(4) of the Act be amended to include a Māori Health Strategy.

We endorse the Crown's commitment to develop and maintain at all times an action plan for the Māori Health Strategy. We recommend that this action plan is co-designed with Māori health experts, including representatives of the Wai 1315 and Wai 2687 claimants.

Further, we make the following recommendations that:

(a) The Crown, in conjunction with Māori health experts, including representatives of the Wai 1315 and Wai 2687 claimants, co-design a primary health research agenda.

(b) The Ministry collect robust quantitative and qualitative primary care data and information relevant to Māori health outcomes. This data and information should be made public and be easily understandable and accessible. To this end, the Crown should, in conjunction with Māori health experts, including representatives of the Wai 1315 and Wai 2687 claimants, co-design measures specific to Māori as a population group.

(c) The Crown ensure that measures relevant to Māori health outcomes are reported on separately. These measures and the reporting against them should be made public and be easily understandable and accessible.

(d) District health boards and primary health organisations prepare, and make publicly available, an annual Māori health plan. The nature and content of these plans should have national minimum requirements that are set and monitored by the Ministry, but should also be co-designed with Māori who are associated with the particular organisation.

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(e) All health sector contracting documents should have a reference to the Treaty of Waitangi and its principles, as we have outlined in our overarching recommendations. Health sector contracts should also include a commitment to achieving equitable health outcomes for Māori.

(f) The Crown review, with a view to redesigning, the current arrangements for the monitoring of the Ministry by external agencies, which are intended to ensure the sufficiency of the design and delivery of health services to Māori. Further, any agency/agencies tasked with these monitoring responsibilities should have particular regard to those matters we mention at section 7.7 of this report.

9.5.3 A Treaty-compliant primary health care framework

In chapter 5, we highlighted several concerns we have about how the primary health care framework fails to recognise and provide for Māori expertise and viewpoints as guaranteed by the Treaty. For example, we noted that in part 2 of the Act none of the Ministerial Advisory committees had a specific focus on Māori health, nor was there a requirement for Māori membership on those committees.

In chapter 8, we concluded that neither the development of the Primary Health Care Strategy nor the framework involved a robust co-design process. We also noted that Māori are significantly underrepresented across a range of health professions, and in the Ministry itself. We were particularly concerned at the disestablishment of Te Kete Hauora, and the impact this may have had on the efficacy of Māori-specific policy making and advice at the Ministry level. Similarly, we discussed the fact that those managers responsible for Māori health within district health boards felt hamstrung by the ambit of their role and had very minimal budget holding functions. The fact that the extent of these roles varies considerably and is effectively at the whim of individual district health boards is particularly concerning to us.

In the governance sphere, we found that Māori members of district health boards are always in the minority, they do not necessarily reflect mana whenua interests or the Māori population of the district they serve, and that the board members are ultimately appointed by the Minister of Health and are thus ultimately answerable to the Minister. Accordingly, we found that the district health board model does not reflect a true partnership relationship.

We further noted that Māori relationship boards do not have the statutory recognition and status that the committees referred to in sections 34 to 36 of the Act have. Further, the actual extent of their role in the governance and operation of district health boards varies considerably throughout the country. We found scant evidence of an accurate reflection of the principle of partnership as required by the Treaty.

We make an interim recommendation that, after considering our findings in chapters 5 and 8, the Crown review, with a view to redesign, its current partnership arrangements across all levels of the primary health care sector. This process should be co-designed with Māori health experts, including representatives from the Wai 1315 and Wai 2687 claimants.

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This recommendation is an interim one because we wish to see what progress is made in the co-design of a stand-alone Māori primary health authority, as outlined earlier in this chapter. Depending on progress or otherwise in that respect, we reserve to ourselves the right to review these interim recommendations and to make more detailed partnership recommendations to the current legislative and policy framework if needed.

9.5.4 Acknowledgement

We recommend that the Crown acknowledge the overall failure of the legislative and policy framework of the New Zealand primary health system to improve Māori health outcomes since the commencement of the New Zealand Primary Health and Disability Act 2000.

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Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**HEALTH SYSTEM COMMITTEE DISCUSSION**
	Date: 17 July 2019

Author	Mairi Lauchland, System Development Manager – Older People
Endorsed By	Rachel Haggerty, Executive Director, Strategy, Innovation and Performance)
Subject	**END OF LIFE BILL: RAMIFICATIONS FOR CCDHB**

RECOMMENDATIONS

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

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

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

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

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

APPENDICES

1. Appendix 1 - Proposed amendments to the End of **LIFE CHOICE BILL**;
2. Appendix 2 – Colleges' positions **ON ASSISTED DYING**.

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

1 END OF LIFE CHOICE BILL

The End of Life Choice Bill[1] (the Bill) aims to legalise voluntary euthanasia in certain circumstances[2], allowing people to request assisted dying if they have a terminal illness or a grievous and irremediable medical condition. The Bill defines assisted dying as "the administration by a medical practitioner of a lethal dose of medication to a person to relieve his or her suffering by hastening death".

[1] http://www.legislation.govt.nz/Bill/member/2017/0269/latest/whole.html#whole
[2] https://www.parliament.nz/en/pb/Bills-and-laws/Bills-digests/document/51PLLaw25081/end-of-life-choice-Bill-2017-member-s-Bill-david-seymour

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There are potential significant implications for CCDHB if the Bill is passed: professionally and personally for individuals who work in CCDHB and for organisational policy, education, and potentially, services.

1.1 Status of legislation

The Bill is a member's Bill introduced by MP David Seymour to parliament, which on 26/6/19 passed its second reading by 70 votes to 50. Labour and National MPs voted on conscience, while New Zealand First, the Greens and ACT voted on party lines for the Bill. The Bill has now moved to the House for amendments to be proposed and debated by all MPs during the third and final reading, prior to the final vote. No date has been set for the third reading, and the Bill is not certain to be passed[3].

1.2 Eligibility Criteria

According to the current proposed Bill, a person would be eligible for assisted dying if they:

- Were aged 18 years or over; and
- Were a NZ citizen; and
- Suffered from
    - A terminal illness that was likely to end their life within six months; or
    - A grievous and irremediable medical condition; and
- Were in an advanced state of irreversible decline in capability; and
- Experienced unbearable suffering that could not be relieved in a manner they considered tolerable; and
- Were able to understand the nature and consequences of assisted dying.

1.3 Other provisions of the End of Life Choice Bill

The Bill also proposes:

- A process for assisted dying, including:
    - a request for assisted dying to a medical practitioner
    - confirmation of the request for assisted dying showing informed consent and compliance with the requirements of the legislation
    - first opinion of the medical practitioner sent to a newly-created role of Registrar (assisted dying)
    - second opinion on request for assisted dying sent to the Registrar, by a newly-created Support and Consultation for End of Life in New Zealand (SCENZ) Group
    - specialist (psychiatrist or psychologist) opinion on competency if there is disagreement between first and second opinions ("third opinion")
- Protection from civil or criminal liability for doctors acting in good faith and without negligence
- Offences if a medical practitioner or specialist does not fully comply with the act.
- A Registrar (assisted dying) to maintain records of decisions and the process of individuals' assisted dying, ensure compliance with the act, make final notification to the attending medical practitioner prior to assisted death, and receive the report of the assisted death
- An End of Life Review Committee appointed by the Minister, which reviews each assisted death.

2 THE CLINICIAN'S DILEMMA

Even when an assisted death is legally allowed, the practical and ethical issues that result from considering and acting upon a competent request can be complicated and troubling for many clinicians. Clinical and bioethical literature shows diverse opinion on assisted dying, within which the

[3] "...with a majority of 20 votes, it will require a shift of only 11 votes to block [the End of Life Choice Bill] at the third and final reading…New Zealand First's nine MPs… supported it at first and second reading…on the expectation that an amendment will be passed putting to a referendum at the next stage of debate. If the referendum vote does not pass… it would be unlikely the party would support the Bill at its final reading".
https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=12244205

ethical principles of patient autonomy, beneficence (acting in the best interests of a patient), and non-maleficence (not inflicting harm) can be difficult to reconcile. Palliative care in particular "intends neither to hasten nor postpone death"[4], working to relieve pain and holistically improve quality of life at the end of life for both patients and their families.

College position statements, summarised in ***Table 1***, are varied and many position statements reference differing views within the colleges. Some common themes are: the importance of patient assessment, information on and access to excellent palliative care; patient right to decline treatment; clinical impartiality and clinician preparation for the discussion following a request for assisted dying, and individual clinician choice on involvement with assisted dying. Differing ethical, professional, and personal clinician perspectives on participation in assisted dying must be understood and respected.[5]

[4] WHO definition of palliative care https://www.who.int/cancer/palliative/definition/en/
[5] MacLeod, R., Wilson, D., & Malpas, P. 2012 Glob J Health Sci 2012 Nov; 4(6): 87-98. doi: 10.5539/gjhs.v4n6p87

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Table 1: Summary of Colleges' Positions on Assisted Dying

College	Position on assisted dying	Member consensus	Discussion with patient	Palliative Care	Other
Royal Australasian College of Physicians (RACP)[6]	Neutral	Diverse views	Clinical neutrality, ensure ongoing care arrangements in place if physician disengages with patient	Ensure benefits of palliative care, explained; should be timely, equitable, good quality.	Assisted dying not part of palliative care
Australia and New Zealand Society for Palliative Medicine (ANZSPM) [7]	Tending against	Diverse views	Explore underlying depression or need for symptom control	Advocates for excellence in palliative care practice, equitable access and provision, facilities, trained workforce, advance care planning. Endorses increased respite for carers so patients don't feel like a burden.	Practice of palliative care does not include the practice of assisting dying. ANZSPM does not support legalisation of assisted dying.
New Zealand Nurses Association (NZNO) [8]	Supports option or choice of assisted dying for individuals	Acknowledges range of views	Need to put personal opinion to one side when involved with assisted dying discussions, which must be held in an environment conducive to considered discussion	Important to respect individual and collective cultural approaches to end of life	Urgent need for education on ethical and legal implications of assisted dying.
The Palliative Care Nurses New Zealand (PCNNZ) [9]	Tending against	Not stated	Patient awareness of and assessment for hospice and palliative care provision	Palliative care to be routinely available to all who need it, appropriately funded, and in all settings Support for ANZSPM's focus on palliative care excellence rather than euthanasia or assisted dying.	Assisted dying is incongruent with ethos and practice of palliative care. Education opportunities are needed for all health care professionals in palliative care in all health care settings.
New Zealand Medical Association (NZMA) [10]	Against	Not stated	Strongly supports right of patients to decline treatment, request pain relief, and access palliative care.	Supports the concept of death with dignity and comfort.	Concept and practice of euthanasia and doctor-assisted suicide is unethical, even if passed into law.

[6] https://www.racp.edu.au/advocacy/policy-and-advocacy-priorities/voluntary-assisted-dying
[7] http://www.anzspm.org.au/c/anzspm?a=sendfile&ft=p&fid=1491523669&sid=
[8] https://www.nzno.org.nz/Portals/0/Files/Documents/Consultation/2016%2011%2008%20%20Guidelines%20-%20Assisted%20Dying%20Position%20Statement.pdf
[9] https://pcnnz.co.nz/wp-content/uploads/2016/05/Euthanasia-position-statement-2012.pdf
[10] https://www.nzma.org.nz/__data/assets/pdf_file/0004/16996/Euthanasia-2005.pdf

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3 CCDHB CLINICIAN POSITION ON THE END OF LIFE CHOICE BILL

Medical Staff position

A wide range of views exist within CCDHB medical staff regarding assisted dying. No position has been taken by CCDHB medical staff on the End of Life Choice Bill, nor is it intended that a position is developed. The Chief Medical Officer advises that individual participation by CCDHB medical staff in assisted dying would need to be by individual clinician choice[11].

Nursing position

A wide range of views exist within CCDHB nursing staff regarding assisted dying and no position has been taken on the End of Life Choice Bill, nor is it intended that a position is developed. The Chief Nursing Officer advice is to await for further developments towards any changes in legislation before any action is taken[12].

4 CONCLUSION

If the End of Life Choice Bill is passed, there are implications for CCDHB services, policy, and education, but also likely a significant lead-in time to prepare. Victoria state legalisation of assisted dying was passed in Australia in 2017 and implemented only in 2019. Legal implications for CCDHB will need careful review and, depending on the provisions within the legislation, a decision may need to be made at DHB Board level regarding providing assisted dying by DHB services, or on DHB premises.

Our Chief Medical Officer and Chief Nursing Officer both recommend that personal participation in assisted dying would need to be by individual clinician choice. Focusing on shared values has been proposed by some researchers[13] as a starting point for difficult inter-professional discussions on assisted dying:

- A focus on the importance of reducing human suffering, with a rejection of suffering as a positive redeeming value.
- A concern that end-of-life care should not reduce human beings to the biological and result in neglect of the patient as a complete person.
- A focus on the importance of control by the patient at the end of life.
- Recognition that a 'good death' is possible.

Support for clinicians providing assisted dying would need to be carefully planned. This support has many implications for CCDHB services, policy, and education and includes at a minimum:

- Assurance of excellent palliative care provision to people with life-limiting conditions
- Education on implications for clinician involvement with assisted dying, including practical, personal, ethical and legal implications for individual clinicians
- Clinician preparation for discussions with patients requesting assisted dying
- Education on cultural approaches to assisted dying
- Potential development of a legally compliant and professionally acceptable assisted dying service separated from palliative care provision
- Competency standards and clinician credentialing for assisted dying at all stages
- Professional, pastoral and collegial supports for clinicians involved with assisted dying
- Potential provision of assisted dying physical environments
- Decisions on links with privately provided assisted dying services.

All planning decisions will need to be made with great care and caution[14], mindful of the legal, professional, personal and ethical issues this legislation will raise.

[11] John Tait, Chief Medical Officer, personal communication 3/7/19
[12] Emma Hickson, Chief Nursing Officer, personal communication 8/7/19
[13] Source: Hurst and Mauron (2006)
[14] Fiona Bailey, CCDHB Palliative Care Clinical Leader, personal communication 2/7/19

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APPENDIX 1 - PROPOSED AMENDMENTS TO THE END OF LIFE CHOICE BILL

Prior to the second reading, a number of amendments were signalled for the third and final reading of the End of Life Choice Bill. Of note, MP David Seymour promised to amend the Bill for the final reading, limiting it to those who have a "terminal illness that is likely to end the person's life within six months". In addition, the Bill would also be changed so that age, disability and mental illness would not be grounds to request assisted dying[15].

Specific amendments are required by different parties as a condition to vote for the final Bill. The Greens require an amendment to make assisted dying available only for the terminally ill. New Zealand First requires an amendment passed in Parliament for a binding referendum on euthanasia at the 2020 election in order to vote in favour of the Bill at the final reading[16].

There are also a number of supplementary order papers to amend the Bill for the final reading. These include proposals for:

- A “sunset clause” where the Act and amendments would expire after three years (Simon O’Connor, SOP 218)
- Amendments to eligibility criteria, the process of administration of assisted dying, and a mechanism of consent through the Family Court; and a name change to “the Court Consent to Physician Assisted Dying Act 2019” (Louisa Wall, SOP 235)
- Advertising prohibition restricting the promotion of assisted dying services and products to the public (Simon O’Connor, SOP 217)
- Restriction on publicity and news coverage of individual assisted deaths to prevent a rise in non-assisted suicides (Chris Penk, SOP 216)
- Education programmes for medical practitioners administering assisted dying (Simon O’Connor, SOP 213)
- Provision of conscientious objection information to the person by the medical practitioner, no requirement to provide information that contravenes their objections (Simon O’Connor, SOP 209)
- Definition clarification distinguishing between purposeful deaths from administration of lethal medication when assisting dying, and the “double effect” of palliative care administration of medication that may also hasten death (Chris Penk, SOP 208)
- A name change to “Euthanasia and Assisted Suicide Act 2019” (Chris Penk, SOP 207).

[15] https://www.newshub.co.nz/home/politics/2019/06/euthanasia-simon-bridges-blasts-greens-new-zealand-first-for-voting-on-party-lines.html

[16] https://www.stuff.co.nz/national/politics/113997049/plenty-of-mps-want-legalised-euthanasia-but-how-many-are-prepared-to-gamble-on-a-referendum

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APPENDIX 2 – COLLEGES' POSITIONS ON ASSISTED DYING (DETAILED)

Royal Australasian College of Physicians

The Royal Australasian College of Physicians (RACP), after extensive consultation with members during 2017 and 2018, did not reach consensus on legislative change on voluntary assisted dying[17]. If legalised, RACP supports:

- Timely, equitable, good quality end of life care
- A clinical approach of dialogue informed by critical neutrality when discussing assisted death requests
- Ensuring ongoing care arrangements are in place if physicians disengage from patients holding different values and beliefs than their own
- Ensuring patients seeking assisted death are made aware of the benefits of palliative care
- Voluntary assisted dying must not be seen as part of palliative care.

Australia and New Zealand Society for Palliative Medicine

Australia and New Zealand Society for Palliative Medicine (ANZSPM) members also hold divergent views on assisted dying. The ANZSPM Position Statement[18]:

- Notes the practice of palliative care does not include the practice of assisting dying
- Recognises the right of government to legalise assisted dying but does not support this
- Endorses international guidelines affirming assisted dying is not part of best practice palliative care
- Affirms patients right to refuse life sustaining treatments, noting this does not constitute euthanasia
- Notes the ethical principles of beneficence and non-maleficence mean withholding or withdrawing treatments that don't benefit the patient, also noting this does not constitute euthanasia
- Treatments that appropriately relieve symptoms, with a secondary or unintended consequence of hastening death does not constitute euthanasia
- Palliative sedation for refractory symptoms does not constitute euthanasia
- Assisted dying requests may have an underlying clinical issue e.g. depression or poorly controlled pain, and particular attention should be paid to good symptom control
- Palliative care may not be able to relieve suffering at all times
- Notes gaps in the equitable provision of palliative care
- Advocates improved access to appropriate facilities, trained workforce and advance care planning
- Endorses increased respite for carers to lessen the sense of patients feeling like a burden.

New Zealand Nurses Association

New Zealand Nurses Association (NZNO) position supports individuals to have the option or choice of assisted dying[19]. NZNO acknowledges the complexity of the assisted dying debate, also acknowledging the range of views held by health professionals. NZNO notes an urgent need to develop guidelines to enable nurses to understand the ethical and legal implications of their professional actions, while upholding nurses' rights when making decisions that honour health consumers' decisions. Also noted is:

- The need to put personal opinion to one side when involved with assisted dying discussions
- The importance of right environment for considered discussion without coercion
- Acknowledgement of the importance of respecting individual and collective cultural approaches to end of life, which may be different from the clinicians.

[17] https://www.racp.edu.au/advocacy/policy-and-advocacy-priorities/voluntary-assisted-dying
[18] http://www.anzspm.org.au/c/anzspm?a=sendfile&ft=p&fid=1491523669&sid=
[19] https://www.nzno.org.nz/Portals/0/Files/Documents/Consultation/2016%2011%2008%20%20Guidelines%20-%20Assisted%20Dying%20Position%20Statement.pdf

Palliative Care Nurses New Zealand Society

The Palliative Care Nurses New Zealand (PCNNZ) states the practice of assisting dying is neither congruent with the ethos and practice of palliative care nor nursing. Their position statement on euthanasia and assisted dying[20] advocates for:

- Palliative care to be routinely available to all who need it, appropriately funded, and in all settings
- Patient awareness of and assessment for hospice and palliative care provision;
- Support for ANZSPM's focus on palliative care excellence rather than euthanasia or assisted dying;
- Education opportunities for all health care professionals in the principles and practice of palliative care to foster compassionate and comprehensive end of life care in all health care settings.

New Zealand Medical Association

The New Zealand Medical Association (NZMA) 2005 position statement[21] unequivocally opposes as unethical the concept and practice of euthanasia and doctor-assisted suicide, even if passed into law. The position statement supports the concept of death with dignity and comfort, strongly supports the right of patients to decline treatment, request pain relief, and access palliative care. Administration of pain relief, even if it hastens the death of the patient is not unethical. A 2017 report by Grant Gillett [22] on euthanasia commissioned by the NZMA reconfirmed this position, but provoked debate amongst NZMO members.

[20] https://pcnnz.co.nz/wp-content/uploads/2016/05/Euthanasia-position-statement-2012.pdf
[21] https://www.nzma.org.nz/__data/assets/pdf_file/0004/16996/Euthanasia-2005.pdf
[22] http://www.nzma.org.nz/__data/assets/pdf_file/0006/77766/NZMA-euthanasia-Gillett-report-Final.pdf

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Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**HEALTH SYSTEM COMMITTEE INFORMATION**
	Date: 12 May 2019
Author	Strategy Innovation and Performance Directorate
Endorsed by	Rachel Haggerty, Executive Director, Strategy Innovation and Performance
Subject	**STRATEGY INNOVATION AND PERFORMANCE REPORT MAY/JUNE 2019**

RECOMMENDATIONS

It is **recommended** that the Committee:

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

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

1. PURPOSE

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

2. MENTAL HEALTH AND ADDICTIONS

2.1 Suicide Prevention and Postvention

On the 1st of May 2019 the suicide prevention and postvention functions were centralised within CCDHB. Since then, the Suicide prevention and postvention team have been receiving direct notifications of suspected suicides across the 3 DHB region, providing us with real time information. This information will highlight opportunities for the health system to respond better to those who have approached us for help, and/or have been engaged with our services at some point. A report format is being developed for this committee, DSAC, the Executive Leadership Team and the Boards so there is clear and transparent oversight across of suicide and suicidal behaviour in our District.

The team have continued to work with the affected schools and wider community in Porirua following the suicide cluster last year, establishing a local stakeholder reference group in Porirua. We are currently working with Hutt and Kāpiti localities to establish the same.

The Ministry of Health recently released the Suicide Prevention Strategy and Action Plan for Aotearoa, New Zealand 2020-2030, entitled “Every Life Matters” (draft). We are in the process of reviewing our current strategy/action plan against this to ensure we are in alignment with the direction and framework provided.

2.2 Te Ara Pai Review

The Te Ara Pai (Stepping stones to wellness) model of care has been in place since 2013 and includes eight community providers who deliver a range of services including, navigation, home based support, housing facilitation, employment services, information hub, family/whanau support, health facilitation, personal connections and skills for life. An independent review was completed in December 2018.The Te Ara Pai Steering Group will be finalising the report and actions in July with a final report in August 2019.

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2.3 The Lived Experience Advisory Group (The LEAG)

The LEAG has now been established for 6 months, its key purpose being to provide a strategic voice and advice into the various mental health and addiction projects being run within the Strategy, Innovation and Performance (SIP) Directorate. The LEAG is a diverse group of 12 members with lived experience across a broad spectrum of mental health and addictions. The forum meets once a month and are actively involved in all current mental health and addictions projects within SIP. Their guidance and insight have proven to be invaluable, providing the human face and reality of what it is like to be a user of our mental health and addiction services. Their stories are often confronting and we are constantly challenged to think differently about service design and delivery.

2.4 Transition of the Pacific Community Mental Health Team (0-19)

MHAIDS, The Pacific Directorate and SIP have agreed to transition this team from MHAIDS (where it is currently managed) to a community setting. This move aligns with the Living Life Well strategy and Mental Health Inquiry report which refers to care closer to home, strengthening the NGO sector, placing people at the centre and culturally appropriate services. A project team has been assembled and will complete a project plan by mid- August.

This service will cover the Wellington, Porirua and Kāpiti regions. The three key deliverables are to develop a Pacific model of care, recruit into the new positions and find a new "home" for this service in the community. The overarching aim of this change is to improve quality of life outcomes for Pacific children, youth and their families by strengthening the capability and capacity of this service.

3. CHILD AND YOUTH

3.1 Integration of Porirua Youth Services

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

Previously at the June HSC an update on the project was given which indicated that the next stage of the project was to run a co-design workshop with a group of rangatahi who are representative of the Porirua community on 18 and 19 June 2019.

The workshop was facilitated by the Change and Innovation Agency and the feedback from rangatahi and providers who were invited to the 'walkthrough' of the design process was overwhelmingly positive.

The workshop had participants from all Colleges as well as a range of community organisations, youth groups, and church groups and easily achieved a wide range of perspectives including Maori, Pacific LGBTQI, disability, marginalised, migrant, refugee, not in school, not in employment. There were 49 participants on day one and 43 participants on day two. The participants were highly engaged throughout the two days offered very useful insights. Some of the messages that came from the discussions were that a youth appropriate service should:

- consider that cost is a barrier for young people and therefore their health.
- make sure rangatahi feel safe, supported and understood.
- keep all information that is shared safe and confidential.
- respect and value the rangatahi culture.

Over 32 different stakeholders came to the walkthrough experience. This was an entirely youth led process. All speakers showed huge confidence and oratory capability to lead and share the group thinking.

We are now in the process of establishing a youth panel. The purpose of the panel is to continue the engagement between the rangatahi and the DHB and ensure there is an enduring connection between the design and implementation phase of the project. The final report is due to be completed by 15 August.

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4. COMBINED DENTAL AGREEMENT

The National Contract for the Combined Dental Agreement (CDA) has a three year term and the most recent review has recently been completed. The new term of the contract is commencing on 1 July 2019 and runs until 30 June 2022. The contracts are with providers for signing. All fees paid under the CDA will be increased by 1.433% in 2019/20.

Other changes to the CDA for the 2019-2022 period are:

- The two CDA schedules; *the Oral Health Services for Adults* and *the Special Dental Services for Children and Adolescents* have been combined to remove unnecessary contract administration.
- *Oral Health Therapists* have been recognised as an Oral Health Practitioner in the CDA and associated Operational Guidelines.
- The word *Amalgam* has been removed from the CDA and Operational Guidelines so that practitioners can apply best practice.
- Instructions for practitioners to access free or subsidised medicines for children under 13 and young people from 14-17 have been included.

4.1 Matua, Pepi, Tamariki service in Porirua

We has been working with Ora Toa PHO to develop a Matua, Pepi, Tamariki (MPT) service in Porirua. The overarching purpose of the MPT service is to ensure all pepi and tamariki in Porirua have the best start to life.

There is a plethora of literature demonstrating the negative consequences of colonisation on Māori and Pacific maternal and child health experience and outcomes. Reconnecting families to the sacredness of pregnancy and children is known to support optimal maternal and child health, and children's development and lifelong wellbeing. The MPT service is a new model designed to incorporate the 'world views' and paradigms of its service users – hāpu mothers, pepi, tamariki and whānau/families in Porirua.

In June, a contract was executed on the developmental phase of this work, which will take place between now and September 2020. Ora Toa will be leading the design and development of the MPT new service and model, which will be in place by 1 October 2019. In the short term, this service is expected to provide immediate, additional capacity to respond to whānau/families' health need as well as project resource to support Ora Toa to fully develop their MPT model. SIP and Ora Toa will continue to work together in the coming year to refine the service and expected outcomes beyond September 2020.

SIP will further enhance and expand this work by developing a Maternal and Child Health Commissioning plan this calendar year. The plan will explore opportunities to invest in kaupapa Maori and Pacific models and approaches, to better support the mothers, babies and families most needing responsive services.

5. 3DHB DISABILITIES SERVICES

5.1 Disability Forum

The Disability Forum was held 21 June 2019. The Forum was co-facilitated with a disabled and able bodied facilitator. Through the day 85 – 90 people attended including a strong presence of Maori and Pacific People with disabilities. The theme of the Forum was "Enabling Partnerships: *Collaboration for effective access to health services".* There were four focus areas: Leadership, Inclusion and Support, Access and Health.

The Forum affirmed the intended Disability SIP work programme with the following recommendations:

- Sign, promote and implement the Accessibility Charter
- Improve communication and information access
- Improve access to health services
- Align the work of the SRDAG, Maori and Pacific Disability Steering Groups and build stronger links across the 3 DHBs, MOH, Councils and the Government with a disability health perspective.

- Action plan for Maori and Pacific people with disabilities
- Implement co-design at all levels

Underpinning these recommendation is a need to implement a robust data monitoring system.

5.2 Accessibility

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

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

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

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

5.3 Supported Decision Making

Moving from Substituted Decision Making to Supported Decision Making is seen as the key tool to end discrimination, promote recovery, social inclusion and respect for human rights. Otago University, through their World of Difference programme offers a mentoring programme to enable organisations to deliver the programme internally. This programme is funded by the Health Promotion Agency and supports the recommendations that came out of He Ara Oranga – The Inquiry into Mental Health and Additions.

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

6. PRIMARY AND INTEGRATED CARE

CCDHB is making progress on developing primary care and integrated care solutions. There has been an investment in the relationships, collaborative service design and implementation of new services. Integrated Care Collaborative (ICC) that includes the DHB, Primary Health Care, Hospital Services and other key stakeholders. The following is a summary on the recent developments that have been supported in partnership.

6.1 Kāpiti – Community Acute Response Service

The Kāpiti Community Acute Response Service was launched in early June with the aim to support people in Kāpiti to receive care closer to home – to travel less for care. There are about 6,200 Kāpiti residents who attend ED each day.

Within four weeks of launching the service has delivered:

- 21 ambulance re-directions to primary care who would have otherwise been transported to ED
- 2 earlier discharges from the Medical Assessment & Procedure Unknit
- 16 claims for community acute packages of care to support advance care services in primary care

The service is supported with a Primary Care Clinical Lead and coordinator. The implementation team including SIP, Primary Care, Wellington Free Ambulance and the service support meet on weekly basis to support the change.

The development of the model involved an engagement process with the Kāpiti community and Kāpiti health services providers that fed into a rapid design process that was linked to the DHB annual budget investment process and existing Health Care Home relationships. Feedback from the community has been positive, as receiving care closer to home has been a positive experience. In addition to benefits to the people from Kāpiti, the process and service is strengthening working relationships to health service providers.

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There are further opportunities for expansion with the potential to expand to other areas in the DHB and/or consider building further components to this successful service.

6.2 System Level Measure Plan

The System Level Measure (SLM) Improvement Plan is a requirement as part of annual planning processes. The SLMs Framework is a lever to support improvements aligned with the CCDHB Health System Plan as it focuses on the following six measures:

- Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0-4 year olds
- Acute hospital bed days per capita
- Patient experience of care
- Amenable mortality rates under 75 years.
- Proportion of babies who live in a smoke-free household at six weeks post-natal
- Youth access to and utilisation of youth-appropriate health services

The MOH requires the DHB alliance partners to collaborate and sign off on the SLM Plan. This requires partners to work together to identify opportunities for improvement and identify actions for improvement. The ICC ALT agreed that the milestones for the SLMs should take into consideration the strategic priorities across the sector and focus on equity. All measures within the plan are stratified for Māori, Pacific and non-Māori/Pacific.

Following a collaborative development process, the CCDHB SLM Plan has been approved by the MOH. Through partnerships across the sector and oversight by ICC the SLM Plan implementation will commence.

6.3 Acute Demand and Bed Capacity

A group of Senior Leaders, comprised of ELT and Primary Health Care, came together as a Steering Group to support the development of solutions to manage the increased demand on the hospital. The focus was to drive improvement initiatives that would enable the provision of safe and quality treatment for the CCDHB population during the winter period.

The work programme has spanned across the patient journey and considered the range of settings of care as outlined in the HSP:

Within the programme of work, initiatives that have progressed include:

- Launch of the Kāpiti – Community Acute Response Service to manage people acutely in the community
- Development of the model of the Community Health of Older People Initiative to provide proactive and acute support for primary care with gerontology specialist support
- Increased resource for the Child Acute Assessment Unit to enable flow from ED
- Strengthen board rounding related activities to support discharge in medical and older persons wards

- Introducing an additional Patient Care Coordinator role as well as revising the focus of the role to support complex patient discharge
- Flexing up of winter beds to support current flow restrictions
- Improving the nursing model and systems to increase the use of the Transit Lounge
- The development of an initiative to support earlier discharge from the hospital with allied health and health care assistant support

Focus on the Acute Demand & Bed Capacity programme will continue through the winter peak period this year. There are linkages to longer term investment planning and models of care that will be scoped to progress further strategic solutions to improving flow.

A report on the status of acute demand will be made at the August Committee meeting.

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Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**HEALTH SYSTEM COMMITTEE INFORMATION**
	Date: 17 July 2019

Authors	Carey Virtue, Executive Director Medicine, Cancer & Community Justine Plunkett, Acting Executive Director Surgery, Women & Children's
Endorsed by	Fionnagh Dougan, Chief Executive
Subject	**HOSPITAL & HEALTHCARE SERVICES (HHS) BI-MONTHLY PERFORMANCE REPORT**

RECOMMENDATIONS

It is **recommended** that the Committee:

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

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

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

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

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

1 PURPOSE

The purpose of this paper is to inform the Health System Committee (HSC) of key activities and performance indicators for the Hospital and Healthcare Services of Capital & Coast District Health Board (CCDHB).

2 KEY ISSUES / PRIORITIES

2.1 Industrial Action

2.1.1 Resident Doctors Association (RDA) industrial action

Following the five-day period of industrial action in May, the RDA and District Health Boards (DHBs) have attended facilitation to resolve the industrial dispute. This has been an extended process and no outcome has been communicated at this time.

2.1.2 APEX industrial action - Medical Physicists

A national MECA has been agreed and is in the process of being signed off by each DHB.

2.2 TrendCare and Care Capacity Demand Management (CCDM)

This month TrendCare has been implemented in PACU: the implementation in Mental Health continues and implementation in Kenepuru and Wellington Dialysis is about to start. The TrendCare team continue to work with wards to improve the use of the tool, with a focus on accurate recording of staff allocation and patient acuity. The team have reviewed the maternity implementation to ensure the implementation encompasses national concerns regarding the reflection of acuity on evening and night shifts. 6 North and SAPU wards are

using the TrendCare workforce modelling to inform levels of staffing whilst the modelling continues for the other wards.

Development of the CCDM dashboard is now complete giving full visibility of the core data set which will support the work of the hospital local data councils and the CCDM council. The CCDM work and dashboard has attracted much national interest and the team are assisting other DHBs in their implementation by sharing CCDHB experiences and best practice through webinars and hosting visits from DHBs across the country.

A data literacy project to build a foundation of understanding of TrendCare statistical output has been piloted with the CCDM and nursing/midwifery leaders' team receiving positive feedback. Consideration is being given to rolling this out to the charge nurse and midwife managers and local data council members.

The emergency department escalation plan is currently being piloted with the Medicine, Cancer and Community directorate. The maternity escalation plan has been distributed for consultation. Further escalation plan development is awaiting the ward demand enhancement to the Capacity at a Glance visual interface.

2.3 Sterile Services

A self-audit against the Australia and New Zealand Sterilisation Standard[1] was completed in June 2019. Audit results were as expected with the majority of standards met and the areas the service with partial or non-compliance confirmed.

The following were identified for corrective actions:

- No Track and Trace system for recycled medical devices
- Unit accessible by theatre staff and consequently there is a risk of instruments being removed before all quality checks are complete.
- Packing work stations not height adjustable.
- Inadequate storage capacity for orthopaedic loan crates (result of increase in orthopaedic patient volumes)
- Inadequate signage to show demarcation of pre and post sterilisation locations at Kenepuru Sterile Services.

Corrective actions are underway to address these and all but the instrument Trace and Trace system will be complete by December 2019. The implementation of a Track and Trace system is more complex and will take 12 to18 months once approved.

2.4 Acute Flow and Winter Planning

CCDHB Shorter Stays in ED (SSiED) performance for June 2019 was that 76.4% of patients seen in ED were either discharged or admitted within six hours against a target of 95%. Hospital occupancy regularly exceeded 100% restricting the flow of patients from emergency department (ED) to the rest of the hospital, creating significant pressure on ED once all the capacity in ED was utilized.

Ward 3 (10 beds) and an additional 14 beds at Kenepuru were opened on 1 June 2019 as part of the winter planning, providing additional winter capacity until October.

An organisation wide escalation process has been introduced to help manage significant overcrowding in emergency department (ED). The plan formalises the set of conditions under which ED will escalate the situation and the responses expected when escalation occurs, ranging from awareness, specialties prioritising

[1] Australia and New Zealand Sterilisation Standard (2014) AS/NZS 4187:2014

seeing their patients in ED, wards admitting over bed numbers and specialties identifying and implementing quicker patient discharges.

Within the Acute Bed Capacity Programme, key focus areas this month within HHS have been:

- Implementing changes to the patient care coordination service
- Identifying process changes to enhance the management of complex patient discharges from general medicine
- reviewing the process for transfer to Kenepuru and streamline discharges from Kenepuru
- Focus on increasing transit lounge use
- Implementing board round process on ward 5N, and planning for implementing of board round process for three surgical wards
- Developing options for early supported discharge
- Introducing ED escalation process
- Establishing a working group comprised of Child Health and ED to support increased flow to the child health acute assessment unit from ED.

2.5 Radiation Therapy Waiting Times and Intervention Rates

2.5.1 Radiation therapy wait times and Ministry of Health (MOH) recovery plan

The MOH have recently requested a recovery plan for Radiation therapy waiting times. They have identified the waiting time to be from the time a decision to treat is made to the point radiation treatment occurs. For patients for whom radiation therapy is identified as the best option, the time they can expect to wait for that treatment will vary between 24 hours and 28 days and is based on the type of cancer, how symptomatic the patient is and the expected outcome.

This is a measure that has previously been used as guidance only for the service to indicate treatment times and has not been reported on formally. Consequently the way the data has been collected was not intended to assist with compliance reporting since it does not differentiate reasons for delays such as clinical or patient choice reasons.

Radiation therapy is only one option for treatment for patients with cancer, other treatment options include chemotherapy and surgery. Therefore if there is a decision to treat but the patient requires surgery before radiation treatment, there may be an acceptable clinical delay beyond the treatment guidelines for individual patients and potentially beyond 28 days.

CCDHB has fed back to the MOH that the information would benefit with further refinement in terms of agreed data elements to ensure meaningful data is collected and can be used to improve wait times. At this stage the FCT data is the best measure for treatment waiting times as this does include reasons for delays such as clinical or patient choice reasons

2.5.2 Low radiation therapy intervention rates for prostate cancer

Recently published results highlight a relatively low radiation treatment intervention rate for curative prostate cancer at CCDHB, which has been highlighted at the Cancer Crossroads Conference and in the media. The reasons for this include an emphasis on the surgical pathway at CCDHB. There is work underway across HHS to review the pathway for referring and treating people with curative prostate cancer at CCDHB.

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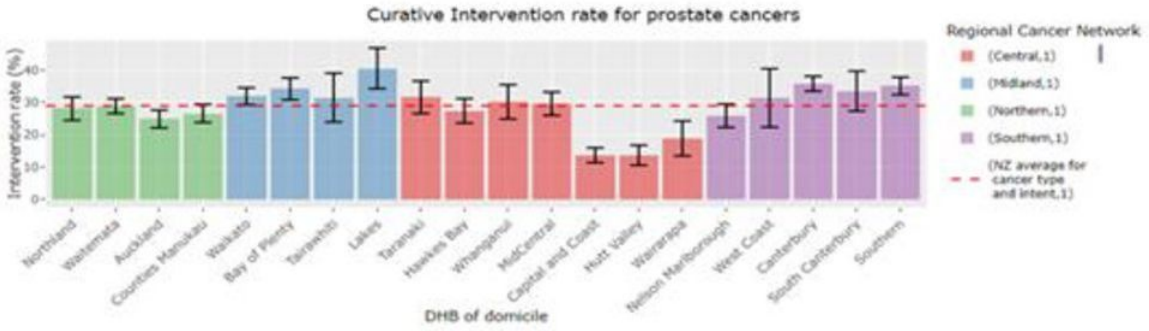

2.6 STEMI Programme

Every day in New Zealand, five people will suffer the life-threatening form of heart attack (myocardial infarction) with a survival rate of 80%.

The Central Cardiac Network has recently introduced a new out-of-hospital treatment pathway for cardiac patients in the Central Region known as the STEMI pathway (ST elevation myocardial infarction) to improve survival rates. This is a collaborative treatment pathway developed by St John, the MOH and the Cardiac Network. This new pathway enables paramedics to give a clot busting drug to patients in situ and then transport them directly to a Percutaneous Coronary Intervention (PCI) capable centre such as Wellington Hospital. This has led to a reduction in the time it takes patients to receive treatment. This reduction in time to treat results in greater preservation of cardiac function so improving outcomes for these patients.

CCDHB and St John's role in providing this 24/7 service has been fundamental to its success.

Around 350 patients each year are expected to benefit from the pathway, resulting in improved long-term survival and the delivery of equitable healthcare to all New Zealanders, particularly those living in rural and remote areas.

2.7 Improving Diabetes Inpatient Management

Hypoglycaemia is associated with poorer outcomes and increased length of stay for in patients with diabetes. Historically there have been approximately 400 potentially preventable hypoglycaemic events each month within CCDHB hospital services.

In November 2017 there was a rollout across 3DHB of a set of major practice changes in the prescription, monitoring, administration and dispensing of insulin for hospital inpatients. The purpose of these changes was to improve blood glucose control and reduce harm, chiefly from low blood sugar levels, for inpatients with diabetes in our hospitals.

The 2017 roll-out was the culmination of a major piece of collaborative work that spanned 5 years and included over 40 experts from endocrine, surgery, anaesthetics, medicine, PACU, pharmacy, laboratory, emergency and intensive care, across the 3 DHBs

Point-of-care blood glucose testing meters, which were purchased and distributed across CCDHB as part of the project, have enabled the collection of hundreds of thousands of electronic results of inpatient blood glucose testing.

Recently the team was joined by a Diabetes Registrar, Dr Brian Corley, with coding, data science and statistical expertise who has analysed the blood glucose data for the Organisation. This analysis has enabled the team to focus on wards where intervention is required and support monitoring of diabetes management on a day-to-day basis across the hospital.

This has led to a 26% reduction in hypoglycaemia in hospital inpatients for a 12 month period between 2017 and December 2018 (1,477 to 1,093), increased testing and awareness of patients with hyperglycaemia and improved data collection leading to, for example, better quantification and analysis of hypoglycaemia in neonatal and paediatric patients.

The project was awarded Best Service Delivery Innovation at the National Diabetes Conference in May 2019 and a number of other DHBs are interested in adopting a similar approach.

3 KEY PERFORMANCE INDICATORS

3.1 Planned Care

At the beginning of June CCDHB received details of the planned care policy framework from the MOH. This framework includes the elective funding schedule and detail around the configuration of the elective health target and other key performance measures. Under the new framework planned care includes planned care interventions, the current ESPI measures, access to cardiology procedures and diagnostics such as MRI and CT and acute readmissions. Planned care interventions consist of inpatient surgical discharges, minor procedures provided as a hospital inpatient, outpatient or in a community setting and non-surgical interventions (specifically the musculoskeletal early intervention programme).

CCDHB submitted proposals for the planned care intervention target volumes under the new framework to the MOH on the 5 July. An update will be provided once the final targets have been agreed.

3.2 Elective Discharge Target

The elective discharge target is 11,208 discharges for the current year and includes arranged surgical procedures and work undertaken by other DHBs for the CCDHB population. Currently CCDHB are reporting 468 procedures behind the in-house year-to-date target of 6,879. The key driver for the adverse position continues to be industrial action and the stretch target built into in-house production. The year-end position including IDF outflow, arranged surgical and non-surgical discharges is currently 79 adverse to the 11,208 target.

Work continues on ensuring utilisation of all available theatre sessions in-house and outsourcing appropriate patients to private providers.

3.3 Elective Service Patient Flow Indicators (ESPIs)

ESPI 2: First Specialist Assessment (FSA) and ESPI 5: Elective Treatment remain non-complaint. Waiting times for FSA and Surgery have improved in most services but Dermatology FSA volumes have been slow to recover due to resource issues. The key drivers for surgical procedures are Cardiology and General Surgery with high numbers waiting for treatment.

The current level of ESPI noncompliance is outlined in the table below. June numbers are a forecast only and may change. Work continues to provide additional outpatient clinics and theatre sessions to treat patients waiting longer than 120 days. All DHBs are in a similar position in relation to ESPI noncompliance.

ESPI 2 and 5 Results as at End of May 2019

	Dec	Jan	Feb	March	April	May	June*
ESPI 2	40	208	72	151	138	48	51
ESPI 5	63	137	140	146	151	116	105

*Forecast

3.4 Coronary Angiography

Rates of elective coronary angiography within 90 days of an accepted referral for CCDHB and central region patients remain below target. Patients waiting over 120 days continue to be prioritised however the volume of elective angiographies undertaken (those shown below in green) are constrained by the demand for urgent angiographies, which necessarily take priority. March 2019 saw the lowest demand for urgent angiographies this year and correspondingly had the highest volume of elective angiographies. However the total number of patients waiting for elective angiographies has reduced as a result of the additional weekday and weekend lists recently introduced alongside continued outsourcing of a number of these procedures. The service forecasts that it will meet the target by the end of Quarter 1 2019/20.

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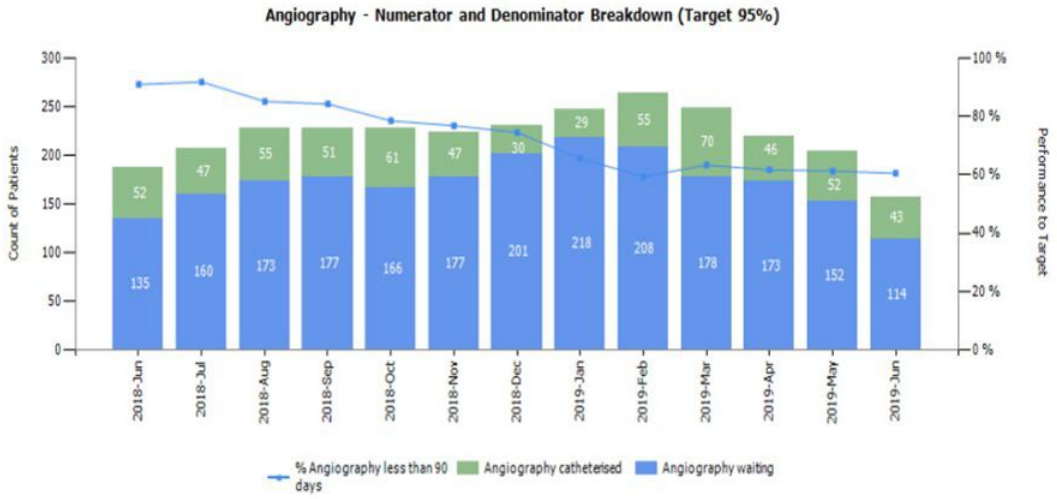


3.5 Access to Diagnostics – Radiology

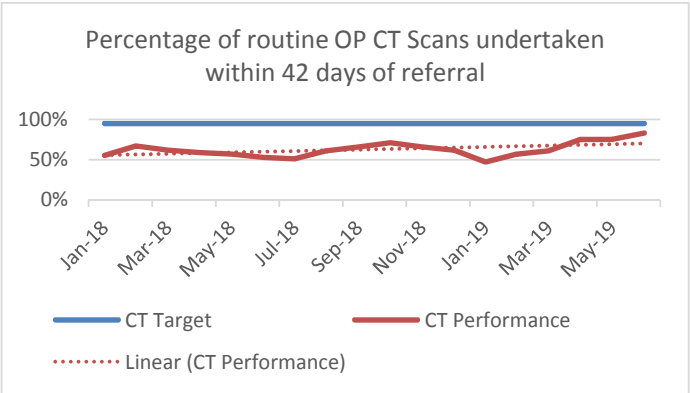
Performance against the CT and MRI MOH indicator for non-urgent referrals have continued to improve through May and June although remain below target.

3.5.1 CT Scanning

There were significant challenges for the CT service through May and June as one of the two CT scanners had to be shut down for two weeks (31 May – 16 June) due to infrastructure issues. In response the service increased outsourcing of scans. The overall impact of this loss of service was estimated as 95 fewer outpatient and 12 fewer inpatient CT scans being performed than planned. A further shutdown later in June was resolved with the loss of an afternoon elective patient list.

Despite the reduction in elective scans due to the issues highlighted and the five day RMO strike in May increased use of outsourcing enabled the service to sustain the improvement in patient waiting times evident since February.

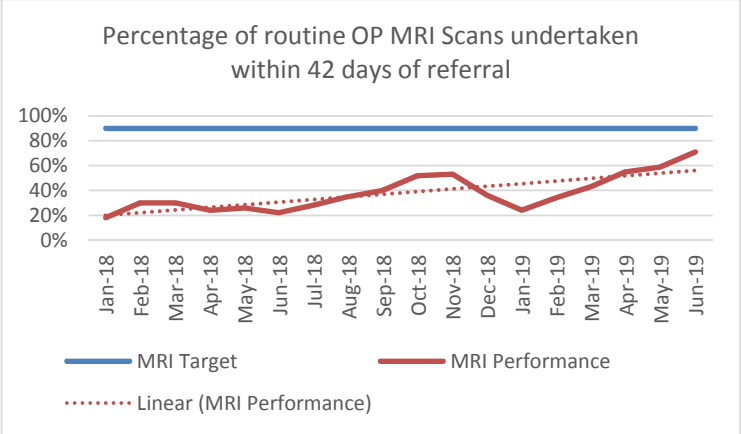
The service continues to work towards a seven day elective service but due to challenges in recruiting Medical Imaging Technologists (MITs) nationally, recruitment to new positions has been delayed until December/January when MIT students qualify.



3.5.2 MRI Scanning

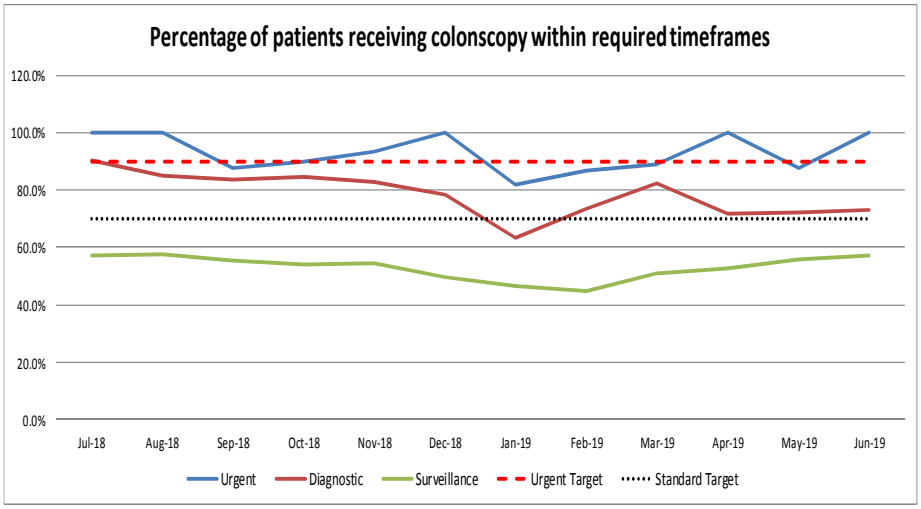
As with CT, MRI rates continue to improve though remain behind target through use of outsourcing and ad hoc elective and weekend lists as capacity and staffing allow.

The service plans to recruit a further MRI technologist trainee in August/September. This will add a third trainee to MRI service. There continues to be a local and national shortage of qualified staff.



3.6 Colonoscopies

The Gastroenterology service has not met the target for surveillance colonoscopy: 57.3% of people had their surveillance colonoscopy within 12 weeks against a target of 70%. This equates to 207 surveillance patients waiting in excess of the intended timeframe, and there are 12 diagnostic patients waiting longer than the target timeframe. The service is considering increasing the volume of outsourced colonoscopies in Quarter 1 2019/20 whilst awaiting the increase in colonoscopy capacity at Kenepuru planned for October 2019.



The MOH has indicated a March 2020 date for Bowel Screening to start at CCDHB. Planning within the service continues to achieve this deadline with particular emphasis on reducing the colonoscopy waiting times to within target as this is a prerequisite to the MOH giving the go ahead to commence Bowel Screening.

3.7 Delivering Faster Cancer Treatment (FCT)

CCDHB has successfully met the targets for Faster Cancer Treatment for the last two Quarters.

There are two FCT indicators that measure time to first treatment, by DHB of domicile:

- 31 day indicator – 85% of patients with a confirmed cancer diagnosis receive their first cancer treatment (or other management) within 31 days of a decision to treat

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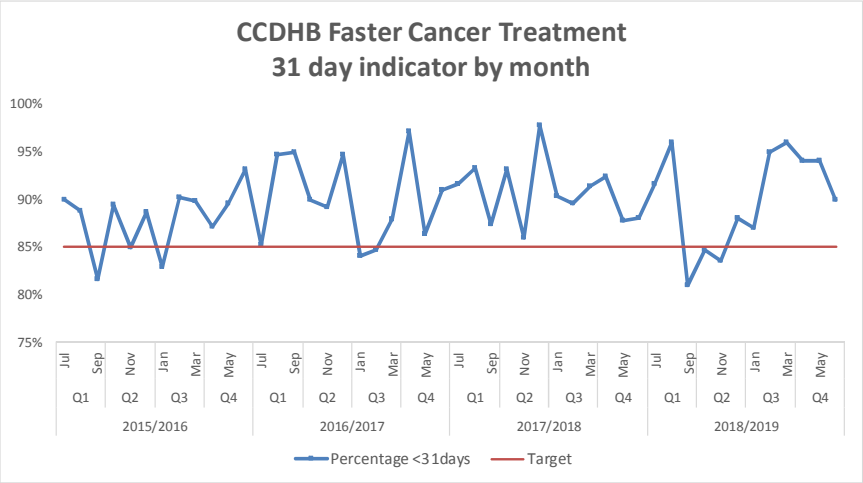
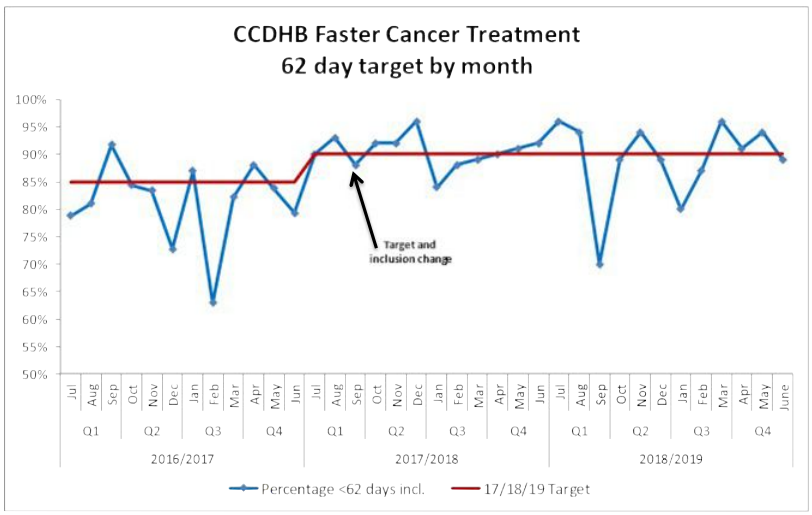


62 day indicator – 90% of patients referred urgently with a high suspicion of cancer receive their first treatment (or other management) within 62 days of the referral being received by the hospital



Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

PUBLIC

Date: 17 July 2019	**HEALTH SYSTEM COMMITTEE** **INFORMATION**
Author	Sipaia Kupa, Senior System Development Manager, Pacific Peoples Health Directorate Vaiola Haunga, Clinical Nurse Specialist, Pacific Peoples Directorate
Endorsed by	Taima Fagaloa, Executive Director, Pacific Peoples Health Directorate
Subject	**PACIFIC HEALTH UPDATE**

RECOMMENDATIONS

It is **recommended** that the Committee:

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

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

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

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

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

1. PURPOSE

The purpose of this paper is to provide the Health System Committee with an update for the following:

- Vaka Atafaga Pacific Nursing Service
- 3DHB Pacific Action Plan

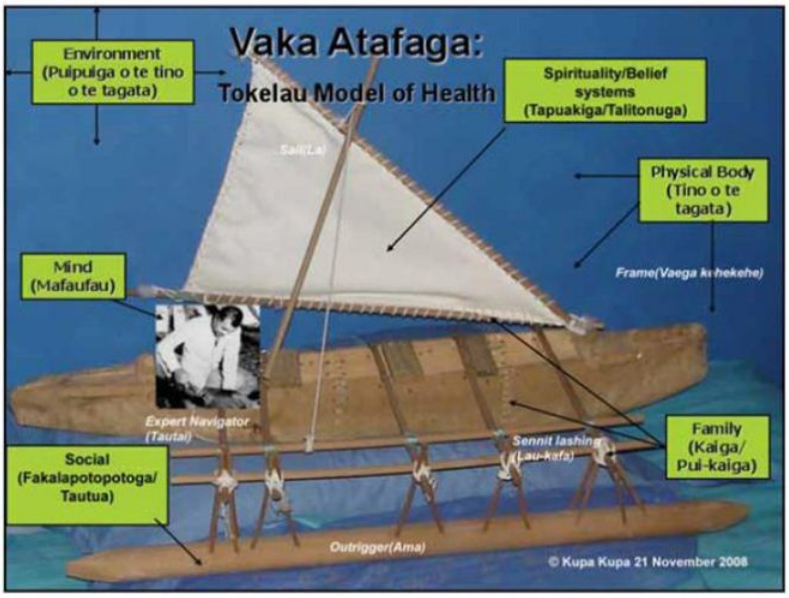
- Tokelau Patient Referral Scheme
- Wellbeing Budget 2019, implications for Pacific Health
- Advanced Care Planning, ATAMU incorporated

Pro-Equity approach: Vaka Atafaga Pacific Nursing Service

The Vaka Atafaga Pacific Nursing Service is part of the prioritisation and localities approach focused on improving health outcomes for Pacific communities in Porirua. The new trading name for the Pacific nurse led service is *Vaka Atafāga Pacific Nursing Service*. Dr Margaret Southwick and the Central Pacific Collective (CPC) developed the service in collaboration with CCDHB[1]. The service commended on 1 April 2019. There wasa small launch on 24 June 2019.

Vaka Atafaga is a Tokelau model consisting of 6 core concepts which are considered key aspects of health for Tokelau / Pacific people. This model was endorsed by Tokelau community representatives and leaders at the Inaugural Tokelau Health National Conference held in Wellington New Zealand in 1992 and has been adopted by Central Pacific Collective to support the delivery of the Pacific Nurse-Led Neighbourhood service.

The author Mr Kupa Kupa relates the personal and professional journey that he has taken 'aboard' Te Vaka Atafaga over a twenty year period from conceptualisation, development and through to application in clinical practice in a mental health setting in Aotearoa, New Zealand. As an experienced registered nurse, Mr Kupa has been employed as a member of the Vaka Atafaga team.



The service works autonomously and collaboratively with other service providers and draws upon a combination of Western and Pacific approaches to ensure clinical and cultural responsiveness. The Vaka Atafaga Pacific Nursing service will sit within the Community Health Networks as part of the Health Care

[1] Agreement between CCDHB and Pacific Health and Social Services Development Trust t/a Central Pacific Collective Pacific Neighbourhood Nurse-Led Service, Porirua Locality

Home (HCH) initiative working alongside Very Low Cost Access (VLCA) General Practitioner (GP) practices, District Nursing Services, Specialist Nursing Services (e.g. diabetes, palliative, respiratory), and Allied Health practitioners.

Dr Margaret Southwick and the Central Pacific Collective have made positive progress establishing the service from the 'ground up'. This has involved the recruitment of staff, securing premises and developing internal systems, processes, and policies.

The next phase is to continue to support the community service integration and alignment with the range of primary and specialist services within the Community Health Networks, and for the service to establish working relationships with the local Pacific community. The Vaka Atafaga Pacific Nursing Service will focus on building their caseload and will report on outcomes quarterly.

Further information can be found about Te Vaka Atafaga model of care through this link https://www.tepou.co.nz/uploads/files/resource-assets/te-vaka-atafaga-a-tokelau-assessment-model-for-supporting-holistic-mental-health-practice-with-tokelau-people-in-aotearoa-new-zealand.pdf

3DHB Pacific Action Plan 2019-2022

The Pacific community consultations began in the month of May and were held in Hutt Valley, Wellington, and Porirua. The consultations focused on engaging local Pacific communities but also Pacific and non-Pacific providers. The Hutt Valley Pacific team held consultations with individual ethnic groups and providers and led the youth consultation and CCDHB held consultations with combined ethnic groups and providers.

The consultations were attended by a good cross section of the community and separate consultations were held with young people. A significant focus of the consultations was to look at how the 3DHBs can work together with Pacific communities and providers to improve health outcomes across the region. There were mixed reactions about a single 3DHB Pacific Action Plan but most saw this as an opportunity to reassess the strategic direction for the Pacific population in future. The next phase is to collate the data collected and to consider how this will be incorporated in the re-development of the overall plan. The first draft of the Pacific Action Plan will be provided at the next joint board meeting in August 2019.

Tokelau Patient Referral Scheme

The Tokelau Patient Referral Scheme (TPRS) provides secondary and tertiary level treatment that is not available in Tokelau and is a critical part of Tokelau's health system. Tokelau is a territory of New Zealand and is made up of three atolls comprised of Fakaofo, Atafu, and Nukunonu. The population of Tokelau in the atolls is 1,285[2] whereas the Tokelau population living in New Zealand is almost 7000. Tokelau residents living in New Zealand are mainly concentrated in Auckland, Taupo, Rotorua, and Wellington. The largest numbers live in Porirua and the Hutt Valley.

In 2004, CCDHB signed a memorandum of understanding (MoU) with the Tokelau Department of Health to establish a more direct relationship for Tokelau patients referred to CCDHB. The objective of the MoU is to improve the continuum of health care for Tokelau patients and provide timely access to specialist services at CCDHB. Tokelau patients with health needs that are beyond the capability of health services

[2] Mafile'o, T., Foliaki, S., Koro, T., leslie, H., Redman-MacLaren, West, C., & Roskrudge for Massey University of New Zealand. (2019). Review report on Tokelau's Clinical Health Services and Patient Referral Scheme.

in Tokelau are generally referred to Samoa. Cases in Samoa that are identified as needing more advanced investigation are referred directly to the CCDHB Chief Medical Officer (CMO) who allocates these referrals to the appropriate Clinical Leads.

The CCDHB Pacific Health Unit for inpatients and the Tu Ora Pacific Navigation Service in the community provide clinical and social support to patients. The Tokelau Department of Health also employs a Wellington based liaison nurse to support patients and families. The feedback from the Tokelau Department of Health about the clinical services provided by CCDHB is always positive.

The patients that come for investigation and treatment are hosted by families in New Zealand and receive a living allowance to support them. Host families also receive an allowance to support them to provide care however they are often faced with challenges and ill prepared for what is expected of them to care for sick family members under the TPRS.

The TPRS referral numbers are relatively low, the largest number of referrals is predominantly for Women's Health.

Specialty	**Patient referrals**	**Initial service**
Cardiology	2	1
Endocrinology	1	1
Gastroenterology	1	1
Gynaecology	1	1
Neurology	2	2
Neurosurgery	3	3
Obstetrics	1	1
Optometry	1	1
Orthopaedics	1	1
Urology	3	2
Vascular	1	1
Blood and Cancer	3	1
Women's Health	7	6
Total	**25**	

Referrals between 13 September 2017 to 13 February 2018

The Ministry of Foreign Affairs and Trade (MFAT) recently commissioned a review of Tokelau's clinical health service and patient referral scheme as part of their own internal evaluation process to improve health services in Tokelau. The review was undertaken by the Massey University of New Zealand.

The objectives of the review were to:

- Review the relevance and effectiveness of clinical health services in Tokelau
- Review the relevance, effectiveness, efficiency, impact and sustainability of the Tokelau patient referral scheme (TPRS)
- Determine the funding required to deliver adequate levels of health service, and the potential budget impact of the growing incidence of Non-Communicable Diseases (NCDs)

- Identify key changes needed to deliver and sustain improved results from health services delivered in Tokelau, and through its patient referral

The final report of the review was completed in May 2019. It identified that the TPRS would be unsustainable for Tokelau in its current form and that key changes were needed to ensure the TPRS IS more effective and efficient.

It was recommended that improvements be made in the following areas:

- Annual review mechanism in Tokelau of the TPRS decisions be undertaken by the Tokelau Health Advisory
- Improved understanding between the Taupulega (council of village elders), Health Department and broader community about the TPRS
- The patient and nurse experience of boat transfers
- Housing support for TPRS patients in New Zealand
- Pastoral support for TPRS patients in New Zealand
- Allowances and support to access WINZ.

The MoU stipulates the continuation of the partnership between the Tokelau Department of Health and CCDHB. The MoU also reflects the goodwill that exists to achieve good health outcomes for patients and their families under the TPRS. The CCDHB Pacific Directorate will continue to support the CMO with patients under the TPRS. A community meeting will be held hosted by CCDHB in conjunction with the Massey Researchers and Tokelau community to present the findings of the report.

Implications for the Wellbeing Budget 2019 focussed on Pacific Health

Budget 2019 focuses on delivering better wellbeing for all New Zealanders and driving intergenerational change. The Wellbeing Budget is about tackling New Zealand's long term challenges, focusing on five priorities – taking mental health seriously, improving child poverty, supporting Māori and Pacific aspirations, building a productive nation, and transforming the economy. These priorities are based around evidence on what will make the greatest contribution to the long term improvement of New Zealander's living standards and wellbeing.

For health, there is a key focus on mental wellbeing, equity for Māori and Pacific, workforce and infrastructure, and addressing cost pressures. Budget 2019 also includes a number of initiatives to support equity, such as $10 million for the Pacific Innovation Fund; and $10 million for the Pacific Provider Workforce Development Fund. The CCDHB and HVDHB Pacific Directorates are in discussions with the MOH Chief Advisor to consider how the 2DHB Pacific health sector can benefit from the additional funding announced in the Wellbeing 2019 budget.

Advanced Care Planning – Pacific Project

Atamu EFKS Porirua Incorporated ('ATAMU') and the Capital & Coast DHB Advanced Care Planning Steering Group identified the opportunity to develop and test processes that enable Pacific families to participate in advanced care planning. ATAMU is a Pacific community Trust established in association with the Porirua EFKS Congregational Christian Church in Porirua. ATAMU is a member of the Central Pacific Collective.

Atamu's proposal was to pilot a programme that will start engaging Pacific families in talanoa (discussions) about the benefits of advanced care planning in order to understand cultural influences, barriers, information available for Pacific people in advanced care planning. As a pilot, the main purpose of this initiative is to collect information and collaborate with families to develop a process for engaging people in advanced care planning that is effective and relevant for Pacific families. The approach aimed to include the following:

- To develop and test systems that enable Pacific families to understand the benefits of advanced care planning
- To encourage conversations among Pacific family members about the importance of planning ahead
- To identify support services within the Pacific community that can assist and guide families
- To identify some of the barriers that prevent Pacific people from planning ahead

Atamu, in conjunction with CCDHB Advanced Care Planning team ran two workshops involving 17 Pacific people predominantly elderly. Feedback included the lack of access to knowledge about Advanced Care Planning for Pacific people. Participants would like CCDHB to consider Pacific language videos to disseminate the key messages. They also identified the need for more discussion workshops to improve community / family understanding of Advanced Care Planning is.

Associated with the idea of Advanced Care Planning for Pacific families, is the current debate about the The End of Life Bill which has generated some interest within the Pacific communities and the Sub Regional Pacific Strategic Health Group who will hear at its next meeting the key messages being disseminated about the implications for Pacific families from a core group of Pacific leaders.

PUBLIC EXCLUDED

Te-Upoko-me-Te-Karu-o-Te-Ika Mental Health, Addictions and Intellectual Disability Service; Capital & Coast District Health Board Ūpoko ki te Uru Hauora	**HEALTH SYSTEM COMMITTEE INFORMATION**
	Date: 17 July 2019
Author	Nigel Fairley, General Manager Mental Health Addictions and Intellectual Disability Service 3DHB
Endorsed By	Fionnagh Dougan, Chief Executive, Capital & Coast District Health Board
Subject	**MENTAL HEALTH ADDICTIONS AND INTELLECTUAL DISABILITY SERVICE (MHAIDS) 3DHB UPDATE FOR CAPITAL AND COAST HEALTH SYSTEM COMMITTEE**

RECOMMENDATIONS

It is **recommended** that the Committee:

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

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

1. PURPOSE

The purpose of this paper is to provide the Boards with an update on initiatives, key performance indicators and projects across the Mental Health Addictions and Intellectual Disability Service (MHAIDS) 3DHB.

The Mental Health, Addictions and Intellectual Disability Service (MHAIDS 3DHB) spans 3DHBs - Wairarapa, Hutt Valley, and Capital & Coast DHBs, and includes local, regional, and national services. Local MHAID services are provided from multiple sites within the 3DHB sub-region – greater Wellington, Porirua, Kapiti, Hutt Valley, and Wairarapa. The regional services have staff throughout the central region and the national services staff throughout the country. The inpatient part of the regional and national services are at Kenepuru and Rātonga o Rua Porirua Hospitals.

2. SERVICE DEVELOPMENT

2.1 Te Whare o Matairangi Remediation

Repair work is well underway to the roof of Te Whare O Matairangi, caused by significant fire damage. Fire engineers and council inspectors have inspected the work, which has resulted in passes. The gib work to the firewalls is nearly complete and work continues in the bathrooms that received significant smoke damage. In the meantime, the Rangatahi regional youth clients will remain based at Te Whare O Matairangi at Wellington Hospital, and Acute Adults in the Rangatahi and Ngā Taiohi units at Kenepuru hospital.

The repairs are still on track for the deadline of 31 August 2019, with the services able to return to their usual locations shortly after.

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2.2 TrendCare Update

The roll-out of TrendCare across MHAIDS inpatient services, is progressing exceptionally well with Rangatahi, Tane Mahuta, Tāwhirimātea, Rangipapa and Purehurehu all up and running with the programme.

Overall, teams have been very responsive to training and implementation and most areas are making great progress with predicting and actualising, and using the 'allocate' and 'inpatient' data screens effectively. There have been recent challenges due to the level of acuity in some areas, and we are working with those teams to ensure that data continues to be entered accurately.

This now means that there are only four remaining areas to implement the programme in— Haumietiketike, including the ID step-down cottages, Hikitia and Te Whare Ra Uta. Training begins for Haumietiketike and the step-down cottages over the next few weeks, followed by Te Whare Ra Uta and Hikitia at the start of August.

It is expected that TrendCare will be operational across all inpatient units by the end of September.

2.3 Mārama Real-time feedback

MHAIDS 3DHB has begun a project to introduce a digital survey for consumers and whānau to tell us about their experience with our services. The tool, called Mārama, operates as an application on a touchscreen device, and contains basic questions for consumers and their whānau to complete anonymously about their experience. Devices will be available at all of our services that have whānau and client contact.

The anonymous survey results will be uploaded automatically to Qlik (software for business intelligence & data visualisation) when connected to Wi-Fi, allowing the data to be visible for each MHAIDS team. The survey will provide an additional avenue for our consumers and their whānau to share their feedback with us, which will be used by Quality and teams across the service for continuous quality improvement.

The Implementation date across MHAIDS is set for 4 November.

2.4 Mental Health Nurse Pilot in Emergency Department (Wellington)

The MHAIDS ED response Nurse based in Wellington Emergency department (ED) has begun. As of 3 June 2019, there is now a Mental Health Nurse based primarily in the emergency department triaging all people (including current MHAIDS service users), who present to the ED with a mental health problem. The response so far has been positive.

The MHAIDS ED Response Nurse determines those who need to be seen urgently, while being able to safely defer less urgent referrals to non-crisis parts of the mental health and addiction services. They have a critical role in both formal and informal training, and supporting Emergency Department staff around mental health presentations.

Recruitment is now underway for a second MHAIDS ED Response nurse for Wellington ED. We plan to appoint to Hutt Hospital ED if the pilot continues to be successful.

2.5 Co-response Service Pilot

Co-response services are being trialled and implemented worldwide, most recently in Scotland and Canada and with great success. The aim of these models is introducing mental health ability during encounters with Police Officers in order to reduce the likelihood of the person in crisis being detained

in police custody. It can also reduce people being hospitalised, or police charging individuals unnecessarily. There is evidence that the co-response approach reduces the distress during these incidents. An important parallel aim is to improve access to mental health treatment afterwards.

MHAIDS, NZ Police and Wellington Free Ambulance has started to pilot a Co-response Service project, in Wellington and the later in Hutt Valley.

The working group has drafted a Memorandum of Understanding which is currently undergoing sign-off between parties.

The group are working towards the start of November 2019 as the 'Go Live' date for this pilot.

2.6 Te Whare Ahuru update

Ministers visit

The Minister of Health, Hon Dr David Clark, visited Te Whare Ahuru on 2 July, as part of an official visit to Hutt Valley DHB with Fionnagh Dougan, Dale Oliff and Andrew Blair.

The Minister and his delegation met with Nigel Fairley, Rod Bartling, Andy Horrigan (lead clinician) and David Taylor (clinical nurse manager), where he received background about the TWA reconfiguration project, and the current status of the bid for Capital Investment Committee funding.

The Minister was taken on a brief tour of the unit to learn about the challenges of the current environment, including overall layout, configuration and impediments to a person's recovery journey.

TWA Admissions

Te Whare Ahuru (TWA) during May had; 59 admissions, 56 discharges, a 12 day average length of stay, and a four percent readmission rate.

This is a real achievement for the team and our clients, and demonstrates a high level of commitment to outcomes for our population. Team work and positivity is a real strength for this team. Overall morale is high and turnover is low, despite the challenges with the current physical environment.

2.7 Te Haika – Project for automatic entry of referrals

MHAIDS and ICT have commenced a 14-week project to implement automatic entry of Te Haika referrals using robot technology. All Te Haika referrals will automatically be entered into webPAS within three minutes of a clinician saving/completing an intake document. This will have a beneficial effect on the efficiency of Te Haika's intake process, vastly improving the accuracy of their referral and activity data. This will also ease the team's administrative workload, allowing them to focus further on the quality of their service.

In a wider sense, the benefits of this project will be substantial for MHAIDS – an efficient, rapid Te Haika intake process will have a favourable effect on wait times and greater certainty for service users' initial entry into the service. Successful implementation of this project will open possibilities for further automation in MHAIDS processes, which will positively impact service users' journey through mental health services.

The Te Haika team are using the project as an opportunity to evaluate and implement changes in their wider referrals process and operations manual. A summary of their actions is listed below:

- Arrange refresher training for team on inputting activities to MAP and completing electronic intake forms in a consistent way.
- Address backlog in open referrals and referrals with no activities recorded.

- Work to eliminate double-handling in administrative processes and ensure all relevant clinical information is recorded on service users' digital client record.
- Focus on confirming people's demographic details and ensuring these are updated on both CCDHB and HVDHB administrative systems.
- Set a service KPI for time taken to complete triage.

Please see section 5 for the latest Te Haika data for June 2018 – May 2019.

2.8 High Performance/High Engagement (HPHE) approach to MHAIDS health and safety

MHAIDS (CCDHB), the Public Service Association and the New Zealand Nurses Organisation are working to improve the overall structure, focus and results of the Health and Safety Programme within MHAIDS, by developing the tools and principles behind a High Performance/High Engagement (HPHE) approach. This is in conjunction with the agreement between ACC and the Council of Trade Unions (CTU).

Managers, union representatives and front line employees are working together using an interest based problem solving (IBPS) methodology to define issues, identify the interests of all stakeholders involved and utilise those interests to develop options and solutions to achieve organisational performance improvement.

Stage one starts this month, with the objective of training representatives in HPHE principles and methodology and undertaking a full review of the current MHAIDS health and safety programme.

3 CORE INDICATORS

With the implementation of QLIK Sense, a new interactive data visualisation tool that is being implemented across Capital & Coast DHB, 3DHB MHAIDS aims to produce an interactive dashboard linking to a range of measures and detail from a range of datasets.

The core indicators we have provided are:

- Access rates;
- Wait times < three weeks;
- Wait times three to eight weeks;
- Seen in the last 90 days;
- 28 day re-admission rates;
- Average Length of Stay;
- Occupancy rate;
- Seclusion hours;
- Pre-admission contact;
- Post-inpatient community contact;
- Did not Attend (DNA) rate;
- Te Haika referrals and calls

3.1.1 Wait times < three weeks; Wait times three to eight weeks

Ministry of Health waiting times measure (PP8) - Shorter waits for non-urgent mental health and addiction services.

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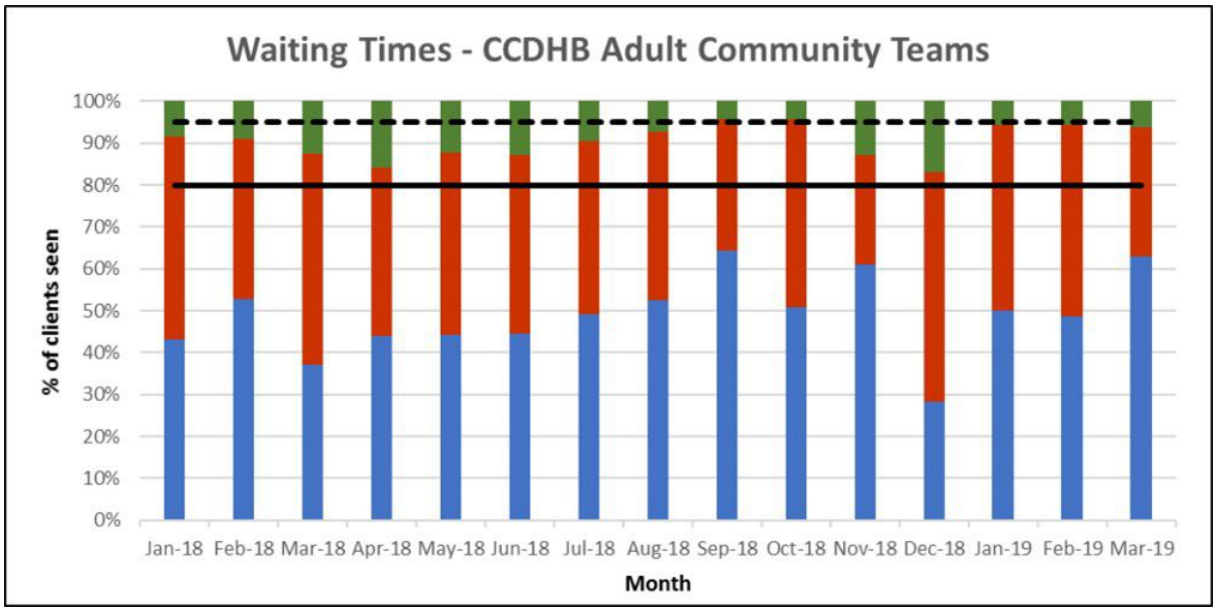
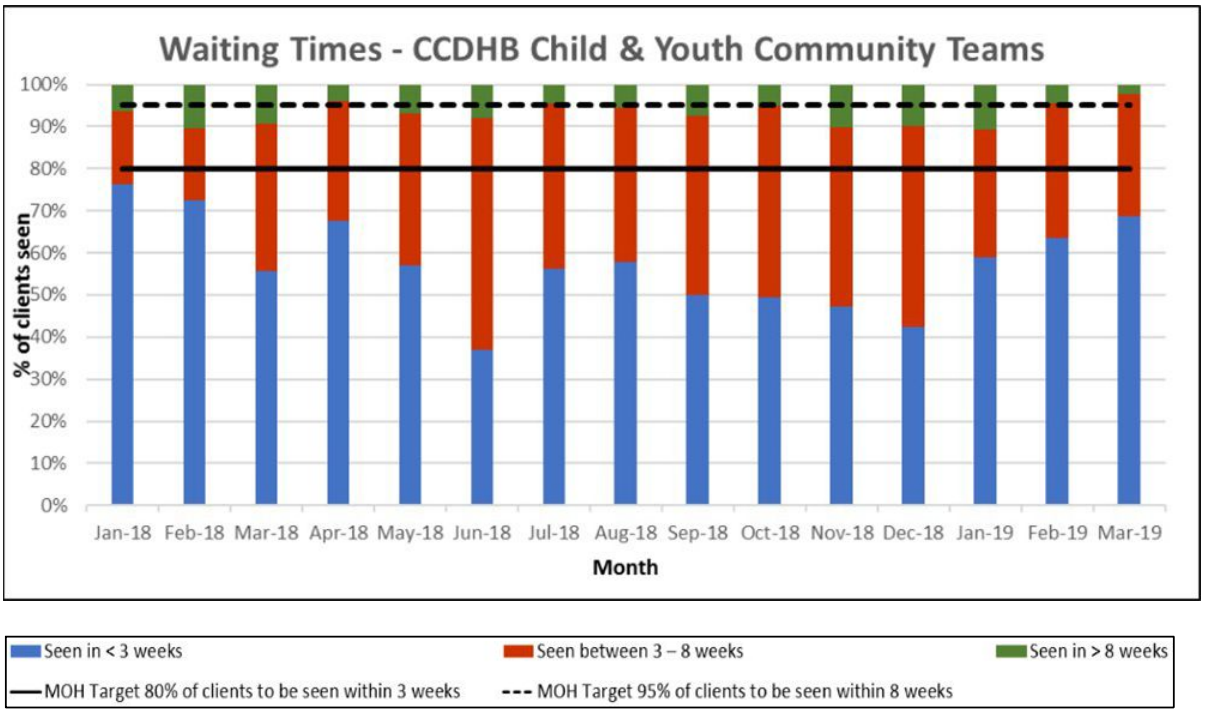
This measure is calculated from the date the referral is received, to the date of the first face to face contact with the client. Time delay required in order to allow clients to fall into the over eight week group. Please note, that although the Ministry's PP8 measure is for non-urgent referrals, all referrals are included in the below.

CCDHB Adult Teams



CCDHB Child and Youth teams



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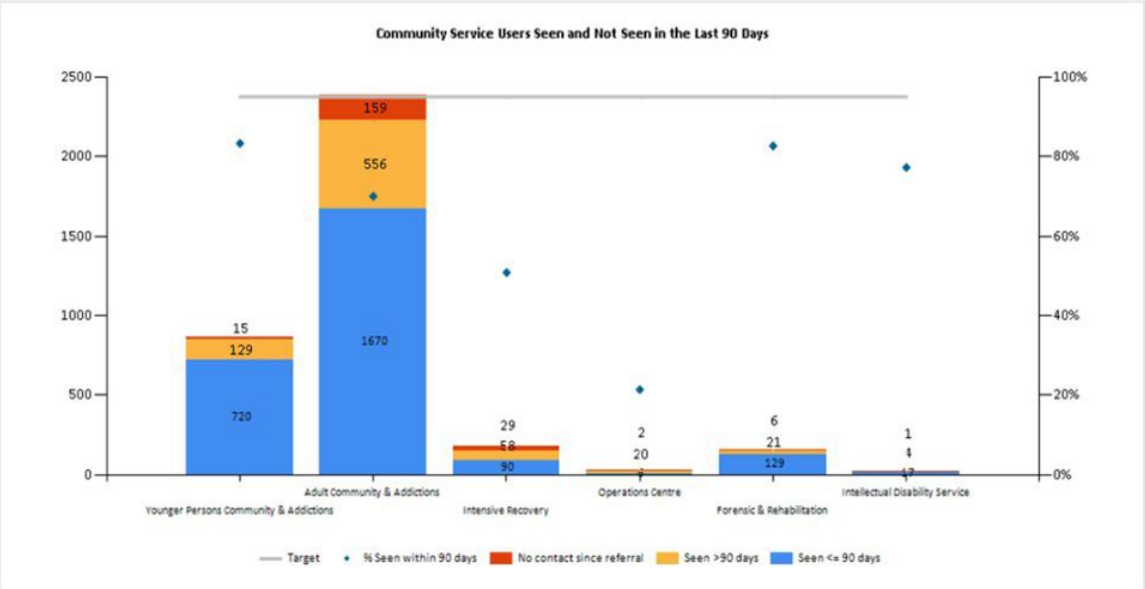
3.1.2 Seen in the last 90 days;

CCDHB – May 2019

MHAIDS 3DHB Sector	0-30 Days	31-60 Days	61-90 Days	91-120 Days	121 Days-1 Yr	1-2 Yrs	More than 2 Years	No Contact since Referral	Total	% Seen within 90 Days
Younger Persons Community & Addictions	495	118	102	57	70	0	0	15	857	83%
Adult Community & Addictions	1,116	322	224	133	245	70	93	159	2,362	70%
Intensive Recovery	66	9	13	5	21	19	1	29	163	54%
Operations Centre	2	1	2	2	13	1	0	2	23	22%
Forensic & Rehabilitation	90	19	14	15	4	0	0	6	148	83%
Intellectual Disability Service	7	2	8	2	2	0	0	1	22	77%
Total	1,776	471	363	214	355	90	94	212	3,575	73%



3.1.3 Average Length of Stay; Occupancy rate; 28 Day readmission

The usual graphs showing admissions, discharges and occupancy cannot be replicated for Te Whare O Matairangi for February, due to the ward changes following the fire on 3 February 2019.

Bed days for Te Whare O Matairangi clients (including people accommodated at Nga Taiohi and Rangatahi) for the month are shown below;

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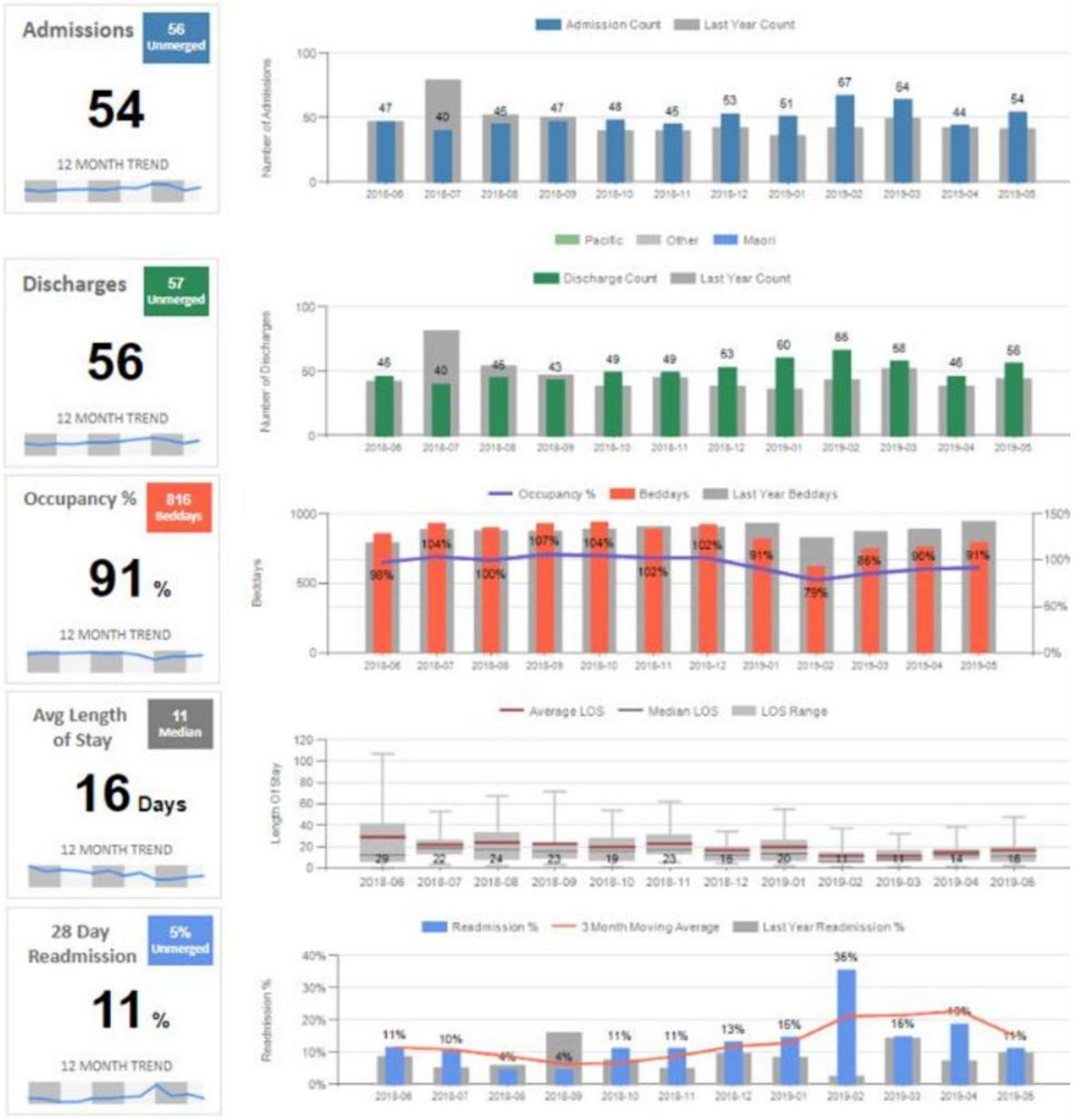
Te Whare o Matairangi (Acute Inpatient unit CCDHB)



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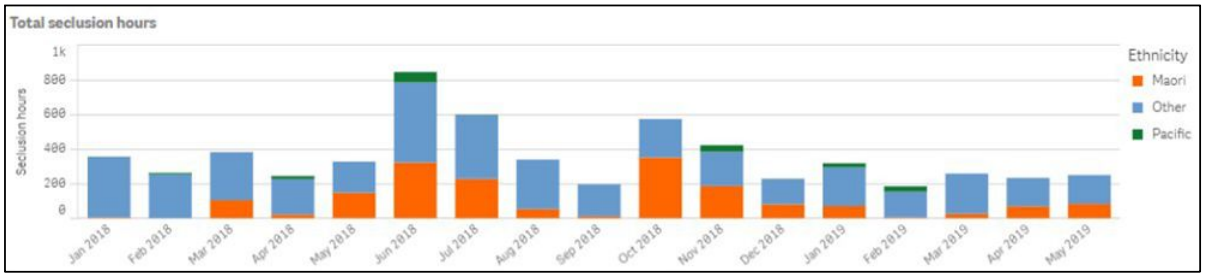
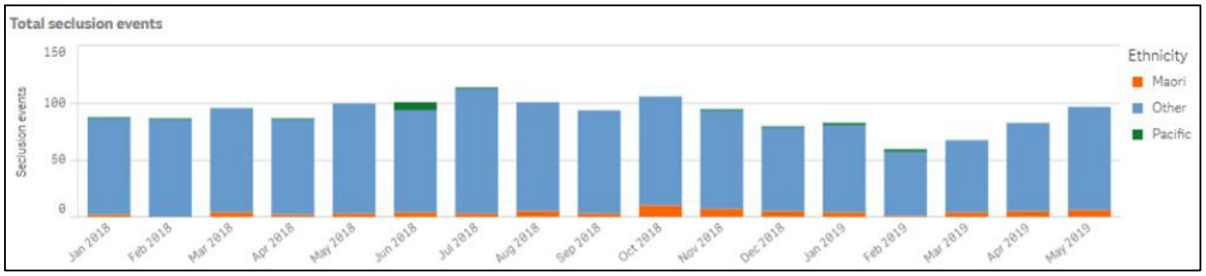
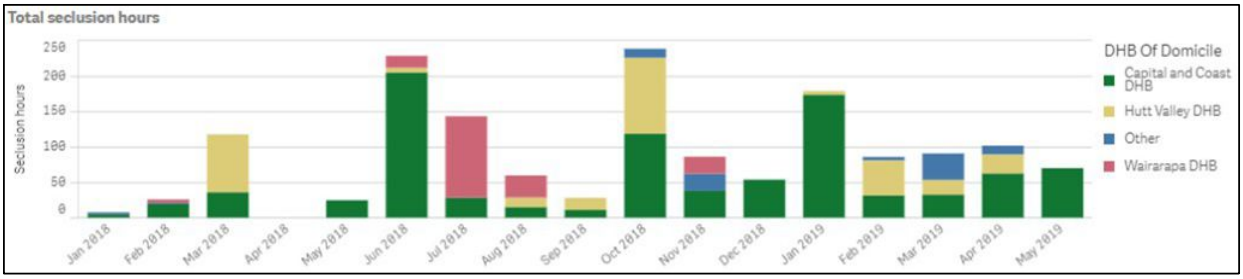
3.1.4 Seclusion hours

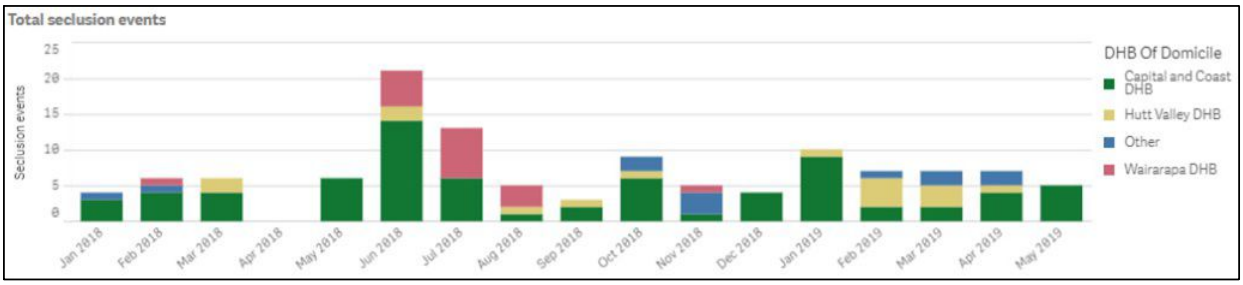
Te Whare O Matairangi seclusion and events by ethnicity





Te Whare O Matairangi (including Te Whare O Matairangi clients accomodated at Nga Taiohi and Rangatahi) seclusion by DHB of domicile:





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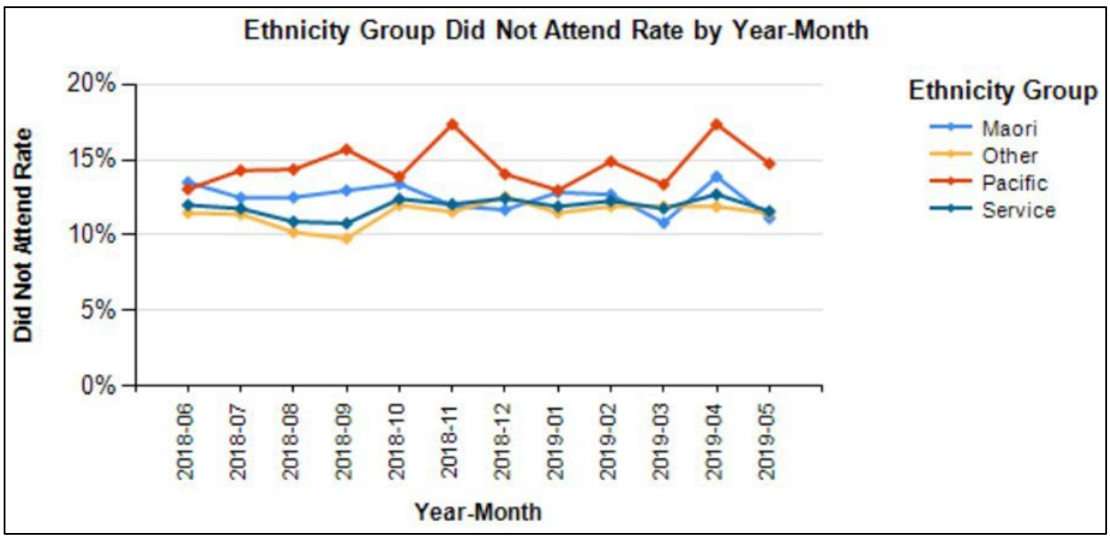
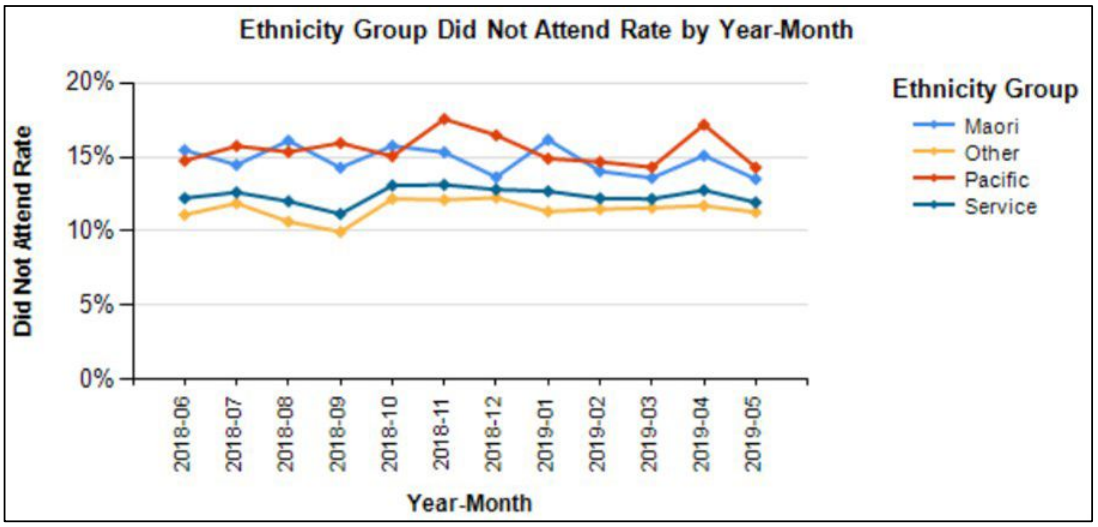
3.1.5 Did not Attend (DNA) rate

DNA Rate is calculated as all DNA contacts divided by all face to face and DNA contacts. This measure was developed as CCDHB and Wairarapa do not currently use the webPAS clinic appointments. Please note the latest month's data is not 100% accurate due to delays inputting activities to webPAS.

Did not attend rate Capital & Coast DHB



All of MHAIDS DNA rate (by Ethnicity)



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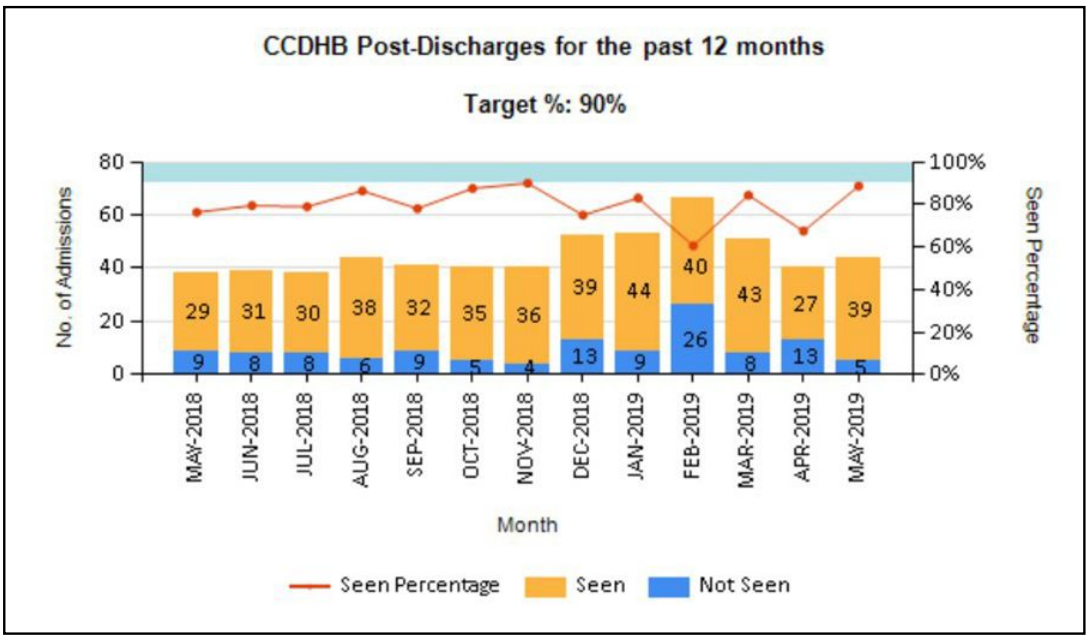
3.1.6 Post-inpatient community contact

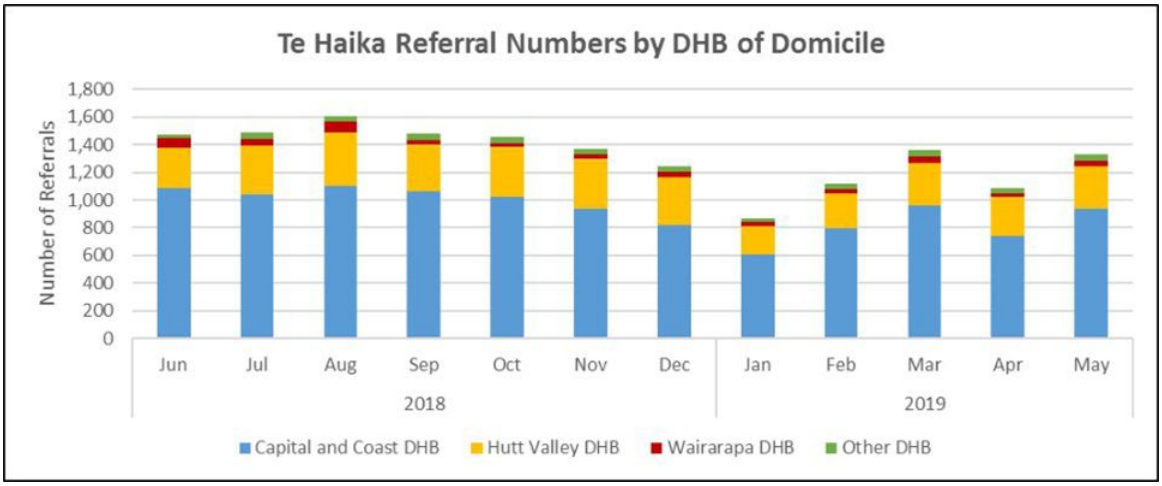
Te Whare O Matairangi figures below include clients currently accommodated at Nga Taiohi and Rangatahi.



The Ministry of Health KPI target for the number of people seen in the community within 7 days of discharge from an inpatient unit, is 90%. MHAIDS continue to make progress towards meeting this target in recent months. The percentage remains above the most recent national KPI average (65%).

3.1.7 Te Haika

Te Haika is the telephone call centre that triages crisis and acute calls 24 hours per day, seven hours per week. Clients phone in on a specific phone number – 0800 745 477. The call centre is staffed by registered health professionals who manage referrals to MHAID Services for 3DHBs. Prior to July 2015, this service only covered CCDHB. In July 2015, the service was expanded to Wairarapa and Hutt Valley DHBs during normal work hours. From 1 July 2016, the service has covered the region 24/7.



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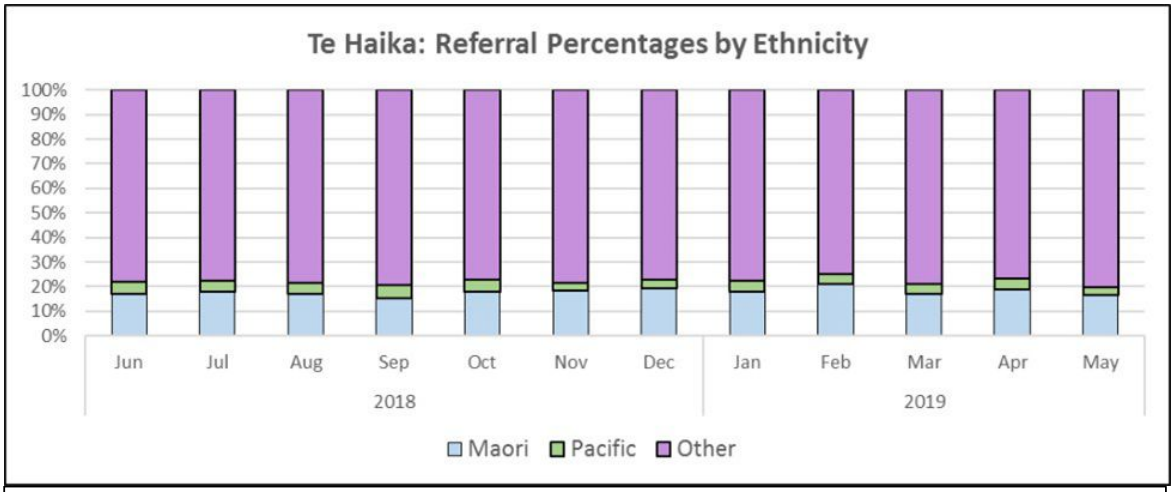

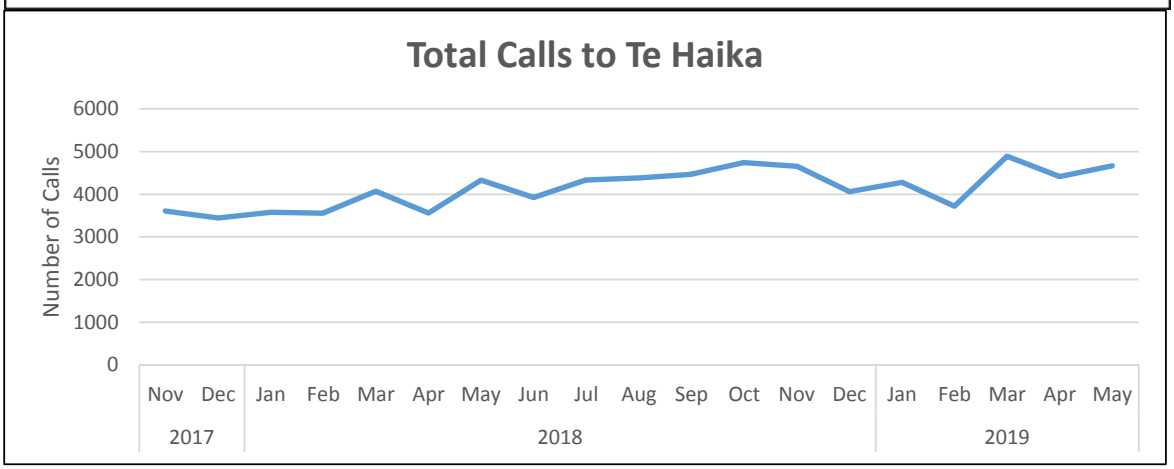

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Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**HEALTH SYSTEM COMMITTEE DECISION**
	Date: 17 July 2019
Author	Fran Wilde, Health System Committee Chair
Subject	**RESOLUTION TO EXCLUDE THE PUBLIC**

RECOMMENDATION

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

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

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

* Official Information Act 1982.