DRAFT 2020 CAPITAL & COAST DISTRICT HEALTH BOARD

Health System Committee

Public Agenda

13 NOVEMBER 2019

Kapiti District Council Chambers, 175 Rimu Road, Paraparaumu
9am to Midday

	ITEM	ACTION	PRESENTER	MIN	TIME	PG
1 PROCEDURAL BUSINESS					9am	
1.1	Karakia					
1.2	Apologies	**Records**	F Wilde			
1.3	Continuous Disclosure – Interest Register	**Accepts**	F Wilde			2
1.4	Confirmation of Draft Minutes 16 October 2019	**Approves**	F Wilde			5
1.5	Matters Arising	**Notes**	F Wilde			
1.6	Action List	**Notes**	F Wilde			9
1.7	Proposed Workplan 2020 1.7.1 Draft 2020 Health System Committee Workplan	**Approves**	A Grey			10 12
2 PRESENTATION						
2.1	Kāpiti update		Kāpiti Health Advisory Group		9.15	
3 DISCUSSION						
3.1	Localities Update - Kāpiti Health Advisory Committee (KHAG) Work Programme 2019/20		Gerardine Clifford-Lidstone		9.45	13
3.2	Equity - CCDHB Pacific Population Health Profile		Gerardine Clifford-Lidstone			20
3.3	Gender Affirming Healthcare at CCDHB - Update		Gerardine Clifford-Lidstone			24
3.4	Investment and Performance – Core Primary Care Services		Jenny Langton			29
3.5	Health of Older People - Areas of Focus		Jenny Langton			36
4 INFORMATION						
4.1	Regional Public Health Update 3.1.1 Measles Map		Peter Gush			42 47

HEALTH SYSTEM COMMITTEE

Interest Register

UPDATED AS AT NOVEMBER 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 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 • Advisor to Chelsea Hospital, Gisborne in relation to strategic opportunities
Ms Sue Kedgley *Member*	• Member, Capital & Coast District Health Board • Member, CCDHB CPHAC/DSAC • Member, Greater Wellington Regional Council • Member, Consumer New Zealand Board • 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 • Brother is Service and Planning Manager of Pathways Health Limited • Father is Acting Director in the Office for Disability Issues, Ministry of Social Development
Ms Eileen Brown *Member*	• Member of Capital & Coast District Health Board • Board member (until Feb. 2017), Newtown Union Health Service Board • Employee of New Zealand Council of Trade Unions • Senior Policy Analyst at the Council of Trade Unions (CTU). CTU affiliated members include NZNO, PSA, E tū, ASMS, MERAS and First Union • Executive Committee Member of Healthcare Aotearoa • Executive Member of Health Benefits of Good Work • Nephew on temporary CCDHB ICT employment contract
Ms Sue Driver *Member*	• Community representative, Australian and NZ College of Anaesthetists • Board Member of Kaibosh • Daughter, Policy Advisor, College of Physicians • Former Chair, Robinson Seismic (Base isolators, Wgtn Hospital) • Advisor to various NGOs
Mr Fa’amatuainu Tino Pereira *Member*	• Managing Director Niu Vision Group Ltd (NVG) • Chair 3DHB Sub-Regional Pacific Strategic Health Group (SPSHG) • Chair Pacific Business Trust • Chair Pacific Advisory Group (PAG) MSD • Chair Central Pacific Group (CPC) • Chair, Pasefika Healthy Home Trust • Establishment Chair Council of Pacific Collectives • Chair, Pacific Panel for Vulnerable Children

	• Member, 3DHB CPHAC/DSAC • Wing representative at NZ Police.
Dr Tristram Ingham *Member*	• Senior Research Fellow, University of Otago Wellington • Chair, Independent Monitoring Mechanism to the UN on the UNCRPD • Member, Disabled Persons Organisation Coalition • Member, Capital & Coast DHB Māori Partnership Board • Member, Scientific Advisory Board – Asthma Foundation of NZ • Chair, Te Ao Mārama Māori Disability Advisory Group • Vice Chairperson – National Council of the Muscular Dystrophy Association • Chairperson, Executive Committee Central Region MDA • Trustee, Neuromuscular Research Foundation Trust • Co-Chair, Wellington City Council Accessibility Advisory Group • Member, 3DHB Sub-Regional Disability Advisory Group • Professional Member – Royal Society of New Zealand • Member, Institute of Directors • Member, Health Research Council College of Experts • Member, European Respiratory Society • Member, Te Ohu Rata o Aotearoa (Māori Medical Practitioners Association) • Director, Miramar Enterprises Limited (Property Investment Company) • Wife, Research Fellow, University of Otago Wellington • Director, Foundation for Equity & Research New Zealand
Sue Emirali *Member*	• Interim Chair, Sub Regional Disability Advisory Group 3DHB • Chair, KCDC Disability Advisory Group • President Retina NZ (Low Vision support organisation) • Member of Eye Health Coalition • Member Kapiti Health Advocacy Group • Board Member of Wellable (Wellington and Districts Disability Centres)
Diane Crossan *Member*	• Chair, CCDHB Citizens Health Council • Chair, International Advisory Board for the Global Centre • Chair, Centre for Finance Education — Massey University • Chair, Retirement Income Group Ltd • Board member, Kaibosh

CAPITAL AND COAST DISTRICT HEALTH BOARD
DRAFT Minutes of the Health System Committee
Held on Wednesday 16 October 2019 at 9.12am
11th Floor Boardroom, Grace Neill Block, Wellington Regional Hospital, Wellington

PUBLIC SECTION

PRESENT

COMMITTEE:	Dame Fran Wilde (Chair) Ms Sue Kedgley Dr Roger Blakeley Ms Eileen Brown (left 11am) Ms Sue Driver Ms Sue Emirali Ms 'Ana Coffey (arrived 9.26am)
STAFF:	Ms Fionnagh Dougan, Chief Executive Officer Ms Rachel Haggerty, Executive Director, Strategy Innovation and Performance Mrs Robyn Fitzgerald, Committee Secretary Ms Anna Chalmers, Interim Communications Director Ms Arawhetu Gray, Director Māori Health Development Team Mr Taulalo Fiso, Director of Community Partnerships (Item 3.2) Ms Gerardine Clifford-Lidstone, General Manager, Child, Youth and Localities (Item 3.1) Ms Rachel Pearce, Senior Systems Development Manager (Item 3.1)
PRESENTERS:	Meena Vallabh, Project Manager, SIP (Item 2.1) Ria Earp, Member of the Citizens Health Council (Item 3.2) Jenny Rowan, Member of the Citizens Health Council (Item 3.2) Sipaia Kupa, Senior Service Development (Item 3.4)

GENERAL PUBLIC:

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1 PROCEDURAL BUSINESS

1.1 PROCEDURAL

Dame Wilde opened the meeting and thanked Eileen Brown and Sue Driver for their services to the Health System Committee and Capital & Coast District Health Board and wished them well.

Eileen Brown reflected and applauded the strong leadership and strategic work that has been undertaken by the Health System Committee. She thanked and acknowledged support and leadership from Rachel Haggerty and the executive team.

Sue Driver thanked the Health System Committee and acknowledged the work undertaken by the committee. She recommended that the committee provide the incoming Health System Committee a briefing and recommendations going forward to maintain the impetus of the current strategies.

Action

1. That a meeting be arranged with Committee members, the CEO, Heather Simpson and Sarah Prentice on the Health and Disability Review.

1.2 APOLOGIES

Andrew Blair, Tristram Ingham and Tino Pereira. Late arrival of 'Ana Coffey was registered.

1.3 INTERESTS

1.3.1 Interest Register

No changes were received.

1.4 CONFIRMATION OF PREVIOUS MINUTES

The minutes of the CCDHB Health System Committee held on 11 September 2019, taken with public present, were confirmed as a true and correct record.

Moved: Roger Blakeley **Seconded:** 'Ana Coffey **CARRIED**

1.5 MATTERS ARISING

Nil.

1.6 ACTION LIST

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

1.7 ANNUAL WORK PROGRAMME

No changes.

2 PRESENTATION

2.1 OUTPATIENT PROJECT UPDATE

The Committee:

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

3 DISCUSSION

3.1 COMMISSIONING FOR EQUITY — ANTENATAL EUCATION

The paper was taken as **read**.

The Committee:

(a) **Noted** the persistent inequities in maternal and child health for Māori, Pacific, migrant/refugee and families in Porirua; including, access to antenatal education.

(b) **Noted** the Strategy, Innovation and Performance (SIP) recently delivered an innovative process, to more effectively commission for equity, characterised by:

a. Targeting investment to the groups we persistently fail to engage in antenatal education (young, Māori, Pacific, migrant/refugee families and families in Porirua).
b. Prototyping new, locally-developed approaches in 2019/20, to inform longer term commissioning decisions from 2020/21.
c. Inviting providers to ideate on approaches they believe will provide more meaningful education to the groups we persistently fail to engage with traditional/mainstream approaches. This is in contrast to the traditional approach of SIP leading the development of a service specification.
d. Rather than relying solely on written proposals, we invited providers to have a conversation with a panel about their ideas.

e. Consumer-led decision making, through an evaluation panel made up of two young Māori and Pacific mothers (who are representative of the cohort that often do not attend antenatal education), one small private practitioner/provider and two SIP representatives.
f. The performance appraisal process will involve the evaluation panel, including mothers, having a conversation about progress in the first few months of service delivery, to inform future commissioning activities.

(c) **Noted** the positive feedback from providers on this new approach to procurement (Attachment 1), including 62.5% of respondents feeling that this process was more likely to improve outcomes for family/whānau than traditional procurement processes.

(d) **Noted** that three innovative approaches to antenatal education will be trialled in the next 9 months, with a view to inform commissioning and contracting decision from 1 July 2020.

3.2 CITIZENS HEALTH COUNCIL

The paper was taken as **read**.

The Committee:

(a) **Noted** the content of this paper.

(b) **Endorsed** the work programme of the Citizens Health Council 2019/20.

A verbal update was provided to the committee. The Committee:

(a) **Noted** the appointment of new appointees on the Council;
(b) **Noted** the tabling of the work programme for 2020. This programme of work is focussed on views of specific issues. First item palliative care. Report to be completed early 2020.

Action:

2. Management to provide an overall statement and a diagrammatic future view of the Health System with key messages for the Citizens Health Council to provide to groups, who they meet with, context of where the Council fits and its purpose.

Roger Blakeley left the meeting (11.05 am) – there was no quorum. The last two papers were discussed.

3.3 INFECTION CONTROL IN AGED RESIDENTIAL CARE

The paper was taken as **read**.

The Committee:

(a) **Noted** the information regarding infection prevention control in age residential care.

(b) **Noted** the intention to scope this opportunity with the Integrated Care Collaborative as a collaboration between primary care physicians and pharmacists, and secondary care AMS team.

3.4 PACIFIC HEALTH UPDATE

The paper was taken as **read**.

The Committee:

(a) **Noted** the report.

Public Meeting closed at 11.25am.

4 DATE OF NEXT MEETING

13 November 2019, 9am, Boardroom, Kapiti District Council Chambers, 175 Rimu Road, Paraparaumu.

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

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

Fran Wilde
Health System Committee Chair

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

AP No:	Item No.	Topic	Action:	Responsible:	How Dealt With:	Delivery Date:
HSC Meeting 16 October 2019						
PO45	**1.1**	**Procedural**	That a meeting be arranged with Committee members, the CEO, Heather Simpson and Sarah Prentice on the Health and Disability Review	Exec Dir SIP	Heather Simpson will attend the Joint Board Meeting on 28 November 2019.	November
HSC Meeting 11 September 2019						
P044	**3.2**	**Health of Older People Investment Performance**	Management to arrange a workshop on the Health of Older People and include NASC representation	Exec Dir SIP	Scheduled a meeting with Sue Kedgley on 9 December 2019.	December

Action Items completed since 13 November 2019

AP No:	Item No.	Topic	Action:	Responsible:	How Dealt With:	Delivery Date:
HSC Meeting						
P046	**3.2**	**Citizens Health Council**	Management to provide an overall statement and a diagrammatic future view of the Health System key messages for the Citizens Health council to provide to groups, who they meet with, context of where the Council fits and its purpose.	Exec Dir SIP	Diagram Provided to Citizens Health Council	Closed

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PUBLIC

Date: 6 November 2019	**HEALTH SYSTEM COMMITTEE DECISION**
Author	Director, Strategy Innovation & Performance – Rachel Haggerty
Endorsed by	Chief Executive – Fionnagh Dougan
Subject	**Proposed Workplan 2020**

RECOMMENDATIONS

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

(a) **Notes** that the proposed work plan has Strategy, Health System Investment and Prioritisation, Health System Integrated Performance Reporting and System and Service Planning sections.

(b) **Notes** that the section focused on Provider Performance - Efficiency, Outputs, is proposed to move to FRAC and the full Board.

APPENDICES

1. **PROPOSED HEALTH SYSTEM COMMITTEE WORKPLAN 2020.**

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

1 INTRODUCTION

1.1 Purpose

The purpose of this paper is to seek approval from the Health System Committee for the draft Work Programme for 2020.

2 DISCUSSION

3 STRUCTURE OF THE WORKPLAN

The work plan outlines the topic areas for each Health System Committee over the calendar year. It is assumed that there is no meeting in January or December. The proposed workplan for 2020 has adopted

a slightly different structure based on the learnings of previous years. It is written for a CCDHB Health System Committee but can be modified to a 2DHB Committee if required, using this structure.

3.1 Strategy

The section in which the key strategies of the DHB are endorsed and regular updates are provided. It is also where investments plans for major service user groups are discussed and agreed.

3.2 Health System Investment and Prioritisation

The section in which the investment and prioritisation for budget processes are discussed, including updates on implementation of these priorities.

3.3 Health System Integrated Performance Reporting

The section in which integrated performance reporting for our major populations is monitored including maternity, child and youth; urgent and planned care; long term conditions, complex care and older people; localities including Kapiti, Wellington and Porirua.

3.4 System and Service Planning sections

Where compliance planning documents and performance reports are agreed and monitored.

4 TRANSFERRED TO THE FINANCE, RISK AND AUDIT COMMITTEE AND BOARD

It is proposed that performance of the DHB provider arm and community services are reviewed by the organisation through the FRAC and full Board. The focus is on use of resources, safety and ICT.

CCDHB Health System Committee (HSC) Work Programme 2020

	February	March	April	May	June	July	August	September	October	November
	CCDHB	CCDHB	CCDHB	CCDHB	CCDHB	CCDHB	CCDHB	CCDHB	Kenepuru	Kapiti District Council Chambers
Strategy	End of Life Investment Plans	Health System Plan Implementation	Investment Plans - TBC	Investment Plans - TBC	Investment Plans - TBC	Investment Plans - TBC	Health System Plan Implementation Plan (Update)	Investment Plans - TBC	Investment Plans - TBC	Investment Plans - TBC
	Pro-Equity Implementation	Living Life Well – A Strategy for mental health and addiction 2019-2025	Toe timata le upega Pacific Action Plan 2017–2020 Update	Taurite Ora Action Plan Update	Sub Regional Disability Strategy 2017-2022 Update	Pro-Equity Update	Living Life Well – A Strategy for mental health and addiction 2019-2025	Toe timata le upega Pacific Action Plan 2017–2020 Update	Taurite Ora Action Plan Update	Sub Regional Disability Strategy 2017-2022 Update
Health System Investment and Prioritisation			Indicative Budget 2020/21 - Whole of System Investment		Final Budget 2020/21	Investment Progress Update		Investment Progress Update		Investment Progress Update
		2DHB LTIP Update		First Draft 2DHB LTIP			Final Draft 2DHB LTIP			
Health System Integrated Performance Reporting	Maternity, Child & Youth Integrated Performance	Urgent and Planned Care Integrated Performance	Long-Term Conditions, Complex Care, Older People Integrated Performance	Locality Perspective; Kapiti, Wellington, Porirua Integrated Performance		Maternity, Child & Youth Integrated Performance	Urgent and Planned Care Integrated Performance	Long-Term Conditions, Complex Care, Older People Integrated Performance	Locality Perspective; Kapiti, Wellington, Porirua Integrated Performance	
System and Service Planning	Non-Financial MoH Reporting (Q1 Reporting) 'Delayed' as HSC is not meeting in December or January 2019	Non-Financial MoH Reporting (Q2 Reporting)			Non-Financial MoH Reporting (Q3 Reporting)			Non-Financial MoH Reporting (Q4 Reporting)		
	Minister's Letter of Expectations		First Draft Annual Plan 2020/21		Final Draft Annual Plan 2020/21			Annual Report 2019/20		
			Citizen's Health Council Plan						Citizen's Health Council Plan	
					Final Draft Regional Services Plan					

To be transferred to the Finance, Risk and Audit Committee and Board

Provider Performance - Efficiency; Outputs; Safety.	Provider Health System Performance (HHS + SIP)	Mental Health System Performance (MHAIDS + SIP)	Provider Health System Performance (HHS + SIP)	Mental Health System Performance (MHAIDS + SIP)	Provider Health System Performance (HHS + SIP)	Mental Health System Performance (MHAIDS + SIP)	Provider Health System Performance (HHS + SIP)	Mental Health System Performance (MHAIDS + SIP)	Provider Health System Performance (HHS + SIP)	Mental Health System Performance (MHAIDS + SIP)
	Community Providers - Primary Health Organisations	3 DHB ICT	Patient Safety	Community Providers - Clinical Services (Pharmacy and Labs)	Community Providers - Healthcare Homes	Community Providers - Primary Health Organisations	3 DHB ICT	Patient Safety	Community Providers - Clinical Services (Pharmacy and Labs)	Community Providers - Healthcare Homes
		SIP Activity		Regional Public Health (RPH)			SIP Activity		Regional Public Health (RPH)	

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PUBLIC

Date	**HEALTH SYSTEM COMMITTEE DISCUSSION**
Author	Director, Strategy Innovation & Performance – Rachel Haggerty
Endorsed by	Chief Executive – Fionnagh Dougan
Subject	Localities Update - Kāpiti Health Advisory Committee (KHAG) Work Programme 2019/20
Appendix	Appendix One. KHAG 2019/20 Work Programme Appendix Two. Members of Kāpiti Health Advisory Committee (KHAG)

RECOMMENDATIONS

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

1) **Note** that the Kāpiti Health Advisory Group works closely with CCDHB to improve access to health services for the Kāpiti Coast community.
2) **Note** the work programme of the Kāpiti Heath Advisory Group for 2019/20.

Health System Plan Outcomes		**Stewardship**	
Wellbeing Strengthen our communities, families and whānau so they can be well	**X**	**Quality & Safety** Quality & safety of service delivery	
People Centred Make it easier for people to manage their own health needs	**X**	**Service Performance** Report on service performance.	**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	**X**	**Government Priority** Equity; Child Wellbeing; Mental Health; Primary Care; Water Safety	**X**

1 INTRODUCTION

1.1 Purpose

The purpose of this paper is to brief the Health System Committee (HSC), on the Kāpiti Health Advisory Group (KHAG) and provide an update on the work programme for 2019/20.

2 BACKGROUND

The KHAG's objective is to improve access to health services for the Kāpiti Coast community. KHAG, is a long standing mayoral committee established by Mayor Gurunathan, in response to perceived lack of

responsiveness from CCDHB to the health needs of the Kāpiti community. The group actively lobbied for a hospital based service on the Coast.

Mayor Gurunathan has an active interest in KHAG, this is primarily based on KHAG's partnership with CCDHB and opportunities to co-design solutions for health services for Kāpiti residents.

Led by Chairperson Kathy Spiers and Co – Chair Adrian Gregory, membership of KHAG comprises of community members/leaders with a wide networks of 'partners' who support community engagement activities. Please refer to Appendix One for a description of the members' contribution to KHAG.

KHAG present to the Health System Committee on an intermittent basis to provide an update on progress and matters of shared interest. This paper has been developed in conjunction with KHAG.

Since November 2017, CCDHB has been working in a more intensified way with KHAG and the Kāpiti community to better understand and address health priorities in the locality. The collaborative approach has led to an integrated work programme designed to improve service coordination, provide higher quality of care and reduced demand for acute services, enabling services closer to home.

CCDHB and KHAG have collaborated using data, analytics and insights from community engagement to identify the following five priority areas:

1. Access to Services (including Transport)
2. Urgent Care (otherwise referred to as Accident and Out of Hours)
3. Mental Health Services
4. Care of Older People
5. Care for people with Disabilities

The Localities, Integrated Care and Mental Health teams within Strategy, Innovation and Performance have responsibility for implementing aspects of the work programme.

3 PROGRESS TO DATE

CCDHB has invested $20,000 supporting KHAG with community activation to provide CCDHB with insights into the health and wellbeing of the Kāpiti community. This has been extremely well received.

The Community Acute Response Services (CARS) an investment of approximately $200,000 has been completed with new services delivered for gastroenteritis management, rehydration and asthma, to enable GP-delivered non-complex case management, with additional subsidies available to treat Maori and Pacific patients.

This investment is also supporting ambulance redirection to GP services instead of secondary and/or Wellington-based services, to support care closer to home. Since going live in May 2019, there have been approximately 100 (75 percent are over 65 years of age) successful ambulance directions to GP services in Kāpiti.

The recent Primary Mental Health RFP process which was run by the Ministry of Health will, if successful, provide a new model of primary mental health and addictions care and support across the entire district including the Kāpiti Coast. The Piki programme which provides mental health support to young people 18-25 years old is also available in Kāpiti.

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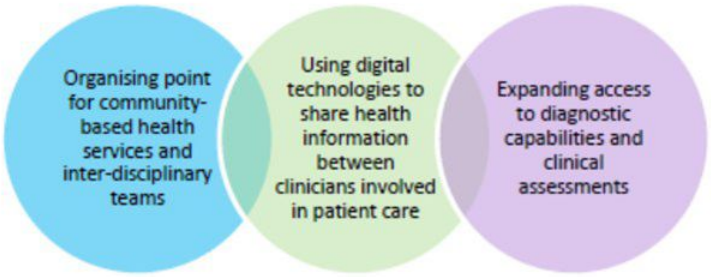
4 THE KĀPITI HEALTH ADVISORY GROUP (KHAG) WORK PROGRAMME 2019/20

KHAG will provide an update to HSC in Nov 2019 on their work programme. The KHAG work programme addresses health and wellbeing issues. The CCDHB contribution to this wider work programme is reflected in Attachment One.

5 FUTURE OPPORTUNITIES

Future opportunities include the continuation of KHAG's advice on aged friendly and end of life care strategies; providing input to Community Health Network development and co-design of services.

As illustrated in the following diagram, Community Health Networks (CHN) are designed to support services in the community. These services are supported by health professionals from disciplines. The use of telehealth for remote assessment and diagnosis would contribute towards the provision of specialist services at the point of care. In addition to 'specialist point of care' expanding access to community diagnostic services will enhance the provision of services closer to home. KHAG will play an important role in the development of the Kāpiti CHN, due to its strong connection to, and representation, of community.



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6 APPENDIX ONE: KĀPITI HEALTH ADVISORY WORK PROGRAMME 2019/20

	Priorities	Who / Teams	By when
	**Access to Services (Transport)** • Improve access to Outpatient services by booking appointments for residents at accessible times, from 10 am – 3 pm. • Development of telehealth service for improved assessment and service coordination, minimising the need to travel to Wellington Regional Hospital. • Provision of 'wheelchair friendly' access for increased utilisation of transport services to Wellington Regional Hospital • Input and advise on Planned Care Strategy • Continued support and service provision of the Otaki MOU to improve access to specialist services for Otaki residents.	• Patient Administration Services (PAS) • Integrated Care Community (ICC) • CCDHB Communications team • Child, Youth and Localities (CYL) team	April 2020
	**Urgent Care Services** • Community Activation Response Service (CARS) for improved GPs management of complex care patients. • Ambulance redirection to GPs services in Kāpiti • Supporting enhanced capability and capacity of Kāpiti Primary Care via Health Care Homes • Development of Community Health Network (CHN) infrastructure; shared care plans, telehealth, Community Radiology	• Integrated Care Collaborative (ICC) • CCDHB, PHO and WFA Communications team • Child, Youth and Localities team • Tū Ora Compass, GPs • Wellington Free Ambulance (WFA) • (KHAG) consumer reps on ICC steering group	Nov 2019 (first update) May 2020 (second update)
	**Mental Health Services** • Implement Living Life Well and align with the direction set by He Ara Oranga • Improve response to suicide presentation and postvention • KHAG representation on the suicide prevention working group for men in Kāpiti	• Mental Health (SIP) • Child, Youth and Localities team (SIP) • Tū Ora Compass, GPs • Wellington Free Ambulance • CCDHB, PHO and WFA Communications team • KHAG's representation in Working Group	Feb 2020 (first update) May 2020 (second update)
	**Care for Older People (Healthy Ageing)** • Community based, services which support ageing in place, palliative and end of life care for Kāpiti • Community pharmacist facilitation which coordinates appropriate age and condition prescribing for frailty • Risk stratification and proactive year of care planning by Health Care Home for complex patients, including end of life services.	• Integrated Care Collaborative (ICC) • Primary Care and Long Term Conditions (SIP) • CCDHB, PHO and WFA Communications team • Child, Youth and Localities team (SIP) • Tū Ora Compass, GPs	Feb 2020 (first update) May 2020

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	• Support with Age Residential Care Services (ARC)	• Wellington Free Ambulance (WFA) • Consumer representation on ICC steering group	(second update)
	**People with Disabilities** • Improved access, in particular transportation • Improve quality of care through working with Home and Community Support Services (HCSS) • Disability Community Engagement Forum March 2020 • Application of the 'disability lens' in other healthcare initiatives within Kāpiti • Application of accessibility tools including the health passport	• Disability SIP Team • Sub Regional Disability Advisory Group • CCDHB Communications team • Child, Youth and Localities team (SIP) • Tū Ora Compass, GPs • Members of HSC	March 2020
	**Community Activation** • Community Asset Mapping, for understanding spheres of influence for the individuals in communities and institutions. • KHAG's leadership and coordination to actively engage communities for self-care and community activation. • Development of service directory of health services in Kāpiti	• Kāpiti Health Advisory Group (KHAG) • Kāpiti Coast District Council (KCDC) • Child, Youth and Localities team (SIP) • Identified community assets	Nov 2019 May 2019
	**Review and Planning** • Review of KHAG priorities, seek input from Mayor and KCDC. • Plan and confirm session topics and timeframes for 20/21.	• Kāpiti Health Advisory Group • Child, Youth and Localities team	April 2020

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7 APPENDIX TWO: MEMBERS OF KHAG

No	Name	**Description**
1	Kathy Spiers (Chair)	Kathy has resided in Kāpiti for over 50 years and is actively involved in local body politics, with a number of interest areas including Age Concern and Grey Power. Kathy is very committed to meaningful engagement with the DHB and has been crucial in building a strong working relationship between Mayor Gurunathan, KHAG and the DHB.
2	Adrian Gregory (Co-Chair)	Adrian is an active Otaki resident, Chair of the Otaki Health, Wellbeing Group and the Kāpiti Mayor Strategy Group. With over 20 years' experience in health, Adrian is active in the Kāpiti community, having established Helix4 Consulting to provide strategic planning, leadership and management services to SME businesses and organisations across health, education, government and community sectors. Adrian has held senior roles with Wellington Regional School Dental Service (out of Hutt Valley DHB), Wellington regional economic development agency, and is Board Chair, Birthright New Zealand Charitable Trust. Adrian is working closely with the DHB to map current community stakeholders, influencers and opportunities to activate and lead change in Kāpiti.
4	Iride McCloy	Iride, a former Kāpiti Mayor, Waikanae resident, is a consumer representative on the CCDHB Acute and Community Care Steering Group (ACC), CCDHB. Iride is a JP and a member of the Institute of Directors, NZ Institute of Travel and Tourism, and the Kāpiti Chamber of Commerce. Iride is involved in many organisations in Kāpiti and has more than 35 years' experience in senior management and owner operator roles. Iride established the Waikanae Advisory Group.
5	Sue Emirali	Sue is a member of the Health Systems Committee and Interim Chair of the Sub Regional Disability Advisory Group 3DHB. A resident of Paraparaumu for 11 years, Sue is involved in local government as Chair of the KCDC Disability Advisory Group. Sue's interest areas and key roles include being President Retina NZ, Member of Eye Health Coalition, Board Member of Wellable (Wellington and Districts Disability Centres) and Disabilities Lead for the Kāpiti Health Advisory Group. Sue is committed to working with the DHB and has been crucial in building a strong working relationship between KHAG, the disability community and the DHB.
6	Sandra Forsyth	Sandra is the vice chair for Well Me. Other networks include, peer support role with Grey Power, Arthritis New Zealand. An active member of the community, other strong community affiliations include Age Concern, Stroke Central, MS Wellington, Scleroderma NZ, Parkinsons, Dementia NZ, NORD, Crohns & Colitis NZ, UK, Cancer Society, Leukaemia & Blood Cancer Foundation NZ, Neurological Foundation NZ.
7	Sandra Daly	Sandra Daly was Chairperson of the Kāpiti Citizens Advice Bureau. She is now retired and is a member of the Kāpiti Mayor Strategy Group, Soroptimists and was a Support Worker for Kāpiti Victim Support from 2008 to 2019. With extensive Project Management experience, Sandra's role is to support KHAG with Project Management capabilities.
8	Don Hunn	Don Hunn was State Services Commissioner from 1987-97. Since 1997, Don has been consulting in public sector management in NZ and overseas. Don is presently under contract for projects in South Australia, Tonga and Niue as well as NZ. Don has extensive community and sector networks based on past roles including: Chair of NZ on Air, National Advisory Panel, Department of Building and Housing, St Johns, Otaki Health Centre, KCDC Water Supply Advisory Group, KCDC Water Meter Technical Advisory Group, and Wellington Free Ambulance. Don is a member of the Kāpiti Mayor Strategy Group and is a founding Chair for Friends of the Otaki River. Current NGO involvement includes, member of IHC Board, RNZ Ballet Board and Chair of Kāpiti Coast Recreational Turf Trust. A wealth of experience, Don steers KHAG on matters of strategy.
9	Leonie Murch	Leonie is a Manager for Birthright Kāpiti. Leonie has strong links with IDEA services and brings to KHAG experience in family harm violence matters. Leonie is also a member of the LMG, – strengthening families management board.

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10	Helen Anderson	Helen is a member of the Kāpiti Mayor Strategy Group and is a member of Cancer Society of New Zealand, both locally i.e. the Kāpiti Branch and the Wellington office. She is a retired Senior Executive of Health. In addition, Helen is active with the Wellington Branch of the Brain Injury Association of New Zealand
11	Vanessa Simpson	Vanessa is a relationship manager of the Wellington Free Ambulance and is a CCDHB's Board member. Vanessa has strong affiliations with St John NZ, Fire and Emergency NZ and Good Sam – National Governance Group. Vanessa is actively involved with DHB's projects, in particular the Urgent and After Hours and Telehealth Projects.
12	Ken Whelan	Ken has extensive appointments to senior health management roles including CEs of DHBs, NZ hospitals in Australia and is a member of the Kāpiti Mayor Strategy Group.
13	Chris Gerretzen	Chris is a Maori representative and a Master Carver and member from Otaki's Te Wānanga o Raukawa and was appointed by Te Whakaminenga o Kāpiti which is a council committee who represent the three iwi being Te Ati Awa ki Whakarongotai, Nga hapū o Otaki and Ngati Toa Rangatira. Chris is also on the Board of Hora Te Pai.
14	Linda Allen	Linda Allen is the Pasifika representative. Linda's experience is working in the community for over 30 years, with 16 years of managerial experience. Linda is a member of the New Zealand Association of Counsellors for the last 23 years. Over the 30 years' time span, Linda has managed multi-cultural social service centres, supporting high risk families. Linda's professional work experience has been strongly focused on the management and development of holistic health programmes to enable the well-being of individuals and families. DV and Child Protection prevention is an area Linda specialises in. Linda is currently working as a consultant who facilitates events for both the community and government.
15	Marilyn Stevens	Marilyn is an active Member of the Otaki Community Board and is heavily involved with Rotary. Marilyn has also recently been appointed Chair of the Waikanae Health Advocacy Group.

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6 November 2019	**HEALTH SYSTEM COMMITTEE DISCUSSION**
Author	Director, Strategy, Innovation & Performance – Rachel Haggerty
Endorsed by	Chief Executive – Fionnagh Dougan
Subject	**Equity - CCDHB Pacific Population Health Profile**

RECOMMENDATIONS

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

1) **Note** that CCDHB has completed it's first Pacific population health profile.
2) **Note** the aim of the Pacific population health profile was to:
   - build a robust evidence base defining issues in relation to Pacific health equity and which would support health services to identify areas for Pacific health improvement; and
   - inform localities planning and service integration activities for Pacific populations across the wider Wellington region.
3) **Note** the key findings of the report which will be discussed briefly by Dr Debbie Ryan at the HSC meeting.
4) **Approve** the release of this report to external stakeholders.

APPENDICES

1. **PROFILE OF DR DEBBIE RYAN**

Health System Plan Outcomes		**Stewardship**	
Wellbeing Strengthen our communities, families and whānau so they can be well	**X**	**Quality & Safety** Quality & safety of service delivery	
People Centred Make it easier for people to manage their own health needs	**X**	**Service Performance** Report on service performance.	**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	**X**	**Government Priority** Equity; Child Wellbeing; Mental Health; Primary Care; Water Safety	**X**

1 PURPOSE

The purpose of this paper is to brief the Health System Committee (HSC), on the CCDHB Pacific population health profile and to seek approval for the report to be released.

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2 BACKGROUND

In May 2019 as part of a joint initiative between the CCDHB Localities team and the Pacific Directorate, Pacific Perspectives Limited was contracted to prepare the inaugural Pacific population health profile describing the health needs and health service utilisation of Pacific peoples in CCDHB and in the wider Wellington region. The aim of this population health profile was to:

- build a robust evidence base for Pacific health equity and which would support health services to identify areas for Pacific health improvement; and
- inform localities planning and service integration activities for Pacific populations across the wider Wellington region.

The profile also establishes a baseline of Pacific health data that can be built on as new information becomes available (for example, Statistics New Zealand has indicated that ethnicity data from the 2018 Census will be released in March 2020).

Dr Debbie Ryan who is the Principal of Pacific Perspectives will attend the HSC to give a high level presentation of the report findings. Dr Ryan's profile is attached as Appendix One.

3 KEY FINDINGS

Key findings from the Pacific population health profile are summarised below.

*There is clustering of Pacific peoples resident in the Wellington region, which may enable localities-based approaches to healthcare service delivery and implementation***.**

There are approximately 33,000 Pacific peoples living in the Wellington region, just over 22,000 of whom reside in the CCDHB catchment area. There are large concentrations of Pacific communities in the urban core of the region, around the cities of Wellington, Lower Hutt and Porirua. Among Pacific peoples resident in the CCDHB region, almost 60% live in Porirua (the majority of whom reside in the Waitangirua-Titahi Bay arc) and 40% live in Wellington City (where there are significant concentrations of Pacific peoples in the southern and south eastern suburbs of Newtown, Kilbirnie and Strathmore Park). Among Pacific peoples resident outside of CCDHB, there are large Pacific communities in the Lower Hutt Valley (particularly in the suburbs of Naenae and Taita) and in Wainuiomata.

The Pacific population in Wellington is diverse and unique. Particular attention should be given to addressing the specific needs of Pacific ethnic groups.

The composition of the Pacific population in Wellington differs to that seen nationally, with 62% of Pacific people in the Wellington region identifying as Samoan (compared to 49% nationally), 20% as Cook Island Māori (21% nationally), 10% as Tokelauan (2% nationally) and 7% as Tongan (20% nationally). More than half of the Tokelauan population in New Zealand resides in the Wellington region.

The distribution of selected social determinants of health among Pacific peoples in Wellington reflects that seen among Pacific peoples nationally. These determinants can play an important role in access to and use of healthcare services. Understanding this role can help services better respond to the social and health literacy needs of different population groups.

Approximately one-third of Pacific peoples in Wellington were born overseas, 10% report that they do not speak English and 40% speak Samoan. Compared to the total population in Wellington, Pacific peoples are more likely to report religious affiliation (77% versus 50%), but less likely to report having advanced technical qualifications (18% versus 41%) or engagement in the workforce (58% versus 62%). Home ownership is also much lower among Pacific peoples (21%) compared to the total Wellington population (48%). The cumulative effect of these inequities can be seen in the reported median individual net worth of Pacific peoples, which is $12,000 - nine times lower than that of Europeans, which is $114,000.

There are marked and long-standing inequities in health outcomes between Pacific and non-Māori non-Pacific peoples. These inequities are driven by a higher prevalence of risk factors and long-term conditions and poorer access to primary health care.

At CCDHB, life expectancy for Pacific peoples is estimated to be eight years lower than for non-Māori non-Pacific peoples (76 versus 84 years). This gap in life expectancy has not narrowed over the last 10 years. The amenable mortality rate (deaths that could potentially have been avoided) is three times higher for Pacific peoples at CCDHB than for non-Māori non-Pacific peoples (189 versus 63 per 100,000). Rates of diabetes, excess body weight and smoking are all significantly higher, leading to a much higher disease burden and health need among Pacific peoples.

While rates of enrolment in Primary Health Organisations remain high, there is still significant unmet need for primary health care among Pacific peoples, as shown by high rates of ambulatory sensitive hospitalisations and self-reported unmet need from the New Zealand Health survey. Despite some success nationally, Pacific children at CCDHB are less likely to be fully immunised and to receive the HPV vaccination than non-Māori non-Pacific children.

While Pacific peoples at CCDHB have higher rates of chronic diseases, they have lower rates of outpatient service use than non-Pacific peoples, but higher use of emergency department and inpatient services, both of which are growing faster among Pacific compared to non-Pacific peoples.

4 CONCLUSION

Taken together, these statistics paint a picture of a health system that is not adequately responding to the needs of its Pacific populations. The detailed analysis provided in this Pacific population health profile enables a better understanding of Pacific peoples in the CCDHB and wider Wellington region. It is intended to support the development of strategies and services that are more responsive to Pacific populations. These initiatives will, in turn, contribute to Pacific health equity.

As one of the intents of this report is to build a robust evidence base for Pacific health equity and which to support health services to identify areas for Pacific health improvement, it is recommended that this report is approved for release.

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5 APPENDIX ONE: PROFILE FOR DR DEBBIE RYAN

Debbie Ryan is the principal of Pacific Perspectives, a policy and research consultancy specialising in Pacific health. Debbie has extensive experience in the health sector as a general practitioner, manager, senior public servant and researcher.

She has qualifications in medicine, public management and company direction. Her research interest over the past 10 years has been the evidence for policy and practice to improve health and social outcomes for Pacific people in Aotearoa, New Zealand.

Debbie has a track record of working with Pacific communities and has contributed over three decades to Pacific workforce development and thought leadership in Pacific health.

Debbie's qualifications and memberships include:

- MBChB, Masters in Public Management (Distinction), currently completing a PhD through Victoria University of Wellington
- Member of the New Zealand Order of Merit
- Certificate in Company Direction, Institute of Directors in NZ
- Institute of Directors in NZ Member
- Institute of Public Administration NZ Member
- Royal New Zealand College of General Practitioners Member
- Recipient Pasifika Medical Association Life Award

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Date: 5 November 2019	**HEALTH SYSTEM COMMITTEE DISCUSSION**
Author	Executive Director, Strategy Innovation & Performance – Rachel Haggerty
Endorsed by	Chief Executive – Fionnagh Dougan
Subject	**Update on Gender Affirming Healthcare at CCDHB**

RECOMMENDATIONS

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

(a) **Note** the Sex and Gender Diverse (SGD) Working Group work which sits under the Youth ICC Steering Group and is supported by Strategy, Innovation & Performance.

(b) **Note** the development of the primary care led prescribing model for hormone therapy that has been prototyped in three practises.

(c) **Note** support from SGD working group for the next investment to be in expansion of the number of primary care sites involved in gender affirming healthcare including mental health support, information and advice to the community.

(d) **Note** the SGD working group are developing a strategy to support the work programme in line with international best practice.

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.	
Equity Support equal health outcomes for all communities	x	Health System Performance Report on health system performance	X
Prevention Delay the onset, and reduce the duration and complexity, of long-term health conditions	x	Planning Processes and Compliance Planning processes and compliance with legislation or policy.	X
Specialist Services Ensure expert specialist services are available to help improve people's health	x	Government Priority Equity; Child Wellbeing; Mental Health; Primary Care; Water Safety	X

1. INTRODUCTION

1.1 Purpose

The purpose of this paper is to inform the Committee of progress on Gender Affirming Healthcare at CCDHB. This work is supported by the Sex and Gender Diverse Working Group.

2. BACKGROUND

The Sex and Gender Diverse (SGD) Working Group work is a group which sits under the Youth ICC Steering Group. Members include community providers of Gender Diverse Healthcare and Support, people with

lived experience and DHB clinicians who support the delivery of gender affirming health care services[1]. The group's mandate is to improve pathways with a future focus for the SGD community within CCDHB.

The first SGD working group meeting was on 4 August 2015. It was formed because there was concern about major service gaps, vulnerability and unmet need of gender diverse people, as well as distress that was felt by the gender diverse community at the impending retirement of John Delahunt, the endocrinologist who supported the service.

The Group now meets regularly, has wide participation and holds public forum. The SGD working group recently held a successful Community Meeting where members of the working group who are involved in services fed back to the community about what pathways are available and how people who are considering gender affirming healthcare can access services.

The Working Group has supported CCDHB in making positive progress to improve the services offered and the pathways to access care.

3. CURRENT PATHWAYS AVAILABLE

Services available throughout the CCDHB catchment include:

3.1 GP Consultation

GPs can readily provide information for people questioning their gender identity and offer them a range options and referral pathways depending on their needs. Some GPs can also prescribe hormones or hormone blockers.

3.2 Readiness Assessments for Hormone Therapy

CCDHB provide readiness assessments for hormone therapy. This is to ensure that people have all of the support they need for their transition and assesses for any other mental health needs. This may be done through CAMHS and then Paediatric Endocrinology for under 16 year olds and the Endocrinology Department for over 16 year olds. This is in line with best practice as required by the agreed standard of care process which is the current CCDHB model.

3.3 Prescribing Hormone Therapy in Secondary Services and Primary Care

Prescription of Hormone therapy can be delivered in primary and secondary care. For under 16 year olds prescribing is through the Paediatric Endocrinology Department. For over 16 year olds prescribing is through the Endocrine Department but also in primary care practices that are supported by the Endocrine Department. This primary care led model is the preferred standard of practice for prescribing Hormone Therapy and is currently available in three primary care practices.

3.4 Community Support Services

There are a number of support services for the SGD community. This includes Gender Minorities Aotearoa, OuterSpaces and InsideOUT as well as others. They offer a range of support services including binder exchange, hair removal, support groups, facebook for parents amongst other things. CCDHB do not hold any contracts with these groups.

[1] Gender Affirming Healthcare services include services available in primary and secondary care.

3.5 Physiotherapy

Willis Street Physiotherapy offer three fully funded sessions to help with a range of skills including breathing, posture, pain, binding, exercising, strengthening, surgical prep and recovery. This programme has proven to be incredibly useful and supportive of the gender diverse community. This initiative is funded as a social enterprise and receives no DHB funding.

3.6 Speech and Language Therapy

CCDHB have a publically funded pathway with access criteria for feminising voice therapy. The Speech and Language Therapy team have been working with the SGD working group to ensure the pathway enables those most in need to access the service. This has been developed and will be published on the 3DHealthPathway shortly. There is also planning for group sessions to widen the scope and availability of the service.

Masculinising speech and language therapy is sought much less often and referrals are assessed on a case by case basis. There is an intention to create a pathway for accessing masculinising voice therapy in future.

3.7 Hysterectomy and Orchidectomy

CCDHB offer publically funded surgery for Hysterectomy and Orchidectomy. These surgeries require a readiness assessment which is not part of the currently funded pathway of care. Once a readiness assessment has been completed at the expense of the individual, the surgery is then publically funded and available within CCDHB. The development of a publically funded pathway for readiness assessments for surgery is a focus of the SGD working group.

3.8 Access to the High Cost Treatment Pool for Gender Reassignment Surgery

CCDHB have now implemented an agreed process which allows GPs to recommend referral to the High Cost Treatment Pool (HCTP) for Gender Reassignment Surgery (GRS). This supports the DHB's primary care led model of care.

4. CURRENT WORK IN DEVELOPING NEW PATHWAYS AND RECENT SUCCESSES

The SGD working group has worked with a range of services and organisations to achieve more equitable outcomes for the SGD community. Some of the group's recent successes are:

4.1 Prototyping a primary care led model of care

Many DHBs in New Zealand offer gender affirming healthcare through secondary services. This requires wait lists and multiple visits to secondary services. The pathways to access hormone therapy can be long and disjointed.

The most enduring relationship we have in healthcare is the one we have with our GP. For GPs to have a constant oversight and a continued relationship with people who are considering gender affirming healthcare is aligned to the DHB's vision to be able to access care in their own community safely and equitably.

CCDHB have prototyped a primary care led model of care for gender affirming healthcare. Gender affirming hormone therapy can now be prescribed in three GP practices. The purpose of the primary care led model is simply that there is no need for people to continually access a secondary service to begin hormone treatment once they have completed a readiness assessment.

Because the primary led model of care is only available in three practises in Capital & Coast, patients may have different experiences, including the number of visits required prior to starting hormones. This will depend on whether they are seen in one of the specialist clinics or one of the three primary care sites.

4.2 Access to the High Cost Treatment Pool for Gender Reassignment Surgery

A recent success of the SGD working group has been to establish a referral pathway for people wishing to be assessed via the HCTP for GRS. Previously there had been no pathway for accessing the HCTP for CCDHB as the Ministry requirement is for the referral to come from a specialist. The SGD working group have agreed a new pathway with the Ministry of Health where primary care will recommend that their patient is referred to the HCTP for GRS and the Chief Medical Officer from CCDHB will sign off the form which is sent to the Ministry of Health who will add the person to the HCTP list for GRS. This aligns with the focus on promoting a primary care led model of care.

Since the development of this pathway to access the HCTP for GRS CCDHB have seen a large number of people referred to the HCTP list for GRS and the Ministry noted that in the first month after the agreed pathway was put in place 85% of referrals to the national list were from CCDHB.

4.3 Speech and Language Therapy

The published pathway and referral criteria described above will be live on 3DHealthPathway in the coming weeks. This will inform the wider medical community of the ability to refer patients to the service for feminising or masculinising voice therapy.

4.4 Gender Affirming Mastectomy

Strategy, Innovation and Performance (SIP) are currently working with the SGD working group and the Operations Manager for Surgery and the Clinical Lead for Breast Surgery to establish gender affirming mastectomy. CCDHB have a new breast surgeon who is working up to a full time position in January 2020. One of the focuses of the new surgeon will be benign mastectomy. The surgeon also has experience in gender affirming mastectomy and the department are very willing to work toward establishing a pathway. The group last met in September 2019 and agreed to begin to draft a pathway and criteria for gender affirming mastectomy. The group will meet again on 19 November 2019 to continue to develop the pathway. The new surgeon will also attend this meeting.

4.5 Surgical Readiness assessments for Hysterectomy and Orchidectomy

A gap in service has been recognised in readiness assessments for surgery for Hysterectomy and Orchidectomy. This is a new area of focus for the SGD working group to meet with Clinical Leaders to discuss the development of a publically funded pathway to obtain readiness assessments for people wishing to access Hysterectomy or Orchiectomy at CCDHB. SIP and members of the SGD working group will meet with Clinical Leaders of Surgical services to discuss the gap in the service and what is required to develop a publically funded readiness assessment.

5. NEXT SERVICE EXTENSION

The SGD working group will continue to work toward establishing pathways and improving access to gender affirming healthcare at CCDHB. The group have enabled many positive changes for the SGD community and will continue to work with the DHB to recognise gaps and find solutions to resolve these.

The SGD working group will continue to advocate for:

- The expansion of the number of primary care sites involved in gender affirming healthcare from three to five or six and to ensure that practice at these sites aligns with contemporary best practice

- supporting the SGD community including mental health support, information and advice to the community.

An investment proposal has been developed and is supported by the SGD working group for investment in 2020/21.

6. FUTURE FOCUS

The United Nations have recently (May 2019) agreed to a change in the terminology in the international classification of diseases (ICD-11). The update has reclassified gender identity disorder, or identifying as transgender, in terms of sexuality, not a “mental disorder”. The reclassification will “reduce the stigma” while ensuring “access to necessary health interventions”. The SGD working group will start to bring this reclassification in to their approach and apply it to the current and future pathways and access work.

The Ministry of Health are considering changes to access to the HCTP for GRS and how this can be streamlined to better meet the needs of people wanting to access GRS surgery. The current system for accessing the HCTP for GRS is that people are placed on a list for assessment without a prioritisation component for readiness. There are active discussions at the Ministry of Health about how access to the surgery can be better utilised as there is now dedicated funding and a New Zealand based surgeon. SIP have an initial meeting with the Ministry of Health to understand the direction and how CCDHB can champion better outcomes for access to GRS surgery beyond the current system.

Finally, the SGD working group are developing a strategy to support the work programme in line with international best practice. This will bring together the current and changing landscape for gender affirming healthcare and support ongoing changes to advocate for gender affirming healthcare.

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Date 13 November 2019	**HEALTH SYSTEM COMMITTEE DISCUSSION**
Authors	Director, Strategy Innovation & Performance – Rachel Haggerty
Endorsed by	Chief Executive – Fionnagh Dougan
Subject	**Investment and performance – Core primary care services**

RECOMMENDATIONS

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

(a) **Note** in 2018/19 CCDHB invested $67 million in core primary care services provided under the PHO Services Agreement. This is forecast to increase to $72 million in 2019/20 as Government initiatives implemented in December 2018 are funded for a full financial year.

(b) **Note** this reporting is part of our process for understanding how our investments in core primary care services are working for our population including equity (or not) of access to health services and outcomes achieved.

APPENDICES

1. Core Primary Care Performance Dashboard

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	**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		**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

This paper updates the Health System Committee (HSC) on the performance of investments in core primary care services provided for the CCDHB population under the nationally negotiated Primary Health Organisation services (PHOs) agreement.

2. INTRODUCTION

2.1 Primary Care in CCDHB

Primary health organisations (PHOs) ensure the provision of essential primary health care services, mostly through general practices, to their enrolled population. The performance of PHOs is a critical element of ensuring performance of the health system. The primary care performance dashboard (Appendix 1) provides a snapshot of the performance of our investment in these services delivered through PHOs.

We have three PHOs in CCDHB:

- Ora Toa PHO, our Iwi-owned primary health care provider who deliver services predominantly in the Porirua basin through five general practices. They have 17,840 people enrolled; 6,240 people who identify as Māori, 6,300 who identify as Pacific, and 5,300 non-Māori non-Pacific.
- Karori Medical Centre (KMC), part of Cosine Primary Health Network with Ropata Medical Centre in the Hutt Valley. They have 14,810 people enrolled; 740 people who identify as Māori, 450 who identify as Pacific, and 13,620 non-Māori non-Pacific.
- Tū Ora Compass Health, our largest PHO with 53 practices located across Kāpiti, Porirua, and Wellington. 282,200 people are enrolled with Tū Ora Compass Health; 27,320 people who identify as Māori, 16,340 who identify as Pacific, and 238,540 non-Māori non-Pacific.

Funding for core primary health care services delivered in general practice is provided through the nationally negotiated PHO Services Agreement. This includes VLCA funding for our twelve VLCA practices, five in Ora Toa PHO and seven in Tū Ora Compass Health.

2.2 Funding

In 2018/19, CCDHB invested $67 million in core primary care services provided under the PHO Services Agreement. This investment purchases services including doctor and nurse visits, immunisation, health promotion, support for people with long term conditions (care plus), management services, and provides performance-based funding.

Primary care is not fully funded and attracts a co-payment per visit from the patient. Specific Government initiatives are targeted to removing the cost barrier and improve access to primary care. From 1 December 2018 additional funding was provided to:

- Expand the zero fees for children scheme to include 13 year olds (zero fees for under 14s), and
- Provide low-cost[1] visits for Community Services Card holders and their dependents.

Investment in core primary care services is forecast to increase to $72 million in 2019/20 (dashboard panel A) as these initiatives implemented in December 2018 are funded for a full financial year.

Board members are aware of the challenges with VLCA funding as outlined by Dr Bryan Betty at the last Board meeting.

3. INCREASING ACCESS TO PRIMARY HEALTH CARE

41% of people enrolled with a CCDHB general practice are able to access primary health care at low- or no-cost. All general practices in CCDHB offer zero fees for children under 14 years of age and 95% offer low-cost fees for community services card holders and their dependents. We also have twelve very-low cost access (VLCA) general practices who receive additional funding to provide service to high needs populations at reduced cost to the patient.

Today in CCDHB:

- 52,200 children are able to access free general practice visits;
- 46,950 community services card holders and their dependents are able to access primary health care at low-cost rates; and
- an additional 24,560 people are enrolled in VLCA practices.

This has increased 12% from 89,340 people who were able to access low- or no-cost general practice visits this time last year through the zero fees for children under 13 scheme and enrolment in VLCA practices.

Our understanding of who is enrolled with primary care services and eligible for subsidised visits is derived from the National Enrolment Service (NES) which provides up-to-date enrolment and identity data[2].

[1] $13 for 14-17 year olds and $19 for those aged 18 years and over
[2] https://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/national-enrolment-service

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4. ENROLMENT WITH PRIMARY CARE PROVIDERS

93% of CCDHB's population[3] are enrolled with a PHO either in our DHB catchment or elsewhere, however coverage is not consistent across ethnicity groups (dashboard panel B). According to Statistics New Zealand population projections all Pacific peoples living in CCDHB are enrolled with a PHO, in contrast with 88% of Māori and 93% of non-Māori non-Pacific peoples.

Implementation of the NES in April 2019 has improved the accuracy of demographic information about our PHO enrolled population and consequently our enrolment coverage for Māori and Pacific populations. The NES links to the National Health Index (NHI) whereas previously enrolment information was obtained from Practice Management System (PMS) records. The implementation of NES resulted in an initial decrease in Māori and Pacific enrolment coverage as ethnicity information held for 1,600 of our people was different across systems. Once this was recognised, we worked with our PHOs to identify people whose recorded ethnicity had changed, establish which ethnicity(s) the person self-identifies as, and update the NHI record.

Accurate ethnicity data is critical for ensuring CCDHB is pro-equity and focused on achieving equity in outcomes. Ethnicity data is the basis for inclusion in screening programmes, service funding, and measuring provider and system performance. All performance measures for core primary care services (Appendix 1) reported to this committee are reported by ethnicity to identify areas for improvement in closing equity gaps.

5. ENGAGEMENT AND ACTIVITY

Engagement with general practice is highest in the very young (0-4 year olds) and oldest (65 and over) age groups (dashboard panel C). Access by young people (15-24 years old) has increased, more young people have visited their general practice in the last twelve months compared with the same time last year. However, young Māori and Pacific people have the lowest rates of engagement. Positive engagement at these ages is important for good health in older years. A large proportion of young Pacific people live in Porirua. We are working with the local community on how we can provide young people in Porirua with additional options for accessing primary health care services through the development of youth service developed by #youthquake.

The average number of nurse visits per enrolled person is increasing over time and the average number of doctor's visits is stable (dashboard panel B). This may indicate increasing uptake of nursing visits or may reflect the increased recording of nurse visits with our renewed focus on understanding how people are accessing primary care. Nurses perform essential roles including childhood immunisations which are core indicators of primary care performance.

6. SYSTEM LEVEL PERFORMANCE

Childhood immunisations and population health screening and interventions are core functions of primary health care (dashboard panels D-E). There are areas of recent improvement, immunisation coverage at 8 and 24 months has increased for Pacific children, and coverage for Māori children increased at 24 months and 5 years. However overall performance on these indicators across the last financial year is flat or declining and equity gaps remain.

Factors driving performance include workforce challenges across primary care practices, a number are experiencing instability in workforce with experienced staff resigning and difficulty in recruitment. Practices and PHOs are reinvigorating their focus on sustainable processes for target achievement to protect against future effects of workforce changes. We are actively working with our PHO partners to identify opportunities to improve performance. These responses differ based on the particular needs and challenges of each organisation. There are a range of other activities being progressed to increase performance on specific indicators, outlined on the following page.

[3] Estimated percentage of the CCDHB population (based on the Statistics New Zealand population projections) who are enrolled in a PHO.

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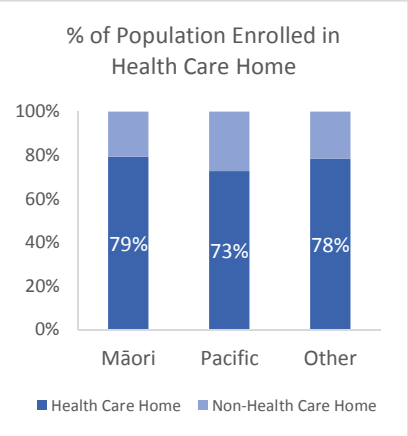
Performance improvement plan

Indicator	Description	Target	Performance	Action Plan
Immunisation (panel D)	Three components: • 95% of infants aged eight months will have completed their primary course of immunisation (six weeks, three months, and five months immunisation events) on time. • At least 95 per cent of two year olds are fully immunised and coverage is maintained • At least 95 percent of four year olds are fully immunised by age 5 years and coverage is maintained	95% 95% 95%	M: 86.0% P: 91.9% O: 95% M: 90.5% P: 92.6% O: 94.4% M: 89.9% P: 87.0% O: 90.8%	The CCDHB Immunisation Network, comprised of primary, secondary, tertiary and community NGO providers are working together on the following strategies to improve timely and full childhood immunisation across all age groups and ethnicities: • Review the pre-call and re-call protocol and Outreach Immunisation Service referral protocol for primary care. This work will provide a resource and reminder for all primary care practices about best practice immunisation management. • Complete a Newborn Enrolment improvement initiative, in partnership with the Maternity Quality and Safety Programme Board. Ensuring timely primary care enrolment of newborns is critical for timely childhood immunisation, given responsibilities for reminding families when their children are due for their vaccinations rests with primary care. • Exploring the variation in primary care practices and behaviours for supporting timely vaccinations and conversations with families about declining and opting off the NIR.
Breast Screening (panel E)	70% of women aged 50 to 69 have had a screening mammogram in the last two years	70%	M: 66.9% (88 women to reach 70%) P: 67.8% (45 women to reach 70% O: 72.0%	• Implementation of a monthly evening breast screening clinic during the working week and aim to screen 15 women at each clinic. • Provide 6 weekend breast screening clinics and aim to screen 40 women at each clinic
Cervical Screening (panel E)	80% of women aged 25 to 69 have had a cervical sample taken in the last three years.	80%	M: 61.2% P: 64.8% O: 75.9%	• Provide 16 free community-based cervical screening clinics focused on Māori, Pacific, and Asian women. • Incentivising practices to achieve 80% coverage for Māori and Pacific women

A number of core primary care indicators are also included in the Health Care Home programme performance framework, as performance on these indicators must be maintained while driving change and innovation. Implementation of the Health Care Home programme has improved performance on the Better Help for Smokers to Quit target as achieving this target is a prerequisite for entry into the programme. As a consequence we have evolved this measure in the performance dashboard (panel F) to reflect the percentage of the population who are current smokers. This measure provides a better indication of the impact of activity on health outcomes for people.

7. HEALTH CARE HOME

78% of the population of CCDHB is enrolled in a general practice in the HCH programme, making HCH a powerful lever to drive primary care performance. Our Health Care Home (HCH) model strengthens primary care to provide comprehensive and continuous health care with the goal of supporting people to optimise health outcomes.



HCH practices receive additional funding directly linked to achieving targets for core primary care indicators including:

- population health indicators - immunisation coverage for children at 8 months and brief advice for smokers to quit,
- access indicators - time to third next available appointment and year of care plans completed,
- acute flow indicators – rates of ED presentations, ambulatory sensitive hospitalisations (ASH), and acute admissions.

If practices do not achieve target in the population health indicators for a given quarter they do not receive their quarterly payment[4], and achievement of the acute flow indicators is required to receive the end of year performance payment from year 2 of the programme. Through this approach, HCH practices are delivering reduced acute admission rates, ED attendances and ASH rates[5], as well as supporting achievement of immunisation and brief advice for smokers to quit targets. 2019/20 marks year four of the HCH programme, and we are exploring with our practices and PHO partners what this means, how we can continue to drive performance and improved patient experience.

Improvements are accomplished through a range of changes in business practice, including extended opening hours, options for phone and email contact, and encouraging diversification of workforce. People are able to access services at times more convenient to them and from the person most able to provide assistance, including primary care practice assistants, clinical pharmacists, nurse prescribers, and health coaches.

At a national level, the Ministry of Health is also driving diversification of the general practice workforce through funding of mental health services delivered in general practice settings.

8. MENTAL HEALTH ACCESS AND CHOICE RFP

In October, PHOs and DHBs across the sub-region partnered to submit a response to the Ministry of Health request for proposal (RFP) opportunity to *develop a service to make a range of supports rapidly available to a general practice's enrolled population to help people manage challenges that adversely affect their wellbeing.* The RFP prescribes the model of care and requires Health Improvement Practitioners (registered health professionals) and Health Coaches (non- registered workforce) to be based on site in general practice clinics, further diversifying the practice workforce. If successful, this service will build upon the

[4] Consideration is given for 8 month immunisation target where one or two people declining vaccination results in non-achievement.
[5] We are currently commissioning three independent evaluations of the impact of the programme for people and providers, overall and from Māori and Pacific perspectives.

Piki programme[6] now in place supporting 18-25 year olds in our communities with mild to moderate mental health concerns.

There is a requirement in the RFP to provide dedicated services for priority groups including Māori, Pacific peoples, youth and people living in rural settings. This complements our local approach to service design and implementation, working with communities in our three localities to identify need and, in response, develop and provide services through our emerging community health networks.

9. LEVERAGING PRIMARY HEALTH CARE TO BUILD COMMUNITY HEALTH NETWORKS

Community Health Networks are our mechanism for developing and delivering services tailored to the needs of particular communities in a particular locality. Health Care Home practices form the core services in the Networks. This allows us to build on the benefits that the HCH model and other service improvements are demonstrating for the population and system.

Goals are tailored to each Network, and built from engagement with the local community through our localities approach. Our approach acknowledges communities as partners in understanding need and service planning, and it is improving co-ordination and integration between those who use services and those who develop and provide them. In Kāpiti we have an example of our localities approach in action.

The Kāpiti locality focus is supporting people to receive more care in the community and reducing their travel. Kāpiti has a population with a higher percentage of older people, lowest rate of self-referral to ED and the highest rate of ED admission. In response to this need, we have developed the Kāpiti Community Acute Response Service (CARS) in partnership with Tū Ora Compass Health, Wellington Free Ambulance, Kapiti General Practices, and the Kāpiti Health Advisory Group.

CARS enhances and expands the services that Primary Care teams can deliver in the community for people with acute care needs by:

- Expanding the scope of community funded interventions of Kāpiti General Practices – with additional subsidy to make the first GP visit free for Māori and Pacific patients if a community acute package of care is delivered
- Providing ambulance re-direction from ED to general practice where clinically indicated
- Providing access to early discharge community packages for ED and Acute Assessment clinicians – avoiding an overnight stay for investigations.

To date, CARS has supported 106 people and early feedback from the people of Kāpiti is positive. We were able to design and implement this programme at pace because of the change mind-set HCH has created.

10. MOVING FORWARD

Our emerging Community Health Networks are leveraging strong primary health care to deliver services tailored to:

- People - Investing in people and family capability to take control of health and wellbeing in the home
- Place – Investing in communities and greater access to services and utilisation more locally
- Priority – Investing in those who are vulnerable and in need, responsive to equity considerations
- Partnerships – Investing in partner relationships and collaborations to keep our communities healthier and well.

Our next steps include developing investment plans to support people with, or at risk of developing, long term conditions, and health of older people. These plans will include initiatives to be developed with communities across our localities and in Community Health Networks to strengthen both planned care and prevention prioritising actions to achieve equity.

[6] https://piki.org.nz/

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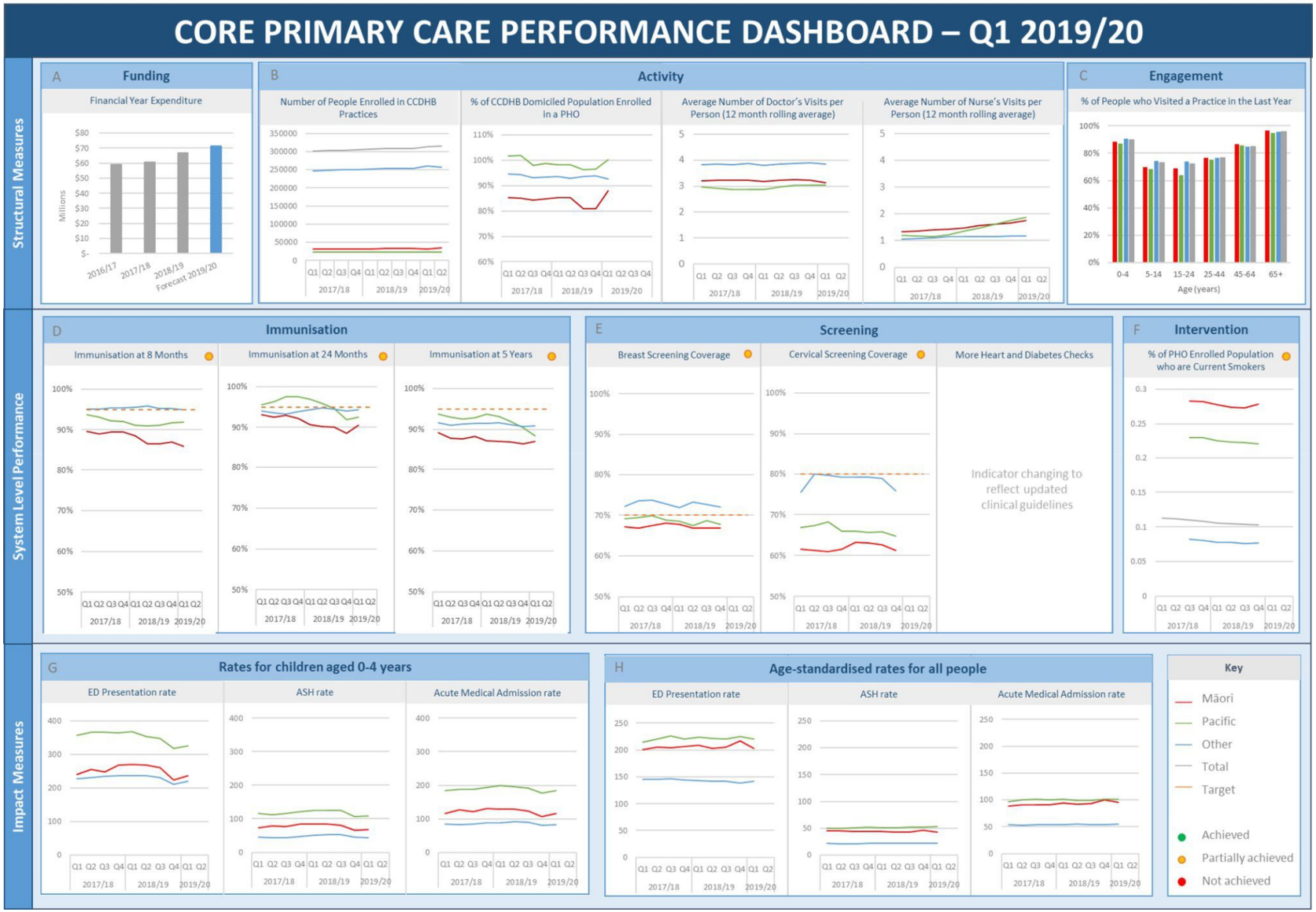
APPENDIX 1 – CORE PRIMARY CARE PERFORMANCE DASHBOARD



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Date: 6 November 2019	**HEALTH SYSTEM COMMITTEE DISCUSSION**
Author	Director, Strategy, Innovation & Performance – Rachel Haggerty
Endorsed by	Chief Executive – Fionnagh Dougan
Subject	**Health of older people in CCDHB and areas of focus**

RECOMMENDATIONS

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

(a) **Note** CCDHB's strong development focus on services that support older people to be well.

(b) **Note** the inequity for Māori and Pacific peoples that means they die earlier and the important relationship between long term conditions investment and that for healthy ageing.

(c) **Notes** the priority focus on older people with frailty to improve both health outcomes and manage demand pressures in our health system.

(d) **Endorses** the establishment of an ICC Steering group for Health of Older People that will initially focus on older people with frailty.

APPENDICES

1. OVERVIEW OF AGED RESIDENTIAL CARE (ARC) FACILITIES
2. SUMMARY OF CONTINUOUS IMPROVEMENT COMMENDATIONS IN RECENT ARC AUDITS

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

1 INTRODUCTION

1.1 Purpose

This paper advises the Health System Committee about older people within CCDHB, their health and access to services. This includes our current and future direction for ensuring older people are able to live well either independently or supported when required.

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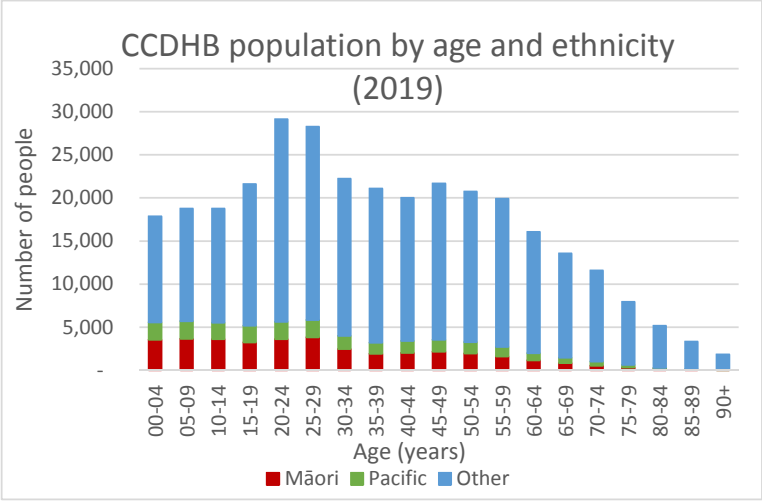
1.2 Previous Board Discussions

The paper responds to discussions at HSC in September and October 2019 about performance of services for older adults:

- "Investment dashboard Health of Older People" – HSC Information paper September 2019
- "Infection Prevention Control in aged residential care (ARC)" – HSC discussion paper October 2019

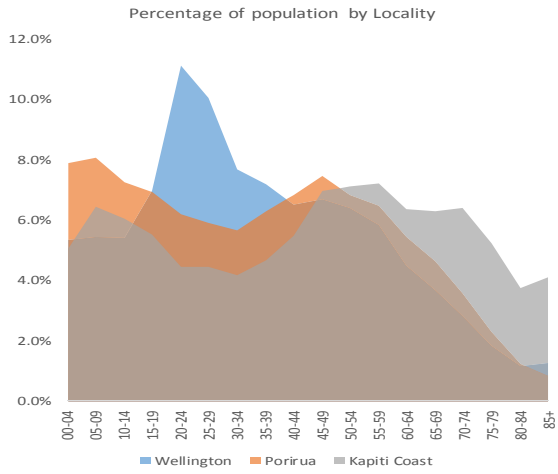
A further paper was presented to the HSC in June 2019 outlining Dementia and dementia care in CCDHB and this paper has been uploaded to the reference library on Boardbooks for ongoing reference.

2 OLDER PEOPLE LIVING IN CCDHB



In 2018 around 318,000 people were living within the CCDHB district, 44,000 (14%) of whom were 65 or over. Only four percent of over 65s identify as Māori and four percent as Pacific peoples. We also know that Māori and Pacific peoples experience complexity in health need much earlier (10 to 20 years) than non-Māori non-Pacific peoples.[1] This means we need to partner with these communities to ensure our responses support people to age well. We need more appropriate supports for Māori and Pacific peoples with long term conditions intensifying supports for older Māori and Pacific peoples who are younger than the usual view of older person's services being for those aged 65 and over. Over the next ten years the numbers of older people living in CCDHB will grow proportionately to our overall population and supporting healthy ageing will become an increasingly important area of focus for CCDHB's service planning and delivery.

Currently, CCDHB's three localities experience notably different age distributions with a greater proportion of older people living in Kāpiti compared with Porirua and Wellington. However, in absolute terms most of our older population live in the Wellington locality. These differences emphasise the value in a localities approach and the establishment of Community Health Networks (CHNs) within those localities so that services are responsive and appropriate for the needs of those communities. For older people in CCDHB, our CHNs will be a critical coordinating point for services that support living well in the community.



	Māori	Pacific	Other
Kāpiti	343	69	10,830
Porirua	671	1,071	4,869

[1] Dr Bryan Betty's presentation to Board in October 2019 describing complexity for Porirua Union Health Service outlines the impacts for the community he serves well

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Wellington	683	768	20,143

2.1 Use of general health services by older people

Consistent with CCDHB's generally wealthier and healthier population, most people over 65 remain living independently at home. This age group is generally well engaged with primary care with around 92 percent of over 65 year olds in CCDHB enrolled with a primary health care provider. However, there is ethnic variation with Māori less likely to be enrolled (88%) and Pacific peoples all enrolled (114%), based on Statistics NZ population projections.

Ninety five percent of this age group enrolled with primary care have visited a primary care practice in the last twelve months.

	Māori	Pacific	Other	Māori	Pacific	Other
Number of people[2]	1,940	1,630	39,910			
Enrolled in a PHO	1,782	1,959	37,845	92%	120%	95%
Accessed primary care in the last 12 months	1,711	1,861	36,331	96%	95%	96%
Admitted to HHS	427	561	5,078	22%	29%	13%

During the same time period, 22 percent of Māori and 29 percent of Pacific peoples, 65 years and over were admitted to our hospitals compared with 13 percent of non-Māori non-Pacific peoples in the same age group. In 2018 there were also 12,414 ED presentations for 7895 people aged 65 and over who live in the CCDHB district.[3]

	Māori	Pacific	Other	Māori	Pacific	Other
Unique people presented to ED	347	485	7061	18%	30%	18%
ED Events (events per person)	638 (1.84)	485 (1.65)	10107 (1.55)			

2.2 Use of older person specific services

We invest around $71.5 million per annum in residential care, community support services and in support for carers for all eligible older people. The number of people in aged residential care (ARC) has consistently reduced from 2016. Approximately 59% of those who receive funded support are being supported at home.

	YTD Actual	Annual Budget
Residential Care	$15.7M	$67.3M
Other Support Services	$0.86M	$4.7M

[2] Based on Statistics New Zealand projections
[3] Source = QlikSense ED Explorer App,

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2.3 Aged residential care

Currently, there are approximately 1900 people living in aged residential facilities within CCDHB, or 4.3 percent of the total population over the age of 65. A detailed overview of ARC including the quality and safety assessment of these facilities is attached as appendix 1. Recent quality and safety audit performance for specific facilities is attached as appendix 2. These audits show that facilities in CCDHB demonstrate a strong commitment to continuous quality improvement and perform well at assessment. The small number of complaints we receive about ARC facilities reinforces that generally our services provide safe and quality care.

Aged residential care is a demand driven service and facilities provide four levels of care: rest home, hospital, dementia and psychogeriatric. Eligibility is determined through the needs assessment and service coordination service (NASC). Well-functioning NASC and community services will enable more people to stay at home delaying the entry to residential care. ARC is also an income and asset tested service. People who are not eligible for subsidy need to pay for their care up to a maximum contribution. ARC will always play an important role in meeting the needs of older people, however our Health System Plan focus on the life course including our "simplify, intensify" approach and Community Health Network (CHN) development anticipates a more diverse range of service responses for older people over the medium term. We have looked at the ratio of people supported at home compared with those in ARC as a broad indication of the DHB's ability currently to enable people to age in place and stay at home longer. Most DHBs have a ratio of 60% (home): 40% (ARC) ratio. CCDHB is consistent with this ratio with 58% (home): 42% (ARC).

At a national level, consideration is being given to the recommendations of the Ernst Young review of the ARC funding model we advised the HSC of in September. The review considered how funding models may reflect different levels of care intensity. The report acknowledges the increasing age and complexity of older people using ARC, the changing nature of the ARC sector itself, and note the demand for ARC has been more muted in recent years than earlier projections suggested

2.2.1 Home and Community Support Services (HCSS)

Within CCDHB there are around 2400 people 65 years and over who are HCSS clients at any given time (5.5 percent of people over 65 in the district). Older Māori access HCSS broadly in line with their population size and Pacific peoples less than their population size would predict. Given Māori and Pacific peoples access ARC services at lower rates than our 'other' population we may have expected them to access higher levels of HCSS. This is an area of focus for us in planning our investment approaches with a view to more pro-equity responses in services for older people.

The revised HCSS contract, with two providers (Nurse Maude and Access) instead of one, went live April 2019 with HVDHB the lead DHB for this process. This contract is a three year contract with an overall value for CCDHB of around $48.1 million for the term. This equates to approximate $14.4 million for the 2019/20 financial year. The HCSS change impacted over 3,000 people and 780 support workers across CCDHB and HVDHB. Within CCDHB alone, 1,066 hours of home support is provided per day. During the transition we did experience an increase in complaints about HCSS however, there has been a steady decline in complaint numbers since a peak in June as the services start to bed in. We are mindful of the pressures experienced by the HCSS workforce and the ability to attract and retain staff needs ongoing focus and support.

2.2.2 Carers

Without carers, older people with frailty require significant funded support to stay at home and generally enter residential care earlier than those who have a spouse or family they live with.

While caring for an older person is rewarding it requires a commitment that grows rather than diminishes over time. It is accepted that having a break from caring is an important part of preserving the relationship

and enabling both the carer and the person receiving the care to 'recharge'. Spouses, who are themselves elderly, particularly need time to rest and maintain their social relationships outside their caring role.

The potentially negative effects of caring on the mental health of carers is widely recognised in the national and international literature on caring. The literature has recently been summarised very well by Bauld and colleagues:

> *"There is now a significant body of literature relating to the mental health of carers, focusing primarily on concepts such as burden and stress. This research stems from the understanding that informal carers can be subject to extreme pressures resulting from the demands of providing care. The nature of these demands is determined by such factors as the dependency of the care recipient, the time and effort needed to meet their needs, the economic costs of providing care, and a lack of respite for the principal carer. Emotional strain and restrictions on time and freedom are prevalent, all of which have an impact on mental health."* (Bauld et al 2000: 104)

Supporting Older Māori & Pacific Peoples in the Central region 2012 (TAS publication) recommendations include supporting whanau caregivers and extending day programmes to include those who are vulnerable/at risk of functional decline through social isolation.

3 CHANGING THE WAYS WE SUPPORT PEOPLE AS THEY AGE

Supporting people to age well and have choices at this life stage is an important feature of a system that is responsive and effective. Developing an older person's investment planning approach that is people centred and takes a whole of system view is a priority. We know also that Māori and Pacific peoples die in greater numbers earlier meaning less people in these communities make it to older ages. This represents a stark inequity in outcomes in our district. Therefore, a critical intersection in investment planning work is action to improve health outcomes for people with long term conditions (LTCs) particular, diabetes and cardiovascular disease. Ensuring these two pieces of work complement and align during 2020 is an important feature of our pro-equity response.

3.1 Responding to frailty

We know that frailty is a contributor to increased use of hospital services and that unless well managed, time spent in hospital can lead to deteriorating health status. This is a poor outcome for patients and their whānau, is not supportive of wellbeing and is an inefficient use of health resources. More effective use of a wider health workforce in community settings to either avoid hospitalisation or support earlier mobilisation and discharge has the potential to prevent further decline for people with frailty. We are prioritising actions to support older people with frailty and have begun to respond to this challenge through the Acute Demand and Bed Capacity programme in place throughout 2019.

3.1.1 Community Health of Older People Initiative (CHOPI)

The Community Health of Older People Initiative (CHOPI) provides proactive, responsive geriatric expertise to support primary care in their management of frail older people. The initiative aims to support frail older people to stay at home longer, and during periods of acute illness. We expect this initiative to become a core part of the early intervention tool kit over time.

CCDHB specialty staff including our Community ORA (nursing and allied health) services are partnering with primary care to deliver timely, responsive specialist gerontology advice that prevents deterioration and supports older people and their carers at home. CHOPI promotes and delivers early intervention that addresses polypharmacy and refers to other services as appropriate (e.g. strength and balance) to promote restoration of function. In the first 5 weeks CHOPI worked with 49 patients – 32 of which were discussed in case conferences with GPs and 17 home visits.

Feedback to date includes:

"I just came along to listen – and now I've got lots of ideas to think about with my own patients" (GP)

"Oh this is well worth our time. And we really appreciate you being flexible to fit in with our monthly meeting" (GP)

3.1.2 Advanced Wellbeing at Home initiative (AWHI)

AWHI aims to help people who have been in hospital return to the level of function they had before they were admitted. To do that, Allied Health, nursing and home support will be provided to people immediately after they are discharged from hospital. It will also link people and their families and whānau, with the services they were receiving before they came to hospital. Ensuring Māori and Pacific peoples receive the right support to enable them to transition home is a priority for AWHI.

Starting as a pilot means we can learn as we go, measuring the impact, and improving and refining the service in response. This proof of concept service went live in August 2019. It is being delivered within existing resources while we test its effectiveness. Wider rollout will require investment in the Allied Health Workforce.

4 NEXT STEPS

We are establishing a Health of Older people steering group underneath the Integrated Care Collaborative (ICC) to develop an across-system model of care and identify priority work for 2020 to better meet the needs of older people with frailty. The group will also identify other priority work to develop and support sustainable health services for older people.

We are discussing the structure of the group currently with the ICC and anticipate the potential system-wide work streams will include:

- Early responsive rehabilitation and restoration
- Managing frailty across system including acute care
- Dementia support
- Palliative care
- Carer support
- Advance Care Planning

The outcomes we will be seeking through this programme of work include:

- Achieving equity for Māori and Pacific older adults in care delivery and outcome
- Address equity for people with disabilities and other priority populations in care delivery and outcome
- Best practice, older adult-focused model of care implemented across the whole CCDHB health system
- Reducing hospital-acquired loss of function ("deconditioning") for older people
- Supporting patients' care in their place of choice as much as possible and timely seamless transitions between settings of care
- Enabling timely appropriate services are available in response to need
- Integrating care across settings and funding streams.

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Date: 31 October 2019	**HEALTH SYSTEM COMMITTEE INFORMATION**
Author	Service Manager, Regional Public Health – Peter Gush
Endorsed by	Chief Executive — Fionnagh Dougan
Subject	**Regional Public Health Update**

RECOMMENDATIONS

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

(a) **Notes** this update.

APPENDICES

1. MAP OF MEASLES CASES IN THE GREATER WELINGOTN REGION

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.	**X**
Specialist Services Ensure expert specialist services are available to help improve people's health		**Government Priority** Equity; Child Wellbeing; Mental Health; Primary Care; Water Safety	**X**

1 INTRODUCTION

1.1 Purpose

The purpose of this paper is to provide an update.

1.2 Previous Board Discussions/Decisions

The report follows up on previous updates from Regional Public Health.

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2 ACTIVITY UPDATE

2.1 MEASLES

2.1.1 Local (Sub-Regional) Picture as at 29 October 2019.

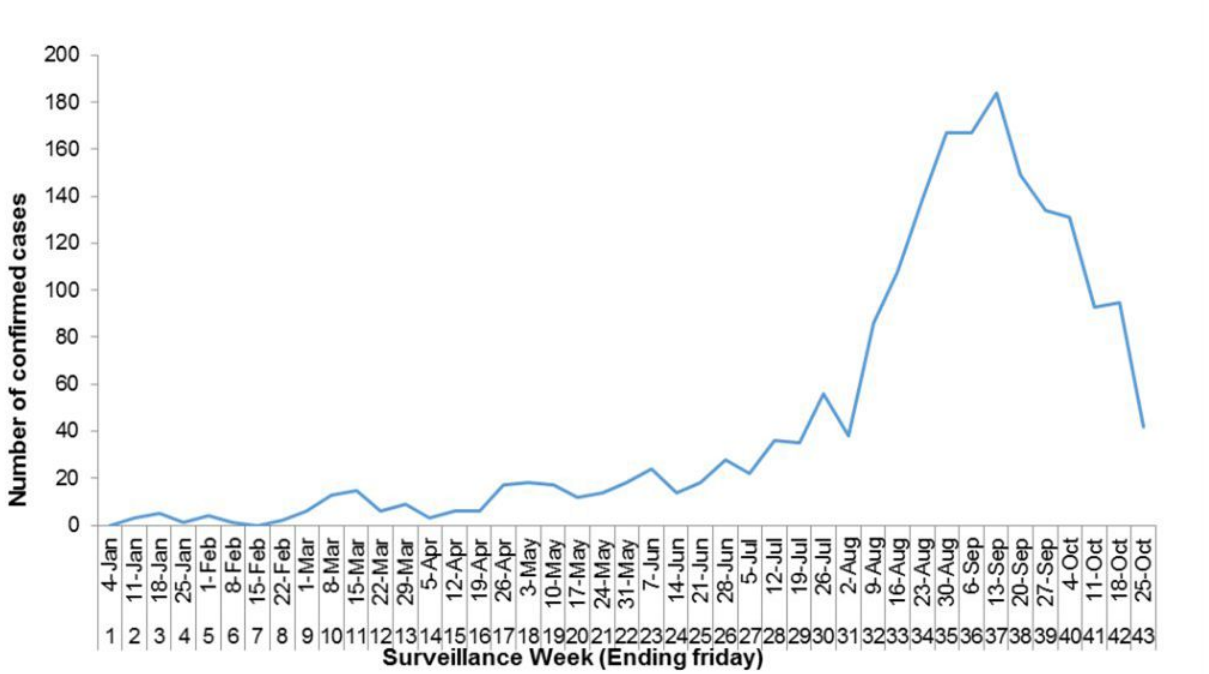
A total of 34 measles cases in the greater Wellington region year to date; to 29 October. All of our cases are linked to either international or domestic outbreaks. A map showing the distribution of cases by DHB is attached as **Appendix 1.**

RPH continues to adopt a 'Stamp it Out' approach to new cases, utilising our Communicable Disease Nursing and Medical Team work forces, whilst supplementing with surge capacity from other parts of RPH as required. We continue to work closely with primary and secondary care as well.

Good use of our own and DHB social media channels has enabled good reach for messaging, with further resources on various health webpages. This is a link to our own page as an example.

National Picture as at 30 October 2019;
From 1 January 2019 to 30 October 2019 there have been 1,957 confirmed cases of measles notified in New Zealand. Over the two week period 16 to 30 October, 100 new cases were notified nationally, 78 in the Auckland region.

Figure 1:
Number of confirmed measles cases nationally, by week, 1 January – 25 October. Weekly notifications appear to have peaked in the week of 20 September.



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3. RELEASE OF TAONGA MOKOPUNA VIDEOS

The Healthy Communities Team from RPH have just launched a new resource for early childhood centres - '*Taonga Mokopuna video learning series'* designed to reduce the spread of illness and keep centre environments healthy.

Taonga Mokopuna includes six short videos:

- Introduction to the series
- Gastroenteritis Outbreaks
- Illness Policy
- Handwashing
- Hygienic Nappy Changing
- Healthy Centre Environments

Each video outlines simple steps that help reduce the spread of illness in a centre. They are easy to follow and implement but are the steps that can often get missed in a busy centre environment. When these steps are followed correctly, they will help centres manage the spread of illness and create the best environment for tamariki and staff.

Taonga Mokopuna is an innovative way to share public health information and is the result of feedback from centre staff across the Greater Wellington region which indicated an online learning tool would be an effective way to get these messages across.

Taonga Mokopuna can be accessed at Healthyecc.org.nz, and is available for all centres across the country to use. However, the advice provided in these videos was developed from the experiences our Public Health Advisors have had with a range of centres in varied communities across the Wellington region.

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

PUBLIC

5. CHILD HEALTH TEAM – EXTRACTS OF ACTIVITY FOR THE FIRST QUARTER 2019

The Child Health Team based at Porirua provides services to 112 primary and intermediate schools across CCDHB, with a total population of 31,804 children. Our Public Health Nurses (PHNs) work predominantly in decile 1-6 schools with high needs children. For the first three months of 2019 the PHNs received 298 new referrals (only 22 in January).

Table 1: Top ten identified personal health referral conditions January – March 2019

	CCDHB	No of Referrals
1	Vision	109
2	Hearing concerns	50
3	Developmental	32
4	Absenteeism	27
5	Social Concerns	27
6	Behavioural	25
7	Dental	16
8	Eczema	15
9	Ears	14
10	Impetigo	14

PHNs have followed up 109 children whose family/care giver were unable to respond to their unmet vision needs, as identified by their school based Vision and Hearing screening programme. This PHN intervention often results in prescription glasses and heavily influences children's ability to learn in a school environment.

Table 2: PHN *open* referrals by ethnicity as at 31 March 2019

DHB	Ethnicity						Total
	Māori	Pacific	NZ European	Asian	Other	Not specified	
CCDHB	135	155	54	12	9	9	**374**

Our Vision & Hearing Technicians (VHT) work with Plunket to complete the Before School Check (B4SC). In the first three months of the year 626 four year olds were screened by our VHTs, the table below gives a breakdown by ethnicity.

DHB		Ethnicity					Total
		Māori	Pacific	European	Asian	Other	
CCDHB	# Screened	62	55	340	126	43	**626**
# Referred re hearing		7	4	9	5	2	**27**
# Referred re vision		7	7	23	15	3	**55**

Four year old children (either from the initial test or retest) that fail their hearing test are referred to Audiology, or their GP based on the pathways set out in the National vision and hearing protocol.

For the small number of four year old children who fail their vision test, they are referred to either an optometrist or the eye clinic depending on their result. Families with a Community Services card are able to access the *Enable* spectacle subsidy of $287.50 at participating optometrist services. This includes the assessment, frames and spectacles.

6. SPIRIT OF SERVICE AWARDS 2019

These Awards celebrate excellence in the Public Service and the Award Ceremony took place last month.

The Prime Minister's Award / Te Tohu a Te Pirimia and overall winner of the year was the Healthy Housing Initiative, which of course includes the Well Homes Partnership between Regional Public Health, Tu Kotahi Maori Asthma Trust, Sustainability Trust and He Kainga Oranga. The initiative also won the Better Outcomes Award.

The Prime Minister noted this was a great example of collaboration across agencies including the Ministry of Health, with Housing New Zealand, Ministry of Social Development, Ministry of Business, Innovation and Employment, Energy efficiency and Conservation Authority, and Auckland City Council.

The Healthy Housing Initiative has significantly reduced hospital visits and antibiotic prescriptions for children and resulted in collaborative housing interventions to create warmer, drier homes. It delivers incredible results with big heart.

The Healthy Housing Initiative is focussed on the needs of whanau and allowing frontline providers to innovate. People on the ground are setting priorities with whanau and telling agencies what is needed. The initiative is now operating across most of the North Island.

Measles 2019

Greater Wellington Region

Total confirmed cases this year to date:

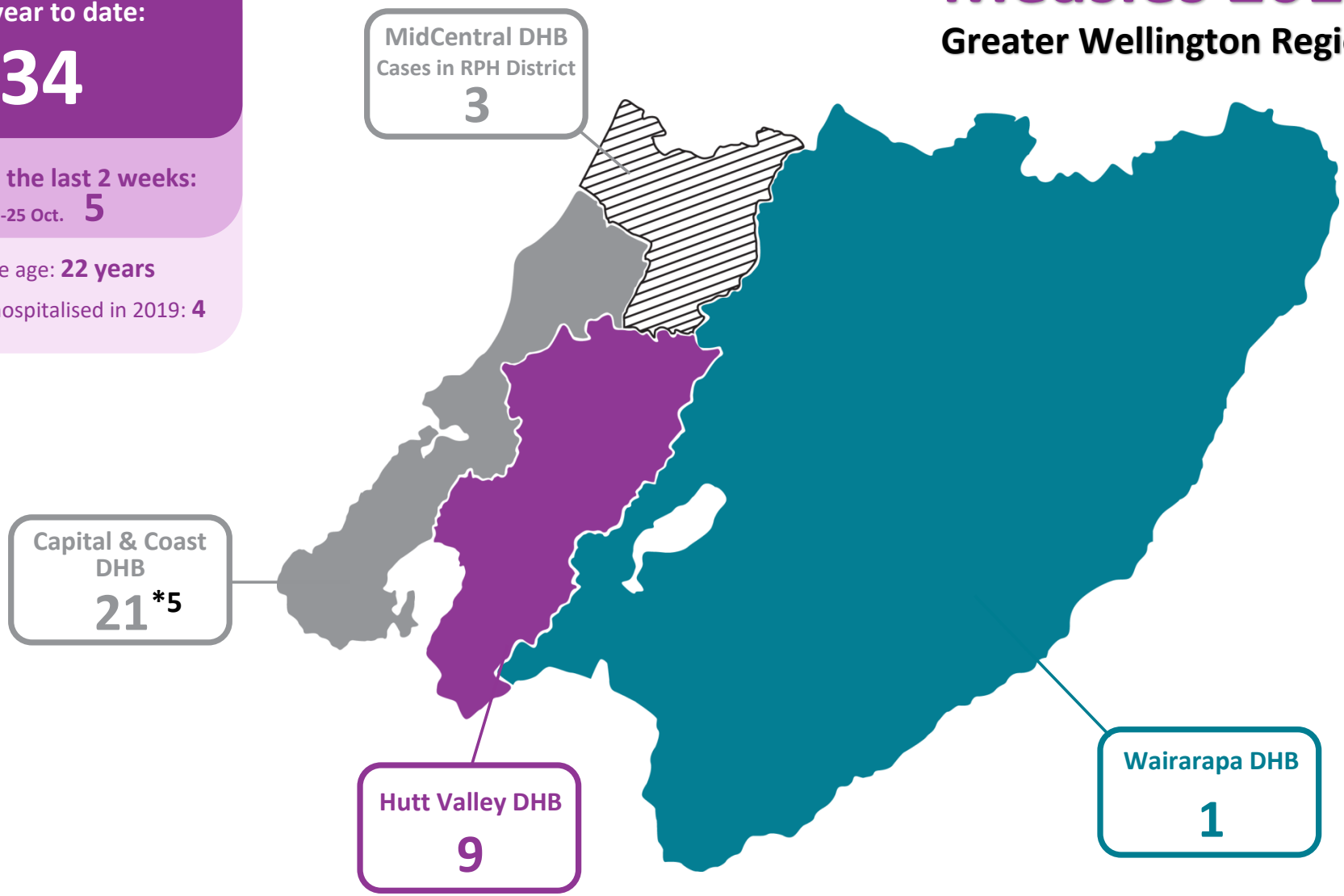
34

***Cases in the last 2 weeks:**

11-25 Oct. **5**

Average age: **22 years**

Number of hospitalised in 2019: **4**



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

Last updated 29/10/2019