**Public Agenda**

29 AUGUST 2018

11th Floor Board Room, Grace Neill Block, Wellington Regional Hospital, Riddiford Street, Wellington, 9.30am

<table>
<thead>
<tr>
<th>ITEM</th>
<th>ACTION</th>
<th>PRESENTER</th>
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<tbody>
<tr>
<td>1 PROCEDURAL BUSINESS</td>
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<td>1.1 Karakia</td>
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<td>1.2 Apologies</td>
<td>Record</td>
<td>F Wilde</td>
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<td>1.3 Continuous Disclosure – <a href="#">Conflict of Interest</a></td>
<td>Accept</td>
<td>F Wilde</td>
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<td>1.4 <a href="#">Confirmation of Draft Minutes 27 June 2018</a></td>
<td>Approve</td>
<td>F Wilde</td>
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<td>1.5 Matters Arising</td>
<td>Note</td>
<td>F Wilde</td>
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<td>1.6 Action List</td>
<td>Note</td>
<td>F Wilde</td>
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<td>1.7 <a href="#">HSC Work Programme</a></td>
<td>Note</td>
<td>F Wilde</td>
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<td>2 PRESENTATION</td>
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<td>2.1 Housing and Health</td>
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<td>2.1.1 Healthy Housing Research <a href="#">late paper</a></td>
<td>N Pierse</td>
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<td>2.2 Regional Public Housing Approach</td>
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<td>2.2.1 Well Homes</td>
<td>T. D'Sousa</td>
<td>16</td>
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<td>2.2.2 Regional Healthy Housing Response Group</td>
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<td>2.3 Pro-Equity Approach <a href="#">late paper</a></td>
<td>R Haggerty</td>
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<td>3 DECISION</td>
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<tr>
<td>3.1 Developing an Investment Plan for Long-Term Conditions</td>
<td>R Haggerty / S Williams</td>
<td>36</td>
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<td>3.2 Investment in Prevention and Treatment of Long-Term Conditions</td>
<td>R Haggerty / S Williams</td>
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<td>4 DISCUSSION</td>
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<td>4.1 Bi-Monthly Regional Public Health Performance Report</td>
<td>S Palmer</td>
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<td>4.2 Bi-Monthly MHAIDS Performance Report</td>
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<td>4.2.1 MHAIDS Development Plan Memo</td>
<td>N Fairley</td>
<td>76</td>
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<td>4.2.2 MHAIDS 3DHB Balanced Score Card June 2018</td>
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<td>4.3 Bi-Monthly SIP Update</td>
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<td>4.3.1 Health Care Home Highlights Newsletter August 2018</td>
<td>R Haggerty</td>
<td>96</td>
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**DATE OF NEXT MEETING** 26 SEPTEMBER – KENEPURU EDUCATION CENTRE, KENEPURU COMMUNITY HOSPITAL, RAIHA STREET, PORIRUA
## Conflicts & Declarations of Interest Register

**UPDATED AS AT JUNE 2018**

<table>
<thead>
<tr>
<th>Name</th>
<th>Interest</th>
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| Dame Fran Wilde       | • Ambassador Cancer Society Hope Fellowship  
                        • Chief Crown Negotiator Ngati Mutunga and Moriori Treaty of Waitangi Claims  
                        • Chair, Remuneration Authority  
                        • Chair Wellington Lifelines Group  
                        • Chair National Military Heritage Trust  
                        • Deputy Chair, Capital & Coast District Health Board  
                        • Deputy Chair NZ Transport Agency  
                        • Director Museum of NZ Te Papa Tongarewa  
                        • Director Frequency Projects Ltd  
                        • Member Whitireia-Weltec Council                                                                                                                                                                               |
| Mr Andrew Blair       | • Chair, Hutt Valley District Health Board (from 5 December 2016)  
                        • Advisor to the Board, Forte Health Limited, Christchurch  
                        • Owner and Director of Andrew Blair Consulting Limited, a Company which from time to time provides governance and advisory services to various businesses and organisations, include those in the health sector  
                        • Former Member of the Hawkes Bay District Health Board (2013-2016)  
                        • Former Chair, Cancer Control (2014-2015)  
                        • Former CEO Acurity Health Group Limited                                                                                                                                                                      |
| Ms Sue Kedgley        | • Member, Capital & Coast District Health Board  
                        • Member, CCDHB CPHAC/DSAC committee  
                        • Member, Greater Wellington Regional Council  
                        • Member, Consumer New Zealand Board  
                        • Deputy Chair, Consumer New Zealand  
                        • Environment spokesperson and Chair of Environment committee, Wellington Regional Council  
                        • Step son works in middle management of Fletcher Steel                                                                                                                                                     |
| Dr Roger Blakeley     | • Member of Capital and Coast District Health Board  
                        • Deputy Chair, Wellington Regional Strategy Committee  
                        • Councillor, Greater Wellington Regional Council  
                        • Director, Port Investments Ltd  
                        • Director, Greater Wellington Rail Ltd  
                        • Economic Development and Infrastructure Portfolio Lead, Greater Wellington Regional Council  
                        • Member, Harkness Fellowships Trust Board  
                        • Independent Consultant  
                        • Brother-in-law is a medical doctor (anaesthetist), and niece is a medical doctor, both working in the health sector in Auckland                                                                 |
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| Ms ‘Ana Coffey        | • Member of Capital & Coast District Health Board  
• Councillor, Porirua City Council  
• Director, Dunstan Lake District Limited  
• Trustee, Whitireia Foundation  
• Brother is Team Coach for Pathways and Real Youth Counties Manukau District Health Board  
• Father is Acting Director in the Office for Disability Issues, Ministry of Social Development |
| Ms Eileen Brown       | • Member 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 |
| Ms Sue Driver         | • 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 | • 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 |
| Dr Tristram Ingham   | • Senior Research Fellow, University of Otago Wellington  
• Member, Capital & Coast DHB Māori Partnership Board  
• Member, Scientific Advisory Board – Asthma Foundation of NZ  
• Chair, Te Ao Mārama Māori Disability Advisory Group  
• Councillor at Large – National Council of the Muscular Dystrophy Association  
• Member, Executive Committee Wellington Branch MDA NZ, Inc.  
• Trustee, Neuromuscular Research Foundation Trust  
• Member, Wellington City Council Accessibility Advisory Group  
• Member, 3DHB Sub-Regional Disability Advisory Group  
• Professional Member – Royal Society of New Zealand  
• Member, Institute of Directors |
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|      | • 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 |
1 PROCEDURAL BUSINESS

1.1 PROCEDURAL
The Karakia was led by Tino Fa’amatuaunu Pereira. Committee Chair, Dame Fran Wilde, welcomed the public, members and the DHB staff.

1.2 APOLOGIES
Apologies was received from Dr Tristram Ingham.

1.3 INTERESTS
1.3.1 REGISTER OF INTERESTS
No changes were registered.

1.4 CONFIRMATION OF PREVIOUS MINUTES
The minutes of the CCDHB Health System Committee held on 30 May 2018, taken with public present, were confirmed as a rue and correct record.

Moved: Roger Blakely    Seconded: Sue Kedgely    Carried:
1.5 MATTERS ARISING

1.6 ACTION LIST

Item 4.2 – Regional Public Health Bi-Monthly Report
It was requested that SIP ensure Regional Public Health are briefed on the previous Board discussions on the role of regional Public Health.

1.7 HSC Work Programme
The Committee noted the plan.

2 PRESENTATION

2.1 INVESTMENT PLANNING APPROACH
The Committee noted the presentation.

Discussion:
There was significant discussion regarding the Investment Planning approach.

HSC recommends to the Board:

a) That the investment planning approach be endorsed and recommended to the Finance, Risk and Audit Committee and the Board as a sound approach; and

b) That future strategies be developed at the “co-design & partnership table” for investment according to the principles of life course investment and health outcomes.

Actions:
1. SIP to present the results of the approach, specifically partnership table at a future HSC meeting.

3 FOR DECISION

3.1 2018/19 CCDHB DRAFT ANNUAL PLAN EXCLUDING FINANCIALS
The paper was taken as read.

The Committee:

a) Noted the Minister’s Letter of Expectations and the MoH Annual Planning Guidance were issued in May and that this draft plan reflect the guidance requirements.

b) Noted the initial draft Annual Plan, using the 2017/18 template, was approved by the Board in March.

c) Noted that the Board approved the Statement of Performance Expectations at the Board meeting of 13 June 2018.

d) Noted that the draft System Level Measures Improvement Plan (SLM) was developed in partnership with PHO, HHS and SIP through the Integrated Care Collaborative (ICC) Alliance Leadership Team (ALT) processes and is with the Health System Committee for endorsement.

e) Noted that the draft Annual Plan has been reviewed and endorsed by the Executive Leadership Team and will also be reviewed by the Māori Partnership Board, the Sub-Regional Pacific Strategic Health Group, the Sub-Regional Disability Group and Clinical Council prior to the final presentation to the Board in July 2018.

f) Noted that the timeline for submission of the final Annual Plan, including financials, has not yet been confirmed by the Ministry of Health.
g) **Review and provide** comment the draft Capital and Coast DHB Annual Plan 2018/19, excluding financial, for endorsement to the Board on 16 July 2018.

**Discussion:**

There was discussion regarding the content of the plan and that it was a public accountability document.

**HSC recommends to the Board:**

a) *That the Annual Plan be adopted as the compliance document, noting that CCDHB is also developing longer term strategies and that these strategies, alongside the locality plans, create opportunities to engage more meaningfully with our communities.*

**Actions:**

1. Committee Secretary to add key documents to the Resource Centre in Board Books.
2. SIP to clarify the health ageing workforce approach and to report at a future HSC meeting.
3. Julie and Rachel to recompose a foreword to replace the Chair and CE message.
4. SIP to provide a graphic of all of the HSP design processes in a compact way to the Board.

### 3.2 SYSTEM LEVEL MEASURE (SLM) PLAN 2018/19

The paper was taken as read.

The Committee:

a) **Noted** the SLM Plan is a DHB Annual Plan requirement and advice from the MOH was released on 14th May.

b) **Noted** the draft SLM Plan has been developed in partnership with PHO, HHS and SIP through the Integrated Care Collaborative (ICC) Alliance Leadership Team (ALT) processes. The draft included has incorporated the first round of feedback from these partners.

c) **Noted** improvement in equity is required across most of the SLM measures.

d) **Noted** the SLM Plan captures collective planning and developments underway. It is expected that collectively CCDHB stakeholders will continue to identify opportunities and implement changes to contribute to the SLM measures and therefore population outcomes throughout the year.

e) **Noted** this draft will be presented to the ICC ALT at its meeting on June 21st for discussion and feedback.

f) **Noted** the CCDHB SLM Plan is required to be submitted to the Ministry of Health (MOH) for consideration on 2nd July 2018 with the aim to have the CCDHB SLM Plan approved by the 30th May 2018.

g) **Noted** the SLMs are being considered in the wider CCDHB Integrated Performance Framework development.

**Discussion:**

There was detailed discussion regarding the System Level Measure Plan. The Plan was noted as one where the MoH identified key measures and we worked with our Alliances to develop our strategies. The importance of care use of ethnicity data was noted to ensure it did not reinforce inappropriate stereotypes and assumptions.

**HSC recommends to the Board:**

a) *That the SLM Plan be endorsed, noting that it fits well with Health System Plan, particularly the measures of system integration.*

**Actions:**
1. SIP provide number of youths in involved in the ED presentation with Alcohol involvement instead of percentages.

4 FOR DISCUSSION

4.1 EVEN BETTER HEALTHCARE (EBHC) PROGRAMME PROGRESS REPORT

The paper was taken as read.

The Committee:

a) Noted HHS has undertaken detailed analysis for the Optimal Ward project during this period, developed a Staff pulse survey and a draft performance Dashboard.

b) Noted the initiation of the System Acute Flow Demand Modelling project to inform opportunities to invest in action that avoids acute Emergency Department presentation.

c) Noted MHAIDS has focused on its 24hr Operations Centre Security Systems Business case, detailed scoping for the Rehabilitation Model of Care and Digital Client Pathways Project and refining the MHAIDS project outcomes to inform benefits metrics and dashboard development.

d) Noted the MHAIDS project outcomes approach.

e) Noted the Integrated Care programme – e-referrals project has started a procurement process to secure an electronic referral platform for GP to specialist referrals.

f) Noted the ongoing development of the Allied health models of care project.

g) Noted that benefits will be presented to the Board at the July meeting.

Discussion:

There was discussion by the ELT sponsors on each aspect of the EBHC programmes. A recent meeting with Treasury had identified greater confidence in our programme management.

HSC notes to the Board:

a) The HSC note that EBHC projects are progressing very well and delivering according to plan, and that positive Treasury feedback demonstrates the impact of this programme.

4.2 HOSPITAL & HEALTHCARE SERVICES (HHS) BI-MONTHLY PERFORMANCE REPORT

The paper was taken as read.

The Committee:

a) Noted that planning has progressed for the winter demand and possible flu outbreak to ensure that we are able to respond to increased demands on services

b) Noted that the contingency planning for the possible Nurses strike is progressing with the focus on maintaining patient safety;

c) Noted the impact of the increased demand on ICU services on elective surgery for the month;

d) Noted that the ICU extension project is progressing and is due to be completed by 1 August as per the project plan;
e) **Noted** that performance against the Shorter Stays in ED health target has remained at the improved level of around 92% against a target of 95%;  

f) **Noted** that the Electives Target continues to be achieved year to date;  

g) **Noted** that the DHB remains within the threshold for compliance with the Elective Services and that the performance in this area has been sustained;  

h) **Noted** that performance against the MRI and CT waiting time indicators has remained at a similar level over the past three months and there are plans in place to improve access and performance, in particular;  
   a. Outsourcing of both MRI and CT scans;  
   b. Additional weekend sessions;  
   c. Referral back to DHB of domicile for the scan to be completed;  
   d. The establishment of a demand management group led by the Chief Medical Officer;  
   e. Review of DHB hours of operation with a view to extending these  

Discussion:  
There was discussion regarding the new structure and that in the future the HHS Bi-Monthly performance report will be split between Medicine Cancer and Community by Carey Virtue and Operations Surgery Women and Children by Delwyn Hunter. There was also discussion regarding cardiothoracic services. The waitlist is now 68 and includes patients awaiting additional procedures. There is weekly reporting in place and we monitor the health of those who are waiting.  

Action:  
1. Committee Secretary to amend the Work Programme reflecting HHS new structure.  

5 FOR INFORMATION  

It is a combined discussion for items 5.1 and 5.2.  

5.1 INVESTMENT PLANNING TO SUPPORT LIVING WELL, DYING WELL  
The paper was taken as read.  
The Committee:  
   a) **Noted** the investments arising from the investment approach will be monitored under the Healthy Ageing Performance Dashboard including metrics enabling us to assess whether benefits from the investment initiatives are realised.  
   b) **Noted** HSC will receive an update in October 2018 on the Living Well Dying Well work programme.  
   c) **Endorsed** the investment planning approach as a framework for developing an investment framework to support Palliative Care across all CCDHB settings of care.  
   d) **Endorsed** the development of an investment plan to support Palliative Care via engagement with a wide range of stakeholders.  
   e) **Endorsed** the investment planning approach as a mechanism to improve equity for our older Maori and Pacific populations  

5.2 INVESTMENT PLANNING TO SUPPORT HEALTHY AGEING  
The paper was taken as read.
The Committee:

a) **Noted** the Older Persons Performance Dashboard will be incorporated into the Healthy Ageing Performance Dashboard and reflect the themes in the investment plan and the impacts across all settings of care.

b) **Noted** the Health Ageing Performance Dashboard will form the basis of measuring and monitoring of changes in investment and will include metrics enabling us to assess whether benefits are realised arising from the investment initiatives.

c) **Noted** HSC will receive an update in October 2018 on the Healthy Aging Investment approach.

d) **Noted** the opportunities to improve and strengthen how the system delivers the themes of ageing well, acute and restorative care, living well with long-term conditions, support for people with high and complex needs and respectful end of life for older people.

e) **Endorsed** the investment planning approach as a framework for developing an investment framework to support Healthy Ageing across all CCDHB settings of care.

f) **Endorsed** the development of an investment plan to support Healthy Ageing via engagement with a wide range of stakeholders.

g) **Endorsed** the investment planning approach as a mechanism to improve equity for our older Māori and Pacific populations.

**Discussion:**

There was discussion regarding the importance of NGO and consumer perspectives in the expert groups. The importance of engagement with consumers and communities was also emphasised. The lack of services for Pasifika and Māori was also emphasised. HSC wants to be kept actively informed about budget regarding this area.

**HSC recommends to the Board:**

a) *That the Board strongly endorses this investment planning approach; and*

b) *That we identify support for Māori & Pacifica communities, and early involvement of consumer groups and NGOs*

**Action:**

1. SIP to provide more information on the investment to increase practitioner’s resources to Māori and pacific areas when we get to the budget.

2. HSC to be kept informed about the budget in this area.

**5.3 OLDER PERSONS PERFORMANCE DASHBOARD**

The paper was taken as read.

The Committee:

a) **Noted** this reporting is part of our process of improving our understanding of how our older persons investment is working for our population including equity (or not) of access to health services, ensuring these services are high quality and safe, and understanding how they improve health outcomes in our community.

b) **Endorsed** the evolution of the Older Persons Performance Dashboard into the Healthy Ageing Performance Dashboard as described in the Investment Planning for Healthy Ageing and Living Well, Dying Well papers. The Dashboard will reflect the themes in the investment plans and the impact across all settings of care forming the basis for measuring and monitoring of changes in investment.

**Discussion:**
1. Sue K said in all areas of the dashboard, staffing levels need to be included. Rachel says we don’t have the answers yet and as we keep working through what the opportunities are we can look at including that information in a report.

2. **Recommendation to the Board: Endorse the dashboard.**

The Chair thanked Chris Lowry for the work she has been doing. The Chair also asked Sue Driver to chair the next HSC meeting while Fran is away.

The meeting closed at 12.15 pm.

5 **DATE OF NEXT MEETING**

## SCHEDULE OF ACTION POINTS – HEALTH SYSTEM COMMITTEE (HSC)

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<td>HSC Public Meeting 27 June 2018</td>
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<td>2.1</td>
<td>Investment Planning Approach</td>
<td>1. SIP to present the results of the approach, specifically the partnership table at a future HSC meeting</td>
<td>Director, SIP</td>
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<tr>
<td>3.1</td>
<td>2018/19 CCDHB Draft Annual Plan Excluding Financials</td>
<td>1. SIP to clarify the healthy ageing workforce approach and to report at a future HSC meeting. 2. SIP to provide a graphic of all of the HSP design processes in a compact way.</td>
<td>Director, SIP</td>
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<tr>
<td>5.1</td>
<td>Investment Planning to Support Living Well, Dying Well</td>
<td>1. SIP to provide more information on the investment to increase practitioner’s resources to Maori and Pacific areas when we get to the budget 2. HSC to be kept informed about the budget in this area</td>
<td>Director, SIP</td>
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<td>HSC Public Meeting 30 May 2018</td>
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<td>2.1</td>
<td>Annual Plan Update</td>
<td>1. SIP to present to the Committee at a future HSC meeting the development of suicide prevention approach and the DHB role as a health system. 2. SIP to share the School Based Health System strategy with the Committee at a future HSC meeting.</td>
<td>Director, SIP</td>
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<td>3.1</td>
<td>Investment in and Performance of CCDHB NGO Providers for Child Services</td>
<td>1. SIP to report on the integration progress of the different programmes at a future HSC meeting. 2. SIP to present the investment planning approach at the next meeting in June. 3. SIP to continue to provide examples in the system for future papers. Board members need</td>
<td>Director, SIP</td>
<td>These items are now scheduled in the work programme</td>
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<td>4.2</td>
<td>Regional Public Health Bi-Monthly Report</td>
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<td>1. Peter Gush to join the meeting when the next Regional Public Health Bi-Monthly Report is presented.</td>
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<td>2. It is important for RPH integration to occur across the DHB services and strategies.</td>
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<td>Peter Gush</td>
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**HSC Public Meeting 2 May 2018**

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<th>Investment in &amp; performance of CCDHB Primary Health Organisations (PHOs)</th>
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<td>1. SIP to create space on the dashboard that focuses on child population to mitigate risk of losing the fidelity of this population in amalgamated data.</td>
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<td>Director, SIP</td>
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<th>3.2</th>
<th>Investment &amp; Performance – Aged Residential Care, Community Dental Agreement, Community Pharmacy Service Agreement</th>
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<td>1. Equity expectation on combined dental agreement is an issue to be added to the work plan to identify how long it takes to work out.</td>
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<td>Director, SIP</td>
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<td>Rachel advises we are still seeking advice.</td>
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<tr>
<td>HSC Public Meeting 27 June 2018</td>
<td>4.2 Hospital &amp; Health Care Services (HHS) Bi-Monthly Performance report</td>
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Included in Actions |
Included in Work Programme |
## CCDHB Health System Committee (HSC) Work Programme 2018

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<td>Planning Projects Suicide Prevention</td>
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### Holding topics for HSC
1. Evaluation of 3D HealthPathways
2. Primary Birthing Unit
3. Healthy Ageing Workforce approach
4. Present results from the Investment Planning Approach – specifically the partnership table
HEALTH SYSTEM COMMITTEE DISCUSSION PAPER

Date: 29 August 2018

Author
Peter Gush, Service Manager, Regional Public Health
Tara D’Sousa, Team Leader, Regional Public Health

Endorsed by
Rachel Haggerty, Director Strategy, Innovation and Performance

Subject
Regional Public Health Housing Approach

RECOMMENDATION

It is recommended that the Committee:

a) Notes RPH’s approach to housing as a key social determinant of health

b) Notes RPH is co-leading a regional healthy housing response group as a collective approach for greater impact in the sub-region

c) Recommends to the Board that they note the importance of quality housing in supporting health and wellbeing in our families.

APPENDICES

1. 2018_05_02 Well Homes Presentation to CCDHB Paediatrics
2. Regional Healthy Housing Response Group Attendees Contacts

1. INTRODUCTION

1.1 Purpose

The purpose of this paper is to provide information about Regional Public Health’s (RPH) approach to housing, as requested for information and discussion at the Capital & Coast District Health Board (CCDHB) Health Systems Committee (HSC).

1.2 Previous Board Discussions/Decisions

This paper should be read in conjunction with the RPH Bi-Monthly Report to CCDHB HSC, being presented with this paper on 29 August 2018.

2. BACKGROUND

2.1 Well Homes Partnership

RPH formed a partnership programme with Sustainability Trust, Tu Kotahi Maori Asthma Trust (TKMAT) and He Kainga Oranga (HKO), called Well Homes. The partnership was set up in 2015 as the housing component of the Rheumatic Fever Prevention Plan (RFPP), and developed into a healthy homes system involving public health nursing assessment of houses, eco-energy expert input to interventions for improving housing quality and social service support for whānau to sustain wellbeing within the home environment. This work was funded by Ministry of Health, CCDHB and HVDHB. HVDHB also supported the Housing Assessment and Advice Service which provided funding for this programme to be public health nurse led.
In 2016 RFPP was revised while the Ministry of Health implemented the Healthy Homes Initiative Expansion which broadened the criteria of referrals for housing assessments. Well Homes has been working with CCDHB and HVDHB on refining the hospital referral systems in order to capture most whānau affected by housing related hospitalisation (HRH). Referral criteria are shown below:

![Referral Criteria](image)

The Well Homes programme aims to address housing related health conditions of whānau, using a population health / social determinants of health approach.

### 2.2 Equity

A warm dry home is the foundation of health and wellbeing, throughout life. Housing is an important underlying determinant of health, with housing quality and household crowding playing a major role in health outcomes\(^1\). Poor living conditions, including dampness and crowding, are significant risk factors for acute rheumatic fever. New Zealand children hospitalised with respiratory infections have high rates of exposure to adverse housing conditions, which increases their risk of future ill health. Housing is also contributing to hospitalisation and re-hospitalisation rates for children in New Zealand\(^2\). The burden of disease associated with housing conditions is particularly high for Māori and Pacific whānau\(^3\).

The Well Homes partnership operates the Healthy Housing assessment and quality improvement programme with a strong equity focus. The majority of whānau receiving services are in high deprivation areas, and of Māori and Pacific ethnicity as shown in the figures below:

---


2 87.3% re-hospitalised at 5502 days following the initial admission (compared to 56% of children admitted with ‘non-preventable hospitalisation’ conditions)

3 “Housing is a health issue too” Dr. Bryn Jones, [https://thespinoff.co.nz/atea/01-03-2018/housing-is-a-health-issue-too/](https://thespinoff.co.nz/atea/01-03-2018/housing-is-a-health-issue-too/)
Appendix 1 provides more detail about the implementation of the Well Homes programme in a presentation to Paediatric RMOs at CCDHB.

2.1.1 Regional Healthy Housing Response Group (RHHRG)
From our experience with the Well Homes programme we know that policy and legislation across the housing continuum from homelessness (supply), social housing, tenancy/landlord relationships, affordability and availability significantly affect housing quality which in turn impacts whānau health, particularly that of Māori and Pacific populations in high deprivation areas.
With this in mind, RPH and Well Homes partners Sustainability Trust, Tu Kotahi Asthma Trust and He Kainga Oranga have explored a joined up coherent approach among all the agencies involved in the housing space on the assumption that this approach will have better more coherent impact and avoid duplication of services and effort.

In conversation with key decision makers we learned that there was significant appetite for joined up work, and the partners began to engage with stakeholders. From July 2017, Greater Wellington Regional Council, specifically Board Chair Chris Laidlaw (initially), now Board Member Roger Blakeley has chaired a series of round table conversations involving representatives from local (five Councils) and central (e.g. MBIE) government agencies in the Wellington sub-region, housing specific agencies (EECA, BRANZ), HVDHB, CCDHB and a number of community organisations such as The Asthma Foundation, Well Homes partners and academia (University of Otago). The agenda moved from information sharing to developing a vision for housing for the region, and a pathway for collaboration to achieve this vision.

2.1.2 RHHRG Vision and Scope

A core group of this collective have continued to meet. RPH provided resource for some external facilitation of a Collective Impact model. We have held five Steering Group meetings since July 2017; at the March 2018 meeting a sub-group emerged to progress the vision and scoping of the group’s work.

Vision: “Everyone in the Wellington Region lives in warm, dry and safe housing by 2025”

The scoping exercise further clarified the collaborative space for this group as shown in the table below.

<table>
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<th>In Scope</th>
<th>Influencing Potential</th>
<th>Out of Scope</th>
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<td>Directly addressing housing availability issues</td>
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<tr>
<td>Energy hardship</td>
<td>Behaviour change &amp; cultural awareness</td>
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<tr>
<td>Healthy housing literacy</td>
<td>Urban design &amp; planning process / housing location</td>
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<tr>
<td></td>
<td>Select Committee Process</td>
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</tbody>
</table>

The sub-group has also developed a Memorandum of Understanding and a proposal to undertake a stocktake of available research / housing data that would provide a baseline and the start of a work programme for the Regional Healthy Housing Response Group.

The housing data stocktake work was further progressed with researchers and data analysts from MBIE, MSD, BRANZ, University of Otago (HKO), Wellington and Porirua City Councils, Sustainability Trust and RPH compiling a Table of “Housing Reports, Strategies and Statement Themes” for the Greater Wellington Region. This is a work in progress and requires resource to be completed, group members are exploring what resource commitment they are able to provide. Apart from the hosting and consultancy contributions of participants, some funding has been contributed from Wellington Mayor’s discretionary fund.

2.1.2 RHHRG Attendees

There has been considerable interest to participate in the discussion and potential work programme of this collective. There is a shared common agenda for doing what each partner is able to make a difference in
the condition of and availability to whānau of housing using a partnership approach and a collective impact model. The attached contact list is a compilation of attendees and interested representatives of agencies.

Attached Appendix 2.

3. DISCUSSION

3.1 Housing Scan CCDHB Catchment Area

RPH has been engaged with all the nine Territorial Authorities (TAs) in the recent Long Term Plan (LTP) submissions process. From our scan of data to understand the urban design and planning aspects of the TAs’ LTPs, we gathered the following data which provides a background on housing for discussion.

- Porirua is to get 53 new state homes, built on Housing NZ land. The houses would be mainly one and two-bedroom, and would be built on a hectare of land in the suburb of Cannons Creek in the city’s east. The houses would probably be built in 2019 and 2020, after a consenting and community consultation process was completed. The Castor Cres land has been empty since 27 ageing and earthquake-prone units were demolished in 2007 and 2008. More were pulled down in nearby Hazard Grove and Esk Place in 2015. Housing NZ is preparing to seek building consent to build 24 one-bedroom, 20 two-bedroom, four four-bedroom and five five-bedroom houses along Castor Cres in Cannons Creek4.

- Up to 800 houses are poised to be built in a major new housing development around Porirua’s old hospital. Early consents will soon be lodged for Kenepuru Landing, a joint project between developer Carrus Corporation and local iwi Ngāti Toa. A mix of medium-density and standalone homes, the 50 hectare development will be built on land Ngāti Toa received as part of a Crown Treaty settlement. Construction is expected to begin next February.

Another potential housing development on Plimmerton Farm north of Porirua has been under negotiation for some years5.

- The Porirua City Council Long Term Plan has noted that while economic confidence is increasing, supported by a number of ongoing and proposed projects like the Transmission Gully Motorway, Porirua Adventure Park, City Centre Revitalisation and the Eastern Porirua Regeneration, without changes in the underlying drivers of household needs in Porirua East, the poor social and economic performance markers will continue to worsen6.

- The Porirua City Council has agreed to put $8 million aside to help revitalise Eastern Porirua in 2025/26. Further work will be done with the community and partners to plan for this over the next three years. PCC noted RPH’s submission relating to housing quality, and their interest in participating in stakeholder meetings and providing advice relating to this. It supports the Council’s strategic priority of children and young people at the heart of our city. The Council will continue to work with RPH into the future on these matters7.

---


6 Porirua City Council Long Term Plan (LTP)

7 PCC Feedback to RPH Submission to LTP
Well Homes Presentation
Healthy Homes Initiative
HEALTH & HOUSING

• Housing is widely acknowledged as a key determinant of health.

• Cold and damp housing, housing affordability, substandard housing and crowding all contribute to the health of our communities.

• Substandard housing and in particular crowded, cold, damp and mouldy homes have been linked to poorer mental health and psychological distress for dwelling occupants.

• Cold, damp homes and indoor pollutants play a role in the development of asthma and other respiratory health problems.
BACKGROUND

HHIs aim to ensure that at-risk children aged 0 to 5 years and those at risk of rheumatic fever are living in warm, dry and healthy homes.

HHIs identify eligible families with children, undertakes a housing assessment, then facilitates access to a range of interventions, such as: insulation, curtains, beds and bedding.

Families must be low-income and meet other eligibility criteria – ensuring that this programme is targeting those most at-risk.

Contracts in place with HHI providers until 2020, but baseline funding in place to continue the programme.
A Comprehensive Approach

- Improving how people live in the house (including affordability):
  - Warmer, drier homes
  - Creating space between sleeping children
  - Budgeting support

- Improving the things in the house:
  - Curtains and curtain rails
  - Floor coverings
  - Heating source
  - Beds/bedding

- Improving the quality of the house:
  - Repairs
  - Insulation (ceiling and underfloor)
  - Mechanical ventilation

Clarifying the needs of who lives in the house:
- Identifying the needs of multiple families
- On-referrals

Getting another house if required:
- Own home
- Suitable private rental
- Social housing
- Temporary housing
- Emergency housing
Well Homes is a **free** service that may be able to help your whānau with:

- Beds & Bedding
- Mould Cleaning Kits
- Carpet
- MSD/Work & Income Assistance
- Curtains
- Other - I.E. Health or Social Referrals
- Heating
- Social Housing Relocation
- Insulation
- Ventilation
- Minor Repairs

Please phone us on 0800 675 675
FREE Health check for your house!!
How to refer!!!!
Phone 0800 675 675

wellhomes@hutvalleydhb.org.nz

Find us on Facebook: Well Homes Wellington
Referrals by deprivation

Health System Committee PUBLIC - 2.2 Regional Public Health Housing Approach
Referrals by Suburb

![Map showing referrals by suburb with deprivation index scale]

Deprivation Index Scale:
- 1 (Least deprived)
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 (Most deprived)
Referrals by Suburb
Referrals by Ethnicity

- Maori: 46%
- Pacific: 29%
- NZ European: 18%
- Asian: 7%
- Pacific sub-ethnicities:
  - Tongan: 10%
  - Tokelauan: 11%
  - Cook Island Maori: 16%
  - Other Pacific Island: 5%
  - Samoan: 58%
### Regional Healthy Housing Steering Group Database

**May-18**

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<tr>
<th>Name</th>
<th>Organisation</th>
<th>Position</th>
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<tr>
<td>Letita O’Dwyer</td>
<td>Asthma and Respiratory Foundation</td>
<td>Chief Executive</td>
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<tr>
<td>Mark Jones</td>
<td>BRANDZ</td>
<td>Building Performance Research Team Leader</td>
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<tr>
<td>Vicki White</td>
<td>BRANDZ</td>
<td>Researcher</td>
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<td>Stephanie McIntyre</td>
<td>Downtown Community Ministry</td>
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<tr>
<td>Henry Nepia</td>
<td>EECA</td>
<td></td>
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<td>Gretchen Saulbery</td>
<td>Connecting Communities Wairarapa</td>
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<tr>
<td>Nicola Shorten</td>
<td>GWRC</td>
<td>Manager, Strategic &amp; Corporate Planning</td>
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<td>Chris Landlow</td>
<td>GWRC</td>
<td>Chair</td>
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<td>Roger Blakeley</td>
<td>GWRC/CDDHB</td>
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<td>Renee Martin</td>
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<td>Alice Daniel-Kirk</td>
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<td>Margaret McDonald</td>
<td>Human Rights Commission</td>
<td>Senior Human Rights Specialist</td>
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<td>Helen Oram</td>
<td>Hutt City Council</td>
<td>Divisional Manager, Environmental Consents</td>
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<td>Greg Street</td>
<td>Hutt City Council</td>
<td>Eco Design Advisor</td>
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<td>John Pritchard</td>
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<td>Lisa Burch</td>
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<td>Chanel Ammon</td>
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<td>Megan Beecroft</td>
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<tr>
<td>Scott Gallacher</td>
<td>MSD</td>
<td>Deputy CE</td>
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<td>Sophie Debaki</td>
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<td>Anne Kelly</td>
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<tr>
<td>Tara D’Souza</td>
<td>Regional Public Health</td>
<td>Team Leader, Analytical &amp; Policy</td>
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<tr>
<td>Kiri Waldegrave</td>
<td>Regional Public Health</td>
<td></td>
<td>Y</td>
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<tr>
<td>Hannah Drew-Crawshaw</td>
<td>Regional Public Health</td>
<td></td>
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<tr>
<td>Kate Day</td>
<td>Renters United</td>
<td>Coordinator</td>
<td>Y</td>
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<tr>
<td>Rosie Gallen</td>
<td>Salvation Army</td>
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<tr>
<td>Phil Squire</td>
<td>Sustainability Trust</td>
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<td>Miranda Struthers</td>
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<tr>
<td>Leighton Karawana</td>
<td>TVK</td>
<td>Te Kawhakarate</td>
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<td>Oliver Parsons</td>
<td>Treasury</td>
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<tr>
<td>Cheryl Davies</td>
<td>Tu Kotahi Maori Asthma &amp; Research</td>
<td>Manager</td>
<td>Y</td>
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<tr>
<td>Lucy Telfar-Barnard</td>
<td>University of Otago</td>
<td>Research Fellow</td>
<td>Y</td>
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<tr>
<td>Carolyn Dick</td>
<td>Wellington City Council</td>
<td>Senior Policy Advisor</td>
<td>Y</td>
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<tr>
<td>David Hannah</td>
<td>Wesley Community Action</td>
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**STILL TO INVITE/CONFIRM ATTENDANCE**

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<td>Wellington Property Investors Association</td>
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<td>Waiwhetu Marae</td>
</tr>
<tr>
<td>Mana whenua</td>
<td>Primary location</td>
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<td>Te Ātiawa ki Whakarongotai</td>
<td>Waikanae</td>
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<tr>
<td>Ngāti Toa Rangatira</td>
<td>Porirua, Wellington, Hutt Valley, Kapiti</td>
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RECOMMENDATIONS

It is **recommended** that the Committee:

a. **Notes** the inequitable burden of long-term conditions by our Māori, Pasifika and/or lower socioeconomic status communities as demonstrated.

b. **Notes** that the Investment Plan will consider prevention and early-intervention, models of care for long-term conditions and self-management.

c. **Notes** working with Regional Public Health to build wellbeing into our locality approach and strengthen our role in creating healthy environments.

d. **Endorses** the development of this investment planning approach as a framework for our future investments to support people with long-term conditions to live well, ensuring there is a coordinated approach to care for people with long term conditions.

e. **Notes** that the draft Long-Term Conditions Investment Plan will be presented to the Committee in December 2018.

f. **Endorses** the investment planning approach as a mechanism to improve equity for our Māori, Pasifika and lower socio economic status populations by developing a people and whānau-led model that supports our communities.

g. **Recommends** to the Board the development of an investment plan for long-term conditions that will improve equity amongst our population and focus on prevention and early-intervention.

1 PURPOSE

This paper proposes an investment planning approach designed to reduce the burden of long-term conditions on people living in CCDHB with a strong focus on the inequities experienced by Māori, Pasifika and those with lower socio-economic status. This approach will focus on our goal to prevent the onset and development of avoidable long-term conditions. It seeks endorsement from the Health System Committee to pursue this approach and prepare a draft investment plan for consideration by the Committee in December 2018.

2 LONG-TERM CONDITIONS

The health of people changes as we age. The onset of illness as we age is significant influenced by our experiences at the beginning of life and then the socioeconomic conditions in which we grow up. These can support us thriving or they can create challenges for us in being well as we age. A long-term condition
is any ongoing, long-term, or recurring condition that can have a significant effect on people’s lives.¹

Long-term conditions affect a person’s life over time and they have a common set of characteristics:

- Usually develop slowly, but can have acute stages
- Persist through life
- Have complex and multiple causes
- Are often preventable
- Can occur at any age, but are more common with increasing age.

Our approach focuses on those long-term conditions that are a consequence of metabolic disease (changes within the body) including cardiovascular disease (CVD), chronic kidney disease, chronic pain, chronic respiratory conditions, diabetes, gout, musculoskeletal conditions and stroke. This investment plan excludes palliative care, dementia and mental health and addictions for which the drivers and responses require their own focus.

The rise in the incidence of long-term conditions are attributed to an increase in lifestyle risk factors, an ageing population with associated increased levels of frailty, and the socioeconomic determinants of health². There is also an increasing numbers of people present with more than one condition. People with multiple long-term conditions have markedly poorer quality of life, poorer clinical outcomes and longer hospital stays, causing them to be the most costly group of patients.

2.1 Long-term conditions affect individuals, families, and communities

In New Zealand, long-term conditions (physical and mental) are responsible for eighty-eight percent of all health loss³. People living with a long-term condition can experience a loss in both quality of life (years lived with disability) and quantity of life (years lost due to premature mortality). The gap between health experience and life expectancy has widened over the last 25 years. This is concerning because despite our life expectancy increasing, it means not all of those extra years are years lived in good health.²

We also know that people who experience long-term conditions are more likely to become poorer over the course of their life due to the challenges of maintaining work over the course of their life. This affects their independence, economic participation and their ability to enjoy family and community life.

2.2 The burden is inequitable

If you are Māori, Pasifika and/or experience lower socioeconomic status, you are more likely to have a long-term condition, it is more likely to occur earlier in your life and you are more likely to have multiple long-term conditions.

As shown in the diagram below, asthma, chronic pain and arthritis has greatest prevalence for Māori, diabetes and gout for Pasifika people and arthritis and chronic pain for the Pākeha population. The incidence for Pākeha is influenced significantly by age.

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¹ https://nsfl.health.govt.nz/service-specifications/long-term-conditions-outcomes-framework
² The socioeconomic determinants of health include housing, income, discrimination, transport, work, education and recreation.
When we also look at age standardised ambulatory sensitised hospitalisations, emergency department presentations, inpatient admissions and acute bed days for long-term conditions we see a marked burden for Māori and Pasifika being as much as 5 times higher than for the Pakeha population (Refer Item ??). This burden impacts on their ability to work, enjoy family life and participate in our communities.

3 CCDHB CURRENT INVESTMENT

Each year CCDHB invests 20% of our budget in direct services in the prevention and treatment of long-term conditions. In 2016/17, this was almost $250 million in services for the direct prevention and treatment of long-term conditions (shown below, depth of colour indicates level of expenditure). Of this investment, 83% is spent in hospital specialty services and only 0.3% is in prevention-based support. As yet, we do not know what the balance of investment should be but it will be a critical part of our consideration.

### 3.1 $207 million in Hospital and Health Services

This investment is for long-term conditions some of which are not avoidable, but a significant proportion will be for those with avoidable conditions and complications. It does not include the Emergency Department and general hospital services that support people with long-term conditions.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Budget (m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>$31.2m</td>
</tr>
<tr>
<td>Cardiac Thoracic</td>
<td>$33.1m</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$1.9m</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>$1.4m</td>
</tr>
<tr>
<td>ENT</td>
<td>$9.1m</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>$7.4m</td>
</tr>
<tr>
<td>Haematology</td>
<td>$14.8m</td>
</tr>
<tr>
<td>Neurology</td>
<td>$12.1m</td>
</tr>
<tr>
<td>Oncology</td>
<td>$30.7m</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>$11.2m</td>
</tr>
<tr>
<td>Pain Management</td>
<td>$3.3m</td>
</tr>
<tr>
<td>Renal Medicine</td>
<td>$17.2m</td>
</tr>
<tr>
<td>Respiratory</td>
<td>$6.5m</td>
</tr>
<tr>
<td>Urology</td>
<td>$12.3m</td>
</tr>
<tr>
<td>Vascular</td>
<td>$14.1m</td>
</tr>
</tbody>
</table>

### 3.2 $42.7 million is invested in the community

Our most significant community investment is in pharmaceuticals being at least $36.1m per annum being $4.2 million for asthma, $0.5 million for cardiovascular disease, $3.1 million for diabetes, $19.1 million for cancer and $9.2 million for arthritis.

We invest is $4.6m in primary care plus funding for those with complex needs in primary care, a further $2.5m to support people living with long-term conditions (e.g. diabetes, respiratory), and $0.8 million to support healthy lifestyles and reduce the risk of developing a long-term condition (e.g. tobacco control, more heart and diabetes checks, nutrition advice).
4 OUR HEALTH SYSTEM PLAN

Our Health System Plan 2030 prioritises people and whānau-led wellbeing. In this next section, we explore what this means in developing our long-term conditions approach. Our focus needs to shift from curative services to preventative practises in all of our work, preventing onset, preventing exacerbation and complications and preventing avoidable burden to people and their whānau.

The principles in the Health System Plan 2030 will determine our approach:

- **Work with communities** to design initiatives for each locality
- **Act early** to identify and treat risk factors
- **Simplify** support for those who can self-manage
- Provide flexible funding opportunities to **intensify** support for those most in need
- Provide care in **different settings** according to the needs of people and families
- **Integrate** services across the system including the community, primary, secondary and tertiary care
- **Use innovative technology** to support people close to home

Importantly our approach must **intensify** for those who are likely to experience the greatest burden of long-term conditions being **Māori, Pasifika and those with lower socio-economic status** to create equity. It must also support the significant increase in our population who are ageing.

Alongside, there are significant opportunities to **simplify** services for those with health resources and strong health knowledge particularly **using technology**.

When successful, our long-term conditions investment approach will support a system that empowers all of our people and their whānau, communities will be actively engaged in their own wellbeing, people and their whānau will have support to prevent the onset of illness and avoidable complications and there is supporting for people to have optimal healthy life expectancy. These experiences will be equitable, regardless of ethnicity, where they live and/or their socioeconomic status.

4.1 Our investment choices can reduce the impact of long-term conditions

We are proposing a whole-of-system approach to support wellness and manage long-term conditions that has a particular focus on prevention and early intervention to reduce the demand for specialty services. We cannot prevent all long-term conditions but we can reduce their prevalence and their impact on the lives of individuals, specifically delaying their onset and the intensity of complications. These are conditions where it is anticipated that elimination of modifiable risk factors could prevent 80% of
premature heart disease, 80% of premature stroke, 80% of type 2 diabetes and 40% of cancer using life course interventions and working closely with our partners to address social determinants.

We have opportunities to intervene early to prevent the development or progression of long-term conditions. Not smoking is the most important single action people can take to reduce their risk factors alongside other target behaviours that can reduce the risk of an avoidable long-term condition:

- increased physical activity
- improved diet and managing weight
- decreased depression
- improving quality of life
- improving self-efficacy
- improving self-monitoring/clinical outcomes
- improving medication adherence
- decreasing health resource use
- managing blood pressure.

We will consider how prevention occurs in our well population through locality planning and how self-care, shared-care and specialist care coordination are organised across our communities, community health networks and hospital specialist services.

**Diagram one: Our settings of care**

4.2 An integrated model of Care for People with long term conditions

Below we outline three of the key elements we will be considering:

- Prevention and early-intervention
- Models of care for long-term conditions
- Key-elements in successful self-management

**Prevention and early intervention**

Prevention and early-intervention is about working to create a system that provides appropriate access to resources, activities and supports that empower and enable communities, whānau/families and individuals to prevent and delay the onset of long-term conditions. As illustrated in the diagram below, it is important that the approach consider how we reduce risk across our whole population, as well as support a risk reduction approach for individuals at high-risk or requiring early intervention.
Diagram two: Reducing population risk for long-term conditions.

Models of care for long-term conditions
The most well recognised model of care for long-term conditions is below. This recognises self-care, shared care and specialist care coordination all need to be part of our model of care and are used to design the service delivery model.

You will note in Item 4.1 on the Agenda an appendix outlining some of the wellbeing work being undertaken in the Porirua community with the Porirua City Council.

Diagram two: Models of care for long-term conditions.

Key-elements in successful people and whānau-led self-management
Good self-management is a continuum of learning experiences and opportunities, where people with long-term conditions and their family and whānau work in collaboration with carers and health professionals.
The essential components in self-management support programmes are:

- health literacy
- cultural relevance
- behaviour change
- social determinants
- use of technology

**Health literacy**

Health literacy, from the patient’s perspective, is the cornerstone in enabling people to make informed choices and take care of their own health. Well-designed services can support better health literacy. More specifically, with good health literacy, they can:

- understand and interpret health information provided in written, spoken and digital form
- understand instructions written on prescribed medicine containers and consent forms
- understand a health professional’s verbal advice and explanations
- navigate complex health systems
- communicate with health professionals, including by describing symptoms accurately and asking relevant questions
- find relevant information needed to make choices and decisions.

Health professionals have a pivotal role in improving health literacy. They must tailor their style of communication to individuals with LTCs (and their family and whānau). If they are culturally competent and strive to understand people’s health beliefs and preferences, health professionals will improve the quality of their health interactions and consequently the health literacy of their patients.

**Cultural relevance**

Any self-management programme, particularly if it is a group programme, must be culturally appropriate. People with LTCs should have access to self-management support that is relevant to their preferences. For Māori, a programme underpinned by kaupapa Māori approaches enriches the environment for effective learning. It focuses on:

- tinorangatiratanga – self determination
- taonga tuku iho – cultural aspirations
- ako Māori – culturally preferred ways of learning
- whānau – the extended family members and their influence and support
- kaupapa – the collective philosophy of the members of the group.

**Behaviour change**

Along with health literacy, people need programmes to support them to change their health behaviour. In self-management programmes, the five essential elements to changing health behaviour are:

- active involvement in problem solving, goal setting and written action plans (especially for conditions where the risk of deterioration is high)
- lifestyle changes, including eating a healthier diet, being physically active and stopping smoking
- informed decision-making, stress management and positive mental health.

**Social determinants**

Some people with LTCs need broader support to deal with challenges related to the wider determinants of their health, such as social and economic conditions. Health navigators, kaiawhina or other support workers can provide support such as social support.
Use of technology
Web-based and mhealth solutions are available to provide self-management education and self-management support. For example, mobile technology can be used to provide information and motivation for self-management. Patients may also see patient portals as a tool to support self-management.

4.3 The opportunities we will be exploring
Some of the opportunities we will be considering are outlined below:

<table>
<thead>
<tr>
<th>Well (potentially at risk) population</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Supporting healthy communities, lifestyles and wellbeing including early detection and intervention.</td>
</tr>
<tr>
<td>• Partnering with Regional Public Health and strengthening our community wellbeing</td>
</tr>
<tr>
<td>• Locality approaches in Porirua, Kapiti and Newtown/Kilbirnie</td>
</tr>
<tr>
<td>• Community Circle Developments with a focus on Disability</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Self-Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• People and their whānau have the knowledge, skills and confidence to care for themselves and/or their whānau members.</td>
</tr>
<tr>
<td>• Whānau and family based approaches that are valued by our Māori and Pasifika people</td>
</tr>
<tr>
<td>• Use of self management mobile apps (e.g. Melon Health) and Health Navigator</td>
</tr>
<tr>
<td>• Health coaches, either independently or in conjunction with mobile technology</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Shared-Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• People and their whānau receive coordinated care and support within their community.</td>
</tr>
<tr>
<td>• Coordinated care for people with non complex care needs by community health teams</td>
</tr>
<tr>
<td>• Bespoke exercise programmes for support and improved outcomes for people post-diagnosis of a long-term condition</td>
</tr>
<tr>
<td>• Psychological and social support for people and families after a diagnosis with a long-term condition (similar to breast cancer support groups)</td>
</tr>
<tr>
<td>• Using our workforce in a different way or in different settings of care (i.e. integration of allied health with primary care practices)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialist Care Coordination</th>
</tr>
</thead>
<tbody>
<tr>
<td>• For people with complex and multiple LTCs care is well coordinated amongst specialist teams supporting whānau preferences.</td>
</tr>
<tr>
<td>• Improve coordinated complex care for people with complex needs in acute and intensive treatment stage</td>
</tr>
<tr>
<td>• Expansion of our successful diabetes nurse practice partnership model to other services such as respiratory, cardiology, or rheumatology.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>End of Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>• People and their whānau have support they need to have positive end of life experiences.</td>
</tr>
<tr>
<td>• Access to advance care planning early in life, that is constantly updated with people and their whānau.</td>
</tr>
</tbody>
</table>

5 DEVELOPING OUR INVESTMENT APPROACH
To guide the development of our investment approach, we will establish a leadership and advice forum to shape the system approach to test and develop with a wider strategic group. There will be engagement of consumers and communities in developing this approach.

There will be a strong focus in understanding the current experience of people living with long-term conditions in CCDHB.

5.1 Key milestones
The table below outlines the key milestones for the development of this Investment Plan.
## Concept Report complete on current investments analysis and who the people are and what their needs are

### PREVENTION INVESTMENT STREAM

<table>
<thead>
<tr>
<th>Design</th>
<th>Present concept and design phase findings to HSC</th>
<th>December 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approve</td>
<td>Implementation planning for HSC approval</td>
<td>April 2019 – June 2019</td>
</tr>
<tr>
<td>Implement</td>
<td>Implementation planning for 2019/20</td>
<td>Quarterly from July 2019</td>
</tr>
<tr>
<td>Evaluate</td>
<td>Investment management and performance reporting</td>
<td></td>
</tr>
</tbody>
</table>

### MANAGEMENT INVESTMENT STREAM

<table>
<thead>
<tr>
<th>Design</th>
<th>Present concept and design phase findings to HSC</th>
<th>December 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approve</td>
<td>Investment Plan submitted to HSC for approval</td>
<td>February 2020</td>
</tr>
<tr>
<td>Implement</td>
<td>Implementation planning</td>
<td>April 2020 – June 2020</td>
</tr>
<tr>
<td>Evaluate</td>
<td>Investment management and performance reporting</td>
<td>Quarterly from July 2020</td>
</tr>
</tbody>
</table>
From Rachel Haggerty, Director Strategy, Innovation and Performance

Authors
Sandra Williams, General Manager Primary and Complex Care
Lisa Smith, System Development Advisor Primary Care

Endorsed By Julie Patterson, Interim Chief Executive

Subject Investment in the prevention and treatment of long-term conditions

RECOMMENDATIONS
It is recommended that the Committee:

a. Notes in 2018/19 we will invest $250 million in services for people with long-term conditions.

b. Notes inequalities for Māori and Pacific populations in prevalence of long-term conditions and outcomes

c. Endorses the draft long-term conditions performance dashboard.

d. Recommends to the Board that it notes the current levels of investment in long-term conditions and the significant inequities experienced in our Māori and Pasifika communities.

APPENDIX:

1. PROPOSED LONG-TERM CONDITIONS DASHBOARD

1 PURPOSE OF PAPER
This paper informs the Health System Committee (HSC) of the services available to the people of CCDHB for the prevention, early intervention and management of long-term conditions and seeks endorsement of the draft dashboard developed to monitor the performance of these services.

It focuses on NGO investments to improve outcomes for people with long-term conditions and reduce the risk factors for developing a long-term condition. Healthy ageing, palliative care, and mental health & addictions are the subject of other dashboards and will not be the focus of this paper.

2 BACKGROUND
Each year we invest 20% of our funding budget in services to support people in the prevention and treatment of long-term conditions. Some of these conditions are not avoidable or preventable. This investment of consists of:

- $207m in Hospital and Health Services (e.g. cardiology, diabetes, respiratory)
- $36.1m in pharmaceuticals for people with asthma, cardiovascular disease, diabetes, cancer, and arthritis
- $3.3m in supporting services in community based NGOs in the community
$2.5m to support people living with long-term conditions (diabetes, respiratory)
$0.8m to support healthy lifestyles and reduce the risk of developing a long-term condition.

Below we outline our current community investment in services for prevention of long-term conditions and early-intervention in long-term conditions.

2.1 Community-based services for prevention

Primary and secondary care physicians routinely work with people to identify risk factors and work with our people to develop strategies to reduce risk. In addition, we invest $0.8 million per annum in services to provide nutritional education and exercise programmes and smoking cessation support. Of the adult population in CCDHB¹:

- 18,000 report little or no physical activity (7%)
- 28,000 smoke tobacco (11%)
- 151,000 are not at a healthy weight (59%)

Early identification of cardiovascular and diabetes risk

More Heart and Diabetes Checks are a national programme to identify people at risk of developing cardiovascular disease or diabetes. This focuses on Māori, Pacific, and South Asian peoples who have higher risk of cardiovascular disease. These checks are funded under the PHO Services Agreement, with an additional $0.13 million per annum in funding targeted to improving coverage for young Māori men.

Supporting improved nutrition and level of physical activity

Green Prescriptions are a community based health initiative promoting lifestyle change through increased physical activity and improved nutritional habits. The service focuses on encouragement and education, nutritional guidance and advice, and realistic goal setting and ongoing support. Each year we fund the service $0.45 million so 1,300 people can access one of the five types of green prescription available. The scripts are written by general practise.

Supporting people to quit smoking

Up to 65% of people who smoke today and continue to smoke will die from tobacco use². It is vital we ensure our people know the risks of smoking and offer support to quit. Cessation support includes nicotine replacement therapy and behavioural support. Our providers who deliver behavioural support are:

- Tākiri Mai te Ata
- Quitline
- Hapū Ora

Tākiri Mai te Ata and Quitline are funded directly by the Ministry of Health. We also contract a local Hapū Ora service that supports our young parents aged 15 – 25 years who are pregnant or have young tamariki up to five years of age. This local, wrap-around service enhances the likelihood of a successful

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quit attempt. Last year Hapū Ora supported 100 people in their journey to quit smoking. We invest $0.08 million per annum in this service. We also invest in clinical champions and provider education, as the evidence shows they are critical to improving smoking cessation outcomes\(^3\): We invest an additional $0.15 million per annum in these services.

Despite the variety of services to quit smoking currently available, our quit rates are not improving over time. In addition, 28% of our Māori and Pacific populations are current smokers\(^4\) whereas 11% of the total population are current smokers. We need to work with our communities to develop different initiatives to reduce tobacco consumption and improve health outcomes.

### 2.2 Community-based services to support people diagnosed with long term conditions

We support integrated care approaches for diabetes and respiratory disease.

**Supporting people with a diagnosis of diabetes**

There are 13,500 adults and children in our DHB diagnosed with diabetes. We support these people through our integrated programme of diabetes services that receive $2.1 million per annum in funding. The programme includes self-management support, clinical treatment, and disease surveillance. The strength of this programme is that services are available across the community, primary and secondary care settings.

Support is tailored to a person’s needs, with a focus on simplifying care and self-management where appropriate and intensive support where required. Primary care podiatry, retinal screening and community-based dieticians are available to support people to live well close to home. The Diabetes Clinical Network, under the Integrated Care Collaborative (ICC), supports the programme and associated services.

Each year the Diabetes Clinical Network identifies key areas of focus to improve outcomes for our population with a diagnosis of diabetes. In 2018/19, the network is focusing on how services are accessible for and accessed by our young (15-39 year old) Māori and Pacific people. Data has shown that this cohort:

- have lower rates of annual testing of blood glucose control
- do not have good blood glucose control and this is associated with poorer long-term health outcomes.

These quality improvement initiatives are run each year to improve health outcomes for all of our communities.

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\(^3\) Gifford, Taylor, Taylor, Nicholls. ‘Improving Smoking Cessation Services for Priority Groups in South Taranaki’. June 2011.

Supporting people with a respiratory illness

Our people with asthma, chronic obstructive pulmonary disorder (COPD) and other respiratory diseases are at higher risk of admission to hospital. To avoid admission and keep people well in their communities we provide education programmes, self-management support and winter management plans to help manage their health needs.

These programmes support over 1,500 people in our community each year. We invest $0.83 million per annum in these programmes. However, hospitalisations for respiratory illnesses continue to increase which may indicate current programmes are not addressing demand or reaching the right populations. We need to work with our local communities to identify new ways to support people to get well and stay well.

3 PERFORMANCE MONITORING

We have developed a draft long-term conditions services dashboard to assist CCDHB to improve our oversight and better understand the effectiveness of services for our people with long-term conditions (Appendix 1). These indicators will evolve and change as we develop and implement the investment plan for people with long-term conditions.

The proposed indicators for 2018/19 include:

- **Structural measures**: What is required to deliver the services?
- **System level performance**: How do we know we are delivering quality services?
- **Impact measures**: What is the expected change or experience?

3.1 Structural Measures

For the services we provide, we monitor the level of activity of the services provided. The activity measures reflect activity across the system, from community into primary, secondary and tertiary care. The indicators also reflect the spectrum of intervention from early detection and management (e.g. more heart and diabetes checks) though to intensive assessment and treatment (e.g. rate of first specialist appointments).

We are working with our providers to understand how risk factors are identified and managed including weight management and brief interventions for alcohol consumption. Then we can include them in our performance monitoring.

3.2 System Level Performance

Understanding evidence markers enables CCDHB to ensure services are meeting system performance requirements. The chosen measures reflect areas where effective primary care can play a key role in improving system level performance. In the current mix of indicators, this includes both managing risk factors and supporting people diagnosed with long-term conditions in the community. These measures include:

- Smoking quit rate
- CVD management

People with a respiratory illness can access:

- Health literacy and education
- Self-management support
- Winter self management plans
3.2 Investment in Prevention and Treatment of Long-Term Conditions

We chose three measures to reflect system performance. Measures are age-standardised to increase accuracy of comparisons between ethnic groups. The measures are 12-month rolling totals and are:

- ED presentation rate of PHO enrolled people presenting to Wellington Hospital Emergency Department for long term conditions\(^5\)
- Acute inpatient admission rate (non-ACC) medical and surgical events for long term conditions
- Acute bed day rate for acute (non-ACC) medical and surgical events for long term conditions.

3.3 Impact Measures

We provide services to people across all ages, ethnicities, and localities within CCDHB as part of a complex system. It is important we measure the impacts of these services for our people and our system. This is the area in the dashboard where there is a lot of development opportunity. Currently, we are able measure the crude amenable mortality rate – crude rate of premature deaths that could be avoided through effective and timely care.

During 2018/19, we will be developing two indicators that measure the impact on the person:

- Quality-adjusted life years
- Disability-adjusted life years
- The experience of people and their whānau and whether services are useful to them.

3.4 Summary of indicators for long-term conditions dashboard

<table>
<thead>
<tr>
<th>Structural Measures</th>
<th>People</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of people with one or more long term conditions</td>
</tr>
<tr>
<td>Community-based Activity</td>
<td>Number of referrals to a Green Prescription service</td>
</tr>
<tr>
<td></td>
<td>Number of referrals to respiratory services</td>
</tr>
<tr>
<td></td>
<td>Number of people with diabetes who have had an HbA1c test</td>
</tr>
<tr>
<td>Hospital-based activity</td>
<td>Number of people with diabetes who have had a retinal screen</td>
</tr>
<tr>
<td></td>
<td>Rate of booked first specialist assessments for long term condition outpatient clinics</td>
</tr>
<tr>
<td></td>
<td>Rate of booked follow up assessments for long term condition outpatient clinics</td>
</tr>
<tr>
<td></td>
<td>Rate of not attended (DNA) first specialist assessments for long term condition clinics</td>
</tr>
<tr>
<td></td>
<td>Rate of not attended (DNA) first specialist assessments for long term condition clinics</td>
</tr>
<tr>
<td>Risk factor identification</td>
<td>More Heart and Diabetes Checks</td>
</tr>
<tr>
<td></td>
<td>Better Help for Smokers to Quit (Primary Care)</td>
</tr>
<tr>
<td></td>
<td>Better Help for Smokers to Quit (Hospital)</td>
</tr>
<tr>
<td>Interventions</td>
<td>Smoking quit rate (Primary Care)</td>
</tr>
<tr>
<td></td>
<td>Faster Cancer Treatment</td>
</tr>
</tbody>
</table>

\(^5\) We have identified long-term condition diagnoses from a full list of codes. We will undertake a review of these codes with our clinical leads to finalise the selection.
### System Level Performance

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>High CVD risk (&gt;20%) and on statins</td>
<td></td>
</tr>
<tr>
<td>HbA1c level of less than 64mmol/mol (an indicator of diabetes control)</td>
<td></td>
</tr>
<tr>
<td>Age-standardised ASH rate for respiratory conditions</td>
<td></td>
</tr>
</tbody>
</table>

### System Performance

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age-standardised ED presentations for long term conditions</td>
<td></td>
</tr>
<tr>
<td>Age-standardised inpatient admissions for long term conditions</td>
<td></td>
</tr>
<tr>
<td>Age-standardised acute bed days for long term conditions</td>
<td></td>
</tr>
</tbody>
</table>

### Impact Measures

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude amenable mortality rate for long term conditions</td>
<td></td>
</tr>
</tbody>
</table>

### Person Impact

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality-adjusted life year (QALY)</td>
<td></td>
</tr>
<tr>
<td>Disability-adjusted life year (DALY)</td>
<td></td>
</tr>
<tr>
<td>Experience of people with LTC</td>
<td></td>
</tr>
</tbody>
</table>

## 3.5 Interpretation of the Performance Dashboard

Key: T – total population, M – Māori, P – Pacific, O - Other. Data used is from the most recent quarter available.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Actuals</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Structural Measures</strong>&lt;br&gt;Annual expenditure for the prevention and treatment of long-term conditions in primary and community and the DHB provider arm.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of people with one or more long term conditions</td>
<td>To be developed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of referrals to a Green Prescription service (quarterly)</td>
<td>T: 817</td>
<td>T: 852</td>
<td>Performance is to contract. Coverage of need and ethnicity is currently unknown.</td>
</tr>
<tr>
<td></td>
<td>M:  P:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faster Cancer Treatment (quarterly)</td>
<td>90%</td>
<td>91.3%</td>
<td>Target achieved. Equity measure to be developed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of people with diabetes who have had an HbA1c test (quarterly)</td>
<td>90%</td>
<td>T: 92%</td>
<td>Performance is meeting expectation of ≥90% coverage.</td>
</tr>
<tr>
<td></td>
<td>M: 90%</td>
<td>P: 90%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O: 91%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of people with diabetes who have had a retinal screen (quarterly)</td>
<td>90%</td>
<td>T: 80%</td>
<td>Performance is below target (90%) but improving after a significant decrease over winter 2017. Equity measure to be developed.</td>
</tr>
<tr>
<td></td>
<td>M:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>P:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>O:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate of booked first specialist assessments for long term condition outpatient clinics (quarterly)</td>
<td>T: 51</td>
<td>T: 51</td>
<td>To ensure people are accessing services. This quarter, performance in this indicator is stable for Māori and the total population but increasing for Pacific. Māori and Pacific have consistently higher rates of booking in line with prevalence of long-term conditions.</td>
</tr>
<tr>
<td></td>
<td>M: 59</td>
<td>M: 60</td>
<td></td>
</tr>
<tr>
<td></td>
<td>P: 61</td>
<td>P: 66</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O: 49</td>
<td>O: 49</td>
<td></td>
</tr>
<tr>
<td>Rate of booked follow up assessments for long term condition outpatient clinics (quarterly)</td>
<td>T: 161</td>
<td>T: 164</td>
<td>This quarter, there are more booked appointments compared with last quarter for all ethnicities. Māori and Pacific have consistently higher rates of booking in line with prevalence of long-term conditions.</td>
</tr>
<tr>
<td></td>
<td>M: 238</td>
<td>M: 251</td>
<td></td>
</tr>
<tr>
<td></td>
<td>P: 505</td>
<td>P: 513</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O: 133</td>
<td>O: 135</td>
<td></td>
</tr>
</tbody>
</table>
Rate of not attended (DNA) first specialist assessments for long term condition clinics (quarterly)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>T (6%)</th>
<th>M (14%)</th>
<th>P (14%)</th>
<th>O (4%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>T</td>
<td>6%</td>
<td>14%</td>
<td>14%</td>
<td>4%</td>
</tr>
<tr>
<td>M</td>
<td>6%</td>
<td>11%</td>
<td>7%</td>
<td>5%</td>
</tr>
<tr>
<td>P</td>
<td>6%</td>
<td>11%</td>
<td>8%</td>
<td>5%</td>
</tr>
<tr>
<td>O</td>
<td>6%</td>
<td>15%</td>
<td>13%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Māori and Pacific have consistently higher rates of did not attends. However, the rate for Pacific peoples decreased by 1.6% this quarter.

Rate of not attended (DNA) follow up assessments for long term condition clinics (quarterly)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>T (6%)</th>
<th>M (11%)</th>
<th>P (7%)</th>
<th>O (5%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>T</td>
<td>6%</td>
<td>11%</td>
<td>7%</td>
<td>5%</td>
</tr>
<tr>
<td>M</td>
<td>6%</td>
<td>15%</td>
<td>13%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Māori and Pacific have consistently higher rates of did not attends. However, the rate for Pacific peoples increased by 0.2% this quarter.

More Heart and Diabetes Checks (quarterly)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>T (89.2%)</th>
<th>M (86.0%)</th>
<th>P (87.3%)</th>
<th>O (89.8%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>T</td>
<td>89.2%</td>
<td>86.0%</td>
<td>87.3%</td>
<td>89.8%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
It is 5 years since the introduction of this measure. As a result, large volumes of checks were due this quarter. We are working with our PHOs to improve performance this quarter.

Better Help for Smokers to Quit - Primary Care (quarterly)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>T (89.9%)</th>
<th>M (90.1%)</th>
<th>P (90.3%)</th>
<th>O (90.9%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>T</td>
<td>89.9%</td>
<td>90.1%</td>
<td>90.3%</td>
<td>90.9%</td>
</tr>
<tr>
<td>M</td>
<td>88.7%</td>
<td>86.0%</td>
<td>86.5%</td>
<td>89.3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Performance continued to be significantly below target but is improving. Analysis has highlighted ED as the area for improvement initiatives to target.

System Level Performance

Smoking quit rate - Primary Care (quarterly)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>T (12.8%)</th>
<th>M (10.0%)</th>
<th>P (10.2%)</th>
<th>O (14.2%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>T</td>
<td>12.8%</td>
<td>10.0%</td>
<td>10.2%</td>
<td>14.2%</td>
</tr>
<tr>
<td>M</td>
<td>12.5%</td>
<td>9.2%</td>
<td>8.7%</td>
<td>14.3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Performance overall in this indicator decreased in the last quarter. The decrease was more marked in Māori and Pacific populations who have consistently higher rates of smoking. Our regional stop smoking provider is launching an incentivised quit programme, focused on these populations, this quarter – which is designed to increase the quit rate.

High CVD risk (>20%) and on statins (quarterly)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>T (83.1%)</th>
<th>M (75.9%)</th>
<th>P (79.0%)</th>
<th>O (84.3%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>T</td>
<td>83.1%</td>
<td>75.9%</td>
<td>79.0%</td>
<td>84.3%</td>
</tr>
<tr>
<td>M</td>
<td>84.3%</td>
<td>76.6%</td>
<td>79.9%</td>
<td>85.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Performance improved for all ethnicity groups this quarter. However, Māori and Pacific have lower rates of statin prescription than other. Improvement on this measure is being monitored as part of the System Level Measures framework to ensure equity.

HbA1c level of less than 64mmol/mol (quarterly)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>T (65%)</th>
<th>M (61%)</th>
<th>P (58%)</th>
<th>O (68%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>T</td>
<td>65%</td>
<td>61%</td>
<td>58%</td>
<td>68%</td>
</tr>
<tr>
<td>M</td>
<td>65%</td>
<td>61%</td>
<td>57%</td>
<td>68%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Performance is stable. The Diabetes Clinical Network is running a quality improvement initiative with practices to improve this indicator – particularly focused on 15-39 year old Māori and Pacific who are overrepresented in not achieving this indicator.

Age-standardised ASH rate for respiratory conditions (quarterly)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>T (245)</th>
<th>M (779)</th>
<th>P (693)</th>
<th>O (180)</th>
</tr>
</thead>
<tbody>
<tr>
<td>T</td>
<td>245</td>
<td>779</td>
<td>693</td>
<td>180</td>
</tr>
<tr>
<td>M</td>
<td>263</td>
<td>876</td>
<td>717</td>
<td>192</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Rates are slowly increasing for all but ASH for respiratory conditions, where there was a 7% increase last quarter. Improvement initiatives include:
### Impact Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>T</th>
<th>M</th>
<th>P</th>
<th>O</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age-standardised ED presentations for long term conditions (quarterly)</td>
<td>T: 37.3</td>
<td>M: 60.4</td>
<td>P: 75.4</td>
<td>O: 32.5</td>
<td><strong>Proactive care through Health Care Homes</strong></td>
</tr>
<tr>
<td></td>
<td>T: 37.5</td>
<td>M: 58.9</td>
<td>P: 76.6</td>
<td>O: 33.0</td>
<td><strong>Tranche 3 rollout of Health Care Home</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Sum</strong></td>
<td><strong>Sum</strong></td>
<td><strong>Sum</strong></td>
<td><strong>Sum</strong></td>
<td><strong>Extending VLCA prices to all community services card holders (1 December 2018)</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Sum</strong></td>
<td><strong>Sum</strong></td>
<td><strong>Sum</strong></td>
<td><strong>Sum</strong></td>
<td><strong>Development of a long-term conditions investment approach</strong></td>
</tr>
<tr>
<td>Age-standardised inpatient admissions for long term conditions (quarterly)</td>
<td>T: 36.1</td>
<td>M: 56.0</td>
<td>P: 73.3</td>
<td>O: 32.0</td>
<td><strong>Sum</strong></td>
</tr>
<tr>
<td></td>
<td>T: 36.5</td>
<td>M: 56.1</td>
<td>P: 75.8</td>
<td>O: 32.4</td>
<td><strong>Sum</strong></td>
</tr>
<tr>
<td>Age-standardised acute bed days for long term conditions (quarterly)</td>
<td>T: 80</td>
<td>M: 146</td>
<td>P: 188</td>
<td>O: 69</td>
<td><strong>Sum</strong></td>
</tr>
<tr>
<td></td>
<td>T: 80</td>
<td>M: 137</td>
<td>P: 190</td>
<td>O: 69</td>
<td><strong>Sum</strong></td>
</tr>
<tr>
<td><strong>Impact Measures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude amenable mortality rate for long term conditions (annual)</td>
<td>T: 56</td>
<td>T: 54</td>
<td></td>
<td></td>
<td>This rate is decreasing. Not available by ethnicity from the Ministry of Health.</td>
</tr>
<tr>
<td>Quality-adjusted life year (QALY) annual</td>
<td>To be developed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability-adjusted life year (DALY) annual</td>
<td>To be developed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience of services for people with LTC</td>
<td>To be developed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 3.6 The significance impact of inequity

In almost all of the measures above we can see that Māori and Pasifika people have significantly poorer impacts and outcomes than our Pākeha population. For ASH rates for respiratory conditions, the burden for Māori and Pasifika is 5 times that of the Pakeha population. For acute bed days, it is almost 3 times the burden.

Our persistent poor performance is not well understood. The focus of future will emphasise equity and the importance of models of care that work for these communities. It is likely that a shift in our models of care and investments will need to be made to change these outcomes.

### 4 OPPORTUNITIES TO DO THINGS DIFFERENTLY

The long-term conditions dashboard shows a number of opportunities to continue to improve the impact of our services through a focus on equity. The Long-Term Conditions Investment Plan will provide the approach for achieving equity and improving outcomes in our community. It will specifically consider how we deliver and invest in prevention and early-intervention services.

In the next six months, we will:

- Work with our providers to ensure all monitoring and reporting of service activity and performance is presented by ethnicity.
- We will also work with our providers to focus on equity and ensure they are targetting effort to our Māori and pasifika communities.
- We will ensure primary care, through the Healthcare Home initiative to improve performance in:
  - More Heart and Diabetes checks and screening outcomes (statins)
  - Annual testing of blood glucose control for people with a diagnosis of diabetes and subsequent discussions on how to improve levels
• We will investigate with our Māori and Pasific Health Teams to reduce did not attend rates for first specialist appointments and follow ups in the Hospital and Health Services

5 PRESENTING THE DASHBOARD TO HSC

The dashboard will be updated six-monthly in March and August each year and presented to HSC with a narrative report describing:

1) outcomes of improvement initiatives for the previous six months
2) performance issues for the current six months
3) action plan of improvement initiatives for the coming six months.
LONG TERM CONDITIONS DASHBOARD

**Funding**
- Number of people with a long term condition
- More Heart and Diabetes Checks
- Green prescription referrals
- Faster Cancer Treatment
- Rate of first specialist assessments booked
- Rate of follow ups booked

**People**
- Better help for smokers to quit in primary care
- Better help for smokers to quit in hospital
- Number of people with diabetes who have had an HbA1c test
- Number of people with diabetes who have had a renal screen
- Rate of EDRAs for booked first specialist assessments
- Rate of DNRs for follow ups

**Early Detection & Management**
- Preventative and diabetic services

**Intensive Assessment & Treatment**
- Preventative and diabetic services

**Structural Measures**
- Preventative and diabetic services

**Interventions**
- Smoking quit rate
- High CVD risk and on statins
- HbA1c level <43mmol
- Age-standardised respiratory ADH1 rate

**Overall System Performance**
- Age-standardised ED presentation rate
- Age-standardised inpatient admission rate
- Age-standardised acute bed day rate

**System Impact**
- Crude Amenable mortality rate for ITC

**Person Impact**
- QALYs
- DALYs

**Impact Measures**
- Under development during 2018/19
- Under development during 2018/19

**Performance Highlights**

**Key**
- Major
- Pacific
- Other
- Total
The purpose of this paper is to update the Health System Committee (also known as Community Public Health Advisory Committee and Hospital Advisory Committee of Capital & Coast District Health Board) on the sub-regional public health unit (Regional Public Health) recent activities.

The most recent bi-monthly provider performance report from Regional Public Health (RPH) to the CCDHB Health System Committee, was provided in May 2018.

This paper should be read in conjunction with the RPH paper on Housing to CCDHB HSC, also presented 29 August 2018.

Regional Public Health is the sub-regional public health unit of Hutt Valley, Wairarapa and Capital & Coast DHBs. All five core public health functions including health promotion; health protection; health assessment and surveillance; public health capacity development; and preventative interventions are provided. In addition, regulatory (health protection) services are extended to the Otaki Ward.
HVDHB is the Ministry of Health contract holder for the core public health services. The range of interrelated services, are shown in the table below. All service areas are sub-regional across the three RPH Service Areas

<table>
<thead>
<tr>
<th>Core MoH contracted services</th>
<th>Non-core MoH contracted services</th>
<th>DHB funded services</th>
<th>Other contracted services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Alcohol and Other Drugs</td>
<td>• Drinking-water Technical Advice Services for Networked Supplies</td>
<td>• Bacille Calmette-Guérin (BCG) Nursing (HVDHB, CCDHB)</td>
<td>• Public Health Medicine Registrar Training</td>
</tr>
<tr>
<td>• Communicable Diseases</td>
<td>• Community Action on Youth and Drugs CAYAD (Hutt Valley)</td>
<td>• Ear Nurse Specialist (CCDHB)</td>
<td>• Public Health Medicine Registrar Supervision (Central Region)</td>
</tr>
<tr>
<td>• Mental Health Promotion (suicide postvention)</td>
<td>• Public Health Clinical Network Secretariat (NZ)</td>
<td>• Healthy Homes: (a) Rheumatic Fever Prevention, Healthy Homes System (HVDHB, CCDHB)</td>
<td>• Public Health Medicine Specialist/Medical Officer of Health (MidCentral DHB)</td>
</tr>
<tr>
<td>• Nutrition and Physical Activity</td>
<td></td>
<td>(b) Healthy Homes Initiative Expansion (HVDHB, CCDHB)</td>
<td>• Public Health Nurse at Naenae Work &amp; Income</td>
</tr>
<tr>
<td>• Physical Environments and Border Health</td>
<td></td>
<td>(c) Public Health Nurse - Healthy Housing (HVDHB)</td>
<td>• SHIVERS II Research Project</td>
</tr>
<tr>
<td>• Public Health Infrastructure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Refugee and Asylum Seeker Health / Refugee Health INH</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sexual Health Promotion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Social Environments</td>
<td></td>
<td>Immunisation: (a) Year 8 HPV school based vaccination (b) Year 7 Boostrix school based vaccination</td>
<td></td>
</tr>
<tr>
<td>• Tobacco Control</td>
<td></td>
<td>(b) Immunisation Outreach Co-ordination (HVDHB)</td>
<td></td>
</tr>
<tr>
<td>• Public Health Advice (Central Region)</td>
<td></td>
<td>(c) DHB National Immunisation Register Administration (HVDHB)</td>
<td></td>
</tr>
</tbody>
</table>

3. UPDATE OF RECENT KEY WORK AREAS, WITH A FOCUS ON COLLABORATIVE ACTIVITY IN PORIRUA AND EASTERN PORIRUA

3.1 Porirua healthy food and drink environments and type 2 diabetes

As reported in the May update, RPH convened a Healthier Food and Drink Environments workshop for local councils in March 2018, which was attended by Porirua City Council (PCC). In April, RPH, together with Ora Toa PHO and Tū Ora Compass Health, made a joint submission to PCC on its Long Term Plan. The focus of this submission was the increase of type 2 diabetes in Porirua City. At the oral hearing for this submission,
PCC were enthusiastic to keep the conversation going and to hear more about what the council could do in this area. We were asked to present additional information about healthy food environments at a full council workshop.

In July, RPH led a workshop with PCC councillors, supported by Ora Toa Primary Health Organisation (Ora Toa PHO) and Tū Ora Compass Health. A draft paper was provided outlining the current activities and commitments of PCC which may have a positive impact on the prevalence of type 2 diabetes. The paper also included ‘other opportunities’ for the council to consider in relation to this chronic disease. The tone of both the paper and the workshop was to present opportunities for partnership, continued conversation and collaborative work (refer appendix 1; Combating Type 2 Diabetes in Porirua City. PCC was very receptive to the opportunities presented with several avenues of potential follow up from the workshop.

A further follow up request was received from Eastern Porirua City Councillors who would like the RPH and Primary Care joint submitters to engage with them and community groups in the Eastern Porirua Ward. The request is for an initial meeting in August, to dialogue about how the community can take the initiative to address the increase in incidence of Type 2 Diabetes.

3.2 Well Homes Partnership - in Porirua and Porirua East

The RPH Housing Approach paper, also part of your Agenda, advises that RPH is involved in a partnership programme with Sustainability Trust, Tu Kotahi Maori Asthma Trust (TKMAT) and He Kainga Oranga (HKO), called Well Homes. Well Homes provides free health checks for homes.

Well Homes acts as a hub for housing referrals across the region. When a referral is received whānau are contacted by Well Homes through a phone call, and linked with the most appropriate housing service (according to their needs, and contract eligibility). Housing assessors visit the home, provide a housing assessment, and provide on-site education. A whānau plan is developed. The service is monitored via an in-house database set up specifically for use within the programme.

Through the Combined Rheumatic Fever and Well Homes Governance group member organisations, Well Homes facilitates access to primary and secondary care services through identification of health, social and housing needs for whānau within the programme.

One of the current opportunities for collaboration in Porirua is in the delivery of injury prevention key messages. Specifically, RPH is currently scoping this with Maraeroa, and Ora Toa injury prevention services.

3.2.1 Well Homes Referral Volumes, Ethnicity and Housing Tenure

Comparing 2016/17 to 2017/18, and Porirua and Porirua East:

<table>
<thead>
<tr>
<th></th>
<th>Porirua</th>
<th>Porirua East</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 July 2016 - 30 June 2017</td>
<td>1 July 2017 - 30 June 2018</td>
</tr>
<tr>
<td>No. of Referrals Received</td>
<td>315</td>
<td>360</td>
</tr>
<tr>
<td>% of total Porirua referrals</td>
<td>69%</td>
<td>71%</td>
</tr>
<tr>
<td>No. of Assessments Completed</td>
<td>200</td>
<td>148</td>
</tr>
<tr>
<td>% of total Porirua referrals</td>
<td>71%</td>
<td>74%</td>
</tr>
<tr>
<td>No. of Interventions Provided</td>
<td>872</td>
<td>1330</td>
</tr>
<tr>
<td>% of total Porirua referrals</td>
<td>74%</td>
<td>73%</td>
</tr>
</tbody>
</table>

Data interpretation:
- Porirua suburbs include Aotea, Ascot Park, Cannons Creek, Elsdon, Porirua, Porirua East, Ranui, Ranui Heights, Takapuwahia, Titahi Bay, WAITANGIRUA and Whitby
Porirua East suburbs include Porirua East, Ranui, Ranui Heights, Cannons Creek and Waitangirua.

"Completed" assessments refers to those that meet the RhF and expansion criteria.

"Referrals received" includes all housing referrals received by the hub.

Ethnicity of individuals from Porirua referred to Well Homes 1 July 2017 – 30 June 2018:

Tenure category and number of Porirua properties in which referred individuals were resident 1 July 2017 – 30 June 2018:

3.3 Synthetic Cannabinoids

Use of synthetic cannabinoids is an increasing cause of morbidity and mortality. This emerged as a significant health issue in July 2017 with deaths potentially attributed to the drug in Auckland (noting this is unsubstantiated by the coroner). Synthetic cannabinoid use in the CCDHB area was being monitored by RPH at this time via data sent from the CCDHB emergency department that showed a consistent level of presentations. Volumes at this time did not appear out of the ordinary. Anecdotally, Porirua police were noticing an increased visibility in its presence. In November 2017, concerns were heightened in the CCDHB area, particularly Porirua, as the number of emergency calls had risen significantly.

Prompted by the need to better understand the problem representatives from RPH, Police, ESR, The New Zealand Drug Intelligence Bureau and Porirua City Council began meeting regularly to update each other with any new information and activities being undertaken. The group also took responsibility for ensuring the public were informed of the immediate danger, and continues to meet. Although there has not been a significant increase in call outs since November 2017, there have been two deaths that are potentially attributed to synthetic cannabinoid use. Through ESR and the Intelligence Bureau RPH is now accessing information previously unavailable. We now understand that the potency of the drug varies, which in turn contributes to the level of harm and that the type of synthetic cannabinoids available shows distinct regional variation.
RPH is working collaboratively with community service agencies focusing on upskilling the knowledge base of the community, supporting providers and developing a prevention/support programme for young people. Agencies involved include Challenge 2000 (social workers in schools), Maraeroa Health, Tū Ora Compass Health, Salvation Army, Porirua City Council and RPH. The programme in development for youth includes educational flash cards that are currently being piloted with community groups as well as health and social workers. The potential to include users and ex-users in the pre-testing is also being explored.

From the CCDHB emergency department data European, Maori and Pacific peoples all have concerning use of Synthetic Cannabinoids. The data also suggests that Maori and Pacific Peoples may have higher rates of use given their significant lower representation in the resident population.

**CCDHB Emergency Department presentations for Synthetic Cannabinoids**

![Graph showing ED presentations by year and ethnicity]

### 3.4 Reducing Alcohol Related Harm

Along with the recent failure of Black Bull Liquor in Newtown to obtain an off licence, in May there were two further important successes in the CCDHB area, both of which will have a significant influence on the future of alcohol control in central Wellington and further afield:

#### 3.4.1 Liquor King Kent Terrace High Court Decision

The appeal by the Medical Officer of Health (MOoH) resulted in the setting aside of the decision by the Alcohol Regulatory and Licensing Authority (ARLA) and the reinstatement of the Wellington City District Licensing Committee (DLC) decision to reduce the trading hours on Friday and Saturday evenings from 11pm to 9pm.

RPH work on this renewal started back in mid 2015. After a three day public hearing, in October 2016 the DLC for Wellington decided to reduce the trading hours on Friday and Saturday evenings from 11pm to 9pm and to impose a condition requiring the use of plastic bags with the name of the store printed on the bags. Lion Liquor Retail Limited appealed this decision to ARLA who, in May 2017, allowed the appeal and modified the condition to permit Liquor King to sell alcohol until 11pm on Fridays and Saturdays. Although there was local evidence of high levels of alcohol related harm, ARLA concluded that the MOoH and the Police were unable to demonstrate a “causal nexus” between granting the renewal and the alcohol related harm.

The MOoH, with the support of the Police, appealed this decision to the High Court. The decision was released on 18 May 2018 reinstating the original DLC decision. Justice Clark agreed with the MOoH that
the statutory objects of the Sale and Supply of Alcohol Act 2012 are orientated exclusively towards public health outcomes:

- Where existing levels of alcohol related harm are clearly not “minimised”, the Act’s objective of “minimisation of alcohol related harm” requires a change in approach to the causal nexus requirement;
- Decision makers are not required to be sure that a change to trading hours will reduce alcohol related harm, and, may apply the “precautionary principle” by making changes that are likely to achieve this outcome.

Lion decided not to appeal this decision to the Court of Appeal. This decision is very significant and will set case law with national implications. A Dom Post article from 21 May is included as Appendix 2.

All the remaining liquor stores in central Wellington are at a stage in their licence application process meaning that in the very near future potentially all these off licences will have reduced trading hours on Friday and Saturday. In order, to start bringing the two supermarkets in line with the liquor stores RPH and the Police are opposing the licence renewal for Schaffer’s New World.

Additionally, as central Paraparaumu has very high levels of alcohol related harm, as a follow on RPH is appealing the Kapiti DLC decision not to reduce the trading hours for Kapiti New World Paraparaumu to be in line with neighbouring liquor stores. The DLC decision was based on the ARLA case law that is now overturned.

3.5 Cooking Confidence RPH is working with Wesley Community Action

Following on from the successful ‘cooking confidence’ sessions held for people who access the Titahi Bay Fruit and Vege Co-op hub, RPH is working with Wesley Community Action to provide two further series of weekly sessions in Cannons Creek starting in August, for six weeks. One series is for people who access the Foodbank and will be part of the ‘Good Cents’ budgeting programme run by Wesley Community Action. The second series is for buyers of the Fruit and Vege Co-op. Fruit and Vege distribution centres in Eastern Porirua include Wesley Community Action Cannons Creek, Mungavin Avenue; Salvation Army Cannons Creek, Warspite Avenue; Te Kura Māori o Porirua, Warspite Avenue; Holy Family School, Mungavin Avenue; as well as Corinna School in Waitangirua.

The primary goal for the classes is to increase cooking confidence. We want participants to be able to look at the contents of their co-op bags and see a meal they can prepare. Minimising food waste is also taught, along with a few cooking basics, knife skills etc.

3.6 Promoting Sugar-free beverages – water kits donated to schools

Water in Schools

A number of water kits have been delivered to schools in Hutt, Porirua, Wellington and Kapiti region. The kits have been donated by local dentists belonging to the New Zealand Dental Association and provided to schools who requested assistance to develop a Water Only Policy in the school survey completed by RPH.

RPH recently responded to Jesse Mulligan from the TV current affairs programme ‘The Project’ about a story on Water in Schools. Jesse encourages schools to adopt a water only policy and ran a story about Randwick School in the Hutt Valley. The Working Group were delighted with this news item and presented further information to bring his attention to the work happening at the moment. In addition, an article on Water in Schools will be in the Education Gazette.
3.7 2018 Australasian Tuberculosis Conference

Since the last report (May), RPH has made good progress with organisation of this Conference on 30 – 31 August at Te Papa. To date registration numbers have exceeded the target set, and the Conference Programme is almost finalised. 28 abstracts were submitted which have provided for three concurrent sessions of six abstract presentations as part of the programme. Several abstracts have been integrated into plenary sessions.

The main content areas are:

- New Strategies for TB Elimination
- Cross-border Issues and Latent TB Infection (LTBI)
- Bio-medical Advances toward TB Elimination
- Laboratory Innovation for TB Elimination
- Clinical Dimensions
- Multi-drug resistant (MDR) TB and Case Studies
- The New Zealand TB Guidelines, 2018 Edition - workshop

3.8 Public Health Nurse (PHNs) in Primary and Intermediate Schools - Top Ten Conditions and Referral Summary and, 1 January – 30 March 2018, CCDHB

PHNs provide personal health support to children attending primary and intermediate schools across three DHBs. The service is focused on deciles one – three schools with at least one visit per week, and then one visit per fortnight to decile four – six schools if required. A response service is delivered to decile seven – ten schools when a need arises.

The complexity of problems for children that PHNs are encountering has increased. Multiple conditions are frequent with behavioural, developmental, social concerns, and child protection all featuring in the top ten conditions for the CCDHB children RPH works with.

**CCDHB Top ten identified conditions in personal health referrals to school based PHNs; April – June 2018**

<table>
<thead>
<tr>
<th>Ranking</th>
<th>Referral condition</th>
<th>Number of referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Vision</td>
<td>110</td>
</tr>
<tr>
<td>2</td>
<td>Social concerns</td>
<td>47</td>
</tr>
<tr>
<td>3</td>
<td>Hearing concerns</td>
<td>46</td>
</tr>
<tr>
<td>4</td>
<td>Developmental</td>
<td>37</td>
</tr>
<tr>
<td>5</td>
<td>Absenteeism</td>
<td>31</td>
</tr>
<tr>
<td>6</td>
<td>Behavioural</td>
<td>29</td>
</tr>
<tr>
<td>7</td>
<td>Impetigo</td>
<td>29</td>
</tr>
<tr>
<td>8</td>
<td>Minor skin infections</td>
<td>29</td>
</tr>
<tr>
<td>9</td>
<td>Dental</td>
<td>22</td>
</tr>
<tr>
<td>10</td>
<td>Asthma</td>
<td>20</td>
</tr>
</tbody>
</table>
The PHN’s work closely with the school social workers and are able to ensure the children are receiving appropriate medical assessments which is vital for children that might otherwise appear to be behavioural, developmental or social concerns. Some of these children require specialist referrals for clinical review of the developmental or behavioural condition.
CCDHB School based PHNS activity summary, April – June 2018

<table>
<thead>
<tr>
<th>Activity</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Referrals In</td>
<td>271</td>
</tr>
<tr>
<td>New Referrals In - # of Conditions Treated</td>
<td>396</td>
</tr>
<tr>
<td>New Entrant Assessment Decile 1-3s</td>
<td>0</td>
</tr>
<tr>
<td>Nursing Consultation</td>
<td>244</td>
</tr>
<tr>
<td>Phone Triage/Assessment</td>
<td>161</td>
</tr>
<tr>
<td>Health Education</td>
<td>4</td>
</tr>
<tr>
<td>Home Visit</td>
<td>53</td>
</tr>
<tr>
<td>Internal &amp; External Agency Liaison</td>
<td>269</td>
</tr>
<tr>
<td>School Liaison</td>
<td>284</td>
</tr>
<tr>
<td>Transport &amp; Advocacy</td>
<td>15</td>
</tr>
<tr>
<td>Referral Out</td>
<td>15</td>
</tr>
<tr>
<td>Referrals Closed</td>
<td>266</td>
</tr>
</tbody>
</table>

CCDHB School based PHNs open referrals by ethnicity, as at 30 June 2018

<table>
<thead>
<tr>
<th>Māori</th>
<th>Pacific</th>
<th>NZ European</th>
<th>Asian</th>
<th>Other</th>
<th>Not specified</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>177</td>
<td>154</td>
<td>53</td>
<td>13</td>
<td>33</td>
<td>-</td>
<td>430</td>
</tr>
</tbody>
</table>
Appendix One: Combating type 2 diabetes in Porirua City

Combating type 2 diabetes in Porirua City
Let’s work together!

Naku te rourou nau te rourou ka ora ai te iwi
With your basket and my basket the people will live

Regional Public Health (RPH), Ora Toa Primary Health Organisation (Ora Toa PHO) and Tū Ora Compass Health celebrate the fantastic work Porirua City Council (PCC) is doing to make Porirua City a great place to grow up. The strategic framework for children and young people demonstrates PCC’s commitment to the health and wellbeing of its population. We encourage Council to press on to make it easy to live a healthy life, no matter which suburb of Porirua you grow up in.

We invite Porirua City Council to partner with Regional Public Health, supported by Ora Toa PHO and Tū Ora Compass Health to further our collective work to combat type 2 diabetes.

You’ve committed to ensuring that our children and young people are healthy, physically active and feel safe.

We are optimistic that the planned activities resulting from this strategic framework will have a positive effect on the health and wellbeing of children and young people in Porirua. They will also make a substantial contribution to combating the increase of type 2 diabetes in Porirua City, particularly in our young people.

“We are a city of contrasts – there are big differences between our communities with high and low income communities living side by side. There are differences in social outcomes.”

“Not all children and young people in Porirua have the same chance at success.”
Porirua City Council’s strategic framework for children and young people.

As the quote above states, “Not all children and young people in Porirua have the same chance at success” and this is definitely the case in terms of who is hit hardest by the burden of type 2 diabetes. In response, we encourage the Council to maintain an equity lens to ensure that resources, leadership and partnership are targeted to the people and in the suburbs where they are most needed.
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This is a living document

In this document, we will highlight and celebrate the work that PCC is already doing, and encourage you to keep going with this important work. Alongside this, we have noted ideas of other opportunities which align with the Council’s current contributions in each focus area and will also support our joint efforts to combat type 2 diabetes. This is intended to be a living document that acts as a spring board for collaboration.

An ongoing partnership

There are opportunities to work together on policy, planning, and projects particularly as they relate to the food and built environment. As primary healthcare, Ora Toa and Tū Ora Compass Health are uniquely situated to provide grassroots health monitoring to complement the survey work the Council work is already undertaking.

Your local GPs, PHOs and RPH see many opportunities for collaboration and we are keen to provide our support and expertise to help Council achieve our shared vision of ensuring that all people in Porirua are healthy and thriving.
**Focus Area 1: Environment and place**

“Why is this important? Research shows that when children have regular contact with nature it improves their social, psychological, academic and physical health.”

Providing safe and interesting opportunities for residents to be physically active promotes physical and mental wellbeing, prevents disease and improves social connectedness and quality of life.

Physical activity levels have been shown to increase by over 160% in communities where people have access to green spaces, streets are well connected, and people live close to schools and shops. People also walk more when neighbourhoods are created to be walkable, safe and aesthetically pleasing. Implementing good urban design principles can support these features in each ‘village’.

**Keep going!**

- Council led programmes for local neighbourhood improvements such as the cage basketball court upgrades and the Bedford Reserve project.
- Involvement in shaping their neighbourhoods through the projects in Village Planning.
- Involvement in playground function and design.
- Targeted involvement in our review of the District Plan.

**Other opportunities**

- Planting fruit trees and edible plants on Council owned land.
- Strengthening support for berm gardens, community gardens and urban foraging such as designated community blackberry picking e.g. Bothamley Park.
- Encouraging “garden to table” initiatives that incorporate both growing and cooking food alongside Council’s existing “partnerships with environmental education programmes such as Enviroschools, Porirua”.
Focus Area 2: Safety and well-being

“All children in Porirua grow up healthy, active, and safe. Public places promote health and well-being and strengthen connections for the well-being of young people.”

Type 2 diabetes can be prevented or onset delayed through adopting a healthy lifestyle (e.g. nutritious diet, drinking water and increased physical activity). As the kaitiaki of the local environment, PCC has a unique perspective on the crucial importance of ‘place’ in promoting safety and well-being. The environment in which Porirua residents live, work and play, the housing they live in, the green spaces around them, access to affordable nutritious food and their opportunities for work and leisure, are all fundamental to their health and well-being. Feeling safe is the foundation on which all other choices that support living a healthy life are built.

Keep going!

- Continuously improving and expanding places and spaces for children and young people to enjoy as our city grows e.g. new playground in the city centre, new cycle trails etc.
- Regularly upgrading our playgrounds and implementing accessibility audit recommendations to ensure playgrounds can be enjoyed by children of all abilities and their parents/caregivers.
- Advocating to central government for improvements in social housing and community regeneration in Eastern Porirua.
- Implementing new policies to make facilities and events healthier, such as improving access to free water at events, more healthy food options and more water fountains in public spaces.
- Exploring the merits of establishing a youth-led safety advisory group.

Other opportunities

The strategic framework for children and young people states:

“We can ensure that we are a good role model by making healthy choices easier in our recreational facilities.”

From our perspective, being a good role model could include:

- Removing sugar sweetened beverages from all Council facilities.
- Developing food and drink guidelines for Council facilities.
- Purchasing at least one hydration station to provide free water at all Council events.
- Expanding on the Creekfest model which includes a ‘water only’ policy and healthier food stalls. Using this successful model for other community events.
- Taking the lead to ensure healthy food options are the easy option at Council meetings and ‘in house’ events.
- Ensuring free water is available at all child-focussed Council run events.
• Improving the food environment within Council facilities e.g. reducing the availability of high sugar and high fat foods.
• Promoting breastfeeding in Council facilities and ensuring appropriate breastfeeding amenities are available in the community.

Continued other opportunities:

• Support schools moving to a ‘water only’ policy.
• Alongside accessibility audits of playgrounds, conduct a water-fountain audit of all Council parks and playgrounds to ensure that water fountains are easily accessible, clean and well maintained. Install water fountains where they are not currently present in recreation locations.
• Complement Eastern Porirua revitalisation efforts by making changes to the food environment – incentivising healthy food and beverage retailers to operate in these areas.
• Develop and promote a window sticker for cafés to indicate their willingness to refill water bottles onsite even for non-customers.
• Alongside “exploring the merits of establishing a youth-led safety advisory group” consider focussing efforts to improve walkability by addressing safety concerns.
• Together with RPH, explore mechanisms within licensing of food outlets to improve access to healthy foods and beverages e.g. include healthy food and beverage criteria.
Focus Area 3: Opportunities and experiences

“Children and young people want equity. They want to ensure everyone has the same opportunities.”

The New Zealand Health Survey shows considerable socioeconomic inequalities in the prevalence of type 2 diabetes in New Zealand, with a significantly higher prevalence of type 2 diabetes in more deprived areas compared with the least deprived areas.

PCC’s strategic framework for children and young people notes the important role the Council plays in providing children and young people with positive opportunities and experiences. The framework also notes the need for the Council to be mindful of barriers to accessing these opportunities. Ensuring equity of access to Council lead opportunities (e.g. education programmes at local pools) that promote physical activity, health and well-being can support an effort to combat type 2 diabetes.

Keep going!

- Te Pahi community bus which offers students from decile 1-4 schools free transport to our facilities and programmes, and trips to educational destinations in the Wellington region.
- Delivering educative programmes in schools on a range of topics such as road safety, environmental issues and graffiti management.
Focus Area 4: Connection and belonging

“Children and young people have many great ideas. They would like more things that bring people together such as teen hang out places, community gardens, environmental programmes and cultural events and celebrations.”

The strategic framework states: “Good urban design helps to make the city easier for children and young people to move about in, for example, child-friendly pedestrian and cycling connections”. By prioritising good urban design the Council not only builds connection for children and young people, it also creates an environment that makes it easy to be physically active, promotes well-being and ultimately contributes to combating type 2 diabetes. We take good urban design to include: prioritising the needs of pedestrians and cyclists when developing new infrastructure; ensuring access to green spaces with good lighting; working with schools and workplaces to encourage walking and cycling; and supporting access to healthy food options when planning and designing networks of cycleways, walkways and new developments.

Keep going!

- Making it easier to get around through a better connected cycling network and supporting cycle programmes to build skills.
- Pedestrian and cycle friendly city centre revitalisation.
- Providing safe and well maintained neighbourhoods, parks and playgrounds.
- Exploring a revitalisation project in Eastern Porirua. Involving young people in revitalisation ideas and plans will strengthen their sense of belonging and connection in Eastern Porirua.

Other opportunities

- When exploring a revitalisation project in Eastern Porirua, keep the health and wellbeing of residents as a key priority. Involve young people in projects that explore opportunities to improve access to affordable nutritious food.
Annex 1. What the data tells us: Porirua City and type 2 diabetes

Although type 2 diabetes is a serious and increasing problem throughout New Zealand, adults living in Porirua are much more likely to develop type 2 diabetes than those living in other parts of the Greater Wellington region (see figure 1). Compared with other TLAs, the prevalence of diabetes is highest for PCC (see figure 2). In turn, the burden of diabetes is not evenly distributed across Porirua. The greatest burden is in Waitangirua, Cannons Creek, Porirua Central and Porirua East (see figure 3) which are areas with high levels of socio-economic deprivation and higher proportions of Māori and Pacific residents.

Figure 1: Age adjusted prevalence in adults (over 25 years old) in Porirua compared with the greater Wellington region

Figure 2: Age adjusted prevalence of diabetes in adults (over 25 years old) for Porirua City Council (PCC), Hutt City Council (HCC), Upper Hutt City Council (UHCC), Wellington City Council (WCC), the Wairarapa Councils, and Kapiti Coast District Council (KCDC) in 2016
Figure 3: Prevalence of diabetes (all ages) in Porirua by Census Area Unit in 2016
Type 2 diabetes in younger people sends worrying signal of future ill health

Simon Haufe

GPs need to be aware of, and to assertively treat, younger patients presenting with type 2 diabetes. National Diabetes Leadership Group member and Porirua GP Bryan Betty says.

Dr Betty says he is seeing an alarming, developing trend of patients with type 2 diabetes in their 30s or even 20s.

His Cawhia Creek practice largely serves high-deprivation patients, seeing mostly people with a Pacific ancestry presenting as prediabetic, or with type 2 diabetes.

The 2017 Virtual Diabetes Register from the Ministry of Health shows more than 345,000 adult New Zealanders, or 7.6 per cent of the population, have type 2 diabetes.

Among Māori, 8.8 per cent have type 2 diabetes, and Pasifika, 15.7 per cent. Diagnosed prediabetic Māori and Pasifika tend to progress to full-blown diabetes at nearly double the rate of Pākehā.

Using New Zealand’s prediabetes threshold of 41–50 mmol/l HbA1c, more than 25 per cent of New Zealanders are now prediabetic.

But, says Dr Betty, if New Zealand used the US widely accepted 60–64 mmol/mol HbA1c prediabetes guideline, “we would double the number of prediabetics overnight”.

“Essentially, we’re the third-fattest country in the world behind the US and Mexico. This is the future; these stats are happening, and this is what should be alarming for every practitioner.”

Ten years ago, he says, he did not see Māori and Pasifika patients diagnosed with type 2 diabetes in their 20s. “This younger-onset diabetes is actually the problem.”

The youngest patient he has seen so far diagnosed as a type 2 diabetic is 21, but plenty of people in their 30s and 40s are diagnosed. They are likely to experience complications at 60 rather than 80.

The “very small but growing” group of 15 to 19-year-olds with diabetes, is also worrying.

For a lot of reasons we still don’t understand”, adolescent type 2 diabetes develop complications earlier, at 12 to 14 years after diagnosis, he says.

Given early onset complications for some, HbA1c blood tests need to begin in their 20s, Dr Betty says.

“Systemwide, I don’t think there is the degree of assertiveness and intervention at these young ages that is required to effect change.”

Secondary care needs to provide more support for front line GPs, he says.

Doctors and clinicians need to better identify and target young patients likely to be at risk in terms of diet and lifestyle.

Emerging evidence shows adolescents whose mother has type 2 diabetes have an increased risk of the condition.

“We know there are environmental factors that drive type 2 diabetes, but there’s now thought to be a genetic component running through families.”

“There can be this sudden change in genetic make-up that can be passed down.”

Treating diabetic patients becomes a “very broad brush” approach when factoring in their family, financial and employment situations, and it’s common for Dr Betty to counsel the family.

A good doctor–patient relationship is “critical” to get the diabetes message through.

“Unless the whānau starts to understand the issues around diabetes and where things can go, you often don’t get traction,” he says.

simon.ude@ndctor.co.nz
Annex 2. Key contacts

The following contacts may be useful and we are able to connect you with other technical expertise within RPH:

**Kiri Waldegrave** – Senior Public Health Advisor  
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[Kiri.Waldegrave@huttvalleydhb.org.nz](mailto:Kiri.Waldegrave@huttvalleydhb.org.nz)

**Hannah Drew-Crawshaw** – Public Health Advisor  
Ph. (04) 570 9126  
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**Jane Wyllie** – Public Health Dietitian  
Ph. (04) 570 9552  
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**Brianna Tekii** – Public Health Dietitian  
Ph. (04) 587 2554  
[Brianna.Tekii@huttvalleydhb.org.nz](mailto:Brianna.Tekii@huttvalleydhb.org.nz)
Court ruling cuts city liquor store’s hours

A central Wellington liquor store has had its licence hours reduced after the High Court found there was “no realistic doubt” that it had contributed to some of the alcohol-related harm in the area.

Liquor King on Kent Tce – close to the city’s party zone in Courtenay Place – applied in 2018 to renew its alcohol licence.

The Wellington District Licensing Committee renewed the licence but reduced its closing time on Fridays and Saturdays from 11pm to 9pm.

This was done after the committee heard from police and Wellington’s medical officer of health, Stephen Palmer.

He cited evidence that showed the store was in an area with a large number of people in their 20s and 30s, where there was a higher number of alcohol-related attendances at Wellington Hospital’s emergency department, and where there had been 368 calls to police over a year for alcohol-related incidents within 500 metres of the store.

Lion Liquor Retail, which owns the store, appealed the decision to the Alcohol Regulatory Licensing Authority after it last year permitted the store’s closing hours to be returned to 11pm.

Palmer and police had appealed that decision to the High Court in October last year.

In a decision released on Friday, Justice Karen Clark said the authority had reached a conclusion that contradicted the evidence put before it and, consequently, made an error of law.

Clark reinstated the decision by the committee, meaning the store’s hours would be cut from 11pm to 9pm.

The store moved to the earlier closing time on Friday.

The judge said the authority had wrongly believed that in order to decline Lion’s appeal, police and the medical officer of health had to show that the liquor store had been “at the centre of the harm” and there needed to be “demonstrable historical harm”.

But the committee, in making its decision, had only to assess the risk of alcohol-related harm occurring in future if there was evidence that implicated the store.

Clark said the evidence showed there was compelling evidence of this risk, and “I agree with that assessment”.

She said that while it was not possible to link individual alcohol-related attendances to specific off licences, “it is known that more than three-quarters of all alcohol consumed is served from an off licence”.

Liquor King was “on the edge of the problematic Courtenay Place entertainment precinct, which is characterised by binge drinking off licence through pre and side-loading, of ready-to-drinks (RTDs) in particular,” she said.

Palmer, who based his evidence on six years of data from alcohol-related attendances at the hospital’s emergency department, had not tried to link specific incidents to specific off licences, “nor do I regard it as necessary,” the judge said.

“There can be no realistic doubt the premises contributes to some of the alcohol-related harm in the locality. Given the proximity of the premises to the entertainment precinct, and the reasonable distance of other off licences to those same consumers, it can reasonably be accepted that alcohol will be purchased from the premises for pre and side-loading.”
It is recommended that the Committee:

a) Notes Corrections is increasing in beds at Rimutaka and Arohata Prisons which will impact MHAIDS Forensic Service and Hutt Valley DHB hospital services.

b) Notes a new Youth respite, 6 bed facility for Hutt Valley & Capital & Coast DHB is to open in Lower Hutt on the 17th September 2018.

c) Notes that MHAIDS 3DHB are well on their way to meeting the Zero Seclusion target. The Key performance indicators have been met, with some inpatient units having a zero seclusion for months at a time.

d) Recommends to the Board that they note this update.

APPENDICES

1. MHAID SERVICE STAFF DEVELOPMENT PLAN
2. BALANCED SCORECARD MHAIDS 3DHB

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

1. HEALTH QUALITY & SAFETY COMMISSION (HQSC) PROJECT UPDATE

HQSC has a quality improvement programme for mental health addictions services. The aim of the programme is to use quality improvement methodology to improve mental health and addiction services. The programme began July 2017. All DHBs have signed up to this programme.

Zero Seclusion

The first priority area under the HQSC is the aim of the zero seclusion by April 2020. This programme supports service providers to use evidence based practises to deliver core whilst ensuring appropriate management of risk and harm.
The MHAIDS 3DHB has been monitoring and working actively to reduce the use of seclusion. Supporting this work is the Restraint and Seclusion Elimination Monitoring and Advisory Group and the development of a seclusion dashboard.

The most recent data available shows that Te Whare Ahuru and Te Whare O Matairangi (the two adult acute units) have met the National key performance indicator (KPI) Forum target of reducing seclusion by 30 percent year-on-year. Most of the other 3DHB MHAIDS units are demonstrating periods of zero seclusion for several months in some cases.

Staff are having the critical conversations about alternatives to seclusion and are starting to believe zero seclusion is possible. Staff and management are also reviewing the reasons and circumstances leading up to seclusion.

Other learnings from the work include:

- Environment influences on seclusion rates, especially when unit occupancy is up and de-escalation areas are full;
- Staffing skill mix makes a difference especially related to suitable experience levels, gender and ethnicity matching the consumer group;
- The ability to flex up the staffing ratios to work more intensively with people rather than lock areas to avoid engagement and observation.

It is important to note that staff have been working hard to reduce seclusion over many years and at times various units have had zero seclusion. Rangipapa Forensic Unit has had zero seclusion since July 2017, the Rangatahi regional adolescence unit has had zero seclusion since September 2017 and Te Whare Ahuru acute inpatient unit had zero seclusion in March 2018.

A project person has been seconded to manage the zero seclusion programme across MHAIDS in order to sustain this.

**Graph 1.\nPercentage of people admitted to inpatient units that are secluded, Capital & Coast DHB and Hutt Valley DHBs, April 2015 – March 2018**
Graph 2.
Percentage of people admitted to inpatient units that are secluded, by Māori and non-Māori, Capital & Coast DHB & Hutt Valley DHB, April 2015 – March 2018
Transition Project

The second priority area is improving service transitions. People can find transferring in and out of services challenging. The programme looks at ways to improve the processes around transfers.

MHAIDS will first focus on the transition processes between the Crisis Resolution Service (CRS) and the Adult Community Mental Health Teams. This was identified because of the long waiting time for individuals to be accepted into community mental health services once acute care was no longer required.

However, it needs to be noted that the increased demand for community mental health services and the need to prioritise clients being discharged from inpatient units impacts on the ability to accept referrals from CRS. This issue will need to be factored into the project and the proposed time-frames for transitions may need to change.

There are three MHAIDS personnel undertaking the HQSC Improvement Facilitation Course and they will be driving much of the improvement work with the support of the Quality and Risk Manager. This ensures that MHAIDS can support the HQSC programme as well as improving the capability of MHAIDS staff to lead quality improvement activities in the future.

Outcome Measure

The initial outcome measure has been discussed, which is, to increase the percentage of clients that are seen within 7 days of transfer from Crisis Resolution Service to Adult Community Mental Health Service from 30% to 80% by 1 March 2019.

Further work on measurements will continue to be developed including the balancing and process measures.

Service Transition Project Detail

The Service Transition Project has three areas of focus
Improving the time-frames for transition. Once the client is no longer in need of acute care, the aim is that the transition process will take place within 7 days of a referral being made to the Adult Community Mental Health Team. The systems and processes of how this occurs is a core component and will form the basis for all transitions across the service in the future.

Improving the consumer and family experience related to the transition processes, for example, what do people require to support them during the transition phase

Improving the capturing and updating of demographic data. It has been identified that wrong information in client’s addresses / phone numbers etc leads to individuals / family / whānau not receiving timely information or not receiving the information at all. This is a risk area across the service, therefore the systems and processes developed will be implemented more widely.

Current Status of Service Transition Project

The following activities are underway in terms of the project

- Identification of the Steering Committee and Working Group, yet to be confirmed
- Commencement of the Driver Diagrams to focus our effort
- Initial data gathering has commenced to form the baseline for future measurements
- Literature search is underway with the focus on best practice standards
- Development of the overall project plan, inclusive of risks, communication planning etc

Next Steps

The next steps are:

- Finalise the Steering Committee and Working Group members
- Finalise the full project plan
- Commencement of communication plan activities

SERVICE DEVELOPMENT

MHAID Service Staff development plan

Mental Health, Addictions, Intellectual Disability Service (MHAIDS) 3DHB staff development plan (2018-19). See Appendix 1 for MHAIDS Staff Development plan (in memo format as went to three ELTS July 2018).

Particular staffing challenges are in the ID Service. This is what we are doing to help resolve this;

Immediate Day to Day Mitigations:

- Staffing and workforce reports sent to senior MHAIDS (Actioned)
- Fortnightly roster vacancy forecasting (Actioned)
- Daily review of cover by Co-ordinators escalating to Op’s manager where cover is required (Actioned)
- ID Prioritised by Casual Pool (Ongoing)
- Senior staff (TL’s and CNS) support staff on floor (Actioned)
- Approaches to former staff to return via casual pool (Actioned)
- Daily MoH briefings about bed status (CCDHB and national) (Actioned and ongoing)
- Bed closures (we have beds closed in the unit) and client diversion (Actioned and Ongoing)
- Daily and formal review of occupancy, client placement and consideration of bed closure (Actioned and ongoing)
- Requests to Court and wider services to hold or redirect assessments where possible (Actioned and Ongoing)
- Approaches to CCDHB and External Nursing agencies for staff cover (Actioned)
- Approach to security company for oversight cover for safety (Actioned)
- Open and ongoing request for secondments from wider MHAIDS services to ID (Ongoing)
- Request for ATA conversion for roster co-ordinator to alleviate nursing co-ordinator (Actioned)
- E-mail updates from leadership team to all staff (Ongoing)
- Internal meetings to brief senior staff of mitigation strategies (Ongoing) example IDCGG minutes attached
- Spreadsheet for recording short staffing established (ensuring accuracy of reports) (Actioned)
- Service Newsletter items thanking staff, acknowledging their support and advising mitigation activities (Actioned and Ongoing)
- Dedicated purchasing of external supervision for staff (Actioned). All staff have access
- Broadening the nursing scope to include enrolled nurses, to support recruitment

**Medium term mitigations:**
- Request formal ID services review Dr Frances Hughes (Actioned)
- Emergency Recruitment in Australia (Commenced)
- Recruitment programme in the UK (Actioned)
- Running recruitment in NZ (Actioned)
- CE letter to MOH re ID service issues (Actioned)
- Renovation of cluster 1 to allow for safer client mix (Actioned)
- Ongoing PMR to MOH re workforces safety, risk register, bed capacity (Ongoing)
- New graduate NESP and NetP targeted to ID (Actioned and starting in August/September)

**Long term mitigations:**
Workforce training initiatives both nationally and directly within CCDHB. At this time these consist of:
- Highlighting workforce and staff safety issues to MOH and wider ITO’s (actioned highlighted in our reporting to MOH). However this requires ongoing monitoring and escalation at every opportunity. (Ongoing)
- CCDHB led initiatives such as the proposal for the nursing training application already sent to Health Workforce (actioned)
- NESP and NetP ID programme expanded (Actioned)
- Ongoing workforce planning. See F Hughes report (Ongoing and some actions required)
- Regular and ongoing briefings to the Ombudsman’s office regarding safety and capacity (Actioned and Ongoing)

I am pleased to report, two RN/EN have been appointed, 2 RN interviews pending, and 3 NESP have started. There has also been over 50 responses to our overseas recruitment campaigning with 4 applications.

**Youth Respite**

Emerge Aotearoa has been awarded the contract for provision of the youth respite service. This will be a six bed facility in Lower Hutt.

The respite and recovery services will offer a welcoming place where people experiencing mental health difficulties can rest and recover in a home-like environment. There will be trained staff available 24 hours a day to support young people using the service. Respite and recovery may be a planned break away from home, transition from hospital, or a way of preventing further distress and possible admission to hospital.
A key priority for the Capital & Coast and Hutt Valley DHBs is the improvement in health outcomes for its child and youth population, and offering a full continuum of services to meet this goal. The service will be one that works collaboratively alongside MHAID Service Child & Adolescent Mental Health Service (CAMHS) teams to deliver a responsive, youth-friendly, family-whānau supportive, and clinically safe environment in which young people are supported towards wellness.

MHAIDS 3DHB and Emerge Aotearoa are currently engaged in a co-design process to ensure there is a joined up approach to how this new service will operate and interface with MHAIDS 3DHB when it commences later this year. Emerge took possession of the facility on the 15 August 2018 with an opening day planned for 17 September 2018. Emerge’s national Māori engagement role will also contact local iwi to introduce the team and the work they do.

An initiative has been created to name the respite centre, encouraging youth under the care of our provider services to put forward names as part of a competition. The theme is around strength, mana and healing—Kaua e mate wheke, mate ururoa—building a safe haven for young people experiencing problems. Providers have been sent information on engaging the youth to take part in the initiative, and entries close on 30 August 2018. Internal communication will be built around the chosen name of the service.

2. KEY PERFORMANCE INDICATORS

Balanced Scorecard June 2018

The Balanced Score Card is a single portal for a range of MHAIDS performance indicators.

The June 2018 Balanced Scorecard is attached as appendix two.

With the implementation of QLIK sense, a new interactive data visualisation tool that is being implemented across Capital & Coast DHB, 3DHB MHAIDS aims to produce an interactive dashboard linking to a range of measures and detail from a range of datasets. The dashboard will focus on twelve core indicators that will be able to be filtered by a number of dimensions, and that will allow users to click into each of the indicators and be taken to further information and related measures. The 12 core indicators are:

- Access rates;
- Wait times < three weeks;
- Wait times three to eight weeks;
- Seen in the last 90 days;
- 28 day re-admission rates;
- Average Length of Stay;
- Occupancy rate;
- Seclusion hours;
- Pre-admission contact;
- Post-inpatient community contact;
- Did not Attend (DNA) rate;
- Staff turnover and Sick leave.
Average Length of Stay and Occupancy for Adult Acute Inpatient units MHAIDS

We continue to see constantly higher occupancies in Forensic Inpatient, Rangipapa (94.3%), Forensic Rehab Tane Mahuta (85.6%), Tawhirimatea (105.9%) and Te Whare O Matairangi (103.7%) and Te Whare Ahuru (89.4%).

MHAIDS inpatient units

Te Whare o Matairangi (TWOM) Occupancy – Leave included

Te Whare Ahuru (TWA) Occupancy – Leave included

28 Day readmission rates
TWOM discharges, ALOS and re-admissions

Discharges: 43
12 MONTH TREND: 

Avg Length of Stay: 22 Days
12 MONTH TREND:

28 Day Readmission: 10%
12 MONTH TREND:

Discharges: 61
12 MONTH TREND:

Avg Length of Stay: 16 Days
12 MONTH TREND:

28 Day Readmission: 29%
12 MONTH TREND:

*Treated Admissions / Discharges: Where a person is administratively discharged from the mental unit and admitted medically for less than 7 days then readmitted to the mental health unit, the administrative discharge to period to non-mental health inpatient services is merged to create a continuous mental health inpatient episode of care.

TWA discharges, ALOS and re-admissions

Discharges: 61
12 MONTH TREND:

Avg Length of Stay: 16 Days
12 MONTH TREND:

28 Day Readmission: 29%
12 MONTH TREND:

Discharges: 61
12 MONTH TREND:

Avg Length of Stay: 16 Days
12 MONTH TREND:

28 Day Readmission: 29%
12 MONTH TREND:

*Treated Admissions / Discharges: Where a person is administratively discharged from the mental unit and admitted medically for less than 7 days then readmitted to the mental health unit, the administrative discharge to period to non-mental health inpatient services is merged to create a continuous mental health inpatient episode of care.
Did Not Attend (DNA) rate

Waiting times, 3 weeks & 3 – 8 weeks

Waiting times for Adult Community & Addictions teams (Capital & Coast teams)
Waiting times for Child and Youth teams (Capital & Coast teams)

Seen in the last 90 days
3. ISSUES

Nationwide Increase in Prison Beds

The Department of Corrections have had an increasing issue with muster challenges due to the prison population increasing by 30 percent in the last five years. Over the last two years, there have been 1,000 new beds, and Corrections has announced plans to build a further 1,500 new beds by the end of 2019.
It has been confirmed that a proportion of the new beds – two modular units (122 beds per unit = 244 bed increase) as well as some ‘double bunking’ will be in the Rimutaka prison, Upper Hutt. Arohata Women’s prison is also increasing.

3DHBs currently have two Forensic units that can take male prisoners – Rangipapa (mixed gender unit) and Purehurehu (male only). People are admitted into these units from two main sources – they are either referred from the courts for assessment and/or treatment as part of the judicial process, or they are admitted from prison for mental health care and treatment.

The additional prisoners will impact the Central Regional Forensics Adult Inpatient Mental Health Service. These units are already running consistently at full capacity and the additional prisoners requiring MHAIDS input, will not be accounted for.

The Forensic service have staff working in the five prisons in the central region, including Rimutaka. The increasing number of prisoners impacts on the provision of mental health care of the prison. Epidemiology studies including NZ research indicate 12-15% of inmates have a major mental illness over 70% have addiction issues.

With increasing numbers in Rimutaka that also has implications for Hutt Hospital and provision of specialist medical care.

We will work with Ministry of Health to better understand the service implications and needs, although, there doesn’t appear to be much coordinated central planning.

**Judicial Review in High Court J vs AG & ORS**

Last year we participated in a Judicial Review in the High Court for a man (JS) in the care of an Auckland Provider and under out statutory remit under the FSC(ID) (an MHAID Service contract. We were represented in this matter (along with the other state agencies and the provider) by Luke Cunningham and Clere (LCC).

Last month we received Justice Culls Judgement. This case was overwhelmingly successful and the applicant and the lawyer (Dr Tony Ellis) were dismissed on each and every claim. Our position and practices were upheld.

**Salient points from the case:**

- This is the first time a case of this nature has been heard in NZ under this legislation (p272). Under s102 IDCC&R (analogous to s84 of the MHCAT)
- Our position was upheld on each claim brought against us and each claim was dismissed in full.
- There are a number of points covered in the judgment pertaining to the balance of public interest and protection vs individual civil liberties. The Judgement is relevant and protective in relation to this case but also as wider case law but also should such breach of rights cases brought against us in the future.

**Acute ongoing demand for the Intensive Recovery Sector**

As previously notified, acute demand has continued to be very high, which is particularly impacting the acute units and the Crisis Resolution Service (CRS). At times, there are no beds available and this in turn puts pressure on Emergency Departments (ED) and Short Stay Units (SSU) at the DHBs. The acute services are operating in a constant crisis mode, with very little respite. Specifically for the CRS, it is not only the volume also the complexity and nature of presentations (complicated by social issues) such as the impact of methamphetamines.
To work towards reducing acute demand, a project is being established to look at both short and longer term measures to try and manage the ongoing demand. Some elements the project will consider are:

- The functioning and role of the community mental health teams (that still operate on an 8.30 am – 5.00 pm Monday – Friday);
- Inpatient rehabilitation and extended care service access to community and NGO services, which in itself frees up acute inpatient use for rehabilitation and extended care;
- After hours medical staff rostering, both first and second on call, and how medical teams work in the acute inpatient units;
- Extension of onsite mental health staff within emergency departments and the role of consult liaison teams.

Immediate actions recommended by the project could reasonably include the following:

- The extension of the acute resource coordinator role across seven days (currently the acute resource coordinator operates 7.00 am – 11.00 pm Monday – Friday);
- The immediate introduction of the newly developed 3DHB MHAIDS escalation tool for business and after hours that includes awareness of the overall bed management for admission and discharge and gives a stepped approach to managing rapid changes;
- Operational management on call;
- Reorganising the MHAIDs casual pool into flexible staffing and the casual pools.

A meeting was held on the 2 August 2018, with the General Manager for MHAIDS, MHAIDS Directors, MHAIDS SMOs and CEOs for Hutt and Capital & Coast DHB. A number of initiatives are being actioned now. These include having operational management on call after hours, to better manage the resource and extension of the acute resource coordinator role to 7 days a week.

5. FINANCIALS MHAIDS 3DHB

**MHAIDS 3DHB FINANCIAL OVERVIEW YTD July 2018**

**Hutt Valley DHB**
MHAIDS delivered a favourable variance of $81k to budget first month of the financial year.
Employee expense, $93k favourable offset by $28k unfavourable in outsourced personnel expenses.
Variances are Medical $40k favourable, nursing $32k favourable, Allied Health $54k favourable in permanent FTEs. Wairarapa utilisation of TWA beds continue to be accounted for revenue in the funder arm.

**Wairarapa DHB**
MHAIDS delivered $25k which was a favourable variance of $37k to budget.
Employed and Outsourced personnel costs combined were $31k favourable for the month.
CCDHB
Overall performance for the first month of the financial year was favourable by $107k.

Total revenue for July 2018 was favourable to budget by $266k. This was contributed by increase in forensic rehab beds, revenue from forensic courts assessments and price variations from external contracts.

Personnel costs was favourable to budget by $31k. Running on vacancies in psychologist and social workers offset by over spend in O/S Allied health and includes savings target of $434k.

Outsourced services unfavourable to budget ($88k). Increase in Locums and in outsourced Allied Health personnel and SA courts assessments offset by increase in revenue and savings in AH personnel.

Paid FTE MHAIDS 3DH

The paid FTE converts all paid hours into a Full Time Equivalent. The operational FTE is a measure of the FTE required to run the SERVICES including cover for annual leave etc. Higher vacancies and sick leave have had huge impact on overtime especially FOR Nursing and RMO’s. Total vacancy across MHAID service after casual utilisation is 46 FTE.

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Total overtime is 3.2% of total hours worked.
MEMO

MHAIDS is the mental health, addictions and intellectual disability service for the Wairarapa, Hutt Valley and Capital & Coast District Health Boards

Date: 10 July 2018
To: 3 ELTS, Wairarapa, Hutt Valley and Capital Coast DHB
From: Nigel Fairley, General Manager
Subject: Mental Health, Addictions, Intellectual Disability Service (MHAIDS) 3DHB staff development plan (2018-19).

MHAID Service 3DHB is committed to the on-going learning and development of all staff. Our learning and development team is responsible for the organisation, coordination, development and delivery of programmes to support workforce capability, and meet sector goals and requirements.

This is achieved through:

- a comprehensive range of in-house programmes and other activities
- externally delivered professional development opportunities (study, workshops, conferences) – in-house and off-site

We also work with services to design and develop on-the-job guides to embed learning in practice (for example, related to new policy and other initiatives).

The following are the specific programmes within MHAIDS that support workforce development.

ALLIED HEALTH NEW ENTRY TO SPECIALIST PRACTICE (AH-NESP)

The MHAIDS AH-NESP programme was established in 2016 to equip and support new graduate occupational therapists and social workers to work in our specialised context. Each year MHAIDS employ 2 social workers and 2 occupational therapists on a fixed-term 0.9 FTE contract from February to December, to complete the programme.

The programme consists of:

- academic study (Postgraduate Certificate in Health Science - Mental Health & Addictions at Auckland University of Technology)
- clinical practice in two service contexts (usually one inpatient and one community)
- service specific training and supervision
- preceptorship and support from the AH-NESP programme coordinator (who sits in the Learning and Development team)

At the end of the programme graduates go on to permanent employment within MHAIDS (to date all graduates have been employed). The plan is to move from 4 positions to 6 in the next intake (January 2019).

PSYCHOLOGY INTERNS

Each year (since 2003) we employ 5 clinical psychology interns on a fixed-term 12-month contract (0.8FTE each). Psychology is a workforce under pressure and is one of the professional groups identified as a priority by Health Workforce NZ. Interns already have a Master’s degree in psychology, and are in their postgraduate diploma year of clinical training at Victoria or Massey Universities (prior to
registration as clinical psychologists). Interns carry an independent caseload within our clinical services, under close supervision from a senior or consultant psychologist.

Approximately 70% of the psychologists we currently employ complete their internship with MHAIDS 3DHB.

**PSYCHIATRY REGISTRARS**

The Lower and Central North Island (LCNI) psychiatry training programme is delivered under the auspices of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and is administered within the Mental Health, Addictions and Intellectual Disability Service (MHAIDS). The LCNI training programme covers MHAID Service 3DHB and the regional centres of Taranaki, Whanganui, MidCentral and Hawkes Bay DHBs.

As of June 11 2018, there are 39 psychiatry registrars within the programme. Within MHAIDS, training runs have gradually increased during 2012 to 2018. There is scope for the introduction of more training runs as competitive interviews per six month intake continue to rise.

New Zealand residents attract funding from Health Workforce NZ, which covers approximately one third of registrar salaries.

The Formal Education Course (FEC) is delivered by The University of Otago, Wellington School of Medicine. The course conveners are also practicing specialist psychiatrists within MHAIDS. The weekly teaching programme is held at Ngā Wāhi Ākonga on the Rātonga Rua-o-Porirua campus and also the School of Medicine.

As employees of MHAIDS 3DHB, registrars are also required to complete core organisational learning requirements. Other training-based professional development courses available and recommended to the registrars include Balint Group, Critical Appraisal Group and examination preparation groups.

The programme is supported by a directors of training role (DoT), a psychotherapy coordinator (0.1FTE) and an administrator (0.5 FTE). The DoT Office coordinates recruitment, and runs allocations and accreditation, supervisor peer review meetings, supervisor training, and the local Training Committee in line with the RANZCP regulations.

**NURSING**

**New Entry to Specialist Practice (NESP)**

During the past 18 months the NESP programme has undergone a number of changes. This this has been in response to the predicted challenges over the next few years related to the nursing workforce in MHAIDS. This has included investment from the Service to supplement the financial support provided by Te Pou.

All NESPs are graduates of a comprehensive nursing programme. MHAIDS provide the practical clinical placement component that includes:

- Study: Post-graduate certificate in mental health and addictions nursing
- Support from a MHAIDS NESP nurse educator, on site preceptors, and clinical assessors
20 hours supervision per year (delivered by an externally contracted supervisor)

The programme is underpinned with the following principles:

- All NESPs are employed at 0.93FTE
- All NESPs are recruited into substantive positions available through vacancies on a 24 month contract except for registered nurses with five years or more experience, they can, by negotiation be recruited on a substantive contract.
- Employment contracts will state that the cost of the post graduate papers can be retrieved if the NESP leaves within first or second year of employment

During 2018 there has been a second intake for the programme and this is building on experiences from 2017 mid-year intake. During 2018 the second intake will start in September which means we have been able to recruit nurses graduating in August.

To complete the programme successfully, the NESP will:

- meet the academic and theoretical outcomes of the programme
- meet the clinical outcomes of the programme
- be awarded a post-graduate certificate in mental health and addiction nursing
- have developed a professional portfolio which demonstrates Nursing Council competencies and reflects professional standards of practice for MHAID nursing.

In 2018 the number of NESPS is 44. In 2019 the plan is to go to 50. This increase of NESPs into the clinical services will mitigate some of the risks associated with nurses retiring in the next 5-15 years. It will also go a long way to address safe staffing numbers for clinical services whilst maintaining appropriate skill mix amongst the nursing teams.

**Bachelor of Nursing Scholarship**

For the past 8 years we have offered up to 3 scholarships per year for mental health support workers (currently employed within MHAIDS) to train as registered nurses. The Service supports the staff member financially and in other ways. The staff member works in the casual pool to help fund their studies, and providing they work no more than 32 hours a week in term time, the Service pays an equivalent of 8 hours pay a week as a “living allowance”. We also pay course fees and associated study costs.

**Post-graduate study programmes**

- Post-graduate paper in Forensic Practice (Whitireia). Each year we full or part-fund some staff to complete this programme, to supplement PDRP funding (full cost: $2,076 per student). Last year 10 staff started the programme. One withdrew due to personal circumstances.
- A new post-graduate programme for Intellectual Disability is planned to be piloted in 2019. New graduate nurses will complete the first MH paper followed by a specialty paper in disability in the second semester. The Service has been working with Whiteria Polytech to develop this course. The qualification will be a Post-Graduate Certificate in Speciality Care.

**OTHER STUDENT PLACEMENTS**

We also provide clinical placements for a number of multi-disciplinary students throughout the year, including:
• 5th year psychology students (typically 1-2 per year) for 12 weeks, 2 days per week
• Occupational therapy
• Social work
• Nursing
• House officers/Trainee Interns

We also participate in a number of seminars and activities (e.g. Career expos) to promote careers in mental health, addictions, and intellectual disability to school leavers.
### Patient Experience

<table>
<thead>
<tr>
<th>Metric</th>
<th>Local/Sub-Regional Services</th>
<th>Te Korowai Whāriki</th>
<th>MHAID 3DHB</th>
<th>Local/Sub-Regional Services</th>
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<th>MHAID 3DHB</th>
<th>Total YTD</th>
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<tbody>
<tr>
<td>28 Day acute readmissions rate - adult acute units (%)</td>
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<td>Long-term consumers with a current wellness plan (%)</td>
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<td>Better help for inpatient smokers to quit (%)</td>
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<tr>
<td>RoHOS complaint inpatient discharges - matched pairs (%)</td>
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<td>Staff with annual leave &gt; 200 hours (n)</td>
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<td>CCDHB</td>
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<td>HVHIDB</td>
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<tr>
<td>Staff turnover (headcount) - YTD average annualised (%)</td>
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<tr>
<td>Seclusion hours</td>
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<td>Seclusion hours - Māori</td>
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<tr>
<td>Seclusion hours - Pacific</td>
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### Healthy Workforce

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<tr>
<td>Staff turnover/headcount - YTD average annualised (%)</td>
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<td>Sick leave (%)</td>
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<td>Staff with annual leave &gt; 200 hours (n)</td>
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<td>HVHIDB</td>
<td>CCDHB</td>
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<td>Physical assaults on staff (n)</td>
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<td>CCDHB</td>
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<td>HVHIDB</td>
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<td>Performance approvals completed (%)</td>
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### Financial

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<td>Operating (actual) costs ($'000)</td>
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<td>Personnel including outsourced ($'000)</td>
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<td>HVHIDB</td>
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<td>Overtime hours (%)</td>
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<td>CCDHB</td>
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<tr>
<td>PTOs – actual</td>
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<td>HVHIDB</td>
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<td>PTOs – vacancies</td>
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### Productivity

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<td>Access rate (%)</td>
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<td>HVHIDB</td>
<td>CCDHB</td>
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<tr>
<td>Acute Adult Inpatients ALOS (days)</td>
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<td>CCDHB</td>
<td>WRDHB</td>
<td>HVHIDB</td>
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<tr>
<td>MHAID 3DHB</td>
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<td>CCDHB</td>
<td>WRDHB</td>
<td>HVHIDB</td>
<td>CCDHB</td>
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</tbody>
</table>

### Notes

- **Alert**
  - One month lag
  - Different measures so not comparable
  - Rolling year, 3 month lag (MoH Report)
- **Key Issue**
  - Not reported, under development
- **Good News**
  - Increased compare to previous month
  - Decreased compare to previous month
RECOMMENDATION

It is recommended that the Committee:

a) **Notes** the update from SIP on current activity.
b) **Notes** the update on the Citizens Health Council establishment.
c) **Recommends** to the Board that they note this update.

APPENDIX

1. HEALTHCARE HOME HIGHLIGHTS NEWSLETTER AUGUST 2018

1 INTRODUCTION

The Strategy Innovation and Performance team have a significant role in commissioning and managing community services. This report provides the Health System Committee an update on some of the community activity.

A very positive note is that CCDHB HCH model was selected as a finalist for a Wellington Gold Award, and the Public Sector Awards. (We missed out winning but was good to see the short HCH clip on the big screen!).

2 CITIZENS HEALTH COUNCIL (CHC)

The establishment group of the CHC met on 15 August 2018. The members of the establishment group are Diana Crossan (Chair), Dr. Alvin Mitkulea, Jenny Rowan, Lauren Webster, Ria Earp, Paul Gibson and Debbie Leyland.

The interim Council received a presentation on the Health System Plan and our approach to Health Equity. It was clarified that this group is not the council. This group is focused on the implementation of the Terms of Reference including ensuring we have the best mix of people to this group, and how we engage positively with our communities. The discussion included the challenges of building relationships with communities and building their understanding of key principles such as equity.

3 PRIMARY AND COMPLEX CARE

3.1 Refugee Dental Project

In April 2017, CCDHB received one-off additional funding from the Ministry of Health to support the resettlement of refugee-background people who arrived in Wellington in 2016/17. A portion of that funding was tagged to improving differences in oral health experienced upon resettlement. In partnership with Red Cross Wellington and HHS we provide a dental service. Red Cross provide the induction course for refugee-background people upon arrival in the Wellington region.

Twenty three refugee-background people are now receiving dental and oral health services. Each person receives an initial consultation and follow up treatment as required. Interpreters are provided as required and to date twelve sessions have been held. Treatments range from small fillings to complex extractions,
with a total of 209 treatments completed to date. As procedures are completed we are working with partners to understand the impact of the programme.

### 3.2 Advance Care Planning

A revised Advance Care Planning (ACP) Guideline has been published this week in the CCDHB Policies and Procedure Library (CapitalDoc). It was developed with wide stakeholder consultation within the DHB. The guideline clarifies roles and responsibilities of clinical staff supporting people with ACP and guides care when a person cannot speak for themselves. Resources available for people and their families and whānau are included.

https://www.healthnavigator.org.nz/health-a-z/a/advance-care-planning/
https://www.hqsc.govt.nz/our-programmes/advancecareplanning/

### 3.3 Long Term Condition Registration Pharmacy Service Cap

The long-term condition (LTC) service is a community pharmacy service for those clients who meet the criteria of having a (a) diagnosed Long Term Condition, (b) poor medicine adherence and, (c) the capacity and willingness to receive additional support. The service provided includes medicines reconciliation, synchronisation of dispensing and reminder services. The community pharmacist is paid $21 per month per client as well as a loading on the medicines dispensed.

In 17/18 the LTC service was extended to mental health patients. A national cap on registrations for this service is part of the agreement. The cap for CCDHB is 6604 people. In June 2018 the numbers within CCDHB had reached 6823 and 103.3% of the cap. Most of the growth had come from three community pharmacies whose numbers of LTC registrations had grown significantly over the past 6 months. The July figures indicated that while the growth had slowed, the numbers had reached 6841 (103.6% of cap). Currently enrolments are closed. Once the registration numbers fall below 99% the Pharmacies will be notified they can start again.

### 4 INTEGRATED CARE

The integrated care programme is progressing strongly and building a performing integrated service for our community.

#### 4.1 System Level Measures (SLM)

The 2018/19 System Level Measure (SLM) Plan has been approved by the MOH. The 2017/18 SLM CCDHB targets have been achieved for ASH 0-4yo, Acute Bed Days (Pacific), Amenable Mortality, Patient Experience of Care, Youth Health and Babies Living in Smokefree Home. The target not achieved was Acute Bed Days (Māori). Based on the Quarter four results, MOH has approved the release of all the final SLM funding to PHOs.

#### 4.2 Health Care Home Tranche 3

The first four Tranche 1 HCHs have completed their Year 2 and all have made progress on their rate of ED presentations compared to their baseline. Ngaio Medical Centre launched on the 1st July 2018 - HCH currently reaches about 50% DHB population coverage.

Implementation of virtual MDTMs for T1 and T2 Practices and introduction of Hospice and Palliative Care Services MDTMs to T1 and T2 Practices continues. Health Care Home Tranche 3 will reach 80% of the population. The Minister of Health, Board Chair, DHB CE, PHO leaders and the project team had a CCDHB Health Care Home visit at Johnsonville Medical Centre.

#### 4.3 Community Health Network

The CCDHB Community Health Network framework is under development, with two working group meetings and supportive analysis completed to consider how we can strengthen our community service networks around our Healthcare Homes.
5 MENTAL HEALTH AND ADDICTIONS

This team work closely with Hutt Valley and Wairarapa DHB with a 3DHB work programme integrated with the MHAIDS service. The team has welcomed a new General Manager, Rawinia Mariner who has extensive senior experience across DHBs, Government and NGOs.

5.1 Suicide Prevention/Postvention and Family Violence Project

A project has started which will explore the health system’s response to suicide prevention and postvention. We know that of the people who have died by suicide in our region they have contact with the health system prior to death. We also want to explore the link with family violence and what opportunities exist across the health system to intervene earlier for better outcomes.

5.2 Integrated Care Collaborative (ICC) Mental Health workstream

This project is leading the development of integrated models of care between primary and secondary mental health and addictions services. This steering group is chaired by Dr Helen Rodenburg (GP) and Dr Alistair Wills (CCDHB). Key NGO stakeholders have enjoyed this forum. We are working closely with the MHAIDS consumer leadership group with a meeting on 22nd of August at Te Whare Marie in Porirua.

5.3 Update on Demand for Acute Mental Health Beds

In recent months demand for acute inpatient mental health beds in Te Whare Matairangi (CCDHB) and Te Whare Ahuru (HVDHB) has been extremely high which has meant more CCDHB clients have gone into Te Whare Ahuru creating capacity issues. Mental Health and Addictions, SIP has a priority project to look at the demand for these services to identify possible strategies to address these issues at the service provision level. This will dovetail into the work being carried out by HVDHB on a plan to procure additional mental health adult acute residential beds in the community.

6 CHILD, YOUTH AND LOCALITIES

The team has welcomed a new General Manager, Te Pare Meihana who has extensive senior experience across DHBs, NGOs and working in localities.

6.1 Youth Engagement

The Youth UCC Steering Group has initiated a co-design process with youth to establish a sustainable infrastructure for youth engagement in CCDHB governance and service design. To date, the co-design plan has been developed and initial discussion with Porirua Schools have begun to organise youth focus groups as part of this process.

6.2 Sex and Gender Diverse Youth

The sex and gender diverse working group (comprising clinicians, community leaders, and people with lived experience) have been overseeing the pilot of an innovative trans-affirmative model of care. The model aims to increase youth access to gender-affirming treatment in a youth-friendly, primary setting. The pilot has now concluded and is currently undergoing evaluation. The working group has also been liaising with Health Navigator to increase accurate, publically available information about sex and gender diversity and health/support services.

6.3 Comprehensive School Based Health Services

We are preparing our approach for a school based health service in our school. We are developing service profiles with our schools with 6 out of 15 schools identifying the school based services (outside of CCDHB funded school nurses/GPs) that are already in place to support our young people. This is part of a stocktake that will support future planning and integration. Contracting discussions have begun to ensure school based health services are available in two additional alternative education centres as part of the service improvement for 2018/19.
6.4 Localities Development

We have three locality developments; Kilbirnie/Newtown, Porirua and Kāpiti.

The Rolleston development in Kilbirnie/Newtown

- A cross agency MOU is under development for the project phase and a service model is under development for the on-going provision of service.
- Concept plans have been developed by Housing NZ and are being readied for resource consent.
- Public consultation in the Mount Cook community is in progress and CCDHB have attended a community drop in session to speak with people around our role in this proposed development.
- Model of care discussions have commenced with services who may provide to the support of the people living at Rolleston Street.

Kāpiti

The focus for Kāpiti is on how we reduce the requirement for travel from Kāpiti to Kenepuru Hospital and Wellington Regional Hospital. A key focus of this work is access to urgent and after hour’s services to support people within Kāpiti.

The Kāpiti Health Advisory Group (KHAG) have a number of work streams they are progressing:

- Transport and access to services
  - Desire for more health services closer to home.
  - Wanting more OPD at Kāpiti Health Centre. Mapping gaps in clinics and discussing telehealth options.
  - A shuttle connection pilot has been received positively and the KHAG is considering a community led initiative for a Kāpiti shuttle.
- Mental health
  - A major focus area for the group. Currently mapping services and gaps.
- Aged care
  - Concerns that care hours have been reduced too far, needs not being met
  - Concern for mental health needs, isolation and principally for the need to travel

Porirua

The approach we will take to working with the Porirua community to support greater service investment and integration is being developed.

7 DISABILITY SUPPORT PROGRAMME

The Disability Team is progressing its work programme. The Director for this programme, Pauline Boyles has resigned and will be farewelled on 30 August 2018.

7.1 Delivering against the actions of the 2017/2018 Annual Plan

Workforce development

The disability, strategy and performance team have been bringing in people with lived experience of disabilities to be involved in training. Targeted disability responsiveness training has occurred on ward 6 north, Wellington Hospital in response to patient feedback. E-learning attainment of the workforce continues to grow with over 900 staff having completed by December 2017.

Dashboard of indicators

A dashboard of indicators, mainly based on disability alert information has been developed. A quality review of the disability alerts also been completed and is near reporting stage for CCDHB. The team are currently considering the initial findings from the review to determine future recommendations with regards to the dashboard, alerts and disability responsiveness education planning. This work will inform future development of the CCDHB disability indicators dashboard.
7.2 Implementing the Sub-Regional Disability Strategy for 2018/19

The disability, strategy and performance team has reviewed its 2018/19 work programme in relation to the disability strategy.
One of the many principles that guide the Health Care Home programme is that no two practices are the same. There is no ‘one size fits all’ solution on offer, and the tools HCH offer can be tailored to a wide variety of situations and circumstances. In the same way, each practice finds some aspects of HCH are more immediately useful than others, and some play to strengths they may have been unaware they had.

Nestled in the Cannons Creek district of suburban Greater Wellington is the Porirua Union and Community Health Services (PUCHS). This modest practice has a ‘dynamic team’ servicing an enrolled population of some 6,065 patients, of whom 90% are deprivation quintile 5: 49% are Pasifika and 24% Maori. In addition 11% are refugee families.

PUCHS started their Health Care Home journey in October 2017, as part of the tranche 2 practices. “Ioana Viliamu-Amusia, our Clinical Coordinator, and I had been shown around some practices that had implemented HCH,” recalls Practice Manager, Hiueni Nuku, “And were impressed with the service improvement and waste reduction they’d achieved. In addition to a general improvement through applying some of HCH’s practices, we had some specific issues we wanted to address. For instance, our DNA (Do Not Attend) rate was somewhere around 40% before HCH, but the various changes we’ve made around our front desk and phone set ups have seen that drop to closer to 10%, a target we’ve consistently hit.”

Some of the DNA patients are also contacted by the doctors during their patient phone triage sessions. These occur daily over the first 15 minutes after a doctor starts their day. The aim of this triage is – where practicable – to enable the patient to avoid having to come in. They can do scripts, too. Continuity of care is important to the PUCHS team and, where possible, the doctors triage their own patients. If they are not available, the doctors will triage other clients in the queue.

Another significant initiative that has taken place at PUCHS following their commencement of HCH can be seen in their efforts to improve appropriate presentation at nearby Kenepuru Hospital’s Accident and Medical (KAMC). Kenepuru lies some 4 km to the west of PUCHS, and had become, over time, the presentational venue of choice for a significant number of PUCHS’ registered patients. This wasn’t doing anyone any favours, least of all the patients themselves, and had long been something that the PUCHS staff wanted to address.

A team, consisting of a number of KAMC staff, PUCHS GP, Dr Simon Saena and Mabli Jones from PHO Compass Health, put their heads together and developed strategies aimed at gently but firmly helping re-direct patients, and educating them about where they could best be seen as quickly and effectively as possible.

Says Ioana “Simon (Saena) and I monitor the mobile phone that we carry, the Kenepuru nurses will ring us directly to see if PUCHS have capacity or not. We’ve managed to take from 6 to 15 patients in the last few successive months, which is high for our clinic. We’re very thankful for the relationship we’ve developed with the Kenepuru team, this has been invaluable for us both, I think.”

Health Care Home’s flexibility gave PUCHS the framework and support it needed to address not only the usual range of improvements they could make to their services, but also the specific issue of supporting patients to get the right help, at the right time, in the right place.

Martin Parker
THE CLUB HAD JUST EXPANDED

Funding for Tranche 3 of the Health Care Home (HCH) Programme in the Capital & Coast region is now confirmed. Fourteen practices have been selected for the programme to be launched in three waves: 1st October 2018, 1st January 2019 and 1st April 2019. With Tranche 3 rolling out, the HCH model is brought to approximately 240,000 patients making up 80% of the region’s population.

Tranche 3 practices include:
- City GPs
- Peninsula Medical Centre
- City Medical
- The Terrace Medical Centre
- Capital Care
- Onslow Medical Centre
- Brooklyn Medical Centre
- Linden Surgery
- Tawa Medical Centre
- Khandallah Medical Centre
- Miramar Medical Centre
- Victoria Student Health
- Coastal Medical Rooms
- Team Medical

HCH Open Day and a series of workshops have been organised for these practices to prepare them for the HCH Implementation. We look forward to embarking the HCH journey with them.

SHOWCASING HEALTH CARE HOME WITH PRIDE

We are always proud of the high trust environment established in our HCH programme. This has built a strong foundation for shared learning spirit among HCH practices. In 2017-2018, three HCH flagship practices were identified to help showcase the implementation of the HCH model of care in general practices: Johnsonville Medical Centre, Newlands Medical Centre, and Karori Medical Centre. These practices had hosted countless visits for both internal and external stakeholders during the past year. They had done a fabulous job in showing ‘HCH in action’ and making it known to wider audiences.

Calls for Expression of Interests in becoming HCH flagship practices 2018-2019 took place this month. A great amount of interest was received. At the end, the following practices have been selected to be HCH flagship practices 2018-2019:
- Karori Medical Centre
- Raumati Road Surgery
- Porirua Union & Community Health Service

We look forward to more opportunities of promoting Health Care Home!