1 PROCEDURAL BUSINESS

<table>
<thead>
<tr>
<th>ITEM</th>
<th>ACTION</th>
<th>PRESENTER</th>
<th>MIN</th>
<th>TIME</th>
<th>PG</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Karakia</td>
<td></td>
<td></td>
<td>9am</td>
<td></td>
</tr>
<tr>
<td>1.2</td>
<td>Apologies</td>
<td>Record</td>
<td>Fran Wilde</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>1.3</td>
<td>Continuous Disclosure – Interest Register</td>
<td>Accept</td>
<td>Fran Wilde</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>1.4</td>
<td>Confirmation of Draft Minutes 24 October 2018</td>
<td>Approve</td>
<td>Fran Wilde</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>1.5</td>
<td>Matters Arising</td>
<td>Note</td>
<td>Fran Wilde</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>1.6</td>
<td>Action List</td>
<td>Note</td>
<td>Fran Wilde</td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>1.7</td>
<td>HSC Work Programme</td>
<td>Note</td>
<td>Fran Wilde</td>
<td></td>
<td>19</td>
</tr>
</tbody>
</table>

2 PRESENTATION

<table>
<thead>
<tr>
<th>ITEM</th>
<th>PRESENTER</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Te Pare Meihana / Astuti Balram</td>
<td>9.30am</td>
</tr>
<tr>
<td>2.2</td>
<td>Rachel Haggerty</td>
<td>9.45am</td>
</tr>
</tbody>
</table>

3 DISCUSSION

<table>
<thead>
<tr>
<th>ITEM</th>
<th>PRESENTER</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Carey Virtue / Toby Stockton</td>
<td>10.15am</td>
</tr>
<tr>
<td>3.2</td>
<td>Carey Virtue / Delwyn Hunter</td>
<td>10.45am</td>
</tr>
<tr>
<td>3.3</td>
<td>R Haggerty</td>
<td>11am</td>
</tr>
</tbody>
</table>

4 OTHER

<table>
<thead>
<tr>
<th>ITEM</th>
<th>PRESENTER</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Fran Wilde</td>
<td>11.15am</td>
</tr>
</tbody>
</table>

5 INFORMATION

<table>
<thead>
<tr>
<th>ITEM</th>
<th>PRESENTER</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Diana Crossan (Chair)</td>
<td>11.45am</td>
</tr>
</tbody>
</table>

DATE OF NEXT MEETING 19 DECEMBER – LEVEL 11, BOARD ROOM GRACE NEILL BLOCK WELLINGTON REGIONAL HOSPITAL
HEALTH SYSTEM COMMITTEE

Interest Register

UPDATED AS AT NOVEMBER 2018

<table>
<thead>
<tr>
<th>Name</th>
<th>Interest</th>
</tr>
</thead>
</table>
| 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  
                        • Chair, Kiwi Can Do Ltd |
<table>
<thead>
<tr>
<th>Name</th>
<th>Interest</th>
</tr>
</thead>
</table>
| 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  
• Son is Deputy Chief Executive (insights and Investment) of Ministry of Social Development, Wellington  
• Invited to join the Board of the Wesley Community Action Group  
• Member of the Regional Steering Group, Warm Healthy Homes |
| 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 |
<table>
<thead>
<tr>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest</td>
</tr>
<tr>
<td>• Member, Wellington City Council Accessibility Advisory Group</td>
</tr>
<tr>
<td>• Member, 3DHB Sub-Regional Disability Advisory Group</td>
</tr>
<tr>
<td>• Professional Member – Royal Society of New Zealand</td>
</tr>
<tr>
<td>• Member, Institute of Directors</td>
</tr>
<tr>
<td>• Member, Health Research Council College of Experts</td>
</tr>
<tr>
<td>• Member, European Respiratory Society</td>
</tr>
<tr>
<td>• Member, Te Ohu Rata o Aotearoa (Māori Medical Practitioners Association)</td>
</tr>
<tr>
<td>• Director, Miramar Enterprises Limited (Property Investment Company)</td>
</tr>
<tr>
<td>• Wife, Research Fellow, University of Otago Wellington</td>
</tr>
</tbody>
</table>
CAPITAL AND COAST DISTRICT HEALTH BOARD
DRAFT Minutes of the Health System Committee (HSC)
Held on Wednesday 24 October 2018 at 9.30am
Kapiti District Council Chambers, 175 Rimu Road, Paraparaumu

PUBLIC SECTION

PRESENT:
BOARD: Dame Fran Wilde (Chair)
Ms ‘Ana Coffey
Ms Sue Kedgley
Dr Roger Blakeley
Ms Eileen Brown
Ms Sue Driver
Dr Tristram Ingham

STAFF: Ms Julie Patterson, Interim Chief Executive arrives 9.39am
Ms Catherine Epps, Executive Director, Allied Health, Technical and Scientific
Ms Arawhetu Gray, Director, Māori Health Services
Michael McCarthy, Chief Financial Officer
Mr John Tait, Chief Medical Officer

CCDHB PRESENTERS: Ms Astuti Balram, Manager, Integrated Care, items 2.1 and 2.2
Te Pare Meihana, General Manager, Child, Youth and Localities item 2.3
Peter Gush, Service Manager, Regional Public Health, items 3.1 and 3.5
Nigel Fairley, General Manager, 3DHB MHAIDS
Carolyn Coles, Associate Director of Midwifery, item 3.3
Wendy Devereux, MQSP Coordinator, item 3.3
Sandra Williams, General Manager, Primary and Complex Care, item 3.4

KHAG PRESENTERS: Kathy Spiers, Kapiti Health Advocacy Group
Adrian Gregory, Kapiti Health Advocacy Group
Sandra Daly, Kapiti Health Advocacy Group
Marilyn Stevens, Kapiti Health Advocacy Group
Ngaire Cook, Kapiti Health Advocacy Group
Conrad Petersen, Kapiti Health Advocacy Group
Sandra Forsyth, Kapiti Health Advocacy Group

GENERAL PUBLIC: One member of the public was present

1 PROCEDURAL BUSINESS

1.1 PROCEDURAL
The Karakia was led by Tristram Ingham. Committee Chair, Dame Fran Wilde, welcomed the public, members and the DHB staff.

1.2 APOLOGIES
Apologies received from Andrew Blair and Tino Fa’amatuainu Pereira

1.3 INTERESTS
1.3.1 Interest Register
Committee members to advise any changes to the Committee Secretary.
1.4 CONFIRMATION OF PREVIOUS MINUTES
The minutes of the CCDHB Health System Committee held on 26 September, taken with public present, were confirmed as a true and correct record.

Moved: Roger Blakely    Seconded: Sue Kedgely    Carried:

1.5 MATTERS ARISING

1.6 ACTION LIST
The reporting timeframes on the other open action items were noted.

1.7 HSC Work Programme
The Committee noted the plan.

Actions:
1. Committee Secretary to start on 2019 Work Programme.

Note the agenda items are presented in the order that the Board considered them.

2 FOR DECISION

2.1 Community Health Networks – the CCDHB Framework
The paper was taken as read.

The Committee:

a. Noted that as identified in the Health System Plan, Community Health Networks are CCDHBs mechanism to organise health services to meet the needs of the population in the network.

b. Noted the attached framework provides a detailed description of the Community Health Networks as a supplement to the Health System Plan. It has been developed in partnership with the stakeholders from across the sector through the Integrated Care Collaborative (ICC). It provides the platform for establishing the Networks in the future.

c. Noted the framework has been endorsed by the Integrated Care Collaborative which includes representatives of primary and secondary care.

d. Endorsed the outcome measures for Networks as outlined in the paper and the development of Network specific measures as they are established.

e. Noted that Health Care Homes and primary care practices will form the core of the Networks, supported by connected specialist services.

f. Endorsed the formation of eight Community Health Networks, noting that some flexibility will be required during the next phase of implementation planning.

i. Endorsed the initial focus on Porirua South and Kāpiti in the establishment of Community Health Network prototypes.

Discussion:

• Prior to discussing the paper, the Committee asked Arawhetu to provide an overview of how the Community Health Networks, Healthcare Homes, PHOs, NGOs RPH and the Localities approach fit in together. The Committee asked for a diagram to be developed and brought back to a future meeting to show the interconnections between these. It was noted this diagram would also be useful for engaging with communities.
The Community Health Networks (CHN) is a developmental process. As a concept it is well supported by the Integrated Care Collaborative (ICC) and the document incorporates feedback from PHOs. Primary healthcare is excited about the opportunities for strengthening relationships through this new way of working.

There was discussion around being careful not to confuse demographic and geographic means of determining an area suitable for a network. Staff clarified that both demographics and geography was used to define the proposed network areas.

It was noted that we need to think beyond primary health care and consider the role of public health within a network.

Eileen asked whether there are sufficient resources to implement the proposed approach and Sue Driver noted we need to look at our skill levels in coordinating potentially competing groups. Staff noted that investment proposals would be put forward to support network infrastructure and governance.

The Committee acknowledged that CHNs are a step forward in terms of health system maturity. They will provide a vehicle for change.

The Chair asked that the Committee receive six monthly reports on progress with implementation as well as any issues in particular for Kāpiti and Porirua.

Tristram suggested that equity measures and cultural responsiveness be more explicit in the outcomes framework

Sue Driver suggested that the Cost quadrant of the proposed outcomes framework should be refined to reflect efficient use of resources and cost-effectiveness rather than simply cost.

HSC recommends the Board:

a) Notes the Committee has considered the proposed framework for implementing Community Health Networks and endorses this mechanism for connecting health services within our communities.

b) Note that Health Care Homes and primary care practices will form the core of the Networks supported by connect specialist services for effectiveness and efficiency.

c) Note the CHN framework has been endorsed by the Integrated Care Collaborative which includes representatives of primary and secondary care.

d) Agrees to the formation of eight Community Health Networks, noting that some flexibility will be required during the next phase of implementation planning.

e) Note that SIP will report six monthly to the Committee on progress with implementing CHNs including any issues and how these are resolved.

Actions:

1. Staff to develop a diagram for presenting at a future Committee meeting showing the interconnections between PHOs, NGOs, Health Care Homes, RPH within Community Health networks and the relationship with Localities.

2. SIP to provide the Committee with six monthly implementation progress updates including any issues, particularly for Kāpiti and Porirua.

3. Outcome measures to include equity and cultural responsiveness

4. Look at feasibility of developing outcomes measures that reflect efficiency and cost-effectiveness rather than simply reduced costs

Moved: Eileen Brown Seconded: Sue Driver Carried:

2.2 Kapiti – Delivering care in the community

See end of minutes - paper was considered at the end of the meeting along with the presentation from the Kapiti Health Advocacy Group.

CCDHB Minutes – 24 October 2018
2.3 Porirua – Supporting Equity and Outcomes

The paper was taken as **read**.

The Committee:

a) **Noted** we are prioritising the development of our localities approach in Porirua through targeted investment during 2018/19 and the establishment of a localities plan grounded in partnership, reciprocity and strong communication and engagement.

b) **Noted** the focus on South Porirua to reconfigure existing funding as well as additional marginal investment in key service development/integration priorities:
   - Nurse-led services to work with family groups in our Pacific neighbourhoods with multiple and complex health services.
   - Youth services for young people who need greater support including sexual health, mental health and addiction and gender/sexual identity.
   - Services to support mothers and families with babies and young children who need greater support in this start of life.

c) **Endorsed** the focus on South Porirua and the development of services to support the formation of the Community Health Network within this locality.

Discussion:

- ‘Ana noted there is still some confusion between Community Health Networks and Localities approaches. There needs to be responsive community engagement and discussion that enables a community led rather than a network discussion. She invites the SIP team to present to Porirua City Council and meet with community representatives, in particular, on the issues of children and youth. There are lots of conversations taking place on social media, noting concern with recent suicides. As a DHB, we need to figure out how we can engage with these conversations.
- Eileen Brown queried whether we are well equipped to be responsive to urgent and immediate issues such as recent suicides when they arise.
- The Porirua locality plan is still in development. The timeline is to be advised. Sue Driver noted we do need to become clearer on timelines.
- Porirua has a strong community. Both Roger and Tristram felt that it would be an opportunity lost if the approach did not begin with the voice of the Porirua community.
- Tristram Ingham noted we should include non-health sector partners in our engagement.

**HSC recommends the Board:**

a) **Endorses** the localities focus on South Porirua and the development of services to support the formation of the Community Health Network within this locality, noting the importance of community responsiveness and the Committee’s request that staff bring back to the Board a graphic showing how community health networks and localities relate to each other.

**Actions:**
1. Report to the Board on the progress of Community Health Network in Porirua at a future meeting.
2. Staff to present the localities work to the Porirua City Council following invitation by ‘Ana Coffey.

**Moved:** Roger Blakely **Seconded:** ‘Ana Coffey **Carried:**
3 FOR DISCUSSION

3.1 Regional Public Health Bi-Monthly Performance Report

The paper was taken as read.

The Committee:

a) Noted the update on work in Porirua.

b) Noted the update on alcohol related harm reduction (including Kapiti).

c) Notes the update on public health nurse services in primary and intermediate schools in the CCDHB area.

d) Noted the update on influenza surveillance and SHIVERS II research project

e) Noted the update on the Australasian Tuberculosis conference 2018.

f) Noted the RPH 2017-2018 visual ‘snapshot.’

Discussion:

- Committee was interested to see the range of activities being delivered by RPH within Porirua and noted this work needs to be joined up with the activity underway to develop Community Health Networks and establish localities approaches.
- Sue Driver noted she still struggles to see the strategic framework that RPH is working within and the need to make connections between the DHB’s strategic direction and that of RPH.
- Chair requested staff work towards future Committee papers incorporating an RPH perspective rather than separate papers so that issues can be considered from multiple perspectives in a coherent way.
- ‘Ana noted the liquor licensing activity and asked about the evidence of the impact of this activity on reducing alcohol harm including hospital admissions for this community.
- Chair suggests that the RPH work programme updates could be reduced to six monthly to allow a more thorough discussion.

HSC recommends the Board:

a) Note the paper.

Actions:

- RPH to provide evidence on how liquor licencing impacts hospital admissions in the Porirua community
- CCDHB staff to look at how RPH perspectives could be incorporated into future issues based Committee papers.
- RPH performance report be reduced to a six month frequency.

3.5 Healthy Housing Update

The paper was taken as read.

The Committee:

a) Noted the information provided as an update from the housing discussion of HSC August 2018 meeting.

b) Considered the investment opportunity proposed for healthy housing assessment and advice services to be provided by Well Homes to those whānau with children experiencing Asthma and Acute upper respiratory tract infection.
c) **Noted** the interim report on Well Homes services provided for Pacific whānau 1 March – 31 August 2018 as interim data prior to definitive qualitative analysis that will emerge from the Well Homes programme evaluation being done in 2019.

**Discussion:**
- Roger recommended to Regional Public Health to get the discount rate linked into the Wellbeing Budget.
- Eileen Brown requested that the submissions on the Healthy Homes Standards and the Residential Tenancies Act (1986) to be made publicly available.
- Letter to the Chair of Greater Wellington Regional Council on the Housing Improvement Regulation has been prepared and to be sent and copied to the Committee.
- Chair recommends to write separate letter to the Government to regulate safe home heating for all citizens.
- Discussed the list of potentially avoidable hospitalisations due to the home environment diseases (PAHHE) and the exclusion of some key illnesses from Ministry of Health criteria for funding for healthy housing assessment – notably asthma and acute upper respiratory tract infections including croup. The Committee agreed this was an investment opportunity that would support achieving health equity. The Chair suggested the Board should write to the Minister in support of extending investment to this group.

**HSC recommends the Board:**

a) **Note the paper**
   - To write to Government Ministers responsible for Housing asking they consider legislative amendments to regulate for safer home heating for all citizens
   - To write to the Minister of health in support of investment opportunities for healthy housing assessment and advice services to whānau with children experiencing asthma and acute upper respiratory tract infection.

**Actions:**
1. Load the Healthy Housing paper onto the resource centre in Board books
2. Publish the submissions to the consultations on the Healthy Homes Standards and the Residential Tenancies Act (1986) on the website
3. RPH to draft a letter on behalf of the Board to Government Ministers asking them to consider legislative change that would support safer home heating methods.
4. RPH to draft a letter on behalf of the CCDHB to the Minister of Health asking that extending investment in healthy housing assessments to whanau with asthma or acute upper respiratory conditions be considered. ..

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

### 3.2 MHAIDS Bi-Monthly Performance Report

The paper was taken as **read**.

The Committee:

a) **Noted** MHAID Service formally opened a new space for the MHAID Service Consumer Advisory Group, this is based at Kenepuru in the Te Manaaki building.

b) **Noted** the Ministry of Health has released the Suicide Facts: Data Tables for 1996 – 2015 with some significant findings, as listed in this report.
c) **Noted** The final Kahukura project for the Regional Rehabilitation and Extended Care Inpatient Service’s (RRS) current model of care (MoC) has been completed. A model of care clinical group is being established to lead the implementation of the operational recommendations.

**Discussion:**
- The Ministry of Health has confirmed a cluster of suicides in Porirua and CASA has been activated. We are working closely with schools, NGOs and Porirua Council, to ensure we respond in the best way.
- There was a question from ‘Ana Coffey linked to the earlier discussion on the number of suicides in Porirua and community use of social media. ‘Ana asked if the DHB utilised social media to connect with parents, communities on suicide prevention and postvention information. Staff noted that we do not use social media for this particular issue as it has pluses and minuses but that we can look at this issue once again and report back our findings.
- Staff noted we are also changing our prevention/intervention/postvention approach and the Board has previously agreed to a zero tolerance for suicides project, which is progressing.
- Tristram Ingham asks if there is a strategy in place within the next 6 to 12 months to reduce demand for acute services. Since 1 October 2018, measures have been put in place to remediate the demand levels. Further upstream investment needs to be worked through and discussed.
- The Committee asked for an update on the current status of the MHAIDS Integration project.

**HSC recommends the Board:**

b) **Notes** the report.

**Actions:**

1. Staff to re-look at the use of social media as a means of engaging with communities and report back to the Committee.

3.3 **Maternity Quality Report**

The paper was taken as **read**.

The Committee:

a) **Noted** the publication of the Women’s Health Service Annual Clinical Report 2017.

b) **Noted** the publication of the Maternity Quality & Safety Programme Plan 2018-2019.

c) **Noted** the Ministry of Health development of maternity services whole of system work programme.

d) **Noted** strategic work the service is undertaking to improve equity in relation to women and babies.

**Discussion:**

- Timeline on the development of the feasibility study on a primary birthing facility in central Wellington was requested. A survey has gone out to the consumers and health providers. The information is being collated currently and we are waiting for the finalised results.
- MQSP consists of 2 LMCs representative and 2 consumer group representatives who feedback to and from DHB, they are involved on the development of projects, feedback outcomes affected by the communities. The LMCs network is independent across all DHBs. CCDHB has regular meetings with the LMCs. Operation Managers and Clinical Leaders attend these meetings as well. These meetings provide a platform for the LMCs to voice their concerns. If women in the community have a complaint forms are available for consumers to feedback anonymously.
‘Ana noted it was important that all consumers had a voice and there would be value in engaging with the Sub Regional Pacific Health Advisory Board and the Maori Partnership Board on ways to ensure the voices of young Māori and Pacific women could be heard.

HSC recommends the Board:

a) Note the paper.

Actions:

1. Staff to discuss the Maternity Quality Report with the Maori Partnership Board and the Sub Regional Pacific Health Advisory Board

Moved: ‘Ana Coffey  Seconded: Eileen Brown  Carried:

3.4 Investment and Performance – PHOs, Older Persons Services and Community Pharmacies

The paper was taken as read.

The Committee:

a) Noted that from 1 December this year the Budget 2018 initiatives to provide people with greater access to primary care which will include access to low-cost general practice visits to all community service card holders; and free general practice visits for children under the age of 14.

b) Noted that in 2018/19 CCDHB will invest $67 million in local providers under the nationally negotiated Aged Residential Care Agreements for services that include rest home, continuing care, dementia and psychogeriatric services;

c) Noted that in 2018/19 CCDHB will invest $86 million in local providers under the nationally negotiated Community Pharmacy Services Agreements for services that include dispensing and other services provided by community pharmacies and the costs of the pharmaceuticals dispensed;

d) Noted the dashboards continue to show similar trends in performance and equity gaps. Health Care Homes and the 1 December implementation of the lower cost general practices fees for community services care holders and thirteen year olds is expected to reduce barriers to access and improve health outcomes for our population.

e) Noted this reporting is part of our process of improving our understanding of how our investments in the national agreements for community pharmacy, primary health organisations and aged residential care, are 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.

Discussion:

- Members asked about qualifications for Aged Residential Care workers. The aged residential care and support workforce do require qualifications and the pay scale is related to qualification. However, we as DHB do not have the information on the hours and qualifications for the aged residential care and support workforce within specific facilities this information is collected by the Ministry but not shared with the DHBs.
- Sue Kedgley suggests that the DHBs collectively request that the national agreement be amended to require the release of information on qualifications and hours to DHBs.
- Tristram pointed out that equity has been a hot topic and he is disappointed to see that equity is still not translating in performance. Community Health Networks and Locality approaches will see an improvement. The Māori Health Strategy includes an action plan including specifics, timeframe and KPIs to address equity.
• The Committee to look more closely at the dashboard at the next meeting.
• Eileen commented that from 1 December 2018 the Budget 2018 initiatives to provide people with greater access to primary care is good news.

HSC recommends the Board:
  a) Notes the paper.
  b) To take the issue of access to information on hours and qualifications level of the aged residential care and support workforce to the National DHB Chairs and Chief Executives meeting for discussion.

Actions:
  1. To work with the DHBs to requests from the Ministry for the information on the qualifications level and hours of the aged residential care and support workforce.

4 FOR INFORMATION

4.1 CCDHB/Regional Public Health Submission on Legislation

The paper was taken as read.

The Committee:
  a) Noted the attached submissions prepared by Regional Public Health on behalf of the Committee for the Healthy Housing Standards and the Residential Tenancies Act (1986).

HSC recommends to the Board:
  a) To note the paper.

PRESENTATION BY KĀPITI HEALTH ADVOCACY GROUP

Kathy Spiers (Chair) introduced the Group. The group has been established for 18 months and they meet on the monthly basis. Kathy also introduced Mayor Guru briefly talked about history Kāpiti health, the community health work, transport issues, accessibility. He would like to work with CCDHB on the Kāpiti Locality plan. Adrian Gregory gave a presentation on the purpose, objectives and priorities of Kāpiti Health Advocacy Group.

The Committee noted the presentation.

Discussion:
• There are opportunities for CCDHB and KHAG to align their priorities in terms of health needs and locality.
• There needs more inclusion of the voices of the younger people. KHAG has been working with primary schools and counsellors. KHAG is also doing their best to get greater representation across all demographics to address the equity issue.
• Otaki boundary. KHAG said this issue needs to be recognise and find a short and medium term solutions. It has to do with how effectively communicate with the residents of Otaki through social media. The CEs of CCDHB and MidCentral are meeting on 1 November to discuss this issue and plan to put together a MOU. Julie will report back to the Board after the meeting.

HSC recommends to the Board:
  a) That CCDHB and Kāpiti Health Advocacy Group (KHAG) and its stakeholders collaborate proactively on the development of a Kāpiti Health and Wellbeing Locality Plan based on the five priority areas and that the planning group should:
• Reflect on the implementation of the Otaki Health and Wellbeing Plan and the establishment of the Otaki Health and Wellbeing Advisory Group
• Establish and sustain open, two-way channels of communication
• Adopt an effective community engagement and communication plan
• Maintain an evidence-based annual review of progress towards and, post-implementation, the outcomes of the Locality Plan.

Sue Kedgley and Roger Blakely left at 12.20pm

2 FOR DECISION

2.2 Kāpiti – Delivering Care in the Community

The paper was taken as read.

The Committee:

a) **Noted** CCDHB is prioritising the development of our localities approach in Kāpiti, as well as Porirua, through targeted service development and investment during 2018/19.

b) **Noted** that with the Kāpiti community our locality focus is supporting service delivery models that support care closer to home to improve outcomes and ensure people do not travel unnecessarily for hospital and specialist care that is avoidable.

c) **Noted** the progress of an acute and urgent care model development, telehealth trial, Health of Older People service development and medication management service development alongside Healthcare Home development are priorities within Kāpiti.

d) **Noted** the change to the shuttle service from Kenepuru to Wellington Hospital increasing the number of patients from Kāpiti using the shuttle.

e) **Endorsed** the ongoing development of the initiatives to improve service delivery models in Kāpiti with the intention of improving health outcomes and reducing the burden of travel for avoidable hospital care for the people of Kāpiti.

**HSC recommends the Board:**

a. **Endorse the focus on initiatives to improve service delivery models in Kāpiti with the intention of improving health outcomes and reducing the burden of travel for avoidable hospital care for the people of Kāpiti.**

b. **Note and endorse the work of the Kāpiti Health Advisory Group and the need for collaboration between CCDHB and KHAG on developing Community Health networks and locality planning for Kāpiti.**

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

The Chair noted that Catherine Epps will be leaving CCDHB and this will be her last meeting. The Chair thanked Catherine for her support.

The meeting closed at 12.50.

5 DATE OF NEXT MEETING

28 November 2018, 9.30am, Board Room, Level 11, Grace Neill Block, Wellington Regional Hospital.
### SCHEDULE OF ACTION POINTS – HEALTH SYSTEM COMMITTEE (HSC)

<table>
<thead>
<tr>
<th>AP No:</th>
<th>Topic:</th>
<th>Action:</th>
<th>Responsible:</th>
<th>How Dealt With:</th>
<th>Delivery Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSC Public Meeting 24 October 2018</td>
<td>1.7</td>
<td>HSC Work Programme</td>
<td>Committee Secretary to start on 2019 Work Programme</td>
<td>Director, SIP</td>
<td>December Meeting</td>
</tr>
<tr>
<td></td>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.1</td>
<td>Community Health Networks – the CCDHB framework</td>
<td>Staff to develop a diagram for presenting at a future Committee meeting showing the interconnections between PHOs, NGOs, Health Care Homes, RPH within Community Health networks and the relationship with Localities. Look at feasibility of developing outcomes measures that reflect efficiency and cost-effectiveness rather than simply reduced costs.</td>
<td>Director, SIP</td>
<td>Presentation</td>
</tr>
<tr>
<td></td>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.3</td>
<td>Porirua – Supporting Equity and Outcomes</td>
<td>Report to the Board on the progress of Community Health Network in Porirua at a future meeting. Staff to present the localities work to the Porirua City Council following invitation by ‘Ana Coffey.</td>
<td>Director, SIP</td>
<td>1. Report scheduled for March HSC Meeting. 2. ‘Ana to advise presentation date.</td>
</tr>
<tr>
<td></td>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.1</td>
<td>Regional Public Health Bi-Monthly Performance Report</td>
<td>RPH to provide evidence on how liquor licencing impacts hospital admissions in the Porirua community. CCDHB staff to look at how RPH perspectives could be incorporated into future issues based Committee papers. RPH performance report to be reduced to a six month frequency.</td>
<td>RPH / SIP</td>
<td>December Meeting</td>
</tr>
<tr>
<td></td>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.5</td>
<td>Healthy Housing Update</td>
<td>RPH to draft letter on behalf of the Board to Government Ministers asking them to consider legislative change that would support safer home heating methods. RPH to draft a letter on behalf of the CCDHB to the Minister of Health asking that extending</td>
<td>RPH</td>
<td>In progress</td>
</tr>
<tr>
<td>Action List</td>
<td>Description</td>
<td>Due Date</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2 MHAIDS Bi-Monthly Performance Report</td>
<td>1. Staff to re-look at the use of social media as a means of engaging with communities and report back to the Committee.</td>
<td>December Meeting</td>
<td>Open</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.3 Maternity Quality Report</td>
<td>1. Staff to discuss the Maternity Quality Report with the Māori Partnership Board and the Sub-Regional Pacific Health Advisory Board.</td>
<td>In progress</td>
<td>Open</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.4 Investment and Performance – PHOs, Older Persons Services and Community Pharmacies</td>
<td>1. To work with the DHBs to request from the Ministry for the information on the qualifications levels and hours of the aged residential care and support workforce.</td>
<td>In progress</td>
<td>Open</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HSC Public Meeting 26 September 2018**

<table>
<thead>
<tr>
<th>Action List</th>
<th>Description</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Key drivers for investment for 2019/20 and beyond</td>
<td>1. SIP to pull together a response and the number of people that Housing NZ and MSD are potentially excluding from this development and its implications.</td>
<td>Director, SIP</td>
</tr>
<tr>
<td>3.1 Long-Term Investment Planning</td>
<td>1. SIP to keep the Board and FRAC updated with the findings as we head into a new financial year.</td>
<td>Director, SIP</td>
</tr>
</tbody>
</table>

**HSC Public Meeting 2 May 2018**

<table>
<thead>
<tr>
<th>Action List</th>
<th>Description</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Investment in &amp; performance of CCDHB Primary Health Organisations (PHOs)</td>
<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>
<td>Director, SIP</td>
</tr>
<tr>
<td>AP No:</td>
<td>Topic:</td>
<td>Action:</td>
</tr>
<tr>
<td>-------</td>
<td>--------</td>
<td>---------</td>
</tr>
<tr>
<td><strong>HSC Public Meeting 24 October</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>Community Health Networks – the CCDHB framework</td>
<td>1. SIP to provide the Committee with six monthly implementation progress updates including any issues, particularly for Kāpiti and Porirua. 2. Outcome measures to include equity and cultural responsiveness.</td>
</tr>
<tr>
<td>3.1</td>
<td>Regional Public Health Bi-Monthly Performance Report</td>
<td>1. RPH performance report to be reduced to a six month frequency.</td>
</tr>
<tr>
<td><strong>HSC Public Meeting 26 September 2018</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.6</td>
<td>3D Health Pathways Update</td>
<td>1. Management to explore the issue of provision of Health Pathways to patients.</td>
</tr>
<tr>
<td><strong>HSC Public Meeting 27 June 2018</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<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>
</tr>
<tr>
<td>5.1</td>
<td><strong>Investment Planning to Support Living Well, Dying Well</strong></td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>---------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>SIP to provide more information on the investment to increase practitioner’s resources to Maori and Pacific areas when we get to the budget</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>HSC to be kept informed about the budget in this area</td>
<td></td>
</tr>
<tr>
<td>2 May</td>
<td>30 May</td>
<td>27 June</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>CCDHB</td>
<td>CCDHB</td>
<td>Ratonga Rua o Porirua</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>System Performance Reporting</td>
<td>TBC</td>
<td>Integrated Performance Monitoring</td>
</tr>
<tr>
<td>Prioritisation and Investment Update for implementing the Health System Plan</td>
<td>Prioritisation and Investment Update for implementing the Health System Plan</td>
<td>Investment Planning Approach</td>
</tr>
</tbody>
</table>

**Holding topics for HSC**

1. Primary Birthing Unit
2. Healthy Ageing Workforce approach
3. Present results from the Investment Planning Approach – specifically the partnership table
4. Integration of Child Health Services
5. School Based Healthcare Model
6. Public Healthcare Funding
HEALTH SYSTEM COMMITTEE
DISCUSSION PAPER
Date: 22 November 2018

Prepared by Carey Virtue, Executive Director Medicine, Cancer & Community
Endorsed by Julie Patterson
Subject CCDHB Bowel Screening Programme Update

RECOMMENDATION
It is recommended that the Committee:

a) Notes that CCDHB have been working with the Ministry of Health (MOH) to develop a local bowel screening service

b) Notes the initial service implementation plan has been drafted for the Ministry of Health in preparation to submit their Treasury Business case in February 2019

c) Notes the scope of the planned programme will require an increase in colonoscopy capacity at CCDHB.

d) Notes that there are two preferred site options for service delivery being considered: Kenepuru and Hutt Valley DHB

e) Notes that although service delivery will be funded (initially directly by the MOH and most likely thereafter through the standard funding model), the capital investment to establish this new service will come from the existing CCDHB capital funding allocation.

f) Notes there will be a treatment impact from early detection of cancers that will bring forward the cost of treating conditions identified through this process.

g) Notes that although CCDHB has an indicative time frame to commence bowel screening there is still some uncertainty in the time frames for the national rollout

h) Notes that the service is expected to begin screening patients in mid 2019/20.

1. INTRODUCTION

This paper updates the Health System Committee (HSC) on progress towards the provision of Bowel Screening at Capital & Coast District Health Board (CCDHB).

2. BACKGROUND

CCDHB have been working with the Ministry of Health (MOH) to develop a local bowel screening service as part of the National Bowel Screening Programme (NBSP). The Ministry is funding DHBs to establish and then deliver services to provide bowel screening colonoscopies to their residents. The planning and establishment phase of CCDHB’s Bowel Screening Implementation Project is currently underway at CCDHB and the Ministry is providing funding to enable the planning and establishment of the bowel screening service.

Each DHB must be able to show that it is capable of providing a safe, efficient, equitable and robust bowel screening service prior to commencement. DHBs must also be achieving all national waiting time targets.
for colonoscopy, and be able to prove that the commencement of screening will not adversely impact symptomatic colonoscopy services.

CCDHB has approximately 41,600 residents who would be eligible for bowel screening. Participants will be invited to take part every two years. The screening programme will generate approximately 600 bowel screening colonoscopies per annum. Although these colonoscopies will be funded by the Ministry (via a service delivery contract), the DHB facilities must be able to accommodate the increased demand.

2.1 Strategic Context

Investment in the bowel screening programme at CCDHB supports a number of key Government initiatives, including the New Zealand Health Strategy, the Faster Cancer Treatment Programme, the New Zealand Cancer Plan 2015-2018, the New Zealand Cancer Information Strategy and the Ministry of Health Statement of Intent 2015-2019.

New Zealand has one of the highest rates of bowel cancer in the developed world, with bowel cancer being the second most commonly registered cancer and the second most common cause of cancer death¹. In CCDHB, although bowel cancer registration (incidence) rates are lower than the average national rate, age-specific mortality rates for those aged 60-74 are very similar to that seen nationally.

Statistics New Zealand population projections estimate that the CCDHB domiciled population aged 60-74 (i.e. eligible for the National Bowel Screening Programme) will be approximately 41,600 for the 2019/20 financial year. Current analysis suggests that each year, the Bowel Screening Programme will identify around 50 colorectal cancers in the CCDHB population. The vast majority of these cancers will be found at an earlier, more treatable stage than seen in the symptomatic population. By the time a person experiences symptoms, a bowel cancer is more likely to be advanced and is less likely to be treated successfully. Bowel screening generally identifies cancers at an early stage where treatment is generally simpler and costs can be lower.

Bowel screening also aims to identify and remove pre-cancerous polyps from the bowel before they become cancerous which may, over time, lead to a reduction in the incidence of bowel cancer in the population.

These benefits have considerable positive implications for colorectal cancer survival rates, mortality rates and incidence rates.

The evaluation of the Bowel Screening Pilot (which ran in Waitemata DHB between 2012 and 2017) concluded that bowel screening will save lives, with data from international studies indicating that a screening programme may reduce mortality from bowel cancer in the population offered screening by at least 16-22 percent, and potentially up to 30 percent, after 8-10 years. The evaluation also concluded that a national bowel screening programme will result in significant cost-savings regarding treatment of bowel cancer, which outweigh the cost of screening.

Key Benefits of Bowel Screening:

- **Improved health outcomes** - reduced mortality and morbidity associated with early detection. Better survival outcomes and, potentially, reduced bowel cancer incidence rates.
- **More cost-effective health care** – cancers found earlier (or cancers averted completely by removing pre-cancerous polyps) will reduce the cost of treatment, and increase both quality and quantity of life, i.e. Quality Adjusted Life Years (QALYs).

• **Improved service delivery** – an increase in people receiving consistent and high quality services, reductions in symptomatic first presentation at Emergency Departments, and improved data capture and reporting. It is a common consequence of screening programmes that the required quality standards associated with population screening lead to improvements in symptomatic services.

• **Significant social and economic benefits** – as well as QALYs saved, bowel screening provides a considerable contribution to society.

**Inequalities in Bowel Cancer**

Bowel cancer is a significant cause of morbidity and mortality, with notable variations within the New Zealand population;

• Age: incidence increases with age, with 94 percent of cases occurring in those aged 50 or over and 82 percent in those aged over 60.

• Gender: Colorectal cancer is more common in men than women, this is consistent worldwide.

• Ethnicity: Bowel cancer is one of the few cancers for which Māori show lower incidence rates than non-Māori. In 2013, Māori showed a rate of 33.6 colorectal cancer registrations per 100,000 population compared to a rate of 42.7 for non-Māori. However, once diagnosed with colorectal cancer, Māori survival is considerably lower than for non-Māori.

The following chart shows cumulative survival over ten years for patients diagnosed with colorectal cancer between 1994 and 2011.

**Survival, by ethnic group**

![Survival chart](image)

• Deprivation: Survival rates for people diagnosed with colorectal cancer vary significantly by deprivation quintile. Quintile 1 and 2 survival rates were 14 percent higher than quintile 5 in 2011.

Analysis of New Zealand data found that while screening will offer health gains to all screened population groups, the gain for Māori will be lower than for non-Māori. This is because Māori have a lower incidence of bowel cancer, screening programmes are less successful in engaging with Māori and Māori have lower life expectancy than non-Māori. However once diagnosed Māori are more likely to die of bowel cancer.

If equal participation in screening was reached for Māori compared with non-Māori health gain inequities would persist. It should be noted, however than once Māori have taken part once, there are no significant differences in participation or colonoscopy uptake for subsequent screens.

---

2 Source: New Zealand Cancer Registry
Note: rates are age-standardised to the WHO World Standard Population
3 McLeod M, Blakely T. 2017. Nationwide Colorectal Screening in New Zealand: a tricky balance of improving overall population health and addressing inequalities
Using a wider screening age for Māori has been considered as a means of improving equity of outcomes for Māori in the national bowel screening programme. Research found that to achieve the same amount of health gain for Māori the screening age would need to be 50-74 years and 60-74 years for non-Māori. The Ministry continues to receive pressure from DHBs and from Māori providers to lower the age range of bowel screening for Māori.

The Ministry indicated it will review its original decision (to screen all New Zealanders from age 60) and will reconsider the benefits and risks of screening Māori at an earlier age.

2.2 Service Establishment

The MOH have agreed to fund the establishment of a bowel screening programme at CCDHB to undertake:

1) The promotion of bowel screening to the CCDHB population
2) The provision of screening colonoscopies and colonoscopy pre-assessments
3) Payments to GPs to manage and refer patients with a positive screening test
4) The provision of surveillance (follow up) colonoscopies generated from the screening programme

Analysis identified that it would only be possible to provide a bowel screening programme to the estimated 41,600 CCDHB residents eligible for the programme by significantly increasing colonoscopy capacity at CCDHB.

The CCDHB service implementation plan has been drafted for the Ministry of Health this month to inform the Ministry of Health 2019/20 NBSP business case for Treasury. CCDHB will continue to work with the Ministry over the next three months to confirm the details of this plan.

2.3 Implementation Options

Since 2016, various options to provide the additional colonoscopy capacity required for the delivery of bowel screening have been considered. Discussions have taken place between clinical teams, the Endoscopy Service and Strategy Innovation and Performance and regional stakeholders.

The key investment objectives identified the requirement to increase colonoscopy capacity by mid 2019/20 and chose an option that will promote equity at CCDHB. Critical success factors included: strategic fit and business needs, potential value for money, supplier capacity and capability within timeframe, potential affordability and potential achievability.

CCDHB currently provides a full range of diagnostic and treatment services for patients with suspected and confirmed colorectal cancer whilst providing tertiary endoscopy services for regional patients. However the service is nearing capacity and has recently arranged to outsource some colonoscopies to private providers in order to meet colonoscopy waiting time targets.

Consideration of the various options for the introduction of a bowel screening programme included outsourcing, and increasing capacity at Wellington Hospital by either facility development or expanding to evening and weekend working.

Outsourcing was judged to have too much risk due to uncertainty around private capacity, and provision at Wellington Hospital was ruled out because of either the constraint on space within the required timeframe or the required changes to employment agreements to enable extended working.

The two preferred options are to either utilize existing capacity at Hutt Hospital or to reinstate colonoscopy services at Kenepuru Community Hospital. The option to reinstate Kenepuru has the benefit of supporting improved access for Kenepuru and Kapiti communities. In addition the service can be established relatively
easily in that location in the short to medium term. The Hutt option utilises free capacity currently available but has increased complexities in terms of staffing models and does not provide the same benefits of access for our communities.

The cost of implementing a bowel screening programme will require capital investment, which will need to be met by the DHB from its capital funding allocation. Operational costs to manage patients with a positive screening test and to deliver screening colonoscopies will be met through national funding.

2.4 Consequential Impact on Treatment Volumes

There will be no additional funding to cover treatment costs relating to the additional cancers identified through this programme. Initial estimates suggest the impact of introducing bowel screening will result in the identification of an additional colorectal cancer each week, equating to a 33% increase in demand for treatment of colorectal cancer. This is because screening detects cancers at early stages when symptoms are less likely to be noticed. Cancer detection will likely peak during the first two years following the introduction of screening. After this time, the numbers of cancers found per year is likely to fall, and at a point (possibly 8-10 years following the introduction of screening) the rate of bowel cancer in the population may be lower than the pre-screening rate. Thus the effect of introducing screening is to bring forward (and therefore probably reduce) the costs of treating these patients rather than significantly expanding the cohort of patients undergoing treatment.

Symptomatic Demand

In addition to increases in demand driven by screening, there will also be an increase in patients presenting with bowel cancer symptoms that will require care. This is referred to as the ‘symptomatic wave’ and will increase the cost of treatment that DHBs experience in the initial rollout of bowel screening. Initial estimations suggest the symptomatic wave could equate to 15 additional cancers in 2019/20.

Demand from sub-regional DHBs

A result of Wairarapa and Hutt Valley DHB’s having implemented their bowel screening programmes is that CCDHB (as a treatment provider) is already experiencing service demand and cost pressures. Note this will continue as these DHBs continue to screen their patients, regardless of our local rollout of bowel screening.

3. IMPLEMENTATION PLANS

Bowel screening is expected to start mid 2019/20. CCDHB will join the Programme using the new NSS (National Screening Solution) IT system, and will therefore not be required to transition from the current IT system (a requirement for all DHBs going live prior to 2019). The Ministry have advised that there is still a risk that the start date may be pushed back if any issues arise with the migration of existing users to the new system.

The Programme timeline can be divided into four distinct phases:

Phase 1 - Implementation Planning: During this phase a Project Manager was appointed to gather information and complete the Ministry of Health’s information template. The information supplied was used to inform the Ministry’s 2019/20 business case to Treasury.

Phase 2 - Implementation Project Team: A project team (including Lead Clinician, Bowel Screening Nurse, Communications Advisor and Primary Care lead) will be appointed to prepare the DHB for bowel screening to commence.
**Phase 3 - Service Delivery, Transition to business-as-usual**: The team will remain in place for 6 months following Go-live, to ensure processes are embedded prior to the business-as-usual phase and to complete the project documentation.

**Phase 4 - Service Delivery, Business-as-usual**: The project team will transfer responsibility to the service manager and the endoscopy team. The Ministry will provide 24 months of fixed funding for service delivery from launch to allow time for an alternative funding model to be put in place.

The project is expected to run until May 2020 with the bowel screening expected to start mid 2019/20. The next significant milestone is for the project team to produce the final implementation plan for the MOH by February 2019. The MOH will use the information to develop their business case for the Treasury. The project team intend to use previous bowel screening programme rollouts, particularly in Hutt Valley and Wairarapa DHBs, to inform planning and implementation for this service. The programme will include specific activities designed to address and minimize inequalities that currently exist in bowel cancer outcomes by promoting and maximising participation in the programme for the priority population groups of Māori, Pacific and those in high deprivation areas.
Authors: Delwyn Hunter, Executive Director Surgery, Women & Children’s
Carey Virtue, Executive Director Medicine, Cancer & Community

Endorsed by: Julie Patterson, Interim Chief Executive

Subject: Hospital & Healthcare Services (HHS) Bi-Monthly Performance Report

RECOMMENDATIONS

It is recommended that the Committee:

a) Notes that the contingency planning for the midwife strike is progressing with the focus on maintaining the safety of the women and babies impacted by this action.

b) Notes the need to relocate and reconfigure aspects of the Wellington Blood and Cancer Centre in light of plans for the new Children’s Hospital.

c) Notes that demand for Coronary Angiography remains higher than capacity which the service is taking steps to address.

d) Notes that pressures on the Cardiothoracic Surgery service have led to patients waiting longer for treatment than clinically appropriate. The service has implemented various measures to address this.

e) Notes that NICU continue to work with regional partners to manage significant demand for NICU beds.

f) Notes that the Hospital Frailty governance group has been established to provide oversight and support for the many projects underway considering how best to manage frailty in the aging population during their hospital stay.

g) Notes that the Ophthalmology service expect to have addressed the recent waiting list issues by the end of November and are considering ways to manage increased referral volumes sustainably.

h) Notes the progress and rollout of Trendcare and the Care Capacity Demand Management programme.

i) Notes the Key Performance and health target results

1. INTRODUCTION

1.1 Purpose

The purpose of this paper is to inform the Health System Committee of key activities and priorities being progressed through the Hospital and Healthcare Services of Capital & Coast District Health Board (CCDHB).

2. KEY ISSUES / PRIORITIES

2.1 Winter Demand

Hospital services experienced a peak in influenza admissions in mid-September with high numbers of admissions to ICU and paediatrics. As a result of undiagnosed cases of influenza inpatients admitted to the...
wards, there were several cases of influenza cross transmission within wards. These events were managed within the established winter plans which are now being stepped down with the onset of spring and the reduction in influenza cases. The overall Shorter stays in Emergency Department (SSiED) performance was 87% for the period. For those patients who were seen, treated and discharged from the ED the SSiED performance was 93%.

2.2 MERAS Midwifery Industrial Action
Midwives who are members of the Midwifery Employee Representation & Advisory Service (MERAS) have given official notice that they intend to undertake strike action around the country later this month. MERAS members will withdraw their services during a set of predominantly two two-hour strikes per day from 22 November through to the morning of 6 December. Detailed contingency planning for the strike is underway to ensure women and babies continue to receive the care and support they need during this time, and to enable eligible MERAS members to take part in the strike if they wish. DHBs are keen to continue talking to MERAS to try to settle negotiations with mediations scheduled for 14 November 2018.

2.3 Children’s Hospital Link Corridor through Cancer centre
The construction of the new children’s hospital includes a link bridge to the Wellington Regional Hospital (WRH) and will join with WRH at the WBCC ambulatory centre. This construction work requires the relocation of the day ward within the centre and the relocation of all or most of the office space to a new location. The outpatient space is also affected and requires some redesign. There is work underway with clinical staff to develop options and concept designs that consider future demand and changes in models of care.

2.4 NICU
Continuing recent trends, NICU saw further increases in the volume of admissions and the acuity of patients admitted over the period and has seen a recent increase in babies with Hypoxic Ischemic Encephalopathy (HIE). The situation continues to be managed through staff overtime although the unit has seen a rise in staff sickness over this period. NICU have focussed renewed efforts regionally to ensure that infants return to their local units once they are well enough.

2.5 Frailty Project
The formation of a Frailty governance group to provide oversight and support for the many projects that are undertaken to improve the care or reduce the risk for the frail older adult while in hospital. This includes projects on improved mobility, early mobility assessment, provision of appropriate equipment and consumables and the implementation of a referral whiteboard. The project is also looking at options to improve therapeutic care for patients requiring one on one observation, moving from understanding the issues to implementing interventions that can be trialled.

2.6 Ophthalmology
The ophthalmology service continues to struggle to meet demand, with the risk that patients continue to wait past their clinically indicated timeframes for follow up and treatment. There is robust reporting now in place and we can readily identify those patients waiting outside clinically indicated follow-up time frames. While we will have no patients waiting over 1.5 times their recommended treatment time frame by the end of November, this has been achieved through the use of many catch up locum Saturday clinics which is not a sustainable solution.

We have explored additional more sustainable models. We have implemented nurse led clinics – these have been successful in some subspecialties such as diabetes and avastins however have not been successful in glaucoma. We are keen to pursue more sustainable models and, for example in glaucoma we would like to undertake a greater number of follow ups into the community. We are training nurses...
to manage other patients, for example in the laser and crosslinking services. We have employed two locums for 5 months starting in February which will help in the medium term, but sustained increased patient volumes mean the service requires additional SMO, registrar and fellow’s to manage demand.

2.7 Trendcare and Care Capacity Demand Management (CCDM)

Partnership with the unions has enabled the CCDM programme to become established quickly and efficiently at CCDHB. A national CCDM governance group who recently visited the hospital was impressed with the progress, the partnership working and the transparency of the programme.

Significant improvements in TrendCare use and data collection are evident and provide the foundation for further developments. A core data set has been determined both to evaluate the effectiveness of care capacity and demand management overtime and to make improvements, using twenty three metrics from TrendCare, payroll, human resources, reportable events and the Health Quality Safety Commission. Twelve of these metrics will shortly be available via QLIK and another six that are currently sourced through TrendCare, will also in time be available through QLIK along with all other TrendCare data.

Each ward area has been supported to establish local data councils to manage Trendcare and CCDM local implementation with SAPU, 4 North Gynaecology, Wards 1 and 2 – child health, 6 North and 7 South being the first to rollout. The TrendCare and CCDM programmes have recruited four new staff to assist with programme implementation including a dedicated co-ordinator for all mental health inpatient areas. Rollout to the remaining wards is currently underway and expected to be complete by June 2019. The initial sites will be used to fine tune the implementation (including escalation plans, standard operating procedures and capacity at a glance screens) ensuring the implementation is tailored to meet our requirements.

3. KEY PERFORMANCE INDICATORS

3.1 Elective Service Patient Flow (ESPI)

The Elective Service target continues to show a favourable position of 29 cases year to date. Elective surgery remains slightly under target but was offset by arranged and non-surgical continued over performance. Outsourced cases remain within the annual budget.

3.2 Waiting Times

October ESPI 2 (First Specialist Assessments) and 5 (Awaiting Treatment) results are to be confirmed by MOH, however the results below reflect internal reporting and show we remain compliant in both measures. We are forecasting 16 non-compliant in ESPI 2 and 19 non-compliant for ESPI 5 for November, which is within tolerance for these measures.

<table>
<thead>
<tr>
<th></th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov'19</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESPI 2</td>
<td>20</td>
<td>13</td>
<td>23</td>
<td>18</td>
<td>17</td>
<td>18</td>
<td>18</td>
<td>16</td>
</tr>
<tr>
<td>ESPI 5</td>
<td>18</td>
<td>8</td>
<td>12</td>
<td>19</td>
<td>14</td>
<td>18</td>
<td>19</td>
<td>19</td>
</tr>
</tbody>
</table>

3.3 Surgery

Session utilisation for Wellington theatres was 91% and for Kenepuru it was 84%, mainly due to surgeon unavailability. Released sessions were subsequently utilized by neurosurgery, gynaecology and vascular. List utilisation (target 85%) was 82% for Wellington and 65% for Kenepuru. A focused piece of work to improve utilisation is underway working initially with orthopaedics as the highest user of Kenepuru sessions.
Late starts at Wellington are at 13% due in the main to surgeon unavailability. Kenepuru late starts are 26% with ‘patient preparation’ the main contributor. Day of surgery cancellations for both sites was 10% with the main reasons being ‘insufficient time to proceed with another case’, ‘patient unfit for procedure’ or because the planned elective case has been replaced by an urgent acute case.

3.4 Coronary Angiography

There continue to be challenges for CCDHB and the central region to meet the target for elective coronary angiography to be undertaken within 90 days of a referral being accepted. The service has seen a fall in the last month to 78.3% of referrals being seen from over 90% in previous months. There is work within the region and at CCDHB to maximise capacity and manage timeframes for this including using the fellow to backfill any available sessions, making changes to afterhours rosters and improved processes to repatriate regional patients in a more timely way. The service is also considering outsourcing some referrals to Wakefield Hospital.

3.5 Cardiothoracic Surgery and Waiting Times

The cardiothoracic service is currently unable to meet demand with a surgical waitlist that has grown to 79 with several patients waiting longer then clinically appropriate for treatment. The service is under additional pressure due to the inability of 1 surgeon to participate in surgery and on-call, and the locum surgeon who has been providing significant support is retiring in December having already previously extended his availability. The cardiothoracic surgeons have a high surgical load compared to all other surgical specialties at CCDHB and work a 1:3-4 roster so any change to the availability of a surgeon has significant impact on the volume of work able to be completed.

There are currently 12 patients waiting longer then clinically indicated for treatment. There is a risk of clinical deterioration, or what may be seen as an avoidable death on the waiting list if a patient dies while waiting outside the recommended treatment time frame for surgery. The MOH calculated maximum waiting list size for CCDHB is 75 patients, which represents 10% of the expected annual throughput.

In order to manage this period of pressure we are utilising the locum surgeon as much as possible, backfilling lists with our own surgeons, outsourcing to private providers and ensuring regular review of patients. We have a fixed term surgeon starting in February 2019 who will cover an 18 month period where the service will be reconfigured so that we have five surgeons providing cover for all sessions and for periods of leave.

3.6 Access to Diagnostics – Radiology

MOH Performance Indicators - CT

Performance against the CT and MRI MOH indicator for non-urgent referrals continues to be a challenge for CCDHB. September and October saw further improvements on August rising to 71% against a target of 95% of referrals seen within 6 weeks.
The high referral numbers continue to place a high demand on the service with an additional 195 referrals received during August/September when compared with the same period in 2018 (6% growth), but at least this is a reduction on the 11.8% July/August growth reported last time.

Internal training to increase the number of CT MITs (Medical Imaging Technologists) will begin in January. With an increased number of CT MITs we intend to increase elective booking slots by offering afterhours appointments (weekends and/or evenings). This has been made possible by the approval of the gold MIT FTE and the successful recruitment of 7 MITs in December.

**MOH Performance Indicators - MRI**

Recovery of performance against the MRI MOH indicator continues and is now 52%, however still remains significantly below the target of 90% of referrals seen within 6 weeks.

Overtime elective lists and outsourcing has reduced the waiting list in MRI by approximately 140 patients this month and has reduced the waiting times for patients. Referral volumes remain relatively unchanged when compared to the previous 2 months. Of note, MRI elective lists will reduce over the December/January period to enable the staff to take annual leave and we will expect some growth in the waiting list.
3.7 **Access to Diagnostics - Colonoscopy**

The CCDHB is measured on access to urgent, non-urgent and surveillance diagnostic colonoscopies.

Demand continues to exceed existing colonoscopy provision due to a number of MoH funded colonoscopy wait list initiatives introduced the last two years. The service continues to prioritise urgent and non-urgent colonoscopies over surveillance colonoscopies.

**Urgent Colonoscopy**

Internal Diagnostic reports for October indicated that 90% of people accepted for an urgent diagnostic colonoscopy received their procedure within two weeks (14 days) against a Target of 90%. Target Met.

**Non-Urgent Colonoscopy**

Internal Diagnostic reports for October indicated that 85% of people accepted for a non-urgent colonoscopy received their procedure within six weeks (42 days) against a Target of 70%. Target Met.

**Surveillance Colonoscopy**

Internal Diagnostic reports for October indicated that 54% of people waiting for surveillance waited no longer than twelve weeks (84 days) beyond the planned date against a Target of 70%. Target Not Met.

There are currently 163 surveillance patients who have waited more than twelve weeks for a colonoscopy. The service is outsourcing approximately 20 patients per month which started in October. Recruitment to expand the team is underway with additional staff expected to start from January 2019.

**** End of Report ****
HEALTH SYSTEM COMMITTEE PUBLIC - 3.3 Strategy Innovation and Performance (SIP) Bi-Monthly Report

PUBLIC

Capital & Coast District Health Board

HEALTH SYSTEM COMMITTEE DISCUSSION PAPER

Date: 28 November 2018

Author
Rachel, Haggerty, Director, Strategy Innovation and Performance

Subject
Strategy Innovation and Performance Report November 2018

RECOMMENDATION

It is recommended that the Committee:

a) **Notes** the update on current activity

b) **Recommends** the Board note this update

1. **PURPOSE**

This paper updates the Health System Committee on the Strategy Innovation and Performance (SIP) priority activities between September and November, including our focus on commissioning and managing community services.

2. **BUILDING COMMISSIONING CAPABILITY**

2.1 **Pro-equity health check**

At the August HSC meeting the Committee was advised of the DHB’s intention to undertake a pro-equity “health check” to assess how well we are currently responding to our health equity objectives and identify opportunities for improvement. The aim of the work being to provide a practical plan for action, so that Capital and Coast DHB makes progress on high level commitments and moves beyond good intentions.

The work is progressing well with the document review largely completed and a staff survey is currently underway to establish workforce perceptions about how well we are doing on health equity. Pro-equity workshops will also take place in December.

2.2 **The Social Services Procurement Strategy 2018-21**

SIP and Procurement staff recently attended a briefing session at MBIE to learn about their plan for investing in training for social services procurement. MBIE has identified the need to work directly with DHBs as their procurement needs are different to central agencies. The Director Pacific health also attended the session and spoke strongly to the important role of the procurement approach to the cultural component of the work programme. The scope of the training will be social services procurement (i.e. a compliance focus), we don’t believe it will encompass a broader commissioning approach as that will be agency specific.

The training investment is driven by central government recognition that procuring social services is different to procuring ‘widgets’ and we have under invested in this skill set over a long period of time. The Office of the Auditor General is also paying attention to this area over the next three years.

Broadly, the approach that MBIE is taking includes:
3. LOCALITIES ACTIVITY

A draft Localities Framework has been developed and is being refined to guide the implementation of key initiatives. The Framework will ensure a well-coordinated approach is taken by CCDHB in partnering with communities.

A CCDHB Localities Steering Group is being established that will include our three locality groupings of Kāpiti, Porirua and Wellington. This group will make sure that our engagement is coordinated and community centric.

3.1 Wellington focus

The focus within Wellington continues to be supporting people with mental health and addictions through our involvement in the Rolleston Street Project.

Rolleston Street Project
The Rolleston Street Upgrade Project is a Housing New Zealand led project with Wellington City Council (WCC), Downtown City Mission, Housing and Urban Development (formerly Ministry of Social Development) as significant partners. The Project was to include a wet housing facility (Te Whare Oki Oki) for homeless, long-term chronic alcohol dependent people.

The Project has since adopted the Housing First model, which, like the wet house model, aims to place the most vulnerable into suitable housing to make it easier to have their alcohol and/or mental health issues addressed – if they so choose. SIP and MHAIDS staff are part of the interagency working group and have been providing advice on the model of care and levels of support required for this group of vulnerable people.

Community Networks Wellington
The Community Network Wellington (CNW) Social Forum is evolving from a Rolleston St focus towards an inter-sectoral approach with the WCC facilitating the transition and new purpose. A new inter-sectoral group is being established and Terms of Reference are being refreshed. The CCDHB GM for Mental Health and Director Community Partnerships (or delegates) will attend these forums on behalf of CCDHB.

3.2 Porirua focus

In October the Committee was advised of opportunities for reconfiguring investment within south Porirua to improve health outcomes and strengthen our focus on achieving health equity. To drive this change we are currently undertaking data and investment analysis to support evidence-based engagement with Porirua communities. This analysis will provide insight and the basis for a respectful and robust approach to working with Porirua. Understanding the history of health service provision and funding is an essential part of the Porirua story, which we expect to have available by early 2019.

3.3 Kāpiti focus

Further to the Kāpiti focused update at the Committee’s October meeting including the presentation from the Kāpiti Health Advocacy Group (KHAG), SIP is actively developing new responsive services to keep...

SIP staff were impressed with both the thinking that MBIE has given and the process they have underway. We anticipate participating in the training when it is offered.
people well in the Kāpiti Community. A workshop will be held in December to start to define the Kāpiti Locality Plan.

**Urgent Care and After-Hours**
The DHB is working with PHO partners, Wellington Free Ambulance and the community to design, invest and implement new services to provide enhanced support in the community. Data analysis, stakeholder engagement and the designing of new pathways for people’s care is underway. CCDHB will develop a more responsive local model with the explicit purpose of reducing transfers to Wellington Regional Hospital ED. The new services will include improved access to primary care, linking paramedics with practices and supporting people with additional resources for acute needs.

We have a goal of an April Go-Live for implementation and there is a strong focus over the coming period on deeper community and stakeholder engagement.

**Transport**
The pilot shuttle connection is scheduled to finish in December but is expected to continue beyond the end of the pilot project. Transport remains a key area for ongoing engagement with KHAG as highlighted in the presentation to the Committee in October. This will be an important feature of the Kāpiti Localities plan discussions including opportunities for partnering with the community to improve transport options.

**KHAG Executive Group**
KHAG remains an important stakeholder and maintaining strong relationships through the regular monthly meetings is a locality priority for SIP. We understand that there is a proposal for the smaller KHAG executive group to report to and advise the Mayor and Council from 2019 with the larger network group meeting less often (potentially quarterly). CCDHB has been asked for representation to participate in this reconfigured group.

### 4. COMMUNITY AND COMPLEX CARE

#### 4.1 Increased access to more affordable primary care

At the October HSC meeting, you were advised of policy changes to support increased access to primary care. Further to that advice, people with a Community Services Card are three times more likely to belong to a VLCA practice than the general population. Currently 20% of our practices offer low cost visits (at VLCA practices) mainly centred in Porirua and Newtown. From 1 December, our people will have new choices in accessing low-cost primary health care services closer to their homes, workplaces, and communities. We have had a highly favourable response from our primary care general practices taking up the new primary care initiatives to lower direct costs for patients. From 1 December:

- All children under 14 years of age will be able to access zero fees general practice visits if they are enrolled at a CCDHB practice.
- 98% of our population with a Community Services Card, and their dependents, who are enrolled in a CCDHB practice will be able to access low-cost general practice visits at their current practice;

<table>
<thead>
<tr>
<th>Percentage of the CCDHB population who are enrolled in a practice that is:</th>
<th>Māori</th>
<th>Pacific</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opting into scheme from 1 December</td>
<td>99%</td>
<td>100%</td>
<td>98%</td>
<td>98%</td>
</tr>
<tr>
<td>Not opting into the scheme at this time</td>
<td>1%</td>
<td>0%</td>
<td>2%</td>
<td>2%</td>
</tr>
</tbody>
</table>
Revenue

To implement the new initiatives the Ministry has indicated CCDHB will receive approximately $3.71 million in additional funding for the period 1 December 2018 to 30 June 2019. The final amount is dependent on the number of general practices that opt into the new initiatives. A small component of the funding is specifically tied to after-hours medical services ($33,217) and pharmacies ($56,944) per annum.

4.2 Advanced Care Planning (ACP)

The ACP initiatives continue to build momentum with growing uptake of training opportunities from health professionals – both workshops and e-learning.

CCDHB Community Investment

We are working with a range of community stakeholders to build understanding of the value of ACP for people’s wellbeing and quality of life. This includes:

- **Community Champions project with Age Concern Kāpiti.** A two day Community Champion training programme has been booked and Expressions of Interest issued in the local Kāpiti paper and local newsletters for volunteers to train as ACP community champions. We anticipate up to 15 people will be trained at the Community Champion training in February and March 2019.

- **Well Elder – Living Alone Workshops** - Workshops will be delivered in Feb & March 2019 with a focus on planning for the future. Two sessions in each course will be about ACP.

- **Stroke Central – Community ACP conversation groups** - Introductory ACP session has been held with Stroke Central Field officers and four field officers have attended ACP workshops. Between January and June 2019 Community conversation groups will be led by Stroke Field officers for people affected by stroke and their whānau.

GP Funding

A one-off payment of $150 + GST is available to GPs. To meet the criteria for funding the patient must:

- Be enrolled with a PHO within the CCDHB catchment and,
- Have the following life-limiting conditions or uncertain prognosis: chronic renal failure, dementia, COPD, Heart failure, liver disease, motor neurone disease, Parkinson’s’ disease, Multiple Sclerosis and
- Be Māori or Pacific of any age OR over 80 years of age (other ethnicities) OR over 70 years of age (Indian)

This funding was made available in April 2018 and 36 claims have been made to date.

Pacific/Maori ACP – GP Claims – we have altered ACP business rules for GP claims from 10/10/18 to remove age restrictions around ACP claims for Māori & Pacific people.

ACP and Health Care Homes (HCH)

ACP is now a quality measure for year 3 HCH practices for their ‘year of care’ (YOC) cohort. All YOC patients should be offered ACP. The four tranche 1 practices are now getting quarterly feedback about numbers of ACP discussions and ACP completed.

Newlands Medical hosted a community session for their YOC patients where the group received information about ACP from the ACP Facilitator and were then able to discuss ACP with the facilitator and the doctor, charge nurse and lead ACP nurse who all attended the session. The patient feedback from this session was excellent and this model of engagement has since been promoted with other HCHs by the HCH team and Newlands Medical.
5. MENTAL HEALTH

5.1 AOD model of care

Work is underway to develop an AOD model of care across the sub-region. The scope of the project has been agreed in principle. Stakeholder engagement workshops will be the key vehicle for ensuring good consultation and input from NGOs and wider stakeholders.

5.2 Consumer Network

The guidance and support of people with a lived experience of mental health and/or addiction is essential to our ongoing work. The mental health and addiction team is re-establishing the Mental Health and Addiction Consumer Leadership Group to support the work of both SIP and Hutt Valley DHB’s Strategy, Planning and Performance team. The group will also have representation from Wairarapa. An initial co-design workshop is being held on 6 December with invited consumers to co-design the terms of reference and agree the partnership going forward.

5.3 Primary Mental Health Liaison (PMHL) Service Review

This review was started over 2 years ago and has been recently revisited. A draft PMHL Review Recommendations and Action Plan document has now been written and is awaiting sign off. This work will be implemented as part of a new Integrated Care Collaborative MHA stream of work.

5.4 Integrated Care Collaborative, Mental Health and Addictions (ICC MHA)

To date there have been three streams of work under the ICC MHA:

- **Performance Framework** – this has now been agreed and will be closed off at the next Steering Group meeting. It will be reviewed again in 6 months’ time.
- **Model of Care** - this will be closed and the work likely done through implementing “Living Life Well” the mental health and addiction strategy currently being finalised for the sub-region. The activity from this work stream will also be covered in the AOD model of care work underway.
- **Mental Health in the Community** - the Referral Systems Improvement project developed a draft ‘request for service’ form that gives GPs and NGOs information about what Te Haika needs to more easily accept a referral, and reduce duplicate assessments. This work will be used on the e-referral platform once developed. A poster with information about how to refer into Te Haika has also been created. This work will now be closed off and further work in this area undertaken in the MHAIDS Improvement Programme.

5.5 Suicide Prevention Approach (CCDHB Lead)

Wairarapa, Hutt Valley and Capital and Coast District Health Boards have agreed to develop a 3DHB strategic approach to suicide prevention and postvention. This work is being led by Capital and Coast District Health Board (CCDHB) as part of the 3DHB work programme since August 2018. You were previously advised of our intention to base this work on a ‘zero suicide’ approach. A Strategic Advisory Group (SAG) has been established to guide the project. SAG Members include Professor Sunny Collings (University of Otago), Peta Ruha & Sonja Eriksen (Ministry of Health), Dr Carlene McLean (Health Quality Safety Commission), Dr Alison Masters (MHAIDS) and Dr Arran Culver (MHAIDS). Other members for the group are still being sought.

Agreement has been reached on the scope of the project which will review how we as the health system are currently responding to people who present as a result of suicide and/or suicidal behaviour. The project will focus on how Emergency Departments, Mental Health and Addictions and other health Non-
Government Organisations are responding and what can be improved. SIP will be commissioning research to inform the work by end of November 2018. It is anticipated the research will be completed by end of January 2019. The research will assist with the development of the broader strategic plan/action plan for suicide prevention and postvention for the 3DHBs and will also inform the commissioning of improvements or new services.

5.6 **Te Ara Pai Review**

An active engagement process with consumers and stakeholders led to the development of Te Ara Pai (Stepping Stones to Wellness) model of care. New services were commissioned under this new Te Ara Pai model of care in 2013/2014. The model and services were put in place with the intent of reviewing and evaluating the services and effectiveness of the model, which to date has not occurred. We invest approximately $9m into the providers who are part of Te Ara Pai and following feedback from Te Ara Pai themselves and other key stakeholders it is important we undertake this work urgently.

A draft scope of the proposed review has been shared with the stakeholders and their feedback sought to develop and finalise the scope through an engaged collaborative approach. The review will be undertaken by an independent consultant.

5.7 **Acute Care Continuum**

This is a 3DHB initiative being led by Hutt DHB and is a continuation of work already done by the DHBs under the project ‘Community Based Acute Crisis Services’. Two stakeholder workshops are planned before Christmas to identify the needs and gaps in acute care services and build an Acute care Continuum. A final closeout workshop will be held in January 2019. This project aims to provide the DHB with guidance on current acute crisis options, identify gaps in the continuum and potential options for how current and new services may be procured.

6. **CHILD AND YOUTH**

6.1 **Primary birthing unit (PBU)**

We have received the final report from the feasibility study and feedback supports the development of an additional PBU close to Wellington Regional Hospital that provides an integrated model of care for mothers and babies. The Primary Birthing Steering Group meeting will be reconvened in December to review the report and decide next steps.

6.2 **SUDI**

A stakeholder planning hui will be held on 4 December in Porirua to understand the services and support already available across CCDHB and inform the development of a district SUDI plan. In parallel to this hui, a part time Child Wellbeing coordinator role is being scoped which would take a lead on coordinating SUDI activities across the DHB.

6.3 **Youth Engagement**

The Youth ICC Steering Group has initiated a co-design process with youth to establish a sustainable infrastructure for youth engagement in CCDHB governance and service design. This work will be discussed at the next Youth ICC meeting on 14 December.

The co-design plan has been developed (not yet finalised) and initial conversations with Porirua Schools have started to organise youth focus groups as part of this process.
6.4 Sex and Gender Diverse Youth

The sex and gender diverse working group 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 the evaluation report is being finalised. The final evaluation report will be presented to the 10 December Sex & Gender Diverse Working Group meeting.

A service specification for $80k towards clinical psychological assessment and support services for gender affirming medical care has been signed by SIP and is awaiting sign off by HHS. The $80k is part of the 2018/19 investment bid.

The working group has also been liaising with Health Navigator to increase accurate, publicly available information about sex and gender diversity and health/support services.

6.5 Comprehensive School Based Health Services

SIP is undertaking a stocktake of school based health services that will support future planning and service integration. We have School Profiles from six out of 15 schools that these were requested from. The profiles detail what school based services (outside of CCDHB funded school nurses/GPs) are already in place to support our young people. We have sought advice from the Ministry of Health about whether we are able to also approach the nine further state schools for which we don’t currently fund health services and what the appropriate way to do this would be.

Contracting discussions are underway to ensure school based health services are available in two additional alternative education centres.
**RECOMMENDATION**

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

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

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>REASON</th>
<th>REFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home and Community Support Services (HCSS) Request for Proposal (RFP) 2018</td>
<td>Papers contain information and advice that is likely to prejudice or disadvantage commercial activities and/or disadvantage negotiations</td>
<td>9(2)(b)(i)(j)</td>
</tr>
<tr>
<td>Evaluation conclusion and preferred providers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>