PUBLIC

HUTT VALLEY DHB / Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**AGENDA** Held on Wednesday 22 July, 2020 Wellington Hospital, Grace Neill Block, Level 11 Boardroom Zoom meeting ID: **915 4854 4621** Time: 9.30am to 12pm

2DHB COMBINED HEALTH SYSTEM COMMITTEE

	ITEM	ACTION	PRESENTER	MIN	TIME
1	**PROCEDURAL BUSINESS**			**15**	**9.30**
1.1	Karakia				
1.2	Apologies	**RECORD**	Chair		
1.3	Continuous Disclosure – Interest Register	**ACCEPT**	Chair		
1.4	Confirmation of Draft Minutes	**APPROVE**	Chair		
1.5	Action List	**NOTE**	Chair		
1.6	DRAFT Annual Work Programme	**APPROVE**	Director Strategy, Planning and Performance – Rachel Haggerty		
1.7	DRAFT Terms of Reference	**APPROVE**	Chair		
2	**COVID-19 Update**			**60**	**9.45**
2.1	Regional Public Health Update	**NOTE**	Director Strategy, Planning and Performance – Rachel Haggerty		
2.2	COVID-19: Impact, lessons learned and the way forward	**PRESENT**	Director Strategy, Planning and Performance – Rachel Haggerty GM Mental Health, Addictions and Intellectual Disability Services – Nigel Fairley		
3	**ENDORSEMENTS**			**20**	**10.45**
3.1	3DHB Pacific Health Strategy	**ENDORSE**	Director Pacific Peoples Health – Tofa Suafole Walsh		
4	**DISCUSSION**			**30**	**11.05**
4.1	Update on implementation -Taurite Ora -Te Pae Amorangi	**DISCUSS**	Taurite Ora Project Manager – Jeanette Harris Director Māori Health – Kerry Dougall		
4.2	Public Health Strategy Update: Early Intervention and Disease Prevention -Rheumatic Fever -Measles	**DISCUSS**	Director Strategy, Planning and Performance – Rachel Haggerty Acting General Manager, Child, Youth and Localities – Rachel Pearce Medical Officer of Health – Craig Thornley		
4.3	Porirua Locality Integration Project Approach	**DISCUSS**	Director Strategy, Planning and Performance – Rachel Haggerty		

			Acting General Manager, Child, Youth and Localities – Rachel Pearce		
4.4	Redesign of Hospice Delivery Model	**VERBAL**	Director Strategy, Planning and Performance – Rachel Haggerty		
5	**OTHER**			**10**	**11.35**
5.1	General Business	**NOTE**	Chair		
5.2	Resolution to Exclude	**APPROVE**	Chair		

	PUBLIC EXCLUDED AGENDA			**15**	**11.45**
1	Confirmation of Draft minutes	**APPROVE**	Chair		
2	Update on Ministry of Health COVID-19 Māori Health Funding -HVDHB -CCDHB	**NOTE**	Manager Accountability, Māori Health – Jim Wiki Director Māori Health – Kerry Dougall		
3	General Business	**NOTE**	Chair		

CAPITAL & COAST AND HUTT VALLEY DISTRICT HEALTH BOARDS

Health System Committee Interest Register

18 March 2020

Name	Interest
Sue Kedgley *Chair*	• Member, Capital & Coast District Health Board • Member, Consumer New Zealand Board • Stepson works in middle management of Fletcher Steel
Dr Ayesha Verrall	• Member, PHARMAC Pharmacology and Therapeutics Advisory Committee's Immunisations Subcommittee • Member, Association of Salaried Medical Specialists • Member, Australasian Society for Infectious Diseases • Employee, Capital & Coast District Health Board • Employee, University of Otago
Dr Roger Blakeley	• Board Member, Transpower New Zealand Ltd • Director, Port Investments Ltd • Director, Greater Wellington Rail Ltd • Deputy Chair, Wellington Regional Strategy Committee • Councillor, Greater Wellington Regional Council • Economic Development and Infrastructure Portfolio Lead, Greater Wellington Regional Council • Member of Capital & Coast District Health Board • Member, Harkness Fellowships Trust Board • Member of the Wesley Community Action 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
Josh Briggs	• Councillor, Hutt City Council • Wife is an employee of Hutt Valley District Health Board / Capital & Coast District Health Board
Keri Brown	• Councillor, Hutt City Council • Council-appointed Representative, Wainuiomata Community Board • Director, Urban Plus Ltd • Member, Arakura School Board of Trustees • Partner is associated with Fulton Hogan John Holland
'Ana Coffey	• Director, Dunstan Lake District Limited • Councillor, Porirua City Council • Trustee, Whitireia Foundation • Member of Capital & Coast District Health Board

	• 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
Dr Chris Kalderimis	• National Clinical Lead Contractor, Advance Care Planning programme for Health Quality & Safety Commission • Locum Contractor, Karori Medical Centre • Contractor, Lychgate Funeral Home
Ken Laban	• Chairman, Hutt Valley Sports Awards • Broadcaster, numerous radio stations • Trustee, Hutt Mana Charitable Trust • Trustee, Te Awaikairangi Trust • Member, Hutt Valley District Health Board • Member, Ulalei Wellington • Member, Greater Wellington Regional Council • Member, Christmas in the Hutt Committee • Member, Computers in Homes • Commentator, Sky Television
Vanessa Simpson	• Director, Kanuka Developments Ltd • Relationship & Development Manager, Wellington Free Ambulance • Member, Kapiti Health Advisory Group
Dr Richard Stein	• Chairman and Trustee, Crohn's and Colitis NZ Charitable Trust • Member, Executive Committee of the National IBD Care Working Group • Member, Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy • Clinical Senior Lecturer, University of Otago Department of Medicine, Wellington • Assistant Clinical Professor of Medicine, University of Washington, Seattle • Locum Contractor, Northland DHB, HVDHB, CCDHB • Gastroenterologist, Rutherford Clinic, Lower Hutt • Medical Reviewer for the Health and Disability Commissioner

Minutes of the Health System Committee

HUTT VALLEY AND CAPITAL AND COAST DISTRICT HEALTH BOARDS
Held on Wednesday 19 February 2020 at 9:30am
Boardroom, Level 11, Grace Neill Block, Wellington Hospital

PUBLIC SECTION

PRESENT

COMMITTEE: Sue Kedgley, Chair
Ayesha Verrall
Josh Briggs
Ken Laban
Keri Brown
Richard Stein
Roger Blakeley

STAFF: Fionnagh Dougan, Chief Executive Officer
Arawhetu Gray, Director Māori Health Development Team
Kerry Dougall, Director Māori Health Group
Rachel Haggerty, Director Strategy, Planning and Performance
Nicola Holden, Director Chief Executive's Office
Anna Chalmers, Director of Communications
John Tait, Chief Medical Officer
Tofa Suafole Gush, Director Pacific Peoples Health
Sisira Jayathissa, Chief Medical Officer
Sandy Blake, Executive Director Quality Improvement and Patient Safety

APOLOGIES: Vanessa Simpson
Chris Kalderimis
'Ana Coffey

1 PROCEDURAL BUSINESS

1.1 Karakia
The Karakia was led by Keri Brown.

1.2 APOLOGIES
Apologies received from Vanessa Simpson, Chris Kalderimis and 'Ana Coffey.

1.3 INTERESTS
1.3.1 Interest Register
Richard Stein noted a change and this has been updated by the Board Liaison Officer.

1.4 CONFIRMATION OF PREVIOUS MINUTES
The minutes of the CCDHB Health System Committee held on 13 November 2019, taken with public present, were confirmed as a true and correct record.

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

The minutes of the previous HVDHB Community and Public Health Advisory Committee were accepted as an accurate record but could not be confirmed as there were not enough members of the previous Committee present.

1.5 MATTERS ARISING

Nil

1.6 ACTION LIST

Nil

1.7 PURPOSE OF HEALTH SYSTEM COMMITTEE

It was noted that the combined Health System Committee requires a new Terms of Reference following the creation of this Committee. The discussion in December identified that the remit of this Committee is to:

- Support decision making
- Support broad accountabilities for outcomes
- Look at what is being commissioned and why
- Ensure decisions align with the strategic priorities

ACTION: Terms of Reference to be drafted and provided to the next meeting.
ACTION: A session on the Health Strategy Plan 2030 and an infographic that demonstrates alignment of the plans.
ACTION: Co-opted members process will be opened and invitations to Advisory Groups sent by the Board Liaison.

2 UPDATE

2.1 CORONAVIRUS UPDATE

The report was taken as **read** and the Committee:

(a) **Noted** this update on the COVID19 and the respective roles in managing the risk.

2.2 WELLINGTON PRIMARY BIRTH UNIT UPDATE

The report was taken as **read** and the Committee:

(a) **Noted** the Wellington Primary Birthing Unit (WPBU) Feasibility Report was completed in July 2019 and found that there is sufficient activity, and support from women and midwives, to support a Wellington-based PBU.
(b) **Noted** that in July 2019, the CCDHB Health System Committee (HSC) and Board endorsed a future WPBU, noting it would be an investment decision for CCDHB.
(c) **Noted** that to determine the affordability of a potential future WPBU, the HSC and Board endorsed that CCDHB explore opportunities for partnerships with private, philanthropic or other agencies, to be delivered to HSC by March 2020.
(d) **Noted** that in late 2019, maternal and neonatal services was identified as a priority work stream in the Joint (2DHB) Hospital Provider Network Programme.
(e) **Noted** that a project to deliver a Te Ao Māori joint maternal and neonatal health system has been initiated.
(f) **Noted** the process to identify potential partners to develop a future WPBU is on pause pending the joint maternal and neonatal system plan in 2020 and will then be represented to the HSC.

2.3 PORIRUA #YOUTHQUAKE UPDATE

The report was taken as **read** and the Committee:

(a) **Noted** that a CCDHB initiated a project to integrate youth services in Porirua in 2018/19.

(b) **Noted** that a co design process with rangatahi, partners and providers was completed between January and September 2019 to inform the model for an integrated youth service for Porirua.

(c) **Noted** that a report and recommendations were endorsed at HSC and by the CCDHB Board in September 2019 with the priority focus being the development of a youth one stop shop (YOSS).

(d) **Noted** that delivering a YOSS requires an additional $600,000 per year investment, which will be a decision for the CCDHB Board in the 2020/21 budget process.

3 INFORMATION

3.1 GENERAL BUSINESS

3.1.1 Work plan approach

The Committee was interested in a session on strategy and would like clinicians to come to the table related to the topic of discussion.

3.1.2 Future Location of Meetings

It was noted that the Committee would have a meeting at some point at a local marae.

4 OTHER

4.1 RESOLUTION TO EXCLUDE THE PUBLIC

The meeting moved into the Public Excluded session.

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

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

Sue Kedgley
Health System Committee Chair

HSC ACTION LOG

Action Number	Date of meeting	Due Date	Assigned	Public or PE	Agenda Item #	Agenda Item title	Description of Action to be taken	How Action to be completed
20-00001	18-Feb-20	Next meeting	ELT Leads and Board Secretary	Public	1.7	Purpose of the Health System Committee	Terms of Reference to be drafted and provided to the next meeting.	Complete
20-00002	18-Feb-20		Board Secretary	Public	1.7	Purpose of the Health System Committee	A session on the Health Strategy Plan 2030 and an infographic that demonstrates alignment of the plans.	Agenda Item/Workshop to be arranged. Delayed due to COVID-19.
20-00003	18-Feb-20	Next meeting	Board Secretary	Public	1.7	Purpose of the Health System Committee	Co-opted members process will be opened and invitations to Advisory Groups sent by the Board Liaison.	Complete
P048			Executive Director Strategy, Planning and Performance	Public	3.1	Localities Update – Kapiti Health Advisory Committee Work Programme 2019/20	Management to provide data on services	To be included on the work programme on the next Kapiti report
P049-1			Executive Director Strategy, Planning and Performance	Public	3.2	Equity – CCDHB Pacific Population Health Profile	Management to provide an update on the housing data.	TBC
P049-2			Executive Director Strategy, Planning and Performance	Public	3.2	Equity – CCDHB Pacific Population Health Profile	Management to invite the Pacific groups and communities to respond to the issues highlighted in the report.	TBC
P049-3			Executive Director Strategy, Planning and Performance	Public	3.2	Equity – CCDHB Pacific Population Health Profile	Management to report back to the Committee on regularly on Pacific Population Health.	TBC

HSC Work Plan

Year	2020	2020	2020	2020	2020	2020	2021	2021	2021	2021	2021	2021	2021	2021	2021	2021	2021	2021
Month	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
DATE	22	No Meeting	23	No Meeting	25	No Meeting	No Meeting	25	31	No Meeting	26	No Meeting	28	No Meeting	29	No Meeting	24	No Meeting
Strategy																		
CCDHB Pro-Equity Implementation/Update																		
CCDHB End of Life Investment Plans																		
CCDHB Taurite Ora Action Plan Update																		
HVDHB Te Pae Amorangi Action Plan Update																		
2DHB Health System Plan Implementation Plan																		
2DHB Investment Plans																		
Sub Regional Living Life Well - a strategy for mental health and addiction 2019 - 2025																		
Sub Regional Pacific Action Plan Update																		
Sub Regional Disability Strategy 2017 - 2022 Update																		
Health System Investment and Prioritisation																		
CCDHB Final Budget 20/21																		
HVDHB Final Budget 20/21																		
2DHB LTIP Update																		
2DHB Indicative Budget 2020/21 - Whole of System Investment																		
2DHB Investment Progress Update																		
Health System Integrated Performance Reporting																		
2DHB Maternity, Child and Youth (MCY) Integrated Performance																		
2DHB Urgent and Planned Care Integrated Performance																		
2DHB Long-term conditions, complex care and Older people integrated performance																		
2DHB Locality Perspective																		
Regional Public Health Report																		
System and Service Planning																		
CCDHB Non-Financial MOH Reporting																		
CCDHB Citizen's Health Council Plan																		
CCDHB Annual Plan																		
CCDHB Minister's Letter of Expectations																		
HVDHB Non-Financial MOH Reporting																		
HVDHB Annual Plan																		
HVDHB Minister's Letter of Expectations																		
Regional Final Draft Regional Services Plan																		
Stakeholder engagement																		
Citizen's Health Council																		

Hutt Valley DHB[1] and Capital & Coast DHB Health System Committee Terms of Reference

Community & Public Health and Hospital Advisory Committee

July 2020

Compliance

In accordance with section 35 and 36 of the New Zealand Public Health and Disability Act 2000, the Boards of Hutt Valley DHB and Capital & Coast DHB shall establish a Community & Public Health Committee and Hospital Advisory Committee (hereinafter called "The Health System Committee") whose members and chairperson shall be as determined by the Board from time to time.

The Committee shall comply with the New Zealand Public Health and Disability Act 2000. The terms of reference of the Health System Committee shall be to do the following in a manner not inconsistent with the New Zealand Health Strategy. The Health System Committee shall comply with both Board's Standing Orders for Statutory Committees.

These Terms of Reference:

- Are supplementary to the provisions of the Act and Schedule 4 to the Act.
- Supersede the previous Terms of Reference for the Hutt Valley DHB Community & Public Health and Hospital Advisory Committees (dated Sep 2017 and Mar 2018) and the Capital & Coast Health System Committee (dated May 2018).
- Are effective from [approval date].

Functions of the Health System Committee

The functions of the Health System Committee are to give advice to the Board on the following:

- The needs and the factors that may affect the health of the population of each DHB.
- The priorities for use of health support funding.
- Monitor the financial and operational performance of the services provided by each DHB and those commissioned by each DHB.
- The strategic issues relating to the provision of health and associated services provided by or through each DHB.

The aim of the Health System Committee's advice is to ensure that the DHB maximizes the overall health gain for the population and promotes the inclusion and participation in society and maximize the independence of the resident population within each DHB through:

- The service interventions the DHB has provided or funded, or could provide or fund for the population.
- The policies each DHB has adopted or could adopt for the population.

[1] District Health Board

The Health System Committee's advice will be consistent with the Minister of Health's priorities, New Zealand Health Strategy and the CCDHB Health System Plan and the HVDHB Our Vision for Change. The Committee shall present its findings and recommendations to the Board for their consideration.

Objectives and Accountability

The Health System Committee shall:

- Monitor the health status and health support needs of the DHB resident population and provide advice to the Board.
- Provide advice to the board on the implications of health needs to support planning and funding of nation-wide and sector-wide health goals.
- Provide advice to the Board on policies, strategies and commissioning (planning and funding) to support improved health outcomes in each DHB.
- Provide advice to the Board on priorities for health improvement and independence as part of the strategic and annual planning process.
- Provide advice to the Board on strategies to achieve equity in modifiable health status amongst the population of each DHB including, but not limited to, Māori, Pacific peoples, people living in high deprivation and people with mental health and addiction conditions.
- Report on DHB provider and commissioned services and, as required, summarise strategic issues for consideration.
- Monitor and advise the board on the impact of health support services being provided for the resident population of each DHB.
- Identify when 'expert' assistance will be required in order for the Health System Committee to fulfil its obligations and achieve its annual work plan by co-opting experience where required.
- Collaborate as required with committees of other District Health Boards in the interests of providing optimum, economical and efficient services.
- Report regularly to the Board on the Committee's findings (usually the minutes of each meeting will be placed on the agenda of the next Board meeting).
- Perform any other functions as directed by the Board.

Authorities and Access

The following authorities are delegated to the Committee:

- To require the Chief Executive Officer and/or delegated staff to attend its meetings, provide advice, provide information and prepare reports upon request.
- To interface with any other Committee(s) that may be formed from time to time.

The following access processes are available to the Committee:

- The Committee has access through the Chief Executive Officer and the Chief Operating Officer to the management and records of the DHB. The Committee is empowered to meet with other relevant health sector groups and entities, to call for reports from management and take independent advice.
- Committee members shall disclose any conflicts of interest and potential conflicts of interests to the Chair of the Committee, as soon as they become aware of them. The Chair of the Committee shall determine in conjunction with the Board the appropriate action that should be taken in accordance with the requirements set out in the Board Standing Orders and Board and committee members Governance manual.

Meetings

The Health System Committee shall hold no less than tbc meetings per annum, but may determine to meet more often if considered necessary by the Committee or upon instruction from the Board.

Quorum

A quorum is a majority of Health System Committee members and must include a minimum of two members of each DHB, and at least one co-opted member from the Sub-Regional Disability Advisory Group, Sub-Regional Pacific Advisory Group or Māori Partnership/Relationship Boards. *This is based on Capital & Coast – Hutt Valley is just a majority.*

Membership

Membership of the Committee shall be as directed by the Board. The Health System Committee has the ability to co-opt advisors as required.

Procedure

Schedule 4 of the New Zealand Public Health and Disability Act will apply to the business and procedure of the Committee.

HSC Information – Public

June 2020

Regional Public Health Update

Action Required

The Health System Committee note:

a) There are legislative changes in progress that may affect Regional Public Health services.

b) The release of the Health System Review report has indicated potential future changes that Regional Public Health will be monitoring as the recommendations are considered and acted on.

c) The Regional Public Health team and function is now part of the 2DHB Strategy, Planning and Performance Directorate.

d) The response to COVID-19 continues with the establishment and co-ordination of managed isolation facilities.

Strategic Alignment	CCDHB and HVDHB Strategic Plans MOH Strategic Plan
Authors	Peter Gush, General Manager, Regional Public Health Dr Craig Thornley, Clinical Head of Department, Regional Public Health
Endorsed by	Rachel Haggerty, Director, 2DHB Strategy Planning and Performance
Presented by	Rachel Haggerty, Director, 2DHB Strategy Planning and Performance
Purpose	Update on the role of Regional Public Health and a brief synopsis of the COVID-19 response to date.
Contributors	N/A
Consultation	N/A

Executive Summary

This report follows previous Regional Public Health updates to the Health Systems Committee, the most recent being for the 19 February 2020 meeting.

The focus of this update is the potential impact of national decisions around governance of regional public health services. The COVID-19 global pandemic has brought unprecedented change to communities across the greater Wellington region. Both the communities served by Regional Public Health (RPH) and the public health unit itself, function within a context of complex systems that, together, create and impact population health and wellbeing.

RPH are well placed to adapt and be nimble in responding to population needs and community aspirations, with forward focused public health approaches. As commented on in section 4, the alignment of the function to be part of the new 2DHB Strategy, Planning & Performance Directorate, provides opportunities to augment existing relationships and support our communities' health outcomes.

Initial Response to COVID-19

- RPH response started in January 2020 with monitoring of the COVID-19 outbreak globally supported by preparing early communications for our priority populations
- RPH staff were progressively assigned to the COVID-19 response
- RPH ran two shifts per day undertaking health assessments at Wellington Airport for five weeks
- 70 staff work intensively on case management, contact tracing and daily monitoring for nine weeks
- The last COVID-19 cases in the Wellington region recovered on 25 June 2020.

Current COVID-19 Response

- Assessed suitability of three hotels as managed isolation facilities
- Worked with the RIQ team and CCDHB to establish and staff, the system response to manage 95 repatriated New Zealanders
- Developed a capacity uplift (surge capacity) plan to show RPH can manage up to 52 cases per day
- Additional nursing staff have been accessed through Massey University and Whitireia Polytechnic
- We are currently completing planning to ensure suitable accommodation, IT equipment and HR processes are in place for additional staff as the period for the response continues.

1. INTRODUCTION

Previous HSC Discussions/Decisions

The COVID-19 global pandemic has brought unprecedented change to communities across the greater Wellington region. Both the communities served by RPH and the public health unit itself function within a context of complex systems that, together, create and impact population health and wellbeing.

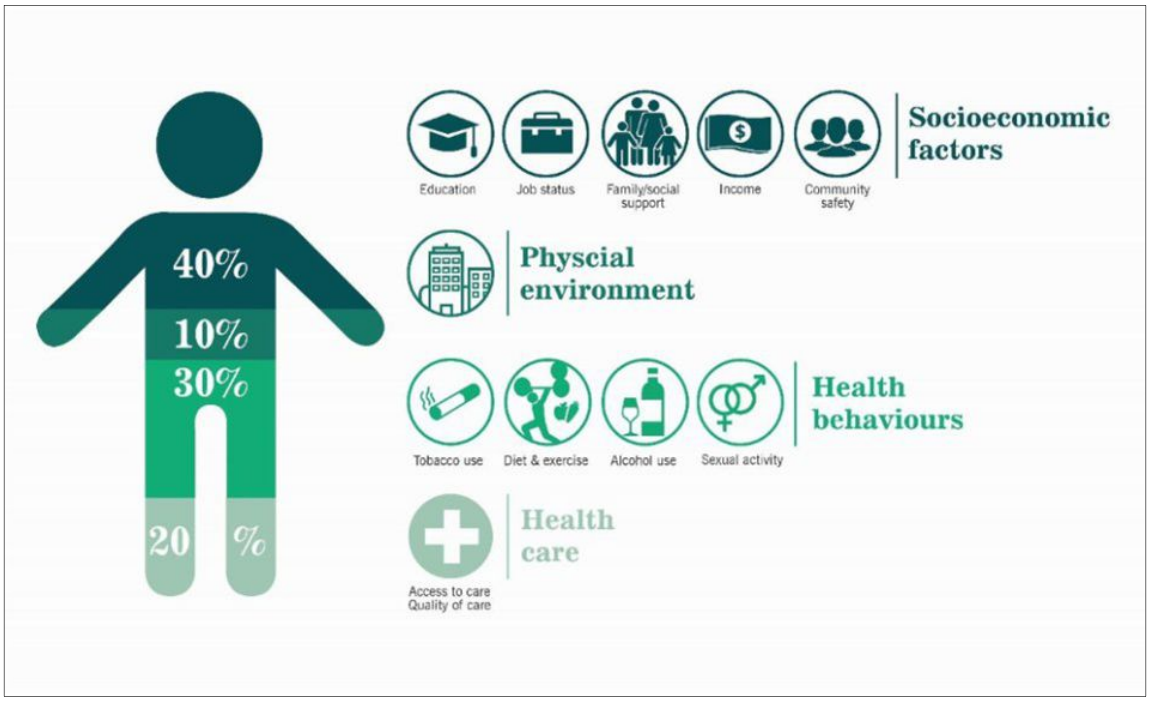
As a result legislative changes have been made which will require RPH to adapt and be nimble in responding to population needs and community aspirations, aligned with forward focused public health approaches. With the public health service now part of the 2DHB Strategy, Planning & Performance Directorate there are opportunities to augment existing relationships and benefit our communities' health outcomes.

2. CROSS SECTOR COLLABORATION AND LEGISLATIVE CHANGES

Public Sector Reform

Public sector reform is underway with the Public Service Bill introduced to parliament in November 2019 and having the second reading on 24 June 2020. The intent for strengthened and more unified leadership arrangements across central government departments has the potential to make locality and District level collaboration easier to realise. RPH is well placed to build on the strengths of existing relationships and partnering agreements in supporting DHBs to focus on long term strategies with recognition that health care services make up only 20 per cent of the factors that influence health and wellbeing (see image below from the final report of the Health and Disability Review)

Figure 6.1: Factors that influence our health and wellbeing



(Source: Health and Disability System Review final report, 2020)

One recent new example is where RPH are leading health sector delivery of the national **Healthy Active Learning** initiative – with a foundation of:

(a) Joint commissioning between the Ministries of Health and Education and Sport NZ, and

(b) RPH's existing coordination and relationships across the education, physical activity and health sectors.

Drinking Water

Over the next year the responsibility for drinking water safety and regulation is proposed to move from the Ministry of Health and DHBs (RPH in this region) to a new standalone water services regulator - Taumata Arowai. The direct implications for RPH are yet to be determined.

The final report of the Health and Disability System Review (March 2020) cautions against further fragmentation of health protection functions and notes that where core public health functions are delivered outside the health and disability sector, mechanisms need to be in place to ensure decisions are informed by population (public) health evidence and expertise.

Cannabis Referendum

Along with the general election in September 2020, there will be a referendum which asks voters, "Do you support the proposed Cannabis Legalisation and Control Bill?" The results and any subsequent legislative change may have implications for RPH such as supporting the regulation of premises for sales and consumption, and supporting measures to reduce young people's exposure to cannabis.

3. HEALTH AND DISABILITY SYSTEM REVIEW

The final report was released to the public in June 2020 (available from systemreview.health.govt.nz). Included in the terms of reference is the requirement to deliver recommendations that "… shifts the balance from treatment of illness towards health and wellbeing." This speaks strongly to recognising and building on the current state of RPH's strengths and potential.

As the recommendations from the review are considered and acted on to improve the whole health system, RPH will need to keep in focus fundamental health protection functions as well as be nimble in order to pivot towards, and influence, opportunities for even better and more equitable population health outcomes.

4. STRATEGY, PLANNING AND PERFORMANCE DIRECTORATE

The development of a joined up Strategy Planning and Performance (SPP) Directorate has moved RPH from the HVDHB provider arm to within SPP (the funding and planning unit for HVDHB and CCDHB).

This 'one team approach' will support RPH staff who work inter-professionally within the health system, often in a 'brokering' role influencing cooperation across professions, sectors and community entities.

RPH evaluation of 2018 change process

RPH is currently completing an evaluation of the 2018 RPH change process. An anonymous survey, interviews and a workshop will provide opportunity for staff to feedback their perception of what has worked well and identify areas for further improvements that can also inform the move into the SPP Directorate.

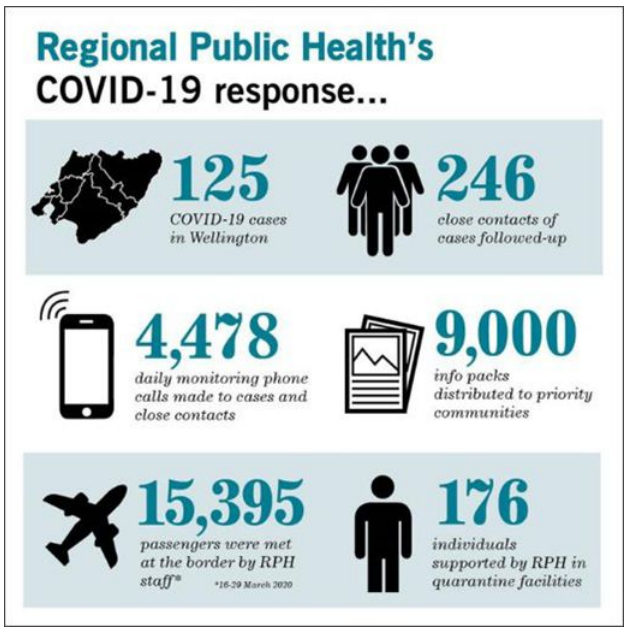
Resourcing

Within the context of the health sector fiscal landscape, and the aspirations of equitable population health outcomes, it is worth noting that there has been no material change to the funding levels for the RPH core contract over the last ten years. In effect, this constrains the potential to further utilise and

scale up the five core functions provided by RPH (health protection, health promotion, health assessment and surveillance, public health capacity development and early interventions) to benefit communities in the three DHB areas.

5. COVID-19

Following is an infographic with high level data that is indicative only, to provide a snapshot of RPH activity from approximately 16 March to 30 June 2020.



Notes on interpreting the data:

- Cases include both confirmed and probable cases
- Close contacts are people in the same household as a case and who were followed up by RPH. It does not include close contacts identified by RPH and delegated to the National Close Contact Service.
- Daily monitoring is a process by which a public health unit makes daily contact with the close contacts of a case to see if they are developing any signs or symptoms of disease.
- Daily monitoring also gives the opportunity to provide advice to contacts on disease management and offer other support such as addressing welfare and mental health needs.

Initial Covid-19 Response

The RPH COVID-19 response started early January 2020, initially to monitor the global outbreak of COVID-19 and to plan our own activity should the virus reach Wellington. Early in February 2020, RPH stood up its Incident Management Team (IMT). Progressively, all RPH staff were moved to working on aspects of the COVID-19 response. Minimal business as usual was maintained. Staff who were not working at the border, in managed isolation facilities, case management, contact tracing or daily monitoring were working in community engagement focusing on our priority populations alongside many other non-government organisations and agencies.

From the second week of March, we were running two shifts per day at Wellington International Airport. 10 staff were rostered onto each shift to health screen arriving international passengers. Daily

shifts at the airport ran through until the first week of April when international flights into Wellington ceased.

RPH was notified of its first case of COVID-19 on 14 March 2020 and between then and 16 April had 123 cases, the last case recovering on 5 May 2020. On 16 June 2020 RPH were notified of two new cases that were staying in a managed isolation facility in Auckland and were then granted an exemption to leave that facility prior to completing their 14-day quarantine to travel to the Wellington region. The second of these two cases recovered on 25 June 2020.

During the March to May period RPH had approximately 70 staff, consisting of nurses, health protection officers, medical officers of health, registrars, house surgeons and technical officers working directly on case investigation, contract tracing and daily monitoring.

Current Covid-19 Response

RPH is still very busy working on the COVID-19 response, in particular, at the border and in managed isolation facilities, and planning for a significant increase in COVID-19 cases.

Some of the key activities include:

- Border response (maritime): planning, screening; responding to ill traveller alerts
- Border response (aviation): planning, screening, support for border agencies
- Surveillance and intelligence gathering; interpretation and dissemination
- End-to-end investigation and oversight of cases, from initial detection through to recovery; this included clarifying case status, investigation for infection source, determining exposure risks, ensuring public health risks managed, oversight while in isolation, arranging clinical assessment if deterioration occurred, and eventually defining as non-infectious.
- Identification and management of close contacts of cases, including providing guidance for quarantine to prevent public health risks, daily monitoring to ensure still in quarantine and to monitor for development of illness, and defining end of quarantine period
- Reporting to and regular liaison with Ministry of Health on case and contact management; providing DHB with data on case activity
- Support for national risk assessment, decision making and policy development through membership of Ministry of Health working groups
- Engagement with and support for persons granted exemptions from managed isolation (primarily for bereavement purposes)
- Establishment of and development of policy around international arrivals entering managed isolation facilities; coordinating agency activities to ensure public health risks are managed.

RPH recently worked with the Regional Isolation and Quarantine team (RIQ) and CCDHB to stand up and resource a managed isolation facility in Wellington to take 95 New Zealanders repatriated from South Korea. This initially involved RPH assessing the suitability of the hotel as a managed isolation facility, then meeting passengers at the border, and working closely with other RIQ team members to establish the systems to manage the people in the facility for 14 days.

Early in May, the Ministry of Health requested that all public health units (PHUs) develop and implement a case management and contact tracing capacity uplift plan. A primary goal of this plan is to ensure that across all PHUs there is capacity to manage up to 500 COVID-19 cases per day. RPHs component of this is to be able to manage:

- 37 new cases per day (day on day) by the week of 29 June;
- Ultimately 52 cases per day (day on day).

The guidelines for planning this surge capacity is under the scenario that a third of all cases are complex cases and two-thirds are non-complex. Complex cases will have 30 close contacts. Non-complex cases will have 20 close contacts and four to five household contacts.

Our initial assessment and plan required up to 454 full time equivalent (FTE) staff to be able to meet the requirements of the scenario as at 29 June 2020. Since then the National Contact Tracing Solution established by the Ministry has been improved, reducing our FTE requirement to 213 FTE. This FTE includes nurses, health protection officers, and technical officers, medical officers of health, registrars, house surgeons and general practitioners. We are currently completing our project plan and while this is being finalised we have been working with Massey University and Whitireia Polytechnic to access second year nursing students to boost our own nursing staff to meet the additional staffing requirements of the plan. We have also been conducting refresher training for our own staff and planning the training of student nurses.

We are still in the process of identifying suitable accommodation, computers/phones and establishing HR and payroll processes to support our surge response. RPH is expected to have concrete plans in place to increase our capacity at short notice.

HSC DECISION – Public

July 2020

Final Draft - Pacific Health & Wellbeing Strategic Plan for the Greater Wellington region 2020-2025

Action Required

Health System Committee endorse for HVDHB and CCDHB Boards approval:

(a) The final draft of the Pacific Health & Wellbeing Strategic Plan for the Greater Wellington region 2020-2025.

Health System Committee note:

(b) The contents of the final draft Pacific Health & Wellbeing Plan, 2020-2025.

(c) The extensive community consultation undertaken by the DHB with the support and guidance of the Sub-region Pacific Heath Advisory Group.

(d) The Pacific Health & Wellbeing Plan, 2020-2025 is one of the key supporting plans for both Hutt Valley & CCDHB strategic direction and transformational change work being undertaken.

(e) This final draft has been endorsed by the Wairarapa Board at their June meeting.

Strategic Alignment	Ministry of Health *Ola Manuia* Pacific Health Plan 2020-2025 CCDHB Health System Plan 2030 HVDHB Vision For Change 2017-2027 WrDHB Well Wairarapa –Better Health for All Vision 2017 Faiva Ora National Pacific Disability Plan Ministry of Pacific Peoples Priorities
Author	Tofa Suafole Gush, Director Pacific Health
Endorsed by	Fionnagh Dougan, Chief Executive Officer, CCDHB & HVDHB
Purpose	Seeking Health System Committee endorsement for Board approval of the final draft of the Pacific Health & Wellbeing Strategic Plan for the Greater Wellington region 2020-2025.
Contributors	Candice Apelu-Mariner, Integration Lead Pacific
Consultation	3DHB Sub Regional Pacific Strategic Health Advisory Group, Pacific communities in Wairarapa, Hutt Valley and Porirua.

Executive Summary

In November 2019, each of the three DHB boards approved the development of a 'Single Pacific Health and Wellbeing Plan' for the Greater Wellington region to guide and inform decision making around Pacific people's health in all three District Health Boards. This is the first joint Pacific Health & Wellbeing Strategy for the 3DHBs of the Greater Wellington region.

The Pacific Health & Wellbeing Strategic Plan for the Greater Wellington region 2020-2025 (the Plan) outlines strategies to address some of the key areas of concern for Pacific Health. The six priorities identified have been developed through extensive consultation with Churches, community groups, Young

people, Providers of Health services across the region and DHB workforce. The Plan provides a framework for reducing inequalities and strengthening Pacific Health outcomes. It is written to be easily understood by people in the community as well as providers of health services and their agency partners. The Plan recognises the importance of identifying the realities Pacific people face but does not focus on negative statistics.

Once the Plan is endorsed and approved it will be launched and implementation will commence in August 2020.

Strategic Considerations

Service	NA
People	NA
Financial	Investment to implement the Plan
Governance	The Pacific Health & Wellbeing Strategic Plan for the Greater Wellington region,2020-2025 be jointly owned by the DHBs and the Pacific communities; The DHBs consider seriously recommendations from the community even if the recommendations do not have identified funding currently.

Engagement/Consultation

Patient/Family	As part of community consultation.
Clinician/Staff	All 3DHB staff were given the opportunity to feedback on the draft
Community	Extensive community consultation with Churches, Pacific Providers and community groups throughout the greater Wellington region was undertaken. An online consultation process was utilised as well.

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
Insert risk #	Limited additional investment to implement the Plan	Tofa Suafole Gush Rachel Haggerty	Ensure approval of funding investment for out years are sought	3	Medium risk

Attachment/s

1. Final draft - Pacific Health & Wellbeing Strategic Plan for the Greater Wellington region 2020-2025.

Pacific Health & Wellbeing Strategic Plan for the Greater Wellington Region 2020 – 2025

Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

HUTT VALLEY DHB

Capital & Coast
District Health Board


Talofa lava
Samoan
Kia Orana
Cook Island
Ni Sa Bula Vinaka
Fijian
FINAL DRAFT
Malo e lelei
Tongan
Malo Ni
Tokelau
Fakalofa lahi atu
Niue
Talofa koutou
Tuvalu
Mauri
Kiribati

CONTENTS

ACKNOWLEDGEMENT

We wish to acknowledge the invaluable contributions of all those who provided input to the development of this Pacific Health and Wellbeing Strategic Plan. In particular, our gratitude is extended to the Pacific communities who supported the development of this plan by contributing their voices, stories, ideas and insights as well as our provider community and DHB staff across the Greater Wellington region. We were delighted at the response we received from communities and the interest there is to improving Pacific health outcomes.

FOREWORD

It is our privilege to present the Pacific Health and Wellbeing Strategic Plan 2020-2025 for the Capital Coast, Hutt Valley and Wairarapa District Health Boards. This plan represents the blueprint for meeting the changing needs of Pacific individuals, families and communities over the next five years.

This plan outlines the three District Health Boards strong commitment to improving the health and wellbeing of Pacific people. Pacific peoples do not always enjoy the same access, service experiences and health and wellbeing outcomes as non-Pacific peoples. This plan recognises that we need a specific and targeted approach to redressing inequities that exist within our health system. We believe that a core role of District Health Boards is to apply the revenue they receive to provide the best health care services that are culturally responsive to the needs of our Pacific populations.

We acknowledge that a range of factors s as education, housing, income, ployment and social policies have a signi ant act on achieving better health outco s f ic peoples. We also recogn that w e operating in an increasingly complex a cha ging health environment, wit cial pressures and health interests, merging lth technologies and pharmac cals, s tages of health workforce nd c ging mographics.

To this proving Pacific people's health is not only a ma te of the three District Health Boards, but it should everyone's business. **Our vision for Pacific peoples is empowered and enabled Pacific peoples living longer quality lives, supported by a culturally responsive health system.**

There are many health challenges facing our Pacific communities. The priorities and strategies identified in this plan represent the key touch points which we believe will enable us to leverage improved outcomes as efficiently and effectively as possible. These priorities are as follows:

1. ***Pacific Child Health and Well g***
2. ***Pacific Young Peo***
3. ***Pacific Adults an ing Well***
4. ***Pacific Health Work e & Pacific Providers/ NGOs***
5. ***Social De min of Health***
6. ***Culturally R ve Integrated Health S***

The s do not cover all possible approa s to reducing health inequalities, but r the phasis is on priorities where there is g reason to believe action by the DHBs and partners outside of health will lead to the ment of better health and wellbeing outcomes for our Pacific people.

The 3DHBs are committed to implementing this Pacific health and wellbeing strategic plan and we look forward to continuing to work with the Pacific communities, partners and stakeholders to achieving equity in access and, most importantly, equity in health outcomes for Pacific people and communities.

David Smol
Board Chair
Capital & Coast District Health Board
Hutt Valley District Health Board

Sir Paul Collins
Board Chair
Wairarapa District Health Board

Fa'amatuainu Tino Pereira
Board Chair
3DHB Sub Regional Pacific
Strategic Health Advisory Group

OUR COMMITMENT

Pacific health and improving equity of health outcomes is everyone's responsibility and a key priority for our district health boards. Illustrating our commitment to this is our Pacific Health & Wellbeing Strategic Plan, which will be incorporated into our day-to-day work as we take a whole of system approach to ensure the priorities in the plan are achieved.

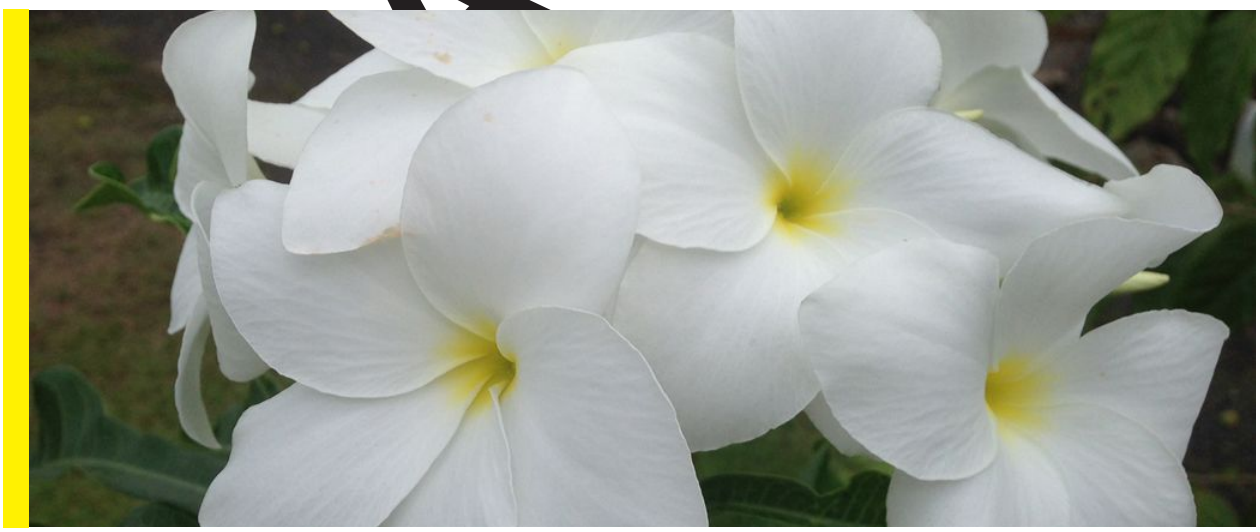
The Pacific Health & Wellbeing Strategic Plan provides the 3DHBs with a guiding framework, enabling us to improve and sustain the development and delivery of health services to Pacific communities. It is our collective responsibility to ensure that this work makes a positive difference in the heath of Pacific people in our greater Wellington region.

This plan has been developed in partnership with the Sub Regional Pacific Strategic Health Group, and reflects our joint commitment to accelerate Pacific health gain and achieve health equity for Pacific peoples.

Our goal requires a collaborative effort and robust leadership across the health system. With demonstrated commitment and shared accountability, the realisation of better health outcomes for all Pacific people will be realised.

Fiona Dougan
Chief Executive
Capital & Coast and Hutt Valley
District Health Boards

Dale Oliff
Chief Executive
Wairarapa District Health Board



Malu i pu'ega –
To lend aid in the undertaking

Samoan proverb

INTRODUCTION

This Pacific Health and Wellbeing Strategic Plan represents the beginning of a new way of approaching service design and delivery for Pacific families and communities and builds on the progress of previous plans;

- "Paolo mo Tagata o le Moana" HVDHB & WrDHB Pacific Health Action Plan 2015-2018
- "Toe timata le Upega" CCDHB Pacific Health Action Plan 2017-2021

This plan adopts a human rights based approach to health. There is a growing body of evidence confirming that health services reflect the dominant economic or cultural group. Consequently in practice, Pacific communities do not receive equitable care.[1] Varying degrees of social isolation, acculturation, the impact of migration, and different views of illness between Pacific communities all impact on the ability to provide services that appropriately meet needs.[2] Across the Greater Wellington region we are committed to ensuring policies, programmes and services provide a level playing field and equal opportunity for best health possible for Pacific people regardless of age, gender, ability, religious beliefs or social economic backgrounds.

We acknowledge the gains and milestones reached in the last five years, with some improvement in access and interaction of Pacific people with the health system, partnerships across the health sector, and innovations delivered in the community by Pacific providers for example Pacific Nurse led services (Vaka Atafaga Nursing service, Pacific Health Service Hutt Valley Primary nurses and Thriving Cores Well Child services, Pacific Navigation Services), Pacific Churches and community leaders to name a few.

Unfortunately, Pacific people's health, as measured by most major indicators of health, still remains poorer when compared to non-pacific. Whilst many of the barriers to people face such as cost, are shared with other groups in the Greater Wellington region, there are issues that are unique to Pacific peoples. Differences in health outcomes confirm that there are also issues for specific groups within Pacific communities.[3]

We are determined to build on the achievements particularly focusing on programmes and services that address health inequity and reduce discrimination. This will be done by advancing strategies that support locally developed solutions, cultural and collaborative models of health care that support individuals and families from a holistic perspective and tailored to meet local need across the Greater Wellington region.

We recognise that many other organisations outside of the health sector hold the levers to progress health outcomes. Inter-professional and inter-disciplinary teamwork, partnering across health service providers and cooperation across sectors, as well as including the voices of Pacific people, families and communities opens the way for new and collaborative partnerships for shared solutions and innovative planning.

1. Southwick, M., Kenealy, T. Ryan, D. (2012). Primary Care for Pacific People: A Pacific and Health System Approach. Wellington: Pacific Perspectives.
2. ibid
3. Southwick, M., Kenealy, T. Ryan, D. (2012). Primary Care for Pacific People: A Pacific and Health System Approach. Wellington: Pacific Perspectives.

KEY STRATEGIC DIRECTIONS

This plan applies a Pacific approach and lens to the strategic directions outlined in key strategic documents which guide our response to improving the health and wellbeing of the Pacific communities in the Greater Wellington region. These include;

- CCDHB Health System Plan 2030
- HVDHB Vision For Change 2017-2027
- WrDHB Well Wairarapa - Better Health for All vision 2017
- Ministry of Health *Ola Manuia* Pacific Health Plan 2020-2025
- Faiva Ora National Pasifika Disability Plan 2014-2016
- The Child and Youth Wellbeing Strategy 2019, Department of the Prime Minister
- PHARMAC Pacific Responsiveness Strategy 2017-2026
- Minister of Pacific People's Priorities
- Whanau Ora commissioning

The key strategic directions in

1. **Equity** – advancing decisions, actions and innovations that elimin[ate] health inequalities for Pacific peop[le].

2. **Collaboration** – st[rengt]hening partnerships including in[te]grated planning and service deli[very] with b[oth] health and non- health pa[rtn]ers across different sectors AND Pacific comm[uni]ties themselves.

3. **Strengthening Accountability and Performance monitoring across the health system** – to hold ourselves liable and answerable to ensuring we are doing more than enough to achieve equitable health outcomes for Pacific peoples through consistent reporting and measurement of progress.

4. **Building the Pacific workforce** – strengthening Pacific health providers providing sustainable resources for long-term, rat[her] than short-term funding.

5. **Inclusiveness** – e[nsu]ring that Pac[ific] disabled children, youth an[d] [a]dults and their families are also at the centre [of] service and programme decision m[ak]ing and are [n]ot left behind. Recognising [t]hat [p]eople with a disability may have extra b[ar]riers to overcome in accessing [h]ealth [s]ervices [t]han most.

6. **Re[l]evant Evidence Base** – implementing and [i]nvesting in what is already working and [b]uilding evidence through research, monitoring and evaluation.

7. **Integrated Planning** – strengthening integrated planning and service delivery and accelerating the shift of services closer to home.

8. **Culturally Responsive Services** – developing and Sustaining a culturally safe and competent health services and work settings including elimination of racism and developing strategies to mitigate negative attitudes and behaviours.

OUR VISION FOR PACIFIC IN THE GREATER WELLINGTON REGION

“Our Pacific peoples are empowered and enabled to live longer quality lives, supported by a culturally responsive health system.”

PRINCIPLES OF PACIFIC HEALTHCARE DELIVERY ACROSS THE 3DHBS

In the development of this plan, it is important to foreground Pacific peoples as diverse with unique values, cultural intelligence, social capital, differing languages and "lived experiences". The term 'Pacific peoples' is an umbrella term used to describe a population made up of 16 distinct and diverse cultures of peoples from Melanesia, Polynesia and Micronesia. In the Greater Wellington region the seven largest ethnic groups are, Samoan, Tongan, Cook Island Maori, Niuean, Fijian, Tokelauan, Tuvaluan (Statistics New Zealand, 2018).

By making this the focal point, we commit as District Health Boards to ensure that Pacific peop are actively involved in co-designing services and programmes that help address difficulties based on "one size does not fit all" due to the growing diversity of Pacific peoples and their ab to access quality and responsive services. We putting a stake in the ground a nowledg that as navigators of this wide o an t call the health system, w owe it Pacific communities and other ind nous nicities to reconstruct a syste t they n voyage through without difficulty.

We have osen e key nciples or values comm across Pa cultures which have been weaved o this plan, and will guide our work along e the input of Pacific communities through com nity leaders, churches, providers and others.

The five key principles include;

FAMILY
Family underpins iden , geneal relationships and a se of belongi for Pacific people. It lies at the r who Pacific people are as every Pacific pers belongs to an aiga or kainga.

ENVI NMEN
B and atura vironments is important to if le. Their connectedness and expe ces of both plays a huge role in the istic a roach to health and wellbeing.

SP ITUAL
urches have historically played a crucial role in the lives of Pacific people providing spiritual guidance with values such as faith, integrity, truth and trust. Churches are still an integral part of Pacific communities and their everyday lives.

RESPECT
Showing respect when relating to one another is an important aspect of Pacific people right from an early age. This includes respect towards elders, people in positions of authority, each other, women and children.

CULTURE
Cultural diversity such as the different languages, ethnicity, gender, generational issues, religion, and sexual orientation influences how Pacific people view and respond to health services. This diversity is also evident and seen in individuals and family practices, behaviours, understanding and responsiveness to the world around them.

SYSTEM ENABLERS & PILLARS OF SYSTEMS CHANGE

PARTNERS & NETWORKS

Build new and strengthen existing partnerships and networks with multiple organisations, Pacific communities and individuals. Leverage off the strengths and skill sets of different organisations. Also look at new partnerships to create a shared sense of ownership and responsibility to deliver the best services for Pacific peoples.

COMMISSIONING

The way we commission services and invest will be more intentional and targeted. We will explore re-commissioning of identified services run by the DHB's into the community. System should also be aligned, sustainable and equitable to ensure resources are distributed to scaling up and supporting programmes that are already working and meet the needs of the Pacific community. For instance initiatives that are run in the Community by Pacific providers or Faith based Pacific organisations. In addition priority activities are explicitly outlined in contracting work to ensure a strong equity focus for Pacific.

INFLUENCE & ADVOCACY

Leverage off the influence we have to accelerate and progress change at not only a policy planning, service and programme levels locally, regionally and national

ICT & KNOWLEDGE RESOURCE

We have access to the technology, evidence based data and resources that can be utilised and shared across to our Primary care and Community based partners to ensure decision making, investments and design processes. We will look at building and strengthening community infrastructure.

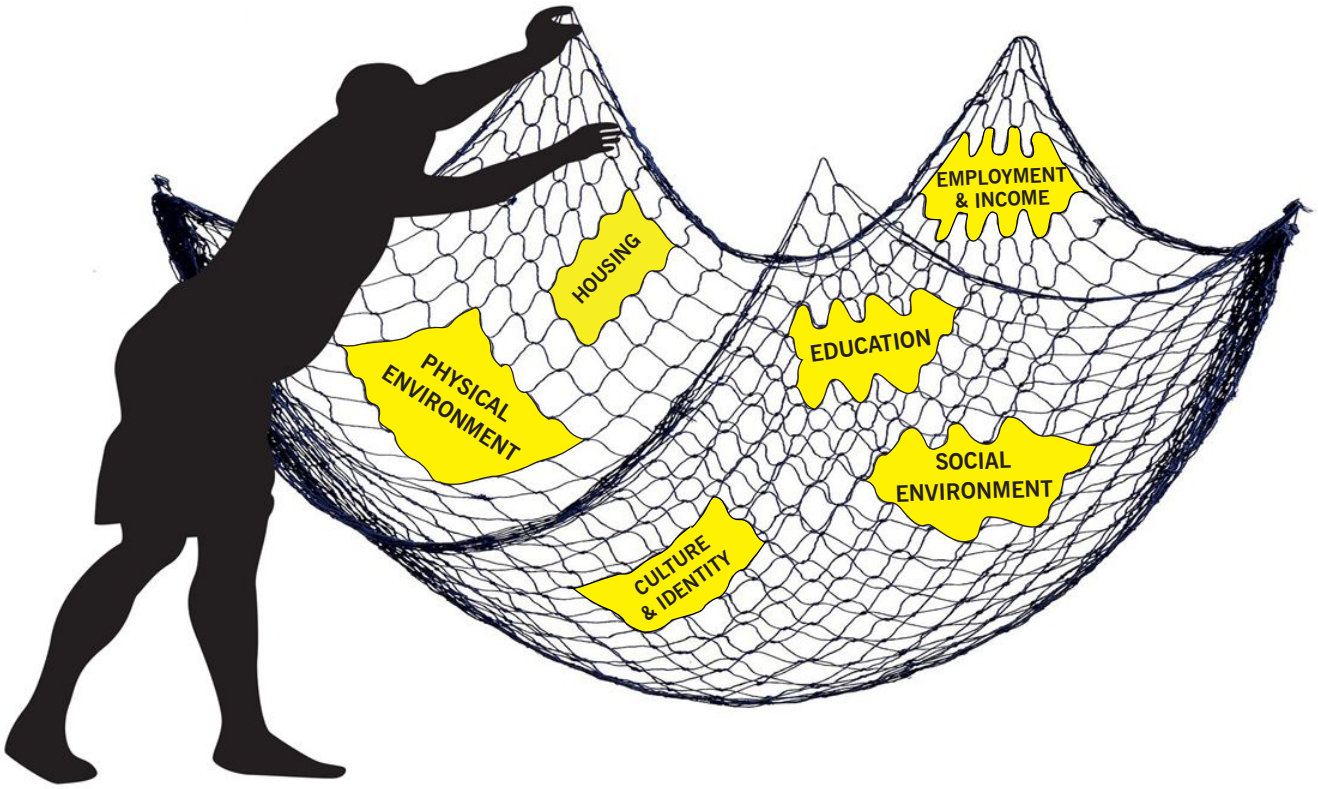
DHBS AS AN EMPLOYER

We have a mandate to create a culturally sensitive work environment that entices and supports employees to feel and be their best. In addition, we can influence creating a work environment that attracts Pacific skilled workforce to want to be a part of.

SO'OSO'O LE UPEGA FRAMEWORK FOR GUIDING THIS PLAN

The plan adopts a well utilised and known Pacific framework to illustrate how the Sub Region is going to work with its partners collectively to achieve better health and wellbeing outcomes for Pacific peoples.. Upega (fishing net) is a Samoan fishing proverb and so'oso'o means connect. So'oso'o le Upega therefore means to connect (so'oso'o) other agencies to health and vice versa so that the Pacific families we serve are being provided the best services that support them addressing issues that have an impact on their health and wellbeing. By being purposeful and intentional in drawing on the knowledge, expertise and understanding of the Pacific communities to partner with the District Health Boards to bring about much needed and sustainable changes across areas of need in the health system.

By utilising this framework, we acknowledge that the cultural wisdom of Pacific peoples still defines and shapes how information is processed, harnessed and acted on. Therefore meaningful and respectful relationships with community are imperative to the design and implementation of this Plan. This ensures that the Pacific communities we serve are not just passive beneficiaries of services but are stewards of their own health care and management.



OUR STRATEGIC PRIORITIES AND MEASURING PROCESS

Our six Strategic Priorities as identified and informed by the Pacific communities are:

1. **Pacific Child Health & Wellbeing**
2. **Pacific Young People**
3. **Pacific Adults & Aging Well**
4. **Pacific Health and Disability Workforce & Pacific Providers**
5. **Social Determinants of Health**
6. **Culturally Responsive & Integrated System**

These strategic priorities and p[illegible]rity actions, activities and performance i[illegible]rs with accompanying budgets w[illegible] be emb[illegible]ed into the Annual Plan and e[illegible]sting performa[illegible]e and accountability mecha[illegible] each District Health Board. Indeed, accounta[illegible] and responsibility towards repo[illegible] inst thi[illegible]rategic Pacific health and wel[illegible]ing [illegible]nd achieving measur[illegible]e outc[illegible]s for Pacific peoples should be the [illegible]ppo[illegible]bility [illegible]ll levels of management.

We kn[illegible]we have been successful when we see i[illegible]prove[illegible]s in the following areas;

Takanga Etau Fohe –
Working together in Harmony will ensure success for our community

Tongan proverb


PRIORITY ONE
Pacific Child
Health Here

Our goal is to give Pacific children and their families the best possible start in life AND ensure they meet key childhood developmental milestones through culturally responsive and safe services and support.

RATIONALE

With a fast growing young population, Pacific children, their families and support networks will benefit from early fanau centred health and wellbeing interventions that are culturally sensitive, community determined, partnerships driven and system enabled. The early years, and in particular the first 1,000 days of life is a crucial time and a window of opportunity whereby efforts need to be concentrated to enable the best start to life for our Pacific children.

WHAT THE DATA TELLS US

Latest data tell us that children aged under 15 years, make up 33% of the Wairarapa Pacific population, 29% in the Hutt Valley and 27% for Capital & Coast DHB respectively. And that over 6[illegible]% of the Pacific population in the Greater Wellington region are now New Zealand born. There have been improvements in health outcomes as evidenced by a decrease in ASH rates for Hutt Pacific and Capital & Coast for Pacific children in the last [illegible] increased newborn enrollment with a General Practice and Community Oral Health service. Also improvements in immunisation rates, increased percentage receiving WellChild or Tamariki Ora core checks in their first year and Before School Checks by the time they are four years old.

However, despite improvements in health we are also seeing higher rates of caesarean for Pacific mothers, lower uptake of antenatal or postnatal maternity services, or pregnant Pacific mothers registering and seeing a Lead Maternity carer in their first trimester, increasing complexities due to gestational diabetes and having heavier babies. Pacific children also made up 55% of CCDHB children aged 0-14 years, 33% of the HVDHB and 12% of Wairarapa living in the most deprived areas.

Most of the ASH presentations of Pacific children to hospital were for asthma, dental conditions, gastroenteritis/dehydration, upper respiratory tract infections and cellulitis across the three DHBs. There also remains a disparity in the percentage of Pacific children being obese by the age of five, higher rates of obesity overweight and Pacific children turning 1 year old are less likely to have had all their scheduled core checks than children of other ethnicities except Maori. For Wairarapa Pacific children, 5[illegible]% had received all their core checks, 5[illegible]% of Hutt Pacific and 69% of Capital & Coast Pa[illegible]

Efforts should be focused on the provision of culturally responsive maternal health services that support healthy pregnancies and delivered close to and in people's homes and in the communities. We want to see easy access and better engagement in reproductive, perinatal, antenatal and postnatal services for Pacific mothers.

In addition, we need to progress health services support and care that focus on good nutrition and physical activity, smoking, positive parenting, immunisation, warm homes, mental health and wellbeing of parents are crucial for healthy physical and social development.

Certainly approaches that focus on the strengths of Pacific families with a spotlight on parents, a mothers overall wellbeing, focus on role of grandparents, strengthening communities and empowering families economically, socially and educationally will provide environments and foundations that bring up strong healthy Pacific children. Research and literature affirms that if we focus our efforts on fanau centred approaches that provide support and work with whole families and what they care about in their homes, our young children benefit.

We want the Greater Wellington region to be one of the best places in New Zealand to raise healthy thriving Pacific children. These actions will focus on supporting timely and quality access to health care and advocating and influencing early childhood development initiatives in other sectors like education and social sectors. We will also be specifically focused on working collaboratively to improve access and engagement of Pacific families with:

- Primary Health Organisations (PHOs) & Pacific Providers
- Well Child Tamariki Ora (WCTO) Providers
- Addressing causes and issues with Ambulatory Sensitive Hospitalisation
- Mental health and wellbeing
- Cross agency collaborations & integrated partnerships to address social determinants of health
- Childhood obesity focused initiatives
- Good oral health
- Breastfeeding Rates
- Smokefree and Warm & healthy homes

Ia ifo le fuiniu i le lapalapa –
As to each coconut leaf belongs to a cluster of young nuts, so each individual belongs to his family

Samoan proverb

PRIORITY ONE:
Pacific Child Health & Wellbeing

KEY FOR SYSTEM ENABLERS

Note: Targets will be set using national targets or to improve on current performance. Targets will be incorporated into DHB annual plans.

- Partners & Networks
- Commissioning
- Influence & Advocacy
- ICT & Knowledge Resource
- DHBs as an Employer

Goal 1: To give Pacific children and their families the best possible start in life

System Enablers	Actions to achieve this outcome	How will we know there's been improvement?	Measures of improvement
	1. Support family-centred initiatives to reach pregnant mothers, parents, babies and families.	• Increased uptake and improved access of Pacific mothers to antenatal and postnatal maternity services. • Responsive child health, oral health and disability support services wrapped around to support the needs of Pacific mothers and children.	• % of Pacific pregnant women registe[illegible]n a Lead Maternity Carer within the first trimester of pregn[illegible]y • % of Pacific mothers using [illegible]tal serv[illegible] • % of Pacific mothers rating s[illegible]vice[illegible]seting their needs
	2. Collaborate with appropriate stakeholders to promote safe environments for bringing up Pacific children including warm homes, smoke free homes, good nutrition, safe sleeping, reducing smoking and alcohol consumption.	• A decrease in avoidable admissions for Pacific children. • Increase the number of Pacific children living in healthy homes that are warm and smokefree. • Improved Pacific provider system integration and coordination between community, across primary, secondary, and tertiary care providers and other sector partners.	• Rate of Ambulato[illegible]ospitalisations for children aged 0-4 years ([illegible]100,0[illegible]people) • % of Pa[illegible]c ba[illegible]living in smokefree households at 6 weeks old • Rate o[illegible]spitalisa[illegible]ons potentially related to housing conditions per 1,00[illegible]pula[illegible]n for children under 15 years age
ICT	3. Work with relevant stakeholders to develop targeted initiatives campaigns that focus on increased rates and duration of breastfeeding and immunisations uptake for Pacific children.	• Strengthened approach through inter-agency partnerships to address timely access to maternity services and birthing options. • Strengthen Pacific breastfeeding services, and child immuni[illegible] services.	• [illegible] of Pa[illegible]fic infants fully or exclusively breastfed at 3 months • [illegible]cific children fully vaccinated at eight months old, two years old and five years old

Goal 2: Ensure Pacific Children meet key childhood developmental milestones through culturally responsive and quality services and support

	4. Leverage existing Well Child Tamariki Ora services and Pacific specific Well Child Services and partnerships and build up these providers to reach the most vulnerable families.	• Increase in children receiving all their core [illegible]cks. • Better collaboration between Well child Tamari[illegible]Ora s[illegible]ices through collective programmes and [illegible]jects deve[illegible]ed across the health system.	• % of Pacific children accessing Well Child Tamariki Ora services and completing Core Checks • % of eligible Pacific children receiving and completing a B4 School Checks
	5. Work collaboratively with Bee Healthy Regional Screening Services and key stakeholders on projects and initiatives to improve coverage of screening and preventative oral health interventions.	• Increased knowledge and understanding of parents and caregivers of healthy foods to nourish young children. • More Pacific children with healthy teeth. • Increase in number of children receiving their annual dental examinations.	• % of Pacific children (0-12) enrolled in Community and DHB oral health services overdue for their scheduled examinations • % of Pacific children caries free at 5 years and at 12 years old
	6. Work collaboratively with key stakeholders to reduce the prevalence rates of family violence in Pacific communities.	• Strengthen support for initiatives that address Family violence and work with relevant stakeholders on preventative measures. • Increased role of health services through inter-agency collaborations to support Pacific families.	• Number of referrals to relevant services during discharge planning • Number of inter-agency collaborations with the DHB to support Pacific families and ensure they access the right services


PRIORITY TWO
Pacific Young People

Pacific young people have timely access to services and programmes that enables them to grow into healthy adults and lead productive lives.

RATIONALE

Pacific young people growing up in the Greater Wellington region are contributing positively to their families and society and are progressing well in many areas. However with the majority now classified as New Zealand born and identifying with more than one ethnicity, our Pacific young people still face issues that previous generations may not have experienced due to exponential social, technological, economic, cultural and educational changes over the years.

WHAT THE DATA TELLS US

Various school based health services are provided in low decile colleges, Teen parent units and alternative education centres delivered by Regional Public Health, VIBE, Evolve and some specific PHOs/DHBs health services across the region. Doctors and Nurses provide students with advice, treatment and referral to other services on problems in general health, sexual health, and mental health. They also provide routine Health Assessments to Year 9 students. Based on the most recent data available for the 2017 calendar year in Wairarapa 27 Pacific students were seen by school based health services (79% of eligible students) and had on average 2 visits. Hutt Valley School Based health nurses saw 133 Pacific students (78% of eligible students) who had on average 2 visits. 100 Pacific Year 9 students in Hutt Valley received a routine health assessment. Capital & Coast school based health nurses saw 589 Pacific students (94% of eligible students) who had on average almost 2 visits.

Even though we see improvements and the availability of youth centred health services and programmes targeted to our young people in schools, we are seeing a rise in mental health issues, suicide attempts, sexually transmitted infections, smoking, preventable injuries, obesity and family violence. Our young people identified during the consultations the close link between mental health issues and the result of identity crises, poverty, lack of cultural sensitive health care models, stigmatisation and discrimination.

Tackling the risk factors associated with these issues alongside sufficient investment to advancing progress made in some areas and investment in new and innovative ways to support our young people to thrive is our goal. Past data given that across the Greater Wellington region in the next 10 years most of the Pacific youth will be in the age groups 15-29 years a 8% increase.[4]

We know that youth is a key transitional period in the life of a young person where they make decisions around relationships, career pathways, and responsibilities alongside rapid brain and body transformations. Research and the data tells us that enabling environments that foster healthy behaviours, resilience and confidence of young people puts them in good stead to transition into adulthood. The research and data also tells us that Pacific young people still face obstacles more so than other ethnicities due to socio-economic and educational disadvantage, inter-generational suffering and prejudice to name a few. We heard from our young people that they want to contribute to policies and programs that impact on them given the right support and opportunities to do so. Sport, music and the Arts are some of the areas they identified as having a significant impact in promoting a sense of wellbeing for them.

In light of this, the following actions will be taken to ensure we are supporting Pacific young people to strengthen their resilience, address mental health and wellbeing, establish the right support networks, and improve sense of belonging, problem solving skills, strong connection to culture and family.

4. 3DHB Pacific Plan Data sets 2019.

PRIORITY TWO: *Pacific Young People*

KEY FOR SYSTEM ENABLERS

Note: Targets will be set using national targets or to improve on current performance. Targets will be incorporated into DHB annual plans.

- Partners & Networks
- Commissioning
- Influence & Advocacy
- ICT & Knowledge Resource
- DHBs as an Employer

Goal: Pacific young people have timely access to services and programmes that enables them to grow into healthy adults and lead productive lives

System Enablers	Actions to achieve this outcome	How will we know there's been improvement?	Measures of improvement
	1. Support and strengthen initiatives that encourage young Pacific people to adopt healthy lifestyles, make informed choices about sexual health, smoking, and risk-taking behaviours.	• More Pacific Youth are making healthy lifestyle choices.	• % of Age-standardized rate of overw[illegible]nd obesity in Pacific aged 15+ years • % of Pacific young people a[illegible]g sexua[illegible]nd reproductive health services either throug[illegible]GPs[illegible]th specific services
	2. Accelerate strategies and innovations that focus on Pacific young people's mental health, self-harm and violence.	• Increased number of Pacific young people engaging with programmes and initiatives such as the Piki free youth Mental Health services, YouthQuake, community driven mental health programmes and others.	• % of eligible Pacific [illegible]ng people's accessing Community Youth mental h[illegible]vices[illegible]mary services) • % of P[illegible]ific youn[illegible]eople accessing suicide prevention and self-harm ed[illegible]tion s[illegible]ices and support
ICT	3. Leverage Technology to promote health messages and campaigns that reach and resonate with Pacific young people.	• Pacific young people receive and respond to health messages on media that they use often.	• [illegible]f A[illegible]-standardized rate of overweight and obesity in Pacific ag[illegible]15+ years
ICT	4. Strengthen and promote partnerships with youth specific health, social and educational service providers.	• Increased access to health and disability servic[illegible]ma[illegible] centred.	• % of Pacific students seen by School based health services • % of Pacific Youth seen at Youth Health services (YOSS)
	5. Implement leadership programmes that encourage the participation of Pacific young people in dialogue and decision-making opportunities and activities to enhance their health.	• Number of collaborations with identified [illegible]lleges and High Schools to promote health as a career but a[illegible]o to collaborate on health promotion initiatives driven by Pacific young people.	• % of Pacific young people involved in DHB and Primary Care relevant Consumer and Health Steering Groups • % of scholarships offered for relevant Pacific young people to complete health related studies at Universities and Polytechnics


PRIORITY THREE
Pacific
Addictions
Answer

Pacific adults and elders are actively engaged in their health care, live productive, active, culturally secure and quality long lives.

RATIONALE

Healthy Pacific adults and elders contribute positively to their families, churches, work places and society overall. Our Pacific elders play a crucial role as the custodians of traditional wisdom to help sustain cultural traditions, languages and practices, through passing on of knowledge, customs and generational blessings across generations. They are cultural champions that need to be engaged to ensure appropriate cultural approaches to health and wellbeing are utilised.

A social wellbeing survey undertaken by Statistics New Zealand in 2017 highlighted that Pacific adults reported higher levels of wellbeing despite challenging socio-economic situations. The life expectancy of Pacific adults has also increased showing that Pacific adults and elders are living an extra 7-8 years when compared to 20 years ago.

WHAT THE DATA TELLS US

Data across the two Primary Health Organisations and the three DHBs in the Wellington region show that Pacific people have high rates of healthcare utilisation, accessing their General Practices 3.5 times more than others.

Pacific adults and elders continue to be high users of health services, and are still more likely to suffer and die prematurely from chronic diseases such as diabetes, heart disease, respiratory illnesses, strokes, cancer, obesity and high rates of avoidable ambulatory hospital admissions compared to others. Based on the NZ Health survey standardised rates, 92% of Pacific adults in Capital & Coast are overweight or obese and 89% of Hutt Valley Pacific. This is similar to all Pacific in New Zealand.

Amendable mortality rates for Pacific are also high particularly for people under the age of 75 due to causes that could have been prevented through treatment or better safety precautions. The causes of death include injuries, suicide, cancer and cardiovascular disease. Over the 5 years from 2011-2015, there were 176 deaths in Capital & Coast Pacific people and 71 Pacific Hutt Valley that could have been prevented. The standardised rate of amenable mortality is higher for Pacific than non-Maori non Pacific people in Capital & Coast and Hutt Valley.

Based on coroner's information on suspected suicides, over the four years from 2014/15 to 2018/19, 5% of Hutt Valley deaths were Pacific people, 7% of Capital & Coast and none of the deaths in Wairarapa were Pacific people.

There is also an increasing trend of individuals suffering from multiple chronic conditions and this impacts on the quality of life of the individual and mainly due to complications from having more than one long term condition. This is despite improvements in treatments, management and access to clinical care services, wrap around programs and services that support and encourage the adoption of healthy lifestyles and focus on addressing social determinants of health.

Therefore we need to provide holistic and appropriate health promotion, prevention efforts and education to improve health literacy of Pacific adults and elders. We want to make sure that Pacific adults and elders are aging well and accessing the appropriate services including aged care facilities, palliative care services maximise their independence and reducing burden of health problems and disabilities.

Fakamalolo ke he tau amaamanakiaga,
ke mafola ai e tau matakainaga –
Strengthen all endeavors
and the community will benefit

Niue proverb

PRIORITY THREE:
Pacific Older People & Aging Well

KEY FOR SYSTEM ENABLERS

Note: Targets will be set using national targets or to improve on current performance. Targets will be incorporated into DHB annual plans.

- Partners & Networks
- Commissioning
- Influence & Advocacy
- ICT & Knowledge Resource
- DHBs as an Employer

Goal: Pacific adults and elderly are actively engaged in their health care, live productive, active, culturally secure and quality long lives

System Enablers	Actions to achieve this outcome	How will we know there's been improvement?	Measures of improvement
	1. Work in partnership with key stakeholders to increase and encourage participation in screening programs (cervical, bowel, breast and other cancers) AND cessation support (smoking and drugs).	• More Pacific people participate in Bowel, Breast and Cervical screening programmes for early diagnosis of cancer. • Pacific people receive cancer treatment sooner.	• % of Age-standardized rate of overweight and obesity in Pacific aged 15+ years • % of Pacific young people accessing sexual and reproductive health services either through Pacific youth specific services

	2. Continue to improve system-wide health service delivery with targeted activities specifically aimed at chronic disease treatment and prevention.	• Increased support and uptake of risk assessment, and early intervention programs for
		  • Diabetes checks
		  • Cardiovascular disease
		  • Respiratory disease
		  • Smoking
		  • High Blood Pressure
		• Increased access to medications and Pharmaceuticals by decreasing the number of prescriptions unfilled due to cost.
			• % of eligible Pacific young people's accessing Community Youth mental health services (primary services)
			• % of Pacific young people accessing suicide prevention and self-harm education services and support

	3. Implement prevention, health education and promotion programmes that draw on Pacific traditional wisdom, languages and cultural strengths to address risk factors and treatment.	• Reduced ASH rates and Pacific people admitted to hospital due to complications from chronic conditions.	• % of Age-standardized rate of overweight and obesity in Pacific aged 15+ years
	4. Strengthen healthy aging initiatives and optimise on opportunities to support Pacific elderly live quality lives in their homes. Effectively integrate and socialise the idea of Advanced Care Planning with Pacific families and communities.		• % of Pacific students seen by School based health services • % of Pacific Youth seen at Youth Health services (YOSS)
ICT	5. Continue identifying change levers in programme and service design that will make the greatest impact on health conditions including cultural competency training for non-Pacific workforce that support Pacific people.	• NNon-Pacific workforce improve their understanding Pacific peoples worldview and what would influences them. • Pacific people better understand their health, their medications and other factors that influence their condition.	• % of Pacific young people involved in DHB and Primary Care relevant Consumer and Health Steering Groups • % of scholarships offered for relevant Pacific young people to complete health related studies at Universities and Polytechnics


PRIORITY FOUR
Pacific Health
Workforce
&
Clinic
Providers
and More

The Pacific health workforce and Providers have the capabilities, resourcing, aspirations, organisational structures, professional opportunities and potential to lead, support and contribute to achieving positive health and wellbeing outcomes for Pacific people.

RATIONALE

The importance of building and maintaining a qualified Pacific health and disability workforce alongside investment in strengthening Pacific Providers is crucial to closing the gap in addressing the health inequalities that exist for Pacific people. A qualified Pacific health workforce with cultural understanding and who are well versed in the cultural nuances of Pacific people will improve and strengthen our ability to provide culturally responsive health system that benefits the communities we serve to engage them to become good and better stewards of their own health and wellbeing.

We want to ensure our current and future workforce is diverse and have the right skills and qualifications to deliver and provide continued improvement across all parts of the health sector. Additional funding investments and commissioning services are directed and help build on Pacific Providers with proven success in providing services that meet the needs of Pacific peoples.

Investing resources and funding into growing the Pacific health and disability workforce & Providers will enable the District Health Boards to close the gap and make a difference in achieving optimum health is achieved for vulnerable groups such as Pacific in the Greater Wellington region.

WHAT THE DATA TELLS US

The Central Region District Health Boards Pacific Workforce Report as at 30 June 2019 identified that across the Wellington Sub Region, the Pacific workforce was spread across with the highest reported proportion of Pacific peoples in the Care and support occupation group with 3% in CCDHB, 2% in HVDHB and 0% in WrDHB followed by those working in Corporate, Admin and other Nursing and with the lowest proportions in Midwives, Resident and Senior Medical Officers.

Across the Central Region, the proportion of Pacific staff with more than four weeks of accrued annual leave was typically lower than the proportion of all employees with this level of accrued leave, with notable staff in the Midwifery, Resident Medical Officer and Senior Medical Officer Occupation groups reportedly accruing more than two years of annual leave. A cause for concern was the reported number of sick leave hours taken in April-June 2019, as a proportion of total paid hours, was typically higher for Pacific employees than the rate across all DHB employees.

The exceptions are the Midwifery and Resident and Senior Medical Officer Occupation groups, but this may be linked to the low numbers of Pacific employees in these occupation groups.

One of the limitations is that the data sets obtained does not include the Pacific workforce in primary and community health care. The DHBs workforce has also have an aging Pacific Health workforce

Certainly in the Greater Wellington region the forecast for the Pacific population is that there will be persistent inequities, increased demand on health services, increased social isolation with volumes of older people with complex health and social needs.

5. TAS Central Region District Health Boards Dashboard Pacific Workforce Report June 2019.

Hence a strong focus should be on investing now and making it a priority to grow the Pacific health workforce to meet the impact and increase in demand of the changing Pacific demographics and support an aging workforce who are small in numbers and are feeling the weight of supporting older people with long term conditions and other health issues affecting our Pacific populations.

Pacific Providers and NGOs in the community are small, we aim to support them by building their capacity further at all levels to collaborate (especially with other providers) as a key way to improve the range, access and cultural appropriateness of services to Pacific communities.

E rima te'arapaki te aro'a, te ko'uko'u te utuutu, 'laku nei –
Under the protection of caring hands there's a feeling of love and affection

Cook Island proverb

PRIORITY FOUR:
Pacific Health & Disability Workforce and Pacific Providers

KEY FOR SYSTEM ENABLERS

Note: Targets will be set using national targets or to improve on current performance. Targets will be incorporated into DHB annual plans.

- Partners & Networks
- Commissioning
- Influence & Advocacy
- ICT & Knowledge Resource
- DHBs as an Employer

Goal: The Pacific health workforce and Providers have the capabilities, resourcing, aspirations, organisational structures, professional opportunities and potential to lead, support and contribute to achieving positive health and wellbeing outcomes for Pacific people

System Enablers	Actions to achieve this outcome	How will we know there's been improvement?	Measures of improvement
	1. Influence HR recruitment policies and processes across the 3DHBs to improve Pacific employment opportunities including increasing number of Pacific on shortlisting, interview panels, Steering groups and governance.	• Number of Recruitment Policies reviewed and updated accordingly. • Increased number of Pacific skilled workforce being interviewed for positions and employed within the District Health Boards in different areas. • Strong pathways in place for mentoring and leadership trainings for the current workforce.	• % of Innovative i rve ons to prove health workforce retention and rec • Number of Pacific s employed in DHB • % of Pac s vac tors and prescribers completing training
	2. The 3DHBs and PHOs demonstrate their commitment to funding and supporting "Pacific by Pacific" Pacific Health Service providers in the community and recognise the crucial part they play within the health system and the achievement of health outcomes. 3. Strengthen and support Pacific Health Providers and align their work with General Practices and hospital services in particular with a focus on Health Care Homes and Integrated family health centres in primary care and the community.	• Review Commissioning and contracting processes within the DHBs ensure Pacific providers are funded, utilized and resourced to support primary and secondary care to reach and serve P peoples. • Pacific Provider Forum in the Greater Wellington Regio established and supported.	• % acific by Pacific Health and Disability Service providers supported
	4. Increasing and attracting our Pacific human capital by targeting students via formal education settings, such as secondary schools to tertiary institutions. This pipeline needs to be socialised as well with the education sector.	• Number of Pacific students showing interest nder ng health studies. • Number of cadetships and relevant lth holars p programmes in place.	• Number of scholarships funded and cadets placed • Number of Pacific graduates employed in the Health workforce (Allied Health, Doctors, Nurses, Health Promoters etc.)
	5. Focus on Pacific Island trained health professionals with overseas training and qualifications and the pathways for qualification in the NZ health system.	• Increase the Pacific health and disability workforce by focusing on supporting island trained health professionals to complete NZ required registrations.	• % of Pacific Health and Disability staff registered with professional associations and councils


PRIORITY FIVE
Social
Determinants
of Health

A health system in the Wellington sub-region that is aligned and better connected to housing, education, employment, social services and other sectors to address environmental, social and economic inequities to achieve better health outcomes for Pacific peoples.

Culturally sensitive models of care are utilised and integrated into health care deliver, education and promotional strategies to enable the best possible mental health and wellbeing for pacific peoples.

RATIONALE

The health and wellbeing of our Pacific communities is heavily influenced by the underlying social determinants of health. These in[clu]de, housing and employment, health behavio[urs], clinical care and the physical e[nvironm]ent.

WHAT THE DATA TELLS US

A higher proportio[n of Pac]ific [peo]ple are living in more deprived are[as] according to the NZ Deprivation In[dex]. Bas[ed] on the 2013 Census populati[on] 51% [of] Capital & Coast Pacific people were l[iv]ing in the m[ost] deprived areas, 40% of Hutt Pac[ific] eople and 36% of Wairarapa Pacific people.

Research suggests that only about 20 percent of a person's health is determined by access to health care. The other 80 percent is determined by health behaviours and the social and environmental conditions where they live, work and play. The feedback from our Pacific people provided valuable insight on how the social determinants of health were impacting on their health and wellbeing. Most importantly, the feedback highlighted what we need to prioritise to improve the health and wellbeing of our Pacific Peoples across Wellington, the Hutt Valley and Wairarapa.

It is well known that income i[s] sociated with health and wellbeing. Fami[lies] o[f] w incomes may struggle to pay all t[he]ir bills, w[hi]h can cause stress and tension wi[th]in a family. The[re]se in housing costs in recent[] in particular, has put many famil[ies] under [fi]cial strain – with a significant pro[por]t[ion] of their income having to be spent on rents [or] mo[rtg]. This may mean they are u[nab]le to a[ffo]rd items and activities that can ha[ve] po[sit]ive im[pa]ct on health and wellbeing.

These [ma]y include, for example:

- [he]althy foods, like fruits, vegetables and milk
- [te]am sports and other outdoor activities
- [sc]hool outings and events
- joining and participating in local cultural or religious groups, hobby groups, or clubs
- appropriate clothing and bedding
- travel or holidays
- electricity for heating
- household items to help keep homes warm and dry, like heaters, curtains, draft stoppers and insulation

Of course, low income will also impact on a family's ability to pay for health care, including regular check-ups and care when they are unwell.

Employment helps to raise a family's income, which can help pay for activities and items that improve health and wellbeing. However, employment can take a parent's time away from their family – especially if they are having to work more than one job, or work at nights and weekends, to make ends meet. Time away from their family while working can also have a negative impact on wellbeing.

6. https://www.health.govt.nz/publication/health-and-independence-report-2017

Many Pacific families told us that both employment and income affect their health and wellbeing in different ways. Often, both the mum and dad were working and the family still did not have enough money coming in to meet all their ongoing bills and household costs. Sometimes the mum or dad had more than more job and were working different shifts and at weekends. Young Pacific people would also often be working to help support their family. Some said that they would often settle for less when interviewing for jobs.

We were also told that many Pacific people are not aware of the Government support available. When they do seek support, many felt the process was administratively burdensome, intrusive, and took away their dignity. The process involved too much paperwork and forms, and having to 'prove' they had low incomes. We were told that many Pacific people felt judged and humiliated by the process.

Income support was especially needed for Pacific families after a baby is born, for the first 12 months of the infant's life. During this time finances are particularly stretched because the family will lose the income of one parent. Additional income during this time would also relief financial stress and help the family provide support the baby during this critical period in a baby's life.

As expected, we were told that low income affects the ability of Pacific people to access health care. They told us that many Pacific people are not having regular check-ups with their general practice due to the high medical costs.

PRIORITY FIVE:
Social Determinants of Health

KEY FOR SYSTEM ENABLERS

Note: Targets will be set using national targets or to improve on current performance. Targets will be incorporated into DHB annual plans.

- Partners & Networks
- Commissioning
- Influence & Advocacy
- ICT & Knowledge Resource
- DHBs as an Employer

Goal: A health system that influences and is aligned to housing, education, employment, social services and other sectors to address inequities AND achieve better health outcomes for Pacific peoples

System Enablers	Actions to achieve this outcome	How will we know there's been improvement?	Measures of improvement

	1. Strengthening partnerships through inter-agency networks to influence and advocate for Pacific communities with housing organisations, Ministry of Social Development, Ministry of Pacific Peoples, Ministry of Education, Pasifika Future, Local councils and other stakeholders and leverage off programmes.
	For example
	• in relation to accessing benefits, housing, income support, disability allowances
	• access to ECE, improved literacy, retention rates, pass rates NCEA and increased number of Pacific students
	• improve response and prevention of family violence, safe guarding children and women
		• Connected and influential health system to social, economic, education and other sectors.
		• Improved access to ECE for Pacific children.
		• Increased number of Pacific young people achieving NCEA qualifications.
			• Number of Pacific children enrolled in an ECE
			• % of Pacific students achieving NCEA level 1,2,3
			• % of Pacific families accessing whanau ora services and support
			• See measures for
			  • Reducing avoidable hospitalisations
			  • Improving outcomes for people with long term conditions

	2. Work closely with Local Councils, Housing NZ and key stakeholders to advocate and influence decision making that will improve healthy housing for Pacific people.	• Increased number of Pacific families accessing warmer, drier homes leads to a reduction in avoidable hospitalisations	• Rate of Ambulatory Sensitive Hospitalisations for children aged 0-4 years and adults aged 45-64 (per 100,000 people) • % of Pacific babies living in smokefree households at 6 weeks old • Rate of hospitalisations potentially related to housing conditions per 1,000 population for children under 15 years age
	3. Reductions in reported police investigations of family violence involving Pacific families.	• Decreased number of reported police investigations of family violence.	• Rate of Pacific reporting being victims of violence by family member to Police per capita


PRIORITY SIX
Culturally
Respo
&
Health

A culturally responsive and respectful health care system across the Wellington sub-region secondary/ hospital care, specialist services, and aged care that meet the needs of Pacific peoples and are delivered close to home.

RATIONALE

Culture for Pacific peoples plays a significant role in their decisions on how, where, when and why they should seek and engage with health services, acceptance of treatment protocols, adherence to treatment and follow up of appointments, as well as the ability to trust and be confident in the system.

Therefore, a culturally responsive and integrated system, culturally competent workforce will lead to more effective health service delivery that achieves equitable and better health outcomes for Pacific peoples. It will improve patient experiences and health outcomes.

We know that effective integration of services that wrap around a person's needs rather than service needs will enhance patient experience, achieve better and seamless care.

By working collectively across all areas clinical and non-clinical within the health system and various settings of care, we can improve the flow of information, continuity of care, and building strong and effective relationships and partnerships which are core to integrated services and design.

Soli tu ena Yalo Loloma kei na Dina –
Gifted in the Spirit of Love and Truth

Fijian proverb

PRIORITY SIX: *Culturally Responsive & Integrated Health System*

KEY FOR SYSTEM ENABLERS

Note: Targets will be set using national targets or to improve on current performance. Targets will be incorporated into DHB annual plans.

- Partners & Networks
- Commissioning
- Influence & Advocacy
- ICT & Knowledge Resource
- DHBs as an Employer

Goal: A culturally responsive and respectful health care system across the Wellington sub-region secondary/hospital care, specialist services, and aged care that meet the needs of Pacific peoples and are delivered close to home

System Enablers	Actions to achieve this outcome	How will we know there's been improvement?	Measures of improvement
	1. Develop and Implement a Sub-regional Cultural Competency Framework, Checklist and Training Package that nurtures a culturally responsive work environment and improve capacity of the health workforce to deliver culturally sensitive services.	• Number of Mandatory Cultural Competency training sessions rolled out across Secondary and Primary care services. Embed Pacific cultural training as a key component of new employees orientation programme.	• % of new employ[illegible] Pacific e-learning and face to face cultural training [illegible] part of mandatory training
	2. Build accountability and leadership for Pacific health outcomes by embedding accountability at all levels of management within the DHBs and also reporting requirements on health impact of Pacific across services.	• All performance and outcome reports show results for Pacific Services actively find ways to reduce inequity of access and outcomes for their Pacific patients.	• % of service p[illegible]s that include actions that improve access for Pacific and improve Pacific health outcomes • [illegible]ee me[illegible]sures for reducing avoidable hospitalisations and [illegible]g outcomes for people with long term conditions
	3. Continue to support integrated programmes in primary care and hospital/specialist services focussed on early identification, treatment and support for individuals with risk factors such as the Community Integration initiative.	• Ensure an Interpreter is available, and relevant informatio[illegible] available for clients in their own language.	• See measures for reducing avoidable hospitalisations improving outcomes for people with long term conditions
ICT	4. Develop a Pacific Communications Strategy for the Greater Wellington Region.	• Increased use of culturally appropriat[illegible]igital t[illegible]s to improve the number of specialist and health ca[illegible]ervic[illegible] clos[illegible]o home and out in the community. • Continue to fund the important 'Catalyst [illegible]ific radio programme and develop comprehensive social media c[illegible]paigns to promote key messages and health information in the different Pacific languages. This will help raise awareness and support Pacific people.	• Well informed Pacific community in the Greater Wellington Region • Partnerships with key Pacific communications providers
ICT	5. Establish a Pacific specific sub regional health pathways for the 3D Health Pathways programme.	• Pacific specific Health pathways are available on the website and in use.	• Number of views of Pacific specific Health pathways on website

APPENDIX

3DHB PACIFIC PLAN 2019 DATA

POPULATION

An estimated 35,165 Pacific people live in the three DHB area in 2019/20, 22,320 in Capital & Coast, 11,900 in Hutt Valley and 945 in Wairarapa. Hutt Valley DHB has the highest percentage of Pacific people representing 8% of the total DHB population. Pacific people are 7% of the Capital & Coast population and 2% of Wairarapa.

Number of Pacific people in 2019/20

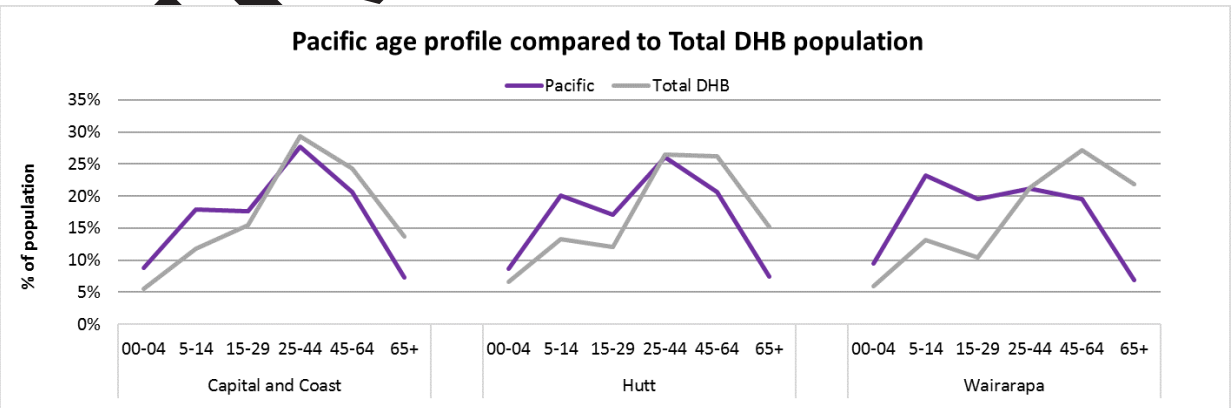
DHB	Number of Pacific People	% of total DHB population
Capital & Coast	22,320	7%
Hutt Valley	11,900	8%
Wairarapa	945	2%
Total subregional population	35,165	

StatsNZ Population estimate 201

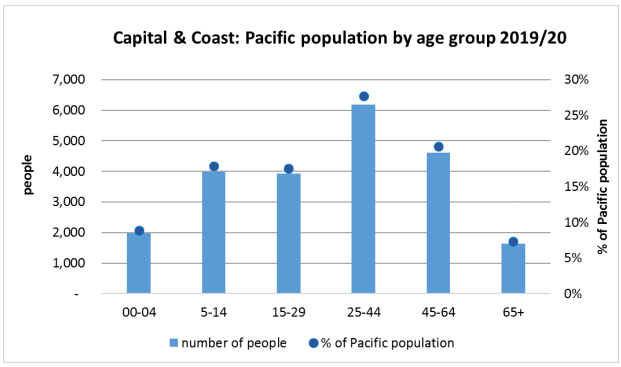
AGE PROFILE OF PACIFIC

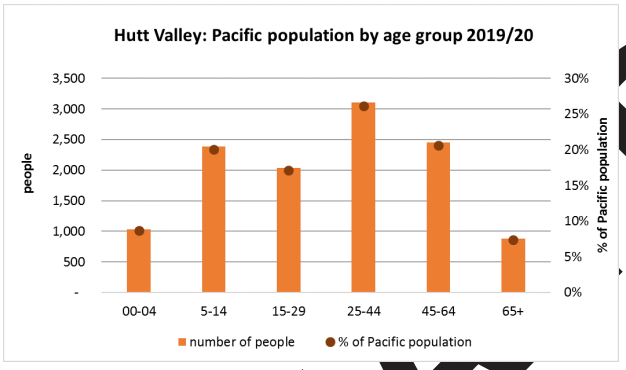
Pacific are a much yo er populati han the Total DHB population 2 9/20 Children aged under 15 years, make up 3% of the Wairarapa Pacific popul ompare 19% of the total DHB populati For Valley, children under 15 years make % of the Pacific population, whe y ma up 20% of to the total po ati For Ca ital & Coast, children under 15 y make up 27% of the Pacific population, reas y make up 20% of the total population. Wh as, people aged 65 and over made up only 7% the Pacific population in each DHB which w much lower than proportion in the total p ulation.

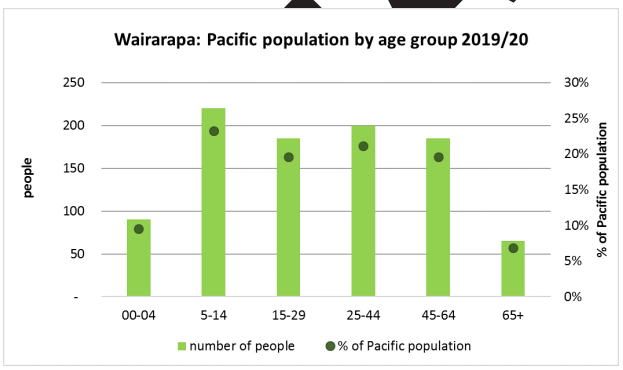
Age profile % bre f Pacific population in 2019/20 compared to total DHB



Pacific population by age group 2019/20 and the percentage of Pacific people in each age group

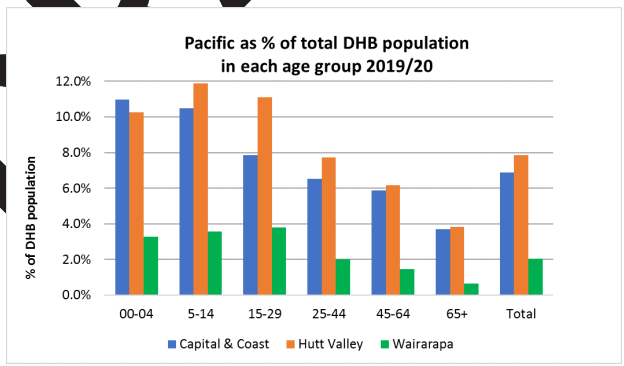






Although Pacific make up 7-8% of the total population of Hutt Valley and Capital & Coast DHBs, Pacific make up a higher proportion of the DHBs' children and young people because they are a younger population. Of the children aged under 15, Pacific make up more than 10% of the Hutt Valley and Capital & Coast population. For Wairarapa, Pacific children under 15 make up 3.5% of the population in that age group.

Pacific population as a percentage of total DHB population in each age group 2019/20



FUTURE POPULATION GROWTH

In the next five years, the Pacific population is expected to grow in all 3 DHBs. Capital & Coast Pacific population is expected to grow by 680 people (3%) by 2024/25, Hutt Valley by 450 people (3.8%) and Wairarapa by 50 people (5%).

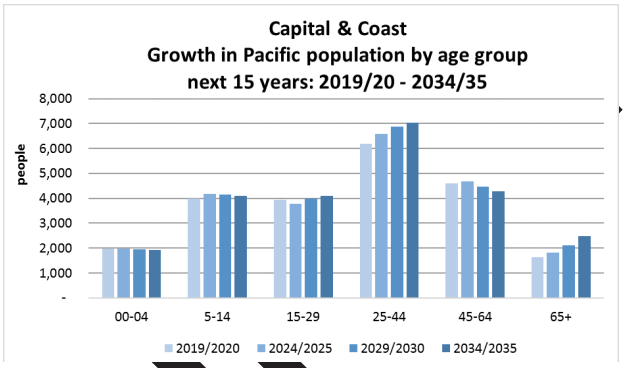
Pacific population growth in next 5 years 2024/2025

DHB	2019/2020	2024/2025	Growth in people in next 5 years	% growth in next 5 years
Capital & Coast	22,320	23,000	680	3.0%
Hutt Valley	11,900	12,350	450	3.8%
Wairarapa	945	995	5	.3%

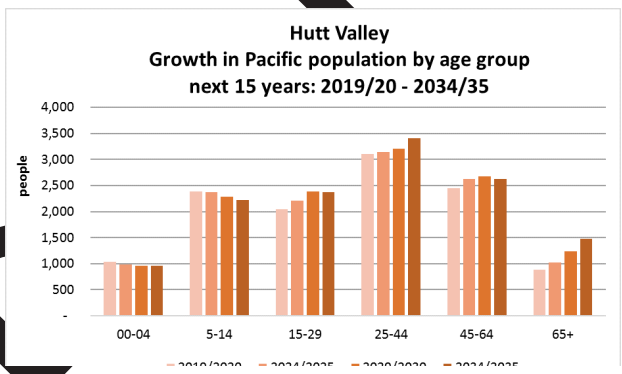
FUTURE POPULATION GROWTH

In the next five years, the Pacific population is expected to grow in all 3 DHBs. Capital & Coast Pacific population is expected to grow by 680 people (3%) by 2024/25, Hutt Valley by 450 people (3.8%) and Wairarapa by 50 people (5%).

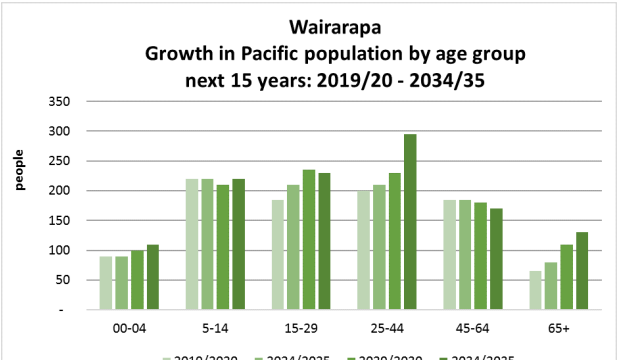
Pacific population growth in next 5 years 2024/2025



Most of the Hutt Valley growth in the next 15 years will be in the age groups 15-29, 25-44 and 65+. In the next 5 years, Pacific aged 15-29 are expected to grow by 170 people (8%) and Pacific aged 65+ will grow by 140 people (16%).

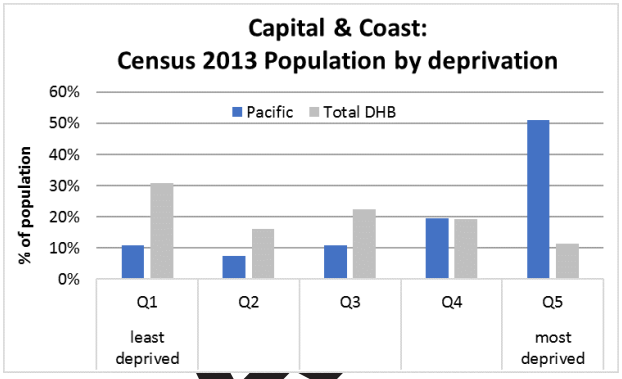


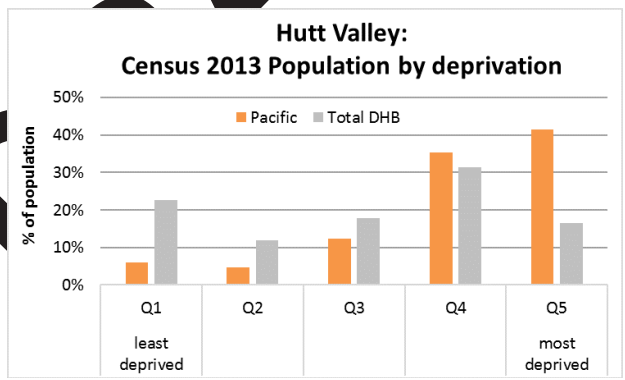
Most of the Wairarapa growth in the next 15 years will be in the age groups 15-29, 25-44 and 65+. In the next 5 years, Pacific aged 15-29 are expected to grow by 25 people (14%) and Pacific aged 65+ will grow by 15people (13%).

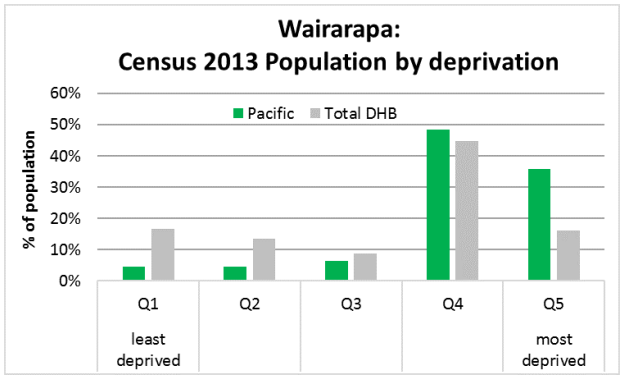


Pacific population in 2019/20 aged under 25 (5 year age groups)

	Capital & Coast	Hutt	Wairarapa
00 - 04	1980	1030	90
05 - 09	2060	1160	110
10 - 14	1930	1230	110
15 - 19	1910	1070	110
20 - 24	2020	970	75
Total	**9900**	**5460**	**495**







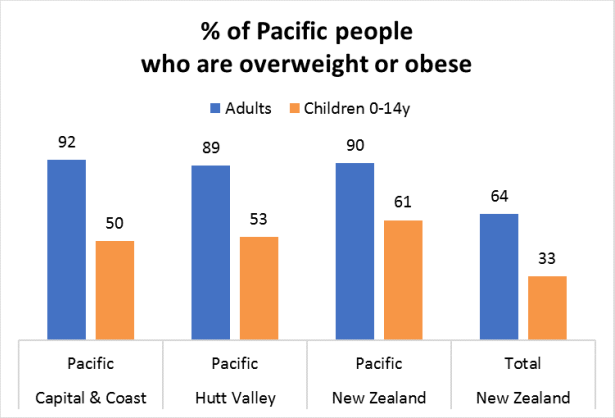
POPULATIONBY DEPRIVATION INDEX 2013

A higher proportion of Pacific people are living in more deprived areas according to the NZ Deprivation Index 2013. The NZ Deprivation Inde is based on variables that reflect socioeconomic factors that have significant influence on health such as income, employment, home ownership, and overcrowding.[1] Based on the 2013 nsus population, 51% of Capital & Coast Pacific ople were living in the most deprive 40% Hutt Pacific people and 36% of irar acific people.

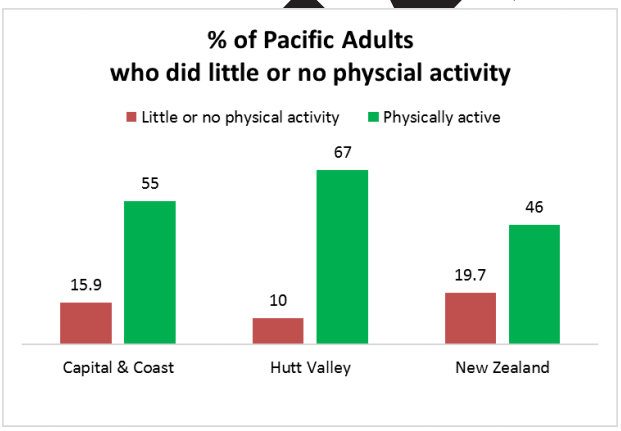
57% of Capital & C Pacific dult aged 65 and over were living in t most ed areas. 47% of Hutt Pacific a ts age 5 and over and 50% of Wairarapa acifi ed 6 nd over were living in the mo deprived a s.

Pacific chi n made up 55% of Capital & Coast children aged 14 living in the most deprived areas. Pacific children made up 33% of Hutt children aged 0-14 living in the most deprived areas. Pacific children made up 12% of Wairarapa children aged 0-14 living in the most deprived areas.

RISK FACTORS
Obesity & Physical activity

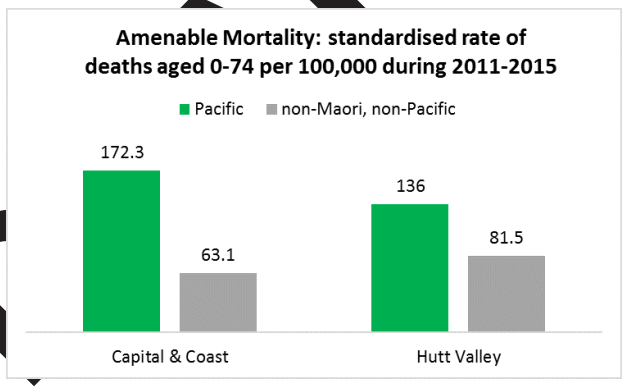


Based on the NZ Health survey standardised rates, 92% of Pacific adults in Capital & Coast are overweight or obese and 89% of Hutt Valley Pacific. This is similar to all Pacific in New Zealand. Around half of Pacific children aged 0-14 years are overweight or obese in Hutt Valley and Capital & Coast, which is less than all Pacific in New Zealand.



Based on the NZ Health survey standardised rates, 67% Hutt Valley Pacific adults are physically active while 10% did little or no physical activity. In Capital & Coast, 55% of Pacific Adults were physically active while 16% did little or no physical activity.

HEALTH OUTCOMES
Amenable Mortality



Amenable mortality refers to deaths in people under the age of 75 due to causes that could have been prevented through treatment or better safety precautions. The causes of death include injuries, suicide, cancer and cardiovascular disease. Over the 5 years from 2011-2015, there were 176 deaths in Capital & Coast Pacific people and 71 Pacific Hutt Valley that could have been prevented. The standardised rate of amenable mortality is higher for Pacific than non Maori non Pacific people in Capital & Coast and Hutt Valley.

Based on coroner's information on suspected suicides, over the four years from 2014/15 to 2018/19, 5% of Hutt Valley deaths were Pacific people, 7% of Capital & Coast and none of the deaths in Wairarapa were Pacific people.

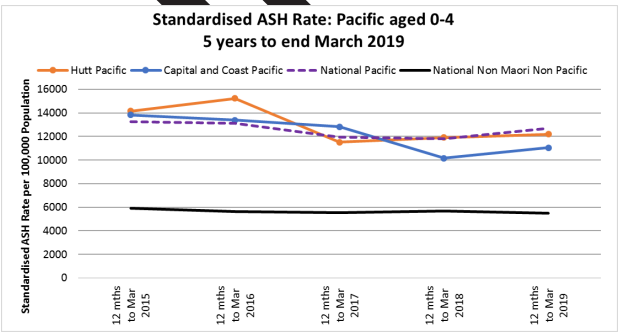
1. https://www.otago.ac.nz/wellington/departments/publichealth/research/hirp/otago020194.html
https://www.otago.ac.nz/wellington/otago069936.pdf - page 8 - list of variables

HEALTH OUTCOMES: HOSPITALISATIONS

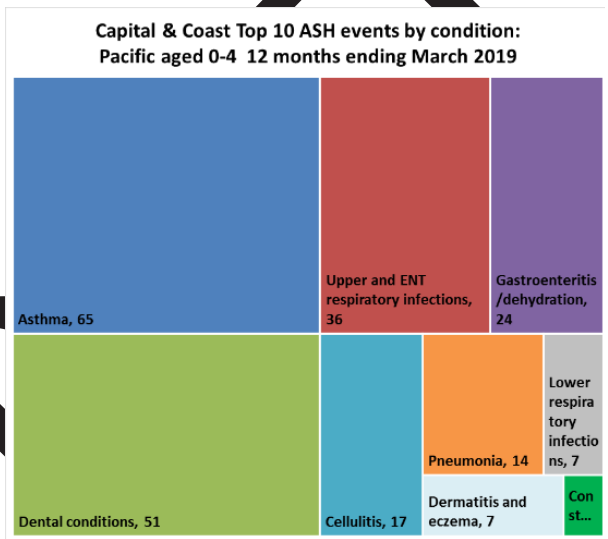
Ambulatory Sensitive Hospitalisations (ASH)

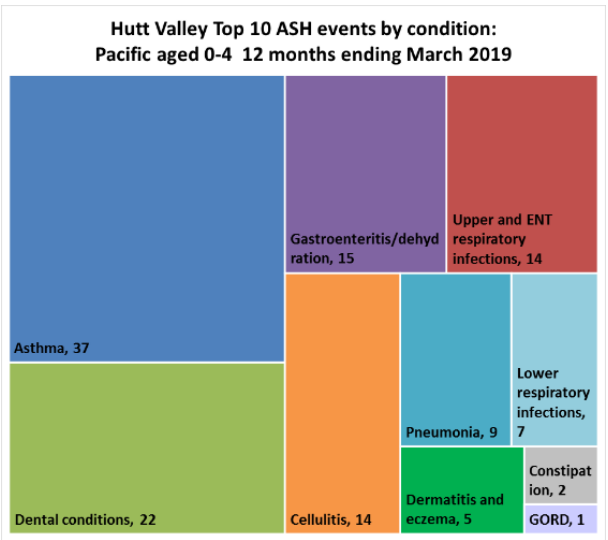
Ambulatory Sensitive Hospitalisations (ASH) are certain conditions where the hospital admission could have been prevented if the person had received appropriate care earlier in community services. The Ministry uses ASH rates as a measure of how the DHB system as a whole is working for the population in preventive and proactive care. The Ministry reports on the rate of children aged 0-4 and adults aged 45-64 who have an ASH event at any hospital including those outside the DHB the person lives in. The Ministry does not report rates for Wairarapa as the Pacific population is too small and with a smaller number of events the data could be identifiable.

Hutt Pacific and Capital & Coast ASH rates for Pacific children have decreased in the last 5 years but are still much higher than the Nat[illegible]l rate for children of Other ethnicities (non-Mao[illegible]on-Pacific). Rates for Hutt Pacific c[illegible]ren were [illegible] times higher than the rates for [illegible]tion[illegible]lon Maori non Pacific children in the year e[illegible]in [illegible]ch 2019. Rates for Capital [illegible]oast P[illegible]ic children were 2.0 times higher than t[illegible] rate[illegible]r National Non Maori non Pa[illegible]

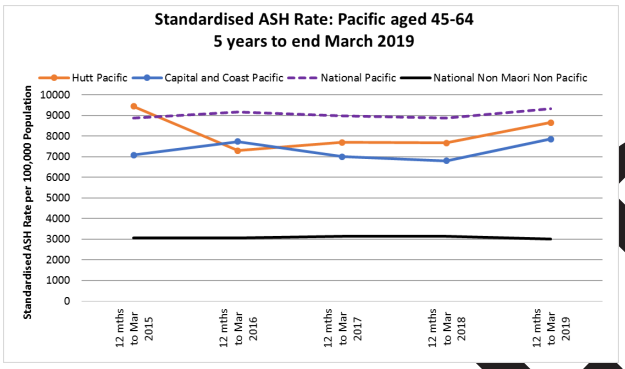


Most of the ASH events in the 12 months ending March 2109 for Hutt and Capital & Coast Pacific children were for Asthma, Dental conditions, gastroenteritis/dehydration, U[illegible]r respiratory tract infections and Cellulitis.

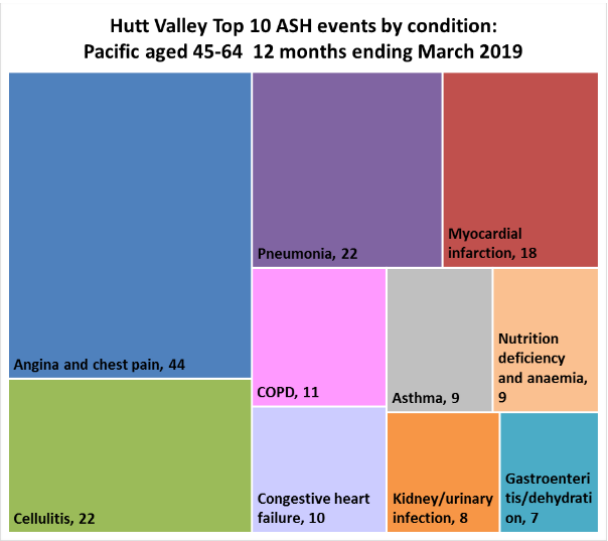


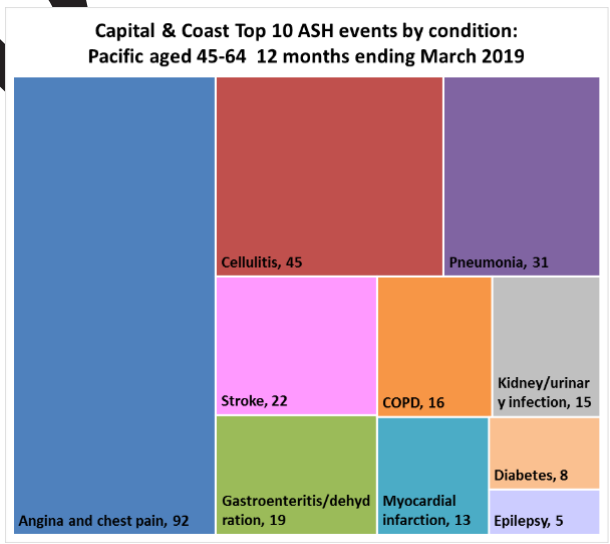


Hutt Pacific and Capital & Coast ASH rates for Pacific Adults aged 45-64 years have been fairly stable in the last 5 years but are much higher than the National rate for Adults of Other ethnicities (non-Maori non-Pacific). Rates for Hutt Pacific Adults were almost 3 times higher (2.9) than the rates for National Non Maori non Pacific adults in the year ending March 2019. Rates for Capital & Coast Pacific Adults were 2.6 times higher than the rates for National Non Maori non Pacific adults.



Most of the ASH events in the [illegible]hs ending March 2109 for Hutt Pacific Adu[illegible] w[illegible] Angina & Chest pain, Cellulitis, [illegible]umoni[illegible] Myocardial Infarction and Chronic Obst[illegible]tive [illegible]monary Disease (COPD). [illegible] for Capital & Coast Pacific Adults [illegible]re for [illegible]na & Chest pain, Cellulitis, Pne[illegible]nia, [illegible]ke and Gastroenteritis/ dehydrati[illegible].





ALL AGES AND CHILD & YOUTH

PHO enrollment

As at July 2019, Wairarapa has 938 Pacific people enrolled with a PHO 99% of the estimated population, Hutt Valley has 11,573 (98%) and Capital & Coast has 21,536 (97%) enrolled.

Most Wairarapa Pacific people are enrolled with the Compass Wairarapa PHO. 87% of Hutt Pacific are enrolled with Te Awakairangi Health Network while 1,398 (12%) Hutt Pacific people are enrolled with one of the PHOs with a contract with Capital & Coast. Note that Cosine PHO includes the practice Ropata Medical which is located in the Hutt Valley. 98% of Capital & Coast Pacific people are enrolled with Compass Capital & Coast, Ora Toa and Cosine. 263 Capital & Coast Pacific people are enrolled with Te Awakairangi Health Network.

Pacific people enrolled with a PHO in July 2019

DHB	Pacific enrolled with any PHO	% of estimated population
Capital & Coast	21,536	97%
Hutt Valley	11,573	98%
Wairarapa	938	99%

Number of Pacific people enrolled with any PHO July 2019 by DHB holding DHB contract

		DHB of domicile						
DHB holding PHO contract	PHO name	Wairarapa	Hutt	Capital & Coast	Total	Wairarapa	Hutt	Capital & Coast
Capital & Coast	Compass Health Capital & Coast		730	14,430	15,166	0.6%	6%	67%
	Ora Toa PHO		91	6,177	6,268	0%	0.8%	29%
	Cosine PHO		577	452	1,029	0%	5%	2%
Capital & Coast DHB total		**6**	**1,398**	**21,059**	**22,463**	**1%**	**12%**	**98%**
Hutt DHB	Te Awakairangi	11	10,075	263	10,349	1%	87%	1.2%
Wairarapa DHB	Compass Health Wairarapa	915	5	6	926	98%	0.04%	0.03%
PHOs in other DHBs		6	95	208	309	0.6%	0.8%	1.0%
Total enrolled with a PHO		**938**	**11,573**	**21,536**	**34,047**	100%	100%	100%

ALL AGES AND CHILD & YOUTH

Practice visits

Pacific people who were enrolled with Compass Wairarapa PHO saw a GP or Nurse on average 5 times in 2018/19. This excludes visits for immunisation only. For Pacific people enrolled with Te Awakairangi Health Network, they saw a GP or Nurse 3.5 times on average over the year. For Pacific people enrolled with Ora Toa or Compass Wellington, they saw a GP or Nurse 4.5 times on average over the year ending March 2019. Pacific people enrolled with Cosine which include Karori Medical and Ropat Medical practices saw a GP or Nurse on average 3.5 times over the year ending March 2019.

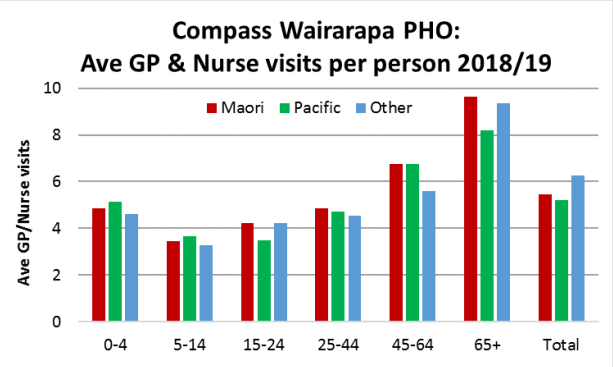
For all PHOs, Pacific aged 65 and over had the most visits on average, followed by people aged 45-64 and children aged under 5. Pacific Adults aged 45-64 in Compass Wairarapa and Te Awakairangi PHOs had slightly more visits on average than other ethnicities including Maori adults.

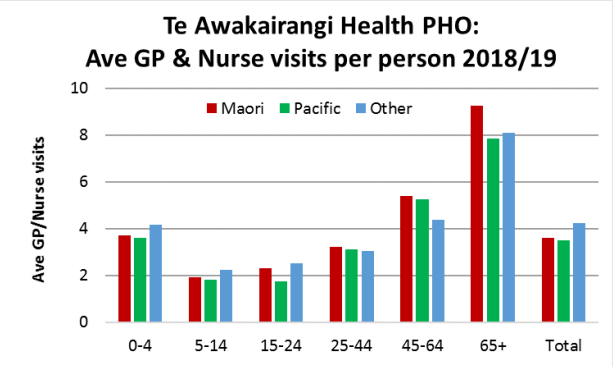
Pacific children aged under 5 years had slightly more visits in Compass Wairarapa compared to other ethnicities including Maori. But Pacific children aged under 5 years had similar number of visits in Te Awakairangi compared to children of other ethnicities including Maori.

Average GP/Nurse visits per person enrolled

Compass Wairarapa 2018/19			
Age group	**Maori**	**Pacific**	**Other**
0 - 4	4.84	5.14	4.62
5 - 14	3.44	3.66	3.26
15 - 24	4.21	3.5	4.22
25 - 44	4.86	4.7	4.53
45 - 64	6.75	6.74	5.61
65+	9.64	8.2	9.34
Total	**5.44**	**5.2**	**6.26**

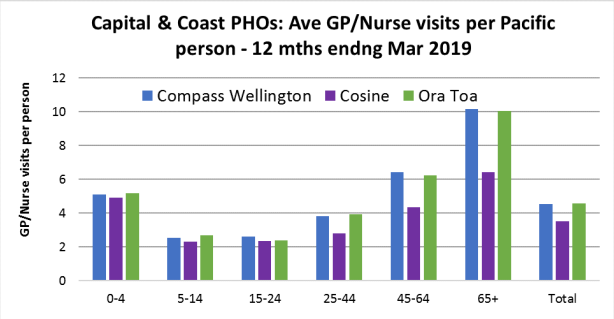
Te Awakairangi Health 2018/19			
Age group	**Maori**	**Pacific**	**Other**
0 - 4	3.72	[illegible]	4.16
5 - 14	1.93	[illegible]	2.24
15 - 24	2.30	1.73	2.52
25 - 44	3.2[illegible]	3.11	3.06
45 - 64	5.39	5.25	4.36
65+	[illegible]	7.85	8.10
Total	**3.6[illegible]**	**3.52**	**4.23**





Average visits per Pacific person enrolled 12 months ending March 2019 – Capital & Coast PHOs

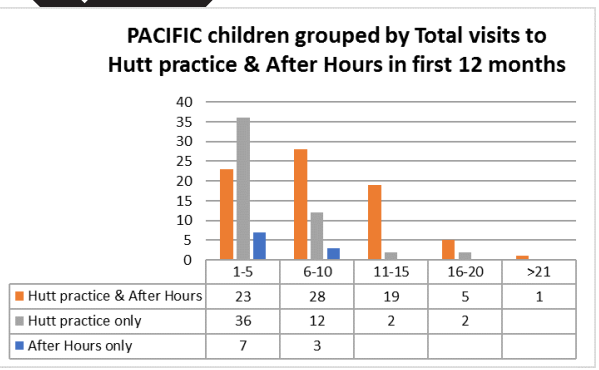
Age group	Compass Wellington	Cosine	Ora Toa
0 - 4	5.1	4.9	5.2
5 - 14	2.5	2.3	2.7
15 - 24	2.6	2.3	2.4
25 - 44	3.8	2.8	4.0
45 - 64	6.4	4.4	6.2
65+	10.1	6.4	10.1
Total	**4.5**	**3.5**	**4.6**



CHILD & YOUTH
After Hours – Hutt Valley [illegible] cohort study

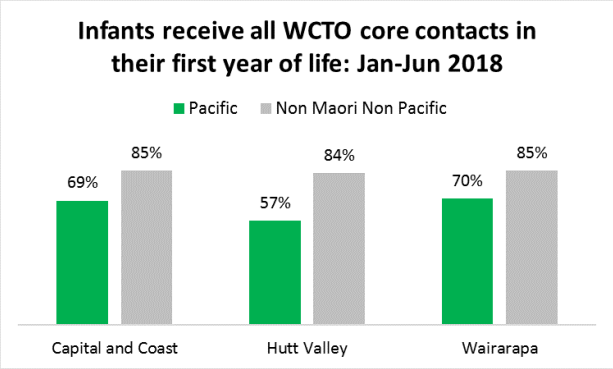
Analysis was done on Hutt Valley children born in 2013 and the use of HB health services in their first four years of life, including 148 Pacific children. It found that Pacific children were using the Lower Hutt After Hours as much as their Hutt GP practice. In their first 12 months of life, 51% of the Pacific cohort had been to both their Hutt GP practice and to Lower Hutt After Hours. 35% of the cohort only went to their Hutt GP Practice. 25 children (17%) had more visits to After Hours than to their GP practice during their first 12 months. While this means that they are receiving good access to Primary Care, they were missing out on continuity of care from their own practice as well as proactive care and preventive care. This also means that children with a high number of visits to After Hours may not be identified by their practice as at risk. There were 4 Pacific children who had 11 or more visits to their GP practice but another 26 Pacific children had 11 or more visits if we include their After Hours visits. 10 children only went to After Hours but may have been enrolled in a practice in another DHB.

Hutt Valley 2013 birth cohort – Pacific children using Lower Hutt After Hours and Hutt practices in first 12 months of life



WellChild/Tamarki Ora Checks

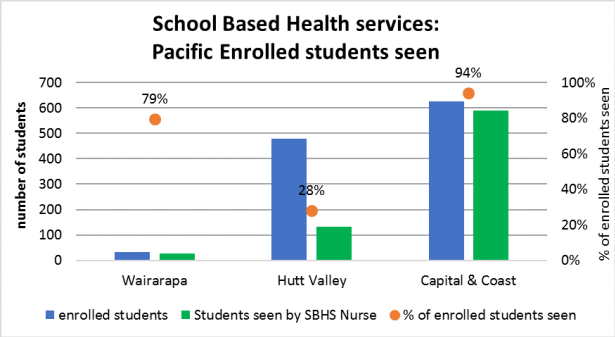
By receiving all WellChild/Tamariki Ora Checks core contacts in their first year, infants are more likely to have health and developmental issues identified in a timely way. Each child is scheduled to have 5 core checks by the time they turned 1 including their first check at 6 weeks old. During January-June 2018, Pacific children turning 1 year old were less likely to have had all their scheduled core checks than children of Other ethnicities excluding Maori. For Wairarapa Pacific children, 70% had received all their core checks, 57% of Hutt Pacific and 69% of Capital & Coast Pacific.



School Based Health services

DHBs provide School based Health services (SBHS) in low decile colleges, Teen Parent units and Alternative Education centres. Nurses provide students with advice, treatment and referrals to other services on problems including general health, sexual health, and mental health. They also provide routine Health assessments to Year 9 students.

Based on the most recent data available for the 2017 calendar year, in Wairarapa 27 Pacific students were seen by SBHS Nurse (79% of eligible students) and had on average 2 visits. Twelve Pacific Year 9 students in Wairarapa received a routine health assessment. In Hutt Valley SBHS nurses saw 133 Pacific students (28% of eligible students) who had on average 2 visits. 100 Pacific Year 9 students in Hutt Valley received a routine health assessment. Capital & Coast SBHS nurses saw 589 Pacific students (94% of eligible students) who had on average almost 2 visits. 121 Pacific Year 9 students in Hutt Valley received a routine health assessment.



Number of Pacific people enrolled with any PHO July 2019 – by DHB holding DHB contract

Pasifika	Eligable students	% of school role	Students seen by SBHS Nurse	% of enrolled students seen by SBHS Nurse	Visits to SBHS Nurse	Average visits per student seen	% of total visits	Year 9 students who received a health assessment
Wairarapa	34	4%	27	79%	59	2.2	4%	12
Hutt Valley	478	20%	133	28%	301	2.3	18%	100
Capital & Coast	626	41%	589	94%	1111	1.9	37%	121

PREVALENCE OF MENTAL HEALTH DISORDER

The survey Te Rau Hinengaro (2006), found that 47% of Pacific people had experienced a mental disorder at some stage during their lifetime compared with 39.5% of the overall New Zealand population. Pacific people also had a higher prevalence of any mental disorder in a 12 month period at 24% and 6% of Pacific people experienced a serious disorder.[2] But they are less likely to make a mental health visit to a health service, 7.8% of Pacific had a mental health visit compared to 13% of Other ethnicities excluding Maori. Within the 12 months prior to the survey, 5.9% of the Pacific people surveyed had a serious disorder, 11.6% had a moderate disorder and 7.6% had a mild disorder.[3] Suicide is also a risk, with 21% of Pacific people aged 16–24 and 20% of Pacific people aged 25–44 reported suicidal ideation over their lifetime. A suicide attempt within their lifetime was reported by 4.8% (almost 1 in 20) of Pacific people.

PRIMARY MENTAL HEALTH

Primary Mental Health is provide[d] by [GP]s and other community services [for] peop[le] with mild to moderate mental health issu[es]. Capital & Coast services saw 363 [people] in the 2018/19, Hutt Valley services [saw] 304 Pacific people and Wairarapa serv[ices] saw [less] than 5 people.

Pacific people seen by Primary Mental Health Services in 2018/19 year			
	Wairarapa	Hutt Valley	Capital & Coast
Youth: 12 - 19 years	<5	31	70
Adults: 20+ years	0	1[illegible]	293
Total	**<5**	**304**	**363**
% of total people seen by servic[es]	0.1	6.6%	7.4%
% of DHB Pacif[ic] population	[illegible]	2.6%	1.6%

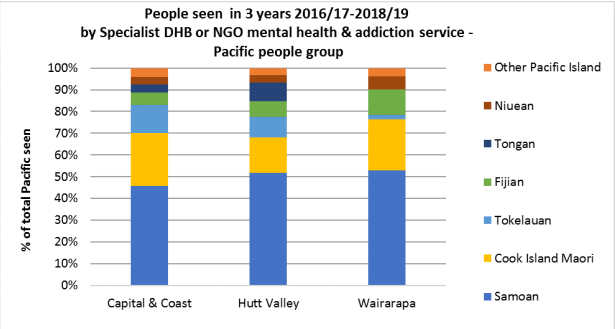
SPE[CIALIST] MENTAL HEALTH SERVICES

Specialist Mental Health services are targeted at peo[ple] with serious mental health issues. They are provided by DHB and NGO services. Services include acute inpatient services, community services and rehabilitation services for addiction. In Capital & Coast, 811 Pacific people (3.6% of the population) were seen by any specialist mental health and addiction service in the three DHBs in 2018/19. For the Hutt population, 419 Pacific people (3.5%) were seen and 45 Pacific people (4.8%) from the Wairarapa.

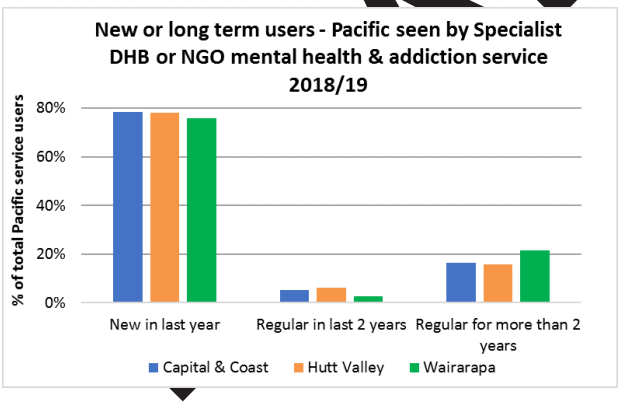
Pacific people seen by Specialist DHB & NGO Mental Health Services in 3DHBs 2018/19			
	Wairarapa	Hutt Valley	Capital & Coast
0 - 19 years	266	101	9
20 - 64 years	526	307	33
65+ years	19	11	3
Total	**811**	**419**	**45**
% of DHB Pacific population	3.6%	3.5%	4.8%

2. https://www.health.govt.nz/system/files/documents/publications/mental-health-survey-2006-aggregated-prevalence.pdf
3. https://www.health.govt.nz/system/files/documents/publications/mental-health-survey-2006-pacific-people.pdf

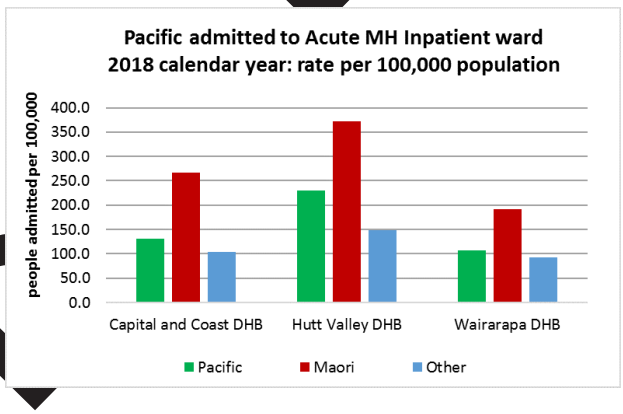
Most of the Pacific people seen in the 3 years 2016/17 to 2018/19 by Specialist Mental Health and Addiction services were Samoan or Cook Island Maori.



In 2018/19, most Pacific people were new having only been seen in the last 12 months by Specialist Mental Health and Addiction services. Pacific people who were long-term users seen regularly for more than 2 years made up 16% of Pacific service users in Hutt Valley and Capital & Coast and 22% of Wairarapa Pacific service users.



Only a small number of service users were admitted to an acute Mental Health inpatient ward, 4% of Capital & Coast Pacific service users were admitted in 2018, 6% of Hutt Valley service users and 2% of Wairarapa. Pacific people had a higher rate of admission to an inpatient ward than people of other ethnicities excluding Maori.



LONG TERM CONDITIONS

Cardiovascular disease

For those enrolled with Compass Wairarapa PHO, 24 Pacific people or 3% of enrolled Pacific people had a diagnosed cardiovascular condition which is lower than proportion in the total PHO population with a diagnosed cardiovascular condition. Another 42 Pacific people have been assessed as having a high risk of cardiovascular disease.

For those enrolled with Te Awakairangi Health Network, 420 Pacific people or 4% of enrolled Pacific people had a diagnosed cardiovascular condition. Another 732 Pacific people have been assessed as having a high risk of cardiovascular disease or 7% of the enrolled Pacific population.

People diagnosed with Cardiovascular disease or assessed as high risk as at September 2019			
	Wairarapa	Hutt Valley	Capital & Coast
0 - 19 years	266	101	9
20 - 64 years	526	307	33
65+ years	19	11	3
Total	**811**	**419**	**45**
% of DHB Pacific population	3.6%	3.5%	4.8%

Diabetes

As at June 2018/19, there were 2,254 Capital & Coast Pacific (10%) diagnosed with diabetes, 1,118 Hutt Pacific (9%) and [illegible] Wairarapa Pacific people (6%). For more than half Wairarapa Pacific people with diabetes (58%) their condition was well managed with their HbA1c levels less than 65 mmol. For Capital & Coast Pacific, 49% had results indicating their condition was well managed and 44% Hutt Pacific.

People with diabetes as at June 2018/19

	Pacific people with diabetes (PHO data)	% of total enrolled population		Well managed condition: % HbA1c < 64mmol	
		Pacific	Total	Pacific	Other (non Maori non Pacific)
Capital & Coast	2,254	10%	4%	49%	67%
Hutt Valley	1,118	9%	5%	44%	63%
Wairarapa	5[illegible]	6%	5%	58%	68%

Produced in May 2020
by Hutt Valley District Health Board
Designed by Siobhan Murphy

Board Discussion – Public

July 2020

Taurite Ora – Second Report, Update from December 2019	
Action Required **Capital and Coast District Health Board to note:** (a) The progress to date. (b) That we will be prioritising foundational activities crucial to the success of Taurite Ora that have not progressed in the last five months due to COVID-19.	
Strategic Alignment	Taurite Ora aligns with the CCDHB Health System Plan 2030
Author	Arawhetu Gray, Executive Director Māori Health
Endorsed by	Fionnagh Dougan, Chief Executive
Presented by	Arawhetu Gray, Executive Director Māori Health
Purpose	Update on the ongoing progress to implement Taurite Ora
Contributors	Jeanette Harris, Project Manager, Māori Health
Consultation	N/A

Executive Summary

The Taurite Ora was officially launched in November 2019 at Maraeroa Marae, Waitangirua. Before the launch, a Project Manager was appointed to deliver on the action plan, which is at the heart of the Strategy. The action plan identifies the following three strategic priorities and two priority service areas:

Taurite Ora action plan also identifies five key measures of equity. These measures are linked to the pro-equity actions with the overall aim of reducing avoidable, inequitable outcomes for Māori:

1. Amenable mortality.

2. Avoidable hospital admission.
3. Accessible appointments.
4. Primary care utilisation (both enrolment and engagement).
5. Community-based services.

The proposition is that success across the strategy and the action plan will become visible in our hospital and community services. Mental Health, Addictions and Intellectual Disability services (MHAIDs) and Mother, Child and Youth (MCY) are service areas where data unequivocally demonstrates that inequitable outcomes for Māori are the norm. By initially focusing on these two areas, we believe that we can make a significant impact on the health outcomes that Māori experience at CCDHB.

Taurite Ora needs sustainable resourcing to continue. Short term, this means that the working group arrangement, agreed by ELG in December 2019 has to proceed as soon as possible. The Equity paper approved by ELG will be progressed to ELT and HSC so that the principles and goals it recommends can be operationalised. Our next report will update you on our success in attracting resources and our progress in delivering against Taurite Ora itself.

Strategic Considerations

Service	Taurite Ora is designed to impact across all levels of CCDHB.
People	Secondment of staff from across the organisation has been agreed.
Financial	Two to three year implementation cost is estimated at $0.5M
Governance	An Equity Leadership Group has been established however, the establishment of a Taurite Ora Governance Group is an outstanding action.

Engagement/Consultation

Patient/Family	None
Clinician/Staff	Clinical Leaders including CMO, Chief Nursing Officer. Members of the Executive Leadership Team.
Community	Taurite Ora was widely consulted and has been endorsed by CCDHB Board and the Māori Partnership Board. Consultation was also undertaken with Kaupapa Māori Providers, Māori academics, and clinicians.

Identified Risks

Risk register for Project Management and an individual register for Outcome Areas will be developed by the Māori Health working group.

Attachment/s

1. Taurite Ora Action Plan (Year One Activities)

1. BACKGROUND/PREVIOUS BOARD DISCUSSION

1.1 A Taurite Ora update was provided to the Māori Partnership Board on 4 December 2019.

1.2 CCDHB began a Change Programme in late 2019. The people and other resources required to undertake the project were drawn from the same pool of resources that Taurite Ora is drawing on. Projects that fundamentally affect our staff have been prioritised and the delay to progress on Taurite Ora from this perspective was inevitable. COVID-19 has also impacted our progress, with the lockdown requiring staff to stay at home or to prioritise COVID-19 related work.

1.3 Work began on the Taurite Ora action plan before the official launch. This involved identifying work streams that could start immediately and reaching agreement with project leads about what we would achieve in the first 12 months.

2. CURRENT STATE

2.1 Since 4 December 2019, then there has been some progress, but overall, the Project has stalled.

2.2 We have not appointed a Governance Group for Taurite Ora, to oversee the implementation of the Action Plan. Noted later in this paper, an Equity leadership Group (ELG) has been convened by the Māori Health Directorate to lead the Equity actions in strategic priority one.

2.3 Given the organisational change work is progressing across parts of CCDHB, and we have moved to response level 1 in relation to COVID-19, we look forward to a renewed focus on Taurite Ora.

Current resources

2.4 The Executive Director Māori Health (EDMH) has appointed a full-time Project Manager to oversee the implementation of Taurite Ora.

2.5 A lead advisor has been engaged to begin the first phase of Taurite Ora. This role is focused on the development of a single Equity goal and additionally developing a set of guiding equity principles for CCDHB.

2.6 Equity in this context is broader than Taurite Ora and will include equity for groups such as Pacific and disability. Therefore, while the Māori Directorate completed the initial work, responsibility for delivering on this part of the project will return to the Director Strategy, Planning and Performance.

2.7 The EDMH has given Taurite Ora project responsibilities to the Manager, Māori Health, Capability and Manager Accountability, to progress.

2.8 Maternal, child and youth have assigned a 0.5 project manager responsible for delivering on Taurite Ora from the permanent staff team.

2.9 Mental Health, Addictions and Intellectual Disabilities (MHAIDs) has nominated a project manager from its permanent staff to lead Taurite Ora and are finalising the initiation plans for each.

Ongoing commitment to Taurite Ora

2.10 At the ELG meeting in December 2019 it was agreed that a working group from key areas/disciplines including Maori, Pacific, Disability, Clinical, and the Provider arm, Human Resources / Organisational Development/People & Capability needed to be included inthe project.

2.11 It is likely that the same staff will continue to work on Taurite Ora projects as part of their business as usual for a period of 12 – 18 months. Without this commitment progress on Taurite Ora inside the DHB is hindered.

3. SUMMARY OF ACTION PLAN PROGRESS

3.1 There are 91 activities and a similar number of sub-activities in the Taurite Ora Action Plan. A table in Appendix One provides the current state of play for first year activities.

3.2 The scale and complexity of the Action Plan has been addressed by breaking it into three tranches:

- Actions that are high priority in year one.
- Actions that are a lower priority in year one.
- Actions that will start in years 2 - 4.

3.3 This year we will also re-engage with Flax Analytics to strengthen the measurement framework in the action plan. Their work will be prioritised to align with the tranches we have identified.

Strategic projects and Service area projects

3.4 The actions set out in Strategic Priority one in particular, and to a lesser extent, Priority two, spell out the conditions necessary for CCDHB to become a pro-equity organisation. Many of these activities are to be finished in year one in order for some other actions to be undertaken.

3.5 For public-facing communications, the Maternal, Child and Youth work stream includes a requirement that CCDHB should apply an equity lens to its Maternity Quality Safety Programme.

3.6 The attached status report is abbreviated to the following: Action required; Completed; On-track or at Start-up. There are also projects in the MHAIDS work stream that we are reviewing in terms of scope. These will be updated in our next report.

Detailed updates on Action Plan Priorities, Outcomes and Outputs

3.7 These activities have stalled and have slowed progress across other activities as a result.

Strategic Priority 1: Outcome 1, Output 2 – Commit to a pro-equity programme of work

3.8 STATUS: In Progress

3.9 This activity describes the environmental changes CCDHB must adopt to become a pro-equity organisation.

3.10 A paper setting out Principles and a high-level Equity goal is under-going consultation with the Māori, Pacific and Disability teams. Once complete this will be provided to ELT and then to the Health System Committee (HSC).

3.11 The actions needed to complete this activity were agreed at the last meeting of the Equity Leadership Group (ELG) on 19 December 2019 and are outlined below.

- Paper to ELT and Health System Committee (HSC)
- Working group nominated by ELG members convened
- Consumer Rep for ELG nominated

3.12 Following the completion of this action, the next steps are the appointment of a working group nominated from the ELG service areas to develop the operational framework that translates principles into policies and practice guidelines. We also need to re-engage with the Project Lead and confirm his availability to continue the project.

Strategic Priority 1: Outcomes 1, outputs 3 – 6

3.13 STATUS: Pending

3.14 These activities describe changes to the key performance indicators at management and clinical leadership level.

3.15 New indicators at this level will leverage off the messages and language developed in Output 2 above. When appropriate resources are made available, a working group will be established to begin further work.

Strategic Priority 1: Outcome 4, output 1 – Implement an improvement programme to ensure CCDHB has high quality, complete and consistent ethnicity data for performance, monitoring and workforce development

3.16 STATUS: Pending

3.17 The actions to complete this activity mean changing the way we collect ethnicity data from our staff in the future so that we can target equity issues across the workforce.

3.18 A clear rationale showing if, and how, the activity will achieve the goal of a strong Māori health workforce is needed before we progress. The action required is to develop indicators measuring the cost/benefit of 'gold standard' ethnicity data compared to current data collection to measure its true value.

Strategic Priority 2: CCDHB will support a workforce equipped to improve Māori health – Outcome 1, output 1 – ***set core competencies and expectation for all staff to achieve health equity and improve Māori health outcomes***

3.19 STATUS: Progressing

Strategic Priority 3: Strengthen our commissioned services – Outcome 1, output 1 – ***the EDMH and EDSPP will develop a work plan that phases all of the actions that are led by SPP.***

3.20 STATUS: Progressing

Service focus area 1: Maternal, child & youth – Outcome 1, output 1 – ***CCDHB applies an equity lens to its MQSP work programme.***

3.21 STATUS: Progressing

Board Discussion – Public

June 2020

Māori Health Team Te Pae Amorangi Update	
Action Required **Hutt Valley District Health Board note:** (a) The progress to date. (b) A review of the previous implementation plans is being undertaken to define areas where action is required and further develop the areas that have note progressed. (c) The information in the attachments.	
Strategic Alignment	Te Pae Amorangi, Our Vision for Change
Author	Kerry Dougall, Director Māori Health
Endorsed by	Fionnagh Dougan, Chief Executive
Presented by	Kerry Dougall, Director Māori Health
Purpose	Update on the implementation of Te Pae Amorangi from a Māori health team perspective. Highlight the organisational and reputational risks to the Hutt Valley DHB
Contributors	Carrie Maniapoto, Māori workforce Development Coordinator Rawiri Hirini, Pou Tikanga Elizabeth Lucie-Smith, Manager Health Intelligence & Decision Support
Consultation	N/A

Executive Summary

This report provides an update for the HVDHB board in relation to the implementation of Te Pae Amorangi.

Strategic Considerations

Service	The HVDHB environment and culture will be improved as a result of this work.
People	Staff will have greater access to resources and services to support their own growth and development and to support their teams.
Financial	Inequitable Māori health outcomes have a direct impact on the financial performance of the DHB. Te Pae Amorangi is a strategic enabler to provide long term cost savings.
Governance	Māori health expertise needs to be strengthened at every level of the system to create the sustainable change which will impact outcomes.

Engagement/Consultation

Patient/Whanau	Targeted involvement with Māori whanau occurs through the Māori health teams
Clinician/Staff	Ongoing involvement with a wide range of staff
Community	Ongoing active relationships and engagement with Māori communities and leaders

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
	Māori Health Equity is under prioritised	HVDHB Board ELT	We have completed a Bowtie risk assessment to identify risks and mitigation strategies		

Attachment/s

1. Māori Health Data Dashboard
2. COVID-19 Māori Health Action Plan

1. BACKGROUND

Te Pae Amorangi was launched in July 2019 to support culture and system change, with a focus on achieving improved Māori health outcomes within nine years.

Te Pae Amorangi explicitly builds on the principles for decision-making provided in *Our Vision for Change*. We know that how we deliver health services has a big impact on health outcomes and so we will look at how we invest, how we work in partnership with and across our communities, and how we engage across the sector.

For the next nine years we will focus our efforts and investments in five key focus areas, including:

- Workforce
- Organisational Development and Cultural Safety
- Commissioning
- Mental Health and Addictions
- First Thousand Days

By identifying and investing in these focus areas we will challenge the 'status quo' and redefine the long standing 'cultural norms' of our organisation that no longer support us to achieve our goals.

2 TE PAE AMORANGI HUTT VALLEY DHB MĀORI HEALTH STRATEGY

2.1 Te Pae Aronga Tuatahi – Increasing Our Māori Workforce across the System

2.1.1 Hutt Valley DHB collaborates with Career force

Career force is dedicated to assisting young people into a career in the health & wellbeing, and social & community sectors. Their Gateway Programme is a work placement initiative for senior school students (Year 11 to 13) funded by the Tertiary Education Commission.

Hutt Valley DHB are piloting a work placement from Hutt Valley High School, a young wahine Māori who has a desire to be a nurse. The aim is to take our learnings from the pilot and improve our internal processes so we can commit to a schedule of work placements in 2021, with Māori and Pacific students taking priority to reflect our commitment to a workforce that reflects our population.

The programme is aimed at introducing students to a variety of career options and providing them with an opportunity to access workplace learning. Students' learning is assessed in the workplace and they can achieve credits on the New Zealand Qualifications Framework (NZQF) towards their National Certificate of Educational Achievement (NCEA).

Our pilot student will start in July 2020 with 10 days of work experience over 10 weeks.

2.1.2 Tuakana Teina Māori Leadership Model Launch

Utilising Matariki as a platform for launching this new Māori workforce initiative, we launched our Tuakana Teina programme on 14 July. Bringing together Māori workforce from across all disciplines

to celebrate the New Year ahead and plan for mobilising our people. This new initiative focuses on growth and development from a Te Ao Māori perspective for all Māori staff across the DHB.

Our Māori Workforce Development Co-ordinator has worked with a wide range of stakeholders to develop and implement a leadership development program focused on the growth and sustainability of Māori, incorporating Te Ao Māori worldviews on a wide range of topics including

- Rangatiratanga
- Kawangatanga
- Tikanga
- Kaiako and Tauira

There were 35 staff in attendance from across the disciplines, and the plan is to increase the momentum, mobilise Māori participation and support the Māori workforce to thrive. Over the coming year, events have been planned to grow this initiative, including deeper connections with Māori across the community.

2.1.3 Pipeline for Rangatahi Māori

We are partnering with Tihei Rangatahi, a Kaupapa Māori Youth Hub in Wainuiomata to identify opportunities to develop a health workforce focus for young Māori. We have deliberately focused this in Wainuiomata as this is the only area that has a Kaupapa Māori youth hub, and they already have a range of options developed. We are working with them to identify the value add across the community with the range of initiatives on offer for Māori. This includes

- Hutt Sciences in schools
- Māori and Pacific focused whanau hui through schools
- Tihei Rangatahi education events

We are also preparing HVDHB Tuakana Teina model to offer this as a program to all years 11, 12 and 13 rangatahi Māori across the Hutt Valley, launching in February 2021.

They will be offered kanohi ki te kanohi with a health professional working in their area of interest to:

- Seek assistance with career pathway planning
- Receive advice and real life experience that cannot be given in a brochure
- Bring along their whanau as their whanau will be their key support system while they are studying
- Ask any questions that are relevant to them and their future dreams.

2.1.4 Pro Māori equity recruitment processes

A small working group to drive a collective approach across the two DHBs has been developed. Scope and explicit actions/outcomes have been defined. While there is still much work to be done in this area some small wins that we can celebrate are:

- All Hutt Valley DHB roles are now advertised using Te Reo Māori translations for the role title
- All Hutt Valley DHB roles will now be advertised using a kowhaiwhai unique and distinct to Hutt and Capital and Coast DHBs

- When applying for a role at Hutt Valley DHB choosing an ethnicity is now mandatory, and not optional as it has been in the past.

The project team is working through the wide list of commitments made by the 20 DHB CEOs and Te Tumu Whakarae. As 2DHBs we are behind on the reporting requirements and are working through how to collect this information from our current systems, as well as how we develop training specific to hiring managers.

2.2 TE PAE ARONGA TUARUA – ORGANISATIONAL DEVELOPMENT AND CULTURAL SAFETY

2.2.1 Te Kawa whakaruruhau – Māori Cultural Safety Training

As an agency of the Crown and under the auspices of Te Tiriti o Waitangi we have an obligation to protect the health of Māori and we have an opportunity to be an active partner in supporting their right to healthcare and a health system that is fair, adequate and appropriate.

Our aspiration is that everyone who works with and for us will be culturally safe, highly skilled and knowledgeable around Māori health, equity and our local community needs. We will implement training that ensures all DHB employees are responsive to whānau Māori and understand the ongoing impacts of colonisation and its effects on health status. Most importantly employees will know and understand how they can contribute to a more equitable environment.

Te Kawa Whakaruruhau is posited within a Māori pedagogy and seeks to take the best of both the Māori and Pākehā worlds and combine them to produce an interesting and thought-provoking training programme for HVDHB staff and employees.

In response to Te Pae Amorangi, Our Vision for Change and the current shift in the health sector we will deliver training to all staff and employees of HVDHB in order to support and lift the competence and awareness of tikanga Māori practices by designing, developing and delivering Māori cultural safety training for the HVDHB workforce. Alongside this the Māori Health Team will also provide advice and guidance, where applicable, to HVDHB staff, leaders, managers and board members with a view to addressing health inequities for Māori.

We are indebted to the ground-breaking PhD dissertation “Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu.” and the ongoing Treaty work of Irihapeti Ramsden and others who have laid the foundation for us to strive even further.

The key objectives over the next 12 months are to:

- Launch the first of a suite of training modules consistent with tikanga Māori for delivery across all vocations within HVDHB. The launch date is set for Monday 27th July during HVDHB pōwhiri and orientation process.
- Define and develop a clear suite of options which include an online presence, face to face, shorter or longer, internal or external and marae based modalities.
- Deliver and evaluate the effectiveness of training for HVDHB employees.
- Design and implement key measures for equity, including key performance Indicators and policy or procedural changes where necessary in order to compliment training outcomes.
- Lift the awareness amoungst HVDHB staff of local history, New Zealand history, marae kawa, kōrero tawhito and te reo me ōna tikanga

2.2.2 Bilingual Signage Project

The Project ownership sits within property, and has not made any gains or progress forward. From a Māori Health team perspective we are developing a principle framework to ensure the active practice of the Treaty principles are maintained throughout any initiatives. And are working through how we enable all departments and services across the HVDHB to be active within their space.

We continue to work with the Project owners to support this and the focus will be on starting with the entrance ways, utilising Waharoa as a visual and wairua driven presences.

2.3 TE PAE ARONGA TUATORU – COMMISSIONING

2.3.1 Whānau Ora Partnership

1. Alongside the Strategy, Planning and Outcomes team, we are currently working with our two whanau ora providers to review their service specifications and reporting frameworks to support the ongoing development of partnerships and outcomes that are relevant to their communities.

2.3.2 Māori Leadership Engagement Framework

2. Through COVID we developed a Māori leadership alliance to work in partnership with our Māori communities to stop the transmission of COVID. From a longer term perspective this group is vital to a sustained approach to overarching service delivery.

2.3.3 Māori Health Dashboard

3. We are developing this alongside HVDHB Business Intelligence managers to inform the work we do across the system and to be transparent and accountability for the areas that need to improve for Māori health.

2.4 TE PAE ARONGA TUAWHĀ – MENTAL HEALTH AND ADDICTIONS – SCOPING PROJECT

2.4.1 Hutt Valley DHB Kaupapa Māori Mental Health Services

4. The purpose of this project is to scope the establishment of Kaupapa Māori mental health and addiction services for the Hutt Valley District Health Board (DHB) region. This will support the implementation of Te Pae Amorangi, Hutt Valley DHB Māori Health Strategy 2018-2027.[1]

   The approach will be implemented using Kaupapa Māori principles, with a strong focus on engaging early with Tangata Tiriti partners that will include, mana whenua, Māori NGO community providers, and key stakeholders, DHB mental health services, whanau and tangata whaiora and other groups identified along the progress of the project. This will ensure that there is a strong community and whanau voice incorporated throughout the project. While also identifying and forming key partnerships that will go on to support the establishment of the service.

   A literature review will be conducted to provide guidance on best practice models of care for Kaupapa Māori mental health and addiction services. Along with consultation with Kaupapa

Māori mental health and addiction services provided nationally to review, build on and adapt models currently used.

A report will then be produced that will provide a set of recommendations to develop and establish a Kaupapa Māori mental health and addictions service for the Hutt Valley region. This will include recommendations for governance, geographical location of the service, skill mix composition, model of care, and recommended quality measures.

The establishment of the service is not within the scope of this project and will be decided at the next phase.

2.5 TE PAE ARONGA TUARIMA – FIRST 1,000 DAYS

5. No specific updates in this area due to workforce shortages within Māori health

3. MĀORI HEALTH UNIT OPERATIONAL WORK

3.1 COVID19 Māori Health Actions

Eliminating health inequities for Māori and their whānau is fundamental to achieving our visions In Te Pae Amorangi. The inequities experienced by Māori who come into contact with our health system are well documented and are widely known across the health system.

The health system is tasked with ensuring that Māori are not left behind during this response and the government has given a clear message of its intention to address the inequities in the health system, particularly in its response to the findings of the Waitangi Tribunal in Stage one of the Wai 2575, the Health Services and Outcomes Inquiry.

We must be proactive to ensure we prioritise and focus on equitable outcomes for Māori and others who have higher vulnerabilities, including Pacific peoples and those living with disabilities.

Clearly, our context has evolved over the past 100 years, but as Wai 2575 highlights, the significant inequities for Māori continue. These two factors are driving iwi, hapu, whānau and the health system to ensure that Māori responses are focused on throughout the COVID-19 response.

Embedding equity for Māori and the principles of Te Tiriti as a structuring framework for all COVID-19 decision-making is critical to ensuring that existing inequitable outcomes are not exacerbated; tangata whenua are actively protected; and the injustices wrought by previous pandemics in Aotearoa are not repeated.

To achieve this we developed a COVID-19 Māori Response Action Plan which outlines the following objectives that are inspired by *Te Pae Amorangi.*

- We will work to advance our Treaty relationships with mana whenua, iwi and Māori.
- We will promote and lead cross-sectorial approaches to support the holistic wellness of whānau.
- Culturally safe service provision is a key component of HVDHB practices for whānau and staff.
- We will champion Māori health equity to ensure it is woven through everything we do, including our policies, practices, norms and organisational culture.
- We will champion the collection, analysis and use of robust data.

Included as appendices is the Māori health Action Plan for HVDHB.

MĀORI HEALTH ACTIONS

This section consists of actions specific to supporting whānau, hapū, iwi and Māori communities, this includes Māori providers and organisations. This is in addition to actions and investment already underway in the broader health system response to COVID-19. This is not an exhaustive list of actions – it is expected this list will grow as Māori-specific actions are identified across other work streams.

Action	Lead	Key Partners	Date	Te Ao Hou (Business as Usual)
Advance Treaty relationships with mana whenua, iwi and Māori				
Established a Māori Providers Leadership Rōpū in the Hutt Valley to connect organisations, share ideas and resources to best support our whānau in need. HVDHB provide assistance and support on the government's response to COVID-19, including leading discussions around the development and delivery of COVID-19 response strategies. Developed commissioning proposals with Māori Providers to access Ministry of Health funding to: - Provide financial support for whānau to eliminate barriers to health care, including payments for prescriptions and health services - Provide continuity of care to kuia and koroua – to keep our kaumātua healthy and well	Director, Māori Health	Kōkiri Marae Hauroa and Social Services Tū Kotahi Māori Asthma Trust Te Runanganui o Te Atiawa Te Paepae Arahi Kahungunu Whānau Services	Rōpū established on 24 March 2020 Accessed on 6 and 7 April 2020	Incorporated in to Te Ao Hou. But frequency has lessened.
Facilitate the development of the terms of engagement between the Māori Providers, HVDHB Māori Partnership Board and HVDHB	Director, Māori Health	Kōkiri Marae Hauroa and Social Services Tū Kotahi Māori Asthma Trust Te Runanganui o Te Atiawa Te Paepae Arahi Kahungunu Whānau Services Māori Partnership Board	Discussions begun on 24 April 2020 Agreement confirmed on 19 April 2020	Incorporated in to Te Ao Hou.
Champion Māori led innovation through all aspects of the system, including design, policy and procedures	Director, Māori Health Director, Strategy, Planning and Performance	Executive Leadership	From 20 March 2020	Incorporated in to Te Ao Hou.
Champion Māori led partnerships and innovation to develop and deliver a Maori focused Flu Vax campaign across the whole of the Hutt Valley	Director, Māori Health	Kokiri Marae Hauora and Social Services Waihetu Medical Centre Whai Oranga Health Service Hutt Union Health Service	From 27 April 2020	Incorporated in to Te Ao Hou.

		Regional Public Health Te Awa Kairangi Health Network		
Cross-sectorial approaches to support the holistic hauora of whānau				
Develop whānau friendly resources for HVDHB whānau to assist with tangihanga during the lockdown period and ensure key messages from the Ministry of Health are maintained throughout all levels of COVID-19	Director, Māori Health	Māori Health	Developed on 1, 14 and 30 April, with further resources to be developed once the alert levels change	
Identify and connect with funeral homes in the Hutt Valley to maintain a relationship and gather key information that is helpful for our whānau in this uncertain time	Māori Health Service Planning And Integration Manager, Strategy Planning & Outcomes	Local funeral homes	Contacted on 1, 2 and 30 April 2020, with a review on 12 May as to further communication	
Work with Police Iwi Liaison to ensure partnership approaches are developed to support seamless tangihanga	Director, Māori Health	Iwi Liaison Officers	From 25th March 2020	
Deliver Te Ao Māori information and resources to local Kohanga, Medical Centres, Community houses, Marae and Providers	Director, Māori Health	Māori Health	16-27 March 2020 – Hardcopy resources delivered Tuesday and Thursday every week electronic resources sent	
Develop a network of community providers to send out regular communications to build and maintain contact and keep the community up to date	Māori Health		From 20 March 2020	Incorporated in to Te Ao Hou.
Work with Māori providers to ensure access to Personal Protective Equipment (PPE). This includes providing support and clarification around the appropriate PPE to be worn in specific situations	Director, Māori Health	Kōkiri Marae Hauroa and Social Services Tū Kotahi Māori Asthma Trust Te Runanganui o Te Atiawa Te Paepae Arahi Kahungunu Whānau Services	From 20 March 2020	
Champion Māori provider access to HVDHB workforce to support needs in community	Director, Māori Health		From 25 March 2020	
Champion Māori health equity ensuring it is front and centre through everything we do, including our policies, practices, norms and organisational culture				
Lead discussions to develop targeted Whānau Ora based approaches for Community Based Assessment Centres (CBAC) with high Māori populations	Director, Māori Health	Kokiri Marae Hauora and Social Services Waihetu Medical Centre Whai Oranga Health Service Hutt Union Health Service Regional Public Health Te Awa Kairangi Health Network	Initiated discussions on 4 April 2020 CBAC up and running 9th April Continue to evolve whanau ora model	

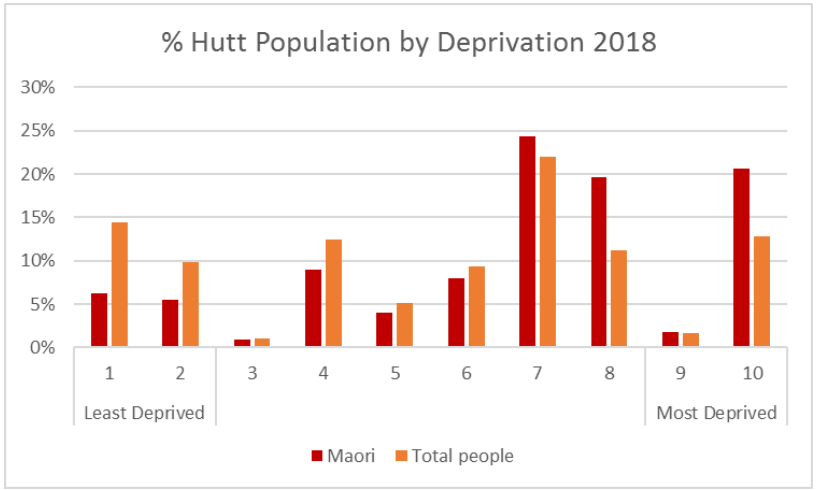
Lead discussions with IMT and Executive Leadership teams regarding Tangihanga, Immunisation prioritisation, kaumātua support, ethnicity data	Director, Māori Health	Executive Leadership	Ongoing	Incorporated in to Te Ao Hou.
Develop a Māori and Equity focus framework utilising the HEAT tool for the Incident Management Team (ITM)	Director, Māori Health		4 April 2020	Incorporated in to Te Ao Hou.
Culturally safe service provision is a key component of HVDHB practices for whānau and staff				
Re-developed the Māori Health Unit's model of care to provide 24/7 access to provide support to whānau	Director, Māori Health		Discussions begun 24 March 2020 once Level 4 was announced. Implemented from 26 March 2020, the first day of Level 4 lockdown	Incorporated in to Te Ao Hou.
Support Māori doctors with opportunities for engagement with community and cultural safety support process	Director, Māori Health		Ongoing	Incorporated in to Te Ao Hou.
Establishment of virtual General Medical Clinic (Pai Whare Hauora) with the HVDHB Whānau ora network, to discuss the key issues, including: - Access to primary care - Delayed hospital appointments, - Social isolation, advocacy, difficulty gaining access to GP (not enrolled, no established therapeutic relationship with GP).	Director, Māori Health		27 March 2020	Incorporated in to Te Ao Hou.
Champion the re-development of the HVDHB visitors policy to include support for Kaumatua	Director, Māori Health	Executive Leadership	29 March 2020	
Provision of karakia through the ward TV's to support whānau during the rahui	Director, Māori Health	Executive Leadership	30 March 2020	Incorporated in to Te Ao Hou.
Development and dissemination of Te Ao Māori resources to support hauora of whānau	Director, Māori Health		From 19 March 2020	
Develop e-card to communicate with whanau in hospital	Director, Māori Health		25 March 2020	Incorporated in to Te Ao Hou.
Development of mortuary viewing policy in all levels to support tikanga and Te Ao Māori practices	Director, Māori Health	Executive Leadership	25 March 2020	
We will champion the collection and analysis of robust data				
Lead the discussions around the collection of data during COVID-19, including: - those who are being turned away from the hospital, - cancellations of surgeries and all other changes to the work programme that have an effect on our Māori communities	Director, Māori Health	Executive Leadership		Incorporated in to Te Ao Hou.

Māori Population Overview

26,184 Māori live in Hutt Valley.

17% of Hutt Valley people are Māori
15% of New Zealand are Māori

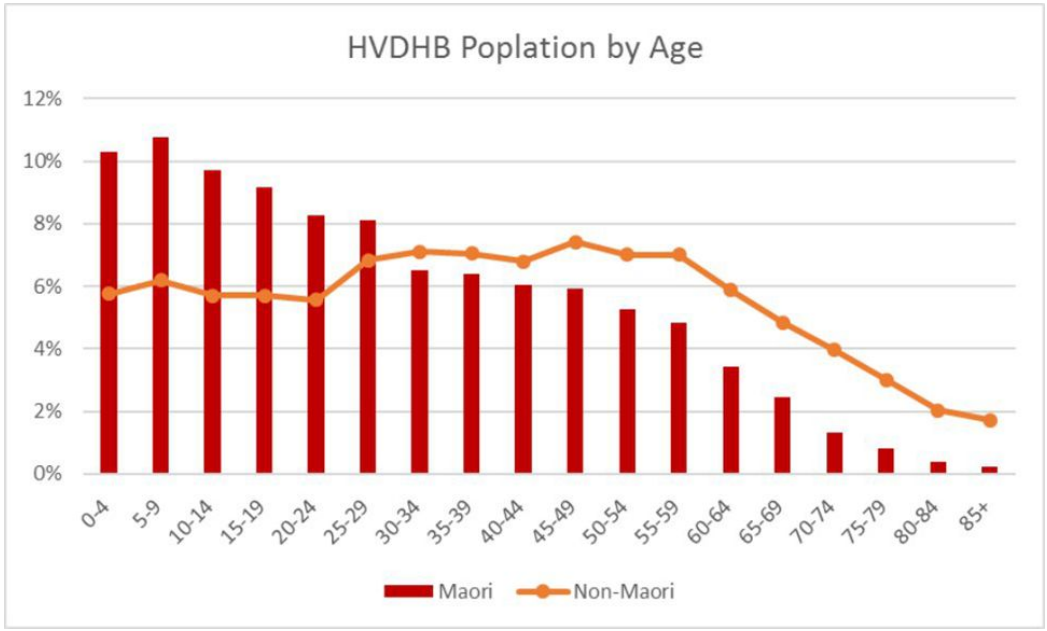
23% of Māori live in the most deprived areas compared to 15% of all Hutt residents



Māori by age

Māori are very young population in Hutt Valley. 48% are under 25 years and 31% are under 15 years.

5% of Māori are aged 65+ compared to 16% Non-Maori aged 65+

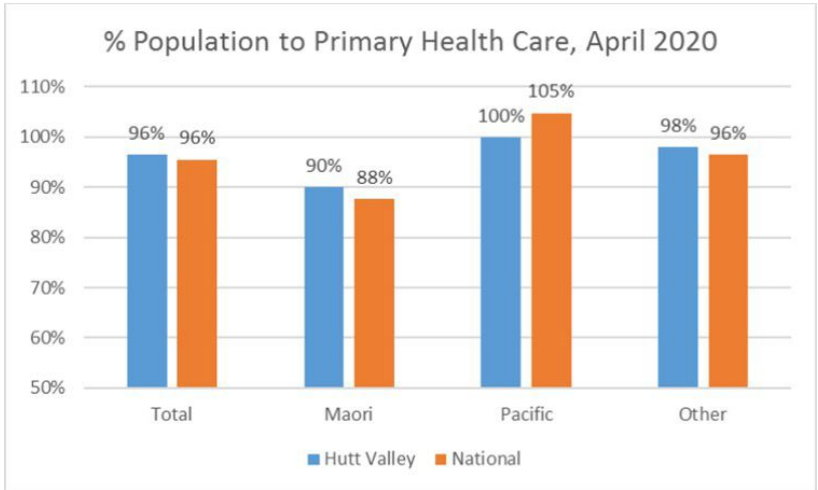


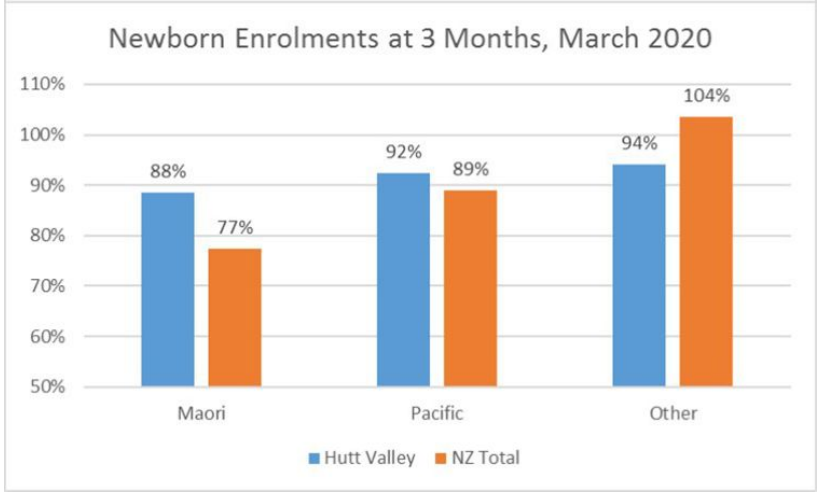
PHO enrolment

90% of Māori have access to primary care in Hutt Valley compared to 91% Nationally. 2,027 are not enrolled

88% new born Māori babies are enrolled with PHO within 3 months of birth in Hutt Valley compared to 77% Nationally.

89.5% new born Māori infants are enrolled with PHO within 12 months of birth in Hutt Valley.

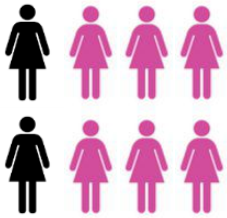




By condition

32% Māori Diabetics aged between 15-74 enrolled in a PHO have well managed diabetes (HbA1c <= 64mmol)

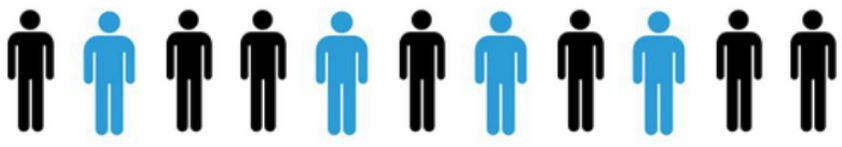
36% Māori enrolled in primary care in Hutt Valley are current smokers.



69% Māori women aged between 25-69 years have had a cervical screening in the last 2 years

69% Māori women aged between 50-69 years have had a breast screening in the last 2 years

Amenable Mortality



Māori are 1.9 times more likely to die from Amenable causes when compared to other ethnicities. 175 deaths per every 1,00,000 people in Hutt Valley.

Life expectancy of Māori Females in the Wellington Region is 78.6 compared to 83.9 for Non-Māori

Life expectancy of Māori Males in the Wellington Region is 74.7 compared to 80.3 for Non-Māori

Top 7 Amenable Mortality Causes 2012-2016			
Hutt Maori		**Hutt Total**	
Coronary disease	24%	**Coronary disease**	25%
Suicide	13%	**COPD**	11%
Diabetes	12%	**Cerebrovascular diseases**	10%
COPD	12%	**Suicide**	9%
Cerebrovascular diseases	8%	**Female breast cancer**	8%
Female breast cancer	7%	**Diabetes**	7%
Land transport accidents excluding trains	6%	**Rectal cancer**	5%
Yearly Average	34	**Yearly Average**	177

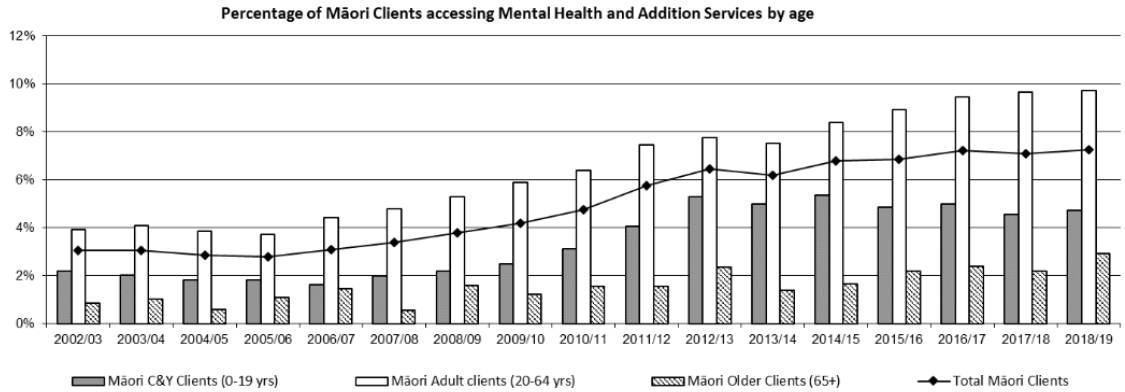
Mental Health

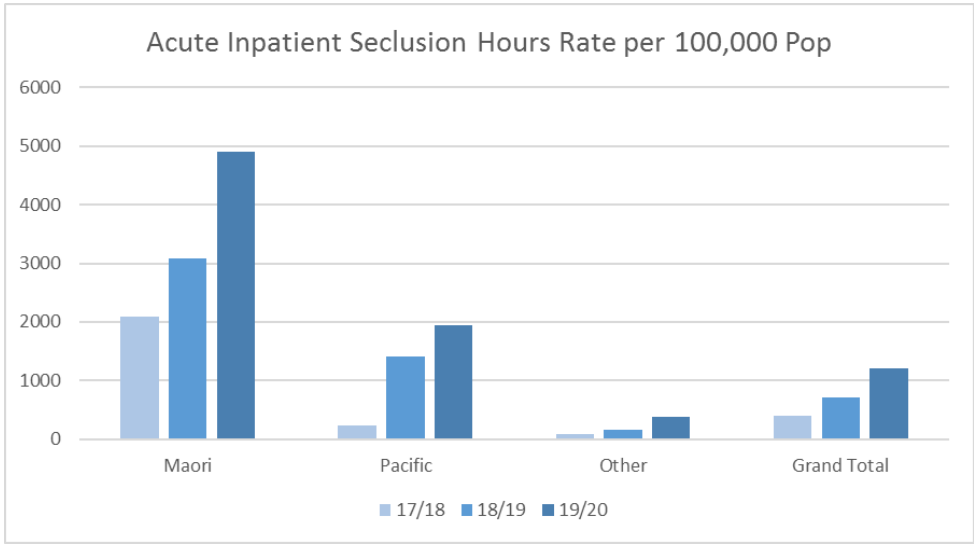
Māori clients (All ages) access to mental health services is 1.3 times higher than other ethnicities.
% Māori C&Y Clients (0-19 yrs) **4.8%**
% Māori Adult clients (20-64 yrs) **9.7%**
% Māori Older Clients (65+) **2.9%**

Māori are 2.1 times likely to have acute inpatient seclusion hours compared to other ethnicities

The Rate of Māori that are under the Mental Health Act is 325 per 100,000 Population, which is 3.1 times higher than Non-Māori

85 Maori are currently under the Act





Child Health

74% Māori women breast feed at 2 weeks
48% Māori women breast feed at 3 months in Hutt Valley as at Sep 2019

- 89.3% of Māori babies who turned 24 months were immunized compared to 86.8% Maori babies nationally as at Q3-1920
- 84% of Māori kids who turned 5 years were immunized , 0.9 times compared to other ethnicities.

74% Māori babies received all WCTO core checks by age 1 as at Dec 2019

44% of Māori babies live in smoke-free households at 6 weeks postnatal period in Hutt Valley.

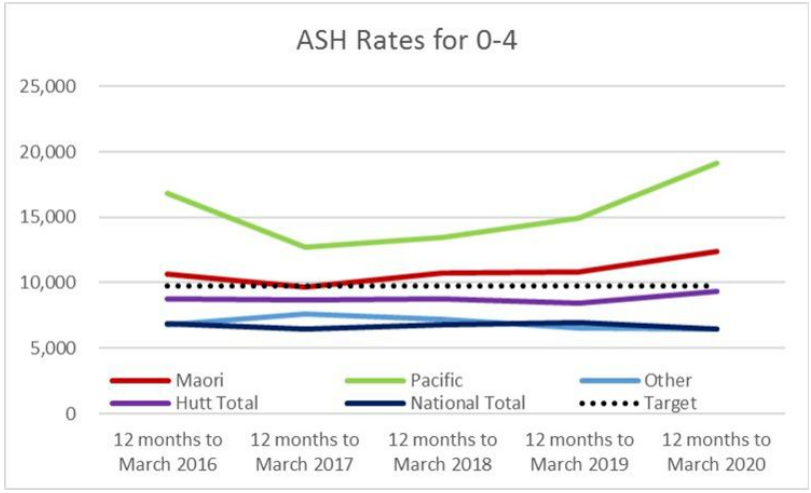
36% of Māori mothers were smokers at the time of giving birth at Hutt Hospital as at May 2020

Child Health

- 52% Māori tamariki under age 5 are caries free compared to 72% from other ethnicities in Hutt Valley as at March 2020
- Māori school year 8 children mean DMTF of 0.81 % which is 1.45 times more compared to other ethnicities

80% of Māori kids have completed their B4School Checks by age 4 compared to 92% other ethnicities.

ASH 0-4 years **Māori** – increase in rate in 2019 mainly due to increase in events for Asthma, U/L-RTI, and gastroenteritis/dehydration



HSC DISCUSSION - Public

July 2020

Rheumatic Fever Prevention Update

Action Required

Health System Committee note:

(a) There has been a high incidence of Rheumatic Fever cases so far this year (9 cases since 1 January 2020), and that all cases were either Māori or Samoan.

(b) Prior to the spike in cases, a review of Rheumatic Fever investment and activity across the two DHBs was underway. The review identified a number of areas for improvement, which are reflected in the 2020 – 2022 2DHB Rheumatic Fever Plan.

(c) Actions are being taken to respond to the increase including communications campaigns, creating more options for access to services and strengthening of monitoring and reporting.

Strategic Alignment	Taurite Ora and Te Pae Amorangi
Author	Rachel Pearce, Acting General Manager, Child, Youth and Localities Dr Craig Thornley, Medical Officer of Health
Endorsed by	Rachel Haggerty, Director, Strategy, Planning and Performance
Presented by	Rachel Pearce, Acting General Manager, Child, Youth and Localities Dr Craig Thornley, Medical Officer of Health
Purpose	Provide an update on the Rheumatic Fever Prevention work programme.
Contributors	Dr Craig Thornley, Medical Officer of Health, Regional Public Health Judi Keegan, System Development Manager, Hutt Valley DHB
Consultation	N/A

Executive Summary

Rheumatic Fever (RF) is an inflammatory disease that can occur after an autoimmune response to an untreated Group A Streptococcal (GAS) infection in susceptible people. A range of environmental, host, and organism factors interact to influence rheumatic fever risk and outcomes, as outlined in Figure 3.

There are nine year-to-date cases of rheumatic fever identified that have all been among Māori and Samoan children and young adults, predominantly living in Porirua and Lower Hutt. There is no known connection between the cases. There has been speculation that the lockdown period led to increased overcrowding in some households which could have contributed to an increase in GAS transmission, and consequently RF. Analysis indicates that for more than half of the nine cases reported in 2020, there was no possibility of a link with the lockdown period due to the timing of their illnesses.

A range of activities have been undertaken to respond to the recent increased incidence of RF in the region including issuing a Public Health Alert, re-issuing an awareness raising campaign and strengthened monitoring and reporting. Additional future work is planned for community outreach and reviewing the effectiveness of existing programmes.

A review of Rheumatic Fever activity across the two DHBs was started prior to COVID-19 Alert Level 4 and is still in progress. It has identified a number of areas for improvement including raising awareness across the community and investment into the Well Homes Programme. MOH has indicated that it will cease funding for the Well Homes Initiative in 2022, placing a high risk on the sustainability of the Well Homes

programme. Early work to consider future options for cross-sectoral working will commence in advance of the expiry of the funding agreement.

Strategic Considerations

Service	While the Rheumatic Fever programme is comprehensive and well resourced, this paper identified a number of opportunities to improve the impact of the programme, particularly for Maori and Pacific.
People	There are minimal implications for DHB staff at this time.
Financial	There are no financial implications – the Rheumatic Fever programme is funding primarily by special purpose, MOH funding (77%) and the remainder by confirmed, ongoing 2DHB baseline funding.
Governance	Oversight and monitoring of the Rheumatic Fever programme is led by the cross-sectoral and inter-sectoral Well Homes / Rheumatic Fever Steering Group. This Group is chaired by a General Practitioner based in Porirua.

Engagement/Consultation

Patient/Family	Not applicable.
Clinician/Staff	Subject matter expertise has been sought, as outlined on page 1.
Community	Primary care and NGO providers have informed the future Rheumatic Fever programme and priorities, but have not been consulted on this paper.

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Description	Control	Current Risk Rating	Projected Risk Rating

Attachment/s

1. Detailed Well Homes Referral Information – 2019/20

1. BACKGROUND

1.1 Rheumatic Fever (RF) is a serious but preventable illness

RF is an inflammatory disease that can occur after an autoimmune response to an untreated Group A Streptococcal (GAS) infection in susceptible people. Up to 3% of untreated GAS infections can lead to RF. RF affects the heart, joints, brain and skin, and although most of the symptoms of RF disappear on their own, the inflammation of the heart valves can cause scarring, leading to rheumatic heart disease.

RF is a notifiable disease. Health practitioners must report any patients that they have 'reasonable suspicion' of RF to the medical officer of health.

1.2 Māori and Pacific Children are Inequitably Affected

Māori and Pacific children are overrepresented in RF incidence. This is largely due to inequitable socioeconomic and housing conditions, and differing opportunities for appropriate and effective healthcare.

There has been an approximately 37% reduction in RF cases in the greater Wellington region since 2012 (when the national Rheumatic Fever Prevention Programme was introduced), in comparison with the 2005-2011 period. This year, there has been an increase in cases reported in the year to date.

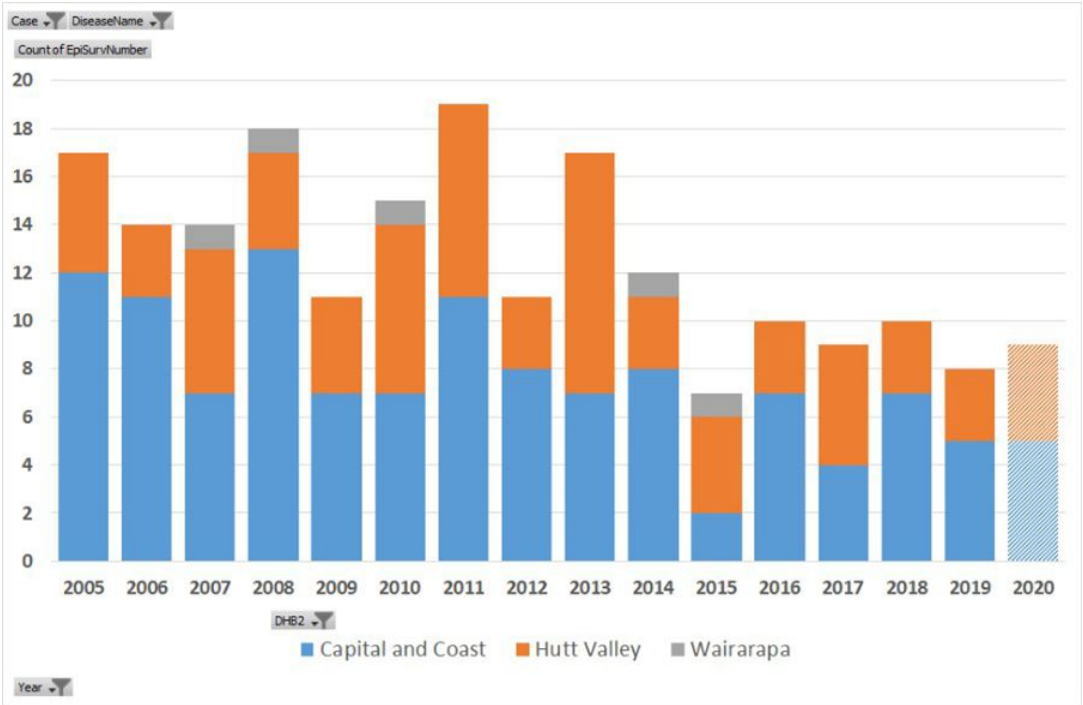


Figure 1. RF cases notified in the Greater Wellington Region by DHB (January 2005 - June 2020)
Note: 2020 data represents January – June data only.

2 Increased incidence in 2020

The nine year-to-date cases of rheumatic fever have all been among Māori and Samoan children and young adults, predominantly living in Porirua and Lower Hutt. There is no known connection

between the cases. It is noted that two of these cases sit outside the Ministry of Health (MOH) target age group of 4 – 19 year olds (refer to Table 1 and Figure 2).

Age group (years)	Cases	Ethnicity	Cases
5-14	6	Māori	3
15-24	1	Samoan	6
25-34	2	Other	0

Table 1. 2020 cases of rheumatic fever

Cases and Rates by District Health Board for Selected Month

Reporting Period: June-2020

Disease DHB		Northland	Waitemata	Auckland	Counties Manukau	Waikato	Lakes	Bay of Plenty	Tairawhiti	Taranaki	Hawke's Bay	MidCentral	Hutt Valley	Capital and Coast	Canterbury	Southern
Rheumatic fever - initial attack	Cases	0	2	3	5	2	0	0	0	0	0	1	0	0	0	0
	Cases Last 12 Months	9	20	16	52	17	3	14	2	1	3	4	6	8	5	2
	Rate Last 12 Months	5.0	3.2	3.0	9.3	4.1	2.7	5.9	4.1	0.8	1.8	2.2	4.0	2.5	0.9	0.6
Rheumatic fever - recurrent attack	Cases	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
	Cases Last 12 Months	0	1	1	8	2	0	0	1	0	0	1	0	1	0	0
	Rate Last 12 Months	0.0	0.2	0.2	1.4	0.5	0.0	0.0	2.0	0.0	0.0	0.6	0.0	0.3	0.0	0.0

Table 2. National cases and rate of rheumatic fever, 2019/20

With the recent spike in cases, both DHBs are behind their set targets, CCDHB - 1.0 case per 100,000 and HVDHB - 1.6 cases per 100,000. For 2019/20 CCDHB's attack rate per 100,000 was 2.5 and HVDHB's rate was 4.0. In terms of national performance, both DHBs are in the middle of the 11 DHBs involved in the RF Prevention Programme (refer to Table 2).

2.1 Analysis of the recent spike

A range of environmental, host, and organism factors interact to influence rheumatic fever risk and outcomes, as outlined in Figure 3[1]. Analysis has been undertaken to assess whether the below factors contributed to the recent spike.

[1] Baker, MG, et al. (2019). Risk Factors for Acute Rheumatic Fever: Literature Review and Protocol for a Case-Control Study in New Zealand, *Int J Environ Res Public Health*. 2019 Nov; 16(22): 4515. Published online 2019 Nov

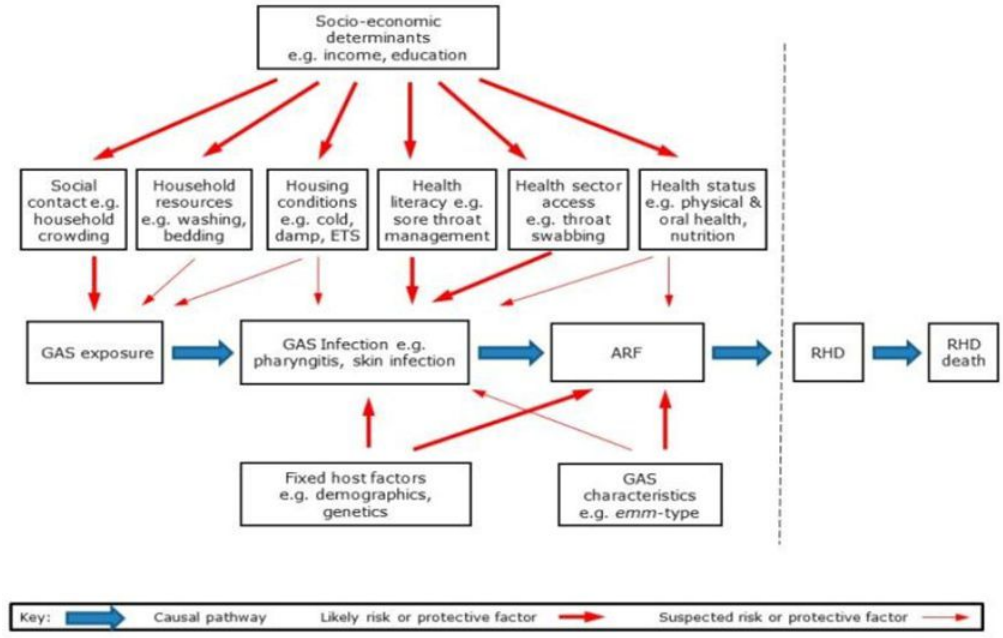


Figure 2. Causal pathway from GAS exposure to ARF and RHD showing major hypothesised groups of risk and protective factors.

2.1.1 COVID-19 Alert Level 4 Lockdown period

There has been speculation that the lockdown period led to increased overcrowding in some households which could have contributed to an increase in GAS transmission, and consequently RF. Analysis indicates that for more than half of the nine cases reported in 2020, there was no possibility of a link with the lockdown period due to the timing of their illnesses. The RF incubation period is the 1-5 week period prior to first rheumatic fever symptoms, and the incubation periods for five of the nine cases wholly preceded the level 3 – 4 lockdown period (23 March to 13 May).

An effect of the lockdown on the development of illness in the remaining four cases cannot be discounted, however no clear link to any particular factor was apparent.

2.1.2 There is no indication of clinical error

It is not apparent that primary care made any errors in the management of sore throats in any of the cases. Only four of the nine cases had a preceding sore throat, all of whom presented appropriately and were treated with antibiotics as per the Heart Foundation guidelines.

2.1.3 Reduced swabbing for Streptococcus following lockdown

Appendix 2 illustrates the number of swabs for strep (red bars) compared to previous years (blue dotted-line). There is a distinct drop from the start of lockdown level 4 through to mid-May when level 2 came in to place. Swabbing rates have since increased. Reduced swabbing for strep during lockdown occurred as:

- The focus across the system was on COVID-19 and the case definition includes sore throats.
- There was reduced attendance at clinics where testing swabbing would usually occur; some ‘enhanced’ CBACs were set up to dual-swab however this was not the norm.

- Community providers report that families were under the impression that they should not go to the doctor (during lockdown) unless it was urgent/serious. This was reinforced through Healthline and reduced face-to-face access to general practice. Healthline was not triaging for patients at high-risk of RF.

There is no strong evidence to suggest that the reduced throat-swabbing was linked to the spike in RF cases because most did not have a sore-throat and those that did, were seen and treated appropriately.

2.2 Actions responding to the increased incidence of Rheumatic Fever

A range of activities have been taken in response to the increased RF incidence:

- A Public Health Alert was issued by Regional Public Health, reminding primary care of GAS testing guidelines. This was widely distributed among the provider network.
- Strengthened and refreshed monitoring and oversight of the Rheumatic Fever Programme. The Well Homes and Rheumatic Fever Steering Group will facilitate cross-sectoral and inter-sectoral feedback and contribution to RF activities.
- An awareness raising campaign among the community was re-issued. While Catalyst Pacific Radio re-iterated RF messaging in early May, there was a delay in launching wider community communications. This was due to concerns about the case-definition for COVID-19 and the possible need to change strep throat swabbing/treatment pathways as a result of the risks. These concerns have since been resolved.
- A comprehensive, proactive Communications Plan has been developed by the 2DHB Communications Team and Regional Public Health, in partnership with the Well Homes and Rheumatic Fever Steering Group. This include a day-by-day calendar of communication activities to providers and community to support prevention of Rheumatic Fever.
- Prior to the spike in cases, a review of Rheumatic Fever activity and investment across the two DHBs was already underway as part of standard contract renewal processes. Following the spike, this work was completed with consideration of possible COVID-19-related impacts.
- Both DHBs have renewed 2020/21 pharmacy and primary care contracts for free, accessible swabbing and treatments of GAS (secondary prevention).
- A new report to monitor Streptococcal swabbing, to understand clinician practice in the Covid-19 environment, has been developed (refer to figure 5). Routine monitoring of this report will continue.

In addition, a number of future activities are underway:

- Refreshed cross-sectoral Stakeholder Engagement and Communications Plan (primary prevention).
- Exploring opportunities to provide additional support for community-based providers to refresh previously successful RF awareness campaigns.
- Automated referral for eligible people with upper respiratory tract and skin infections to the Well Homes programme.
- Extending the reach of existing mobile nursing programmes beyond support for 16 – 21 year olds, to support people with RF to have consistently timely antibiotics.

- Commissioning work to review the effectiveness of existing programmes, in the context of changes to MOH funding from 2020. This work with consider the growing body of evidence of the impact of institutional racism on the experience and impact of young people at risk of and diagnosed with rheumatic fever.

3 2DHB Rheumatic Fever Investment Plan 2020-2022

Rheumatic fever almost exclusively impacts young Māori and Pacific people; as such, the target age group (set by the MOH) for the rheumatic fever prevention programme is 4 – 19 year olds Māori, Pacific and quintile 5. However, locally we've seen incidence for 20 – 29 year olds, so DHB plans and activities consider this extended age group. Table 3 outlines the numbers of target population across the two DHBs.[2]

	4-19 year old		20 – 29 year olds		4 – 29 year olds
	CCDHB	**HVDHB**	**CCDHB**	**HVDHB**	**2 DHB**
Maori	9,944	7,533	6,502	3,971	27,950
Pacific	6,145	3,281	3,891	1,802	15,119
Other, Q5	2,946	2,634	3,389	2,044	11,013
Total	19,034	13,448	13,782	7,817	54,081

Across CCDHB and HVDHB, $1.749 million will be invested into the 2020 – 2022 Rheumatic Fever Prevention Plan. Crown Funding Agreements with the Ministry of Health fund 77% of the programme, with the remaining funded from CCDHB and HVDHB baseline funding.

A high-level overview of the 2DHB RF Plan's activities is illustrated below:

[2] Based on enrolment data. The true count, including unenrolled, will be higher.

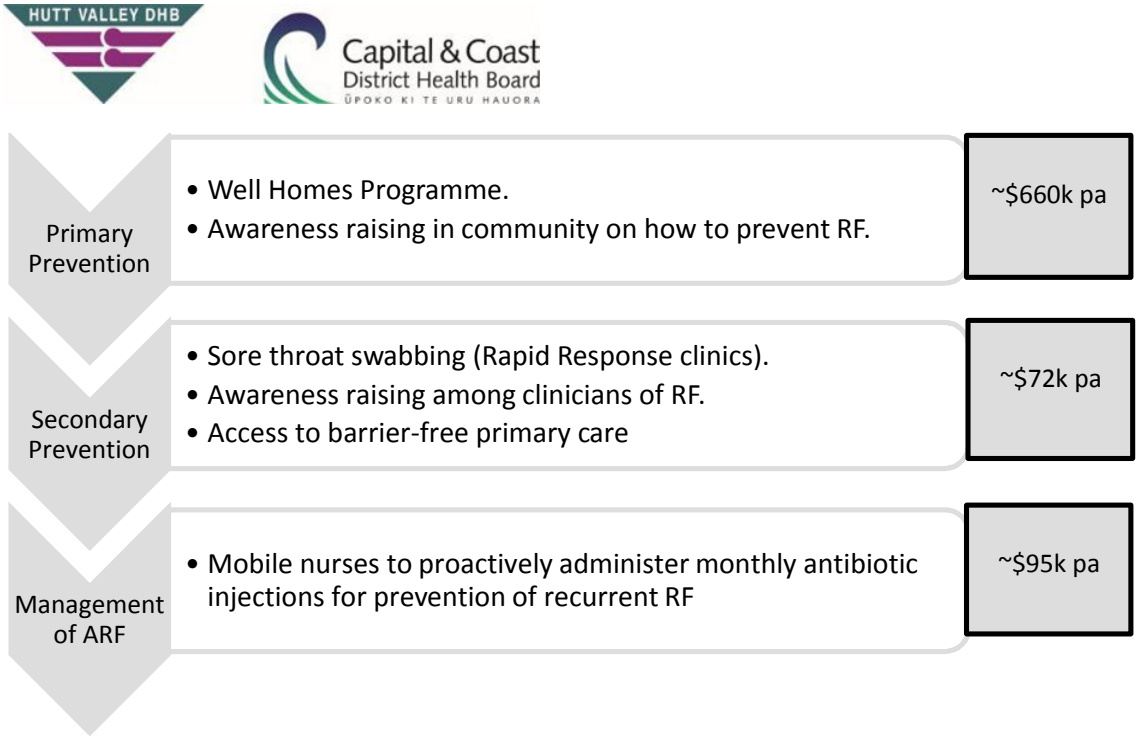


Figure 3. Overview of 2DHB Rheumatic Fever Plan

3.1 Primary Prevention – Well Homes Programme

Healthy housing is fundamental to the prevention of avoidable illness beyond RF, including asthma, other respiratory conditions, skin infections, and meningococcal disease. The Well Homes programme supports whānau to keep their homes warm, safe and dry, and encourages family members to spread out in the house.

The Well Homes programme is a partnership between Tu Kotahi Māori Asthma Trust, Regional Public Health (RPH), Sustainability Trust and He Kāinga Oranga. Visits to families' homes are delivered by the most appropriate partner agency for individual whānau need.

The Well Homes programme provides the following support:

- Coordination of interventions for families living in overcrowded, cold and/or damp homes, including support to obtain better quality/more appropriate housing through Kāinga Ora, where required. Interventions are provided by partner organisations with the cost of physical materials (e.g. curtains, insulation) covered by philanthropic funds.
- Maintenance and promotion of cross-sectoral referral processes into Well Homes programme including automated referral from hospital discharge, community providers (primary care, LMCs, social workers etc.) and self-referral
- Public Health Nurses to complete the home assessments (where appropriate).

The Well Homes programme aims to enrol 650 whānau/families per year across the 2DHBs. In 2019/20, the Well Home team received 617 referrals to the programme (95% against target). Due to the impact of Covid-19 lockdown, 429 visits to families were completed in 2019/20, compared to 626 in 2018/19.

Detailed information on the reach and impact of Well Homes in 2019/20 is provided Appendix 1. It shows that:

- The programme has an equity focus in terms of its activity, with Māori and Pacific referrals making up the majority of referrals.
- Most referrals come from self-referrals, which demonstrates that the programme is well promoted, recognised and trusted.
- There are opportunities to increase referral number with health providers, particularly given recent expansion to referral criteria. This is a 2DHB priority area for the coming months.

3.2 Secondary Prevention – treating GAS infection quickly and effectively

Free sore throat rapid response services increase the likelihood of families getting early GAS throat swab and antibiotics by removing access and cost barriers.

CCDHB invests in rapid response clinics based in general practices in high risk areas (under Tū Ora Compass Health and Ora Toa). CCDHB primary care practices also follow up with other members of young people's households, who could be at risk of GAS. This follow-up of household contacts does not currently happen for HVDHB whānau.

For HVDHB, rapid response sore throat clinics are provided through a mixed model, between pharmacies and general practices in high risk areas. This approach is due to strong, and embedded behaviours to engage with community pharmacies. Selected pharmacies in high risk areas have a standing order to treat sore throats with antibiotics based on clinical guidelines.

At the time of writing this paper, the most recent available data for sore throat services was Q2 2019/20 (October – December 2020), as outlined in Table 3 below. Presenting both DHBs performance information in parallel demonstrates the need for more detailed assessment of the strengths of each model and opportunity to learn from each.

	CCDHB	HVDHB
Number of eligible people who presented with sore throats	108	137
Percentage of people given antibiotics in the same day they were assessed (target 100%).	71%	100%
Percentage given appropriate antibiotics (target 100%)	86%	61%
Percentage of household contacts were assessed and given appropriate antibiotics (where required).	100%	0%

Table 3: Quarter 2, 2019/20 Sore Throat Clinic Performance data

3.3 Management of Acute Rheumatic Fever

This component of the RF plan aims to prevent secondary infections, by ensuring that people with rheumatic fever receive timely prophylactic antibiotics. This prevents secondary infections, to improves quality of life and avoid complications including rheumatic heart disease.

In recognition of the barriers, facing particularly young Māori and Pacific people accessing timely primary care, both HVDHB and CCDHB invest in services that provide free monthly injections to young people aged 16 – 21 who have had or are diagnosed with RF with monthly injections. These services include:

- Supporting patients with acute rheumatic fever as they exit the paediatric service and enter adult Primary Care services.
- Supporting Primary Care providers to enable them to provide monthly injections after the age of 21 years if needed.
- Collaborating with other stakeholders to improve the overall prevention and management of RF.

Both DHBs are progressing options to extend these services beyond 16 – 21 year olds, to all people with rheumatic fever.

4 Future challenges and opportunities

The Ministry of Health has indicated that it will cease funding for RF in 2022, placing a high risk on the sustainability of the Well Homes programme. Early work to consider future options for cross-sectoral working will commence in advance of the expiry of the funding agreement. As recommended above, this work will be completed with consideration of the growing body of evidence on the impact of institutional racism on the experience and impact of young people at risk of and diagnosed with rheumatic fever.

There have been recent changes and impact of some of the Macro drivers for RF, which we will continue to monitor:

4.1 Housing drivers:

- The new Healthy Housing standards became law on 1 July and will help general housing quality but are unlikely to significantly help the families that Well Homes has relationships with. Part of their role is supporting families to make requests of their landlords, if they are worried about jeopardising their tenancy. The standards are a positive step but are considered unlikely to reduce or mitigate the need for the Well Homes programme.
- The Warmer Kiwi Homes programme recommences in April 2020. This programme includes grants for lower-income home owners and covers two-thirds of the cost of ceiling and underfloor insulation and/or an efficient heat pump, wood burner or pellet burner (heater grants are capped at $2,500).
- Housing stock continues to be an issue and there is concern that the COVID-19 economic impact will increase pressure on housing availability.
- The removal of planning permission requirements for sheds/sleep-outs may be seen as an opportunity to add an extra room for some households. These additional ‘rooms’ will not be up to health standards or actually reduce the impact of overcrowding (as shared spaces will still be crowded).

4.2 Economic Stability post Covid-19

- The COVID-19 economic impact on unemployment rates will increase the number of families experiencing fuel poverty or crowding to make efficiencies (i.e. supporting each other by all living under one roof to save on rental costs).
- An additional impact of the expected economic downturn, is that that there is likely to be less philanthropic funding available to support the installation of physical housing improvements (curtains etc.). These improvements are usually beyond the finances of the families receiving them so will not happen, without the donated funds/goods.

4.3 Access to health services

- If there is a resurgence in COVID-19 cases and return to higher lockdown levels, there could be a repeat reduction in access to health services. However, there are significant learnings from the March – May period for the sector to improve on.

APPENDIX 1: WELL HOMES REFERRAL INFORMATION 2019/20

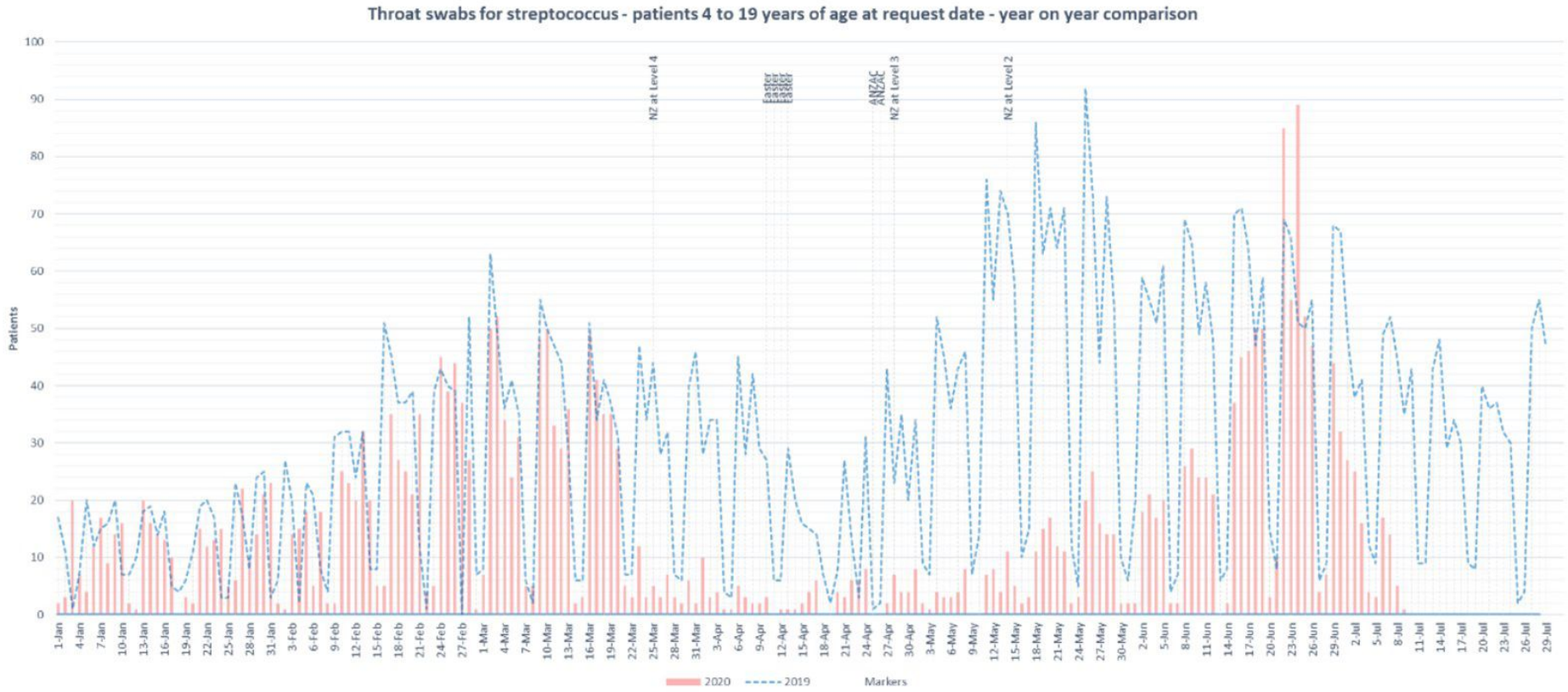
Top 10 Interventions	Total
Sustainability Trust Curtain Bank (Curtains)	354
Key Messages	301
Door snake (Other)	251
Electric - Portable (Heating Sources)	195
Safe Kids - Hazardous Items (Safe Kids)	177
Cloth (Mould Kit)	171
Wa Kainga - Healthy Housing Book (Other)	163
Linen set - single bed (Beds and Bedding)	149
Towel (Bathroom)	130
Flannel (Bathroom)	120

Top 10 Housing Types	Total
HNZC	254
Private Rental	186
Home Owner	106
Social housing	19
Temporary accommodation	10

Top 10 Ethnicities	Total
Māori	240
Pacific	144
NZ European	103
Other	29
African	20
Asian	19
Indian	18
Other European	9

Top 10 Referrers (Pathway)	Total
Self referral community	128
HVDHB (Automated Referral)	46
2020 Tumai Hauora, Housing Support Project	34
Ward 1 Paediatrics - CCDHB	29
CCDHB (Automated Referral)	23
RPH - Public Health Nurse	20
Christmas N Da Hood	19
Kokiri Health and Social Services	14
Porirua Union and Community Health Services	12
Tu Kotahi Māori Asthma Trust	12

Appendix 2: Throat swab data for Streptococcus



Note: The spike in streptococcus swabbing from 20 June coincides with an increase in Covid-19 testing activity, following the two positive cases from Auckland. Almost half of the streptococcus swabs in this June spike are from Porirua, where the CBACs test for both COVID-19 and GAS in eligible people. The subsequent reduction in early July aligns with CBAC activity.

HSC Discussion – Public

July 2020

Measles Immunisation Campaign

Action Required

Health System Committee to note:

(a) The Ministry of Health (MOH) has allocated CCDHB $713,100 and HVDHB $281,752 in 2020/21 to deliver a measles campaign, targeted at 15 – 29 year olds.

(b) A 2DHB Measles Campaign Plan has been developed and jointly endorsed by Director, Strategy, Planning and Performance and Directors, Maori and Pacific Health. .

(c) Work to implement the plan has commenced, including the recruitment of a Campaign Manager.

Strategic Alignment	This paper aligns to the Health System Plan 2030, Taurite Ora, Te Pae Amorangi and the 3DHB Pacific Plan.
Author	Rachel Pearce, Acting General Manager, Child, Youth and Localities
Endorsed by	Rachel Haggerty, Director, Strategy, Planning and Performance
Presented by	Rachel Pearce, Acting General Manager, Child, Youth and Localities
Purpose	Update on the development and implementation of a 2DHB Measles Campaign.
Contributors	Julia Jones, System Development Manager, CCDHB Judi Keegan, System Development Manager, HVDHB
Consultation	Tofa Suafole-Gush, Director, Pacific Health Directorate, 3DHB Kerry Dougal, Director, Maori Health, HVDHB Jim Wiki, Manager, Accountability, Maori Development Group.

Executive Summary

In 2019 there was a measles outbreak in New Zealand with 2,193 cases confirmed. Most of these cases were concentrated in Auckland (1,736 79%). There were a total of 31 cases across the 2DHBs –23 cases in CCDHB and 9 cases in the HVDHB.

In February 2020, the Ministry of Health announced a $23 million investment in a national measles campaign, to improve measles immunisation coverage in the 15 – 29 year old cohort. Across the 2DHBs $994,852 was allocated – $713,100 for CCDHB and $281,752 for HVDHB.

The MOH supported the development of a 2DHB plan. CCDHB and HVDHB worked with our provider network, including PHOs and Youth One Stop Shops (YOSS) to develop a high level plan, which was submitted to the MOH in June.

In recognition that 15 – 29 year olds typically under-utilise (engage with) primary and preventative health care and behaviours, we will take leadership from young people around how best to design, deliver and communicate about immunisations. The campaign will segment the youth population, to be targeted and tailored to meet the diverse and unique needs of different young people, eg school aged youth, young people in university, young people in employment, etc. We will promote and offer MMR immunisations in settings that young people already gather, including through 'pop-up' services that proactively engage our Māori and Pacific youth.

We are progressing a recruitment process to appoint a dedicated, fixed term manager to lead the implementation of the endorsed plan.

Strategic Considerations

Service	This Measles Campaign presents a unique opportunity to focus on increasing young people's engagement in primary and preventative health behaviours, beyond just immunisations.
People	There are no implications for DHB staff at this stage. The Measles Campaign will primarily impact primary and community providers. Impact for DHB will be worked through by the future Measles Campaign Manager.
Financial	There are no financial implications for the 2DHBs – this campaign will be 100% funded by special purpose, MOH funding.
Governance	The oversight arrangements for this work are yet to be finalised; however, the intention is to maintain youth leadership, for example using existing groups such as CCDHB's #YouthQuake panel to oversee the campaign's design and delivery.

Engagement/Consultation

Patient/Family	None
Clinician/Staff	This work has been developed with primary care providers, Youth One Stop Shops and (community based) Immunisation Coordinators.
Community	Not applicable. Members of both DHBs and provider network's youth group will be involved in the design and delivery of the campaign.

Identified Risks

Not applicable

Attachment/s

Not applicable

1. BACKGROUND

1.1 Measles in NZ

Measles is one of the most infectious diseases in humans and is the third most common vaccine-preventable cause of death among children throughout the world. Complications from measles are common, particularly for children under five years and adults over 20 years of age. In New Zealand, more than 15% of measles cases are hospitalised. Approximately 0.1% of cases develop encephalitis (inflammation of the brain), of which 15% die and approximately one third are left with permanent brain damage.

In New Zealand, children receive their first measles vaccination (MMR) at 15 months (12 months in Auckland) and their second dose at four years. Regardless of their citizenship, children are eligible for publicly funded vaccinations on the Immunisation Schedule. People born before 1969 don't need an immunisation, as measles used to be very common, so they are considered immune.

In 2019 there was a measles outbreak in New Zealand with 2,193 cases confirmed. Most of these cases were concentrated in Auckland (1,736 79%). There were a total of 31 cases across the 2DHBs –23 cases in CCDHB and 9 cases in the HVDHB.

1.2 National context

In February 2020, the Ministry of Health announced a $23 million investment in a national measles campaign, to improve immunisation coverage. In March 2020, DHBs were advised of their allocation and that the focus of the campaign was on 15 to 29-year olds, with a particular focus on Māori and Pacific youth. Across the 2DHBs $994,852 was allocated – $713,100 for CCDHB and $281,752 for HVDHB.

The Ministry of Health is working with the Health Promotion Agency (HPA) on a nationwide strategy to complement local DHB and primary and community provider strategies.

1.3 Local context population

The MOH supported the development of a 2DHB plan. CCDHB and HVDHB worked with our provider network, including PHOs and Youth One Stop Shops (YOSS) to develop a high level plan, which was submitted to the MOH in June.

Preliminary analytics work was completed to understand the scale of the campaign required for CCDHB and HVDHB. Obtaining accurate immunisation data for the 15 – 29 year old group is very manual; however, using estimates based on Immunisation Advisory Centre advice, PBFF data and PHO enrolment data, we estimate there are approximately 38,000 unvaccinated 15 – 29 year olds across the 2DHBs.

Estimated Vaccination Rates / Numbers							
		CCDHB			**HVDHB**		
Category	Rate	Total	# Vaccinated	# NOT vaccinated	Total	# Vaccinated	# NOT vaccinated
15 - 19	75%	18074	13556	4519	8957	6718	2239
20 - 24	60%	22987	13792	9195	8521	5113	3408
25 - 29	60%	24165	14499	9666	9992	5995	3997
unenrolled	60%	11247	6748	4499	1964	1178	785
Total		76,473	48,595 (63.5%)	27,878 (36.5%)	29,434	19,004 (64.6%)	10,430 (35.4%)

2. 2DHB Campaign Approach

The high level plan has been developed and key features of the plan include:

- **Focused and pro-equity** – In partnership with our providers, we agreed the following goals for the campaign:
    - Increase immunisation rate by at least 20% across all ethnic groups.
    - Have equitable immunisation rates across all ethnic groups (i.e. more activity to immunise Maori, Pacific).
- **Youth-led** – In recognition that 15 – 29 year olds can be difficult to engage in primary and preventative health care and behaviours, we will take leadership from young people of how best to design, deliver and communicate about immunisations.
- **Targeted and segmented** – We will segment the youth population, to be targeted and tailored to meet the diverse and unique needs of different young people. For example school aged youth, young people in university, work, etc.
- **Locality based, using a range of (non-health) settings** – We will promote and offer MMR immunisations in settings that young people already gather. Locality-targeted mobile and 'pop-up' services that proactively engage our Māori and Pacific youth will be crucial to delivering on our equity goals.
- **Build on strong primary care foundation** – Primary care (general practices) will remain a foundational service in offering immunisations, and will boost uptake through drop-in clinics (oriented to youth lifestyles e.g. weekends/evenings).
- **Drive opportunistic, secondary benefits** – A secondary aim of the campaign is to increase engagement of this cohort in primary healthcare services beyond MMR immunisation. We will do this by offering wraparound services alongside MMR immunisation. For example, STI testing.
- **Youth-led communications planning** – We will take our lead from young people about what communications works. We will also partner with Maori and Pacific leaders and providers to ensure messaging is culturally appropriate and available in Te Reo, Pacific and other languages.
- **Dedicated resource –** We will recruit a Campaign Manager, to provide focussed leadership and support to providers and stakeholder groups, to ensure we deliver on the goals and intent.

HSC Discussion – Public

July 2020

Porirua Locality Re-Integration Project Update

Action Required

Health System Committee to note:

(a) The *Health and Disability System Review* signals a shift toward locality-based commissioning, including a specific recommendation for adopting a devolved, population health approach to serving the Porirua locality.

(b) In that context, CCDHB has partnered with Ngāti Toa to progress the operationalisation of a locality-based Tier 1 integration prototype in Porirua.

(c) A devolved commissioning approach for Porirua will commence from 2021/22.

Strategic Alignment	This paper aligns to the Health System Plan 2030, Taurite Ora and the 3DHB Pacific Plan.
Author	Rachel Pearce, Acting General Manager, Child, Youth and Localities
Endorsed by	Rachel Haggerty, Director, Strategy, Planning and Performance
Presented by	Rachel Pearce, Acting General Manager, Child, Youth and Localities
Purpose	To provide an initial briefing to the Health System Committee on the development of an integrated commissioning approach for the Porirua population.
Contributors	Arawhetu Gray, Director, Maori Development Group
Consultation	N/A

Executive Summary

People who live in Porirua have high regard for their community and express satisfaction with their lives in Porirua. There are great strengths and capital within the Porirua community however, against many respects Porirua has fewer resources than other communities.

Over 100 health and social service providers serve the South Porirua community. Some providers, such as Ora Toa and Porirua Union Health Clinic, provide a range of whānau/family centred services. However, complex funding arrangements, multiple commissioners, and inflexible national contracts make serving the South Porirua community unnecessarily difficult.

In February 2020, the Strategy, Planning and Performance (SPP) team at CCDHB developed an integrated commissioning approach prototype for Porirua, for consideration by the *Health and Disability System Review* group (Appendix 1). A key tenet of the proposal was that integrated, devolved health system commissioning will more rapidly impact the social determinants of health and improve health outcomes.

The proposal was included in the final *Health and Disability System Review* report as a case study for Tier 1 Service integration (refer to page 105 of the Review). This paper outlines SPP's plan to operationalise the model. The Strategy, Planning and Performance team is working with Ngāti Toa to appoint to the change team. The Chief Executive of Te Rūnanga o Toa Rangatira, the Director Strategy, Planning and Performance and the Executive Director Māori Health will meet fortnightly to oversee the progression of this work programme.

Strategic Considerations

Service	This work is focussed on transforming the way services are designed, delivered and contracted, so they are responsive to whanau need and deliver improved outcomes.
People	There are no implications for DHB staff at this stage. Activities in 2020/21 will focus on establishing the future governance arrangements, approach to allocating resources, and contracting mechanisms to support future commissioning and operating environments.
Financial	There are no financial implications. This work will be done within existing resources. However, this approach to investing in health services is expected to be more efficient and deliver better outcomes.
Governance	This project will deliver transformational, community and iwi-led governance arrangements for commissioning health services in the Porirua locality.

Engagement/Consultation

Patient/Family	Not applicable
Clinician/Staff	Not applicable
Community	This project is being scoped with iwi leaders from Porirua.

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
N/A					

Attachment/s

1. SPP Submission to Health & Disability System Review Team (February 2020)

1. BACKGROUND

1.1 Porirua

Porirua is a vibrant and diverse community of approximately 57,000 people, of which 41% are Māori and Pacific. Overall, Porirua is a younger population than other localities in our DHBs' – over 700 babies are born every year in Porirua and a quarter of the population is under 25 years of age.

People who live in Porirua have high regard for their community and express satisfaction with their lives in Porirua. There are great strengths and capital within the Porirua community however, against many respects Porirua has fewer resources than other communities.

Over 100 health and social service providers serve the South Porirua community. Some providers, such as Ora Toa and Porirua Union Health Clinic, provide a range of whānau/family centred services. However, complex funding arrangements, multiple commissioners, and inflexible national contracts make serving the South Porirua community unnecessarily difficult.

There are a number of reports that identify the historic and persistent failure of health and social services in the Porirua community. Reports show that in Porirua more people live in crowded housing (22%), substantiated findings of abuse continue to rise (24%), young people die by suicide (6 in 2018), and Porirua babies have a life expectancy at birth 3 years less than babies born elsewhere in the greater Wellington district. Children are more likely to have their teeth removed under general anaesthetic and have avoidable admissions to hospital. Most of the adult Māori and Pacific population have two or more health risk factors including cardiovascular disease, diabetes and obesity.

1.2 Local Strategic Context

The development of locality-based approaches, including Community Health Networks (CHNs), is a core strategy of the Health System Plan 2030, and is part of the Neighbourhood Strategy at Hutt Valley DHB. The critical thinking that drives this approach was supported by the Productivity Commission' *More Effective Social Services* report, the Government's social investment approach and the *Health System Plan 2030*.

The 2DHB integrated commissioning work programme provides significant opportunity to align with and enable the implementation *Taurite Ora* and the *Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region*.

1.3 National context

In February 2020, the Strategy, Planning and Performance (SPP) team at CCDHB developed an integrated commissioning approach prototype for Porirua, for consideration by the *Health and Disability System Review* group (Appendix 1). A key tenet of the proposal was that integrated, devolved health system commissioning will more rapidly impact the social determinants of health and improve health outcomes.

The proposal was included in the final *Health and Disability System Review* report as a case study for Tier 1 Service integration (refer to page 105 of the Review). The report includes the following recommendations:

- Adopting a population health approach to serving the South Porirua locality, to allow services to be designed for the unique needs of the community.
- DHB-commissioning, rather than national commissioning of health services, to enable a whānau wellbeing outreach service, including a mix of midwives, nurses, social workers and kaiāwhina, to support whānau to meet their health and social aspirations.

- DHBs should be fully accountable for planning and organising Tier 1 services on a locality basis for their population.
- Where a rohe (area) is a defined locality, the plan could be the shared responsibility of the DHB and rūnanga.
- A mix of service types and business models should be a part of the network, with NGOs and kaupapa Māori services playing a vital role.
- The default timeframe for contracts should be longer-term to provide greater financial certainty and stability for service providers, encourage investment and a sense of shared ownership of the network and the population served.

2. PARTNERING TO LEAD LOCALITY-BASED TIER 1 INTEGRATION

Government is yet to respond to the *Health and Disability Review* recommendations however, many recommendations and themes are expected to be universally supported. Further, many of the recommendations align with/enhance our existing local plans, and resonate with our key partners in Porirua. CCDHB is therefore working with our Porirua partners to devolve commissioning closer to community in advance of a formal response to the report.

These are some of the components of our approach to operationalising locality-based, Tier 1 integration in Porirua:

- CCDHB will become a health system commissioner in Porirua, and provide leadership and stewardship of an integrated health and wellbeing approach.
- Designing new governance approaches that embed partnership with iwi, community and clinicians.
- Establishing an outcome based, performance and accountability framework for service delivery.

Broadly this work will be delivered in two phases:

- Phase 1 (July – December 2020):
    - Establish the change team and partnership approach. This will include appointing dedicated resource within the community, hosted by Ngāti Toa as well as SPP.
    - Create the kaupapa, including setting the principles, values and purpose of the work programme.
    - Consider all Porirua populations and stakeholders, and how their voices will be heard in both the change process and future governance and accountability frameworks.
    - Complete a detailed analysis of health investment, with a view of identifying and reallocating health resources (note: this will be a staged approach, starting with DHB controlled investment).
    - Design and establish a new locality-based approach to contracting (i.e. longer-term, outcomes based contracts).
    - Establish the performance management and accountability framework for service delivery and population outcomes.
- Phase 2 (January – July 2021):
    - Develop a transparent, detailed 2021/22 Porirua investment plan, including identification of changes to investment/contracting arrangements.
    - Communicate changes to impacted stakeholders.

- Executing new contracts for recommissioned services.
- Commence working to the new performance management and accountability framework for service delivery.

3. FINANCIAL IMPLICATIONS

This work will proceed on the basis that the level of funding available for Porirua under this 'recommissioned' approach will not increase. However, the following strategic projects and priorities may increase the allocation to Porirua:

- DHB-led programmes including 2DHB hospital network planning, Community Health Networks and maternal health system planning.
- Nationally/centrally-led changes following the *Health and Disability System Review*, including devolution of Ministry of Health controlled Crown Funding, including Well Child Tamariki Ora and midwifery services.

Capital and Coast DHB and Hutt Valley DHB

Combined Health System Committee

Meeting to be held on 22 July 2020

Resolution to exclude the Public

Moved that the public be excluded from the following parts of the proceedings of this meeting, namely:

- for the Agenda items and general subject matter to be discussed as set out in the first column in the table below,
- on the grounds under clause 34 of Schedule 3 to the New Zealand Public Health and Disability Act 2000 as set out in the second column in the table below and
- for the reasons set out in the third column of the table below (including reference to the particular interests protected by the Official Information Act, where applicable).

TABLE

Agenda item and general subject of matter to be discussed	Grounds under clause 34 on which the resolution is based	Reason for passing the resolution in relation to each matter, including reference to OIA where applicable
Confirmation of minutes of previous meeting (public excluded session) and Matters Arising from those minutes.	paragraph (a) i.e. the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982	OIA, section 9(2)(ba) to protect information which is subject to an obligation of confidence where the making available of that information would be likely to prejudice the supply of information from the same source, and it is in the public interest that such information should continue to be supplied. OIA, section 9(2)(j) to enable this organisation to carry on, without prejudice or disadvantage, commercial and industrial negotiations.
Update on Ministry of Health COVID-19 Māori Health Funding	As above	As above

NOTE
The Act provides that every resolution to exclude the public shall be put at a time when the meeting is open to the public, and the text of that resolution (or copies of it) must:

- be available to any member of the public who is present; and
- form part of the minutes of the board or committee.