CAPITAL & COAST DISTRICT HEALTH BOARD

Health System Committee

Public Agenda

11 SEPTEMBER 2019

Kenepuru Education Centre, Kenepuru Community Hospital, Raiha Street, Porirua
9am to Midday

	ITEM	ACTION	PRESENTER	MIN	TIME	PG
1 PROCEDURAL BUSINESS					9am	
1.1	Karakia					
1.2	Apologies	**Records**	Fran Wilde			
1.3	Continuous Disclosure – Interest Register	**Accepts**	Fran Wilde			2
1.4	Confirmation of Draft Minutes 14 August 2019	**Approves**	Fran Wilde			5
1.5	Matters Arising	**Notes**	Fran Wilde			
1.6	Action List	**Notes**	Fran Wilde			10
1.7	Annual Work Programme	**Approves**	Rachel Haggerty			11
2 DISCUSSION						
2.1	Report and Recommendations of an Integrated Model of Care for Youth Services for Porirua 2.1.1 Integrated Model of Care for Youth Services for Porirua		Rachel Haggerty Gerardine Clifford-Lidstone			12
2.2	Healthy Housing Update 2.2.1 Regional Healthy Housing Response Group MOU 2.2.2 Regional Healthy Housing Response Group Logic Map draft 2.2.3 Regional Health Housing Response Group Submission on the Kainga Ora – Homes and Communities Bill		Peter Gush			33
2.3	Non-Financial Performance Monitoring 2.3.1 Apr-June 2019 Quarterly Performance Monitoring Report		Rachel Haggerty Peter Guthrie			47
2.4	Antimicrobial Stewardship Report 2017 – 2018 2.4.1 Antimicrobial Stewardship Report		Sandy Blake Michelle Balm			168
3 INFORMATION						
3.1	Strategy, Innovation and Performance (SIP) Bi-Monthly Update		Rachel Haggerty			190
3.2	Health of Older People Investment Performance		Rachel Haggerty / Jenny Langton			196
4 OTHER						
4.1	Resolution to Exclude		Fran Wilde			202
DATE OF NEXT MEETING 16 OCTOBER 2019, RATONGA RUA O PORIRUA, 20 UPPER MAIN DRIVE, KENEPURU, PORIRUA						

HEALTH SYSTEM COMMITTEE

Interest Register

UPDATED AS AT SEPTEMBER 2019

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

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

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

CAPITAL AND COAST DISTRICT HEALTH BOARD
DRAFT Minutes of the Health System Committee
Held on Wednesday 14 August 2019 at 9am
Board Room, Level 11, Grace Neill Block, Wellington Regional Hospital

PUBLIC SECTION

PRESENT

COMMITTEE:	Dame Fran Wilde (Chair) Ms Sue Kedgley Dr Roger Blakeley Ms Eileen Brown Ms Ana Coffey Ms Sue Driver Dr Tristram Ingham Ms Sue Emirali
STAFF:	Ms Fionnagh Dougan, Chief Executive Officer Ms Rachel Haggerty, Executive Director, Strategy Innovation and Performance Mrs Robyn Fitzgerald, Committee Secretary Mr Arish Naresh, Chief Allied Health Officer Mr Peter Gush, Regional Public Health Officer
BOARD MEMBERS	Dr Kathryn Adams
PRESENTERS:	Peter Guthrie (Item 3.1) Dame Diana Crossan, Chair Citizens Health Council (CHC) (Item 2.1) Ria Earp, CHC member Jenny Rowan, CHC member Brad Olsen, CHC member Jenny Chong Bradley, Localities Taulalo Fiso, Director Community Partnerships Gerardine Clifford-Lidstone, General Manager, Child, Youth and Localities Rachel Pearce, Senior Systems Development Manager Julia Jones, System Development Manager Arawhetu Gray, Executive Director, Māori Health Michael McCarthy, Chief Financial Officer
GENERAL PUBLIC:	A member of the public

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1 PROCEDURAL BUSINESS

1.1 PROCEDURAL
Tristram opened the meeting with a karakia and blessing. Dame Fran Wilde, welcomed committee members, members of the public and DHB staff.

1.2 APOLOGIES
Apologies received from Tino Pereira and Andrew Blair.

1.3 INTERESTS

1.3.1 Interest Register

No changes were received.

1.4 CONFIRMATION OF PREVIOUS MINUTES

The minutes of the CCDHB Health System Committee held on 17 July 2019, taken with public present, were confirmed as a true and correct record.

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

1.5 MATTERS ARISING

Nil.

1.6 ACTION LIST

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

1.7 ANNUAL WORK PROGRAMME

No changes.

2 PRESENTATION

2.1 CITIZENS HEALTH COUNCIL

The presentation was **noted**.

The Committee:

(a) **Noted** and thanked the presenters for their presentation and update on the Citizens Health Council (CHC);

(b) **Noted** that the CHC are currently recruiting more members specifically looking for Maori/Pacific youth and an elderly representative to the council;

(c) **Noted** that the Health System Committee recommended to the CHC that public views and feedback from the public should be looking for systemic change that will prepare the health system for the future

Actions:

1. Management to arrange a meeting to discuss the issues raised during the discussions with the Health Citizens Council;
2. Committee members to recommend to Diana Crossan possible community groups (non-health) that they can approach to speak to during the consultation phase;
3. Management to provide CHC with a future Health framework and list the challenges ahead to use during their consultation with the community.

3 DECISION

3.1 FINAL DRAFT REGIONAL SERVICE PLAN 2019/20

The paper was taken as **read**.

The Committee:

(a) **Recommended** that the Board Chairs and Deputy Chairs sign the final draft Regional Services Plan 2019/20, subject to feedback from the Ministry and Boards being incorporated;

(b) **Noted** that the Central Region CEs and senior leadership teams have worked closely with TAS to ensure the work programmes, and plan reflect the priorities of the six DHBs, and the Ministry of Health;

(c) **Noted** the final draft Central Region Regional Services Plan 2019/20 submitted by Central Technical Advisory Services (TAS) to the Ministry of Health on 21 June 2019;

(d) **Noted** that TAS incorporated initial feedback from the Boards on the draft Central Regional Services Plan 2019/20 before submitting a final draft to the Ministry of Health on 21 June 2019.

(e) **Noted** the Ministry of Health will consider the final draft Regional Services Plan 2019/20 and advise DHBs when their plans can be signed and sent to the Minister of Health;

(f) **Noted** that consideration be given when offering services in other regions that personal needs are considered, e.g. whanau support; disability needs.

HSC recommends the Board:

(a) **Notes** the paper.

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

Actions:

4. Management to write a paper exploring the issues of public vs private sector
5. Management to provide an update of access to radiation therapy in the next HHS report.

4 DISCUSSION

4.1 PRO-EQUITY WORK PLAN - UPDATE

The paper was taken as **read**.

The Committee:

(a) **Noted** the update on progress in relation to the pro-equity work plan.

(b) **Noted** the purpose of the pro-equity work plan is to deliver a clear CCDHB equity goal and direction with an agreed set of equity principles; an operational framework that translates these principles into practice; and a performance framework to monitor and guide equity progress.

HSC recommends the Board:

(a) **Notes** the paper.

4.2 MATERNAL, CHILD AND YOUTH INVESTMENT AND PERFORMANCE

The paper was taken as **read**.

The Committee:

(a) **Noted** the intervention logic underpinning current maternal, child and youth health investment in NGO and community settings (Appendix 1);

(b) **Noted** that while CCDHB mothers, babies and youth compare favourably to the national experience against many measures, there are areas of inequitable outcomes for our families/whānau;

(c) **Noted** the work underway to improve the impact of our investment, particularly for Māori, Pacific and other groups.

Actions:

6. Management to bring the proposal for Porirua youth to the next HSC meeting and invite the youth to present to the Committee.
7. Tristram to circulate his research paper on *Damp mouldy housing and early childhood respiratory infections* to committee members
8. CEO to meet with Roger Blakeley to discuss Wellington Housing initiatives.

4.3 3DHB ALCOHOL AND OTHER DRUG (AOD) MODEL OF CARE

The paper was taken as **read**.

The Committee:

(a) **Noted** the progress in relation to the 3 DHB AOD Model of Care work;

(b) **Noted** the next steps in the 3 DHB AOD Model of Care work;

(c) **Noted** that the AOD Model of Care will be presented in December 2019.

4.4 BOARD CHAMPIONS – ROLE AND RESPONSIBILITY

The paper was taken as **read**.

The Committee:

(a) **Noted and discussed** the evidence presented here with a view to agreeing what they believe to be the core functions of a Board Champion;

(b) **Endorsed** management to develop this feedback into a role description, outlining scope and responsibilities, to present to the CCDHB Board for endorsement;

(c) **Noted** that the Board champion should be a Governance role with a Governance lens. That should the Board champion view papers that are purely operational then the champion should inform the CEO;

(d) **Noted that**

(e) **Noted** that this paper should be available to the new Board**.**

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

Actions:

9. Management to remove section 6 of paper and send paper to Board with agreed amendments.

5 OTHER

5.1 RESOLUTION TO EXCLUDE

The paper was taken as **read**.

The Committee:

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

SUBJECT	REASON	REFERENCE
Joint Hospital Network Planning Update Joint Health System Committee Proposal	Papers contain information and advice that is likely to prejudice or disadvantage commercial activities and/or disadvantage negotiations	9(2)(b)(i)(j)

* Official Information Act 1982.

Moved: Fran Wilde **Seconded**: Roger Blakeley **CARRIED**

Public Meeting closed at 11.52am.

6 DATE OF NEXT MEETING

11 September 2019, 9am, Kenepuru Education Centre, Kenepuru Community Hospital, Raiha Street, Porirua.

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

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

Fran Wilde
Health System Committee Chair

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

AP No:	Item No.	Topic	Action:	Responsible:	How Dealt With:	Delivery Date:
HSC Meeting 14 August 2019						
P039	**3.1**	**Final Draft of Regional Services Plan 2019/20**	1. Management to provide a paper exploring the issues of public vs private sector service delivery. 2. Management to provide an update service delivery access to radiation therapy in the next HHS report.	Dir. SIP Dir. Operational		December
HSC Meeting 17 July 2019						
P032	**3.1**	**Dementia in our Community**	Disability Sub Regional Group to provide advice to be included in the Investment Plan to be presented to HSC.	Dir SIP	Advice	December

CCDHB Health System Committee (HSC) Work Programme 2019

	13 February	13 March	17 April	15 May	12 June	17 July	14 August	11 September	16 October	13 November
	CCDHB	CCDHB	CCDHB	CCDHB	CCDHB	CCDHB	CCDHB	Kenepuru Education Centre	Ratonga Rua o Porirua	Kapiti District Council Chambers
Health System Investment and Prioritisation	Investment & Prioritisation - TBC	Investment & Prioritisation - TBC	Investment & Prioritisation - TBC	Investment & Prioritisation - TBC	Investment & Prioritisation - TBC	Investment & Prioritisation - TBC	Investment & Prioritisation - TBC	Investment & Prioritisation - TBC	Investment & Prioritisation - TBC	Investment & Prioritisation - TBC
System performance Reporting										
Provider Performance	MHAIDS Bi-Monthly Performance Report EBHC Bi-Monthly Performance Report	HHS Bi-Monthly Performance Report SIP Bi-Monthly Performance Report	Regional Public Health Performance Report MHAIDS Bi-Monthly Performance Report EBHC Bi-Monthly Performance Report	HHS Bi-Monthly Performance Report SIP Bi-Monthly Performance Report	MHAIDS Bi-Monthly Performance Report EBHC Bi-Monthly Performance Report	HHS Bi-Monthly Performance Report SIP Bi-Monthly Performance Report	MHAIDS Bi-Monthly Performance Report EBHC Bi-Monthly Performance Report	HHS Bi-Monthly Performance Report SIP Bi-Monthly Performance Report	Regional Public Health Performance Report MHAIDS Bi-Monthly Performance Report EBHC Bi-Monthly Performance Report	HHS Bi-Monthly Performance Report SIP Bi-Monthly Performance Report
	Community Providers Performance Report - Older persons	Community Providers Performance Report - Long Term Conditions	Community Providers Performance Report - Palliative	Community Providers Performance Report	Community Providers Performance Report	Community Providers Performance Report	Community Providers Performance Report	Community Providers Performance Report	Community Providers Performance Report	Community Providers Performance Report
			Update on CHN progress						Update on CHN progress	
System and Service Planning	Youth Counselling Services Children's Health in Schools Pacific Nursing Service Primary Birthing Citizens Health Council	Youth Services in Porirua Kapiti Investment update MH Investment update								

Holding topics for HSC
Healthy Ageing Workforce approach
Present results from the Investment Planning Approach - specifically the partnership table
Integration of Child Health Services

Capital & Coast District Health Board
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PUBLIC

Date: 3 September 2019	**HEALTH SYSTEM COMMITTEE** **DISCUSSION**
Author	Julia Jones, System Development Manager, SIP
Endorsed by	Gerardine Clifford-Lidstone, General Manager, Child, Youth and Localities
Subject	**REPORT AND RECOMMENDATION OF AN INTEGRATED MODEL OF CARE FOR YOUTH SERVICES FOR PORIRUA**

RECOMMENDATIONS

It is **recommended** that the Committee:

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

(b) **Supports** the content of the report and recommendations.

(c) **Endorses** SIP to move to implementation of the recommended model of care for young people for Porirua with the focus on the establishment of a YOSS (subject to increased funding).

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

APPENDIX

1. Integrated Youth Services In Porirua Draft Report

1. INTRODUCTION

1.1 Purpose

The purpose of this paper is to request that HSC endorse the recommendations in the report for an Integrated Model of Care for Youth Services for Porirua.

1.2 Previous Board Discussions

The paper follows up on an earlier paper at the HSC's meeting on South Porirua Integration Priorities, Youth Health Services for Porirua in October 2018. Most recently an update of the project, an Update on Integration of Youth Services in Porirua was delivered to HSC in June 2019.

Capital & Coast District Health Board
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PUBLIC

2. BACKGROUND

In 2018 the Board approved $300k of ongoing funding to support an integrated youth service for Porirua with a specific focus on providing equitable outcomes for young people in Porirua.

The project focus was to develop an integrated model of care for young people in Porirua and focussed on co-design. SIP has gathered information and insights from partners and providers in the Porirua Community and engaged with young people through a two day Hui to understand what the needs for an integrated youth service are from a community and youth perspective. Research on the relevant literature has also been completed for analysis and to support the recommendations.

The two-day Hui was facilitated by the Change and Innovation Agency and the feedback from Rangatahi and providers who were invited to the 'walkthrough' of the design process was overwhelmingly positive.

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

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

CCDHB have established a youth panel to continue the engagement between the Rangatahi and CCDHB. This is to ensure that there is an ongoing connection between the design and implementation phase of the project.

3. AN INTEGRATED MODEL OF CARE FOR YOUTH FOR PORIRUA

3.1 Report

The report on an integrated model of care for Porirua describes the unique locality of Porirua including the youthful population and the high proportion of Maori and Pacific young people who live in Porirua City. The report recognises that there are a number of young people in Porirua who live in high levels of deprivation which is identified as a contributing factor to poor health and wellbeing outcomes.

The recommendations are:

- We begin implementation of #YouthQuake. This includes continuing to work in co-design with the #YouthQuake panel to design a service specification.
- That procurement for services is subject to funding decisions for the 2019/20 financial year.
- If funding is approved an RFP process is commenced with the aim to contract for services from 1 July 2020.
- We continued conversations with other agencies to secure additional funding for the #YouthQuake.
- We undertake a review in partnership with PHO's of current services and providers to identify and strengthen existing youth services.
- We establish a governance structure to better support youth in Porirua.
- We establish the #YouthQuake panel and their continued expert voice of the Porirua community.
- We ensure a meaningful evaluation component.
- A future online service for young people in Porirua to provide online support and education on accessing services be scoped.

The recommendations in the report are based on evidence that has been gathered from three sources.

- Literature Review. A review of the literature on integrated models of care.
- Partners and Providers in Porirua. Individual and Group meetings with service providers' to confirm their views on the Tumai Hauora mo ngā Rangatahi ki Porirua and gain their insights into what an integrated service looks like.
- Young People in Porirua. Representation in the project-working group and a specific two-day co-design Hui enabling young people to share their views on how an integrated service model should look for the Porirua community.

The critical success factors (CSF) identified for an effective integrated model of care identified by key partners and providers and the youth are, on the whole, consistent. The few variances are due to their different points of engagement and experiences with youth services and the youth health system i.e. partners and providers as funders and providers of youth services and the youth as consumers of these services. Importantly, the CSFs identified by both groups are consistent with the World Health Organisation's (WHO) principles and key characteristics of integrated care services for adolescent and youth adult-friendly services and other CSFs identified in the literature review. This indicates that what they are seeking is not "out of the box"; but rather good "standard practice" that is evidence-based.

3.2 Recommendations for a Model of Care

Based on the evidence and the analysis the report is recommending five workstreams to implement an integrated model of care for youth for Porirua:

Workstream One: Implementation of #YouthQuake – The YOSS.

- CCDHB currently fund two successful YOSS's in Wellington and Kapiti. The youth were clear in their message that a visible and tangible representation of what integration looks like for them means that #YouthQuake is established as a priority. Young people need a service where they feel safe, comfortable and understood. The establishment of the service will send the message to the Rangatahi that they are important and have been listened to.

Workstream Two: Review and support of existing youth services

- SIP will work with PHO's to gather existing information about providers of youth services that are presently active in the Porirua community with an intention to enhance and strengthen existing services.

Workstream Three: Governance of an Integrated Model of Care for young people in Porirua

- To establish Governance to strengthen and maintain linkages across the integrated model of care and ensure that the voice of youth by youth is continued after the #YouthQuake is established.

Workstream Four: Evaluation of the model of care

- To develop an evaluation framework. This will include metrics and a return to the community on an annual basis to gather further insights and considerations for CCDHB and the service provider.

Workstream Five: Online Services

- Develop and design an online pathway for young people to access information and understand how to access services available to young people in Porirua.

The report's recommendations compliment previous recommendations made in the *Tumai Hauora Mō Ngā Rangatahi Ki Porirua: Improving Outcomes for Young People in Porirua.* This report was prepared as part of the Porirua Social Sector Trial which was commissioned by Service, Integration and Development Unit (SIDU) of the sub-regional District Health Boards.

4. RISKS

4.1 Partnership with Key Agencies

Engagement with other key agencies at a local level continues to indicate positive support. Commitment from our partner agencies will continue to be negotiated to support a Youth One Stop Shop (YOSS) in Porirua.

4.2 CCDHB Funding

To ensure the continued success of a YOSS for Rangatahi in Porirua ongoing funding needs to be agreed to ensure the sustainability of the service. Current funding that has been committed by CCDHB is less than the funding for existing YOSS services. Additional funding needs to be considered including working with our social agency partners and the Porirua City Council.

CCDHB will consider additional funding opportunities as part of the development of the model of care for consideration in 2020/2021 annual planning.

Item 2.1.1 Appendix 1

Capital & Coast District Health Board
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WORKING DOC

Integrated Model of Care for Youth Services for Porirua

Last updated: 31 Aug 2019

Table of Contents

Abbreviations

CCDHB	Capital & Coast District Health Board
SIP	Strategy, Innovation and Performance directorate, CCDHB.
YOSS	Youth one stop shop
CSF	Critical Success Factor
WHO	World Health Organisation
SBHS	School Based Health Service

Glossary

Youth One Stop Shop	Youth One Stop Shops provide a range of accessible, youth-friendly health and social services at little or no cost to young people.
Integrated model of care	The organisation and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money.
#YouthQuake	The name given to a YOSS for Porirua by the young people at the two day engagement hui.
Porirua Social Sector Trial (Tumai Hauora ki Porirua Alliance)	A research project undertaken between 2013 and 2015 which focussed on improving outcomes for people in Porirua with a specific focus on youth.
Tumai Hauora Mō Ngā Rangatahi Ki Porirua	The report written specifically to recommend how ways of improving outcomes for young people in Porirua.

1 Purpose

The purpose of this paper is to present an integrated model of care for youth services for Porirua which supports equitable outcomes for young people and that is evidence-based and culturally relevant to the Porirua community.

This paper focuses on the model of care and provides recommendations for implementation.

2 Overview of the Porirua Youth Population

This section provides an overview of the demographic and socio-economic profile of youth in Porirua and their health status. It also provides the rationale for, and background to this project.

2.1 Porirua community

Demographic profile

The population in Porirua is youthful with the latest statistics indicating that 36 percent of the Porirua population is under the age of 25 years; with more than 20 percent of the total population in Porirua aged between 10-24 years (11,486 young people; Porirua City Council, 2019). The most dominant feature of the Porirua youth population is the proportion of Maori and Pacific young people who live in the city (48 percent in 2018). Samoan is the second most spoken language after English.

Porirua has a concentration of families living in high deprivation which is a proven contributing factor to poor health and wellbeing outcomes. The youth population in Porirua is geographically spread across Porirua City. However, 35 percent of youth reside in the most socio-economically deprived (deprivation level 10) suburbs: Eastern Porirua, Waitangirua, Cannon's Creek East, Cannon's Creek North, Cannon's Creek South and Porirua East[1]. Social housing and migrant populations are features of these suburbs.

Socio-economic status

Socio-economic factors and access to health services are reported to be the main determinants of Maori and Pacific peoples' health inequalities[2].

Typically, young people in Porirua come from families with lower formal educational qualifications. Porirua youth and/or their parents are more likely to be unemployed or over-represented in lower-skilled and lower-waged occupations. They also have significantly lower annual incomes compared with the rest of the CCDHB catchment area[3]. This is important because a child/young person's health and development is influenced by the health behaviours and status of the adults in their community. When a child or young person is exposed to adults who exhibit health risk behaviours, they too are exposed to increased potential adverse consequences.

A Snapshot of Youth Issues in Porirua

Some of the prevalent health and wellbeing issues, identified in literature, affecting youth in Porirua are highlighted below.

[1] Statistics New Zealand Census Data 2013 projection
[2] Ministry of Health, The Social, Cultural and Economic Determinants of Health in New Zealand 1998
[3] Ministry of Health, The Social, Cultural and Economic Determinants of Health in New Zealand 1998

MENTAL HEALTH

Children and young people are exhibiting high levels of distress leading to deliberate self harm, risk taking, anxiety disorders and other troubling behaviours. (Principal)

Maori and Pacific youth are over represented with 75% of those accessing secondary services being of Maori and Pacific descent (CCDHB data)

EDUCATION

Attendance levels in Porirua are declining. The problem is more prevalent in low deciles schools and for Maori and Pacific.

There is a high rate of transience, students changing schools twice or more in one year. (Porirua Status Report, 2019)

LGBTQI

I remember going to my school counsellor because I'd been outed to my parents by a staff member at the school. I was told I should focus on my studies and not worry about my sexuality as it would make me more confused and upset....I didn't get help for years and my mental health got worse (Out Loud Aotearoa , 2018)

PRIMARY CARE

Young people want youth friendly health services (Primary Care Provider, Porirua)

SUICIDE

The number of (provisional) deaths by suicide in Porirua peaked in 2018 at nine.

Five suicides were young people who had only recently left school (Principal)

Maori and Pacific young people are adversely affected by suicide (Porirua Status Report, 2019)

STRESS

The numbers of young people are reporting feeling stress increasing from 10% to 43% in 2018. (Porirua Status Report, 2019)

SEXUAL HEALTH

Larger proportion of high deprivation students report having sex (Youth 12 Report)

Maori and Pacific young women are less likely to terminate pregnancies (Young Peoples Sexual Health in NZ, 2018)

Culture

Culture, as determined through spiritual connection to land, sea, sky, community and whakapapa, ancestry and genealogy is a source of strength and resilience for Maori and Pacific communities. Family relationships are more complex with responsibility for children extending beyond biological parents to extended family and community. Central to a culturally safe journey for Maori and Pacific young people is one which:

- is delivered by a culturally competent workforce
- is delivered in a culturally safe environment
- recognises the cultural dynamics and values that underpin their world views, and that of their parents or caregivers
- has a model of care that reflects a holistic view of health and wellbeing

2.2 Porirua youth – a target population

In December 2015, Capital & Coast, Hutt Valley and Wairarapa District Health Boards and Porirua City Council commissioned the Porirua Social Sector Trial (now known as Tumai Hauora ki Porirua Alliance) to undertake a study to determine what they considered it is they need to keep well. This included their voice and perspective; and provided recommended strategies for youth to improve their health, social, educational and cultural outcomes. The Tumai Hauora mo nga Rangatahi ki Porirua Report (2015) found that youth services in Porirua are fragmented and there is considerable variation in how the different sectors engage with, and follow-up with youth; and within localities (schools, health services and the community). Youth, whanau and service providers also have little awareness and knowledge of the range of services available to them.

The Porirua Tumai Hauora mo nga Rangatahi ki Porirua Report recommended:

- early detection of areas of concern
- follow-up on identified areas of concern
- provision of a cohesive youth service and the filling-in of service gaps
- improving whanau capability
- increasing youth resilience
- increasing provider capability to deliver youth-friendly services
- evaluation activities to measure impact and success.

2.3 The Integration of youth services in Porirua project

2.3.1 Project aim/purpose

The purpose of this project is to design an integrated model of care that supports equitable outcomes for young people, which is evidence-based and culturally relevant to the Porirua community.

2.3.2 Project design process

A two-stage process was endorsed for this project:

- *Stage one* – project establishment, including confirming project outcomes and establishing the working group and implementation structure.
- *Stage two* – designing the integrated model of care, including a literature review, kōrero with partners & providers of services in Porirua and kōrero with young people including a two day co-design hui.

2.4 Strategic alignment

Capital & Coast District Health Board's (CCDHB) HSP2030 specifically discusses youth hubs as a healthcare resource stating that for those who are socially vulnerable, access to healthcare services is made available through community clinics, schools and youth hubs[4].

The Porirua City Council (PCC) Porirua Growth Strategy 2048 identifies dwelling and population projections that inform growth modelling, strategy development, planning and investment decision making. This work concludes that Porirua is well placed to capture a large share of regional and population growth over the next 25 years with the upper end projections between 24,700 and 29,400 additional people by 2048. Current planning estimates an additional 11,370 new dwellings which would accommodate 30,699 people (at an average of 2.7 people per dwelling). In Porirua East the current average number of people per dwelling is 3.7.

In addition PCC in partnership with HLC[5] (HNZC), Ngati Toa Rangatira (Iwi) have commenced master planning for Porirua's regeneration project which will see 1,500 new homes in Eastern Porirua and the demolition and rebuilding of approximately 1,978 HNZC properties. In addition it is intended that the regeneration project has an overall focus on wellbeing outcomes (health, education, employment, community connectedness). Among other things it will include:

- A review of how social services are provided and delivered
- Community led projects
- Social enterprises

[4] CCDHB Health System Plan 2030, page 18

[5] The wholly-owned subsidiary of Housing New Zealand Corporation

- A review of educational provision
- New urban design that creates increased accessibility across Eastern Porirua
- Regeneration of the Cannons Creek and Waitangirua Village centres
- A review of community facilities
- Opportunities for whole of government support for the vision of the project, joint funding of projects might sit outside of the current parameters of the project.
- Opportunities for local people to shape what happens in their community.

This project is also aligned to two goals in the Government's Wellbeing 2019 Budget: 'Taking mental health seriously' and 'Supporting Maori and Pasifika aspirations'.

3 Project design process and key findings

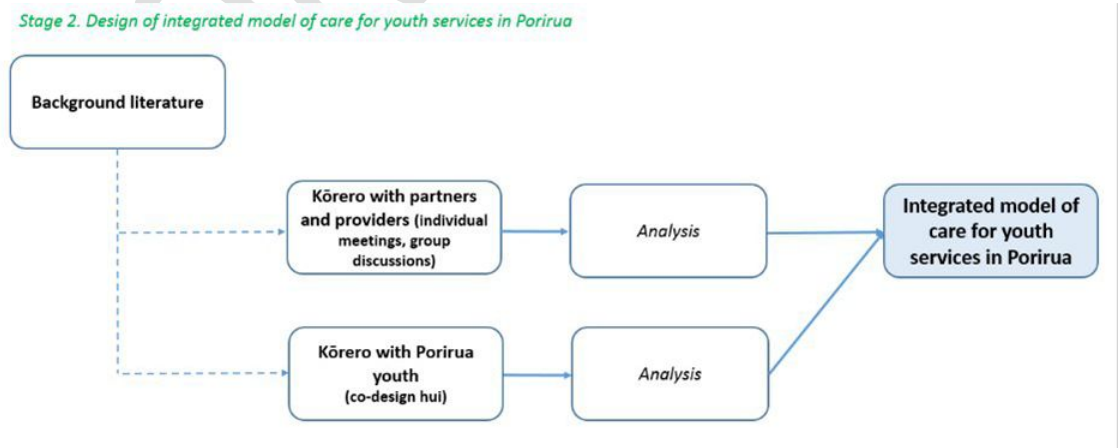
This section provides an overview of the design process for the project, and the key findings obtained.

3.1 Project design process

As previously noted, co-designing the proposed model of care was central to this project. We did this through 3 key activities:

1. A review of literature on integrated models of care for youth services.
2. Engagement with our key partner and service providers' to confirm their views on the Tumai Hauora mo nga Rangatahi ki Porirua and the critical success factors (CSFs)[6] for integrated youth services for Porirua to understand what an integrated service "looks like". This was achieved through individual meetings and group discussions.
3. Engagement with our young people in Porirua, including participation in the project working group and a specific two day co-design hui enabling young people to feel comfortable sharing their views on the CSF's for an integrated service model for the Porirua community.

The figure below depicts the design process for this stage.



[6] CSFs are "…… those characteristics, conditions or variables that, when properly sustained, maintained, or managed, can have a significant impact on [the] success… (Leidecker & Bruno, 1984:24). CSFs have been used across a range of health domains to support improved health outcomes. These include health management.

3.2 Background literature

This section provides background literature on integrated models of care for youth services, their key principles and effectiveness generally and in New Zealand. The detailed literature review can be found in *Appendix One: Literature Review*

Critical success factors

The international literature and New Zealand based experience suggests that the critical success factors (CSF) of an integrated youth service are:

Critical success factors
The service should be community based and have a range of services available in one location.
Services take a youth-centred approach. They must be youth friendly and offer spaces that enable young people to feel comfortable.
Services must attract underserviced parts of the community with a specific focus on Maori and Pacific young people and those with higher need.
Services must include Mental Health Services
Services are accessible
Staff are welcoming, skilled and experienced
Innovative youth health and development programmes and youth workers are continually developed

3.2.1 Integrated models of care for youth services

Integrated models of care are increasingly being used within public health to improve health services and population health. This is particularly in relation to mental health and addiction services for youth. While there is no one universal definition for 'integrated care services', it is generally accepted that integrated care is a practice unit with clinical and non-clinical personnel working collaboratively to provide comprehensive, multidisciplinary care; and ideally in one location (Porter, 2013; Hetrick, Bailey, Smith, Mathias, Singh, O'Reilly… McGorry, 2017; Halsall, Manion & Henderson, 2018).

Accessible, acceptable, appropriate, effective and equitable youth services are the key principles for integrated care stipulated in the WHO's framework for adolescent and young adult-friendly services (WHO, 2001, 2012).

Evidence supports the effectiveness of community based integrated youth services including that young people respond better to youth specific services, there are improved mental health outcomes and that young people who would otherwise not access services engage with a youth specific service.

3.2.2 Integrated models of care for youth services in New Zealand

Integrated youth services are a key approach within the public health sector in New Zealand. These services are typically delivered via school-based services, community-based services (i.e. youth one-stop shop services [YOSS]) and services provided in general practice settings (Fleming & Elvidge, 2010).

The literature suggests that a New Zealand based model needs to be designed to reduce inequities, be resourced appropriately to support young people, have a governance structure that covers a wide skill set and is representative of the community and that Maori and Pacific are a priority population.

The evidence supports a community based youth health service. There is no one model of practice rather it should be flexible and reactive to the community's needs. Young people often access a range of services so it is important that any door is the right door for youth to access services. Youth workers should be

able to help facilitate access to services for youth and mentoring programmes should be available to encourage and support the transition to adulthood.

3.3 Kōrero with partners and providers

Kōrero (individual meetings, group discussions) were conducted with 15 stakeholders to obtain their views and build on the research in the Tumai Hauora mo nga Rangatahi ki Porirua Report (2015). Their insights on what an integrated model of care for youth services for Porirua "looks like" (the CSFs) was also discussed. Engagement was conducted between January and May by CCDHB supported by a contracted resource. A list of the stakeholders is attached as *Appendix Two: Engagement with Partners and Providers in Porirua about an integrated youth service for Porirua*.

Critical success factors

The partners and providers described a number of factors they considered key for effective integrated youth services in Porirua. The CSF's are listed in the table below:

Critical success factors (CSFs)
Services take a youth-centred approach. They must be youth friendly and offer spaces that enable young people to feel comfortable.
Services reflect the community particularly Maori and Pacific young people including cultural nuances that define the way they access help and support.
Services are accessible
Existing services are strengthened and extended
Staff are welcoming, non-judgemental, skilled and experienced and understand Maori and Pacific young people(workforce development)
CCDHB funding and commitment is long-term and sustainable
Governance structure is representative
Evaluation activities are conducted to measure impact and inform services modification

Services reflecting the community and being culturally appropriate was a factor considered crucial by partners and providers. This was not only in terms of the workforce but also service design and delivery. Most felt 'culture', 'religion' and 'whanau' needs to be considered throughout because of the high Maori and Pacific populations.

Accessibility – the need for services to be easily accessible to youth was considered to be important by partners and providers. Basing a main service in Porirua City close to the transport hub and providing free transport, were considered advantageous by most.

Most partners and providers felt existing services needed to be enhanced, and where possible, extended to increase their reach and impact. Prime examples shared were adding to school-based services because of their "captured population"; and satellite services to service unmet need, particularly in areas where access is an issue.

A welcoming, skilled and experienced workforce was another factor most partners and providers considered crucial. Ensuring young people feel comfortable and confident to approach the "front desk"; and listened to and "safe" were recurring themes. Similarly, growing "our own" (Porirua) workforce. Work opportunities for Year 13 students was one option suggested.

Partners and providers considered CCDHB's long-commitment to this work critical to its success. This was not only in terms of funding support but also leadership and project management support. They felt the

service design/delivery and behavioural changes sought would not "happen overnight" and that providers, youth and whanau needed time for changes to occur and become the new "normal."

A governance structure that is representative and includes youth, community and sector representation was considered crucial because youth health and youth development is a "community" priority. The make-up of the structure should be skills-based.

Evaluation and ongoing evaluative activities were also considered key. This was not only for measuring services progress and impact; but also for informing services modification to ensure the services are achieving their outcomes and meet the youths' needs.

3.4 Kōrero with Porirua youth

Kōrero (co-design hui) was facilitated with young people from Porirua to obtain their views and perspectives on what an effective integrated model of care for youth services in Porirua "looks like" (the CSFs). Approximately 50 young people participated in the two-day co-design hui. Most were of Maori and Pacific decent, aged 16 to 24 years; and from a range of colleges, church groups, youth groups and community organisations. The hui was facilitated by the Change and Innovation Agency which included three experienced facilitators, two of which were young people. One of the youth leads from the Model of Care working group which has specific expertise and experience in youth engagement also supported facilitation of the hui.[7] The report from the Change and Innovation Agency is attached as *Appendix Three: Final Porirua Youth Insights Report for CCDHB July 2019*.

Critical success factors

Services take a youth-centred approach
Youth are engaged in the design and delivery
Services reflect the community (culturally)
Services are accessible
Services are connected
Health and counselling services are highly confidential and private
Social services, support and engagement activities encompass the home life and upbringing of Porirua young people
Staff are non-judgemental, maintain your confidence, friendly, skilled and experienced (workforce development)

An integrated model of care = A dedicated, youth one-stop shop

The youth were unanimous in their view that a centrally located, dedicated, youth one-stop youth (YOSS) providing holistic services for youth was **the** integrated model of care for youth services for Porirua. This was named #YouthQuake by the young people during the course of the workshop and was presented by youth in a short skit at the stakeholder walkthrough.

The youth had strong views on what the YOSS should look like, in terms of layout design.

[7] The working group member is Simone Workman. She has been contracted as the Youth Lead for this project and will support, coordinate and co-lead the youth membership and administration of the project.

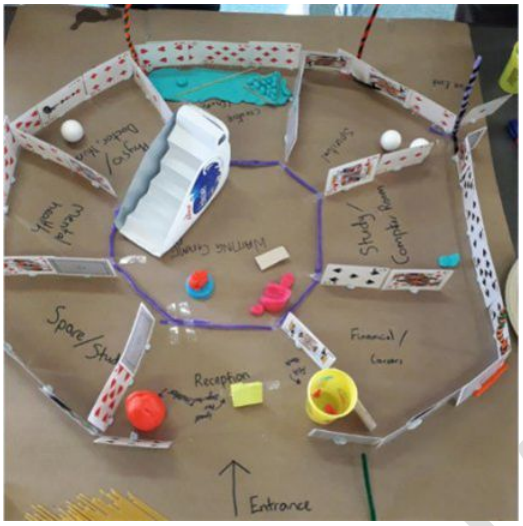


Image One: One example of what the layout might look like from the co-design workshop.

The youth described a number of key factors they considered crucial for the YOSS's success and for the integration of existing youth services. As with the feedback received from engagement with partners and providers, adopting a youth-centred approach is vital. A youth centred approach must be considered in all aspects of the service including design, management, communication and service deliver.

> *"There are heaps of services, but they aren't youth-friendly" (co-design participant)*

Engaging young people in the design and delivery of services was a factor considered crucial by the youth. It would help to ensure the services are relevant, delivered "the right way" – leading to greater impact and success. This was seen as particularly important for ensuring the service met the needs of Maori and Pacific young people.

Youth believed services needed to reflect the community and be culturally appropriate; and for the same reasons expressed in findings from engagement with CCDHB partners and providers.

> *"Services should value and respect my culture"*
>
> *"I want to feel safe, supported and understood"*

Accessibility was another key factor considered crucial by the youth for effective integrated youth services, and for the same reasons as those expressed by partners and providers. However, for the youth, "accessibility" was also about the cost and opening hours of the services. They felt free or 'at least affordable' services was a "must"; as was services being available and "open" when needed (by the youth). This means the service should consider accessibility outside of traditional office hours.

Existing and future services being connected, working together and "talking to one another" was another factor the youth believed crucial. Many shared instances of having to repeat their stories to numerous providers to the point of "turn-off." Making the sector easy for young people to navigate was a priority.

> *"Services working together, saying the same thing…"*
>
> *"How can we trust you to communicate with us if you can't communicate with each other?"*

Health and counselling services that are confidential and ensure privacy was another key factor that the youth considered to be essential for the 'success' of a supportive integrated youth service. It was not only their expectation but a 'need' that all information shared with providers be kept confidential and not divulged to third persons without their consent (confidentiality). This was particularly in relation to sexual health and mental health matters. Paradoxically, this notion of "absolute confidentiality" did not appear to apply to social determinant-related conditions and social services matters (e.g. Driver Licencing or CV writing classes). In these instances, the youth considered whanau involvement and inclusive and holistic approaches important.

"I want the information I tell you to be kept safe"

In terms of privacy, youth being able to access a YOSS inconspicuously without being seen or drawing attention to themselves was considered important (privacy). The youth at the hui unanimously supported a YOSS in the centre of Porirua as they felt it was a place that most young people access regularly and keeps them safe accessing the service without being seen. Positive youth-wording signage rather than health and social services were suggested as the most appropriate design to encourage uptake of the service.

Friendly, skilled and experienced staff was also considered crucial by youth, and for the same reasons as those expressed by partners and providers.

3.5 Discussion and Summary

The background literature and engagement with key partners and providers and Porirua youth highlight a number of key points:

- There is no one integrated model of youth services that will achieve optimal outcomes for all young people. Rather, it is a mixed model comprising school-based services, community-based services such as youth one-stop shops services and general practice services.
- Not surprisingly, the partners and providers see 'integrating of services' first and foremost as a reorganising, enhancing and extending of current services already in the system – whereas, the youth see it as the establishment of a youth one-stop shop service. A visible and tangible representation of what integration looks like for them; and that they are important and have been listened to.
- The CSFs for an effective integrated model of care identified by key partners and providers and the youth are, on the whole, consistent. The few variances are due to their different points of engagement and experiences with youth services and the youth health system i.e. partners and providers as funders and providers of youth services and the youth as consumers of these services.
- Importantly, the CSFs identified by both groups are consistent with the WHO's principles and key characteristics of integrated care services for adolescent and youth adult-friendly services and other CSFs identified in the literature review. This indicates that what they are seeking is not "out of the box"; but rather good "standard practice" and evidence-based.

4. An Integrated Model of Care for Youth Services for Porirua

An integrated model of care for youth services for Porirua requires that the organisation and management of health services allows young people to get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money.

During the two day co-design workshop the young people were unanimous in their thinking that a YOSS was the integrated model of care that was needed for young people. Participants developed the name *#YouthQuake* for the YOSS . The by-line "We are the youth, we are the movement" underpins the name which pays homage to Wellington's shaky (earthquake) reputation as well as conveying the participants vision and desire to be part of a movement of positive change in their community. To maintain the integrity of the co-design process it is recommended that #YouthQuake be adopted as the name of the YOSS.

To empower young people to continue to participate CCDHB must commit to continued youth engagement. CCDHB need to encourage youth-adult partnerships to promote youth leadership and their role to contribute to social change. Contribution from young people should be in an advisory capacity with the DHB as well as having decision-making roles to ensure ownership, and representation at governance level to ensure service relevancy and the success of #YouthQuake.

CCDHB has established a #YouthQuake Panel initially for a 12 month period. The majority of panel members participated in the co-design process. The establishment of the panel is in line with best practice by ensuring youth leadership and input is included in all aspects of the design and implementation process. Participants are representative of the Porirua community.

4.1 Recommendations for an Integrated Model of Care for Young People for Porirua

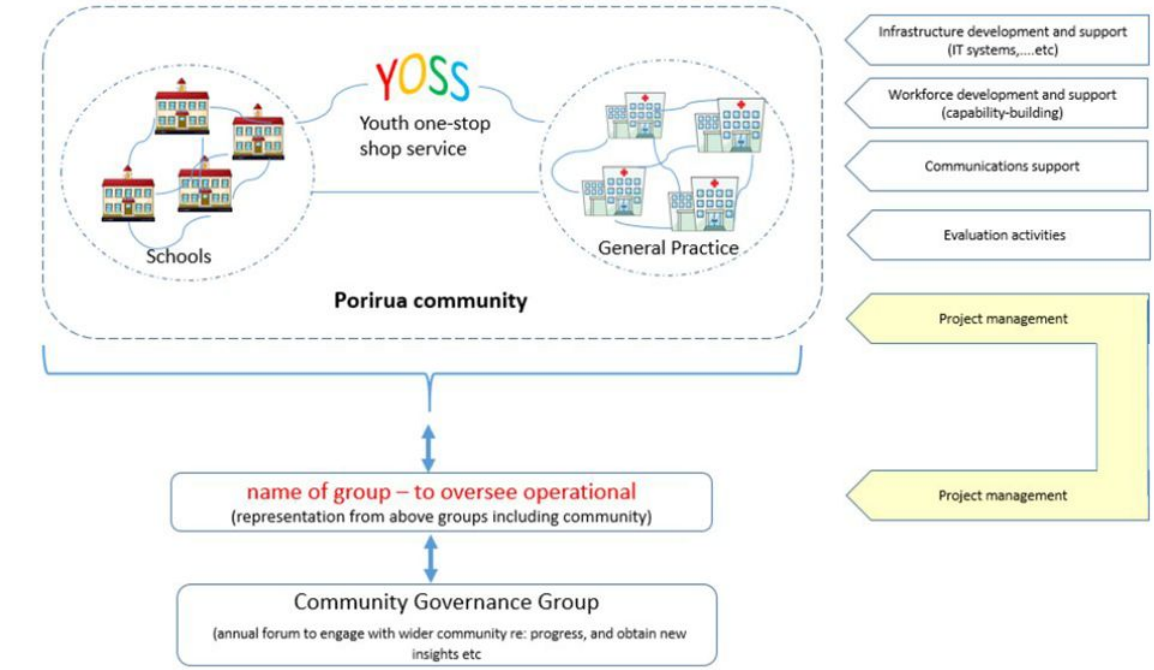
This section describes the proposed integrated model of care for youth services for Porirua across the range of providers of services that are available and with the addition of a YOSS.

The key recommendations for an integrated model of care for youth services for Porirua are:

1. To first establish the #YouthQuake for Porirua to improve the health and well-being of young people in Porirua aged 10-24 years by providing youth-centred, culturally appropriate, affordable, accessible health and social support services.
2. To work with social services, local government and other key sectors to increase the services scope, reach, impact and success of the #YouthQuake.
3. To enhance and strengthen existing services to become exemplar youth-focused/based services by incorporating the CSFs and other new insights.
4. To establish governance between existing school-based and general practitioner services and the #YouthQuake to support optimal performance and outcomes.
5. To develop online access for young people to better understand the pathways to accessing youth services and where they are available.

The service components are depicted in the following graphic.

Image Two: An Integrated Model of Care for Young People for Porirua



4.2 Implementation approach

The approach that is recommended to establish and implement the integrated model of care for young people for Porirua, has complimentary activities which can be delivered concurrently. There will be a number of workstreams to support the implementation of an integrated model of care.

Workstream One: *Implementation of #YouthQuake – The YOSS.*

- Identify and engage a senior implementation lead to work with the #YouthQuake panel throughout the project implementation.
- CCDHB to continue to work with key government agencies such as Oranga Tamariki, Police, ACC, the Ministry of Social Development and Porirua City Council to garner financial input and support for the project.
- Design a broad service specification in co-design with the #YouthQuake panel which will inform an RFP process to establish a service to deliver the #YouthQuake.
- To focus on the establishment of the #YouthQuake in partnership with the successful provider and any other agencies who have committed funding to the service.

Workstream Two: *Review and support of existing youth services*

- To gather existing information about providers of youth services that are presently active in the Porirua community.
- Work with PHO's and providers to enhance and strengthen existing services so that they become exemplar youth-focused services.

Workstream Three: *Governance of an Integrated Model of Care for young people in Porirua*

- Support and work with the #YouthQuake panel as expert advisors to CCDHB throughout the implementation of the #YouthQuake.
- To ensure the voice of youth by youth is continued after the #YouthQuake is established.
- To establish a governance board that will work across existing school based and general practitioner services and the new YOSS to support optimal performance and outcomes.

Workstream Four: Evaluation of the model of care

- To develop an evaluation framework. This will include metrics and a return to the community on an annual basis to gather further insights and considerations for CCDHB and the service provider.

Workstream Five: Online Services

- Develop and design an online pathway for young people to access information and understand how to access services available to young people in Porirua.

5. Risks and variables for consideration

5.1 Funding

The two existing YOSS's in CCDHB are Evolve and Kapiti Youth Support. They are funded approximately $780,000 and $390,000 respectively for the youth service component. Both of the YOSS's hold additional contracts with the DHB (eg. SBHS) which provide further funding. Both services run at full capacity and demand for the services are greater than what funding allows.

A service in Porirua needs to reflect the specific Porirua community and the needs of the youth. As discussed a focus of CCDHB to provide equitable outcomes across the CCDHB catchment and the Porirua community has been highlighted as an area of higher need. Young people in Porirua live in the highest levels of deprivation and have larger numbers of Maori and Pacific people. These factors suggest that an intensive focus which includes elements of both the Evolve and the KYS models are required for Porirua youth and that funding for a YOSS service should be reflective of that.

5.2 Partners

As our analysis of the evidence shows, a YOSS or wraparound service for young people must include social support services. While the investment by CCDHB focusses on health related outcomes we need to continue to work with our partners to provide a space which can include a range of separately funded social and support services that deliver more equitable outcomes for our rangatahi in Porirua.

CCDHB need to continue to work with government, local government and other agencies to secure additional funding for the sustainability of a YOSS for youth in Porirua.

5.3 Governance

An effective model of care that will lead to a better integration of services for young people in Porirua requires a strong governance structure that is supported by the DHB. This structure needs to include members from all of the service types that are available and includes: the #YouthQuake panel, the YOSS, school based health services, general practice and any supporting partners who provide services in the YOSS.

5.4 Balancing the workforce

Consideration of the workforce is a priority for any YOSS that is established. The youth of Porirua were clear that the welcome they receive and the service that follows must be culturally appropriate and that the people they interact with are approachable and enable them to feel safe and supported. The youth would like to be seen by people who look and feel like them.

6. Cost for Delivery

6.1 Operating costs for a #YouthQuake YOSS

CCDHB fund the Kapiti Youth Support and Evolve to deliver a range of services to young people that best meet the needs for young people in their unique localities. CCDHB would look to request proposals from different community based organisations to deliver a mix of services that is appropriate to the Porirua community. There will be a specific Mental Health component and funding for services currently operating in the Porirua community may be redirected through the YOSS over time. This may include some mental health activity, sexual health funding as well as other activities that are recognised in the implementation and evaluation stages of Workstream one, three and four.

The existing YOSS's in CCDHB have operating budgets of between $1.5 million dollars and $2.3 million dollars. Both YOSS's offer a different mix of health and social support services that are specifically designed to cater to the needs of their locality. The bulk of the funding is provided by CCDHB and MSD for both of the YOSS's. A breakdown of services and consultation rates for the existing YOSS's is attached as *Appendix Four: Evolve overview* and *Appendix Five: KYS overview*.

Table One: Current YOSS Budget and CCDHB funding

YOSS	Approximate Funding (dollars)		
	CCDHB	Other	Total
Evolve	$1,163,000	$337,000	$1,500,000
Kapiti Youth Support	$522,000	$1,778,000	$2,300,000

Table Two: 2018/19 YOSS Service Usage and average cost per visit

YOSS	Total number of service users	Average cost per visit
Evolve	13,860	$108.23
Kapiti Youth Support	21,912	$104.97

NB. The average cost per visit includes all consultations and is not health specific funding. The type of consultation may vary by speciality.

The successful YOSS structures in CCDHB suggest that a sustainable YOSS will need to secure ongoing funding of at least $1.5 million dollars and up to $2.3 million dollars if services are developed to create a wide range of social services. Evidence from the two day workshop with young people in Porirua indicate that the social service component is very important to their wellbeing.

Porirua is the only locality in CCDHB which has young people living in the highest deprivation. In Porirua, 35% of youth are recognised as living in the highest deprivation (deprivation level 10). Porirua has been recognised by CCDHB as a locality of higher need and a focus on improving more equitable outcomes. It is recommended that there is consideration to support the #YouthQuake to a higher level to work toward improving outcomes and progress more equitable outcomes for our rangatahi in Porirua.

To support and ensure the sustainability of a service to improve outcomes for our rangatahi in Porirua for a #YouthQuake YOSS it is recommended that combined health funding may be $900,000. This will be a mix of redirecting existing funding lines and increasing the amount of funding that was committed in 2018 by the Board to establish an integrated youth service for young people for Porirua.

7. Recommendations

To support a successful integrated model of care for young people for Porirua it is recommended that CCDHB:

1. SIP begin implementation of #YouthQuake. This includes continuing to work in co-design with the #YouthQuake panel to design a service specification.
2. That procurement for services is subject to funding decisions for the 2019/20 financial year.
3. That if funding is approved an RFP process is commenced with the aim to contract for services from 1 July 2020.
4. The continued conversations with other agencies to secure additional funding for the #YouthQuake.
5. SIP to undertake a review in partnership with PHO's of current services and providers to identify and strengthen existing youth services.
6. SIP to establish new governance structures to better support youth in Porirua.
7. The establishment of the #YouthQuake panel and their continued expert voice of the Porirua community.
8. A meaningful evaluation component.
9. A future online service for young people in Porirua to provide online support and education on accessing services be scoped.

PUBLIC

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**HEALTH SYSTEMS COMMITTEE DISCUSSION**
	Date: 4 September 2019

Author	Tara D'Sousa, Team Leader Analytical and Policy, Regional Public Health
Endorsed by	Peter Gush, Service Manager, Regional Public Health
Subject	**HEALTHY HOUSING UPDATE**

RECOMMENDATION

It is **recommended** that the Committee:

(a) **Notes** the information provided as an update on housing activity in the CCDHB district.

APPENDICES

1. **REGIONAL HEALTHY HOUSING RESPONSE GROUP (RHHRG) MEMORANDUM OF UNDERSTANDING (MOU);**
2. **REGIONAL HEALTHY HOUSING RESPONSE GROUP (RHHRG) LOGIC MAP - DRAFT;**
3. **REGIONAL HEALTHY HOUSING RESPONSE GROUP (RHHRG) SUBMISSION ON THE KAINGA ORA – HOMES AND COMMUNITIES BILL.**

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

1. INTRODUCTION

1.1 Purpose

As requested, the purpose of this paper is to provide information on housing activity in the Capital and Coast District Health Board (CCDHB) district.

1.2 Previous Board Discussions/Decisions

This paper provides an update on housing activity in response to research recently released by Dr Tristram Ingham, et al. The case control study found that almost 20% of hospital admissions for children under two years old, with acute respiratory infections, could be prevented if their houses were free from damp and

mould.[1] This paper also follows up on earlier papers on housing presented to the CCDHB Health Systems Committee (HSC) in August and October 2018, by Regional Public Health (RPH).

2. BACKGROUND

RPH views housing as a key social determinant of health, and delivers the Well Homes Healthy Housing Initiative in the wider Wellington region with partners He Kainga Oranga (Housing and Health Research Programme, University of Otago, Wellington), Sustainability Trust and Tu Kotahi Maori Asthma Trust; and is a founding member of the Wellington Regional Healthy Housing Response Group (RHHRG).

2.1 Well Homes

The Well Homes partnership, as described in the previous paragraph, operates under the auspices of the Ministry of Health's Rheumatic Fever Prevention and Healthy Housing Initiative (HHI) combined programme. The partnership was established in 2015, and developed into a healthy homes response involving public health nursing assessments of houses, eco-energy expert input to interventions for improving the housing environment and social service support for whānau to sustain wellbeing within the home environment. All partners want homes that will keep children healthy and in school.

2.2 Regional Healthy Housing Response Group

The Regional Healthy Housing Response Group (RHHRG) was established in July 2017 to support a collaborative, regional approach to healthy housing in the Wellington region with the vision;

"Everyone in the Wellington Region lives in warm, dry and safe housing by 2025."

Representatives are from central government, local councils, district health boards, iwi and pacific providers, research, social outreach, and community organisations. Using a collective impact model (shared governance, strategic planning, community involvement and evaluation), RHHRG is driven by collaborative leadership to develop creative solutions to the problem of Wellington region's poor housing quality using a pro-equity approach.

The RHHRG is has a Steering Group and a Working Group, and a Memorandum of Understanding (MoU) that sets out principles of engagement, among them Te Tiriti o Waitangi and a pro-equity approach (Appendix one). The Steering Group is made up of over 30 agencies. The Working Group is tasked with the planning and implementation of agreed activities including research on housing data, a community-based housing insulation upgrade, and advocacy on healthy heating. A draft logic map of the RHHRG plan and vision is provided (Appendix two).

3. UPDATE ON ACTIVITY

3.1 CCDHB Housing Sensitive Hospitalisations for Māori and Pacific children 2014-2018

The table below summarises CCDHB Housing Sensitive Hospitalisation data (by ethnicity), between 1 July 2014 and 30 June 2018. There were 806 housing sensitive hospitalisations for Māori children aged 0 to 14, and 795 for Pacific children of the same age.

[1] Ingham et al (2019). Damp Mouldy Housing and Early Childhood Admissions for Acute Respiratory Infection: A case control study. *Thorax.*

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Table 1: CCDHB Housing Sensitive Hospitalisations for Māori and Pacific Children aged 0-14 years

CCDHB HOUSING SENSITIVE HOSPITALISATION ADMISSIONS, JULY 2014-JUNE 2018	
MĀORI – AGED 0-14 YEARS	
Total Population (2018)*	11,530
Total number of admissions (July 2014 – July 2018) **	806
Average number of admissions annually	202
Average annual hospital admission rate	18 per 1,000 population per year
Average annual bed days	484
PACIFIC PEOPLES – AGES 0-14 YEARS	
Total Population (2018)*	8,780
Total number of admissions (July 2014 – July 2018)**	795
Average number of admissions annually	199
Average annual hospital admission rate	23 per 1,000 population per year
Average annual bed days	539

**Subnational ethnic population projections (2018), sourced from Stats NZ 21/08/2019*

***Admission data and annual bed days sourced from National Minimum data set (for the period 1 July 2014 – 30 June 2018)*

3.2 Well Homes Data in CCDHB district 2017-2019

In 2016, the Healthy Housing Initiative (HHI) criteria for referrals was broadened. Well Homes has been working with CCDHB and HVDHB on refining the hospital referral systems in order to capture most whānau affected by housing sensitive hospitalisation. Well Homes assessment data has been captured in the graphs below.

Between 1 July 2017 and 30 June 2019, 559 homes were assessed by Well Homes in the CCDHB district (Figure 1). Almost 50% of these were Housing New Zealand (HNZC) homes (Figure 2). The majority of homes assessed were in Porirua City (56%, 312) and Wellington City (39%, 219) (Figure 3).

Well Homes has a strong equity focus with the majority of referrals received for whānau living in high deprivation areas (NZDep levels 9 and 10) (Figures 4 and 5), and of Māori or Pacific ethnicity (Figures 4 and 6).

Figure 1: Homes visited (assessed) by Well Homes in the CCDHB area 1 July 2017 - 30 June 2019 (n=559)

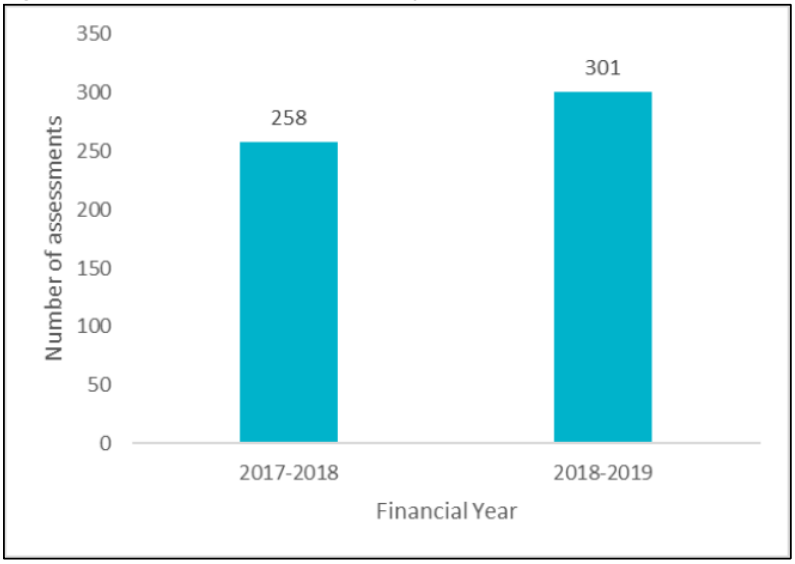

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Figure 2: Homes visited (assessed) by Well Homes in the CCDHB area 1 July 2017 - 30 June 2019, by tenure (n=559)

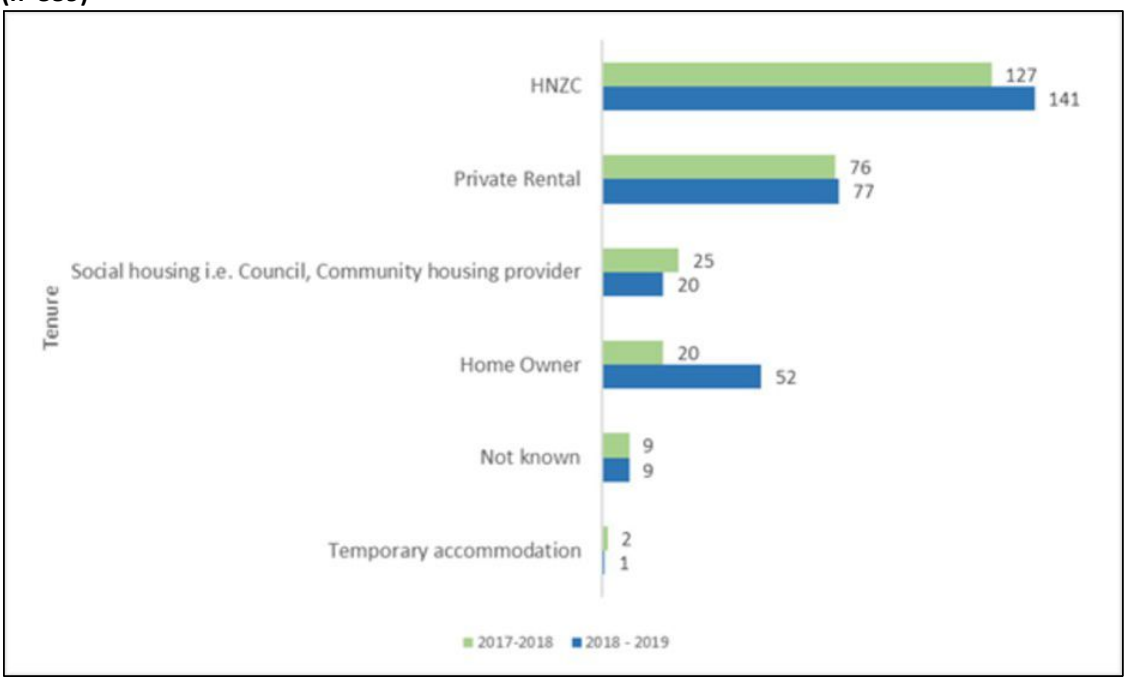
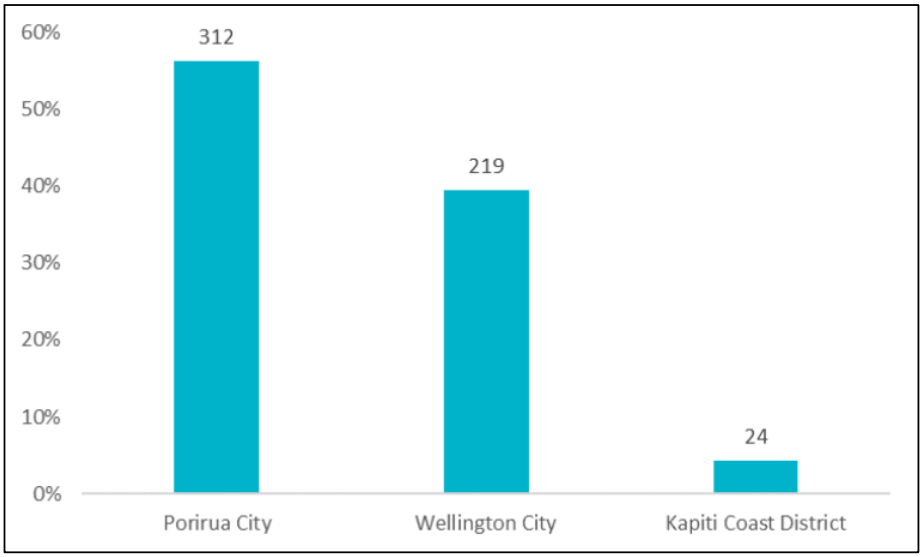


Figure 3: Homes visited (assessed) by Well Homes in the CCDHB area 1 July 2017 - 30 June 2019, by territorial authority (n=555)[2]



[2] Lower total number is likely to be due to missing geocoding information.

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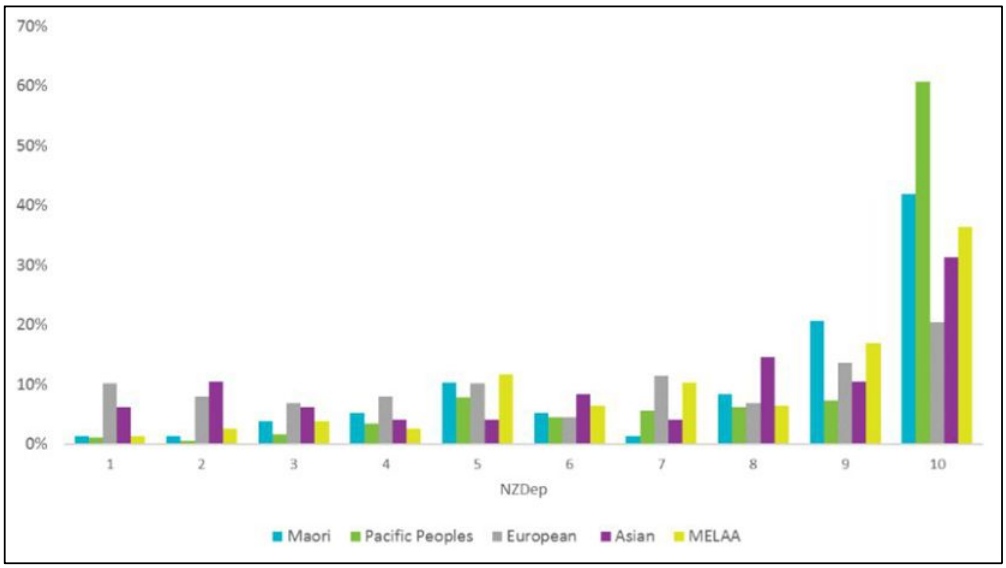
Figure 4: Distribution of clients from CCDHB area visited (assessed) between 1 July 2017 - 30 June 2019, by ethnicity and NZDep



NZDep 10 = most deprived; MELAA – Middle Eastern/Latin American/African

Figure 5: Distribution of clients from CCDHB visited (assessed) between 1 July 2017 - 30 June 2019, by NZDep (=553)[3]

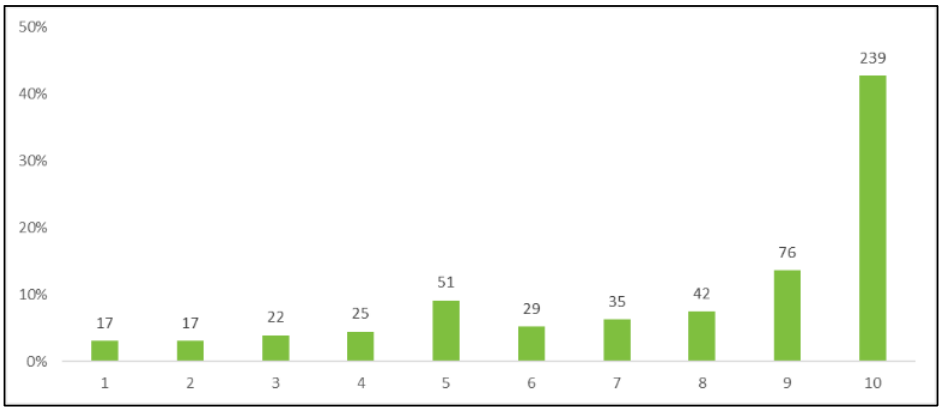
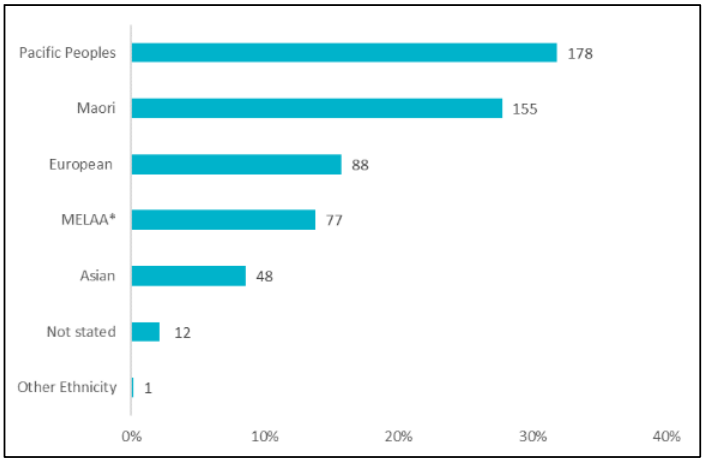


Figure 6: Distribution of clients from CCDHB area visited (assessed) between 1 July 2017 - 30 June 2019, by ethnicity (n=559)



[3] Lower total number is likely to be due to missing geocoding information.

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3.3 Regional Healthy Housing Response Group (RHHRG)

Over the last year, the RHHRG has made significant progress in each of the four focus areas: Advocacy, Education, Collaboration, and Projects.

1) **Advocacy:** The RHHRG uses the power of its collective voice to advocate for warm, dry and safe housing in the Wellington Region. In July this year, the Working Group wrote a submission in support of the Kainga Ora – Homes and Communities Bill with recommendations to include more public health and wellbeing support, as well as opportunities for financial assistance for immediate home repairs. The submission was supported by the signatories to the MoU (submission provided in Appendix three).

2) **Education:** The RHHRG is utilising the skills, knowledge and information of its members to disseminate key messages and education to the public in the Wellington region where there are known knowledge gaps that are preventing everyone from living in warm, dry, safe housing. The RHHRG is also embarking on research that will provide a stocktake of all the data sources available on housing in the Wellington region. The overall purpose of this stocktake is to:

    a) Provide an indication of what regionally specific research and data sources exist for housing related topics, and
    b) Utilize these data sets to answer specific questions around housing quantity and quality. This will help inform the RHHRG about where they can best use their collective energy and resources to achieve their vision.

3) **Collaboration:** The most powerful instrument RHHRG has as a group is the ability to collaborate by working together to collectively impact housing in the region. The RHHRG has facilitated ongoing collaborations on housing improvement activities and information with all interested parties working in the housing space in the Wellington region.

4) **Projects:** The RHHRG is piloting and implementing collaborative projects that contribute towards warm, dry and safe homes. One example is locality-based home upgrade projects (HUP) targeting areas that have a high proportion of households with Māori, Pacific, low-income and high health-needs. Based on RPH's analysis of housing sensitive hospitalisations data cut by age and the deprivation index, Otaki has been nominated by RHHRG and Kapiti Coast District Council (KCDC) as a potential location. There are also strong community connections in Otaki with high interest to lead the project. The RHHRG has been in discussions with KCDC, Energise Otaki and local Hauora providers as project partners and will engage with local iwi and other interested partners to refine and deliver portions of the project.

4. NEXT STEPS

This year, the RHHRG secured $30,000 from the Building Research Association of New Zealand (BRANZ) for the research stocktake activity and is working on securing sustained, long-term funding. Additionally, RHHRG is identifying a lead agency or resource to drive and support the work of the Steering and Working Groups. The working group is also developing the legal framework in order to receive and deliver on funds. A strategic plan, action plan and communications plan have been drafted to be approved at their next steering group meeting on 6 September 2019.

Item 2.5.1 Appendix 1

Everyone in the Wellington Region Lives in Warm, Dry and Safe Housing by 2025

Memorandum of Understanding
Regional Healthy Housing Response Group

August 2018 to July 2025

Background

A warm dry home is the foundation of health and wellbeing throughout life. Housing is an important underlying determinant of health, with housing quality and household crowding playing a major role in health outcomes[1] . Poor living conditions, including dampness and crowding, are significant risk factors for acute rheumatic fever. Housing is contributing to hospitalisation and re-hospitalisation rates for children in New Zealand, notably for respiratory infections[2] . These conditions increase their risk of future ill health and poorer performance across a range of social indicators. The burden of disease associated with housing conditions is particularly high for Māori and Pacific whānau[3] .

This MoU confirms the commitment of key organisations, decision-makers and implementers in the healthy housing space in the greater Wellington region. We commit to joined-up action on improving housing for better health outcomes and to achieve our vision that Everyone in the Wellington Region Lives in Warm, Dry and Safe Housing by 2025.

Role

The policy and legislative environment that spans housing is complex – from homelessness (supply and demand) to tenancy/landlord relationships, fuel poverty, housing/health literacy (quality). Given that policy and legislation significantly affect housing quality and housing supply, a coherent approach among all the agencies involved in the housing space will have better impact and avoid duplication. The role of the Regional Healthy Housing Response Group (The Group) is to support a collaborative regional approach to healthy housing in the Wellington region. The Group will provide advice and leadership to develop an effective work plan and ensure implementation.

Responsibilities

Signatories to this MoU agree to:

- Uphold Te Tiriti o Waitangi principles with a view to reducing inequities and improving health outcomes for Māori, upholding the partnership relationship and working together in a spirit of collaboration and collective responsibility.
- Attend quarterly meetings and receive reports of working groups as required, providing high level monitoring of agreed measures.
- Support a core sub-group of organisations to consult on and coordinate a regional work plan (including Annual Plan and 3- year Plan).
- Commit to supporting administration of The Group (through a backbone organisation) and items detailed in the Annual Plan.
- Commit to a joint approach to action across government, health, social and housing sectors in the Wellington region;
- Engage in regional and national dialogue and information exchange to, provide learning, and identify challenges/opportunities to influence strategic decision-making for local, regional and national policy development, regulations and legislation.

Responsibilities *continued*

- Ensure inclusive engagement that privileges the voice of those directly affected by poor housing, and reflects community aspiration in collaborative housing work. This especially includes representation from Māori, Pacific and other groups overrepresented in poor health outcomes.
- Develop cross-sector partnerships within the Wellington region to design and deliver integrated effective healthy housing services that meet the needs of individuals, whānau and communities.
- Ensure the planning, delivery and evaluation of work-plans meets the needs of Māori and Pacific communities, including the collection of specific data and frameworks for evaluation that are meaningful to Māori and Pacific communities.
- Create an enabling environment that allows the work of The Group to succeed. This includes providing or planning for resources as well as delegation of responsibility for implementation and administrative support of The Group.
- Identify success criteria to deliver and measure impact and facilitate strategic learning.

Vision

Everyone in the Wellington Region Lives in Warm, Dry and Safe Housing by 2025

Scope

In order to realise our vision and achieve measureable change, we commit to focussing our work in a number of key areas. These are:

- Housing quality
- Energy hardship
- Healthy housing literacy

The Group seeks to influence the following areas where they intersect with the provision of healthy housing:

- Homelessness
- Location and supply of housing
- Behaviour change and cultural awareness
- Urban design and planning process
- Policy development in local and central government.
- Social connectedness

To guide our work our baseline standards for a healthy home are:

- It is warm and affordable to heat, and has adequate ventilation to support good air quality and thermal comfort even in extreme conditions;
- It is free from hazards, safe from harm and promotes a sense of security;
- Its occupants have security of tenure

Notes

Non-Binding:

The Group recognises that this MoU is non-binding. Local councils and Government departments and ministries have existing work programmes addressing issues the Group will focus on and prescribed processes for changing those. The Group understands that changes to those work programmes and areas of focus would be through these processes and by agreement with the organisations.

Confidentiality and Storage of Information:

Information shared within the Group including minutes and information related to members' programmes is understood to be shared in confidence with the Group i.e. it should not be shared in the public domain unless specifically authorised by the member sharing that information. Information such as minutes, member lists and other documents will be stored securely by the Secretary. The core sub-group is explicitly empowered to make public statements on behalf of the Group.

Disputes:

Any disputes between members on the direction or programmes being delivered by the Group that are not able to be resolved by consensus will be adjudicated by the core sub-group. The core sub-group's decision will be final.

Membership:

Membership of the Group is open to any organisation who shares the vision of the Group. Formal membership is signified by signing of the MoU. A current list of members will be held by the Secretary. Any member may request to leave the Group by sending a request to Secretary and the Secretary will remove the member's name from the list.

References

1 Krieger, J. and D.L. Higgins, Housing and health: time again for public health action. American Journal of Public Health, 2002. 92(5): p. 758-768.

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

3 "Housing is a health issue too" Dr. Bryn Jones, https://thespinoff.co.nz/atea/01-03-2018/housing-is-a-health-issue-too/

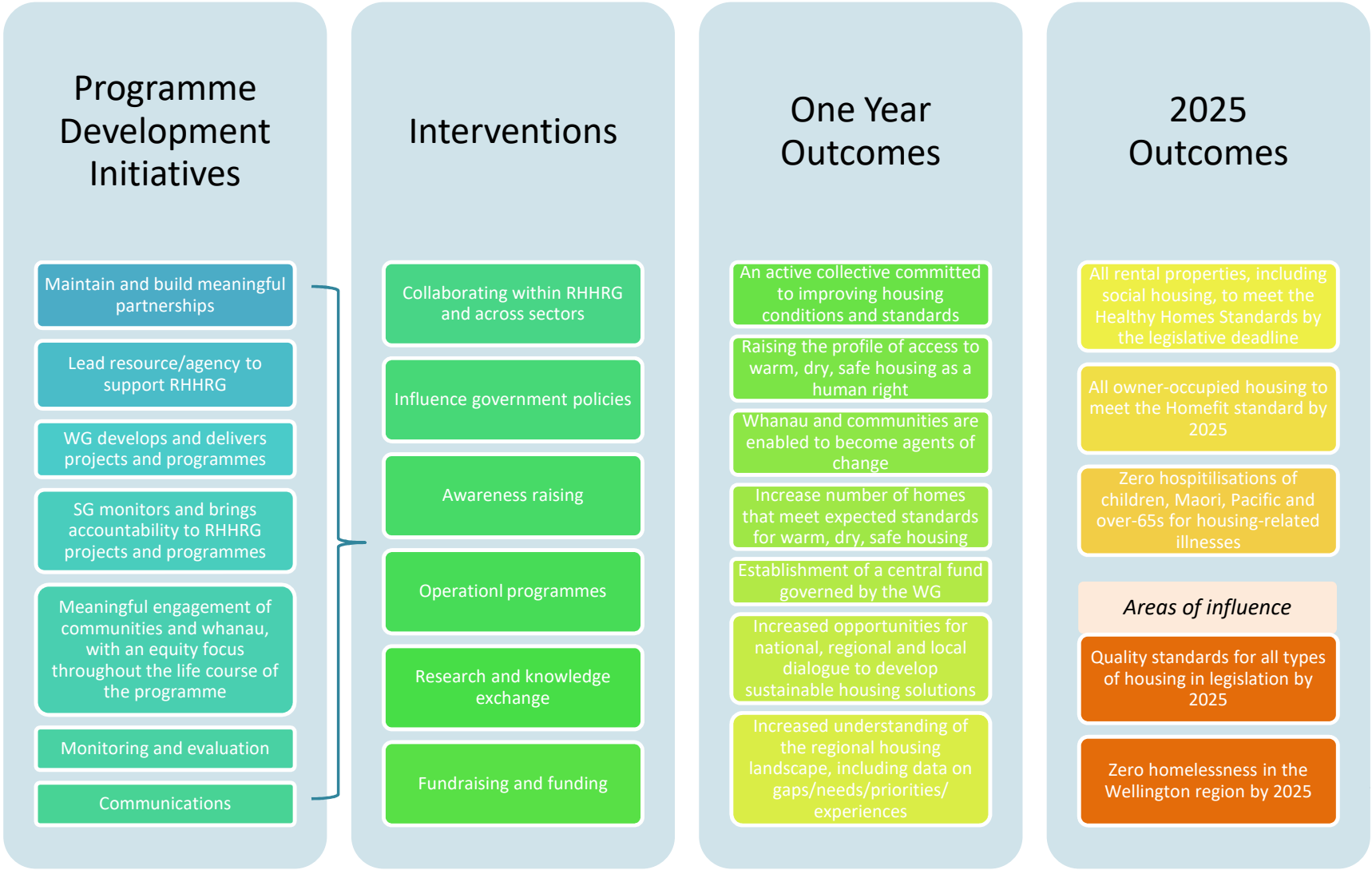
Item 2.5.2 Logic Map

DRAFT

APPENDIX 1: Logic Map

Regional Healthy Housing Response Group

VISION: Everyone in the Wellington region lives in warm, dry and safe housing by 2025



Item 2.5.3 Appendix 3

10 July 2019

Committee Secretariat
Environment Committee
Parliament Buildings
Wellington

Re: Kāinga Ora – Homes and Communities Bill

Tēnā koe,

The Wellington Regional Healthy Housing Response Group (RHHRG) would like to formally register support for the Kāinga Ora – Homes and Communities Bill.

A warm dry home is the foundation of health and wellbeing throughout life[1]. Housing is an important underlying determinant of health, with housing quality and household crowding playing a major role in health outcomes. Poor living conditions, including dampness and crowding, are significant risk factors for acute rheumatic fever. Housing is contributing to hospitalisation and re-hospitalisation rates for children in New Zealand, notably for respiratory infections. These poor housing conditions increase risk of future ill health and poorer performance across a range of social indicators. The burden of disease associated with housing conditions is particularly high for Māori and Pacific whānau.

The policy and legislative environment that spans housing is complex – from homelessness (supply and demand) to tenancy/landlord relationships, fuel poverty, housing/health literacy (quality). Given that policy and legislation significantly affect housing quality and housing supply, a coherent approach among all the agencies involved in the housing space will have better impact and avoid duplication. The RHHRG was established to support a collaborative, regional approach to healthy housing in the Wellington region with a stated vision of "Everyone in the Wellington Region lives in warm, dry and safe housing by 2025". The RHHR Steering Group is made up of over 30 agencies working in the housing space in the wider Wellington region with a working group who are actively involved in: research on housing data, a community-based housing insulation upgrade, and advocacy on healthy heating.

The RHHRG acknowledges and commends the work of the Ministry of Housing and Urban Development in seeking to bring together urban development powers and functions to support community wellbeing through this Bill. The Bill successfully looks beyond the provision of houses to the importance of community and recognises the role urban development can play in creating both homes and communities. Reorienting the work and role of Housing New Zealand (HNZ) towards to do this will be a positive step forward for both clients and Aotearoa as a whole.

The RHHRG **recommends the following amendments be made** to the Bill to recognise the link between the provision of homes and communities and population health and wellbeing:

- Section 10: Membership of board of Kāinga Ora–Homes and Communities – include in ***health and public health*** as an important capability for members to the board.

[1] New Zealand College of Public Health Medicine (2013). "Housing Policy Statement." Available from: https://www.nzcphm.org.nz/media/120350/nzcphm_healthy_homes_standard_submission_2018.pdf.

- Section 12: Objective of Kāinga Ora–Homes and Communities – introduce an additional objective of ***supporting health and wellbeing***.
- Section 13: Functions of Kāinga Ora–Homes and Communities – include opportunities for financial assistance for immediate home repairs. Financial limitations are often the reason for home owners not maintaining their houses in good repair, and there are certain repair priorities that if not addressed can accelerate physical deterioration of the house[2].

Further observations and requests:

RHHR members have observed that the current ad hoc urban development is struggling and unable to deliver the very real need of people, particularly the vulnerable, for secure tenure, allowing them to live within a supportive community and close to services. **Critical to the success of Kāinga Ora is the building of meaningful partnerships, consultation at the community level and clear and timely communication with stakeholders.**

This Bill is primarily concerned with a structure of a new entity with good intentions for improved, joined-up urban development to advance the need for increased housing and changes to the ways in which New Zealanders live, work and get from one place to another. While this is greatly needed, it remains to be seen how this will work in practice and will require workplace culture change of those moving from working for HNZ to working for Kāinga Ora to ensure an organisation and team who prioritise people and partnership.

Members of the RHHRG deliver the Ministry of Health's Healthy Homes Initiative programmes which works with families, agencies and local partners to provide education and access to interventions which will create warm, dry and uncrowded home. This programme has already developed referral processes with the Ministry of Social Development (MSD) and HNZ to include fast tracking onto social housing waitlists and benefit reviews for clients assessed under these programmes. However, even though there are these protocols in place, the experience is that the effectiveness relies wholly on staff engagement – high turnover does not help. **RHHRG recommends that Kāinga Ora have strong engagement and high-level buy-in with relevant programmes and services available.**

One challenge experienced by many seeking social housing is the MSD housing assessment process. Social services have commented on this, noting: (1) the assessment process varies depending on MSD staff; (2) MSD sees everything through the lens of benefit receipt; and (3) MSD staff do not have a housing perspective. These challenges contribute to the highly stressful reality of being homeless and in temporary accommodation while searching for more permanent solutions. **RHHRG requests that this challenge be considered during the process of disestablishing HNZ and establishing Kāinga Ora.**

While the process of disestablishing HNZ and establishing Kāinga Ora will have no direct impact on current tenants, it is likely even the change of names and appearance could cause some stress and concern among tenants. **RHHRG requests that a considered effort is made to communicate in a timely manner to relevant stakeholders and particularly with tenants to explain clearly the changes that are happening.**

Thank you for the opportunity to make this submission. The point of contact for this submission is:

Dr. Elinor Millar
Public Health Medical Specialist, Regional Public Health
Email: Elinor.Millar@huttvalleydhb.org.nz

[2] https://www.branz.co.nz/cms_show_download.php?id=4158d0bdfcc81dacb0caf37e9423259fabec292d

Nāku noa, nā

Roger Blakeley
Regional Healthy Housing Response Working Group Chair

Capital & Coast District Health Board
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Date 4 SEPTEMBER 2019	**HEALTH SYSTEM COMMITTEE DISCUSSION**
Author	Peter Guthrie, General Manager Planning & Performance, Strategy, Innovation and Performance (SIP) Sam McLean, Senior Advisor Accountability, SIP
Endorsed by	Rachel Haggerty, Executive Director, Strategy Innovation & Performance
Subject	**Ministry of Health Non-Financial Monitoring Report - Quarter 4 2018/19**

RECOMMENDATIONS

It is **recommended** that the Committee:

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

(b) **Notes** that of the six core health target we have:

a. Achieved: Faster Cancer Treatment and Better help for Smokers to Quit – Maternity;

b. Partially Achieved: Shorter stays in Emergency Departments and Increased Immunisation;

c. Not Achieved: Better Help for Smokers to Quit – Primary Care; and

d. Not Assessed: Raising Healthy Kids (data not available)

(c) **Notes** that of the 60 non-financial performance indicators reported to MoH in quarter 4 2018/19 we achieved and partially achieved 56 indicators, did not achieve three and one was not assessed;

(d) **Endorses** a condensed non-financial performance report for inclusion in the 25 September Board papers (Appendix 1) focussed on the core health targets.

APPENDICES

1. **APRIL – JUNE 2019 QUARTERLY PERFORMANCE MONITORING REPORT**

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

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1. PURPOSE

This paper provides an overview of the 2018/19 quarter four Non-Financial Monitoring report as assessed by the Ministry of Health (MoH). This includes the six core health targets and 58 non-financial measures.

2. BACKGROUND

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

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

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

A redesign of DHB non-financial performance framework has occurred in consultation with DHBs in 2018/19. The redesign aims to emphasise a stronger population view of performance and change the conversation to one of improvement and benefits for people within the context of the existing policies and levers, including financial sustainability. The objective is to give confidence the decisions are improving health outcomes for New Zealanders.

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

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

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

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

3. OVERVIEW OF PERFORMANCE

In quarter four 2018/19, we received the following results for the core health targets from the MoH:

Achievement	Health Target	Performance	Target
Achieved	Faster Cancer Treatment	89%	90%
	Better Help for Smokers to Quit – Maternity	96%	90%
Partially Achieved	Increased Immunisation	93%	95%
	Shorter Stays in ED	81%	95%

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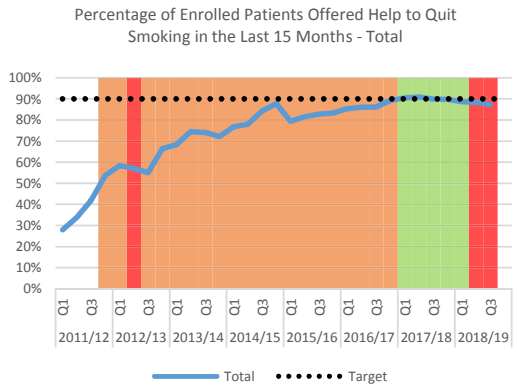
Not Achieved	Better Help for Smokers to Quit – Primary Care	87%	90%
Not assessed	Raising Healthy Kids	Data not available	95%

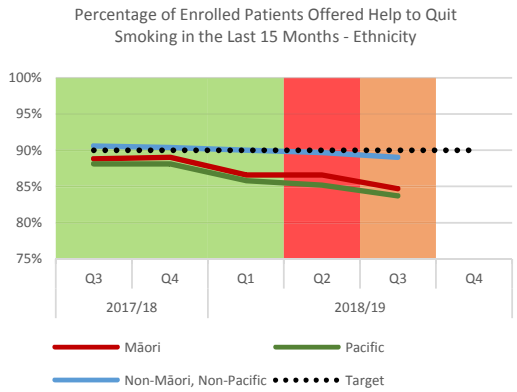
3.1 Better Help for Smoker to Quit – Primary Care

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

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

Performance to Quarter 4 2018/19: We have achieved 87%. Performance has declined over the previous three quarters. Performance for Māori and Pacific is declining at a faster rate compared to Non-Māori, Non-Pacific.





Action Plan:

This indicator is a count of the number of current smokers who are offered a brief intervention. A more meaningful indicator, which we will be reporting to the HSC in October would be the number of current smokers, or smoking rate. This will measure the efficacy of brief interventions and subsequent smoking cessation support. We will continue to also report actions against the MoH priority as below:

- We are working with our PHOs to identify general practices that face challenges in achieving the target early in the quarter and planning additional support for these practices.
- We are working with our PHOs to share and promote the new Vaping Facts website and its resources amongst general practices.
- Tū Ora Compass Heath has succeeded in obtaining a standing order for Nicotine Replacement Therapy (NRT) for nurses to dispense to support people to quit smoking.
- We are implementing a pilot incentives programme in Porirua to support pregnant Māori women and their whānau to quit smoking. This compliments our work with PHOs to support current smokers who share the residence with babies or young children to quit smoking.
- We are shifting our focus to the number of people who identify as current smokers

3.2 Increased Immunisation

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

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

Performance to Quarter 4 2018/19: We have achieved 93%. There are significant variations for Māori and Pacific due to small numbers, as well as embedded inequities.

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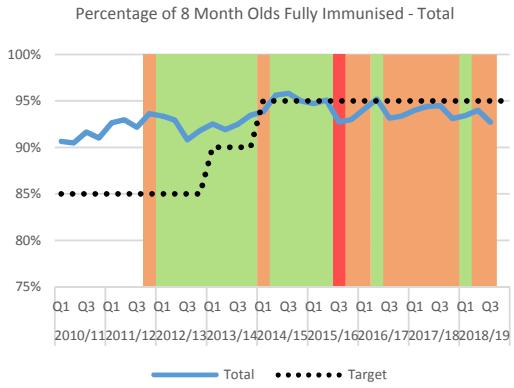
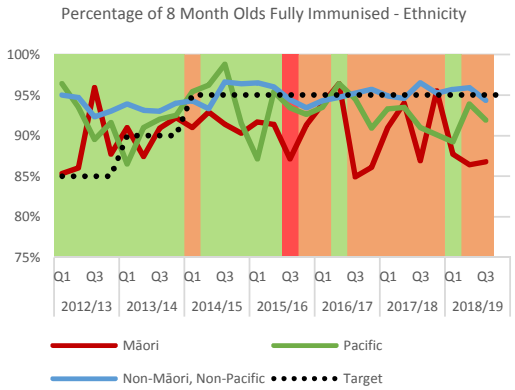




Action Plan:

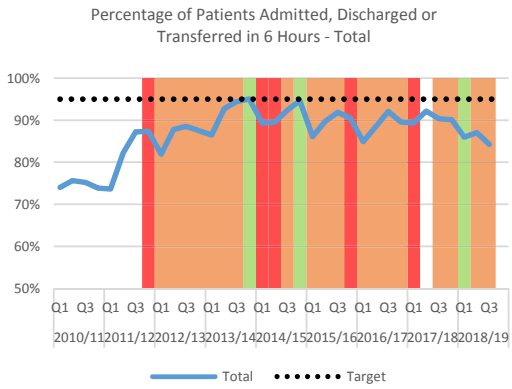
- We are implementing a project to improve newborn enrolment to enable timely pre-call and re-call for 6-month immunisations by primary care.
- We are investigating successful approaches to promoting immunisation, including a comparison of initiatives across general practices that have high/low coverage and high/low decline rates.
- Improving enrolment rates of our families/whānau in Porirua presenting to Kenepuru A&M to support engagement with general practice to enable timely pre-call and re-call immunisation messages through primary care.
- Working with Ora Toa PHO to implement a Mātua, Pepi, Tamariki service in Porirua to provide additional, proactive support to families with young children in Porirua

3.3 Shorter Stays in Emergency Departments

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

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

Performance to Quarter 4 2018/19: We have achieved the 95% target once in nine years. Consistent pressure on acute beds remains the most significant driver of this non-achievement.



Action Plan:

- Implementing the Community Health of Older Person Initiative (CHOPI) to support primary care to manage pre-frail and frail older people in the community.

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- Implementing new discharge processes for complex patient, early supported discharge processes and recommendations from the review of long stay General Medicine patients.
- Completing recruitment of ED-based mental health nurses to support patients presenting with mental health concerns.
- Update Health Pathways for acute referrals to ED from primary care and speciality areas

4. OVERVIEW OF PERFORMANCE – NON-FINANCIAL PERFORMANCE FRAMEWORK

This paper covers the indicators assessed in Quarter 4 of 2018/19 only; indicators assessed six-monthly or annually in quarters 1, 2 and 3 are not reported here.

4.1 We have improved our performance status across some performance indicators

In quarter four 2018/19, CCDHB achieved or partially achieved 56 of the 60 performance indicators reported against to MoH.

Achievement	Number of indicators achieved
Achieved	36
Partially Achieved	20
Not Achieved	3
Not assessed	1

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

- Inpatient average length of stay (ALOS) - Elective
- Newborn enrolment with general practice

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

- Inpatient average length of stay (ALOS): Elective
- Reduce the rate of Māori under the Mental Health Act section 29 community treatment orders

Compared to quarter three, we have deteriorating performance across four performance indicators:

- Improving the quality of identity data within the National Health Index (NHI);
- Immunisation coverage: Focus area 2 – HPV coverage;
- Shorter waits for non-urgent mental health and addiction services for 0-19 year olds;
- Ambulatory Sensitive Hospitalisations (ASH) - 45-64 year olds;

All 20 of the partially achieved performance indicators have resolution plans in place to ensure an achieved status is attained. The Not Achieved ("N") targets (below) also have a resolution plan in place although the MoH requires these to be more specific or comprehensive:

a. Better Help for Smokers to Quit in Public Hospitals;
b. Maternal mental health;
c. Appoint Cancer Psychological and Social Support Workers (CFA).

As previously reported improvement continues to prove difficult for the 'Better Help for Smokers to Quit – Hospital' indicator. CCDHB continues as one of five DHBs challenged by this target. The Maternal Mental Health indicator is discontinued from the first quarter of 2019/20. The Cancer Psychological and Support Workers position was vacant at the time of reporting. This will resolve in Q1.

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5. OVERVIEW OF PERFORMNACE

Each quarter, we will present the Health System Committee an overview of performance in three areas. There areas will reflect where we are experiencing challenges, persistent inequities or achieved notable success. This quarter, we present:

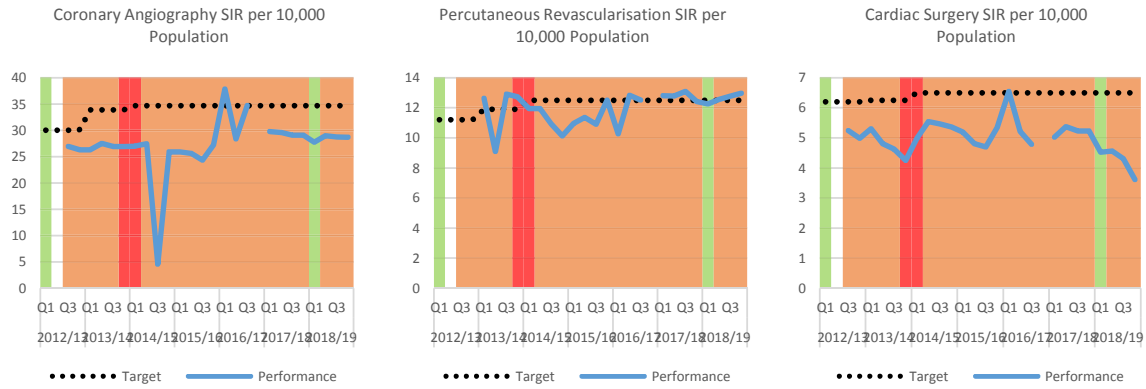
- Elective Services Standardised Intervention Rates
- Improved Management for Long Term Conditions - Diabetes
- Cervical screening

Elective Services Standardised Intervention Rates (SIR);

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

Ministry Requirement: For coronary angiography services a target rate of at least 34.7 per 10,000 of population; for percutaneous revascularization a target rate of at least 12.5 per 10,000 of population; for cardiac surgery a target intervention rate of 6.5 per 10,000 of population.

Performance to Quarter 4 2018/19: We achieved 28.7 per 10,000 for coronary angiography; 13.0 per 10,000 for percutaneous revascularization; and, 3.6 per 10,000 for cardiac surgery.



Together, these three indicators are used by the Ministry of Health to monitor access to cardiac services.

The Ministry measurement for achievement against the standard intervention rate for coronary angiography does not include private provision of service. When private provision is included we achieve the standard intervention rate. In addition, this intervention rate does not account for alternate imaging techniques to diagnose coronary artery disease, namely Cardiac Computed Tomography (CT), which is routine international practice and at CCDHB. With the above taken into consideration we are confident that the angioplasty standard intervention rate means our population has appropriate access to an intervention for coronary arterial disease despite a diagnostic indicator that is below the national standard.

For percutaneous revascularisation we have consistently achieved the target (or come close to achieving the target, currently within 0.03 of the SIR, which the Ministry deems to be acceptable) for a number of years and expect this to continue subject to being able to manage pressure on access to the Cath Lab and inpatient beds.

Access to cardiothoracic surgery remains an area of concern nationally with a number of contributing factors, which are mirrored at CCDHB. These include access to surgical beds, intensive care beds, operating theatres, workforce constraints including cardiothoracic surgeons and cardiac sonographers. Capital and Coast is the Central Region's tertiary provider for Cardiac services (Cardiology and

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Cardiothoracic specialties). Growth in cardiology service demand is driven by regional patients (excluding Hutt Valley DHB) with increasing:

- Case Weighted Discharges (CWD),
- Average Length of Stay (ALoS),
- Bed days; and,
- Complexity (measured by Patient Clinical Complexity Level).

Since March 2019, bed occupancy at Wellington Regional Hospital has been consistently at 99% for normal adult beds. This slows access to the Cardiac Catheter labs and theatres due to limited bed availability making achievement of the target challenging.

Short term options to be further explored are employment of additional clinical staff and outsourcing of volumes. However, the real gains to be made in this space are outlined in our medium and long term planning priorities. In particular the Long Term Investment Plan identifies the need to continue to invest in additional surgical capacity. We also expect this work to be enhanced by the focus on Cardiology in the Joint Hospital Network Planning work. Other plans which make a contribution to improving capacity and managing demand for services delivered by CCDHB are:

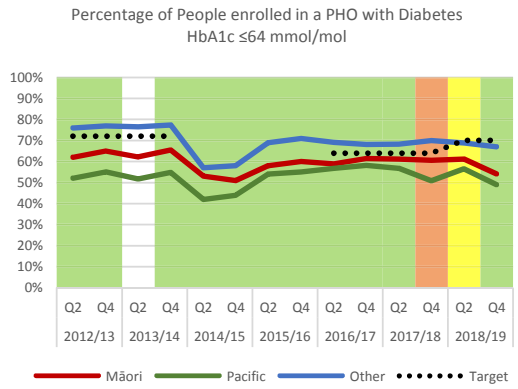
- Central Region Cardiac Services Plan
- CCDHB's Long Term Conditions Plans
- Regional Care Arrangements
- The Ministry of Health's Planned Care Initiative

Improved Management for Long Term Conditions - Diabetes;

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

Ministry Requirement: Report on the progress made in self-assessing diabetes services against the Quality Standards for Diabetes Care, and percentage of people with HbA1c (blood glucose levels) less than 64 mmol/mol.

Performance to Quarter 4 2018/19: We have achieved 62% of the population enrolled in a PHO with a diagnosis of diabetes with good blood glucose control (54% for Māori, 49% for Pacific).



The Ministry of Health has identified CCDHB as a national leader in driving improved outcomes for people with diabetes. We achieve this through our primary/secondary diabetes clinical network who identified that outcomes for Māori and Pacific people with a diagnosis of diabetes can be improved through a focus on these populations at a younger age. We know that Māori and Pacific are likely to be diagnosed earlier in their lives and experience more complications in their lives from diabetes as a result.

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This year, we focused on ensuring we were engaging and responding to the needs of our young people who are Māori and Pacific (15-39 years). We achieved a 4% increase in the proportion of young Māori who have a diagnosis of diabetes who have good glycaemic control (HbA1c<64mmol/mol). We did not achieve the same reduction for Pacific people and so are intensifying our efforts in 2019/20 for this population group.

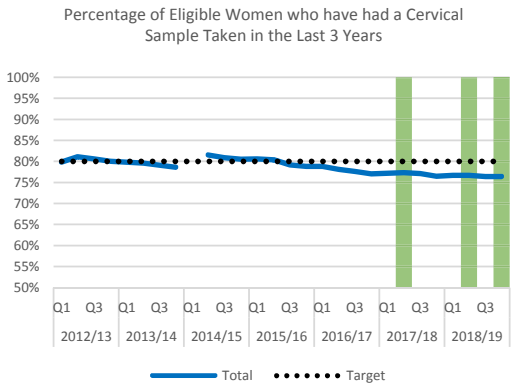
The graph above is for people with a diagnosis of diabetes aged 15-74 years. It shows that our focus on equity, particularly for younger people where the numbers are small but the impact is big, can produce a decrease in performance at a total population level. However, over the longer term, improved control for younger people will produce better outcomes for them, their families and a longer term reduction in impact for people and system.

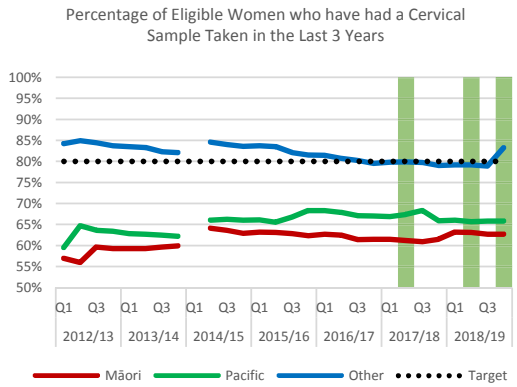
Improving Cervical Screening Coverage

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

Ministry Requirement: 80% of eligible women aged 25-69 years have had a cervical sample taken in the last 3 years.

Performance to Quarter 4 2018/19: We have achieved 76% for the total population. We achieved 63% for Māori, 66% for Pacific, 62% for Asian and 83% for other ethnicities.





The National Cervical Screening Programme (NCSP) was established to reduce the number of women who develop and die from cervical cancer. Nationally there is an equity gap in cervical screening coverage for Māori, Pacific and Asian women (priority women) which is also experienced in CCDHB. The majority of screening is undertaken in primary care and there are recall processes in place to ensure identification and follow up of women who are due and overdue for a screen. Primary care providers and our regional screening service work collaboratively to remove barriers to accessing screening.

We know that the barriers for priority women to access screening include cost, health literacy, accessibility and cultural sensitivity. In response, we will have an increased presence at community health events to increase awareness for both the benefits and importance of cervical screening. Primary care practices and the regional screening service are removing the cost barriers by providing free smears to priority group women in a number of general practices and to provide increased opportunity for screening, the regional screening service is running the following:

Annual Plan 2019/20 Action	Target	Maximum Coverage
4 weekend cervical screening clinics at Kenepuru	35 women at each clinic	140 women
18 evening cervical screening clinics across CCDHB	15 women at each clinic	270 women

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18 free community-based cervical screening clinics in high-needs communities	No target	N/A

We acknowledge this is a pathway to equity in screening coverage across CCDHB. This is part of a three-year plan to achieve the target and equitable outcomes. We are working with the regional screening service and the Ministry of Health to explore the potential of self-swabbing in cervical screening. The convenience and privacy of this option has been shown to increase cervical screening coverage, particularly for Māori women.

6. NEXT STEPS

There are specific action plans in place to improve performance on the two Partially Achieved health targets and one Not Achieved health target. There are significant challenges for CCDHB to improve equity.

The Ministry of Health has confirmed the non-financial performance measures for DHBs in 2019/20. The next report to the Health System Committee on non-financial performance will be against this framework.

Strategy, Innovation & Performance

Capital & Coast DHB Non-Financial Monitoring

Performance Measures – Q4 2018/19

Capital & Coast District Health Board
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Introduction

About the Performance Measures

Performance Measures

The information in this report is about the deliverables set out in the 2018/19 Performance Measures by the Ministry of Health, the five Health Targets, and the Crown Funding Agreement variations also set by the Ministry of Health.

Indicator Type	Description
PP - Policy Priorities	Achieving Government's priority goals/objectives and targets.
SI - System Integration	Meeting service coverage requirements and supporting sector inter-connectedness.
OP - Outputs	Purchasing the right mix and level of services within acceptable financial performance.
OS - Ownership	Providing quality services efficiently.
HS - Progress Update	Highlights regarding delivery of the NZ Health Strategy (no target/performance expectation is set).
HT – Health Target	Improve the performance of health services.
CFA - Crown Funding Agreement	Service provision as specified in the CFA.

Descriptions for the indicator types come from the 2018/19 guidance document from the National Service Framework Library, which was last updated in 2018/19, and the National Service Framework Library Health Targets section.

Exclusions

From the Ministry of Health Performance Measures, there are five exclusions which are not reported in this report: SI7: SLM total acute hospital bed days per capita, SI8: SLM patient experience of care, SI9: SLM amenable mortality rate, SI12: SLM youth access to and utilisation of youth appropriate health services, and SI13: SLM Babies living in smokefree households.

SI7, SI8, SI9, SI12 and SI13 have all been excluded from the report as they are all reported through PP22: Improving system integration (SLM).

There are also several CFAs which have been excluded due to not being reported on the Ministry of Health Quarterly Reports website in the 2017/18 or 2018/19 financial years, including: Appoint Cancer Nurse Coordinators, Appoint Regional Cancer Centre Clinical Psychologists, and Health Services for Emergency Quota Refugees.

Data

Unless specified otherwise in the notes for each deliverable, the targets come from CCDHB's Annual Plans and the data and Ministry of Health report rating come from the Ministry of Health Non-Financial Quarterly Report website.

Ministry of Health Rating

Where available, the previous criteria for 'Outstanding', 'Achieved', 'Partially Achieved' and 'Not Achieved' Ministry of Health report ratings has been included for each deliverable as there are many cases where there are specific criteria to reach each rating, particularly 'Outstanding' and 'Partially Achieved'.

The Ministry of Health rating does not always just take the quantitative performance into account but also includes other measures at the discretion of the Ministry of Health for how CCDHB is performing and whether we are on track to the target.

Previous Quarterly Reporting Criteria

Rating	Criteria
Outstanding performer/sector leader	1. This rating indicates that the DHB achieved a level of performance considerably better than the agreed DHB and/or sector expectations. 2. This rating is applied when the DHB has met the target agreed in its Annual Plan **and** has achieved the target level of performance for the Māori population group, and the Pacific population group. Note: this rating can only be applied in the fourth quarter for measures that are reported quarterly or six-monthly. Measures reported annually can receive an 'O' rating, irrespective of when the reporting is due.
Achieved	1. Deliverable demonstrates targets / expectations have been met in full. 2. In the case of deliverables with multiple requirements, all requirements are met. 3. For those measures where reporting by ethnicity is expected, this rating **should only** be applied when the DHB has met the target agreed in its Annual Plan **and** has achieved significant progress for the Māori population group, and the Pacific population group. 4. Data, or a report confirming expectations have been met, has been provided through a mechanism outside the Quarterly Reporting process, and the assessor can confirm.
Partial achievement	1. Target/expectation not fully met, (including not meeting expectations for Māori and Pacific population groups or other specified equity gaps) and the resolution plan satisfies the assessor that the DHB is on track to compliance in the year the assessment applies to. 2. A deliverable has been received, but some clarification is required. 3. In the case of deliverables with multi-requirements, where all requirements have not been met at least 50% of the requirements have been achieved, and a resolution plan satisfies the assessor that the DHB is on track to compliance for the requirements not met.
Not achieved **– escalation required**	1. The deliverable is not met. 2. There is no resolution plan if deliverable indicates non-compliance. 3. A resolution plan is included, but it is significantly deficient. 4. A report is provided, but it does not answer the criteria of the performance indicator. 5. There are significant gaps in delivery. 6. It cannot be confirmed that data or a report has been provided through channels other than the quarterly process.

Source: National Service Framework Library 2018/19 Performance Measures document.

Note that many of the performance measures have their own rating criteria included in their section.

Crown Funding Agreement Variation Criteria

Rating	Criterion
Satisfactory	1. The report is assessed as up to expectations. 2. Information as requested has been submitted in full.
Further work required	1. Although the report has been received, clarification is required. 2. Some expectations are not fully met.
Not Acceptable	1. There is no report. 2. The explanation for no report is not considered valid.

Source: National Service Framework Library 2014/15 Quarterly Reporting Guidance document.

Reading the Graphs

For the graphs, where available, there is shading representing the Ministry of Health's report rating received by CCDHB for that period.

Where a graph is shaded red, CCDHB received a 'Not Achieved' or 'Not Acceptable' rating. Where a graph is shaded orange, CCDHB received a 'Partial Achievement' or 'Further work required' rating. Where a graph is shaded green, CCDHB received an 'Achieved', an 'Outstanding' or a 'Satisfactory' rating. Where a graph remains unshaded, there is missing information which is highlighted in the notes, if applicable, for each indicator.

SIP – Rachel Haggerty

Health Target HT5: Better help for smokers to quit – Primary care

Indicator

≥90 percent of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months.

Notes

For Q1, 2 & 3 2011/12, there were no Ministry of Health quarterly reports available.
Since Q2 2018/19, there has been no performance information for Other ethnicity.

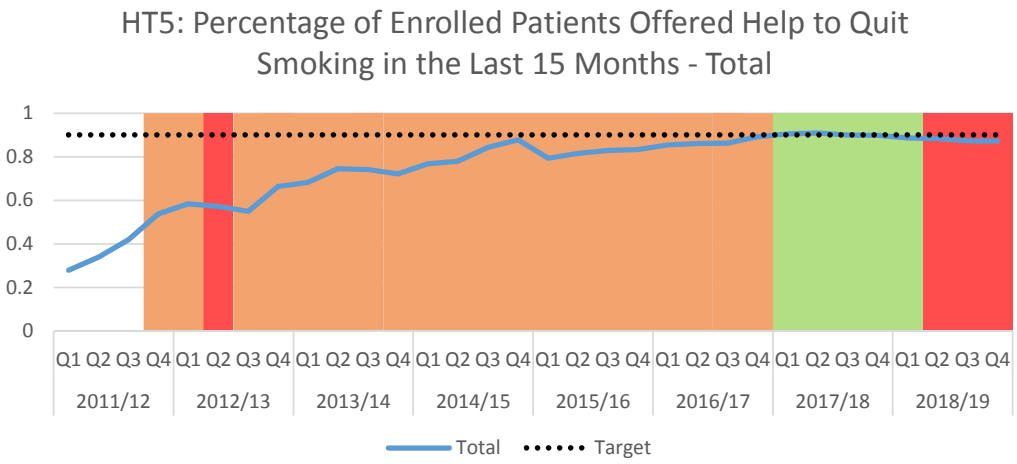
The Ministry of Health quarterly report rating is the same for the total performance graph, as well as the graph of performance by ethnicity.

Reporting Frequency

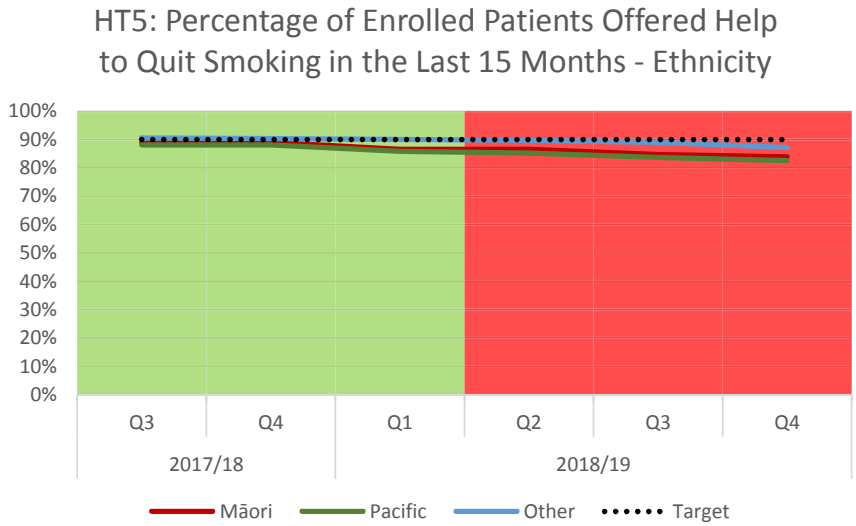
Quarterly

Achievement Scale

Rating	
Achieved	The DHB has met the percentage target for the quarter.
Partially Achieved	The DHB has not met the percentage target, but has improved on its result from the previous quarter.
Not Achieved	The DHB has not met the percentage target, and its result has dropped since the previous quarter.



Financial Quarter	CCDHB Performance	# of DHBs Achieving Target	CCDHB Rank
Q4 2018/19	87%	4	10



Health Target HT4: Increased Immunisation

Indicator

≥95 percent of eight-month-olds will have their primary course of immunisation (six weeks, three months and five month events) on time.

Notes

From Q1 2010/11 to Q3 2011/12, there were no Ministry of Health quarterly reports available.
From Q2 2018/19 onwards, the performance for Other ethnicity is unknown.

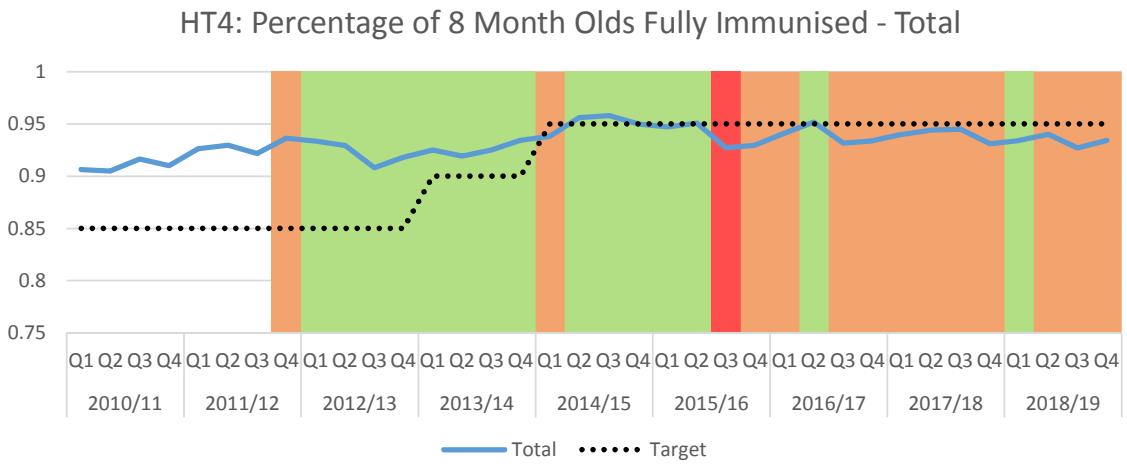
The Ministry of Health quarterly report rating is the same for the total performance graph, as well as the graph of performance by ethnicity.

Reporting Frequency

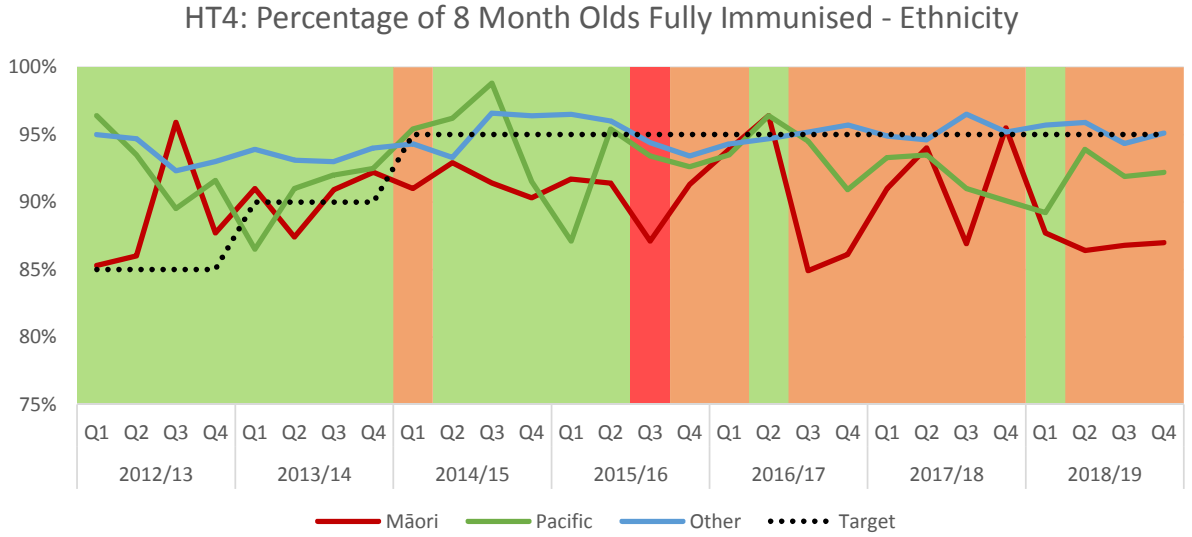
Quarterly

Achievement Scale

Rating	Quarters 1, 2 & 3	Quarter 4
Achieved	95 percent of eight-month-olds will have their primary course of immunisation (six weeks, three months and five month events) on time.	The DHB has reached the "Total population" immunisation coverage target for children at 8 months of age. This score requires that the DHB has met the target agreed in the Annual Plan and has achieved significant progress for the Māori population group, and (where relevant) the Pacific population group.
Partially Achieved	The DHB's immunisation coverage is progressing towards the target and coverage is acceptable relative to national coverage.	The DHB's immunisation coverage is progressing towards the target and coverage is acceptable relative to national coverage.
Not Achieved	The DHB's immunisation coverage has failed to substantially progress towards the target and/or coverage is unacceptable relative to national coverage.	The DHB's immunisation coverage has failed to substantially progress towards the target and/or coverage is unacceptable relative to national coverage.



Financial Quarter	CCDHB Performance	# of DHBs Achieving Target	CCDHB Rank
Q4 2018/19	93%	0	3



Health Target HT7: Raising healthy kids

Indicator

≥95 percent of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a heath professional for clinical assessment and family based nutrition, activity and lifestyle interventions.

Notes

The Ministry of Health quarterly report rating is the same for the total performance graph, as well as the graph of performance by ethnicity.

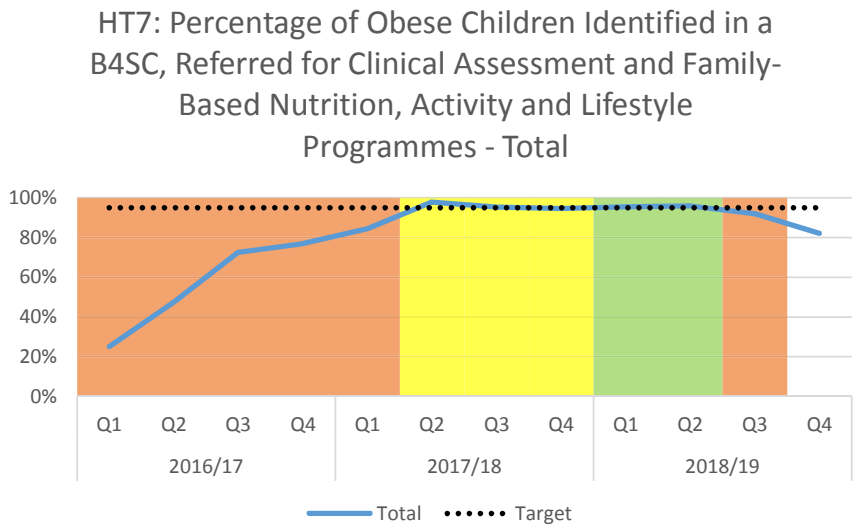
For Q4 2018/19, there is no rating or DHB ranking available.

Reporting Frequency

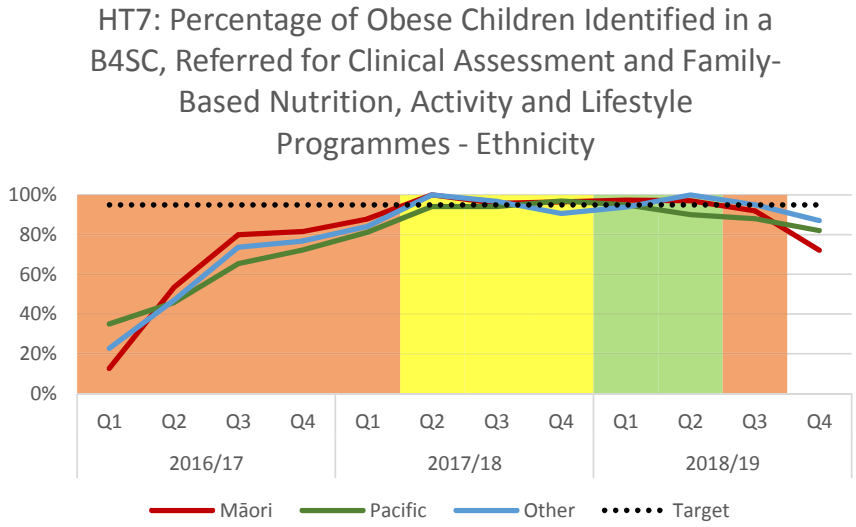
Quarterly

Achievement Scale

Rating	Quarters 1, 2 & 3	Quarter 4
Achieved	The DHB has met the target percentage.	The DHB has reached the target and made progress towards closing the equity gap.
Partially Achieved	The DHB has not met the target percentage but the narrative comments provided satisfy the assessor that the DHB is on track to compliance.	The DHB's progress towards target has improved from the start of the year and has made significant progress towards the target.
Not Achieved	The DHB has not met the target percentage and the narrative comments provided do not satisfy the assessor that the DHB is on track to compliance.	The DHB's progress towards target has not improved from the start of the year and has not significantly progressed towards the target.



Financial Quarter	CCDHB Performance	# of DHBs Achieving Target	CCDHB Rank
Q4 2018/19	82%		



Policy Priorities PP12: Utilisation of DHB-funded dental services by adolescents from School Year 9 up to and including age 17 years

Indicator

≥85 percent access to DHB-funded adolescent dental services.

Notes

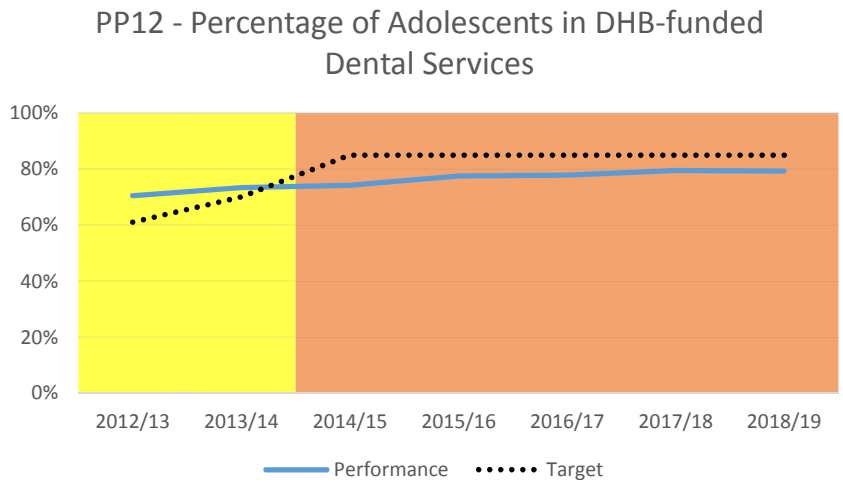
No notes.

Reporting Frequency

Annually (Q4)

Achievement Scale

Rating	
Outstanding	The DHB has met the targets agreed in the Annual Plan, and are more than 5% over specified targets, and has also has also reached the same level of performance for the Other population group, and the Māori population group, and the Pacific population group (where applicable).
Achieved	All targets agreed in the Annual Plan are met, within 95% - 105% of specified targets. **and** A resolution plan with appropriate actions is provided if the total population target is not met for the Māori population group, and the Pacific population group.
Partially Achieved	Some or all targets agreed in the Annual Plan are not met, but delivered results are same as, or better than, the results delivered in the prior year. **and/or** The DHB has not met the target/performance expectation agreed in its Annual Plan, and a resolution plan with appropriate actions is provided, including actions to deliver improved performance for the Māori population group, and the Pacific population group.
Not Achieved	Some or all expectations are not met, and actual results are worse than the results delivered in the prior year.


PP12 - Percentage of Adolescents in DHB-funded Dental Services
100%
80%
60%
40%
20%
0%
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
Performance
Target

Policy Priorities PP20: Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke) – Focus areas 1, 2 & 3

Focus Area 1: Long Term Conditions

Indicators

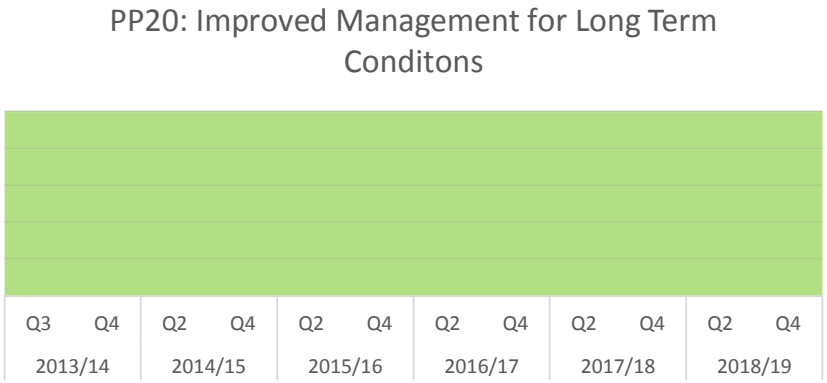
Identify actions with an equity focus underway to support people with LTCs to self-manage and build health literacy.

Notes

No notes.

Reporting Frequency

Six Monthly (Q2 & Q4)



Focus Area 2: Diabetes Services

Indicators

≥70 percent of people enrolled in a PHO with diabetes with managed HbA1c levels (≤64mmol/mol).

≥90 percent of people enrolled in a PHO with diabetes with HbA1c levels ≤80mmol/mol.

≥98 percent of people enrolled in a PHO with diabetes with HbA1c levels ≤100mmol/mol.

≤2 percent of people enrolled in a PHO with diabetes with HbA1c levels >100mmol/mol.

Notes

For 2014/15 and 2015/16, there is no information on the target available.

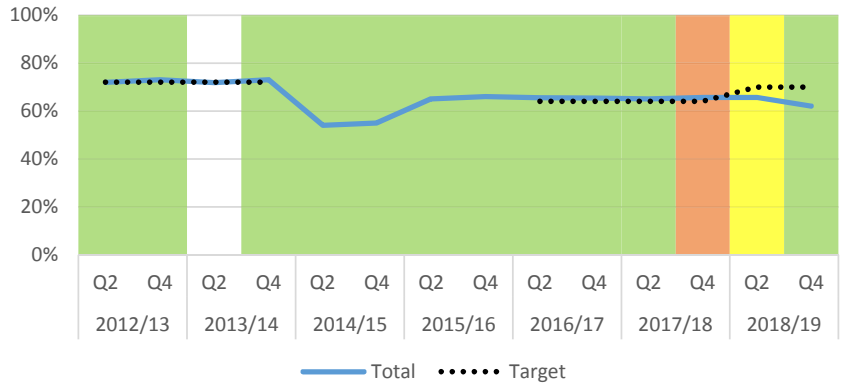
For Q2 2013/14, there is no Ministry of Health rating available as PHOs were using the templates from the previous year.

The Ministry of Health quarterly report rating is the same for all of the different HbA1c levels.

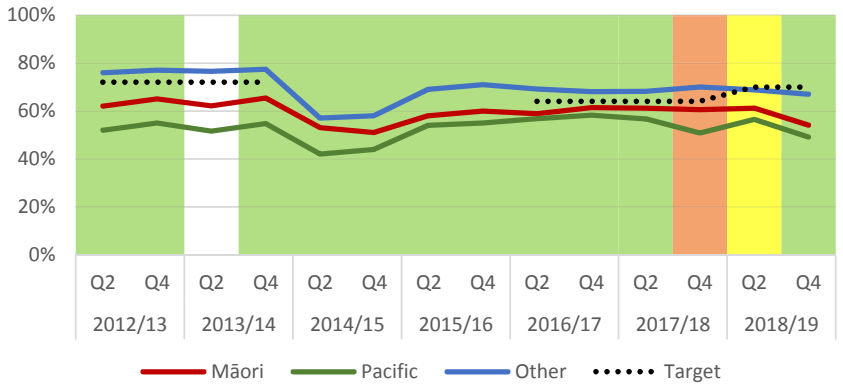
Reporting Frequency

Six Monthly (Q2 & Q4)

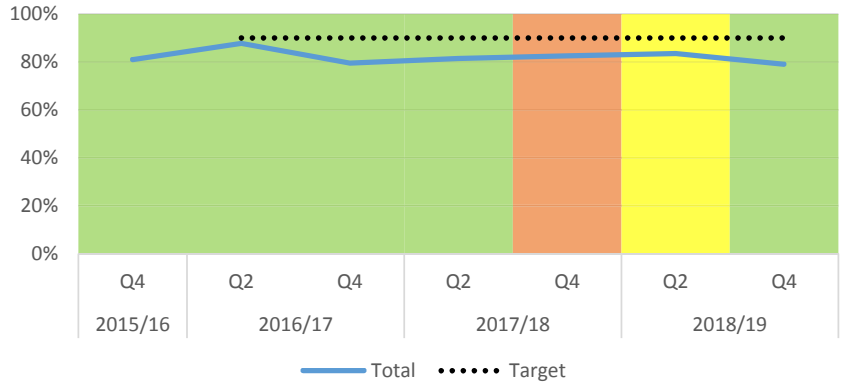
PP20: Percentage of People Enrolled in a PHO with Diabetes HbA1c ≤64 mmol/mol - Total



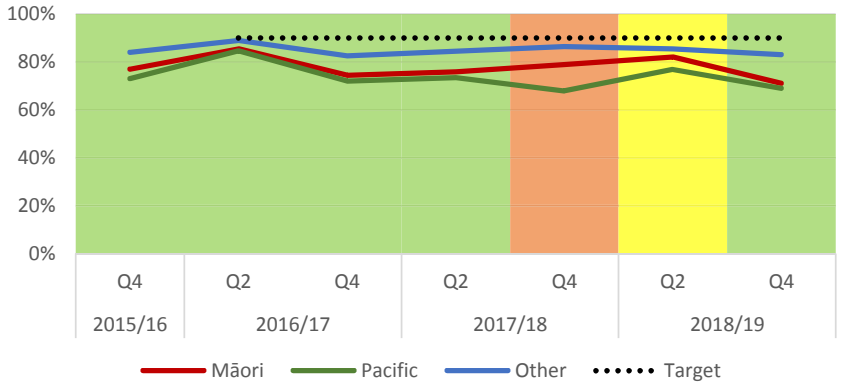
PP20: Percentage of People enrolled in a PHO with Diabetes HbA1c ≤64 mmol/mol - Ethnicity



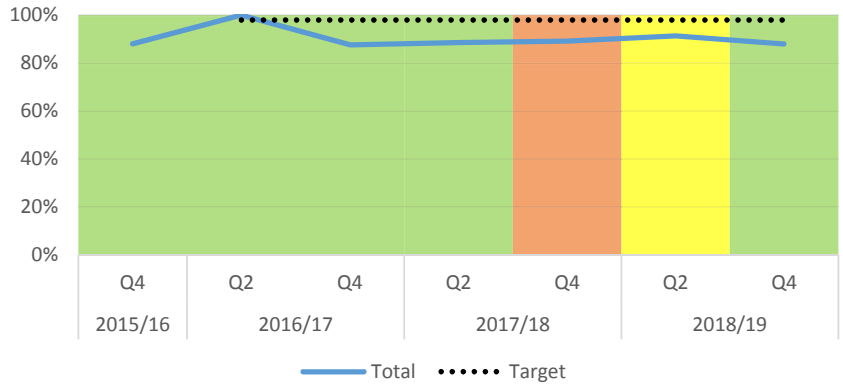
PP20: Percentage of People enrolled in a PHO with Diabetes HbA1c ≤80 mmol/mol - Total



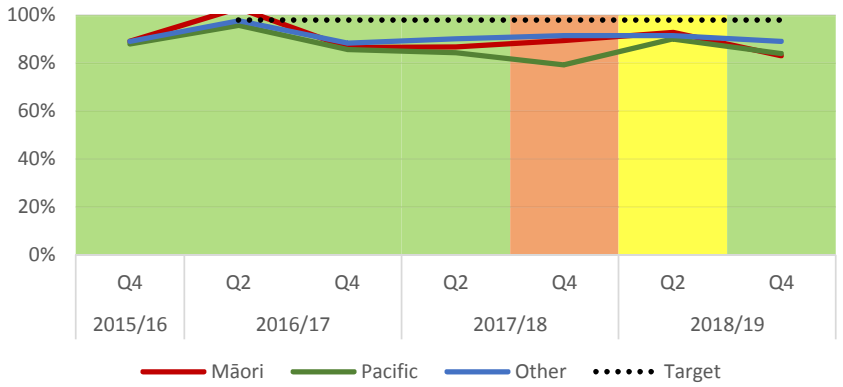
PP20: Percentage of People enrolled in a PHO with Diabetes HbA1c ≤80 mmol/mol - Ethnicity



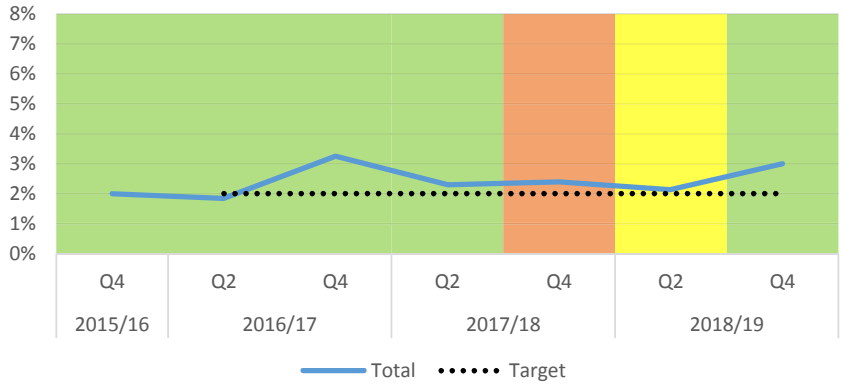
PP20: Percentage of People Enrolled in a PHO with Diabetes HbA1c ≤100 mmol/mol - Total



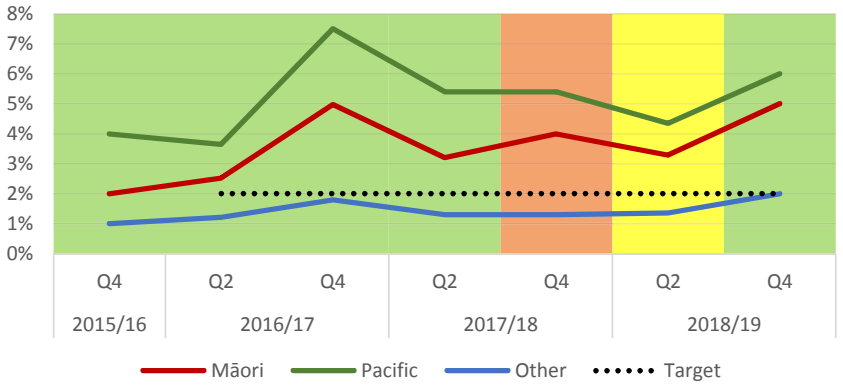
PP20: Percentage of People Enrolled in a PHO with Diabetes HbA1c ≤100 mmol/mol - Ethnicity



PP20: Percentage of People Enrolled in a PHO with Diabetes HbA1c >100 mmol/mol - Total



PP20: Percentage of People Enrolled in a PHO with Diabetes HbA1c >100 mmol/mol - Ethnicity



Focus Area 3: Cardiovascular Disease (CVD)

Indicator

≥90 percent of the eligible population who have had their CV risk assessed in the last five years.
In Q2&4: Update on delivery of actions identified in its Annual Plan (for the milestones are relevant to the reporting period) in relation to the following government planning priority focus areas; CVD and diabetes risk assessment.

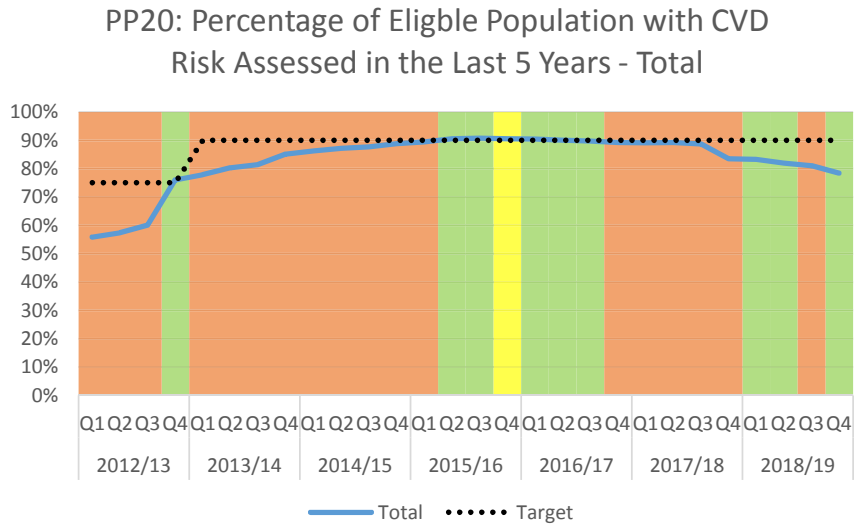
Notes

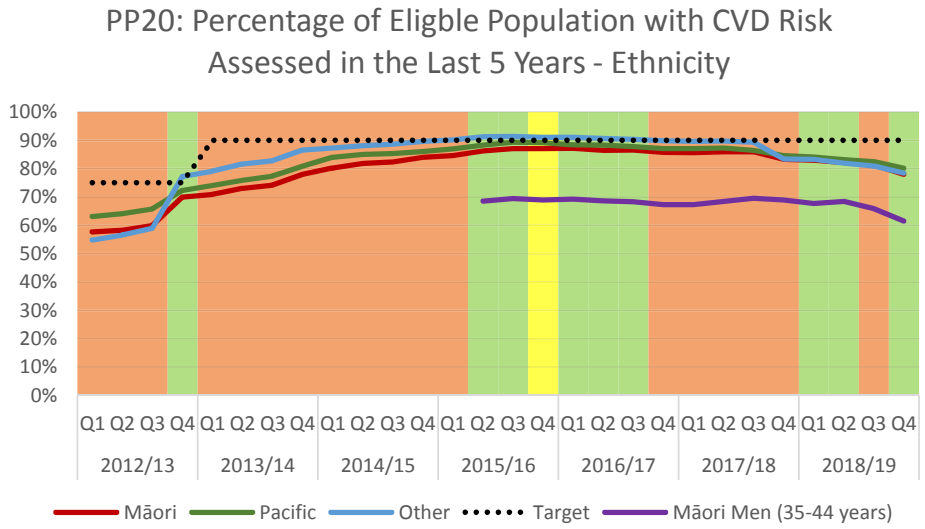
For Q2 2018/19, there was no performance by ethnicity available other than for Māori Men. For Q3, performance information was available for Māori and Pacific populations also.

The Ministry of Health quarterly report rating is the same for the total performance graph and the graph of performance by ethnicity.

Reporting Frequency

Quarterly





Policy Priorities PP21: Immunisation coverage (includes previous health target)

Focus Area 1: 2 Year Old and 5 Year Old Immunisation Coverage

Indicators

≥95 percent of children fully immunised at age 24 months.
≥95 percent of children fully immunised at age 5.
In Q2&4: Update on delivery of actions identified in its Annual Plan (for the milestones are relevant to the reporting period) in relation to the following government planning priority focus areas; Immunisation.

Notes

For Q3 2012/13 & Q3 2013/14, CCDHB received an initial rating of "P" from the Ministry of Heath which was changed to "NA" for the final rating.

The Ministry of Health quarterly report rating is the same for the total performance graph and the graph of performance by ethnicity, for both indicators.

For 2012/13 to 2016/17, the Ministry of Health rating is the same for all focus areas in PP21.

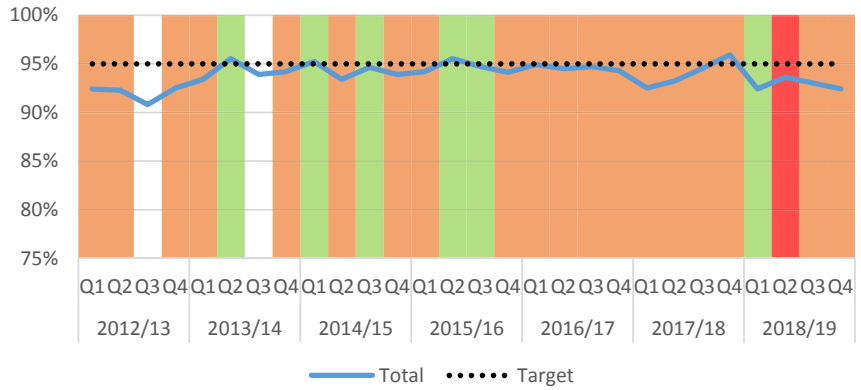
Reporting Frequency

Quarterly

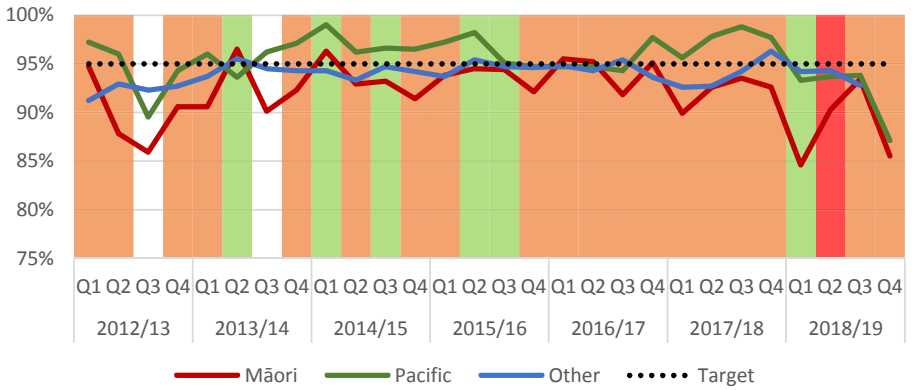
Achievement Scale

Rating	Quarters 1, 2 & 3	Quarter 4
Outstanding	The DHB has met the "Total population" immunisation coverage target for children at 2 years of age and children at 5 years of age and; the DHB has substantially exceeded the coverage target for one or both targets and/or the DHB has met the coverage target for one or both targets for: the total population, and the Māori population group, and (where applicable) the Pacific population. This score requires that the DHB has met both targets agreed in its Annual Plan and has achieved significant progress for the Māori population group, and (where relevant) the Pacific population group, for both targets.	
Achieved	The DHB has reached the "Total population" immunisation coverage target for children at 2 years of age and children at 5 years of age**.** This score requires that the DHB has met both targets agreed in its Annual Plan **and** has achieved significant progress for the Māori population group, and (where relevant) the Pacific population group, for both targets.	The DHB has reached the "Total population" immunisation coverage target for children at 2 years of age and children at 5 years of age. This score requires that the DHB has met both targets agreed in its Annual Plan **and** has achieved significant progress for the Māori population group, and (where relevant) the Pacific population group, for both targets.
Partially Achieved	The DHB's immunisation coverage is progressing towards the target and coverage is acceptable relative to national coverage, for both targets.	The DHB's immunisation coverage has substantially improved from the coverage at the start of the year **and** progress towards the target is acceptable relative to national coverage for both targets.
Not Achieved	The DHB's immunisation coverage has failed to substantially progress towards the target and/or coverage is unacceptable relative to national coverage for one or both targets.	The DHB's immunisation coverage has failed to substantially progress towards the target **and/or** coverage is unacceptable relative to national coverage for one or both targets.

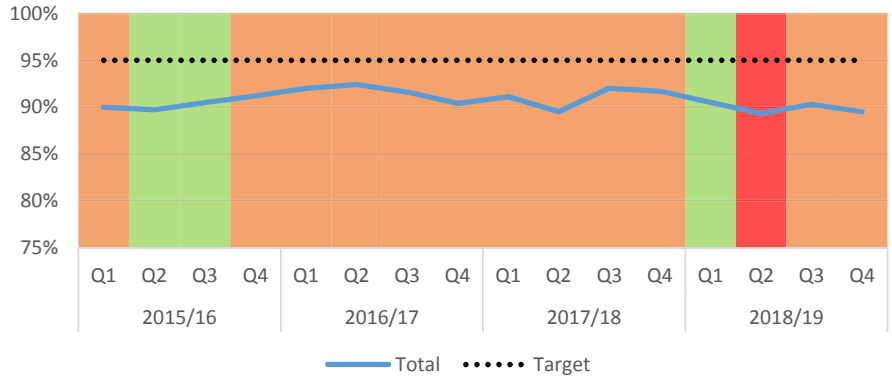
PP21: Percentage of children fully immunised at age 24 months - Total



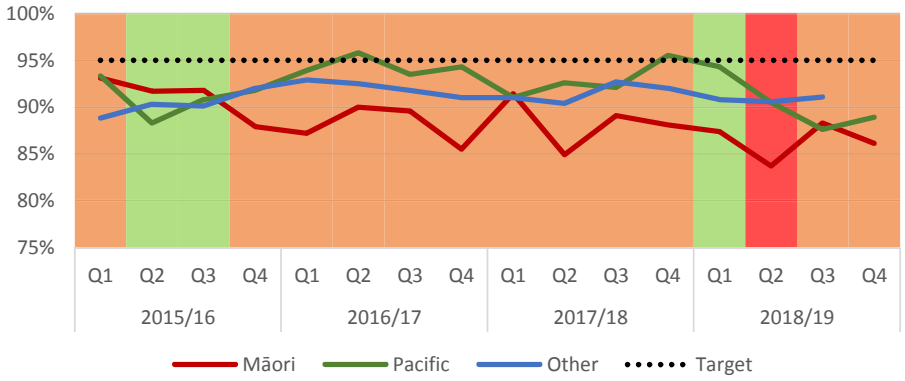
PP21: Percentage of children fully immunised at age 24 months - Ethnicity



PP21: Percentage of children fully immunised at age 5 - Total



PP21: Percentage of children fully immunised at age 5 - Ethncity



Focus Area 2: HPV Coverage

Indicator

≥75 percent of eligible girls fully immunised against HPV.

Notes

For 2012/13 and 2013/14, there is no information on "Other" performance available.
For 2014/15, there is no information on CCDHB's performance by ethnicity available.
For 2013/14 and 2014/15, the data comes from the annual reports.

The Ministry of Health quarterly report rating is the same for the total performance graph and the graph of performance by ethnicity.

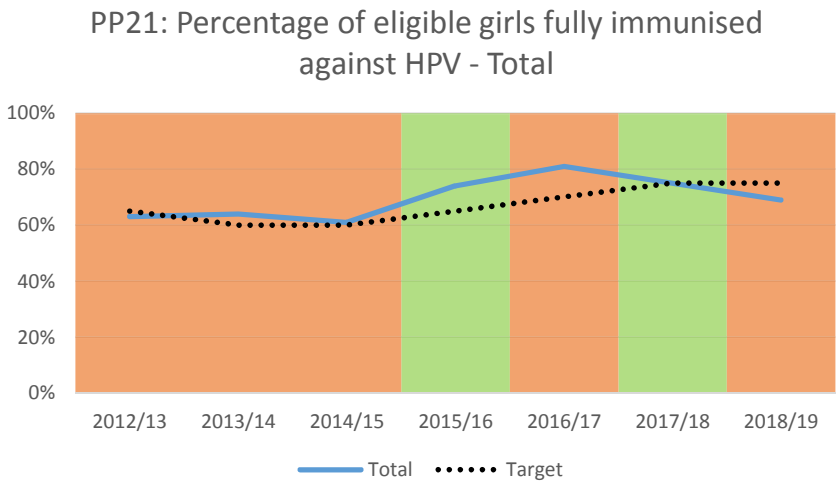
For 2012/13 to 2016/17, the Ministry of Health rating is the same for all focus areas in PP21.

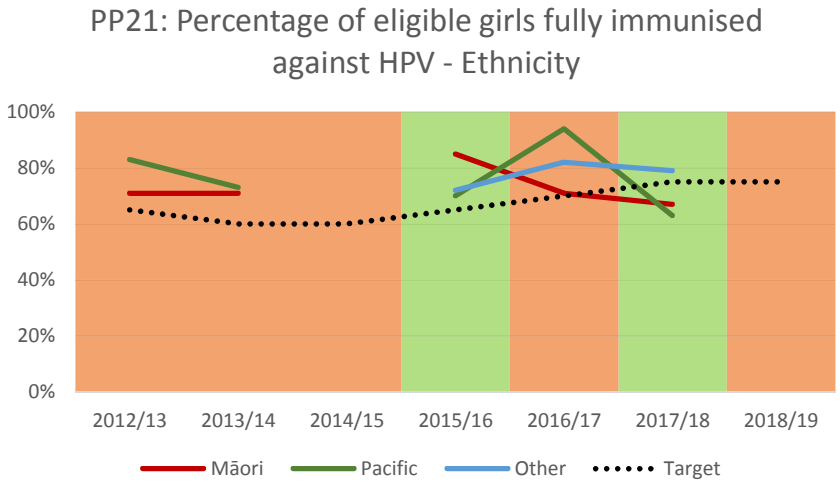
Reporting Frequency

Annually (Q4)

Achievement Scale

Rating	
Outstanding	The DHB has substantially exceeded the "Total population" HPV immunisation coverage target for eligible girls; and/or the DHB has reached the HPV target for eligible girls for: the total population, and the Māori population group, and (where applicable) the Pacific population. This score requires that the DHB has met the target agreed in its Annual Plan and has achieved significant progress for the Māori population group, and (where relevant) the Pacific population group.
Achieved	The DHB has reached the "Total population" HPV immunisation coverage target for eligible girls. This score requires that the DHB has met the target agreed in its Annual Plan and has achieved significant progress for the Māori population group, and (where relevant) the Pacific population group.
Partially Achieved	This score requires that the DHB's HPV immunisation coverage has substantially improved from the coverage in the previous year **and** progress towards the target is acceptable relative to national coverage.
Not Achieved	This score requires that the DHB's HPV immunisation coverage has failed to substantially progress towards the target **and/or** coverage is unacceptable relative to national coverage.


PP21: Percentage of eligible girls fully immunised against HPV - Total
100%
80%
60%
40%
20%
0%
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
Total
Target


PP21: Percentage of eligible girls fully immunised against HPV - Ethnicity
100%
80%
60%
40%
20%
0%
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
Māori
Pacific
Other
Target

Policy Priorities PP22: Improving system integration and SLMs (includes SI7, SI8 and SI9)

Indicator

Report on delivery of actions and milestones to improve system integration and introduction of System Level Measures. Jointly agreed Alliance/DHB Improvement Plan to be provided at the end of Q1 to support achievement of this.

Notes

PP22 covers SI7, SI8, SI9, SI12 and SI13, as well as SI1 0-4 ASH rate, as part of reporting the System Level Measures.
For Q1 2018/19, no Ministry of Health rating is available.

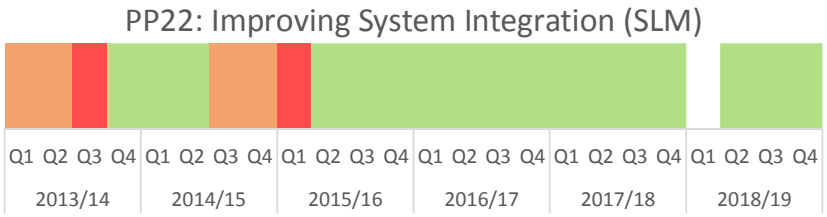
This is only measured as a Ministry of Health rating.

Reporting Frequency

Quarterly

Achievement Scale

Rating	
Achieved	Quarters one, two and three - Implementation of the SLM improvement plan by the district alliance is on track for the reporting period. Quarter four – the SLM improvement plan was successfully implemented by the district alliance.
Partially Achieved	Quarters one, two and three - Implementation of the SLM improvement plan by the district alliance is on track for the reporting period. Quarter four – the SLM improvement plan was successfully implemented by the district alliance.
Not Achieved	Quarters one, two and three - Implementation of the SLM improvement plan by the district alliance is not on track and adequate mitigation strategies are not presented or there are any missing deliverable components. Quarter four – the SLM improvement plan was not fully implemented by the district alliance and adequate rationale and mitigation strategies are not presented or there are any missing deliverable components.



Policy Priorities PP23: Implementing the Healthy Ageing Strategy

Indicators

≥95 percent of older people who have received long-term home and community support services in the last three months who have had an interRAI Home Care or a Contact assessment and completed care plan.

Report progress on actions and milestones about Future Models of Care
Report progress on actions and milestones about Integrated Falls and fracture prevention and rehabilitation services.
Report on steps taken to improve the coding of falls at the point of entry to hospital.
Report the number of older people that have received in-home strength and balance retraining services; received community/group strength and balance retraining services; been seen by the fracture liaison service or similar fracture prevention service; been prescribed bisphosphonates for treatment of osteoporosis.
Report progress on actions and milestones to improve equity.
Report progress on actions and milestones about workforce regularisation.
Report on a locally prioritised implementation of the Healthy Ageing Strategy.

Notes

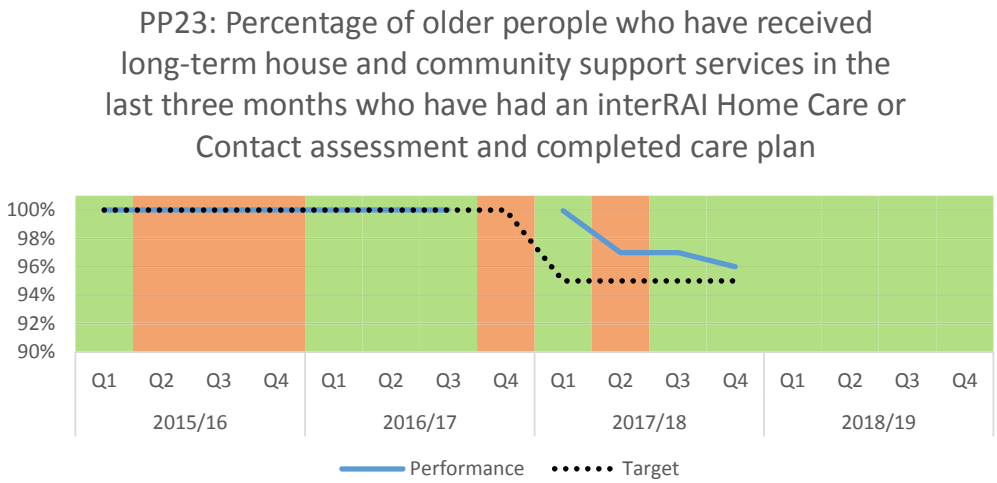
For Q4 2016/17, there is no information on CCDHB's performance available.
Since Q1 2018/19, no target or performance information has been available.

Reporting Frequency

Quarterly

Achievement Scale

Rating	
Outstanding	The DHB reports on the following: •key actions (in brief) undertaken in the quarter to deliver on Healthy Ageing commitments agreed in its Annual Plan; and •one (or more) DHB-identified key action or actions (in the DHB's Annual Plan or more broadly) that the DHB is currently doing to implement the Healthy Ageing Strategy; and •by exception, the interRAI: Comprehensive Clinical Assessment in aged residential care and in home and community support settings (PP23) measure (2016/17 PP23 refers), if there are departures from targets, the reasons for departures and any relevant associated remedial actions; and •significant improvements in its level of performance for the action to improve equity identified in its Annual Plan.
Achieved	The DHB reports on the following: • key actions (in brief) undertaken in the quarter to deliver on Healthy Ageing commitments agreed in its Annual Plan; and • one (or more) DHB-identified key action or actions (in the DHB's Annual Plan or more broadly) that the DHB is currently doing to implement the Healthy Ageing Strategy; and • **by exception**, the interRAI: Comprehensive Clinical Assessment in aged residential care and in home and community support settings (PP23) measure (2016/17 PP23 refers), if there are departures from targets, the reasons for departures and any relevant associated remedial actions; and • identified action(s) to improve equity and reported any related activity to improve its level of performance as per commitments in its Annual Plan.
Partially Achieved	The DHB does not report on some of the following: • key actions (in brief) undertaken in the quarter to deliver on Healthy Ageing commitments agreed in its Annual Plan; and • one (or more) DHB-identified key action or actions (in the DHB's Annual Plan or more broadly) that the DHB is currently doing to implement the Healthy Ageing Strategy; and • **by exception**, the interRAI: Comprehensive Clinical Assessment in aged residential care and in home and community support settings (PP23) measure (2016/17 PP23 refers), if there are departures from targets, the reasons for departures and any relevant associated remedial actions; and • an identified action(s) to improve equity and any related activity to improve its level of performance as per commitments in its Annual Plan.
Not Achieved	The DHB does not report key actions undertaken in the quarter to deliver on Healthy Ageing commitments agreed in its Annual Plan and one or more DHB-identified action or actions (in the DHB's Annual Plan or more broadly) that the DHB is currently doing to implement the Healthy Ageing Strategy.


PP23: Percentage of older perople who have received long-term house and community support services in the last three months who have had an interRAI Home Care or Contact assessment and completed care plan
100%
98%
96%
94%
92%
90%
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2015/16
2016/17
2017/18
2018/19
Performance
Target

Policy Priorities PP25: Prime Minister's Youth Mental Health Project

Indicator

Progress update reports on actions to implement initiatives 1 (School based health services), 3 (Youth primary mental health) and 5 (Improving the responsiveness of primary care to youth) of the Prime Minister's Youth Mental Health Project.

Notes

For Q3 & Q4 2013/14, there was no Ministry of Health report available.

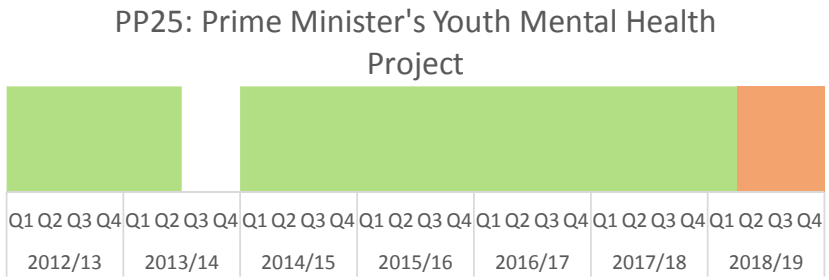
This is only measured as a Ministry of Health rating.

Reporting Frequency

Quarterly

Achievement Scale

Rating	
Achieved	All actions, milestones and measures are on track.
Partially Achieved	Some actions, milestones and measures are not on track but adequate mitigation strategies are presented.
Not Achieved	Some actions, milestones and measures are not on track and adequate mitigation strategies are not presented.



Policy Priorities PP26: Rising to the Challenge: The Mental Health and Addiction Service Development Plan – Focus areas 1, 2 & 5

Indicators

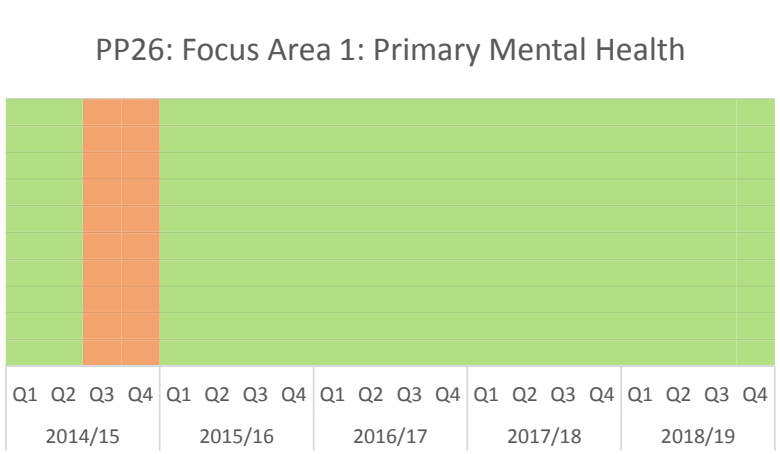
Focus Area 1: Primary Mental Health: Template and narrative report on services delivered.
Focus Area 2: District Suicide Prevention and Postvention: Report on highlights, exceptions, who and how many trained.
Focus Area 5: Improving employment and physical health needs of people with low prevalence conditions: Exceptions report where actions identified in the Annual Plan are not on track.

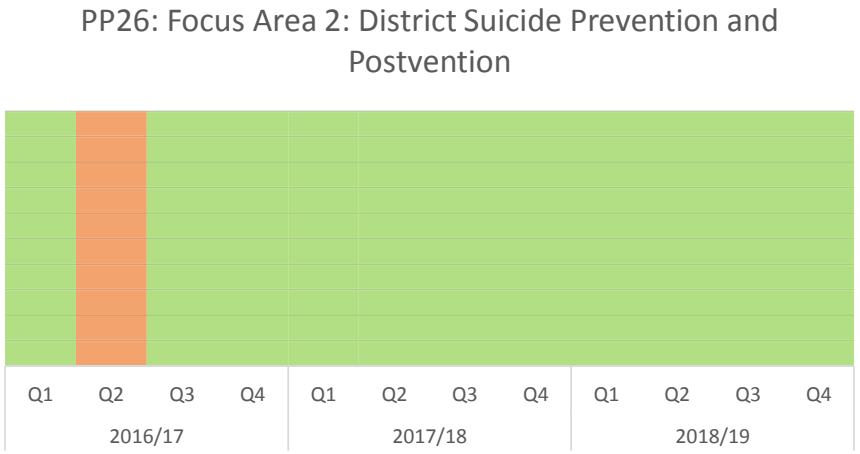
Notes

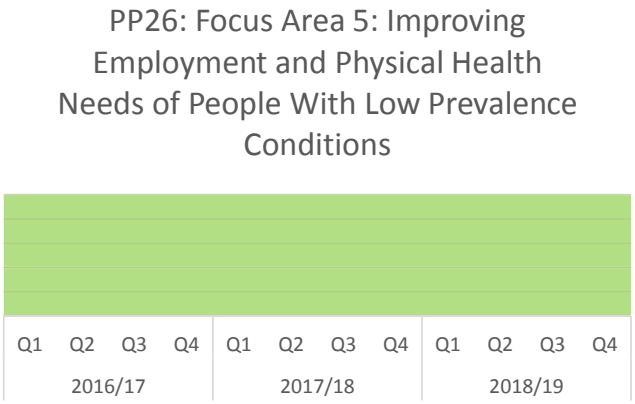
These are only measured as Ministry of Health ratings.
For Q1 2018/19, focus area 2 uses the previous Ministry of Health rating system.

Reporting Frequency

Quarterly


PP26: Focus Area 1: Primary Mental Health
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2014/15
2015/16
2016/17
2017/18
2018/19


PP26: Focus Area 2: District Suicide Prevention and Postvention
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2016/17
2017/18
2018/19


PP26: Focus Area 5: Improving Employment and Physical Health Needs of People With Low Prevalence Conditions
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2016/17
2017/18
2018/19

Policy Priorities PP27: Supporting Child Well-being

Indicator

Checklist report and progress update against actions and milestones agreed in the Annual Plan.

Notes

This is only measured as a Ministry of Health rating.
For Q1 2018/19, no Ministry of Health rating is available.

For Q1 2013/14, CCDHB received an initial rating of "A", which was changed to a "NA" for the final rating.

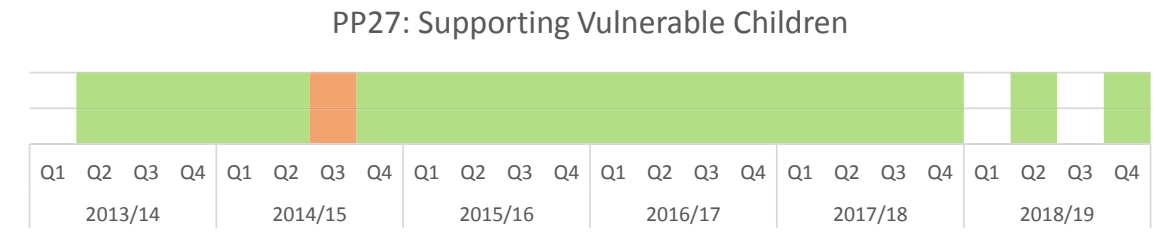
As of Q2 2018, the reporting frequency has changed from quarterly to six monthly.

Reporting Frequency

Six Monthly (Q2 & Q4)

Achievement Scale

Rating	
Achieved	All actions, milestones and measures are on track.
Partially Achieved	Some actions, milestones and measures are not on track but adequate mitigation strategies are presented.
Not Achieved	Some actions, milestones and measures are not on track and adequate mitigation strategies are not presented.



Policy Priorities PP32: Improving the quality of ethnicity data collection in PHO and NHI registers

Indicator

Report on delivery of actions and milestones to improve the quality of ethnicity data collection.
Percent of patients enrolled in a CCDHB PHO with ethnicity recorded as not stated.

Notes

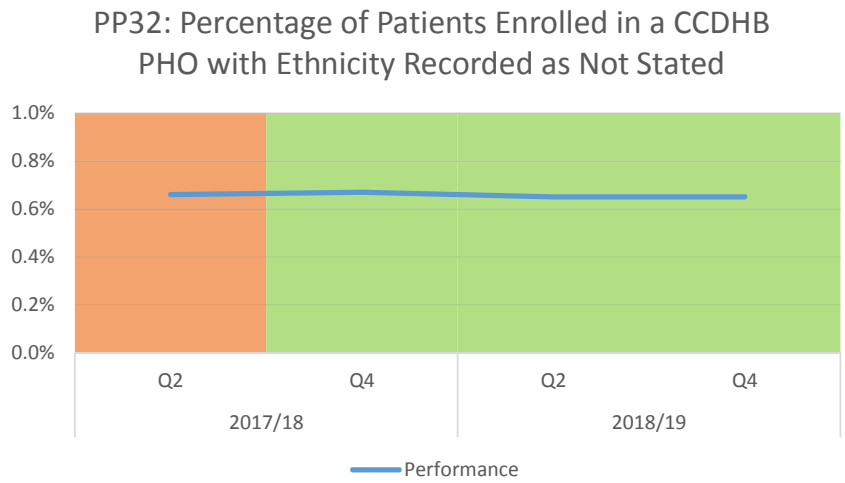
There is no target information for this indicator.

Reporting Frequency

Six Monthly (Q2 & Q4)

Achievement Scale

Rating	
Outstanding	DHB/PHO has implemented, trained staff and audited EDAT tool, has processes in place to ensure ongoing maintenance of ethnicity data quality, documented training programme for new staff with an established process for reviewing and correcting errors identified in quality of ethnicity data collected. Current baseline information and target provided.
Achieved	All actions, milestones and measures related implementation stage of EDAT toolkit for the reporting period are on track. Current baseline and target provided.
Partially Achieved	Some actions, milestones and measures are not on track for the related implementation stage but adequate mitigation strategies are presented. Current baseline and/or target information not provided.
Not Achieved	Performance measures are not on track and adequate monitoring strategies are not presented or there are missing deliverable components. Current baseline and target information not provided.


PP32: Percentage of Patients Enrolled in a CCDHB PHO with Ethnicity Recorded as Not Stated
1.0%
0.8%
0.6%
0.4%
0.2%
0.0%
Q2
Q4
Q2
Q4
2017/18
2018/19
Performance

Policy Priorities PP33: Improving Māori enrolment in PHOs to meet the national average of 90%

Indicator

≥90 percent of Māori enrolled with a PHO.

Notes

The drop-off in Q4 2018/19 is explained as follows:

Māori enrolment in CCDHB mirrors the national enrolment trend - a decrease in enrolment coverage in this period, prior to which enrolment was stable or increasing. The change coincides with the formal introduction of the National Enrolment System (NES) as the PHO enrolment data source. Investigations to date show the change is a result of mapping information between systems, the change does not reflect large-scale un-enrolment of individuals.

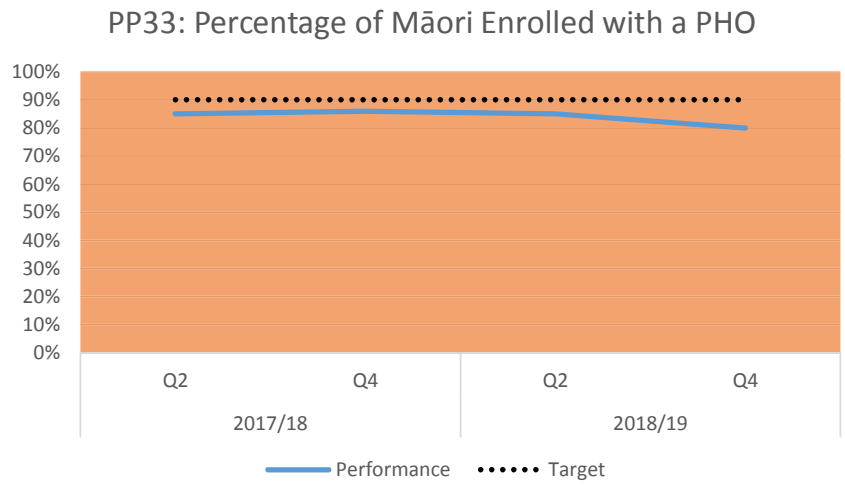
Our primary care partners are using their data sources to identify where recorded ethnicity has changed for an individual. They are then establishing which ethnicity is preferred for the individual, based on either the primary care enrolment form and/or conversation with the person concerned. We expect that coverage will return to previous levels as this work is completed and increase as a result of our ongoing programme of work to improve Māori enrolment.

Reporting Frequency

Six Monthly (Q2 & Q4)

Achievement Scale

Rating	
Outstanding	DHB has an enrolled Māori population of 90% or above and is maintaining and increasing their enrolment rates.
Achieved	DHB has enrolled Māori population of 90%
Partially Achieved	DHB has an enrolled Māori population of 80 – 90% and has activities underway to ensure enrolment messages are delivered to the un-enrolled population.
Not Achieved	DHB has enrolled Māori population > 80%


PP33: Percentage of Māori Enrolled with a PHO
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Q2
Q4
Q2
Q4
2017/18
2018/19
Performance
Target

Policy Priorities PP39: Supporting Health in Schools

Indicator

Update on delivery of actions identified in its Annual Plan (for the milestones are relevant to the reporting period) in relation to the following government planning priority focus areas; Supporting health in schools and school based health services.

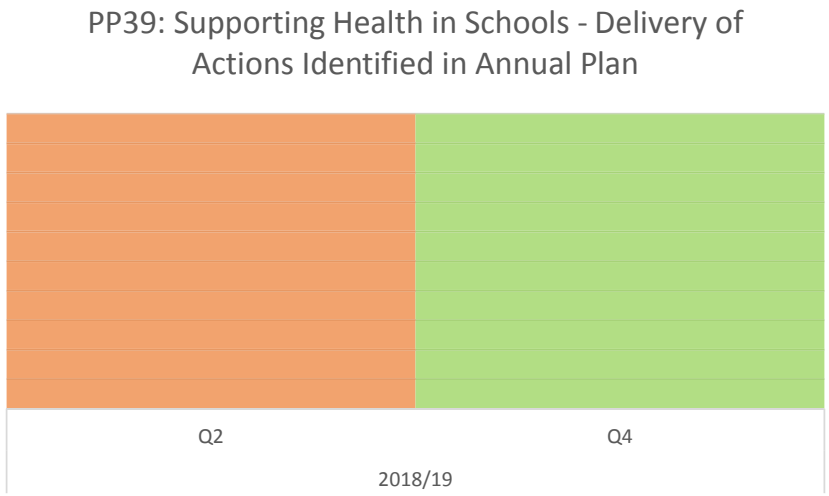
Notes

This is a new measure for 2018/19.

This is only reported as a Ministry of Health rating.

Reporting Frequency

Six Monthly (Q2 & Q4)



Policy Priorities PP43: Population Mental Health

Indicator

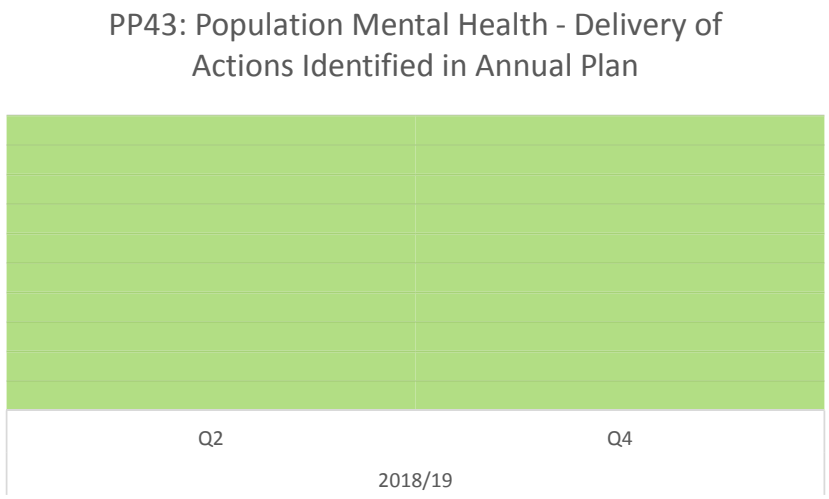
Update on delivery of actions identified in its Annual Plan (for the milestones are relevant to the reporting period) in relation to the following government planning priority focus areas; Population mental health.

Notes

This is a new measure for 2018/19.

Reporting Frequency

Six Monthly (Q2 & Q4)



Policy Priorities PP44: Maternal Mental Health

Indicator

Update on delivery of actions identified in its Annual Plan (for the milestones are relevant to the reporting period) in relation to the following government planning priority focus areas; Maternal Mental Health.

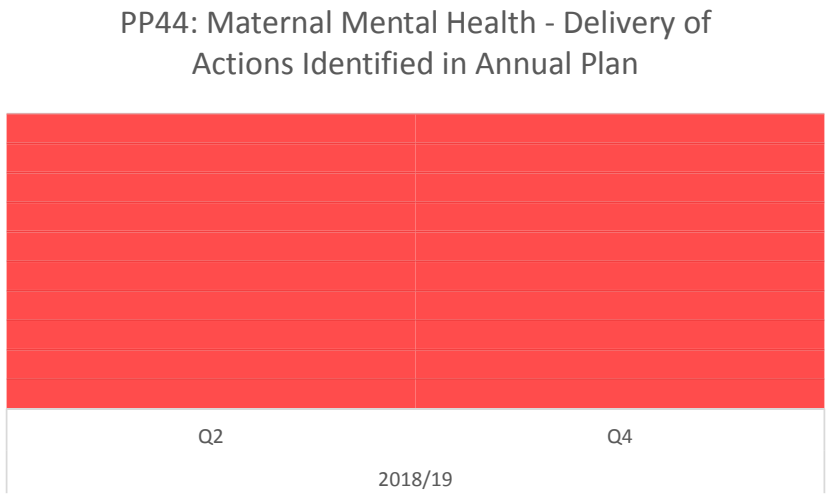
Notes

This is a new measure for 2018/19.

This is only reported as a Ministry of Health rating.

Reporting Frequency

Six Monthly (Q2 & Q4)



Policy Priorities PP6: Improving the health status of people with severe mental illness through improved access

Indicator

Number of people accessing specialist mental health service.

Notes

For 2012/12 and 2013/14, the target for CCDHB was only specified as a percentage of the population and so are not represented on these graphs.
For 2015/16, the target for CCDHB was given as the target for the total population and not broken down by ethnicity.
For Q2 2018/19, there is no target information by numbers available.

The Ministry of Health quarterly report rating is the same for the total performance graph, as well as the graph of performance for Māori, and Pacific.

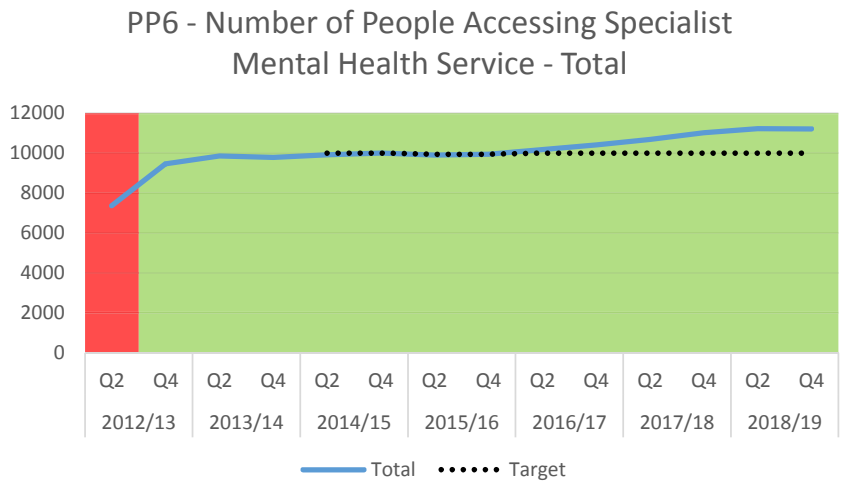
The graphs for Māori and Pacific have been separated into different graphs as they have different targets.

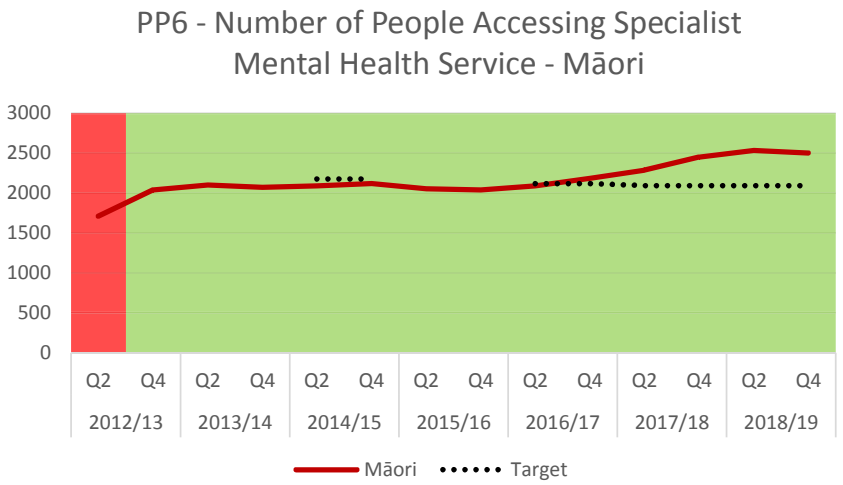
Reporting Frequency

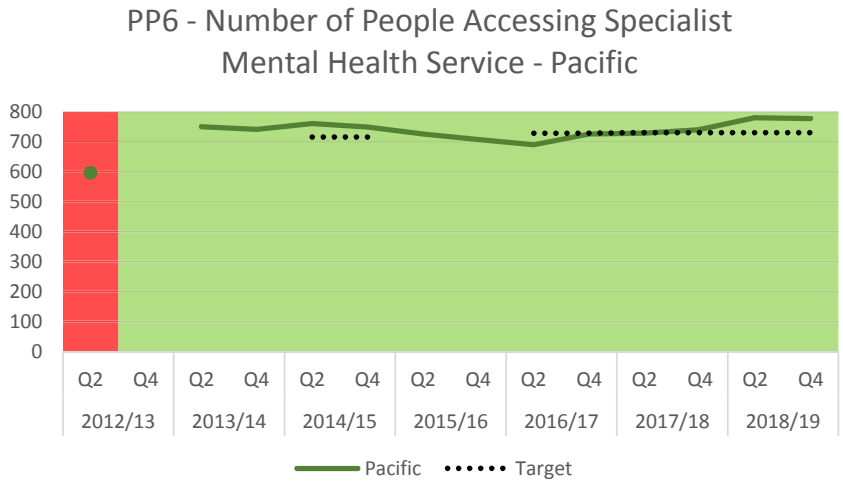
Six Monthly (Q2 & Q4)

Achievement Scale

Rating	
Outstanding	The DHB has met the target agreed in the Annual Plan, and has also reached or improved on the performance for the Māori population group, and the Other population group.
Achieved	The DHB has met the target agreed in the Annual Plan.
Partially Achieved	Applied in quarter 2 if the DHB has not met the target agreed in the Annual Plan, but is on track for achievement by year end.
Not Achieved	Applied in quarter 2 if the DHB has not met the target agreed in the Annual Plan, and is not on track for achievement by year end.


PP6 - Number of People Accessing Specialist Mental Health Service - Total
12000
10000
8000
6000
4000
2000
0
Q2 Q4 Q2 Q4 Q2 Q4 Q2 Q4 Q2 Q4 Q2 Q4 Q2 Q4
2012/13 2013/14 2014/15 2015/16 2016/17 2017/18 2018/19
Total
Target


PP6 - Number of People Accessing Specialist Mental Health Service - Māori
3000
2500
2000
1500
1000
500
0
Q2 Q4 Q2 Q4 Q2 Q4 Q2 Q4 Q2 Q4 Q2 Q4 Q2 Q4
2012/13 2013/14 2014/15 2015/16 2016/17 2017/18 2018/19
Māori
Target


PP6 - Number of People Accessing Specialist Mental Health Service - Pacific
800
700
600
500
400
300
200
100
0
Q2 Q4 Q2 Q4 Q2 Q4 Q2 Q4 Q2 Q4 Q2 Q4 Q2 Q4
2012/13 2013/14 2014/15 2015/16 2016/17 2017/18 2018/19
Pacific
Target

System Integration SI1: Ambulatory sensitive hospitalisations (ASH)

Indicators

Age-standardised ASH rate per 100,000 population, age 45 to 64.
ASH rate per 100,000 population, age 0 to 4.

Notes

There is no target information available for ASH rate of 0 to 4 year olds.
For 2013/14, 2014/15 and 2015/16, there is no information about the target ASH rate for 45 to 64 years old available.
There is no target breakdown by ethnicity for either group.
SI1 is only reported the Ministry of Health in Q2 & Q4, so the shading of the graph is only on every second quarter but rates are provided for Q1&3 for DHBs information.
From Q1 2018/19, performance for the 0-4 age group will be assessed through the SLM improvement plan reporting (as part of PP22).

The Ministry of Health quarterly report rating is the same for the total performance graph and the graph of performance by ethnicity, for both indicators.

From Q3 2015/16 to Q1 2018/19, the numbers reported for ages 45 to 64 were based on the WHO standard population. As of Q3 2018/19, these numbers have been retrospectively changed to use the SNZ standard population. Where possible, the numbers have been taken from the report published for the relevant quarter. The exceptions are:

- Q3 2015/16 and Q3 2016/17, where no report was available. The numbers for these quarters came from the Q3 2017/18 report (ie for five years ending Dec 2017)

Up to and including Q3 2015/16 (five years ending Sep 2015). These reports contain only one ASH rate, and it is unclear whether or not it is standardised. The numbers for these quarters have been filled in from the most recent available report (reports go back five years).

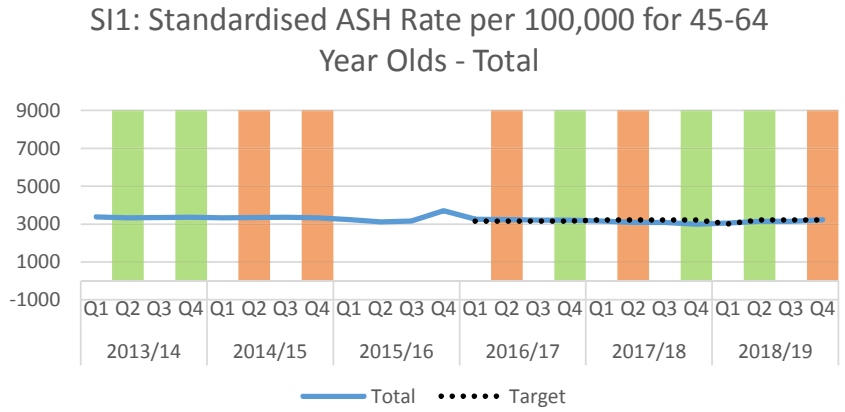
Reporting Frequency

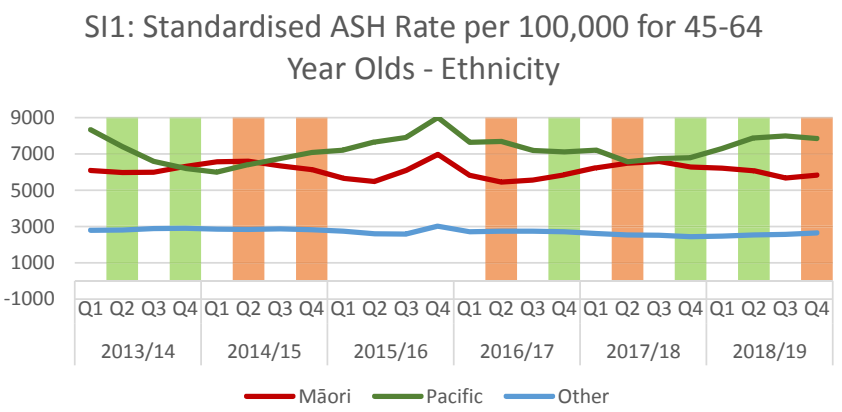
Six Monthly (Q2 & Q4) for 45-64, Quarterly for 0-4

Achievement Scale

Rating	
Outstanding (3rd quarter only)	The DHB has met all targets agreed in the Annual Plan, and has similar ASH rates for Māori, Pacific, and "Total" populations.
Achieved	An achieved rating is applied when the DHB has met all the targets agreed in its Annual Plan. A realistic resolution plan is provided that demonstrates how the DHB will achieve equitable ASH rates for Māori and Pacific.

Partially Achieved	The DHB has not met all of the targets agreed in its Annual Plan. A realistic resolution plan is provided that demonstrates how the DHB will achieve target ASH rates for Māori and Pacific.
Not Achieved	A realistic resolution plan that demonstrates how the DHB will achieve target ASH rates for Māori and Pacific has not been provided.





System Integration SI3: Ensuring delivery of Service Coverage

Indicator

Report on progress towards resolution of exceptions to service coverage identified in the annual plan, and not approved as long term exceptions, and any other gaps in service coverage identified.

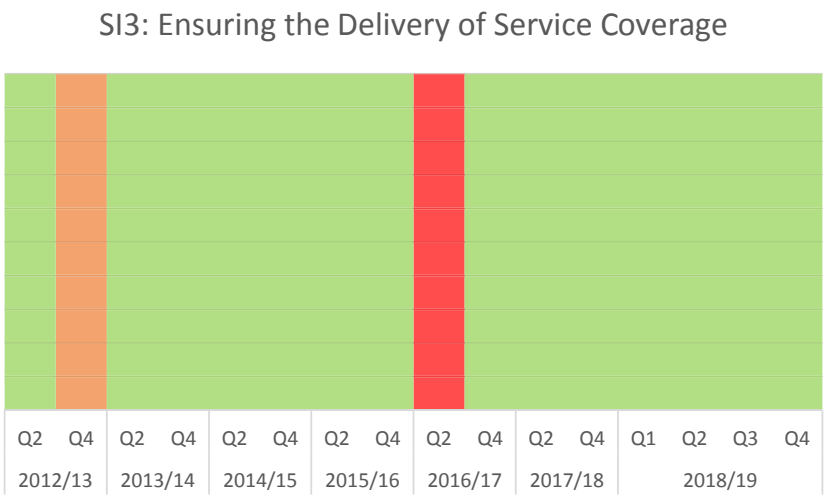
Notes

As of Q1 2018/19, the reporting frequency has changed from six monthly to quarterly.

This is only measured as a Ministry of Health rating.

Reporting Frequency

Quarterly



System Integration SI4: Standardised Intervention Rates (SIRs)

Indicators

21 Major joint replacement procedures SIR per 10,000 population.
27 Cataract procedures SIR per 10,000 population.
6.5 Cardiac surgery SIR per 10,000 population.
12.5 Percutaneous revascularisation SIR per 10,000 population.
34.7 Coronary angiography SIR per 10,000 population.

Notes

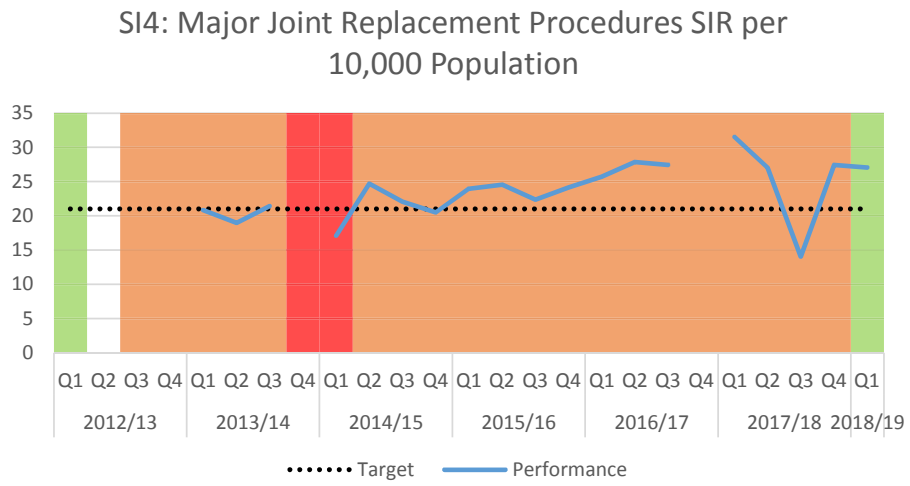
From Q3 2015/16 to Q3 2016/17, the data comes from the annual plan.
For major joint replacements, the data for; Q1, 2 & 3 2013/14, Q2 & 3 2014/15, Q1 & 2 2015/16, and Q1, 2 & 3 2017/18, come from a Ministry of Health standard report not on the quarterly reports website.
For cataract procedures, the data for; Q1, 2 & 3 2013/14, Q1, 2 & 3 2014/15, Q1 & 2 2015/16, and Q1, 2 & 3 2017/18, come from a Ministry of Health standard report not on the quarterly reports website.
For cardiac surgery, the data for; Q1 & 2 2014/15, and Q1, 2 & 3 2017/18, come from a Ministry of Health standard report not on the quarterly reports website.
For percutaneous revascularisation, the data for; Q1 & 2 2013/14, and Q1, 2 & 3 2017/18, come from a Ministry of Health standard report not on the quarterly reports website.
For coronary angiography, the data for; Q2 2013/14, Q1 & 2 2014/15, and Q1, 2 & 3 2017/18, come from a Ministry of Health standard report not on the quarterly reports website.

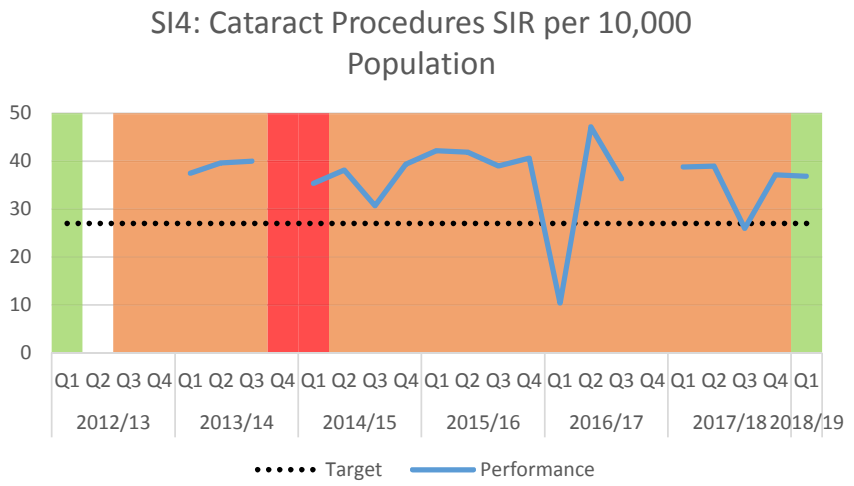
For Q2 2012/13, there is no Ministry of Health rating available.
For 2012/13, Q4 2014/15 and Q4 2016/17, there is no information about performance for major joint replacement available.
For 2012/13, Q4 2013/14 and Q4 2016/17, there is no information about performance for cataract procedures available.
For Q1 & Q2 2012/13 and Q4 2016/17, there is no information about performance for cardiac surgery available.
For 2012/13 and Q4 2016/17, there is no information about performance for percutaneous revascularisation available.
For Q1 & Q2 2012/13 and Q4 2016/17, there is no information for coronary angiography available.

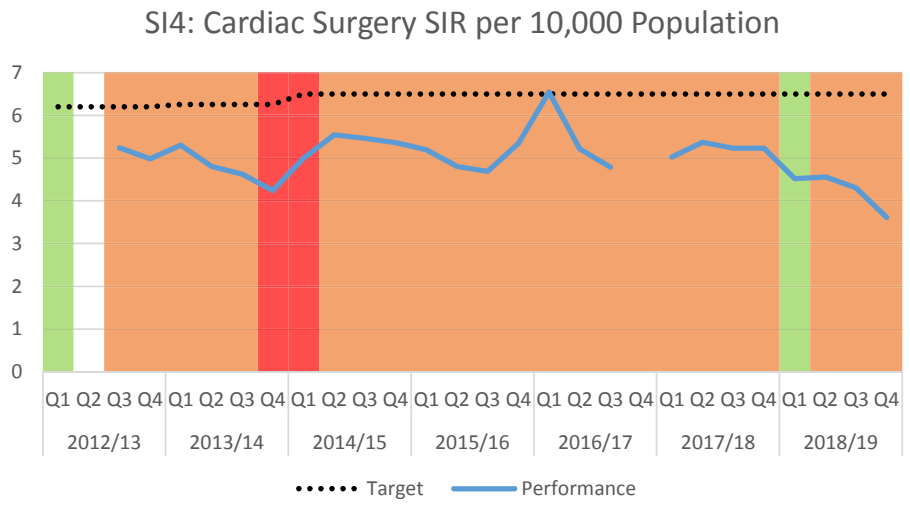
The Ministry of Health quarterly report rating is the same for all five of the indicators.

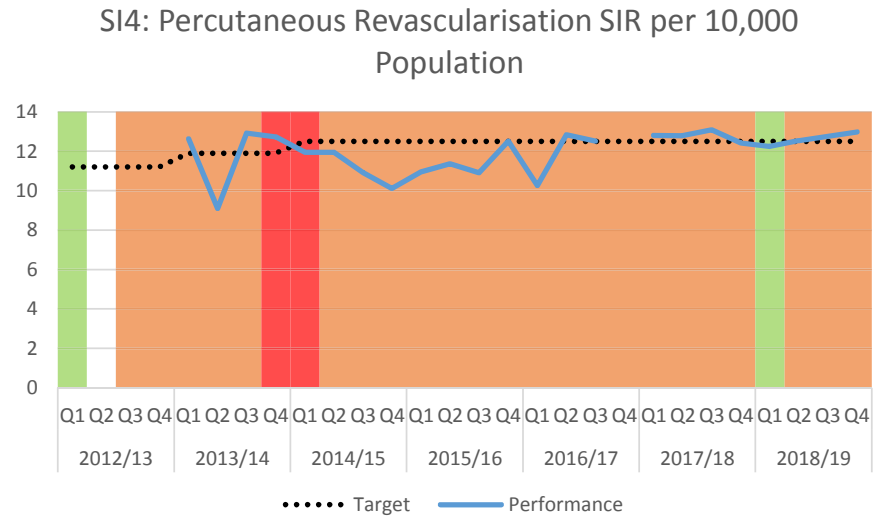
Reporting Frequency

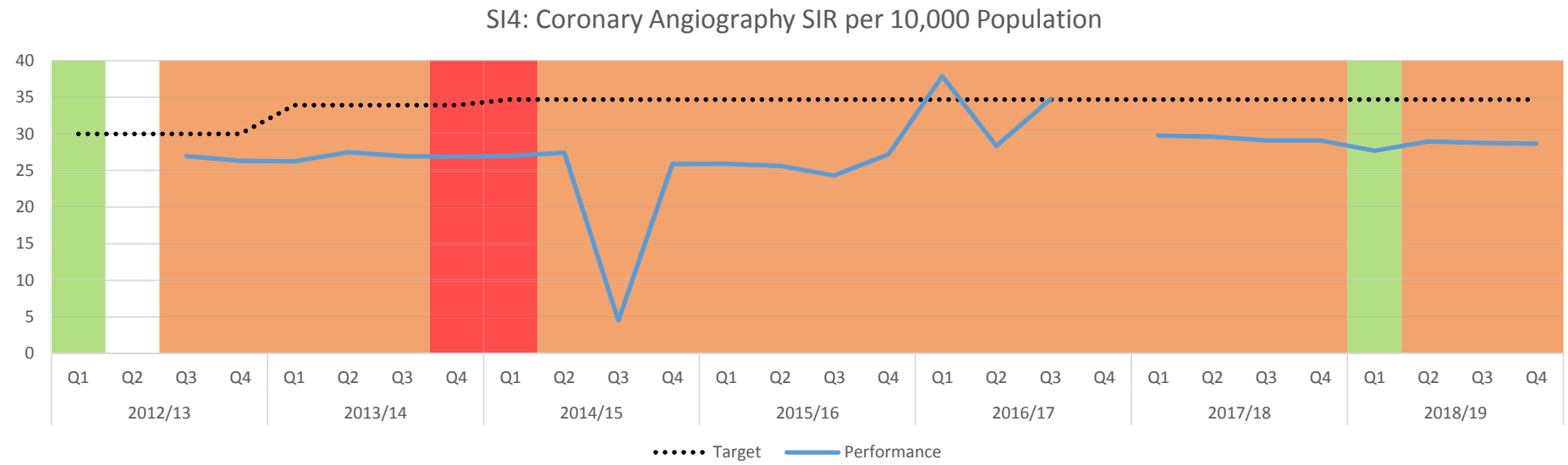
Annually (Q1) (Cataracts & Major Joints), Quarterly (Cardiac Surgery, Coronary Angiography & Percutaneous revascularisation)


SI4: Major Joint Replacement Procedures SIR per 10,000 Population
35
30
25
20
15
10
5
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
Target
Performance


SI4: Cataract Procedures SIR per 10,000 Population
50
40
30
20
10
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
Target
Performance


SI4: Cardiac Surgery SIR per 10,000 Population
7
6
5
4
3
2
1
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
Target
Performance


SI4: Percutaneous Revascularisation SIR per 10,000 Population
14
12
10
8
6
4
2
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
Target
Performance


SI4: Coronary Angiography SIR per 10,000 Population
40
35
30
25
20
15
10
5
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
Target
Performance

System Integration SI10: Improving Cervical Screening Coverage

Indicator

≥80 percent of eligible women who have had a cervical sample taken in the last three years.

Notes

For Q1 2014/15, there is no performance information available as the eligible population was being updated due to the 2013 Census.
There are only 2 Ministry of Health ratings; Q2 2017/18 and Q2 2018/19.
The data for this measure comes from the National Screening Unit's DHB quarterly reports.

The Ministry of Health quarterly report rating is the same for the total performance graph and the graph of performance by ethnicity.

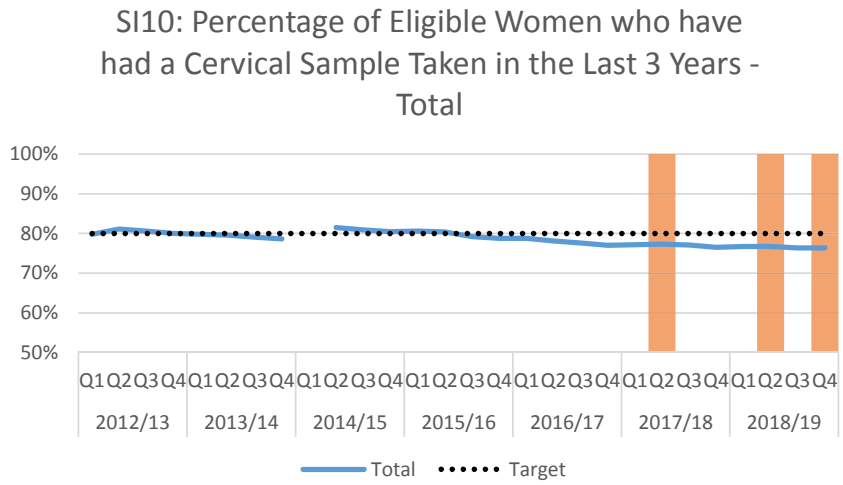
For Q3 2018/19, there was no MOH rating available.

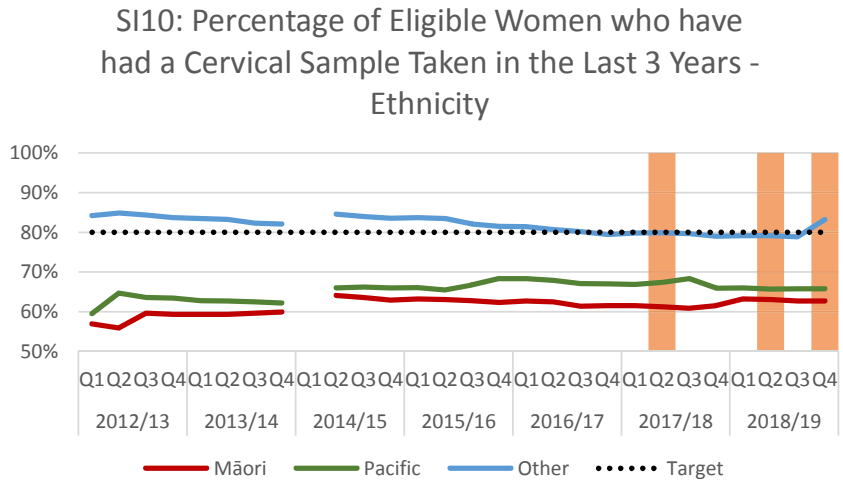
Reporting Frequency

Quarterly

Achievement Scale

Rating	
Outstanding	>80% coverage
Achieved	80% coverage.
Partially Achieved	70-80% coverage.
Not Achieved	<70% coverage.


SI10: Percentage of Eligible Women who have had a Cervical Sample Taken in the Last 3 Years - Total
100%
90%
80%
70%
60%
50%
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
Total
Target


SI10: Percentage of Eligible Women who have had a Cervical Sample Taken in the Last 3 Years - Ethnicity
100%
90%
80%
70%
60%
50%
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
Māori
Pacific
Other
Target

System Integration SI11: Improving breast screening rates

Indicator

≥70 percent of eligible women have had a screening mammogram in the last two years.

Notes

There are only 2 Ministry of Health ratings; Q2 2017/18 and Q2 2018/19.
The data for this measure comes from the National Screening Unit's DHB quarterly reports.

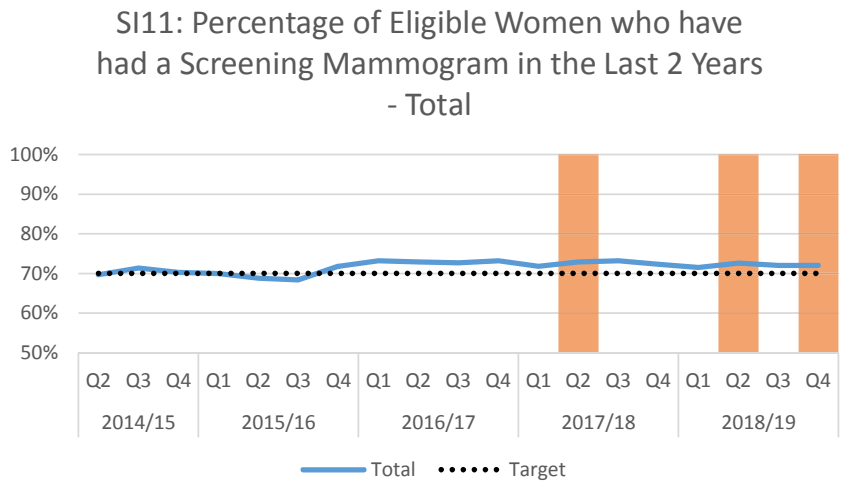
The Ministry of Health quarterly report rating is the same for the total performance graph and the graph of performance by ethnicity.

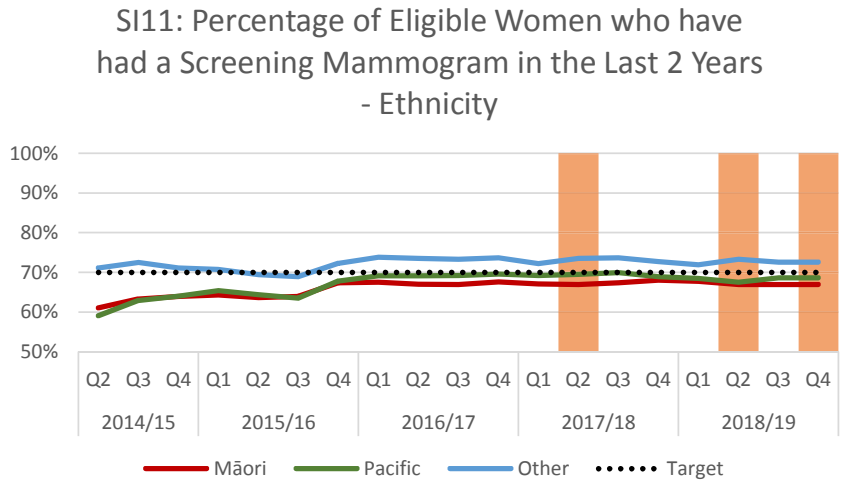
Reporting Frequency

Six Monthly (Q2 & Q4)

Achievement Scale

Rating	
Outstanding	>70% coverage
Achieved	70% coverage.
Partially Achieved	65 – 70% coverage.
Not Achieved	<65% coverage.


SI11: Percentage of Eligible Women who have had a Screening Mammogram in the Last 2 Years - Total
100%
90%
80%
70%
60%
50%
Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2014/15
2015/16
2016/17
2017/18
2018/19
Total
Target


SI11: Percentage of Eligible Women who have had a Screening Mammogram in the Last 2 Years - Ethnicity
100%
90%
80%
70%
60%
50%
Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2014/15
2015/16
2016/17
2017/18
2018/19
Māori
Pacific
Other
Target

System Integration SI14: Disability support services

Indicator

Update on delivery of actions identified in its Annual Plan (for the milestones are relevant to the reporting period) in relation to the following government planning priority focus areas; Disability support services.

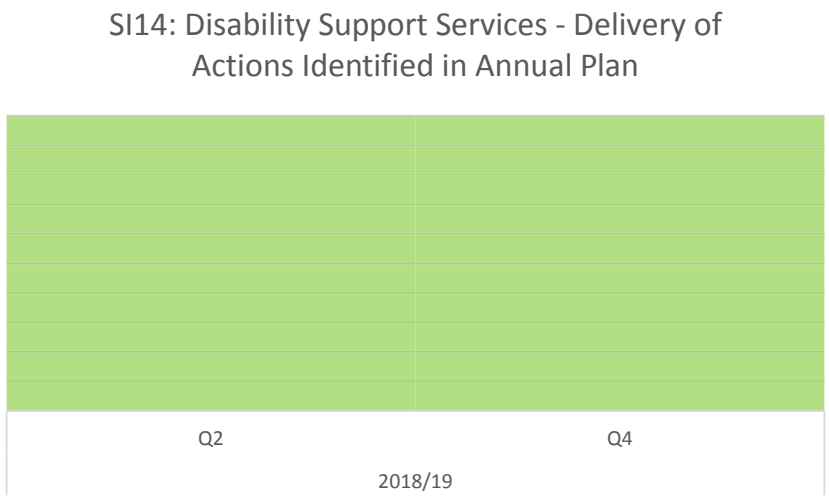
Notes

This is a new measure for 2018/19.

This is only reported as a Ministry of Health rating.

Reporting Frequency

Six Monthly (Q2 & Q4)



System Integration SI15: Addressing local population challenges by life course and overall progress in improving equity

Indicator

Update on delivery of actions identified in its Annual Plan (for the milestones are relevant to the reporting period) in relation to the following government planning priority focus areas; Strengthen public delivery of health services.

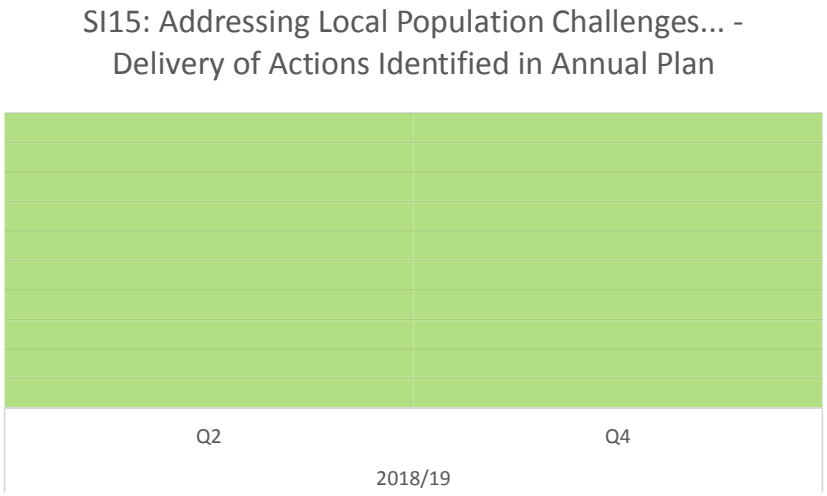
Notes

This is a new measure for 2018/19.

This is only reported as a Ministry of Health rating.

Reporting Frequency

Six Monthly (Q2 & Q4)



System Integration SI16: Strengthen public delivery of health services

Indicator

Update on delivery of actions identified in its Annual Plan (for the milestones are relevant to the reporting period) in relation to the following government planning priority focus areas; Strengthen public delivery of health services.

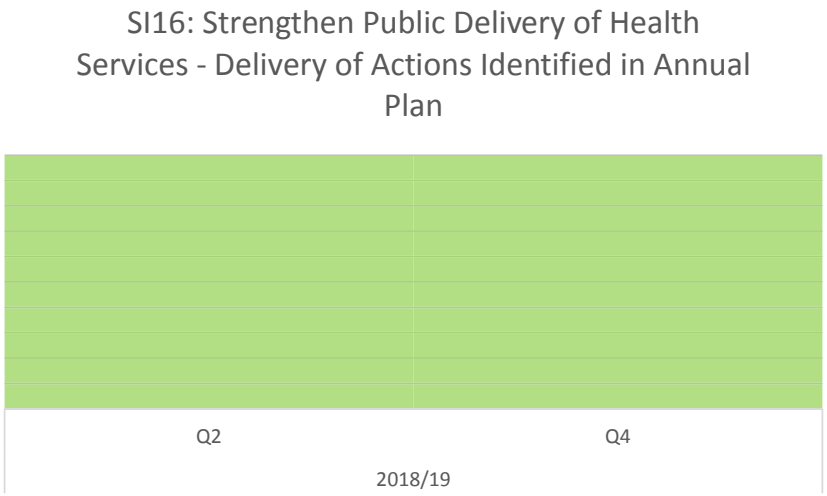
Notes

This is a new measure for 2018/19.

This is only reported as a Ministry of Health rating.

Reporting Frequency

Six Monthly (Q2 & Q4)



System Integration SI18: Improving newborn enrolment in General Practice

Indicator

Update on delivery of actions identified in its Annual Plan (for the milestones are relevant to the reporting period) in relation to the following government planning priority focus areas; Primary health care integration.

Notes

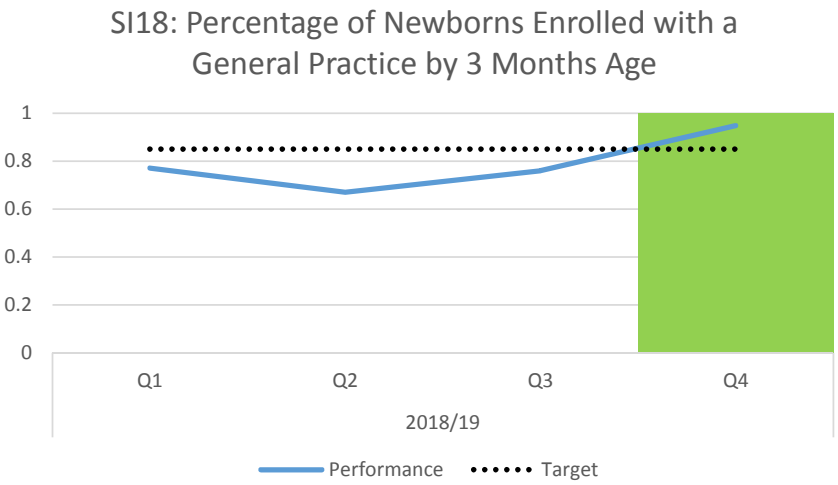
This is a new measure for 2018/19.
For Q1, 2, & 3 2018/19, there is no Ministry of Health rating available.

Reporting Frequency

Quarterly

Achievement Scale

Rating	
Outstanding	The DHB has met the "Total population" target for children enrolled with a general practice by 6 weeks of age and by 3 months of age and the DHB has substantially exceeded the target for one or both targets and/or the DHB has met the target for one or both measures for: the total population, the Māori population group, and (where applicable) the Pacific population.
Achieved	The DHB has reached the "Total population" target for children enrolled with a general practice by 6 weeks of age and by 3 months of age and has delivered all the actions and milestones identified for the period in its annual plan and has achieved significant progress for the Māori population group, and (where relevant) the Pacific population group, for both targets.
Partially Achieved	The DHB has reached the "Total population" target for children enrolled with a general practice by 6 weeks of age or by 3 months of age and/or an adequate resolution plan has been provided if it has not delivered all the actions and milestones identified for the period in its annual plan.
Not Achieved	The DHB's level of new born enrolment in general practice has failed to substantially progress towards the targets identified and/or an adequate resolution plan has not been provided for any actions and milestones identified in the annual plan that have not been delivered.


SI18: Percentage of Newborns Enrolled with a General Practice by 3 Months Age
1
0.8
0.6
0.4
0.2
0
Q1
Q2
Q3
Q4
2018/19
Performance
Target

Crown Funding Agreement CFA: B4 School Check

Notes

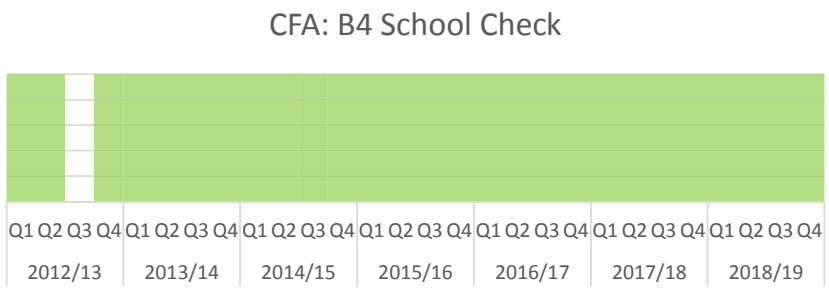
For Q3 2012/13, there is no Ministry of Health rating available.

Reporting Frequency

Quarterly

Achievement Scale

Category	Criteria
Satisfactory	1. The report is assessed as up to expectations 2. Information as requested has been submitted in full
Further work required	1. Although the report has been received, clarification is required 2. Some expectations are not fully met
Not acceptable	1. There is no report 2. The explanation for no report is not considered valid.



Health Strategy HS: Supporting delivery of the New Zealand Health Strategy

Indicator

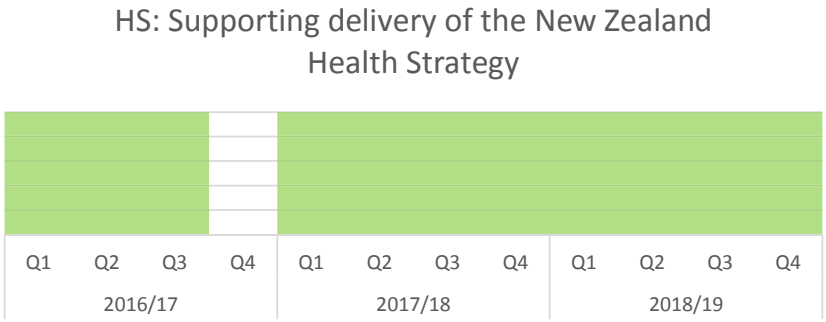
Each DHB is asked to provide one brief example (single dot point) per strategy theme each quarter, to highlight an action, initiative or activity delivered in the quarter.

Notes

No performance assessment is made on this, but the highlights are included on the DHB quarterly dashboards for sharing with the Minister.

Reporting Frequency

Quarterly



HHS – Delwyn Hunter

Health Target HT5: Better help for smokers to quit – Maternity

Indicator

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

Notes

For 2013/14, CCDHB received a not applicable rating from the Ministry of Health.
For Q1 2013/14, there is no information about Māori performance available.
For 2014/15, the target information comes from a Ministry of Health report.

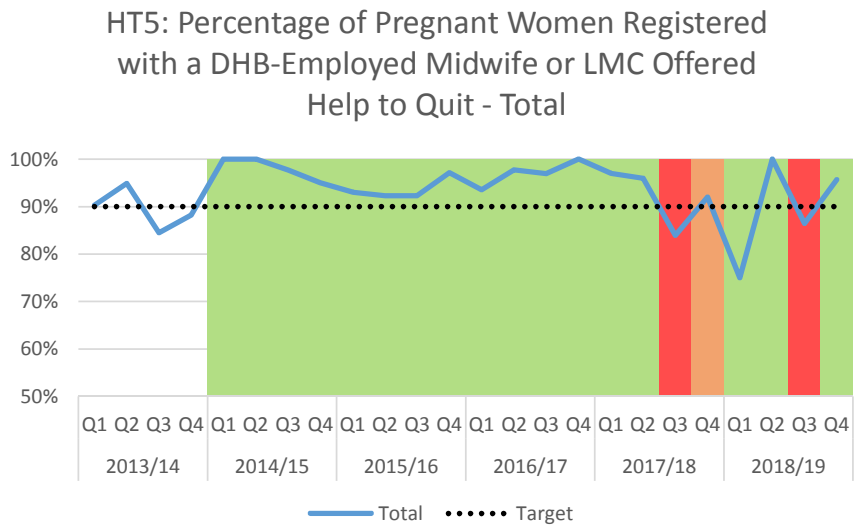
The Ministry of Health quarterly report rating is the same for the total performance graph, as well as the graph of performance by ethnicity.

Reporting Frequency

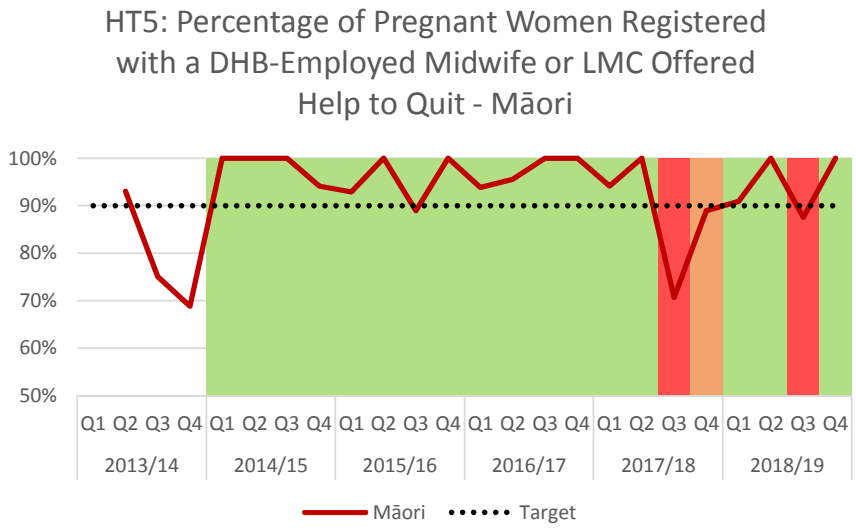
Quarterly

Achievement Scale

Rating	
Achieved	The DHB has met the percentage target for the quarter.
Partially Achieved	The DHB has not met the percentage target, but has improved on its result from the previous quarter.
Not Achieved	The DHB has not met the percentage target, and its result has dropped since the previous quarter.



Financial Quarter	CCDHB Performance	# of DHBs Achieving Target	CCDHB Rank
Q4 2018/19	96%	14	8



Ownership OS3: Inpatient Average Length of Stay (ALOS) - Elective

Indicators

Elective surgical inpatient standardised ALOS.

Notes

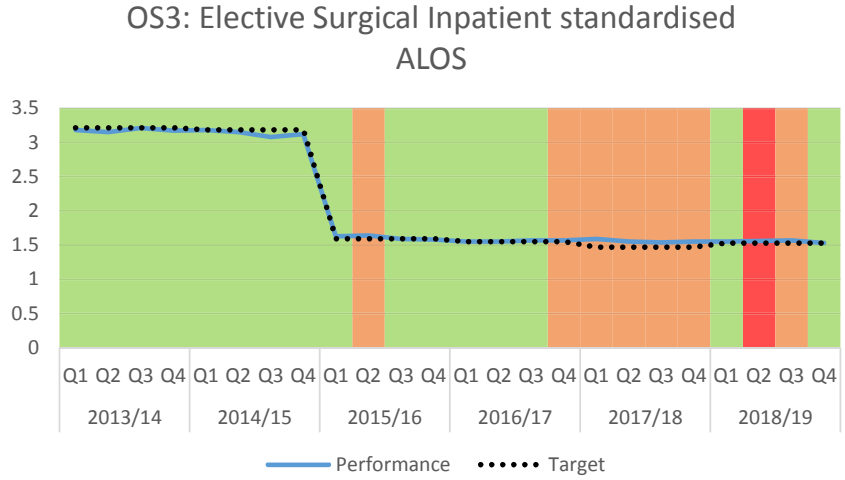
No notes.

Reporting Frequency

Quarterly

Achievement Scale

Rating	
Achieved	The DHB has achieved their agreed elective surgical inpatient ALOS target for the quarter.
Partially Achieved	The DHB has not achieved the agreed target for the quarter, but has demonstrated an adequate work-out plan to reach the target by year-end.
Not Achieved	The agreed ALOS target for the quarter has not been achieved, and the DHB has not demonstrated an adequate work-out plan to reach the target by year-end.


OS3: Elective Surgical Inpatient standardised ALOS
3.5
3
2.5
2
1.5
1
0.5
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
Performance
Target

Policy Priorities PP45: Elective Surgical Discharges (previously HT2)

Indicator

DHBs will provide 100% of their agreed planned elective surgical discharges for each quarter.

Notes

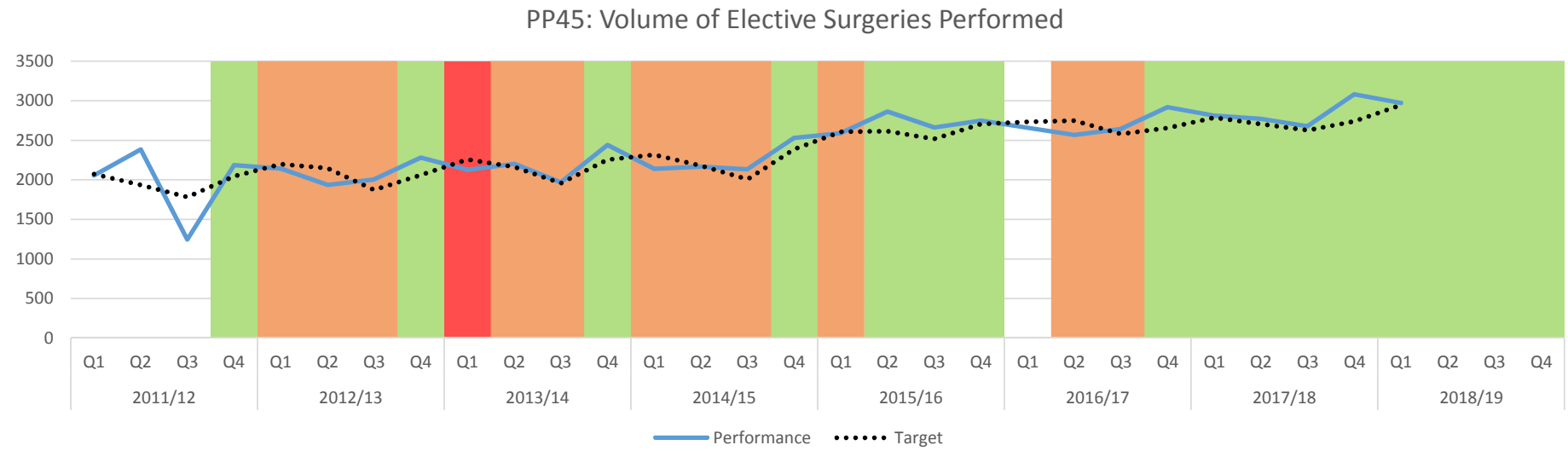
PP45 stopped being a Health Target in Q1 2018/19.
In Q2&4: Update on delivery of actions identified in its Annual Plan (for the milestones are relevant to the reporting period) in relation to the following government planning priority focus areas; Access to elective services.
From Q2 2018/19, no report required – only MoH rating.

Reporting Frequency

Quarterly

Achievement Scale

Rating	
Achieved	The DHB has achieved the planned delivery of elective surgical discharges for the quarter.
Partially Achieved	The DHB has either; achieved 99% of the planned delivery of elective surgical discharges or not achieved 99% of their plan for the quarter but has provided an adequate work-out plan to reach the target by year-end.
Not Achieved	The DHB has not achieved the planned delivery of elective surgical discharges, and has not demonstrated an adequate work-out plan to reach the target by year-end.


PP45: Volume of Elective Surgeries Performed
3500
3000
2500
2000
1500
1000
500
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
Performance
Target

Crown Funding Agreement CFA: Elective Initiative and Ambulatory Initiative

Notes

For Q1 2016/17, there is no Ministry of Health rating available.

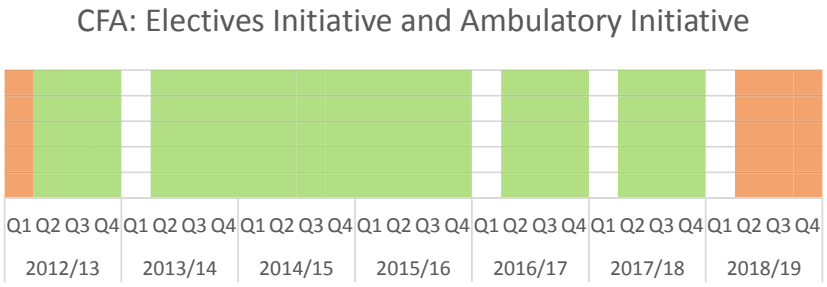
For Q1 2013/14, Q1 2017/18 and Q1 2018/19, there are no Ministry of Health reports available.

Reporting Frequency

Quarterly

Achievement Scale

Category	Criteria
Satisfactory	1. The report is assessed as up to expectations 2. Information as requested has been submitted in full
Further work required	1. Although the report has been received, clarification is required 2. Some expectations are not fully met
Not acceptable	1. There is no report 2. The explanation for no report is not considered valid.



HHS – Carey Virtue

Health Target HT3: Faster cancer treatment

Indicator

≥90 percent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.

Notes

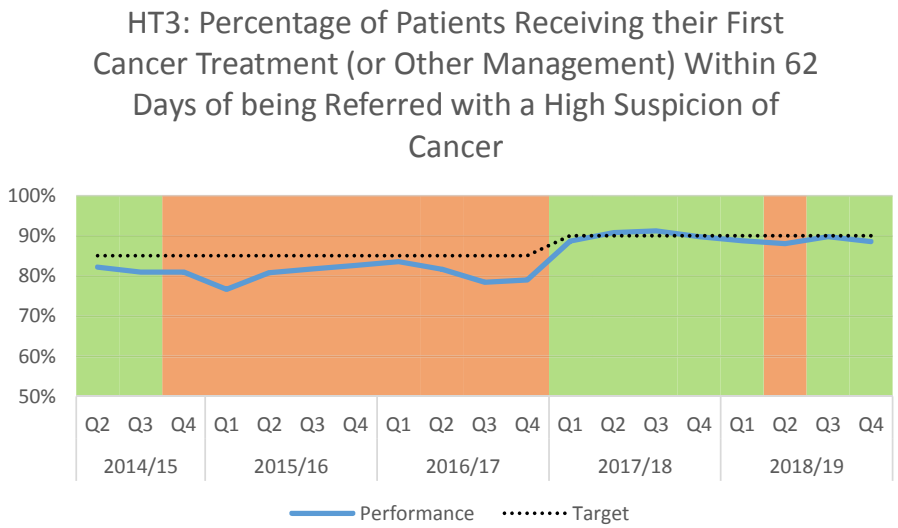
No notes.

Reporting Frequency

Quarterly

Achievement Scale

Rating	
Achieved	Will apply where the DHB has met the target percentage.
Partially Achieved	Will apply where the DHB has not met the target percentage but achievement has improved compared to the previous quarter and the narrative comment satisfies the assessor that the DHB is on track to meet the target.
Not Achieved	Will apply where the DHB has not met the target percentage and achievement has decreased compared to the previous quarter and/or the narrative comment does not satisfy the assessor that the DHB is on track to meet the target.



Financial Quarter	CCDHB Performance	# of DHBs Achieving Target	CCDHB Rank
Q4 2018/19	89%	6	9

Health Target HT1: Shorter stays in Emergency Departments

Indicator

≥95 percent of patients will be admitted, discharged or transferred from an Emergency Department within six hours.

Notes

From Q1 2010/11 to Q3 2011/12, there were no Ministry of Health quarterly reports available.

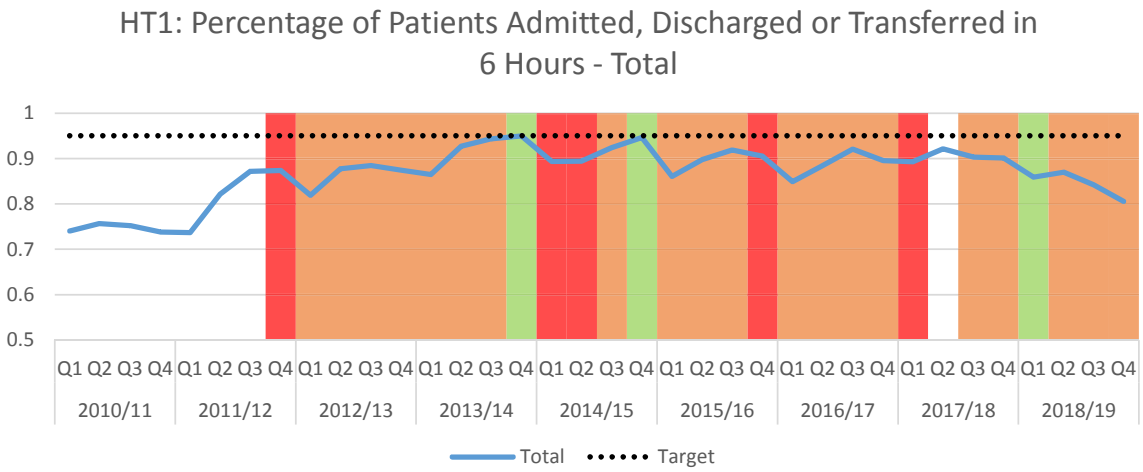
The Ministry of Health quarterly report rating is the same for the total performance graph, as well as the graph of performance by ethnicity.

Reporting Frequency

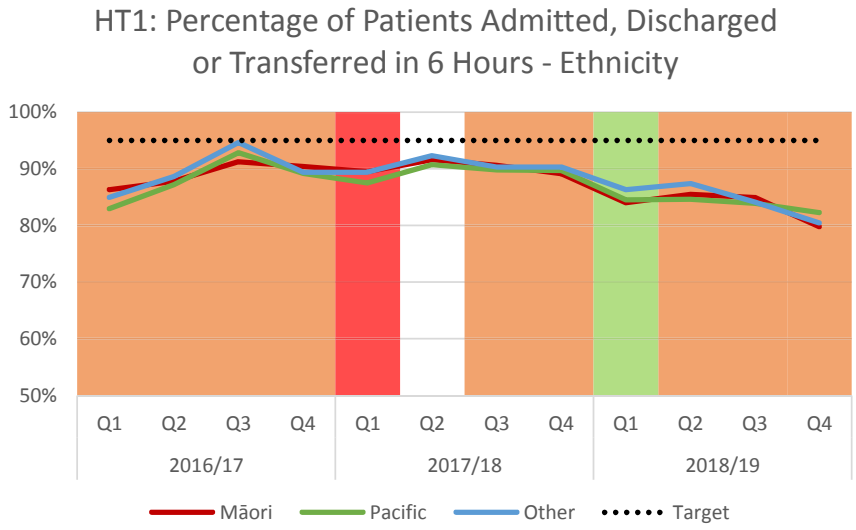
Quarterly

Achievement Scale

Rating	
Achieved	The DHB has met the target percentage for the quarter.
Partially Achieved	The DHB has not met the target percentage but the narrative comments provided satisfy the assessor that the DHB is on track to compliance.
Not Achieved	The DHB has not met the target percentage for the quarter and the narrative comments provided do not satisfy the assessor that the DHB is on track to compliance.



Financial Quarter	CCDHB Performance	# of DHBs Achieving Target	CCDHB Rank
Q4 2018/19	81%	3	18



Ownership OS3: Inpatient Average Length of Stay (ALOS) - Acute

Indicators

Acute inpatient standardised ALOS.

Notes

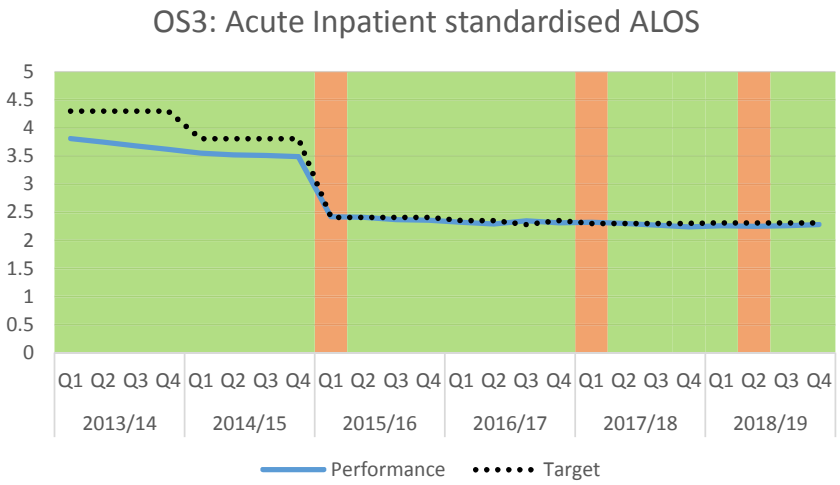
No notes.

Reporting Frequency

Quarterly

Achievement Scale

Rating	
Achieved	The DHB has achieved their agreed elective surgical inpatient ALOS target for the quarter.
Partially Achieved	The DHB has not achieved the agreed target for the quarter, but has demonstrated an adequate work-out plan to reach the target by year-end.
Not Achieved	The agreed ALOS target for the quarter has not been achieved, and the DHB has not demonstrated an adequate work-out plan to reach the target by year-end.


OS3: Acute Inpatient standardised ALOS
5
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
Performance
Target

Ownership OS8: Reducing Acute Readmissions to Hospital

Indicator

Acute readmission rates to hospital within 28 days.

Notes

For 2012/13, there is no information about a target available.
For Q3 & Q4 2014/15, the Ministry of Health is reviewing the model.
For 2015/16 & 2016/17, there is no Ministry of Health report available.
For Q1, Q3 & Q4 2017/18, there is no Ministry of Health rating available.

The Ministry of Health quarterly report rating is the same for the total performance graph and the graph of performance for age 75+.

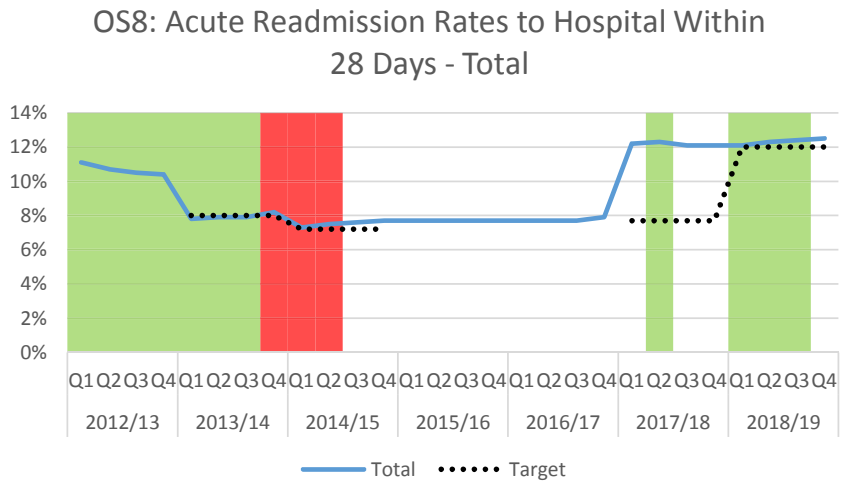
For Q4 2018/19, there was no MoH rating available.

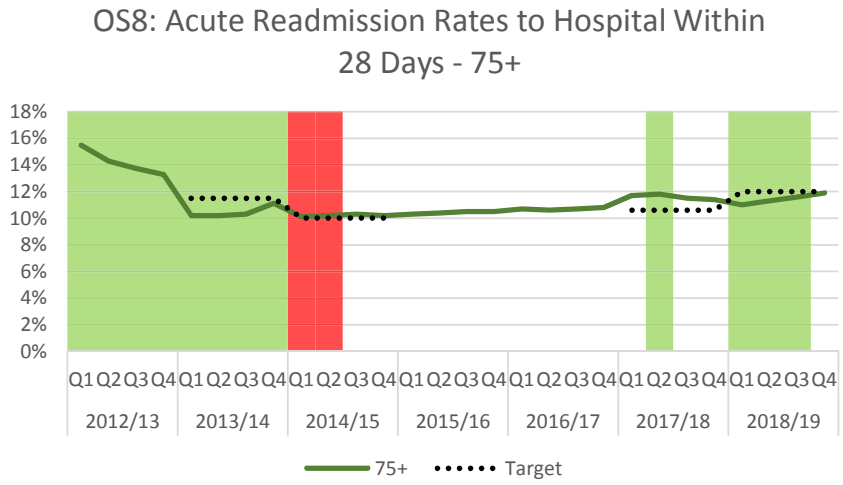
Reporting Frequency

Quarterly

Achievement Scale

Rating	
Achieved	The DHB achieves the agreed target for the quarter.
Partially Achieved	The DHB has not achieved the agreed target for the quarter, but has demonstrated an adequate work-out plan to reach the target by year-end.
Not Achieved	The agreed target for the quarter has not been achieved, and the DHB has not demonstrated an adequate work-out plan to reach the target by year-end.


OS8: Acute Readmission Rates to Hospital Within 28 Days - Total
14%
12%
10%
8%
6%
4%
2%
0%
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
Total
Target


OS8: Acute Readmission Rates to Hospital Within 28 Days - 75+
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
75+
Target

Policy Priorities PP20: Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke) – Focus Areas 4 & 5

Focus Area 4: Acute Heart Service

Indicators

≥70 percent of high-risk patients receiving an angiogram within three days of admission.
≥95 percent of ACS patients undergoing coronary angiography having registry data completion within 30 days and 99 percent within 3 months.
≥85 percent of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF.
In the absence of a documented contraindication/intolerance ≥85 percent ACS patients who undergo coronary angiogram should be prescribed, at discharge, aspirin, a second anti-platelet agent, statin and an ACEI/ARB (4-classes), and those with LVEF<40% should also be on a beta-blocker (5-classes).

Notes

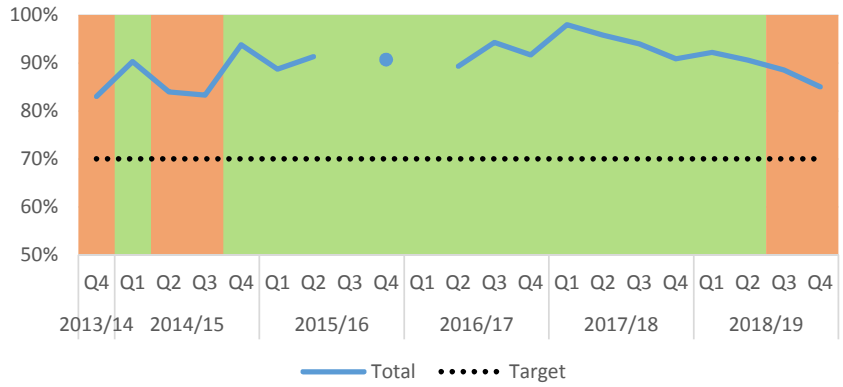
For Q3 2015/16 and Q1 2016/17, no performance information is available, however, CCDHB did achieve the target.
For Q1 2018/19, no performance information by ethnicity is available for registry data within 30 days.

The Ministry of Health quarterly report rating is the same for the total performance graph and the graph of performance by ethnicity, for both indicators.

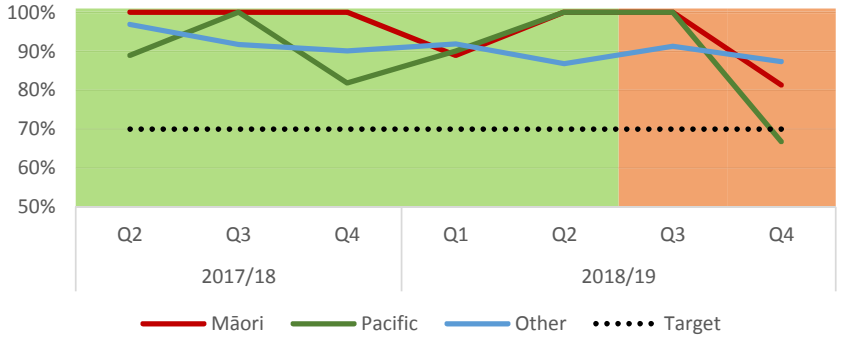
Reporting Frequency

Quarterly

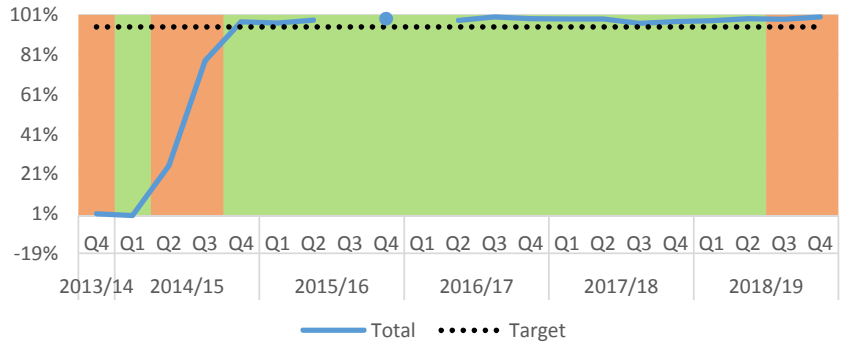
PP20: Percentage of high-risk patients receiving an angiogram within 3 days of admission - Total



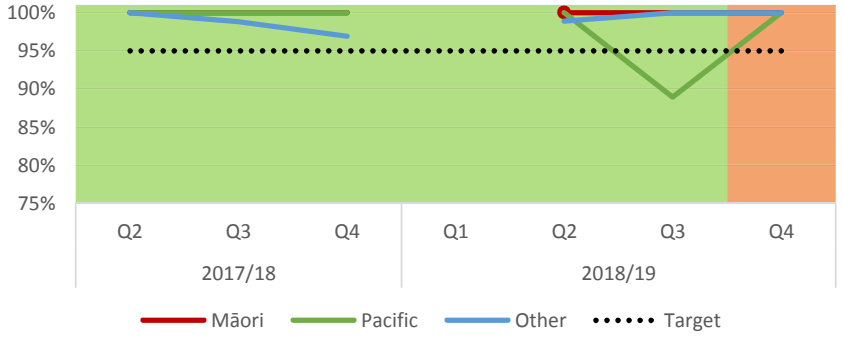
PP20: Percentage of high-risk patients receiving an angiogram within 3 days of admission - Ethnicity



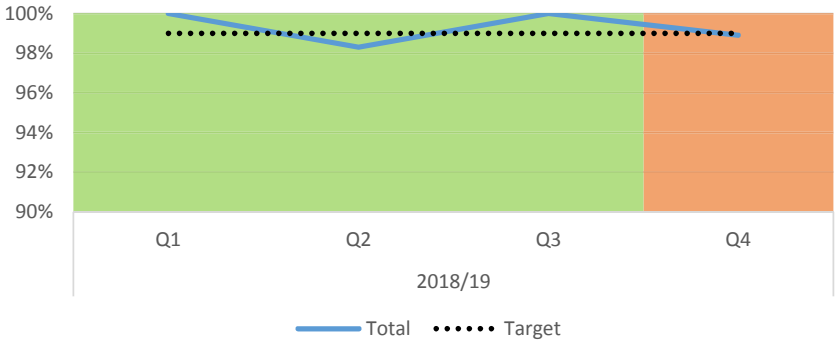
PP20: Percentage of ACS patients undergoing coronary angiography having registry data completion within 30 days - Total



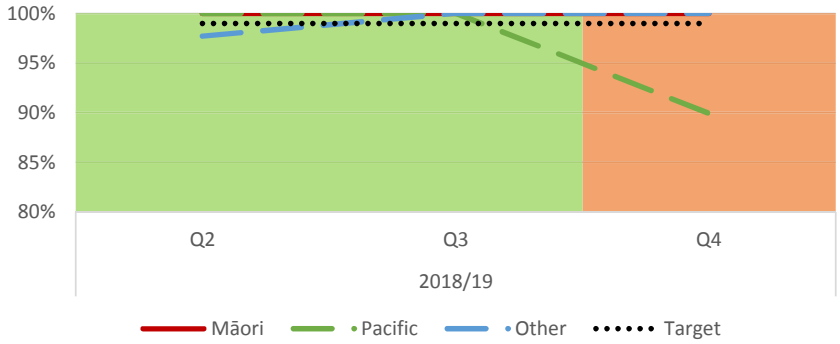
PP20: Percentage of ACS patients undergoing coronary angiography having registry data completion within 30 days - Ethnicity



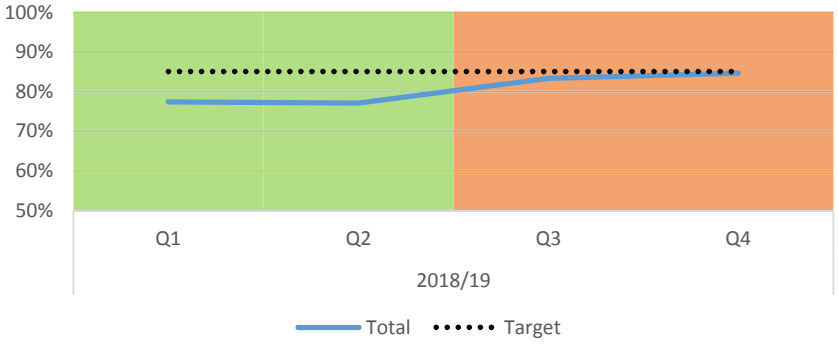
PP20: Percentage of ACS patients undergoing coronary angiography having registry data completion within 3 months - Total



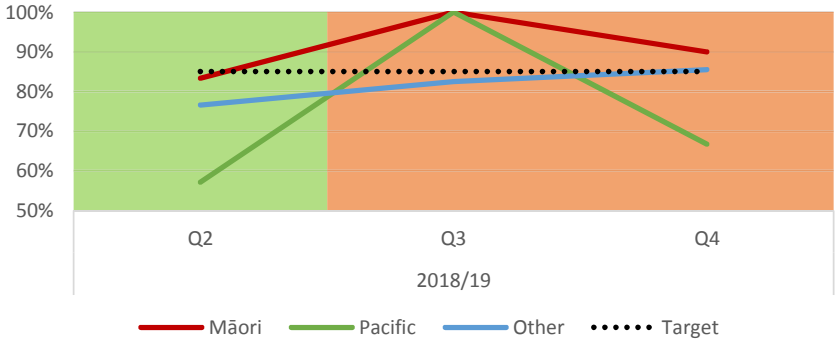
PP20: Percentage of ACS patients undergoing coronary angiography having registry data completion within 3 months - Ethnicity

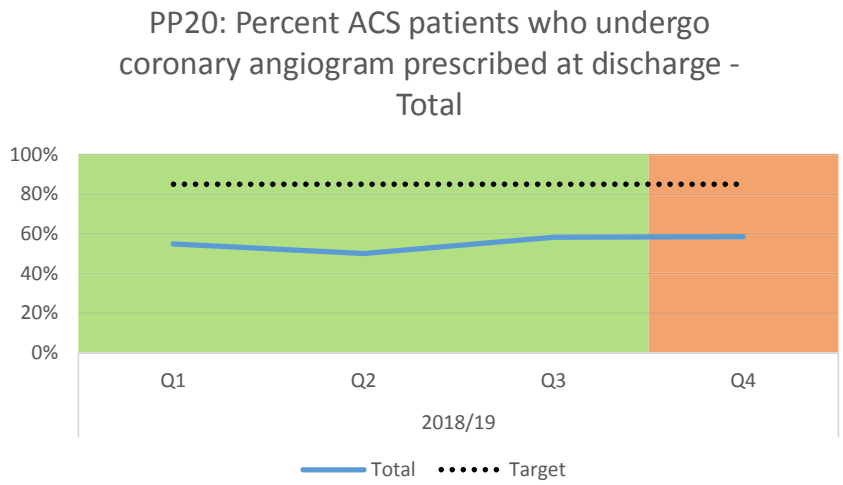


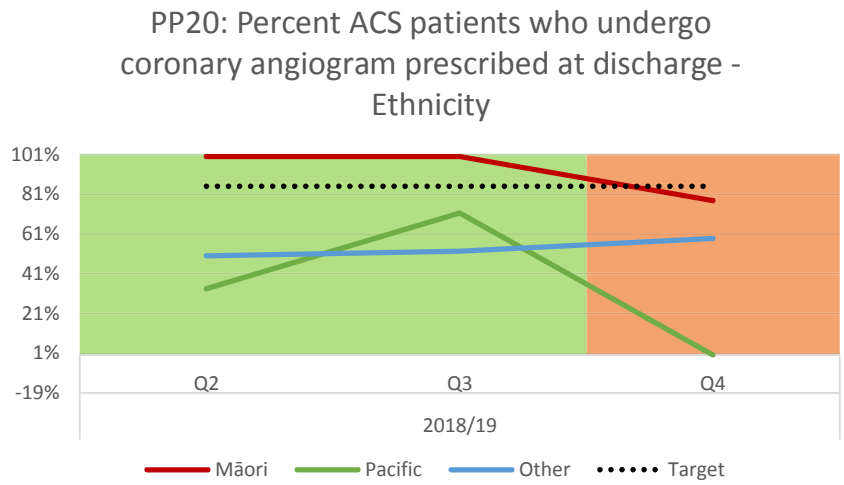
PP20: Percentage of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF - Total



PP20: Percentage of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF - Ethnicity




PP20: Percent ACS patients who undergo coronary angiogram prescribed at discharge - Total
100%
80%
60%
40%
20%
0%
Q1
Q2
Q3
Q4
2018/19
Total
Target


PP20: Percent ACS patients who undergo coronary angiogram prescribed at discharge - Ethnicity
101%
81%
61%
41%
21%
1%
-19%
Q2
Q3
Q4
2018/19
Māori
Pacific
Other
Target

Focus Area 5: Stroke Service

Indicators

≥10 percent of potentially eligible stroke patients thrombolysed.
≥80 percent of stroke patients admitted to a stroke unit or service with demonstrated stroke pathway.
≥80 percent of patients admitted with acute stroke transferred to inpatient rehabilitation services within seven days.
≥80 % of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team ie RN/PT/OT/SLT/SW/Dr/Psychologist within 7 calendar days of hospital discharge.

Notes

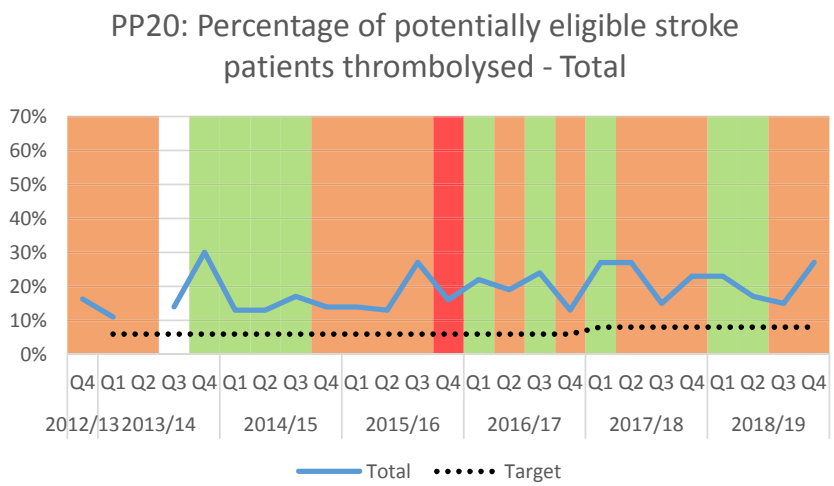
For Q2 2013/14, there is no information on CCDHB performance available.
For Q3 2013/14, there is no Ministry of Health rating available.
For Q2 2016/17, there were no Māori patients transferred to inpatient rehabilitation within seven days.
For Q4 2017/18, there is no information on Māori patients admitted with acute stroke transferred to inpatient rehabilitation services within seven days.
For Q1 2018/19, there is no performance information for Pacific for any focus area or Māori for focus area 3.
For Q1 2018/19, uses the previous Ministry of Health rating System.
For the breakdown by Māori, there were six or fewer Māori patients for all of the reports.

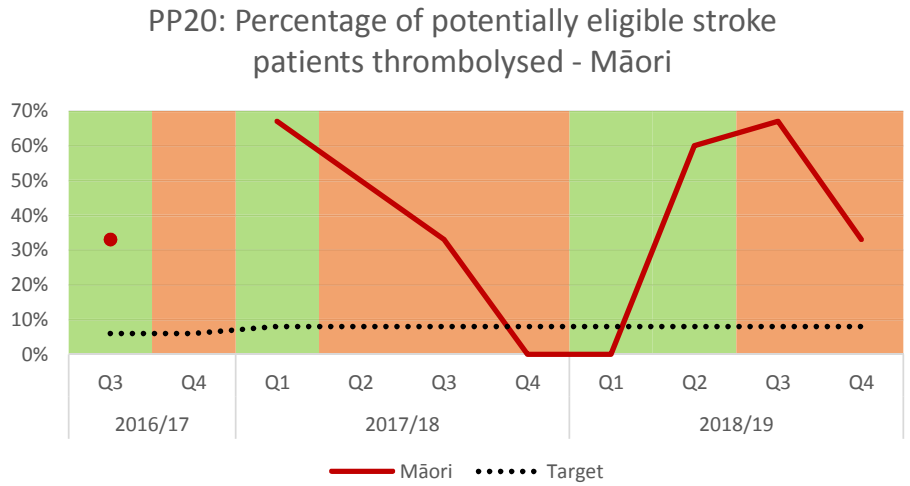
For Q3 2018/19, all reports were unavailable

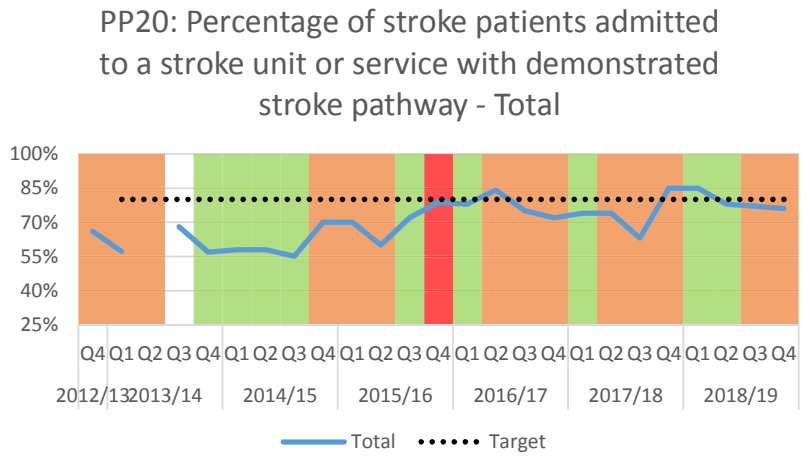
The Ministry of Health quarterly report rating is the same for the total performance graph and the graph of performance for Māori, for all three indicators.

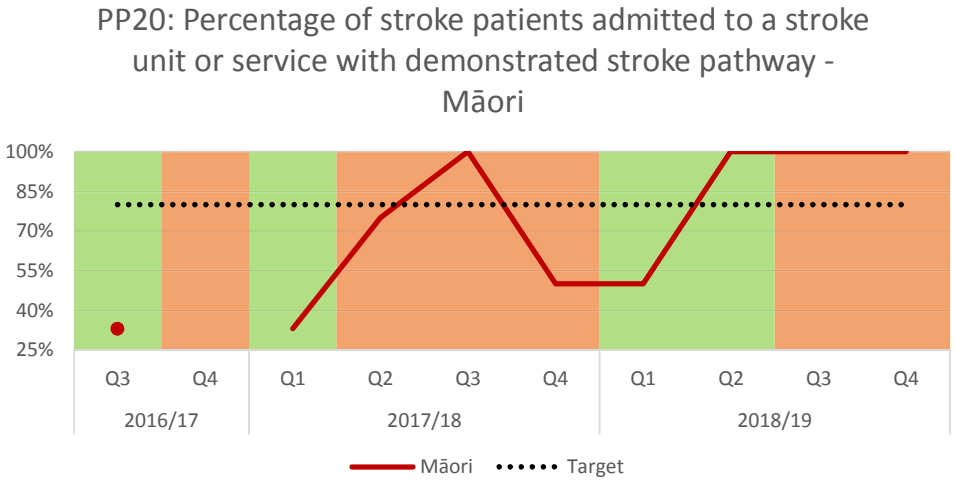
Reporting Frequency

Quarterly

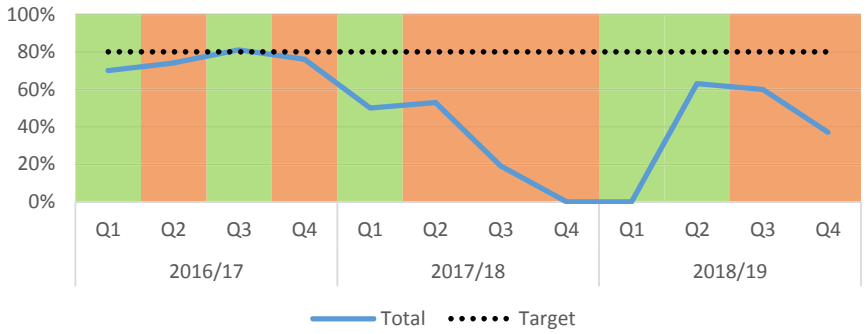

PP20: Percentage of potentially eligible stroke patients thrombolysed - Total
70%
60%
50%
40%
30%
20%
10%
0%
Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2012/13 2013/14 2014/15 2015/16 2016/17 2017/18 2018/19
Total
Target


PP20: Percentage of potentially eligible stroke patients thrombolysed - Māori
70%
60%
50%
40%
30%
20%
10%
0%
Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2016/17 2017/18 2018/19
Māori
Target

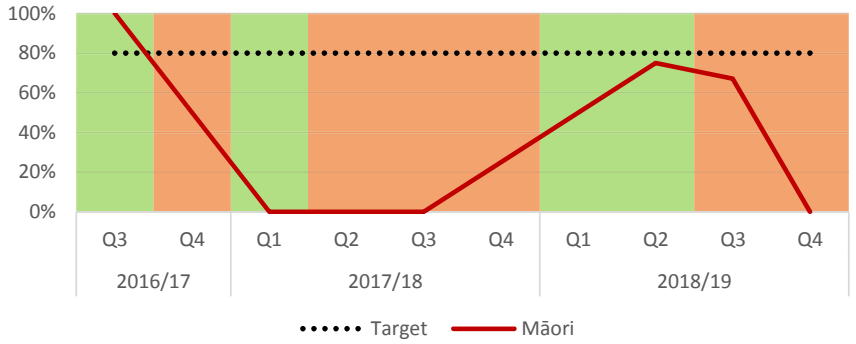

PP20: Percentage of stroke patients admitted to a stroke unit or service with demonstrated stroke pathway - Total
100%
85%
70%
55%
40%
25%
Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2012/13 2013/14 2014/15 2015/16 2016/17 2017/18 2018/19
Total
Target


PP20: Percentage of stroke patients admitted to a stroke unit or service with demonstrated stroke pathway - Māori
100%
85%
70%
55%
40%
25%
Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2016/17 2017/18 2018/19
Māori
Target

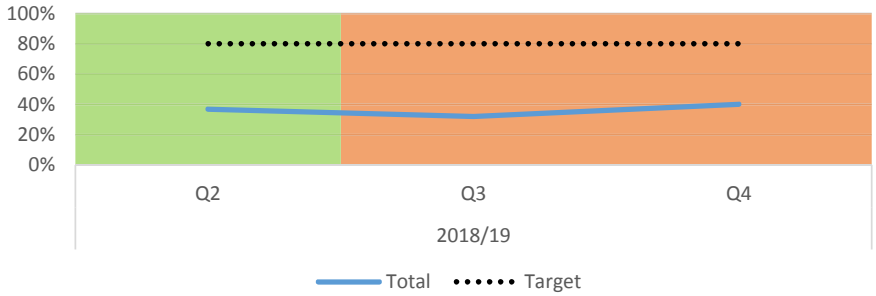
PP20: Percentage of patients admitted with acute stroke transferred to inpatient rehabilitation services within 7 days - Total



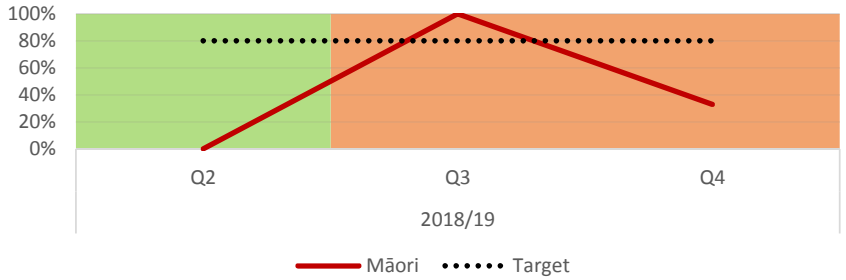
PP20: Percentage of patients admitted with acute stroke transferred to inpatient rehabilitation services within 7 days - Māori



PP20: Percentage of patients referred for community rehabilitation are seen face to face by a member of the community rehab team within 7 calendar days of hospital discharge - Total



PP20: Percentage of patients referred for community rehabilitation are seen face to face by a member of the community rehab team within 7 calendar days of hospital discharge - Māori



Policy Priorities PP29: Improving wait times for diagnostic services

Indicator

Elective Coronary Angiography: ≥95 percent of accepted referrals receiving angiography within 90 days.
Computed Tomography: ≥95 percent of accepted referrals receiving scan within 42 days.
Magnetic Resonance Imaging: ≥90 percent of accepted referrals receiving scan within 42 days.
Urgent Diagnostic Colonoscopy: ≥90 percent of accepted referrals receiving procedure within 14 days.
Non-Urgent Diagnostic Colonoscopy: ≥70 percent of accepted referrals receiving procedure within 42 days.
Surveillance Colonoscopy: ≥70 percent of people receiving procedure within 84 days.

Notes

For Q1 2014/15, there is no information about CCDHB's performance available.
For Q1 2016/17, there is no information about MRI or angiography available.
For Q1 2018/19, colonoscopy uses the previous Ministry of Health rating system.
For Q2, 2018/19, there is no performance information for urgent and non-urgent colonoscopy, however, the target was met.

For Q3, 2018/19, the elective coronary angiography was rated NR. This is represented as N on the graph below.
For Q3, 2018/19, the information for the non-urgent diagnostic colonoscopy was not available.

For Q4, 2018/19, the CT and MRI measures are reported monthly; the most recent monthly value was taken.

The Ministry of Health rating is unique both for angiography and MRI, while the three colonoscopy indicators have the same rating applied.

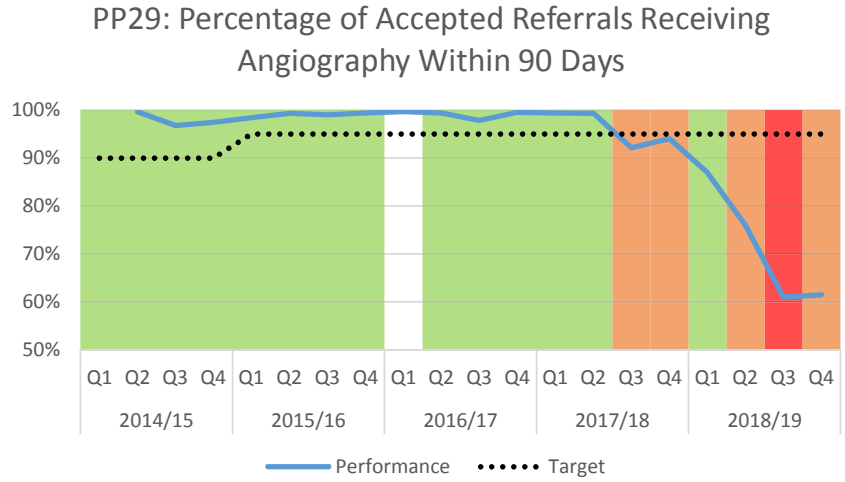
Reporting Frequency

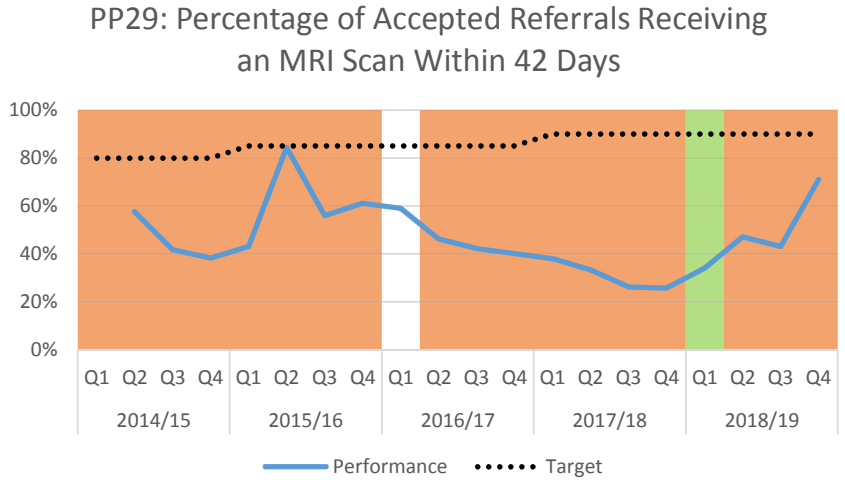
Monthly as outlined

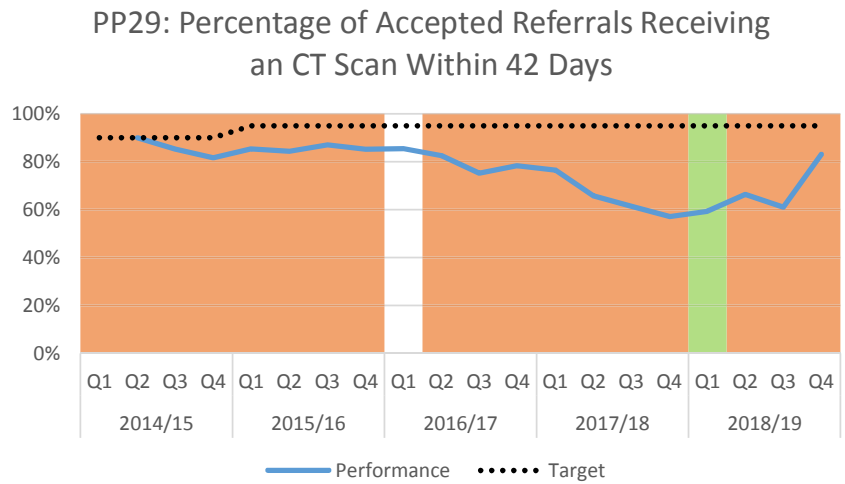
Achievement Scale

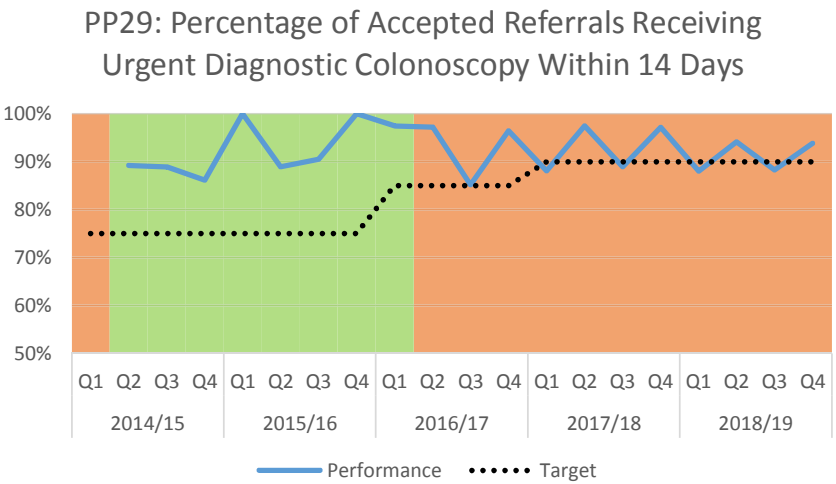
Rating	
Achieved	The DHB has achieved all the waiting time indicator or indicators for the respective diagnostic area.
Partially Achieved	The DHB has either: - achieved some, but not all, of the waiting time indicators for the respective diagnostic area (for example, achieved the CT indicator but not the MRI indicator), and has provided a report that includes planned actions to lift performance; **or**

	- achieved none of the indicators for the respective diagnostic areas, but shows improvement over the previous quarter, and has provided an adequate work-out plan to reach the target by year-end.
Not Achieved	The DHB has not achieved the waiting time indicators for the respective diagnostic area, and has not demonstrated an adequate work-out plan to reach the target by year-end.

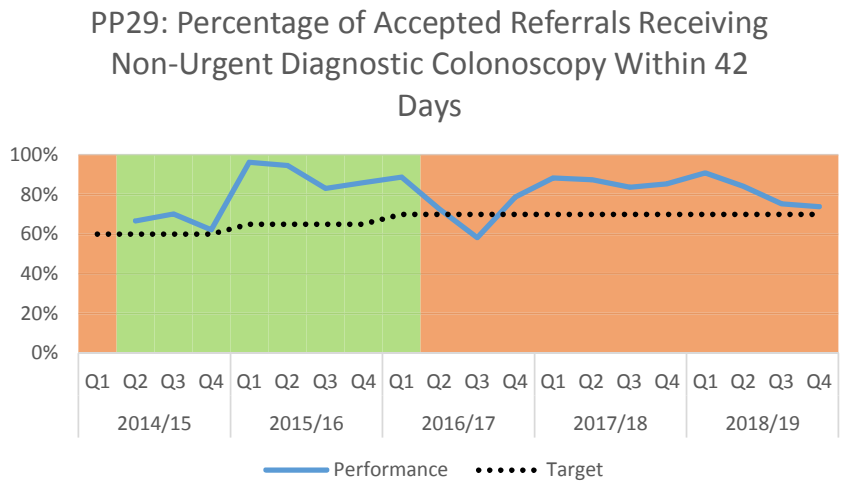


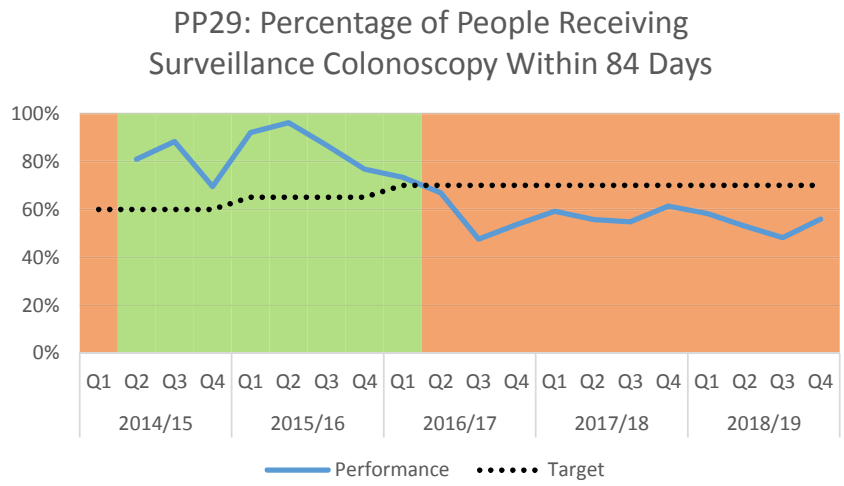






Non-Financial Monitoring – Q4
2018/19 80


PP29: Percentage of Accepted Referrals Receiving Non-Urgent Diagnostic Colonoscopy Within 42 Days
100%
80%
60%
40%
20%
0%
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2014/15
2015/16
2016/17
2017/18
2018/19
Performance
Target


PP29: Percentage of People Receiving Surveillance Colonoscopy Within 84 Days
100%
80%
60%
40%
20%
0%
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2014/15
2015/16
2016/17
2017/18
2018/19
Performance
Target

Policy Priorities PP30: Faster cancer treatment

Indicator

≥85 percent of patients receiving their first cancer treatment (or other management) within 31 days from date of decision-to-treat.
In quarters two and four the DHB is expected to provide an update on delivery of actions identified in its Annual Plan (for the milestones are relevant to the reporting period) in relation to the following government planning priority focus area; Cancer services.

Notes

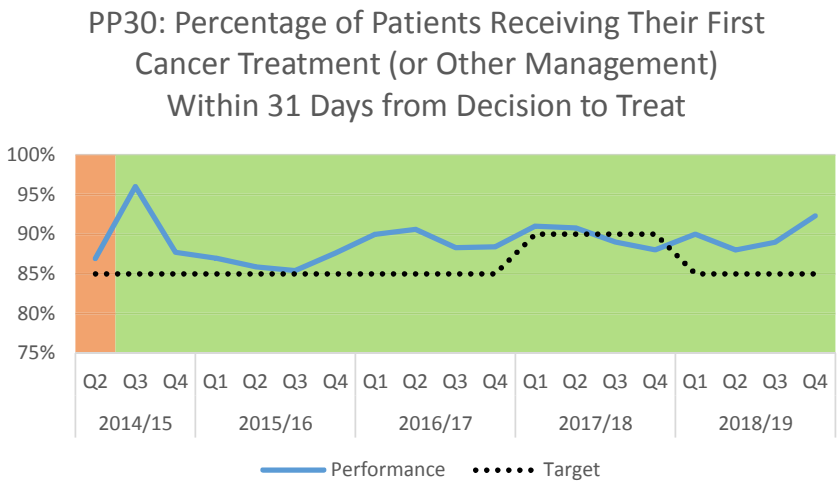
No notes.

Reporting Frequency

Quarterly

Achievement Scale

Rating	
Achieved	Will apply where at least 85 percent of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.
Partially Achieved	Will apply where less than 85 percent of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat, but the narrative comment satisfies the assessor that the DHB has a plan to improve achievement.
Not Achieved	Will apply where less than 85 percent of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat and the narrative comment does not satisfy the assessor that the DHB has a plan to improve achievement.


PP30: Percentage of Patients Receiving Their First Cancer Treatment (or Other Management) Within 31 Days from Decision to Treat
100%
95%
90%
85%
80%
75%
Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2014/15
2015/16
2016/17
2017/18
2018/19
Performance
Target

Policy Priorities PP31: Better help for smokers to quit in public hospitals (previous health target)

Indicator

≥95 percent of adults admitted to hospital as inpatients who identify as a current smoker receive brief advice and support to quit smoking.

Notes

PP31 stopped being a health target in Q2 2014/15.
There is no Ministry of Health rating for Q1, 2 & 3 2012/13 as the historical reports don't go that far back.

The Ministry of Health quarterly report rating is the same for the total performance graph and the graph of performance by ethnicity.

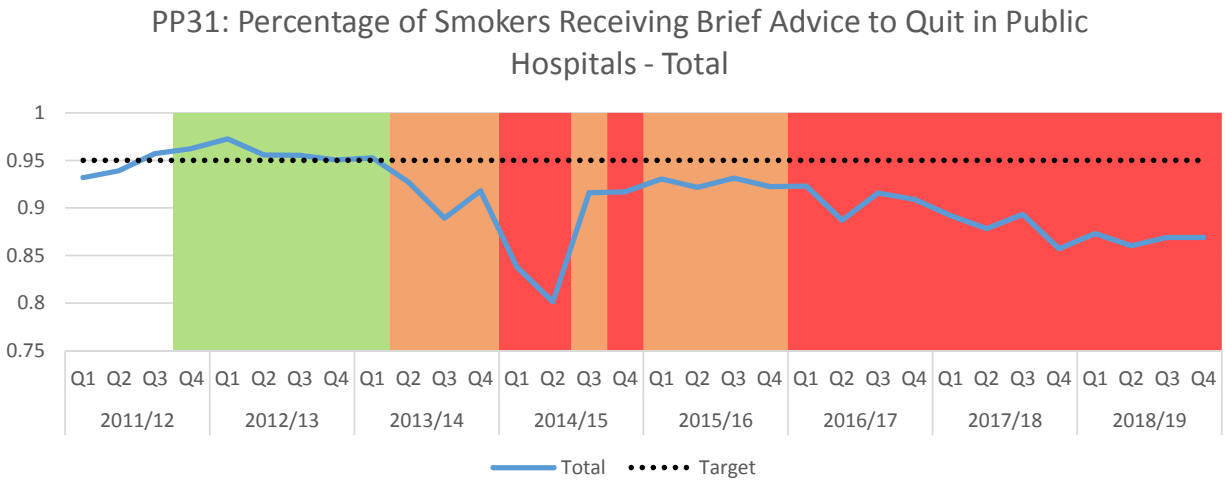
For Q3, 2018/19, the MOH rating was NR. This is represented as N on the graph below.

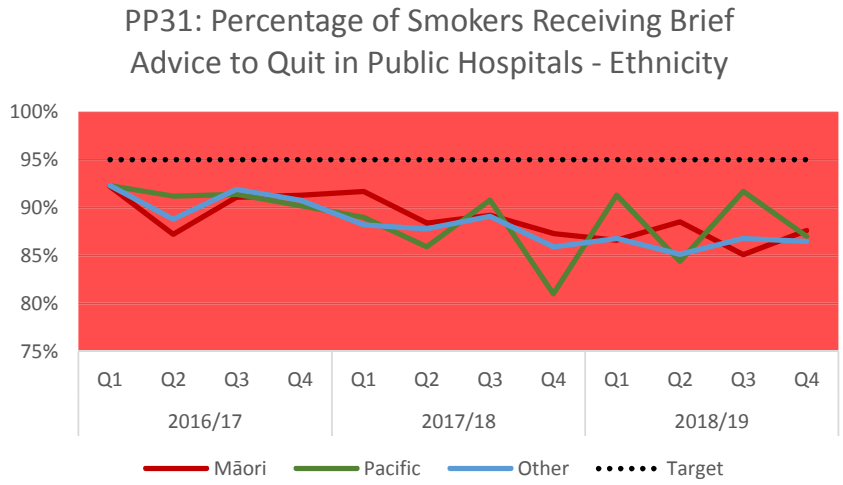
Reporting Frequency

Quarterly

Achievement Scale

Rating	
Achieved	The DHB has met the percentage target.
Partially Achieved	The DHB has not met target, but has improved on its result from the previous quarter.
Not Achieved	The DHB has not met target, and its result has dropped since the previous quarter.


PP31: Percentage of Smokers Receiving Brief Advice to Quit in Public Hospitals - Total
1
0.95
0.9
0.85
0.8
0.75
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
Total
Target


PP31: Percentage of Smokers Receiving Brief Advice to Quit in Public Hospitals - Ethnicity
100%
95%
90%
85%
80%
75%
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2016/17
2017/18
2018/19
Māori
Pacific
Other
Target

Crown Funding Agreement CFA: Appoint cancer psychological and social support workers

Notes

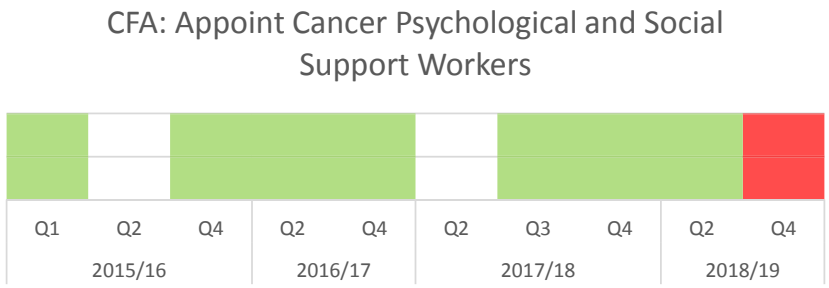
For Q2 2015/16 and Q2 2017/18, there are no Ministry of Health reports available, however, there are reports available for Q1 2015/16 and Q3 2017/18.

Reporting Frequency

Six Monthly (Q2 & Q4)

Achievement Scale

Category	Criteria
Satisfactory	1. The report is assessed as up to expectations 2. Information as requested has been submitted in full
Further work required	1. Although the report has been received, clarification is required 2. Some expectations are not fully met
Not acceptable	1. There is no report 2. The explanation for no report is not considered valid.



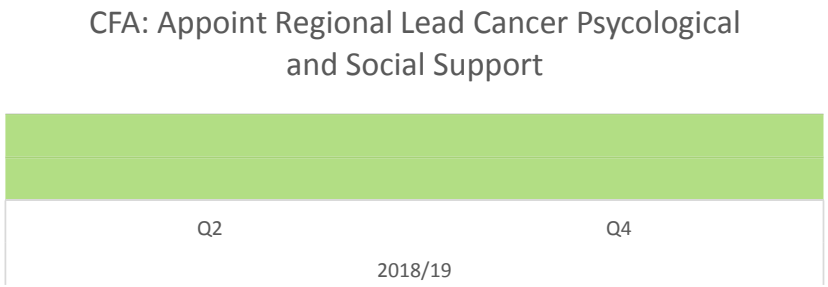
Crown Funding Agreement CFA: Appoint Regional Lead Cancer Psychological and Social Support

Notes

New measure 2018/19.

Reporting Frequency

Unknown (New measure 2018/19)



Crown Funding Agreement CFA: Disability Support Services Funding Increase

Notes

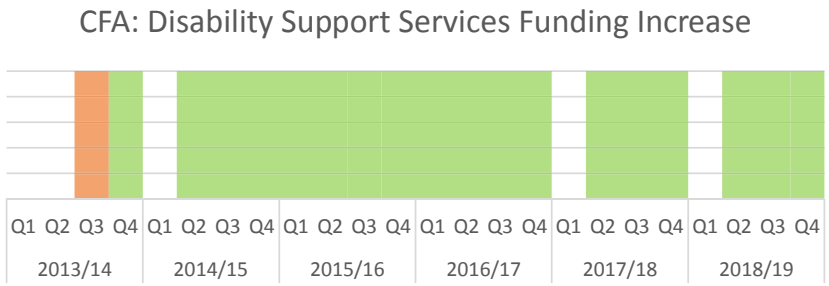
For Q1 & 2 2013/14, Q1 2014/15 and Q1 2017/18, there are no Ministry of Health reports available.
This is stated as not reported on the Ministry of Health quarterly reporting website for Q1 2018/19.

Reporting Frequency

Quarterly

Achievement Scale

Category	Criteria
Satisfactory	1. The report is assessed as up to expectations 2. Information as requested has been submitted in full
Further work required	1. Although the report has been received, clarification is required 2. Some expectations are not fully met
Not acceptable	1. There is no report 2. The explanation for no report is not considered valid.



MHAID – Nigel Fairly

Output OP1: Mental Health Output Delivery against Plan

Indicator

Volume delivery for specialist Mental Health and Addiction services is within: a) five percent variance of planned volumes for services measured by FTE, b) five percent variance of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day, and c) actual expenditure on the delivery of programmes or places is within five percent of the year-to-date plan.

Notes

This is only measured as a Ministry of Health rating.

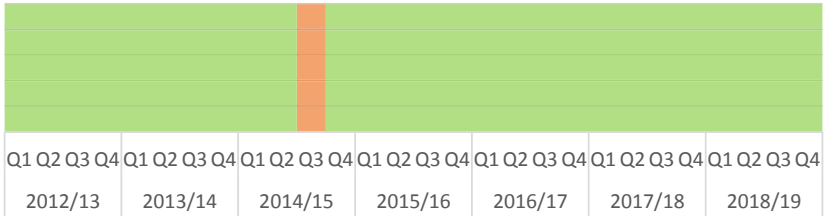
Reporting Frequency

Quarterly

Achievement Scale

Rating	
Achieved	Volume delivery for specialist Mental Health and Addiction services is within: a) five percent variance (+/-) of planned volumes for services measured by FTE, b) five percent variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day, and c) actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.
Partially Achieved	Volume delivery is outside the bounds for an 'Achieved' rating and the accompanying exception reporting is satisfactory.
Not Achieved	Volume delivery is outside the bounds for an 'Achieved' rating and the accompanying exception reporting is not satisfactory.

OP1: Mental Health Output Delivery Against Plan



Ownership OS10: Improving the quality of identity Data within the National Health Index (NHI) and data submitted to National Collections – Focus area 3

Indicators

Focus Area 3: Report on PRIMHD data quality audits and corrective actions.

Notes

Focus Area 3: There is no information about the target available. For Q1 2016/17, there was no Ministry of Health report available.

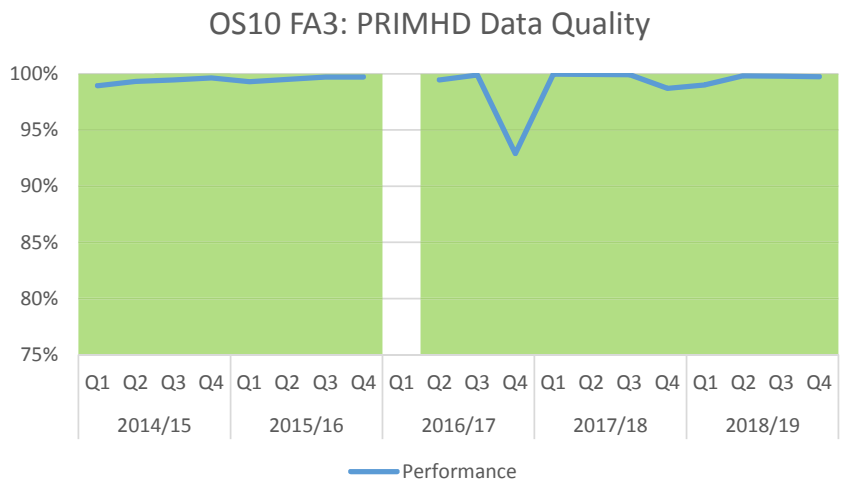
The Ministry of Health quarterly report rating is the same for each number focus area, but is different between them, except for 2012/13 & 2013/14 where the rating is the same for all focus areas.

Reporting Frequency

Quarterly

Achievement Scales

Rating	Focus Area 3
Outstanding	Routine audits undertaken and no corrective actions were required.
Achieved	Routine audits with appropriate corrective actions where required.
Partially Achieved	Routine audits undertaken but inadequate information on corrective actions.
Not Achieved	No routine audits undertaken.


OS10 FA3: PRIMHD Data Quality
100%
95%
90%
85%
80%
75%
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2014/15
2015/16
2016/17
2017/18
2018/19
Performance

Policy Priorities PP26: Rising to the Challenge: The Mental Health and Addiction Service Development Plan – Focus areas 3 & 4

Indicators

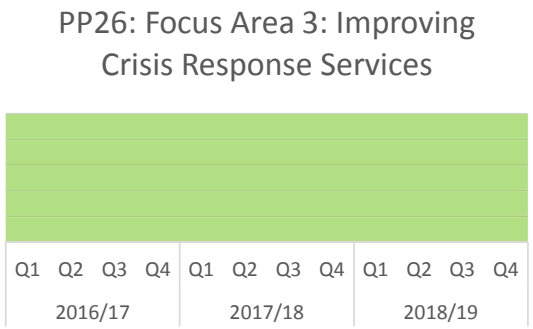
Focus Area 3: Improving Crisis response services: Report on actions undertaken to reduce rate of known clients being referred to by police to crisis teams, and outcomes.
Focus Area 4: Improve outcomes for children: Exceptions report where actions identified in the Annual Plan are not on track.

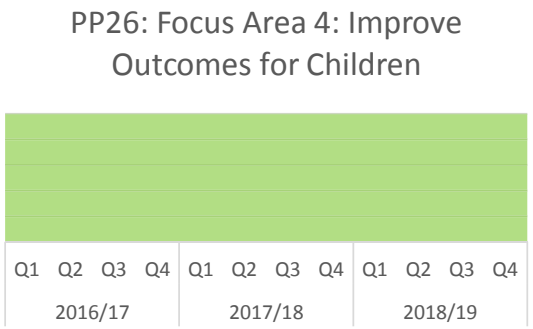
Notes

These are only measured as Ministry of Health ratings.
For Q1 2018/19, focus areas 3 and 4 do not have a MoH rating available.

Reporting Frequency

Quarterly





Policy Priorities PP36: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders

Indicator

10 percent lower rate than the previous year per 100,000 Māori under the Mental Health Act: section 29.

Notes

Reduce the rate of Māori under s29 of the Mental Health Act by at least 10% by the end of the reporting year.

The Ministry of Health quarterly report rating is the same for the Māori performance graph and the non-Māori performance graph.

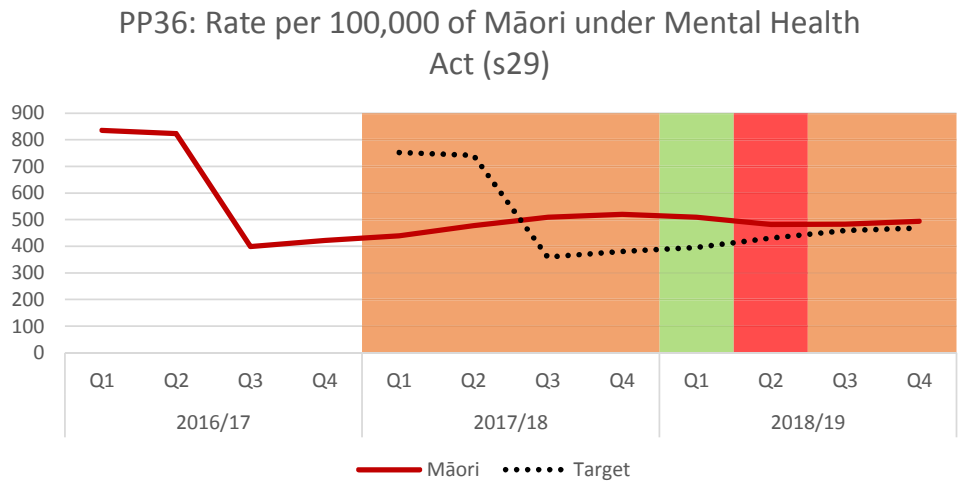
The indicator started in 2017/18, so the data for 2016/17, and thus the target for 2017/18, come from before there was a target in place.

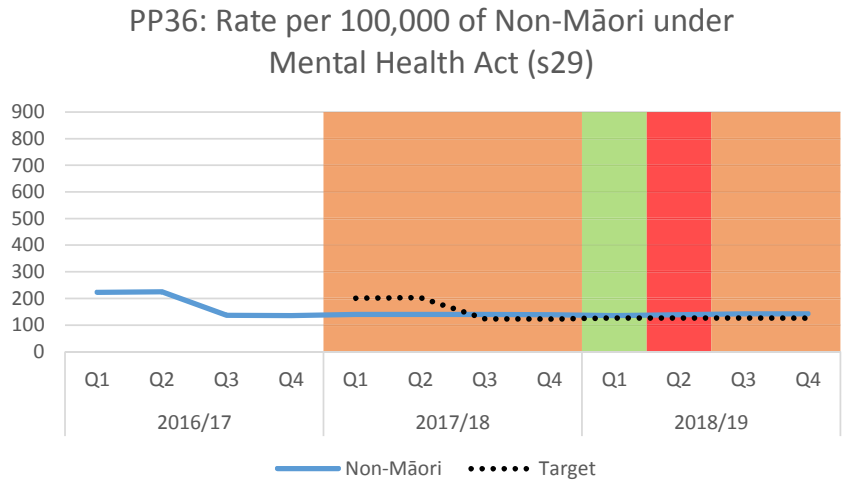
Reporting Frequency

Quarterly

Achievement Scale

Rating	
Outstanding	The DHB's rate of Māori under community treatment orders (Mental Health Act s29) is at the same rate as non-Māori.
Achieved	Milestones outlined in the annual plan are being reached and the rates of Māori under community treatment orders has reduced.
Partially Achieved	Milestones outlined in the annual plan are being reached and the rates of Māori under community treatment orders have not reduced.
Not Achieved	Milestones outlined in the annual plan are not being reached.


PP36: Rate per 100,000 of Māori under Mental Health Act (s29)
900
800
700
600
500
400
300
200
100
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2016/17
2017/18
2018/19
Māori
Target


PP36: Rate per 100,000 of Non-Māori under Mental Health Act (s29)
900
800
700
600
500
400
300
200
100
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2016/17
2017/18
2018/19
Non-Māori
Target

Policy Priorities PP7: Improving mental health services using wellness and transition (discharge) planning

Indicators

≥95 percent of clients discharged will have a quality transition or wellness plan.
≥95 percent of audited files meet accepted good practice.
In Q2&4: Update on delivery of actions identified in its Annual Plan (for the milestones are relevant to the reporting period) in relation to the following government planning priority focus area; Mental Health and Addictions Improvement Activities.

Notes

Reporting Requirements:
From 2012/13 to 2013/14; percent of long term clients (2+ years) with crisis prevention/resiliency plan.
From 2014/15 to 2017/18; percent of 0-19 year olds with discharge/transition plans.
From 2017/18; percent of all clients discharged with a wellness plan.

From Q1 2018/19, new documentation being rolled out which should show results by 2/11/2018.
From Q1 2014/15 to Q2 2017/18, data has not been collected as CCDHB/MHAIDS 3DHB has not had the data systems in place to collect information on discharge/transition plans.
From Q3 2017/18 to Q4 2017/18, data has not been collected as MHAIDS 3DHB has been rolling out new plans and tools to ensure consistency across MHAIDS.

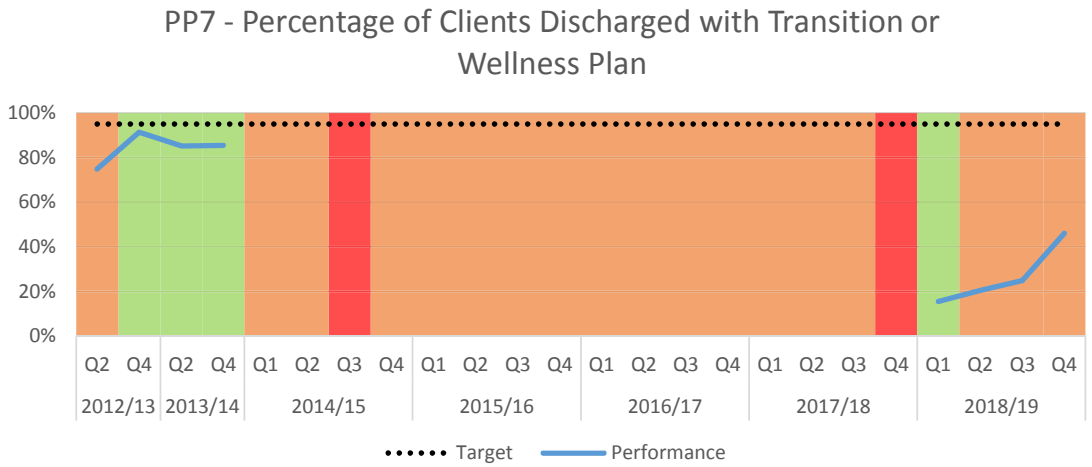
For Q3 2018/19, no data was available for the audited files meeting accepted good practice indicator.

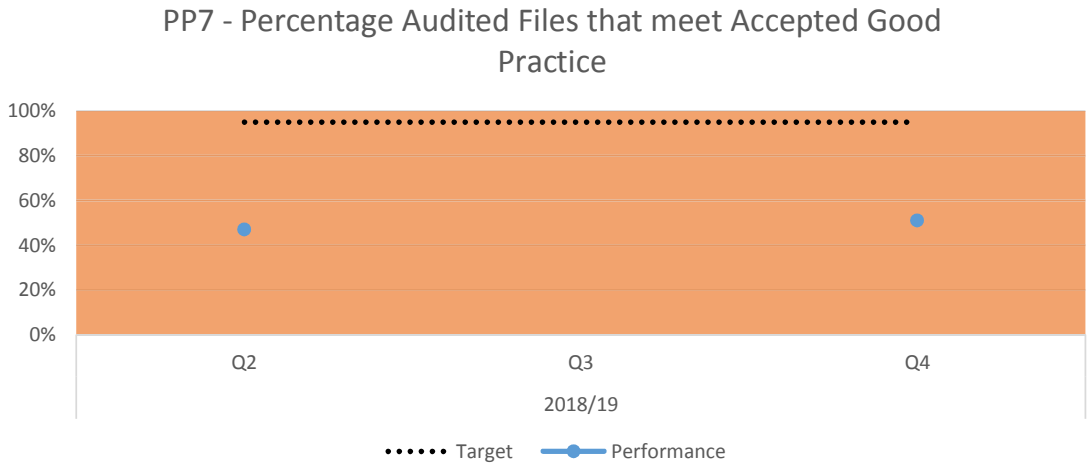
Reporting Frequency

Quarterly

Achievement Scale

Rating	
Achieved	All agreed rates are met.
Partially Achieved	Some or all agreed rates are not met.
Not Achieved	All agreed rates are not met.


PP7 - Percentage of Clients Discharged with Transition or Wellness Plan
100%
80%
60%
40%
20%
0%
Q2 Q4 Q2 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2012/13 2013/14 2014/15 2015/16 2016/17 2017/18 2018/19
Target
Performance


PP7 - Percentage Audited Files that meet Accepted Good Practice
100%
80%
60%
40%
20%
0%
Q2 Q3 Q4
2018/19
Target
Performance

Policy Priorities PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds

Indicators

≥80 percent of people seen by Mental Health Provider Arm or Addictions Services (Provider Arm and NGO) within three weeks.
≥95 percent of people seen by Mental Health Provider Arm or Addictions Services (Provider Arm and NGO) within eight weeks.
In Q2&4: Update on delivery of actions identified in its Annual Plan (for the milestones are relevant to the reporting period) in relation to the following government planning priority focus area; Addictions.

Notes

For Q3 2012/13, there is no Ministry of Health report available.

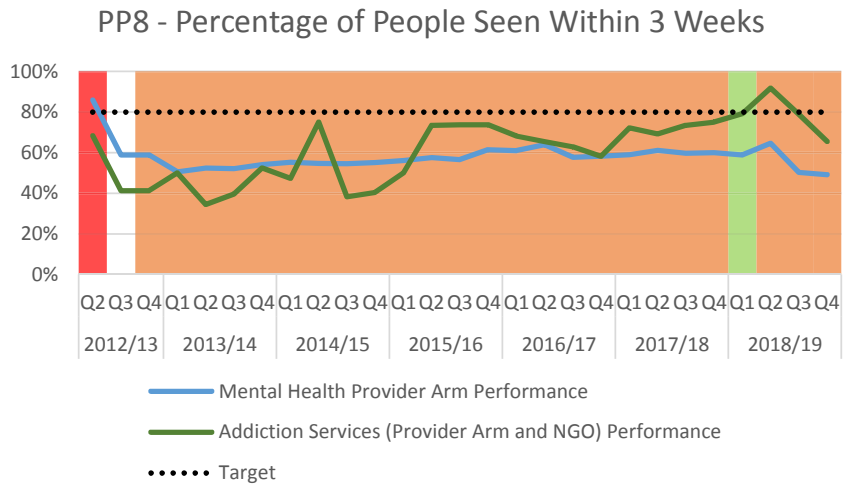
The Ministry of Health quarterly report rating is the same for people seen within three weeks and people seen within eight weeks by either the Mental Health Provider Arm or Addictions Services (Provider Arm and NGO).

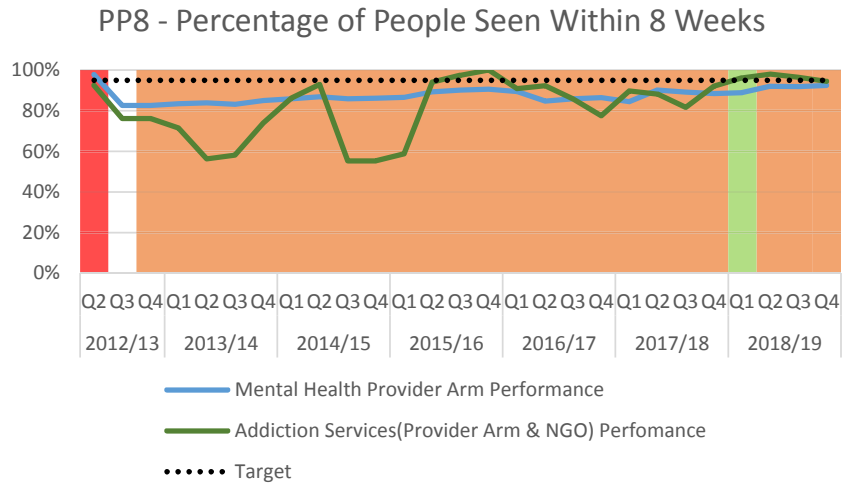
Reporting Frequency

Quarterly

Achievement Scale

Rating	
Achieved	All agreed rates are met.
Partially Achieved	Some or all agreed rates are not met.
Not Achieved	All agreed rates are not met.


PP8 - Percentage of People Seen Within 3 Weeks
100%
80%
60%
40%
20%
0%
Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2012/13 2013/14 2014/15 2015/16 2016/17 2017/18 2018/19
Mental Health Provider Arm Performance
Addiction Services (Provider Arm and NGO) Performance
Target


PP8 - Percentage of People Seen Within 8 Weeks
100%
80%
60%
40%
20%
0%
Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2012/13 2013/14 2014/15 2015/16 2016/17 2017/18 2018/19
Mental Health Provider Arm Performance
Addiction Services(Provider Arm & NGO) Perfomance
Target

QIPS – Sandy Blake

System Integration SI17: Improving quality

Indicator

Update on delivery of actions identified in its Annual Plan (for the milestones are relevant to the reporting period) in relation to the following government planning priority focus areas; Improving quality.

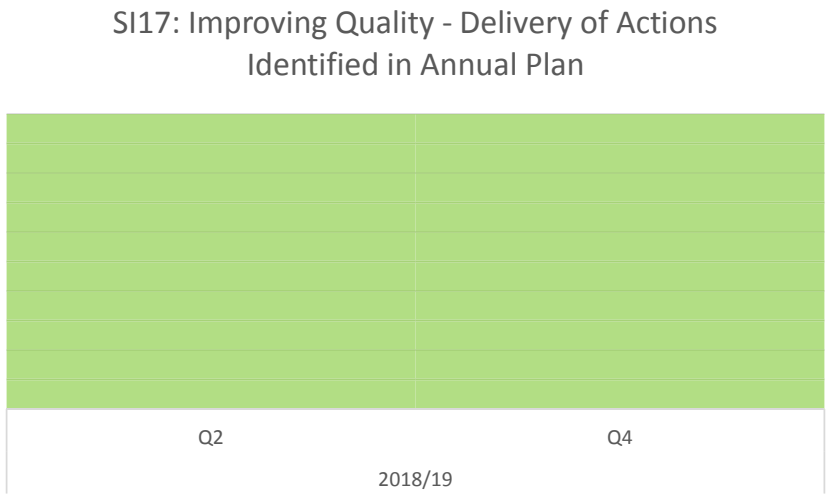
Notes

This is a new measure for 2018/19.

This is only reported as a Ministry of Health rating.

Reporting Frequency

Six Monthly (Q2 & Q4)



Non-Financial Monitoring – Q4
2018/19 100

Corporate – Mike McCarthy

Ownership OS10: Improving the quality of identity Data within the National Health Index (NHI) and data submitted to National Collections – Focus areas 1 & 2

Indicators

Focus Area 1a: ≤4 percent of new NHI registrations in error (causing duplication).
Focus Area 1b: ≤2 percent of non-specific ethnicity in new NHI registrations.
Focus Area 1c: ≤2 percent of updates to ethnicity in existing NHI records with a non-specific value.
Focus Area 1d: ≥76 percent of validated addresses.
Focus Area 1e: Invalid NHI data updates (No graph has been included for this indicator).
Focus Area 2a: ≥97 percent of NBRS records that have accurate dates and link to NNPAC and NMDS.
Focus Area 2b: ≥98 percent of National Collection records successfully loaded.
Focus Area 2c: ≥75 percent of diagnosis code descriptors submitted to NMDS edited from standard descriptions.
Focus Area 2d: ≥95 percent of NNPAC events loaded more than 21 days post month of discharge.

Notes

For Focus Area 1a & 1b: For Q4 2012/13, there is no information about performance available due to migration to the new NHI Legacy Broker.
For Focus Area 1c: For Q1 2014/15, there is no information about performance available as the indicator was not ready for measurement.
For Focus Area 1d: For 2015/16, the target information comes from the Ministry of Health reports. From Q3 2014/15 to Q1 2015/16, results were not published by the Ministry of Health. From Q2 2015/16 onwards, results were not given by the Ministry of Health
For Focus Area 1e: There is no information about the target available. For 2014/15, there is no information about performance as the indicator is not yet ready for measurement. From 2015/16 onwards, there is no information about performance available.

Focus Area 2b: For Q1 2012/13, there was no data submitted due to not achieving NCAMP12 PRIMHD compliance. For Q2 & Q3 2012/13, there were no PRIMHD records.
For Q2&3 2018/19, there was no individual performance information available, although the target was met.
Focus Area 2c: For 2016/17, there was no information about performance available other than that the 75% target was achieved.

The Ministry of Health quarterly report rating is the same for each number focus area, but is different between them, except for 2012/13 & 2013/14 where the rating is the same for all focus areas.

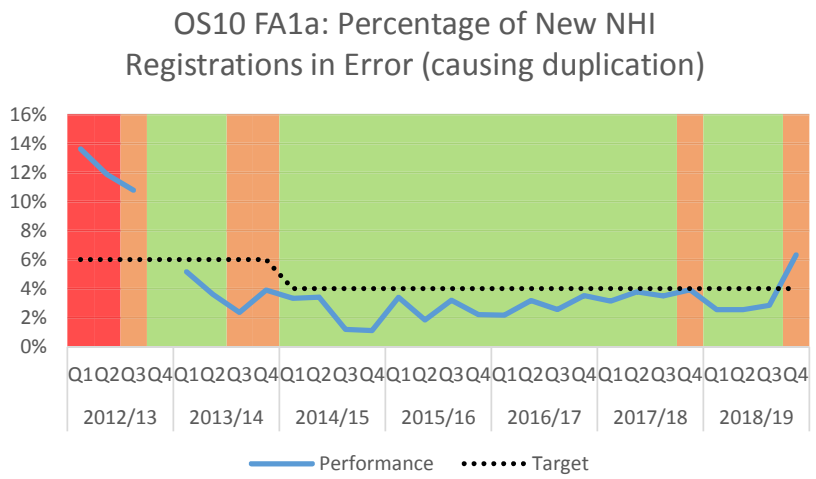
Reporting Frequency

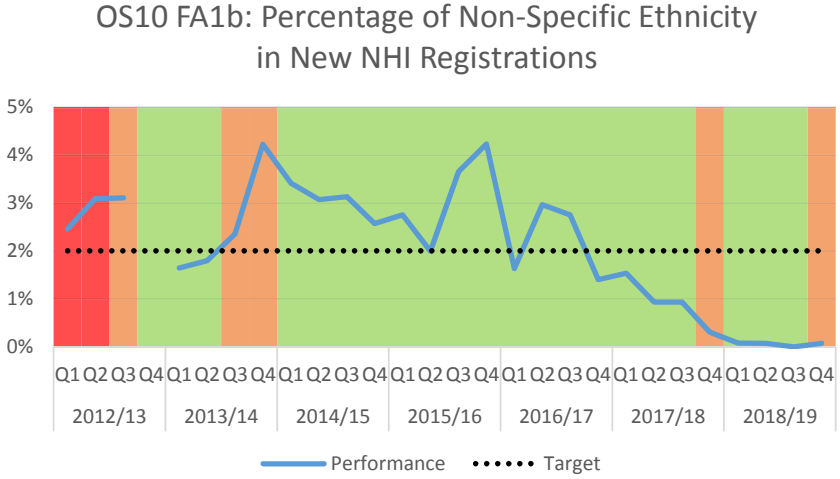
Quarterly

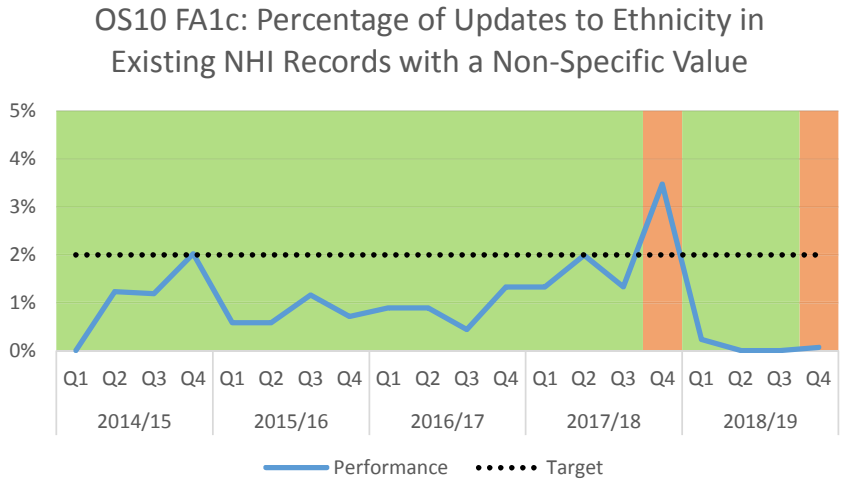
Achievement Scales

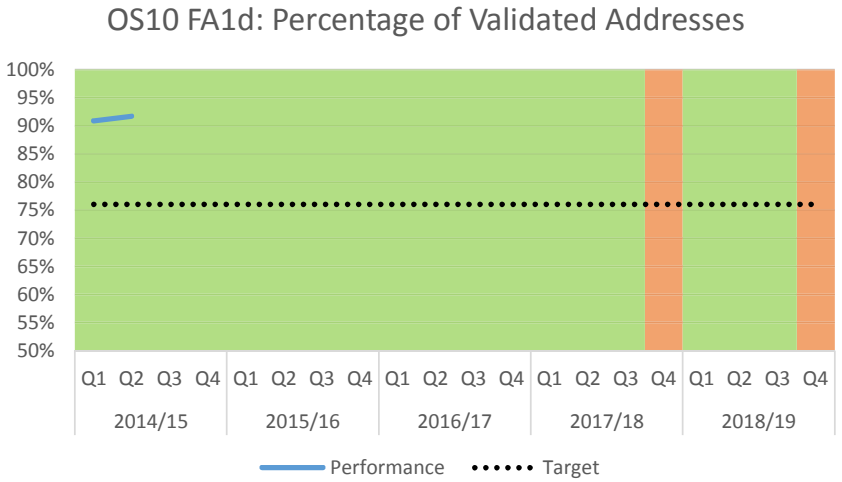
Rating	Focus Area 1a	Focus Area 1b	Focus Area 1c	Focus Area 1d	Focus Area 1e
Outstanding	≤2%	<0.5%	<0.5%	≥85%	Still to be confirmed
Achieved	≤4%	≤2%	≤2%	>76%	Still to be confirmed.
Partially Achieved	>4% and ≤6%	>2% and ≤4%	>2% and ≤4%	>70% and ≤76%	Still to be confirmed.
Not Achieved	>6%	>4%	>4%	≥70%	Still to be confirmed.

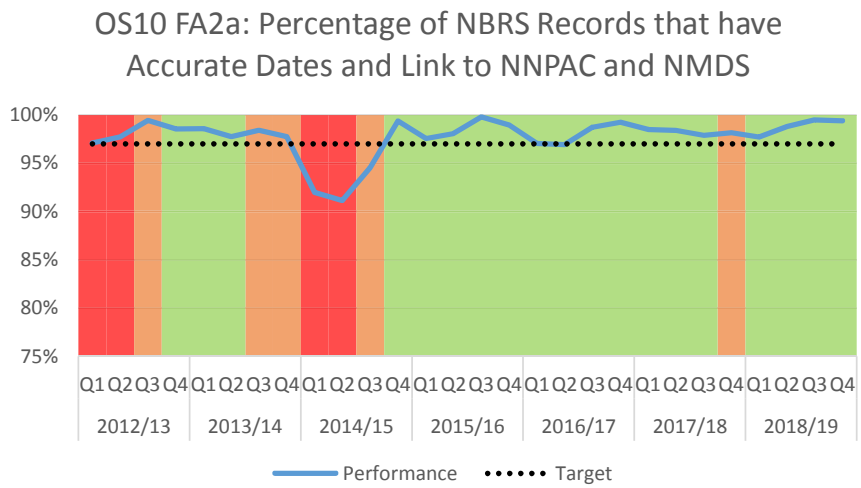
Rating	Focus Area 2a	Focus Area 2b	Focus Area 2c	Focus Area 2d
Outstanding	≥99.5%	≥99.5%	N/A	≥98%
Achieved	≥97%	≥98%	≥75%	≥95%
Partially Achieved	≥95% and <97%	≥95% and <98%	≥60% and <75%	≥85% and <95%
Not Achieved	<95%	<95%	<60%	<85%

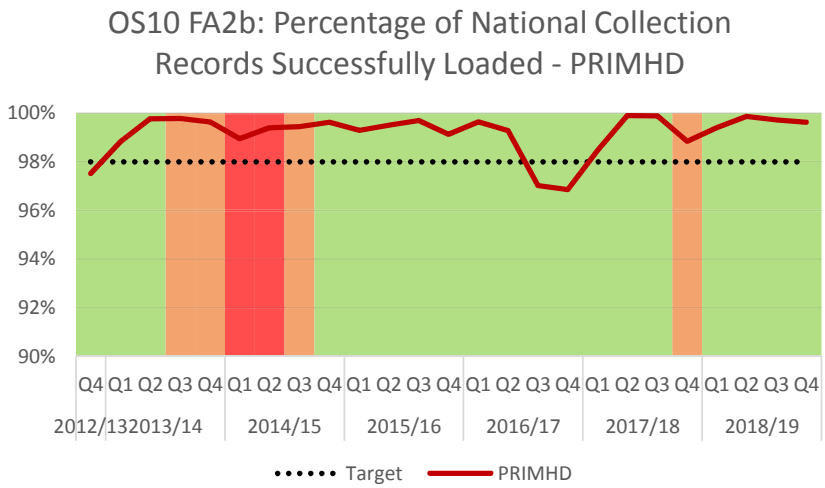

OS10 FA1a: Percentage of New NHI Registrations in Error (causing duplication)
16%
14%
12%
10%
8%
6%
4%
2%
0%
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
Performance
Target

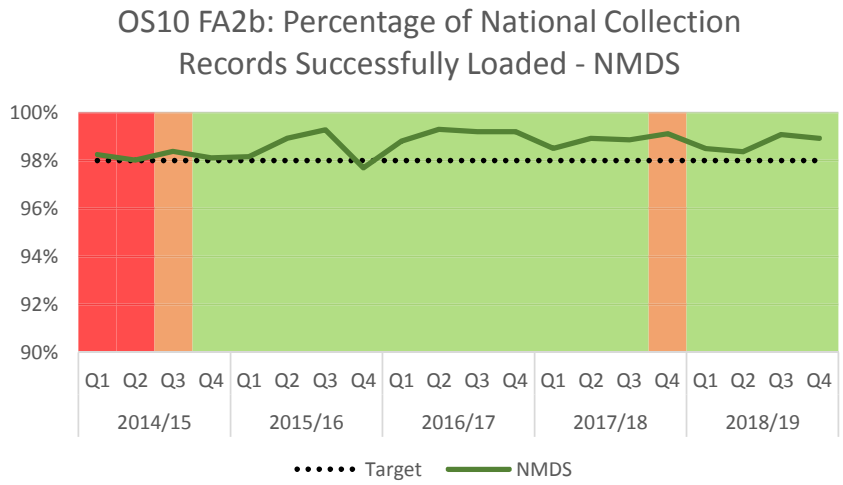

OS10 FA1b: Percentage of Non-Specific Ethnicity in New NHI Registrations
5%
4%
3%
2%
1%
0%
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
Performance
Target

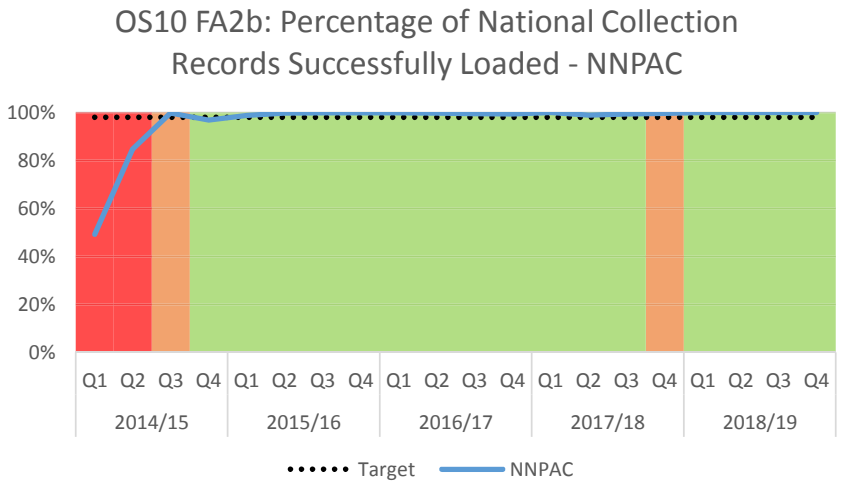

OS10 FA1c: Percentage of Updates to Ethnicity in Existing NHI Records with a Non-Specific Value
5%
4%
3%
2%
1%
0%
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2014/15
2015/16
2016/17
2017/18
2018/19
Performance
Target

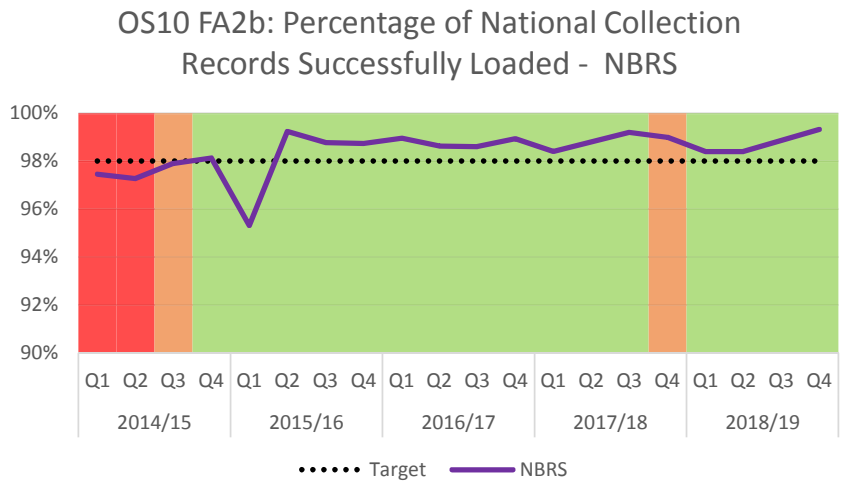

OS10 FA1d: Percentage of Validated Addresses
100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2014/15
2015/16
2016/17
2017/18
2018/19
Performance
Target

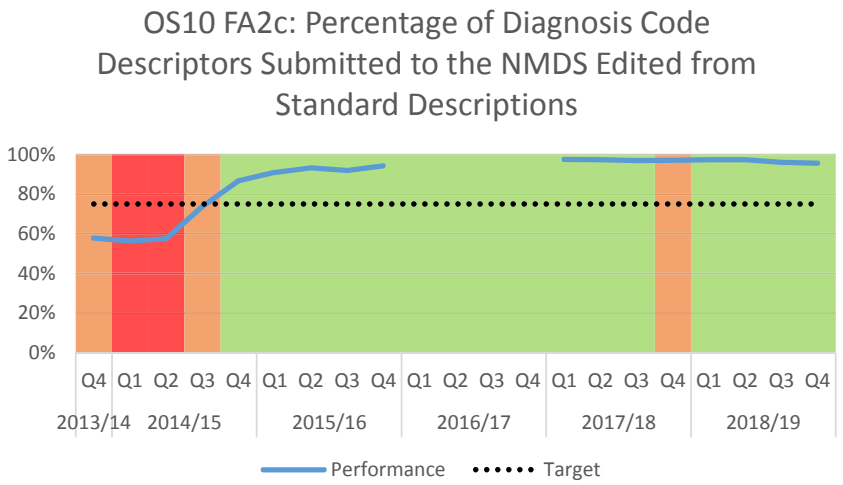

OS10 FA2a: Percentage of NBRS Records that have Accurate Dates and Link to NNPAC and NMDS
100%
95%
90%
85%
80%
75%
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
Performance
Target

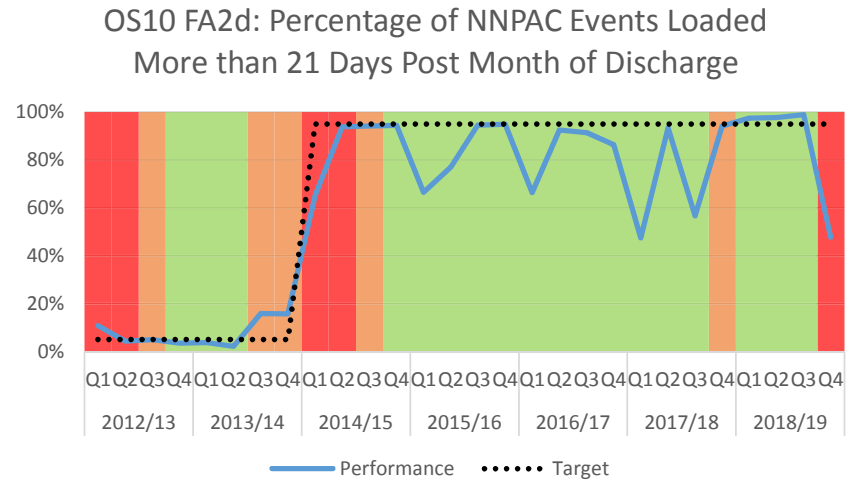

OS10 FA2b: Percentage of National Collection Records Successfully Loaded - PRIMHD
100%
98%
96%
94%
92%
90%
Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
Target
PRIMHD


OS10 FA2b: Percentage of National Collection Records Successfully Loaded - NMDS
100%
98%
96%
94%
92%
90%
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2014/15
2015/16
2016/17
2017/18
2018/19
Target
NMDS


OS10 FA2b: Percentage of National Collection Records Successfully Loaded - NNPAC
100%
80%
60%
40%
20%
0%
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2014/15
2015/16
2016/17
2017/18
2018/19
Target
NNPAC


OS10 FA2b: Percentage of National Collection Records Successfully Loaded - NBRS
100%
98%
96%
94%
92%
90%
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2014/15
2015/16
2016/17
2017/18
2018/19
Target
NBRS


OS10 FA2c: Percentage of Diagnosis Code Descriptors Submitted to the NMDS Edited from Standard Descriptions
100%
80%
60%
40%
20%
0%
Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
Performance
Target


OS10 FA2d: Percentage of NNPAC Events Loaded More than 21 Days Post Month of Discharge
100%
80%
60%
40%
20%
0%
Q1Q2Q3Q4Q1Q2Q3Q4Q1Q2Q3Q4Q1Q2Q3Q4Q1Q2Q3Q4Q1Q2Q3Q4Q1Q2Q3Q4
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
Performance
Target

MH – Arawhetu Gray

System Integration SI5: Delivery of Whānau Ora

Indicators

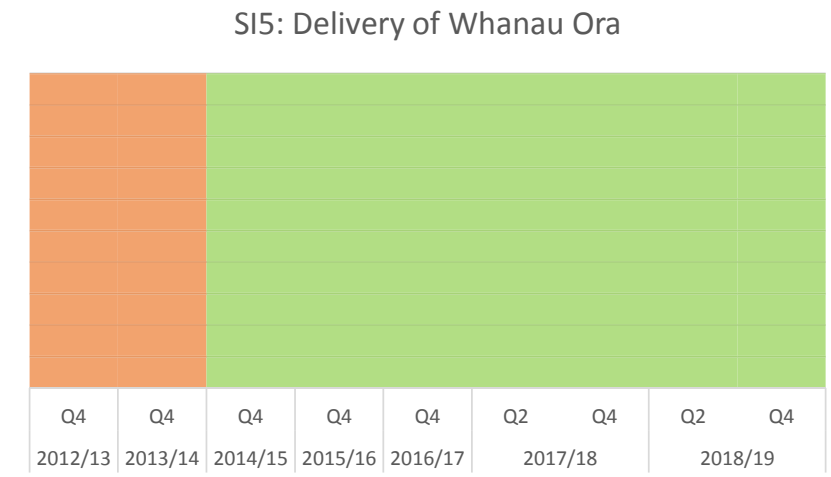
Mental health: Report on the progress of Whānau Ora in the district.
Asthma: Report on the progress of Whānau Ora in the district.
Oral health: Report on the progress of Whānau Ora in the district.
Obesity: Report on the progress of Whānau Ora in the district.
Tobacco: Report on the progress of Whānau Ora in the district.
Commissioning agencies: Report on engagement and collaboration with Whānau Ora commissioning agencies.

Notes

These are only measured as a Ministry of Health rating.

Reporting Frequency

Six Monthly (Q2 & Q4)



Non-Financial Monitoring – Q4
2018/19 106

Crown Funding Agreement CFA: Well Child / Tamariki Ora Services

Notes

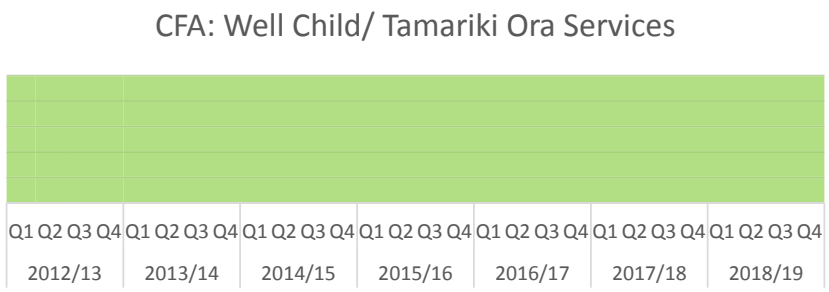
No notes.

Reporting Frequency

Quarterly

Achievement Scale

Category	Criteria
Satisfactory	1. The report is assessed as up to expectations 2. Information as requested has been submitted in full
Further work required	1. Although the report has been received, clarification is required 2. Some expectations are not fully met
Not acceptable	1. There is no report 2. The explanation for no report is not considered valid.



CentralTAS

System Integration SI2: Delivery of Regional Service Plans

Indicators

Progress report on implementation of RSP priorities, including related actions supporting implementation of the Healthy Ageing Strategy (Dementia and interRAI).
Reported Q2 & Q4:
Number of people diagnosed with hepatitis C per annum (by age bands and genotype).
Number of HCV patients who have had a Liver Elastography Scan in the last year; new patients and follow up, by age and ethnicity.
Number of people receiving PHARMAC funded antiviral treatment per annum (by age and ethnicity).

Notes

Reported as one rating by the Ministry of Health.
For Q1 & Q3 2012/13 and Q4 2014/15, there was no Ministry of Health rating available.
For Q1 2018/19, there is no Ministry of Health report available.

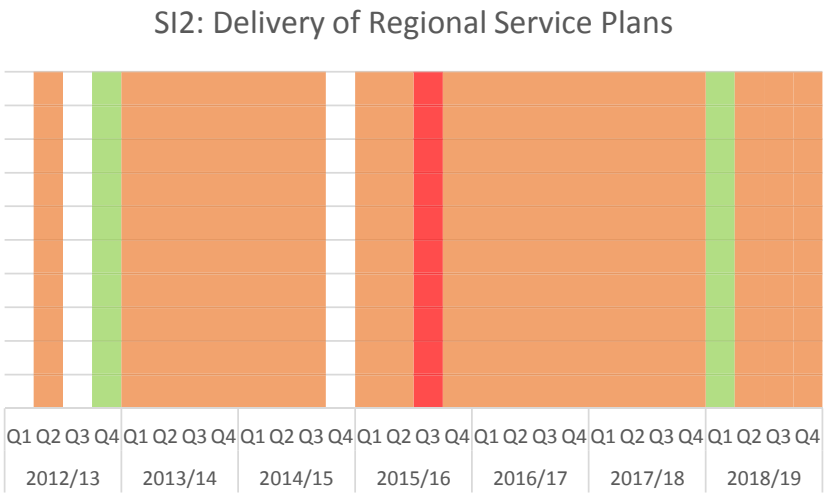
These are only measured as a Ministry of Health rating.

Reporting Frequency

Quarterly

Achievement Scale

Rating	
Achieved	All regional government priorities are tracking to plan.
Partially Achieved	Some priorities are not tracking to plan but an adequate resolution plan has been provided.
Not Achieved	One or more priorities are not tracking to plan and resolution plan is inadequate.


SI2: Delivery of Regional Service Plans
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19

Capital & Coast District Health Board
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PUBLIC

Date: September 2019	**HEALTH SYSTEM COMMITTEE INFORMATION**
Author	Dr Michelle Balm, Infectious Diseases/Microbiology, CCDHB
Endorsed by	Sandy Blake, Executive Director Quality Improvement and Patient Safety
Subject	ANTIMICROBIAL STEWARDSHIP REPORT 2017-2018

RECOMMENDATION

It is **recommended** that the Committee:

(a) **Endorse** initiatives to optimise antimicrobial use within the hospital and community of CCDHB.

APPENDIX

1. **ANTIMICROBIAL STEWARDSHIP REPORT 2017-2018.**

1. INTRODUCTION

1.1 Purpose

The purpose of this paper is to inform the Board regarding Antimicrobial Stewardship (AMS) activities at CCDHB.

1.2 Previous Board Discussions/Decisions

The paper was requested by the Board for the August 2019 meeting.

2. BACKGROUND

2.1 Antimicrobial Stewardship service

2.1.1 Need for Antimicrobial Stewardship

Antimicrobial resistance (AMR) has been identified as one of the major threats facing modern healthcare globally. Delivery of complex care to patients is heavily reliant on having antimicrobials to prevent or treat infections, and misuse of antimicrobials is a key driver for antimicrobial resistance.

2.1.2 Antimicrobial Stewardship service at CCDHB

The aim of the antimicrobial stewardship programme at CCDHB is to ensure that the optimal antimicrobial strategy (right antimicrobial, right dose, right route of administration, right duration) is used in the patients who need them, to improve patient outcomes, reduce unintended adverse events (including AMR) and contain expenditure. Antimicrobial stewardship programmes have been shown to be cost-effective and improve patient outcomes.

The AMS service was established by Infectious Diseases and Pharmacy in 2010. The service was reviewed in 2018, and a strategic plan developed. It consists of 1.0FTE antimicrobial pharmacist and 0.1FTE Infectious Diseases SMO with support from the Infection Services team (from existing FTE). International estimates recommend ~3.0 FTE for a DHB of our size.

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3. MAJOR INITIATIVES

3.1 Guidelines & Clinical support

A key role for the AMS team is development of prescribing guidelines. We have empiric antibiotic guidelines, which are updated from best practice literature every 2-3 years. In 2018, these were developed into a mobile app form, becoming the first CCDHB-made app available. Our guidelines are used at CCDHB, HVDHB, Wairarapa DHB and Whanganui DHB. In addition, we have formulary restrictions on key broad-spectrum or high cost antimicrobials.

In the past two years, we have also updated clinical pathways for management of influenza, meningococcal disease, cellulitis, community acquired pneumonia, sepsis, febrile neutropenia, UTI, wound infections, syphilis and gastroenteritis.

We do formal liaison rounds in ICU and Haematological transplant patients twice weekly. In February 2019, antimicrobial stewardship rounds were introduced in adult medical and surgical wards whereby a non-discretionary prescription review of all patients on >3 days of intravenous antibiotics or on restricted antibiotics.

3.2 Surveillance

Antimicrobial usage is monitored by volume (measured in Defined Daily Dose, DDD) and by cost. Expenditure on antimicrobials has been contained over the past five years, with reduction overall in DDDs. This is largely due to campaigns targeting cessation of unnecessary antimicrobials or using correct duration of treatment. Variance due to high cost antimicrobials continues to be problematic to control.

We perform 2-3 point prevalence surveys of antimicrobial use each year to review the quality of prescribing. Key findings are that 35-40% of inpatients are receiving antibiotics every day, with 55-60% given intravenously. Around 80% of prescribing is appropriate and according to guidelines, about 15% could be improved in some way and <5% is inappropriate.

Further details are available in the AMS annual report 2017-2018.

3.3 Campaigns

Major campaigns in 2018-2019 have been “Review at Day 2” – a campaign focused on optimising empiric prescribing and stopping/switching to oral antibiotics if safe and appropriate. This resulted in a reduction in one day of IV antibiotics given per course. This equates to ~450 doses/day or 150-200 hours of nursing time/day (~18-20 FTE of nursing time!).

3.4 Audit and Research

In 2017-2019, the following audits have been performed:

- Penicillin allergy de-labelling audit and trial
- Vancomycin dosing audit
- Meropenem use
- Surgical antimicrobial prophylaxis
- Community acquired pneumonia audit
- Febrile neutropenia pathway audit
- Sepsis pathway audit

3.5 Education

Education for prescribers and prescriber supporters is integral to success of any programme. The AMS team has led education campaigns annually for World Antibiotic awareness week, including a regional

(2017) and national (2018) competition for school age children. Additionally, educational activities supported by the AMS team include:

- Pharmacy ID club
- Infection Prevention and Control study day
- Grand rounds – medical and nursing
- Monthly newsletters: Antimicrobial of the Month
- Talks at conferences: NZ Hospital Pharmacy Association conference, NZ Pharmacy Technicians conference, NZ Infection Prevention and Control conference, Australasian Society for Infectious Diseases conferences
- Ward in-service/departmental teaching
- Resident medical officer teaching.

3.6 National leadership

Members of the team contribute to national steering or working groups including:

- Ministry of Health – Healthcare Antimicrobial Resistance Coordination Group – responsible for development and implementation of the National Antimicrobial Resistance Action Plan
- Ministry of Health – Vaccines advisory group
- ACC – Healthcare associated infection prevention steering group
- ACC – national antimicrobial guidelines steering group
- NZ National Antimicrobial Susceptibility Testing Committee.

4. FUTURE DEVELOPMENT

A General Practitioner joined the DHB AMS committee in 2019. The aim will be to develop initiatives targeting community AMS. This is of paramount importance as in NZ, 95% of antimicrobials used are prescribed in the community. NZ hospitals perform well in antimicrobial usage surveys (2nd lowest) but community usage is 6th highest of 25 OECD countries (2015 data). Providing prescribing support to optimise community use of antibiotics will improve patient outcomes, minimise collateral damage of antibiotics to patients, in terms of resistance, may prevent admissions, and will reduce overall costs. This will need a small amount of investment to gain these outcomes, but will be cost-saving overall.

Sustainability of the existing services within the hospital is a concern with our current resources. Securing FTE for the service will be a priority to ensure we continue to sustain the improvements and cost-savings.

Details of further initiatives are available in the AMS annual report and in the AMS Strategic Plan. Data referenced in this paper available on request.

Item 3.2.1 Appendix 1

CCDHB Antimicrobial Stewardship Committee

Antimicrobial Stewardship Report: 2017 - 2018

Lead authors: Dr Michelle Balm – Clinical Leader, Infection Services
Cat Li – Antimicrobial pharmacist

Acknowledgments: Laith Kourgy – Informatics pharmacist
Dr James Taylor – Infectious Diseases physician, AMS lead 2018
Dr Chris Little – Antimicrobial pharmacist

Capital & Coast District Health Board
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Contents

Introduction

Background

Antimicrobial Stewardship (AMS) at CCDHB

The aim of the Antimicrobial Stewardship Programme (ASP) is to ensure that the optimal antimicrobial strategy (right antimicrobial, right dose, right route of administration, and right duration) is used in the patients who need them, to improve patient outcomes, reduce unintended adverse events and contain expenditure.

This should be achieved by a multi-disciplinary and collaborative approach, facilitating initiatives within directorates or across the organisation, with the aim of optimising use of antimicrobials and enhancing prescriber practices.

This is entirely in line with the triple aims of the organisation: shorter, safer patient journeys, growing our people, living within our means.

AMS is a cornerstone of the national Antimicrobial Resistance action plan released in 2017. It is a key component of DHB Choosing Wisely strategies. A major challenge is the lack of national guidance on the core elements for an ASP and for reporting. Our programme follows international recommendations from Australia, European Union and USA.

Established core programmes for ASP at CCDHB include:

- Education and Awareness
- Guidelines, pathways and formulary restrictions
- Outpatient parenteral antibiotic therapy service
- Audit and surveillance of antimicrobial consumption and expenditure

Restructuring in 2018

The AMS service was established in 2008 with the employment of a fulltime Infectious Diseases (ID) pharmacist working collaboratively with the ID SMOs and registrars. The Antimicrobial Stewardship Committee was established in October 2012. In order to optimise our programme, the AMS service and its governance was reviewed and revised in 2018. This process was led by Dr Michelle Balm (ID physician) and Dr Chris Little (ID pharmacist). A Strategic Plan was written in 2018, including annual work plans for 2018-2020. 0.1FTE was secured for a physician leader for the service in 2018.

The AMS team consists of 1.0FTE Antimicrobial pharmacist, 0.1FTE Infectious Diseases for physician leadership, and support from Infectious Diseases SMOs and registrars (unprotected time). This is well under international estimates for an acute healthcare facility with the size and complexity of CCDHB.

The AMS service reports monthly to the AMS Committee. The Committee reports to Choosing Wisely and the Clinical Governance Board quarterly.

AMS Committee Membership

The AMS committee meets monthly and reviews antimicrobial expenditure, consumption and AMS activities on a monthly basis. The committee also ratifies the ASP and work plan.

2017

Chair: Anne Aitcheson
Michelle Balm (ID physician/Clinical Microbiologist)
Lindsay Bates (Pharmacy service leader)
Belinda Bennett (ADON SWC directorate)
Tim Blackmore (ID physician/Clinical microbiologist)
Olivia Bupha-Intr/Max Bloomfield/Mel Tan (RMO)
Claudine Daniel (Pharmacy Technician)
Chris Little (ID pharmacist)
Nigel Raymond (ID & General physician)
Regan Spillane (Service leader, Surgical)
James Taylor (ID & General physician)

2018

Chair: Anne Aitcheson
Michelle Balm (ID Physician/Clinical Microbiologist)
Olivia Bupha-Intr/ Mel Tan (RMO)
Claudine Daniel (Pharmacy Technician – production unit)
Juliet Elvy (Clinical Microbiologist)
Marilyn Gibson (NICU nurse)
Chris Little (until Oct 2018)/Lucy Stewart (Oct-Dec 2018)
Michelle Saunders (Pharmacy Service Leader)
James Taylor (ID & General physician)
Stewart Whittaker (CNM 5 North - until Nov 2018)
Donna McLennan (CNM 7 North - from Dec 2018)

Planned changes for 2019 include widening of AMS committee membership to include:

- Primary care member
- Paediatric member

Antimicrobial usage

Antibiotic use over time

Antimicrobial use is monitored by key outcome and process measures. Outcome measures focus on consumption of and expenditure on total or key antimicrobials used at CCDHB. Process measures include point prevalence surveys, adherence to guidelines and appropriateness of prescribing.

Antimicrobial consumption is monitored by calculating antibiotics removed from Pyxis machines in inpatient wards, ED and theatres. ED and theatres (including day stay theatres) are included to more accurately capture total antimicrobial usage. Data are measured as Daily Defined Doses (DDD) according to WHO criteria to standardise reporting between different types of antimicrobials, and are represented either as total DDDs or as a rate per 1,000 occupied bed-days to account for changes in patient numbers over time. Paediatric wards are not included as DDDs are a poor measure in children.

Table 1: Antimicrobial consumption in DDD for 2014-2018

Anti-infective	2014	2015	2016	2017	2018
Antibacterials	120,512.1	110,616.3	111,188.9	110,960.5	104,771.4
Anti-mycobacterials	2,215.7	1,217.5	564.9	1,763.2	2,044.5
Antifungals	4,940.4	4,765.9	5,440.6	5,691.7	6,445.5
Antivirals	2,256.9	2,085.9	2,481.2	3,427.3	3,868.7
Total	**129,925.1**	**118,685.6**	**119,675.6**	**121,842.7**	**117,130.1**

With recent efforts in raising the profile of antimicrobial stewardship and optimising antimicrobial use, there has been a significant reduction in total antibiotic use. Antifungal and antiviral stewardship programmes in transplant patients will help to ensure appropriate use of these agents. This will be a target for future years.

Table 2: Antibacterial consumption in DDD/1,000 OBD for 2014-2018

DDD/1000 bed days	2014	2015	2016	2017	2018
Tetracyclines (J01AA)	18.9	24.1	20.4	18.5	20.5
Amoxicillin (J01CA)	66.2	67.5	56.0	60.9	52.4
Penicillin (J01CE)	9.4	15.5	18.6	16.4	13.7
Flucloxacillin (J01CF)	142.2	120.6	131.3	126.6	127.3
Amoxicillin-clavulanate (Augmentin) (J01CR)	67.9	70.3	77.4	79.6	94.8
Piperacillin-tazobactam (Tazocin) (J01CR)	27.3	32.6	44.4	41.3	36.5
Cephazolin/Cephalexin (J01DB)	85.1	93.4	91.4	97.4	84.2
Cefuroxime/cefaclor (J01DC)	100.0	96.9	100.2	87.8	78.5
Ceftriaxone/Ceftazidime (J01DD)	32.2	28.6	31.3	30.8	31.1
Cefepime (J01DE01)	0.0	0.0	0.0	0.0	0.8
Aztreonam(J01DF)	0.1	0.0	0.0	0.6	0.2
Carbapenems (J01DH)	17.6	22.5	17.9	18.2	15.2
Trimethoprim (J01EA01)	9.8	12.9	11.3	10.1	6.5
Sulphonamides (J01EC)	0.1	0.0	0.0	0.0	0.0
Co-trimoxazole(J01EE)	13.7	13.7	16.7	13.8	17.1
Azithromycin/ erythromycin(J01FA)	127.7	78.8	69.2	68.4	56.2
Clindamycin(J01FF)	8.8	6.6	9.3	6.7	8.3
Gentamicin/ tobramycin/ amikacin (J01G)	25.0	27.6	18.1	22.8	18.5
Ciprofloxacin/ moxifloxacin (J01MA)	46.8	17.3	17.1	14.8	10.7
Vancomycin/ teicoplanin (J01XA)	12.9	14.6	13.1	13.6	15.5
Metronidazole (J01XD)	38.8	35.2	34.3	30.5	30.4
Nitrofurantoin (J01XE)	4.4	3.6	3.1	6.6	6.1
Polymixins (J01XB)	0.4	0.1	0.1	0.2	0.1
Steroid antibacterials (J01XC01)	0.2	0.4	0.0	0.3	0.1
Amphenicols (J01BA)	0.0	1.0	0.0	0.0	0.0
Rifampicin (J04AB)	7.8	7.0	3.7	5.9	3.3
Rifaximin (A07AA11)	0.6	2.0	2.1	2.7	1.9
Other agents (J01XX08)	0.8	2.3	1.6	0.8	1.8
Total	**874.1**	**803.7**	**788.7**	**766.8**	**722.4**

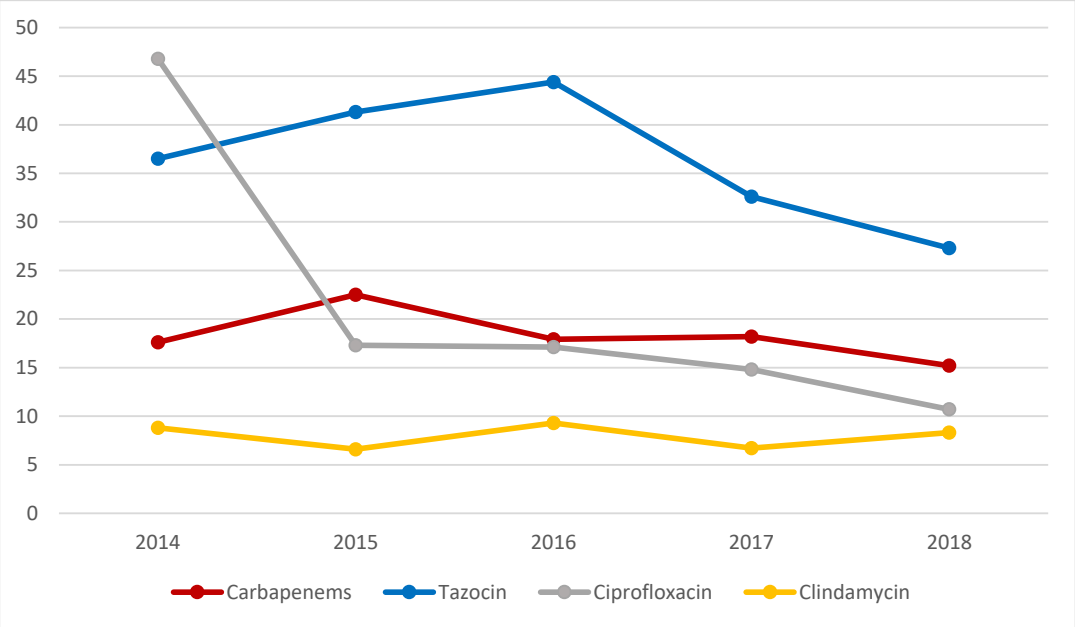
For 2017 and particularly in 2018, there was a reduction in overall antibiotic use. The reduction in piperacillin-tazobactam (Tazocin), cefaclor and trimethoprim (and rise in Augmentin and nitrofurantoin use) reflect changes to the empiric antibiotic guidelines for hospital acquired pneumonia and for cystitis respectively. These changes were made based on the updated antibiotic susceptibility patterns from the microbiology laboratory. Additional reduction in antimicrobials may have been influenced by AMS promotion of review at day 2 of antimicrobial prescription

(encouraging to stop inappropriate antimicrobial use or switch to more appropriate antimicrobials), and AMS promotion of evidence-based duration of therapy (e.g. five days for pneumonia).

Restricted antibiotics

Broad-spectrum and high cost antimicrobials have prescribing restrictions placed by PHARMAC. Funded access to these medicines is restricted to specific specialists (such as Clinical Microbiologists or Infectious Disease physicians) or as part of an approved guideline or protocol. Key antibiotics are known to drive development of antimicrobial resistance in hospitals. Use of these antibiotics (carbapenems, Tazocin, ciprofloxacin and clindamycin) are monitored closely.

Figure 1: Key restricted antibiotic use across inpatient wards, ED and theatre (DDD/1000 OBD)



A large reduction in ciprofloxacin use resulted from a campaign in 2015 to restrict inappropriate prescribing of fluoroquinolones due to the risk of antimicrobial resistance. This reduction has been sustained since 2015. Reduction in Tazocin use has occurred in part due to the change in the empiric guidelines for hospital acquired pneumonia and in efforts to encourage narrow spectrum antibiotic use for empiric treatment of undifferentiated fever. Reassuringly, carbapenems use has remained stable.

Point prevalence surveys

Point prevalence surveys (PPS) are a snapshot of antibiotic use in inpatient wards on a single day. This is an important process measure for antimicrobial prescribing in the hospital. At least two PPSs have been performed each year since 2016, despite the logistic challenges and time requirements involved due to the utility of data obtained.

Table 3: Key findings PPS for 2017 and 2018

Indicator	April 2017	October 2017	February 2018	September 2018
Inpatients on antibiotics	37%	41%	36%	40%
Number of antibiotic doses in day	394	416	465	530
Proportion of IV antibiotic doses	62% (245 doses)	55% (256 doses)	65% (301 doses)	56% (298 doses)
Documented allergy	12%	11%	14%	36%
Antibiotics reviewed within previous 48h	76%	82%	-	-
Stop/review date documented	-	-	24%	37%
Indication documented	-	-	31%	18%
Appropriate	79%	77%	61%	82%
Suboptimal	17%	20%	29%	14%
Inappropriate	4%	3%	10%	4%

The proportion of patients on antibiotics is stable and consistent or slightly lower than published international PPS data. The majority of antibiotic doses are intravenous, which requires considerable nursing resource (material and time) for administration. 250 doses of intravenous antibiotics requires in excess of 22 hours of reconstitution time plus infusion time. There is also increased risk for line associated complications including infections, with use of intravenous antibiotics. This will continue to be a focus for our AMS programme.

Data was obtained in 2018 regarding documentation of review or stop dates, and of indication for antimicrobial use on the drug chart or in the notes. This is recognised good practice and will be a focus for an AMS campaign in 2019. Prescription appropriateness is a subjective measure of guideline adherence. Appropriate prescribing was in accordance with DHB guidelines, and suboptimal was prescribing that was reasonable for the indication according to patient notes but not strictly adherent to guidelines.

Analysis of the Point prevalence surveys over recent years indicates that key areas for targeting campaigns to improve optimal prescribing include:

- Documentation of stop/review date

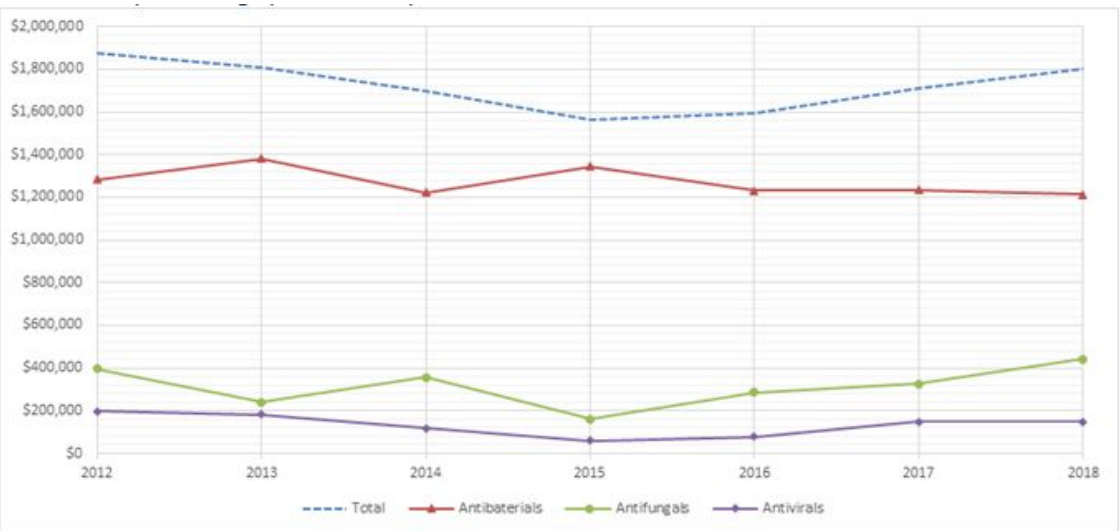
    - This will enhance regular prescribing review and encourage cessation of no longer necessary antibiotics or switch to more optimal therapy. It also acts as a useful communication tool for staff (nurses, pharmacists, other clinical teams). This intervention is planned for late 2019. A re-invigoration of the IV to oral switch campaign in 2020 will assist as well.
- Documentation of indication
    - This is essential practice for team communication
- Accurate documentation of allergy status
    - Including de-labelling (see de-labelling project under AMS initiatives)

Antimicrobial expenditure

Overall expenditure

Total expenditure on antimicrobials has been increasing despite decreasing in the antibacterial expenditure. Antibacterial expenditure is currently lower than it was in 2012. This is largely the result of stewardship initiatives. However, a key area for future work is a stewardship programme targeting antifungal and antiviral use, particularly in Haematology and Oncology patients.

Figure 2: Total antimicrobials



Highest expenditure antimicrobials

The following table shows the 20 antimicrobials with the highest total expenditure (volume used x cost) for the years 2017 and 2018. The costs between years are subject to fluctuation in both unit cost of the drugs and in volume used.

Several high cost agents are present on the top 20 list due to use in a very small number of patients. Systemic antifungals and antivirals are generally much more expensive than antibacterials, so will disproportionately increase cost (compared with volume). Notable examples of this are Liposomal amphotericin, foscarnet, and caspofungin. These costs will always be difficult to predict and control. Furthermore, due to changes in international guidelines on antifungal prophylaxis in haematopoietic transplant patients, there will be a greater number of patients on prophylaxis with posaconazole and liposomal amphotericin during their treatment. The high cost and toxicity of these agents makes this an important target for further stewardship activities.

Also worth noting is that the expenditure on Tazocin and meropenem both increased, despite significant reductions in usage. This was due to increases in unit costs.

Table 4: Top 20 antimicrobials based on expenditure by year

Antimicrobial	Drug	2017		2018	
		Cost	Units	Cost	Units
Antifungal	Liposomal amphotericin	$180,969	584	$280,151	812
	Caspofungin	$70,046	125	$73,967	103
	Posaconazole	$18,727	1,631	$62,058	1,957
	Voriconazole	$46,903	636	$15,005	528
Antivirals	Foscarnet	$71,871	60,000	$68,069	56,500
	Valganciclovir	Not Top 20	682	$24,084	1,349
Antibacterial	Piperacillin-tazobactam	$155,698	17,229	$168,574	14,217
	Ertapenem	$70,195	995	$69,458	945
	Meropenem	$47,184	7,324	$61,682	6,064
	Flucloxacillin	$40,548	54,201	$37,716	52,883
	Cefuroxime	$34,939	34,861	$35,607	24,142
	Metronidazole	$30,481	23,186	$33,319	22,872
	Amoxicillin-clavulanate	$22,137	36,210	$27,982	41,973
	Vancomycin	$23,732	23,732	$25,441	10,278
	Cefazolin	$27,836	41,193	$24,538	36,296
	Amoxicillin	$18,345	35,690	$19,831	32,783
	Tigecycline	$17,612	139	$41,492	59
	Fosfomycin	Not Top 20		$17,074	332
	Co-trimoxazole	Not Top 20		$15,654	10,607
	Benzylpenicillin	$15,235	14,968	$12,343	11,906
	Amikacin	$32,816	380	Not Top 20	
	Linezolid	$18,583	232	Not Top 20	

Outpatient parenteral antimicrobial therapy (OPAT)

Background

Intravenous antimicrobials have been administered to patients in their own homes as part of the Hospital in the Home service. This part of the service was developed as an informal collaboration between Infectious Diseases, Pharmacy and Community Nursing services since 2008. Over the past ten years, the service has grown to a point where a more formal structure is required. Currently the size of the service is limited by the number of patients able to be managed by the Community Nurses and as the service has grown, there has been a small but preventable number of delays or wastage of antimicrobials due to inefficiency within the system. This led to a review of the HITH approach and recommendation to restructure the service as an independent formal Outpatient Parenteral Antimicrobial Therapy (OPAT) service. The model recommended was a nurse-led service. CCDHB is one of the few DHBs with an OPAT service that does not include a dedicated OPAT nurse. Introduction of an OPAT nurse would enable integrated care of the inpatient and outpatient phases of the patient's management, reduce wastage of antimicrobials and prevent delays in discharge. The nurse would also be able to train patients or their whanau/caregiver to self-administer their own antimicrobials (where appropriate), thus facilitating an increased number of patients to be cared for in their own homes, rather than in hospital.

Pilot for OPAT CNS led service

From August to October 2018, a pilot programme was run as proof-of-concept for a nurse-led OPAT service. During this time, formal guidelines for OPAT referral and care of patients on OPAT were developed and training material for patient self-administration of antimicrobials were developed. The pilot showed that there would be improved efficiency with a nurse-led system. There remains work to do but the AMS team believes that this is the way forward for a sustainable and safe OPAT programme. This programme would have many benefits for the organisation including reduction in length of stay. Ideally the OPAT service could be used to facilitate care of patients within the community without requirement for admission. This would require resourcing of the service. In 2019, an investment proposal will be submitted for a 1FTE OPAT nurse position. Further development of the service is dependent on this bid.

OPAT activity

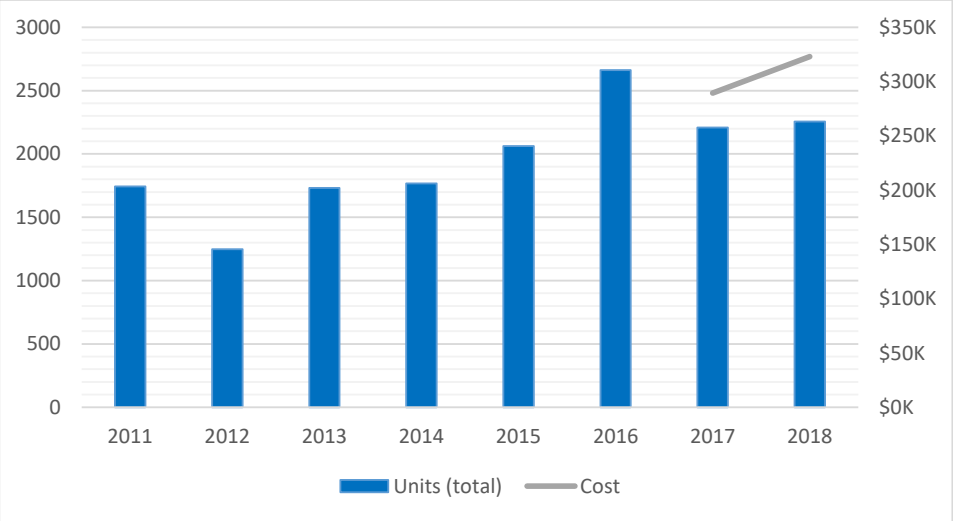
The OPAT service treated 197 patients and provided 3012 days of outpatient care in 2018. This number continues the recent trend for slight year on year increases in patients served. The most commonly used antimicrobials were flucloxacillin (~25% of patients), benzylpenicillin (~16%) or vancomycin (~15%). Of note, ertapenem, a carbapenem antibiotic used to treat antibiotic resistant Gram negative infections was required for 9% of patients.

Table 5: OPAT activity 2018

Month	Number of patients	Days of therapy	Cost of antimicrobials ($)	Number of dispensings	Bed-Days saved	Estimated cost of care saved ($)
January	15	263	$30,000	72	256	$153,600
February	12	193	$16,700	46	181	$108,600
March	28	424	$44,900	86	402	$241,200
April	14	270	$32,500	48	256	$153,600
May	16	332	$44,248	62	268	$160,800
June	13	190	$22,446	43	190	$114,000
July	9	79	$19,330	20	61	$36,600
August	13	198	$28,243	36	191	$114,600
September	15	190	$21,088	34	181	$108,600
October	19	350	$44,606	67	350	$210,000
November	24	272	$34,267	66	260	$156,000
December	19	264	$31,356	52	264	$158,400
Total	**197**	**3,025**	**$369,686**	**632**	**2,860**	**$1,716,000**

Figure 3: Number of infusors

This chart displays only those antimicrobials ordered in from Baxter. This represents an opportunity for savings if the CCDHB production unit were able to make up infusors on site. Note that estimates for infusor costs are not available prior to 2017.



AMS activities

Initiatives

Empiric app development

With the imminent introduction of smart phones to replace pagers for RMOs, the AMS team worked with a team of students from The School of Computer Science and Engineering at Victoria University (VoW) to develop a mobile app for our antimicrobial guidelines. The design work, clinical decision tool and content was developed by the AMS team and the VoW students did the coding for the initial front page and directory, and for one of the systems arms. Mansour Jahaver, an Honours student from VoW, completed the rest of the work as a summer student project, working closely with Dr Olivia Bupha-Intr, Infectious Diseases advanced trainee. The app is called Empiric, to reflect the aim of our empiric antibiotic guidelines. The Empiric app was launched via the CCDHB intranet in May 2018. It was the first locally developed app available on the CCDHB webstore.

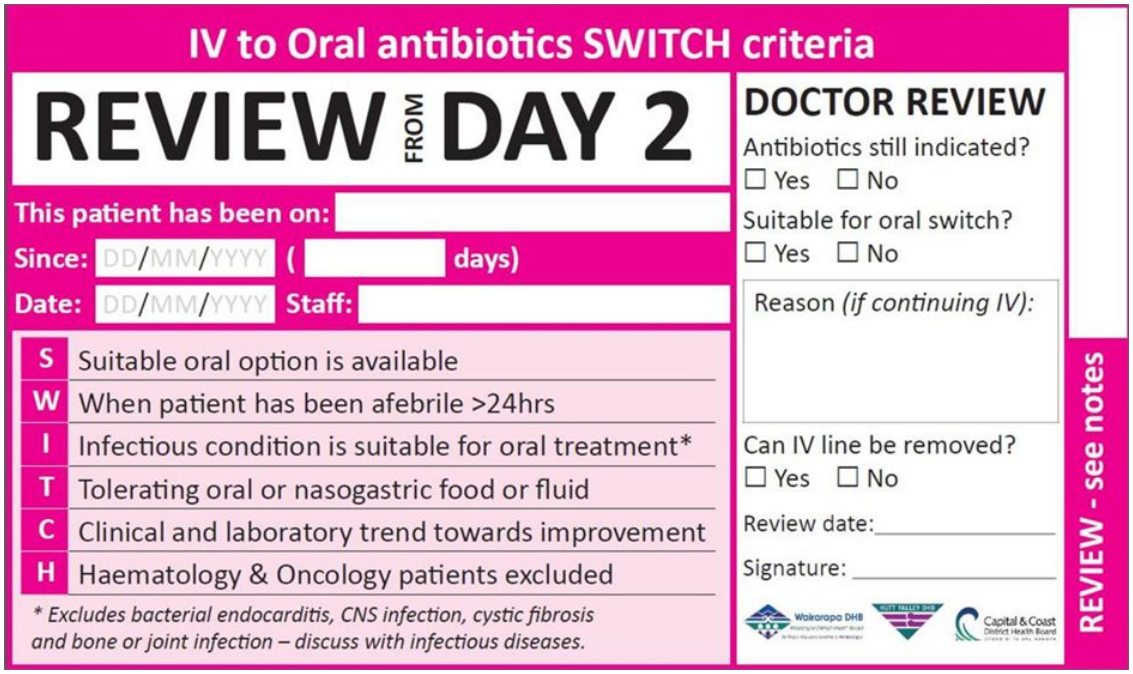
A post-implementation audit has been performed showing that >75% of users prefer the app to other available formats and the vast majority of junior doctors use it several times a week. There was no significant increase in guideline adherence, but this was already good and was not the main aim of the app. Most importantly in terms of what we were trying to achieve, qualitative feedback was that the app empowered junior doctors to challenge inappropriate antibiotic use and gave confidence to new prescribers. Development of this app has also contributed to plans to develop national antimicrobial guidelines.

The Empiric app won the Best Technology Innovation at the Celebrating our Success awards in 2018. The app is in use at CCDHB, HVDHB, Wairarapa DHB and Whanganui DHB. It is available free on the Apple store and on the Google Play store.

IV to Oral switch

One of the best examples of regional collaboration was the IV to Oral switch campaign in 2018. The campaign plan and educational materials were developed by staff at four regional DHBs (Whanganui, Hutt Valley, Wairarapa and Capital & Coast District Health Boards). The campaign was launched at CCDHB in May 2018. The aim was to encourage review of empiric antibiotic prescribing at day 2 of the prescription, and to stop unnecessary antibiotics (if no bacterial infection confirmed) or to switch to targeted, preferably oral antibiotic therapy in appropriate clinical situations.

The campaign was driven by ward pharmacists and nursing staff and supported by the AMS team. IV to Oral switch stickers were placed in patient notes, with a peel off section put on the prescription chart. Medical staff were encouraged to fill in the sticker to justify ongoing prescription of IV antibiotics or to switch to other alternatives where this was more appropriate. Removal of the IV line was encouraged.



Following the campaign, there was a 30-40% reduction in the number of IV doses given each day and reduction in duration of IV antibiotics of 0.5-1.0 days. This was sustained for three months following the campaign but reverted to higher levels by the time of the point prevalence survey six months later. Most educational interventions sustain behavioural change only for 2-4 months. Long term culture change requires a coordinated multi-modal approach over time, and the IV to Oral switch forms an integral part of that approach.

Audit and research

Vancomycin audit

An audit of vancomycin use was performed by Dr Karen Sims, House surgeon, supervised by Dr Melissa Tan (ID registrar) and Dr Michelle Balm (ID SMO). The audit was performed on adult inpatients from January – June 2018 prescribed IV vancomycin for 3 or more days. Key outcomes were that only 57% of patients attained therapeutic levels of vancomycin, usually due to loading dose omission or delays in giving the twice daily intermittent dose. Adherence to dosing guidelines in the PML was only 24%. On wards familiar with use of IV vancomycin (ICU, 6N) results were much better. Main outcomes of the audit were targeted education of RMO and nurses, particularly on 7N and 7S, greater involvement of ward pharmacists in supervising dosing and using AMS rounds to push review of dosing.

Meropenem audit

Surgical prophylaxis audit

Dr Carman Chan, House surgeon, performed an audit of adherence to surgical prophylaxis guidelines in August 2018. This audit was supervised by Dr Juliet Elvy (Clinical Microbiologist). Thirty patients from each surgical specialty were reviewed. Compliance with guidelines could be improved in all specialties, but were largely adherent in Orthopaedics (87%), cardiothoracics (76%). This result is reassuring as there are established guideline and a national surveillance programme providing

recommendations on prophylaxis for arthroplasty surgery and for CABG and valve surgery. More concerning is that, ENT Surgeons use prophylaxis for clean surgery when no specific indication for prophylaxis, and urology surgical prophylaxis is adherent to guideline recommendations only in 40% of patients. Outcomes from this audit will be to work with surgeons to clarify the guidelines and ensure endorsement by surgical teams.

β-lactam allergy de-labelling trial

In 2018, a summer studentship project was performed by Joy Hu under the supervision of Dr Juliet Elvy and Dr James Taylor. Joy assessed the number of patients admitted with a label of penicillin or other beta-lactam allergy. She found that 44% could be "de-labelled" through history taking alone, and would therefore be able to receive optimum antibiotics in the future. A further proportion of patients could be investigated further (with oral challenge to amoxicillin) and also likely de-labelled. Notably this was not a time consuming or resource intensive task.

In 2019 this project is going to be expanded to allow ward pharmacists to appropriately de-label allergies. Much of the information required is already collected, and this is therefore optimising the current use of our resources. We are also exploring preoperative orthopaedic assessment, as there are clear benefits to optimising perioperative antibiotics (ie using penicillin based antibiotics) for joint replacement.

Febrile neutropenia pathway audit

In 2017, Dr Jessica Luey, House surgeon, performed an audit of adherence to the febrile neutropenia guidelines, supervised by Dr Olivia Bupha-Intr (ID registrar) and Dr Michelle Balm (ID SMO). In addition, assessment of two scoring systems, the MASCC score and CIGNE score, was performed to determine if these could be used to stratify patients into high risk (requiring inpatient treatment) or lower risk (possibly allowing outpatient/oral antibiotic management). Outcomes of the audit were that 86% of patients were triaged appropriately, median time to first antibiotic dose was 46 min (guideline <60 min) and 94% were adherent to antibiotic recommendations. Better documentation in notes is required to evaluate the scoring systems adequately but on the basis of this small sample, a scoring stratification may be possible to introduce here to identify patients who may safely be managed as outpatients with oral antibiotics. Outcomes from this audit will be used to modify the febrile neutropenia pathway during the next review.

Education and awareness

World Antibiotics awareness week campaigns

The World Antibiotic awareness week is held in the 3rd week of November each year. In 2017, the campaign utilised recent trends in the UK, using the #KeepAntibioticsWorking hashtag and a week long programme of themed messages targeting awareness and good prescribing. This was publicised within the hospital via the communications team, and also formed the basis for a wider social media campaign. The "daily dose" messages and our posters were shared on social media (largely by our ID pharmacist, Dr Chris Little) achieving recognition by over 60,000 users on all seven continents! The outcomes of that campaign were presented in a combined presentation with Public Health England at the ECCMID 2018 in Madrid. Members of the AMS team were interviewed for national radio and YouTube videos and these were included on the Ministry of Health website for WAAW 2017.

In addition, the AMS teams at HVDHB and CCDHB ran an education programme for children in year 5-8 at four local schools. The children were given some education about antibiotic use and hand hygiene and were asked to create a poster with a message. The poster winners won a meeting with

local celebrities from the Hurricanes rugby team, a tour of the Microbiology laboratory showing how bacteria are grown and then a pizza lunch.

In 2018, this local programme was taken up by a joint team at the Ministry of Health and Ministry of Education as a national programme. A full educational package was developed and rolled out in August. The winner and her family were flown to Wellington, met the Minister of Health, Rt Hon. David Clark at the Microbiology laboratory and spent time discussing the importance of antimicrobial stewardship with members of the Infection team.

Pharmacy ID club

The Pharmacy ID club was introduced in 2015 as part of the clinical pharmacists' regular continuing education (CE) session. In 2017, online multiple choice assessments based around each module were developed on ConnectMe. This enables pharmacists to claim level 2 rather than level 1 CE points with the Pharmaceutical Society of NZ if the assessment is passed.

IPC study day

The annual Infection Prevention and Control regional study day is held in May each year and is attended by >250 nurses, pharmacists and laboratory scientists from around the 3DHB region. It includes an update on antimicrobial stewardship and recent initiatives.

Grand round

In 2017, Dr Chris Little (ID pharmacist) gave a presentation on Antimicrobial Stewardship in November. In 2018, Dr Olivia Bupha-Intr (ID registrar) gave a presentation on the Empiric app and optimising antimicrobial prescribing.

Antimicrobial of the Month

Each month the AMS team produces a one page "Antimicrobial of the Month" which is published on the Intranet, Daily Dose and shared with other DHBs (such as Whanganui DHB and Wairarapa DHB). The AotM provides fun facts and pearls about an antimicrobial or related topics aimed at improving knowledge about use of antimicrobials.

NZHPA Conference

Claudine (Pharmacy Technician – production unit) presented on "Antimicrobial stewardship – pharmacy led audit and feedback improvement cycles" to hospital pharmacists to demonstrate how simple audit cycles can have a positive impact to help deliver better patient and expenditure focused services. Dr Chris Little was unable to present at the conference, however did submit 2 posters "Kissing goodbye to IV antibiotics: Have you made the SWITCH?" and "Raising antibiotic awareness with school kids in Aotearoa, a first step on a long journey"

Clinical support

Guideline updates

The empiric antimicrobial guidelines were updated by the Infection Service across the 3 DHBs in consultation with specific specialties in 2017. No changes were made to the current guidelines in 2018 and all will be due for review by September 2019.

CCDHB guidelines updated in 2017 and 2018 included the sepsis guideline, the febrile neutropenia guideline and meningococcal guideline. New guidelines for Influenza management and for HIV Post-Exposure Prophylaxis were developed in 2018.

HealthPathways guidelines

Several HealthPathways guidelines were updated by Infection Services and AMS team members in 2017 and 2018. These included the urinary tract infection, pyelonephritis, gastroenteritis, meningitis and zika virus infection pathways. In 2019, pathways for measles, cellulitis and wound management will be updated/regionalised.

AMS liaison rounds

AMS team members (clinical microbiologist/ID physician and antimicrobial pharmacist) attend twice weekly rounds in ICU to provide formal review of infection management. This initiative has been in place at least eight years now. Since 2013, there has been a once weekly liaison round with the Haematology team to provide shared care discussion for prevention, investigation and management of infections in patients undergoing haematopoietic transplants or chemotherapy.

Nurses strike 2018

In July 2018, in preparation for the national nurses strike, the AMS team prepared safe alternative antibiotic selections to avoid intravenous infusions. The AMS team also reviewed every inpatient in the two days prior to the strike and recommended an individualised antibiotic management plan for the strike days. Oral antibiotics or IV antibiotics given by injection (not infusion) were used.

Priorities for 2019

The Antimicrobial Stewardship team will introduce several major projects in 2019. These will aim at improving patient care, optimising antimicrobial use and reducing unnecessary antibiotic expenditure.

AMS ward rounds

The AMS team proposes to introduce AMS ward rounds on all inpatient adult wards in February 2019. Regular AMS rounds have been proven to reduce length of stay, reduce infection related readmissions, hospital costs, antimicrobial costs, and total antimicrobial use (Nathwani, D et al. Antimicrobial Resistance and Infection Control 2019). This has been approved by the DHB Executive leadership team. Chart review and written feedback on antimicrobial prescribing will be performed by an Infectious Diseases physician/Clinical Microbiologist working with the antimicrobial pharmacist. AMS rounds will not substitute for an Infectious Diseases consult and for complicated infections, a formal review by the ID team is still recommended. AMS rounds will provide an opportunity to clarify antimicrobial recommendations, antimicrobial allergy status, and provide education and support for junior medical staff and ward pharmacists. AMS rounds will be subject to ongoing audit.

Documentation of antimicrobial indication, stop/review date

This intervention is planned for the second half of 2019 following implementation of the AMS rounds. The aim is to improve clinical communication regarding antimicrobial use in patient notes and prescription charts, particularly relating to prescriber's intent with using antimicrobials and establishing a date for stopping or reviewing the antimicrobial prescription.

Implementing learnings from audits

Meropenem audit:
Education and prescriber assistance will be targeted at Haematology and Oncology inpatient teams as this was shown as the key area for reducing excessive (non-guideline based) carbapenem prescribing.

Vancomycin audit:
Education and prescriber support will target ensuring adequate loading doses of vancomycin are given on wards where staff are less familiar with vancomycin use.

Allergy de-labelling audit:
A larger project will be initiated to develop a pharmacist-led programme to remove falsely-labelled penicillin allergies.

PUBLIC

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**HEALTH SYSTEM COMMITTEE DISCUSSION**
	Date: 4 September 2019
Author	Strategy Innovation and Performance Directorate
Endorsed by	Rachel Haggerty, Executive Director, Strategy Innovation and Performance
Subject	**STRATEGY INNOVATION AND PERFORMANCE REPORT July / August 2019**

RECOMMENDATIONS

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

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

1. PURPOSE

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

2. MENTAL HEALTH AND ADDICTIONS

2.1 Suicide Prevention and Postvention

According to the annual provisional suicide statistics, for deaths reported to the Chief Coroner between 1 July 2007 to 30 June 2019 the total number of suicide deaths in New Zealand for 2018/19 is 685 or 13.93 per 100,000 population. This is the highest number since records began and an increase of 23 deaths from the previous year.

For 2018/19, the total number of deaths for Capital & Coast District Health Board (CCDHB) was 41, up one from the previous year. For Hutt Valley District Health Board (HVDHB), the total number of deaths was 12, down one from the previous year. For Wairarapa District Health Board (WrDHB), the total number of deaths was eight with no change from the previous year.

The total numbers for the 3DHB area have not decreased and further work is needed in this area. The recently released Coroner's provisional suicide data shows that deaths in CCDHB are increasing at a faster rate than the New Zealand total, and the gap between the national rate and CCDHB is getting smaller.

Current developments include, a storyboard that paints a clear picture of the suicide story within the 3DHB sub-region, an automated report that details the journey of individuals who have died by suicide (i.e. touchpoints and interventions within the health system) and development of a project plan to implement the recommendations from a report we commissioned on how the health system responds to people who present in distress.

3. CHILD AND YOUTH

3.1 Antenatal Education Prototype

For many years, CCDHB has invested in traditional antenatal education, predominantly group classes and/or blocks of classes run over a few weeks. We know this approach to education works well for many women and families, but we also know that many women and family do not engage with this type of education.

As a large government organisation, CCDHB typically runs traditional tender and procurement processes. Usually, the DHB develops a service specification and approaches the market or particular provider/s to request a proposal outlining how they can deliver the specified services. The DHB then asks providers to demonstrate their skills and experience through a formal, written proposal. This traditional approach advantages a particular group of providers, and often larger providers with non-clinical, non-front line resources.

To redress some of the inherent inequities in this traditional process, SIP is currently running a non-traditional Request for Proposal (RFP) process for antenatal education. In this process, rather than SIP prescribing the service specification, we are asking the providers that work every day with families least likely to connect with services antenatal to pitch their ideas and experience around what will work for the families' most needing support.

Rather than the DHB making decisions, through this process the DHB is working with Maori and Pacific mothers to inform our contracting decisions.

This process is seeking solutions that better meet the needs of:

- Māori, Pacific and refugee/migrant families;
- Young mothers; and
- Areas of high deprivation, in particular Porirua

We are inviting solutions that meet as many of the following characteristics as possible:

- Providers and programmes that are strongly connected to the community and other services, in order to provide:
    - familiar, trusted, integrated support to women and families;
    - links with existing services and partners, to demonstrate an 'intensification' of existing support available; and
    - continuum of care antenatal through to postnatal.
- Whole of whānau approaches which proactively include partners, grandparents, siblings, and other whānau to enhance support and outcomes for women.
- Programmes and approaches underpinned by cultural frameworks and world views, including but not limited to kaupapa Māori approaches.
- Provide a focus on the areas of greatest inequity, including breastfeeding, smoking and safe sleep.

Providers will present to our panel (compromised of mothers and DHB Māori, Pacific and service leaders) on 16 September. Services are expected to be in place from 1 November.

3.2 SUDI Prevention – Safe Sleep Programme

The CCDHB safe sleep programme is due to commence the week of 9 September. Pepi pods and wahakura (image below) will be available for free to babies that meet any two of the following criteria:

- Smoke exposed baby in pregnancy or in the home
- Safety concerns identified by clinicians (e.g. premature baby, unsafe co-sleeping arrangements, other environmental risk)
- Māori or Pacific

It will be a 'soft launch' targeted at midwives, and the safe sleep devices will be available from various locations across CCDHB, including distribution points in Wellington, Porirua and Kāpiti. The intention is to extend the launch to include community providers and partners including Tamariki Ora providers, Plunket, Wellington Free and other community and NGO providers.

3.3 Integration of Porirua Youth Services

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

The development of a model of care for the integrated youth service has been completed. The paper will be considered by the HSC at the September meeting.

The working party that was established to oversee and provide input to the development of the model of care has now completed its contribution to the project.

A youth panel was established to contribute to the ongoing to development of the service will continue to meet. CCDHB will provide ongoing support to this group.

3.4 Localities

Good progress continues to be made in the localities space.

A community asset-mapping project is underway in Kāpiti, Porirua and high deprivations areas in Wellington (Kilbirnie, Strathmore, Newtown, and Mt Cook). The mapping exercise will identify community assets at the individual, community and institutional levels across the three localities.

A Pacific population profile with a specific locality lens is also underway and will add to the data gathered as part of the Māori population profile. Preliminary findings from the analysis of the Pacific data highlights significant opportunities to channel efforts in a few key areas which are likely make an impact on Pacific health.

In Porirua discussions with HLC have commenced regarding the Eastern Porirua regeneration project. This project provides significant opportunities for contribute a health perspective to the urban planning process. A paper on this is being considered by HSC in the September meeting.

3.5 Joint Maternity and Neonatal Service Planning

As part of the Joint Hospital Planning work, in late August SIP completed a first stage scoping document for a joint maternity and neonatal services plan between CCDHB and HVDHB. The document articulated a high-level approach to deliver a joint HVDHB and CCDHB maternity and neonatal services plan that achieves equitable and optimal outcomes and experiences for women, babies and families accessing maternity and neonatal services.

The initial scoping document signalled that both DHBs clinical teams and planning and funding team will contribute to a detailed joint plan by May 2020.

The process will run separate to, but in parallel with, the urgent response to the HVDHB maternity review and the process to seek partners for future primary birthing services previously considered by HSC.

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4. PRIMARY AND INTEGRATED CARE

CCDHB is making progress on developing primary care and integrated care solutions. The Integrated Care Collaborative (ICC) alliance that includes the DHB, Primary Health Care, Hospital Services and other key stakeholders has supported this progress. The following is a summary on the recent developments that have been support in partnership.

4.1 Kāpiti – Community Acute Response Service

The Kāpiti Community Acute Response Service was launched in early June with the aim to support people in Kāpiti to receive care closer to home – to travel less for care. There are about 5,600 Kāpiti residents who attended ED in 2018/19.

Between 10th June – 25th August, there have been 87 ambulance re-directions to primary care who would have otherwise been transported to ED. This has exceeded the estimated re-directions planned for delivery by the service at this early stage.

The implementation team including SIP, Primary Care, Wellington Free Ambulance and the service support continue to meet on weekly basis to support the change. The team have completed a post implementation report which will be presented to the related ICC Steering Group and the Kapiti Health Advisory Group.

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

4.2 Health Care Home

The Health Care Home model has reached the 80% population coverage with the final tranche of practices embarking on their change process. The first meet and greet sessions are being facilitated with the Community Health Teams and the practices to initiate the Community Service Integration aspect of the model, which is unique to the CCDHB model.

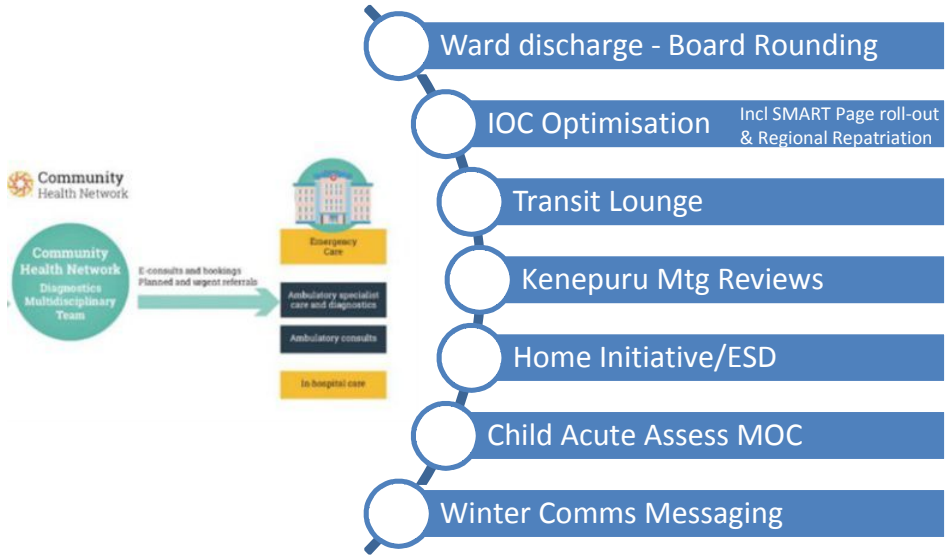
Health Care Home programme innovations continue with: 3 practices have held five successful Shared Medical Appointments; 8 Health Coaches trained; a Primary Care Practice Assistant (PCPA) peer review supported; and national certification/re-certification of practices continuing. With ten Health Care Home certified, CCDHB has the highest number of Health Care Homes certified.

Early acute demand analysis completed has demonstrated a positive impact. An annual reflection publication is being developed that aims to summarise learnings and insight during this third year. In addition to our local reflections the programme is entering a phase of formal evaluation. A procurement process including a request for quote has been released to gather proposals for the evaluation of the local model. Submissions will be considered by a collaborative group including the DHB, PHO, Health Care Home National Collaborative leads, MOH member, Māori Health Director and the Pacific Health Director. The evaluation is aiming to cover the overall programme as well as the Māori and Pacific world views.

4.3 Acute Demand and Bed Capacity

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

A number of the initiatives have been scoped and either delivered or paused due to resourcing restraints. The initiatives that the Steering Group have identified as requiring further support are focused mainly on the internal hospital flow. These are outlined below and will be supported through till December 2019.



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

5. 3DHB DISABILITY SERVICES

5.1 Data

Unlike ethnicity, data on disability is not widely collected, reported nor subject to Statistics New Zealand for standardisation. Furthermore, the ability to view disability data at a more granular level (e.g. by ethnicity or locality) is limited. A working group with members of the Strategy, Innovation and Performance (SIP) Analytical team and the Disability team are working to improve the information we have available about the sub-regional population with a disability. The aim of the working group is to develop a 'spine' of disabled people's NHIs that can be used to match the NHI-level datasets we have access to. This will enable an understanding of disabled people experiences across the health system including equity of access and equity of outcomes; not just the disabled population accessing secondary / tertiary care services as currently achieved through Disability Alert. The scope of this project includes all data systems for services currently funded or delivered by the sub-regional DHBs.

We are piloting this approach in CCDHB where we have Bilateral Data Sharing Agreements in place with major health service providers and look to rapidly roll this approach out across the sub-regional DHBs. We will be working with the Ministry of Health and be guided by the frameworks and existing work undertaken by Statistics New Zealand, the Human Rights Commission and Office for Disability Issues.

Defining exactly what data is required and how it will be used within the DHBs is a priority. This is part of the paper being developed and progressed to keep this work moving with urgency.

5.2 Alerts and Health Passport

Alerts

Disability Alerts were developed in 2013. The aim was to enable disabled people to communicate their reasonable accommodation needs to staff working with them. This information forms part of their electronic health record. Discussions with wider group stakeholders has identified that the Alerts provides us with the opportunity to illustrate how diversity is valued and invited everyone by asking "what do you need us to know in order for you to have the best experience here." This can encompass disability, mental health, cultural, rainbow identity and language needs.

A recent quality review suggests only 22 percent of Disability Alerts identify the support / access needs of the patient. This analysis first assessed the 7,630 Disability Alerts created between 2 October 2013 and 6 October 2017. These Alerts were then split into five specific categories:

1. Physical
2. Psychiatric
3. Sensory
4. Intellectual
5. Other

The review has identified that knowledge of the existence of Disability Alerts is sporadic and if accessed the reputation of being value add is low. The mechanism by which the detail contained in the Disability Alert is accessed on the electronic health is also cumbersome. The existence of an Alert is identified by a wheelchair symbol on the electronic patient record, which some would deem inappropriate.

The Disability team is working with the SIP Analytical team to better develop the Disability Alert platform, so that it will deliver disability and demographic related information. This phase is at an early stage and we are currently identifying key players to support effective implementation. The intended outcomes of this work is to ensure the Disability Alert is entered and updated across all platforms simultaneously, is readily available across all platforms used within the DHB and can be seen by all staff across the 3 DHBs following only one process of entering the information. Having a designated ICT person connected with this work is a recent advancement. We will engage with this person shortly.

Electronic Health Passport

The Electronic Health Passport project did not progress as hoped as the external contractor to lead the development of the project became unavailable. We have now engaged an internal team to rejuvenate the project. The Health and Disability Commission continue to act as a partner for this work. Because of the history surrounding the many reviews developing a final review and development phase. The purpose of this phase is to use available information to review current content, make required changes, agree format and style of paper based versions of the Health Passport and to support the development of an electronic version of the Health Passport, one that is transportable, easy to access while ownership of information is retained by the person the information pertains to. Having a designated ICT person connected with this work is a recent advancement. We will engage with this person shortly.

5.3 Accessibility

CCDHB is exploring the actions and resources required to implement 'The Accessibility Charter'. The Accessibility Charter documents a statement of commitment after considering Article 9 – Accessibility of the United Convention of the Rights of People. The Chief Executives of the Disability Forum are committed to ensuring that the public sector is accessible for everyone. Committing to the Accessibility Charter requires the Chief Executive, and Communications and IT managers to sign the Charter, which endorses their organisation's commitment to accessibility and mandates staff to work towards an accessible environment.

5.4 Supported Decision Making

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

We have now been assigned with a mentor and will work with stakeholders within the 3DHB to propose an implementation programme across the DHBs including community services.

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Date 11 Sept 2019	**HEALTH SYSTEM COMMITTEE INFORMATION**
Authors	Jenny Langton, GM – Commissioning Primary Care, LTC & Older Adults Mairi Lauchland, System Development Manager – Older People
Endorsed by	Rachel Haggerty, Director of Strategy, Innovation & Performance
Subject	**INVESTMENT DASHBOARD – HEALTH OF OLDER PEOPLE**

RECOMMENDATIONS

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

(a) **Notes** in 2018/19 CCDHB budgeted $72 million for services for older people.

(b) **Notes** that complaints related to the home and community support service are trending downwards as vacant staff positions are filled. That weekly monitoring of provider performance is still in place for these providers. The dashboard measure for HCSS is being revised to ensure the measure is reporting the same data across both providers. The revised measure will include complaints and missed cares.

(c) **Notes** this reporting is part of our process of improving our understanding of how our investments in the services are working for our population including equity (or not) of access to health services and outcomes achieved.

APPENDIX

1. HEALTH OF OLDER PEOPLE INVESTMENT DASHBOARD

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

1. PURPOSE

This paper updates the Health System Committee on performance against key indicators monitored through the health of older people investment dashboard. This paper also includes updates on national processes, local highlights, the 2018/19 year-end performance of investments in services provided for the CCDHB population under the nationally negotiated agreement Aged Residential Care (ARC), and the 2DHB negotiated Home and Community Support Services (HCSS) agreement.

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2. HEALTH OF OLDER PEOPLE INVESTMENT DASHBOARD

In 2018/19, CCDHB budgeted $72 million in older persons' services, which includes ARC, HCSS, and other community support for older people. ARC agreements include rest home, continuing care, dementia, and psychogeriatric services. The dashboard provides us with an ongoing view of the performance of our investment in services for older people (see Appendix). Performance at this time follows in line with previous reports to you.

2.1 Funding performance

DHB investment in ARC remained within budget for 2018/19, with actual spend below budgeted spend. While HCSS and day programme spend was greater than budgeted we consider this to be indicative of a desired shift towards more home-based supports. HCSS spend overall was within budget for the 2018/19 year.

2.2 Older people in subsidised ARC performance

The number of people residing in ARC has consistently reduced from 2016. Māori and Pacific peoples access ARC at a lower rate than 'other'.

2.3 Home and Community Support Service performance

Māori people in our older population access HCSS broadly in line with their population size and Pacific peoples less than their population size would predict. Given Māori and Pacific peoples access ARC services at lower rates than our 'other' population we may have expected them to access higher levels of HCSS. This is an area of focus for us in planning our investment approaches with a view to more pro-equity responses in services for older people.

Change to two providers

The revised HCSS contract strategy, with two providers instead of one, went live April 2019 with HVDHB the lead DHB for this process. The HCSS change impacted over 3,000 people and 780 support workers across CCDHB and HVDHB. Within CCDHB alone, 1,066 hours of home support is provided per day. Since the new service started Access Homehealth are reporting business as usual. Nurse Maude have experienced difficulty in recruiting support workers and have vacancies particularly in the Wellington city area.

Winter illnesses have also affected the providers and, while they manage to fill the vast majority of the service gaps, there are instances where care has been prioritised to the people who need it the most. This has meant support workers have not always been present at a specific time. Early communication with clients about any changes to care is essential and this has been reiterated to providers.

Recruitment is however starting to improve. Since April Nurse Maude has recruited an additional 10 FTE support workers and they anticipate they will need a further 10 FTE to meet optimal staffing for the anticipated service demand over the next 6 months. This improvement in staffing levels has seen missed cares as a percentage of total rostered cares drop from 0.5% on the 29th April to just over 0.2% in August.

Access Homehealth participates in monthly Careerforce whanaungatanga hui[1] where 60+ support workers are invited to participate in workshops. Here the connections are made between culture and they work they do. In May the hui was about making connections between personal values, ethical behaviours, loss and grief, and their assessments. In June the hui was about reporting issues, concerns, incidents, and accidents in their everyday work. 93% of their support workers have a qualification.

[1] An infrastructure of relationships to support the holistic needs of Māori in order to achieve success.
https://www.careerforce.org.nz/whakawhanaungatanga-redefining-pastoral-care/

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2.4 Complaints

Complaints about HCSS support since the change in contract has reached the media recently. We are building a dataset to ensure ongoing monitoring of complaints can be easily reported and issues addressed, and working with providers to ensure consistency of information. Overall we have seen a drop in complaints over the past three months as the services have become more established. Both Access Homehealth and Nurse Maude are consistently reporting fewer complaints each month.

2.5 Older people supported to live at home

We have looked at the ratio of people supported at home compared with those in ARC as a broad indication of the DHB's ability to enable people to age in place and stay at home longer. Most DHBs have a ratio of 60% (home): 40% (ARC) ratio. CCDHB is consistent with this ratio with some opportunity for improvement 58% (home): 42% (ARC).

2.6 Audit and Compliance

Four-year certifications are an indicator that the ARC facilities are providing good quality services. There has been an increase in the number of four-year certifications: 63% of 32 eligible ARC facilities. We have one facility with a one-year certification, which is standard for any new facility or a facility that has changed ownership as is the case here. The facility with a 2 year certification has made significant changes; the clinical and facility managers are new and a comprehensive quality improvement plan is in place.

2.7 Acute Flow from ARC Facilities performance

We are seeing fewer people from ARC facilities presenting to ED and admitted acutely. However acute bed days and average length of stay for those people has increased, suggesting complexity. Our work for the HOP investment plan has a particular focus on complexity and frailty across the whole health system.

2.8 Individual Impact

The InterRAI assessment captures a snapshot of a person's needs. These measures show that the *carers' feelings of stress* measure remains steady at approximately 25%. We have been working with the NASC to allocate more respite services for carers. The impact of this is reflected in the increased expenditure on day programmes. Other measures show a positive trend; there are more advance care plans being completed and more Enduring Powers of Attorney in place.

2.9 System Impact for priority populations

The non-admitted ED rates (per 1000) for people aged 65+ is stable.[2] The acute admission rate and acute bed day rate for Māori is below that for 'other' and Pacific peoples. The rate for both ED presentations and admissions is highest for Pacific peoples. The Pacific Neighbourhood nurse-led service based in Porirua, supporting Pacific families and individuals with management of complex care is a step towards supporting our Pacific families.

3. ARC FUNDING REVIEW

The recent aged residential funding model review report[3] prepared by Ernst & Young (EY) for the Ministry of Health considers how funding models may reflect different levels of care intensity. The report acknowledges the increasing age and complexity of older people using ARC, the changing nature of the

[2] Note: because of the earlier ageing profile of Pacifica and Māori, these groups are analysed aged 65+, and 'other' analysed aged 75+.

[3] https://tas.health.nz/dhb-programmes-and-contracts/health-of-older-people-programme/aged-residential-care-funding-model-review/

ARC sector itself, and note the demand for ARC has been more muted in recent years than earlier projections suggested. Core components of ARC funding are accommodation, everyday living services and core support and care provided for all residents. Additional care and support currently falls into four care categories: rest home, continuing care, dementia, and psychogeriatric services. EY found that these four care categories are no longer sensitive enough to the range of resident's needs within ARC.

EY proposes a refreshed national pricing approach, aligned with resident care need, noting this needs to be supported by a strong accountability framework, regulatory system and policy settings that support sustainable service delivery. The report recommends that the number of funded care categories are expanded using the interRAI Resource Utilisation Group (RUG) to prospectively fund according to resident need, nationally equitably. The report further recommends an adjustor for diseconomies of scale and consideration of a "turnover payment" e.g. for respite or palliative care. A decision by the MOH will be needed regarding the recommendations, then significant change work with subsequent refinement of any new model needed once implemented.

4. AGED RESIDENTIAL CARE FUNDING AND CONTRACT REVIEWS ARE COMPLETE FOR 2019/20

The annual general review of Aged Residential Care Agreements is complete for 2019/20. This review occurs each year under the terms of the agreement with ARC service providers and covers both services and price. An MOH-managed uplift of 3.2% plus a pay equity uplift occurred for ARC providers for the 2019/20 year.

5. MECA AND PAY EQUITY IMPACTS

The effects of the MECA on the ARC nursing workforce continues to flow through the sector. Nationally, as previously reported, the General Managers of Planning and Funding agreed an additional 0.43% payment to ARC as a contribution towards offsetting the effect of the MECA on the nursing workforce in ARC.

The Ministry of Health is carrying out formal workforce planning for the older persons sector. Data collected from ARC facilities has started to determine the extent of reported staffing issues with the recruitment and retention of registered nurses within aged care. ARC providers report significant staffing impact since the MECA, with registered nurses exiting to the DHB in greater numbers. In 2018 in the CCDHB district, 123 RNs exited ARC. Of all registered nurses who left ARC in 2018, 43% went to a DHB and 33% left the workforce. 14% of all internationally-qualified nurses work in aged care (2,299 of 16,408).

ARC is not a popular practice setting for new graduates. In the November advance choice of employment national recruitment process 5% of applicant preferred to work in aged residential care compared to 10% preferring to work in HOP in DHB settings.

6. PALLIATIVE CARE SYSTEM DEVELOPMENT

Palliative care system development work has been occurring under the ICC project umbrella, driven by a multidisciplinary stakeholder group. Recommendations for primary-led palliative care supported by specialist palliative services are before the palliative care steering group for endorsement before presenting these to the ICC alliance leadership team October 2019. A health care home pilot will test these recommendations before system-wide rollout. Data and metrics development is underway.

Formal consumer engagement will start 1 November with a Victoria University summer studentship supervised by the consumer representative on the palliative care steering group. Information from the consumer engagement will help identify palliative equity issues and inform initiatives to address equity issues. The engagement aims to explore community perspectives regarding home-based palliative care, reaching those who have palliatively cared for a family/whānau member at home with primary-led or minimal support. Six focus groups are planned, integrating Pacific and Māori feedback into the engagement methodology, which will gather narrative for thematic analysis. A Māori-specific focus group, in conjunction with a PHO, a Pacific-specific focus group supported by CCDHB Pacific Health Directorate, and four geographically-based focus groups are planned.

Other associated palliative care work underway includes

- strengthening links between Wellington Regional Hospital patient care coordinators and Mary Potter Hospice services,
- credentialing for Mary Potter specialist physicians with radiology services in Wellington Regional Hospital,
- hospice community and ARC education planning for next year focusing on palliative system development priorities,
- input into the adult palliative Health Pathway
- input into the 2DHB revision of the ambulance plan pending endorsement of the final document by the palliative steering group.

7. OLDER PERSONS AND PALLIATIVE CARE DASHBOARD

The performance of our system for older people is considered in the dashboard below. Of not is the increase in advance care plans across the CCDHB population. The evaluation of the impact of these plans will be considered in 2020.

The attendance of people from age residential care is measured including ED attendances and acute bed days. There has been a continuous decline in acute admission and an increase in acute bed days for ARC clients. This is considered to be the impact of complexity including dementia.

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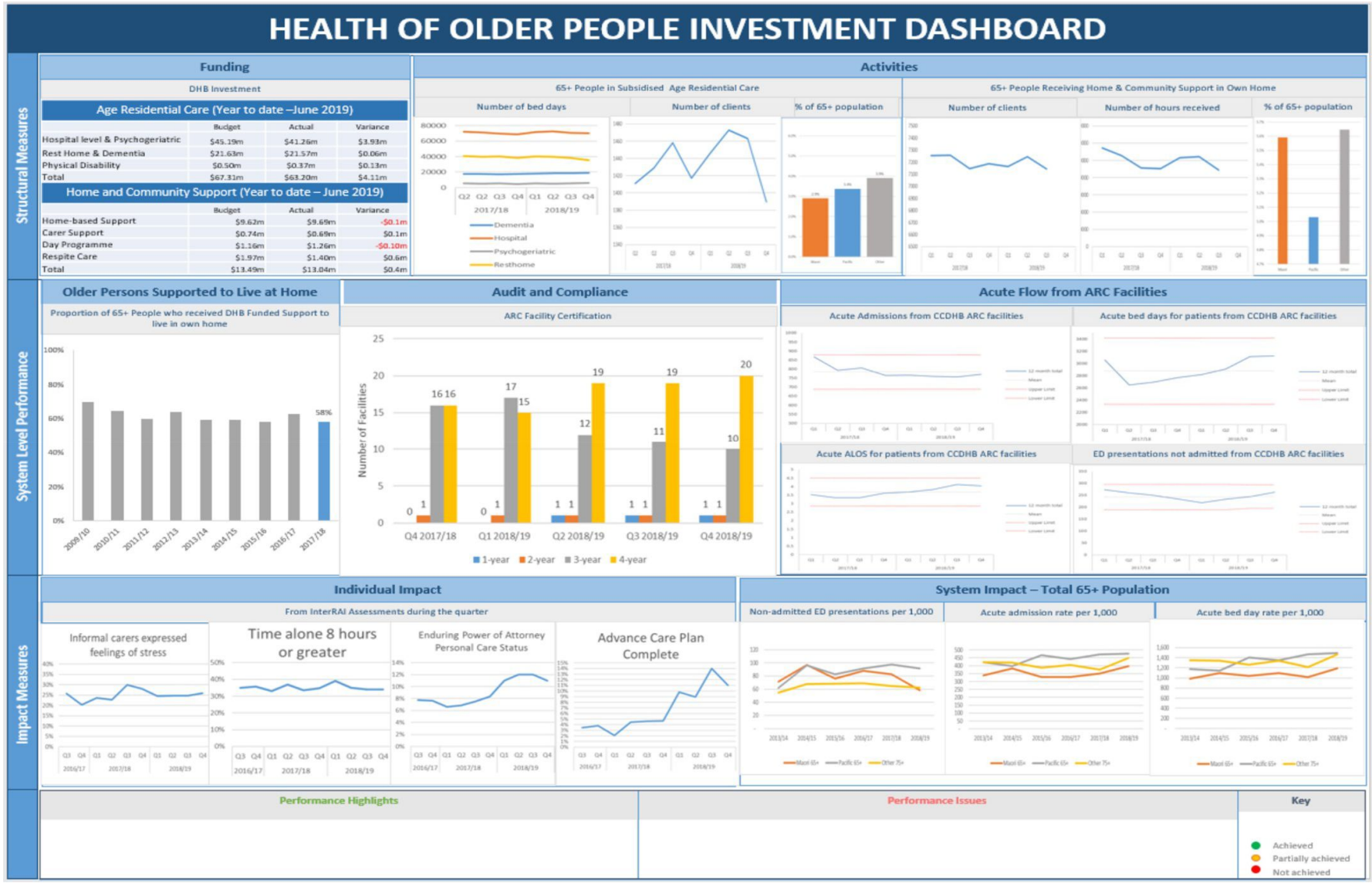
8. APPENDIX 1. HEALTH OF OLDER PERSONS INVESTMENT DASHBOARD



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Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**HEALTH SYSTEM COMMITTEE DECISION**
	Date: 4 September 2019
Author	Fran Wilde, Health System Committee Chair
Subject	**RESOLUTION TO EXCLUDE THE PUBLIC**

RECOMMENDATION

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

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

SUBJECT	REASON	REFERENCE
Regeneration Porirua and Housing	Papers contain information and advice that is likely to prejudice or disadvantage commercial activities and/or disadvantage negotiations	9(2)(b)(i)(j)

* Official Information Act 1982.