PUBLIC

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**BOARD DECISION** **Date: 13 June 2018**

Author	Andrew Wilson, Acting General Manager People and Capability
Endorsed by	Ashley Bloomfield, Interim Chief Executive
Subject	**PEOPLE & CAPABILITY BI-MONTHLY UPDATE REPORT**

RECOMMENDATIONS

It is **recommended** that the Board:

People Strategy

(a) **Notes** the process used to develop the draft People Strategy;

(b) **Approves** the draft People Strategy as proposed;

(c) **Agrees** to the process to progress the People Strategy to People Plan;

(d) **Agrees** to the proposed next steps including development of a programme of work to refresh CCDHB's values.

Supporting Safety Culture

(e) **Notes** Speaking Up For Safety initiative was launched in the week of 14-18 May;

(f) **Notes** the development of the research and evaluation framework, network and programme;

(g) **Notes** the upcoming activity - Safety Attitudes Questionnaire – which will be run in late June/early August.

APPENDICES

1. CCDHB People Strategy
2. Supporting Safety Culture: Research and Evaluation.

1. PURPOSE

This paper is the second bi-monthly People & Capability Update Report. The first bi-monthly People & Capability report included information on the development of the People Strategy. This Update Report provides an update on the progress of development of CCDHB's People Strategy and Supporting Safety Culture Programme.

2. OVERVIEW

The People & Capability Directorate provides human resources support and advice to managers across CCDHB – this includes the full range of human resources activities which includes, but is not limited to, employment relations, recruitment and employment records support. It also provides organisation-wide leadership development and training, and organisational development advice and support.

In the period since the last report to the Board, key appointments – including Tony Stone to the Employment/Industrial Relations Manager role – have continued to stabilise the Directorate. Andrew Wilson continues to act as the General Manager, People & Capability.

3. THE PEOPLE STRATEGY

The People Strategy has a distinct function, to optimise our people resource to meet the organisation's goals. The development of the People Strategy has also provided a mechanism to increase and improve communication and engagement across the organisation.

The process to date has involved over 200 staff directly in co-design workshops. These workshops focused on the areas staff identified in our 2017 Staff Engagement Survey.

This was then analysed, shared and discussed by subject matter experts, which has led to the development of key principles and intentions to guide our work. The outcome of this process is contained in the attached paper.

3.1 Background

In early 2017 we began a conversation with our staff about what is important for them. The first part of the conversation was the Staff Engagement Survey. This was the first organisation wide activity of this kind since 2013. The focus of the 2013 survey was primarily patient safety culture and while a number of changes and developments occurred as a result of that, these were not always visible to staff. There was consequently a level of expressed scepticism and cynicism about the survey, however in spite of this 52.5% of staff took part.

The survey was a first look, to get a broad sense of where the red flags are and where we are in good heart. It was also the start of a longer process to develop a people strategy that reflects what is important to our people and our organisation. Lastly, it was embedded in action, with an undertaking that teams at all levels of the organisation would undertake action planning and that this would be part of ongoing activities at CCDHB.

Two primary areas for action came out for the organisation as a whole:

1. **Safe and Supportive Workplace** - staff identified this as an area of challenge for the organisation, which has led to the Healthy Workplace and Supporting Safety Culture programmes (detailed in previous papers).
2. **Engaging our People** - the desire for reciprocal communication that enables staff to contribute ideas and observations and be informed of the bigger picture in a meaningful and authentic way.

4. NEXT STEPS

4.1 Value

The outcome points us to a conversation about what is important to us as an organisation and what are our values to help guide us? A significant theme throughout the conversation to date has been the desire for clarity and confidence in the quality of decision making at all levels of the organisation. Every day, in every situation, our people make decisions and choices. Those choices involve weighing up a range of factors, at times conflicting and almost always complex. Working together to refine and refresh CCDHB values, provides the opportunity to lift both the quality of decision making, and to strengthen confidence in our efforts to provide best outcomes for patients and best experience for staff. We are currently identifying the process for this, but would see it as involving the Board, senior leaders, staff, patients and the community.

4.2 People Strategy to People Plan

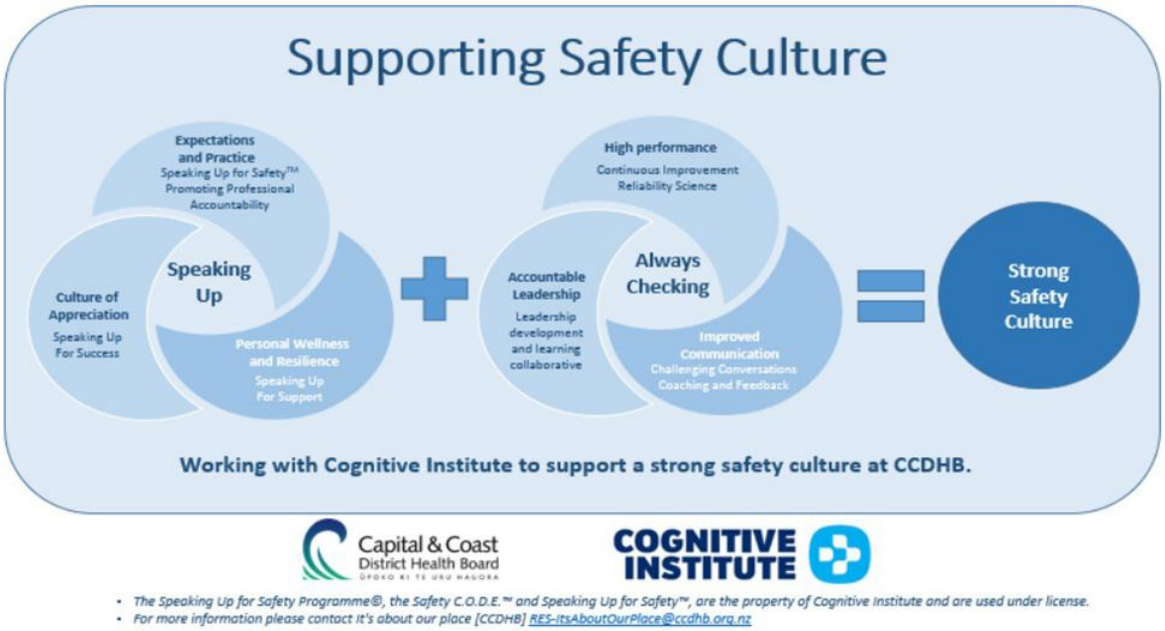
We propose a workshop process, aligned with the values work, starting with the Executive and broadening to encompass all our leaders, to identify how we will incorporate the principles of the People Strategy into planning and action. The outcome of this will be the creation of a People Plan with a 6-12 month view, reflecting the desire to keep steadily moving forward during our leadership transition period.

5. SUPPORTING SAFETY CULTURE

5.1 Background

The Staff Engagement Survey 2017 identified ensuring a 'safe and supportive workplace' as a key area of focus for our organisation. As a result, the three year Supporting Safety Culture programme was developed, working with Cognitive Institute.

As explained in the March bi-monthly People & Capability Update Report, the following conceptual framework outlines our approach for 2018-2020 to build a strong safety culture.



14-18 May was launch week for Speaking Up For Safety, the first element of the programme. The week included ELT and project team walk-abouts, lunchtime kiosks, 200+ t-shirts and 2000 badges. The goal of launch week was to prompt conversations about safety culture, to signal the first training sessions and to enable managers to book teams through Connect Me. Over 100 people had completed the SUFS workshops by the end of launch week. By the end of May (our first 3 weeks) we will have trained over 300 people.

A key element of any change initiative is the evaluation of activities and progress. A framework has been developed by the project team, consisting of QIPS, OD and Capability Development staff, with oversight from the steering group and in particular the professional heads.

An additional expectation following the staff engagement survey was that there would be a follow up assessment, with a focus on 'safe and supportive workplace' mid-2018, as part of the ongoing cycle of assessing staff engagement.

A research and evaluation framework has been designed to meet both requirements, by helping us to understand our culture and to measure our success in the Supporting Safety Culture programme.

Earlier in 2018, the Organisational Culture Research Network was formed. More than 25 staff with an interest or experience in supporting research into culture and leadership across the organisation have joined. The research network is facilitated by the Organisation Development team and provides a way for staff to connect and contribute to making our place a great place to work. Members of the network have formed teams to progress elements of work identified in the framework and some are utilising this to achieve post graduate qualifications or to support initiatives already underway in their areas.

5.2 The Framework

Organisational culture is shaped by values, beliefs and behaviours that are practised because of shared subconscious assumptions and tacit beliefs. It is widely recognised that multiple sub-cultures exist in organisations, including healthcare environments (Travaglia *et al*. 2011, Schein 2004).

Edgar Schein, a key author and former MIT professor, defines organisational culture as:

> "*A pattern of shared basic assumptions that the group has learned as it solved its problems that has worked well enough to be considered valid and is passed onto new members as the correct way to perceive, think and feel in relation to these problems*." (Schein 2004)

Schein's model illustrates the complex and multi-layered nature of organisational culture. Culture is depicted as an iceberg where much lies below the surface, making culture difficult to examine or observe.

Figure 1: Schein's model of culture

The aim of the research programme is to understand safety culture at our place over a three-year period. A mixed methods approach will achieve this aim as it acknowledges the complex and multi-dimensional nature of culture. The triangulation of multiple data sources will increase confidence in our conclusions and will assist in identifying potential confounding variables, such as coincidental improvements.

As a consequence the research framework includes multiple research and evaluation projects, with central oversight by the project research team and governance provided by the Supporting Safety Culture steering group.

We have not included the full framework in this paper as it runs to 12 pages, however an extract is included in the section below which illustrates one component, and the full framework can be provided on request.

5.3 The Safety Attitudes Questionnaire (SAQ)

One component of the framework is an annual survey of staff safety attitudes. We are partnering with Victoria University of Wellington, under our existing MOU in this research project.

A communications plan is in development, with activities modelled from the staff engagement survey process last year. The proposed timing for the survey is late June/early July.

As a result of our existing partnership with Victoria University, the survey tool and analytics will be managed through their systems. This addresses the technical and resource challenges experienced throughout our 2017 Employee Engagement survey.

Below, is an extract from the framework, which illustrates the SAQ approach.

Study Topic	Aim	Data Source	Metrics /Methods	Frequency	Analysis	Requirements
CCDHB Safety culture: Espoused beliefs and values	To determine any change in CCDHB safety culture over a three-year period	Safety attitudes questionnaire https://psnet.ahrq.gov/resources/resource/3601/the-safety-attitudes-questionnaire-psychometric-properties-benchmarking-data-and-emerging-research-- Inclusion criteria: All CCDHB and MHAIDS staff will be sent a link via Survey Monkey to the survey.	6 Factors Teamwork climate, safety climate, perceptions of management, job satisfaction, working conditions, stress recognition Limitations: only accounts for espoused beliefs and values	Baseline (August 2018). Formative assessment (Nov 2019) Summative assessment (March 2021). May not be able to achieve formative assessment here	OD SPSS.	OD Business as usual (BAU) Potential database of SAQ data for comparison

The short form of the Safety Attitudes Questionnaire (SAQ) was derived from a questionnaire widely used in commercial aviation. Researchers found that most airline accidents were due to breakdowns in interpersonal aspects of crew performance such as teamwork, speaking up, leadership, communication, and collaborative decision making.

The SAQ has been used to assess safety culture in healthcare organisations across the world. It allows comparisons between hospitals, patient care areas, and types of caregivers, as well as tracking of change over time. Peter Roberts (SMO, Medicine) was an author on the version of the SAQ that we are proposing to employ and has been involved in development of the framework. The SAQ is a tool utilised in evaluation of Cognitive Institute programmes by Royal Melbourne and other partners.

Leadership & Research Approval

This research is led by CCDHB organisational development staff (Jo Wailling lead) and academic staff members from Victoria University of Wellington. This research has been approved by the Victoria University of Wellington Human Ethics Committee (number 0000026056). Locality approval was provided by the CCDHB Supporting Safety Culture Steering Group and checked with CCDHB's Legal function and the Research Office.

What will the project produce?

The information from this research will be used to understand and support a positive safety culture and will contribute to organisational reports, academic publications and conferences. Analysis will allow us to understand where we need to focus support and where we can learn from excellence in our organisation. The survey will help us to understand where to focus ongoing research efforts so we can learn and grow from innovation. A secondary outcome is that it provides opportunities for staff to develop research skills.

5.4 How will the Treaty of Waitangi be considered?

Information provided by people who identify as Maori or Pacific will be analysed and interpreted by cultural experts as a unique data set, as well as alongside other employees with similar characteristics e.g. occupation, place of work.

It's about our place

CCDHB People Strategy

We would like to recognise and thank everyone who completed the engagement survey and contributed to staff workshops and panels. Without your input we would not have been able to develop this exciting proposal. We hope we have clearly represented the thoughts and ideas you shared, and we look forward to your ongoing contribution to our CCDHB People Strategy. Thank you very much.

Contents

People Strategy – Executive Summary - Key Principles and strategic intentions

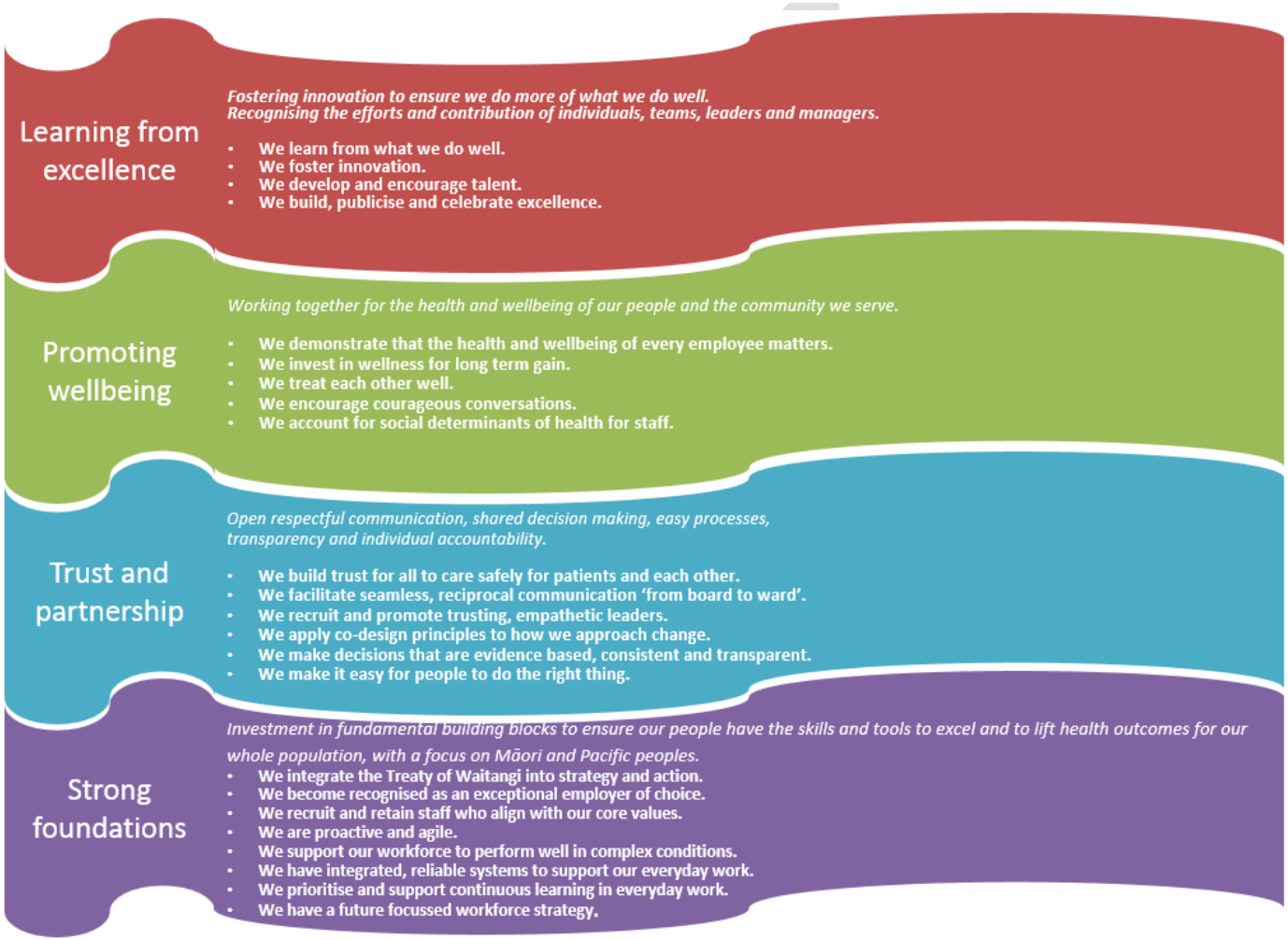
This people strategy provides a strong formulation of what is important to our people. It offers key principles and strategic intentions to ensure we optimise our greatest resource, our people.

The strategy provides a reference for the development of work plans and service development initiatives across the organisation. Ensuring that activities incorporate these four principles will maximise the success of those actions, by ensuring consistency with the values and expectations of our people.

The strategic intentions provide a guide for identifying how to honour the principles when developing action plans and work programmes.

Organisational commitment to combine principle based strategic intentions with frontline innovation will minimise the gap between *work as experienced* and *work as imagined* and create an organisation in which our people are excited to come to work here, able to do their best work here, and are proud to say they work here.

Key Principles and Strategic Intentions - Summary

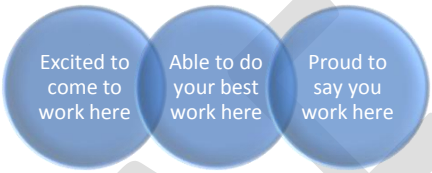


1.0 Introduction

> Better health and independence for people, families and communities – keeping people well and eliminating health inequalities, everyone will enjoy the best possible health throughout life.
>
> CCDHB Vision

Our people are our biggest investment and our most valuable resource. Every day over 5000 of our people play a part in delivering excellent healthcare to the community we serve. Each individual contributes in a unique way as part of the team. Our organisation is our people.

The goal of our people strategy is to identify how we can ensure that our people are excited to come to work here, able to do their best work here, and proud to say they work here.



With this in mind we have used co-design principles in developing our people strategy. We have brought together strategic plans and vision, with practical operational considerations, and last but not least, we have talked to our people to establish what is important to them.

This paper presents key principles that were developed from engagement survey results, workshops with our staff, and subject matter expert panels, where we sought to understand:

- '*Work as experienced*'; the reality of everyday work in our organisation
- '*Work as imagined';* what our people and our subject matter experts believe should and could happen now and and in the future

The key principles give us shared understanding of how to optimise work throughout our organisation. These principles underpin both every day work and how we support our people to excel. Each principle is broken down into strategic intentions, the base for action planning in teams, services and the organisation as a whole.

Development of this strategy has brought together staff who work for Capital & Coast District Health Board (CCDHB) and those who work for our 3DHB Mental Health Addictions and Intellectual Disability Services (MHAIDS).

2.0 Context

The Minister of Health has identified a strong public health system as a key priority for 2018, with a focus on addressing inequalities and on provision of primary care and mental health services. Addressing inequalities of health outcomes for Māori and Pacific peoples is a key priority, which will require deliberate action to build capacity and capability within health and disability sector workforces.

A people strategy supports delivery of the New Zealand Health Strategy[1], in particular actions to build 'one team'. The NZ Health Strategy outlines a number of actions to drive our efforts in this area:

NZ Health Strategy: One team | Kotahi te tīma

- Operating as a team in a high-trust system that works together with the person and their family and whānau at the centre of care
- Using our health and disability workforce in the most effective and most flexible way
- Developing leadership, talent and workforce skills throughout the system
- Collaborating with researchers

NZ Health Strategy 2016

CCDHB Health System Plan: Working Together for Better Lives

Capital & Coast DHB is part of an extensive local health system, situated in a context characterised by complexity. Constant and increasingly rapid changes of health care provision, demographic impacts and workforce dynamics all influence our ability to predict, plan and prepare for the future (Figure 1).

Our recently developed Health System Plan[2], provides a vision to 2030 and guides us as to how we can improve the performance of the health system to deliver excellent healthcare across the community.

The Health System Plan emphasises a focus on people and whānau-led wellbeing to support more health being managed in community settings, with hospitals as centres of expert specialist care.

[1]NZ Health Strategy 2016, Ministry of Health.
[2] Capital & Coast District Health Board Health System Plan: Working together for better lives, 2018.

The health system plan moves away from traditional organisation or sector (e.g. health vs social) boundaries to encompass the whole community we serve. The strategy emphasises the role of inter-disciplinary teams and digital technology and signals six vital ingredients for successful transformation.

Our people strategy cannot be considered in isolation. The NZ Health Strategy and CCDHB Health System plan combined, give vision and direction to our organisation. As our organisation matures, strategies that intend to deliver this vision in our everyday work are emerging in key areas (figure 1). Strategy has a specific role to play in each of these areas, however it is essential that each interacts and enables organisational success and health system sustainability.

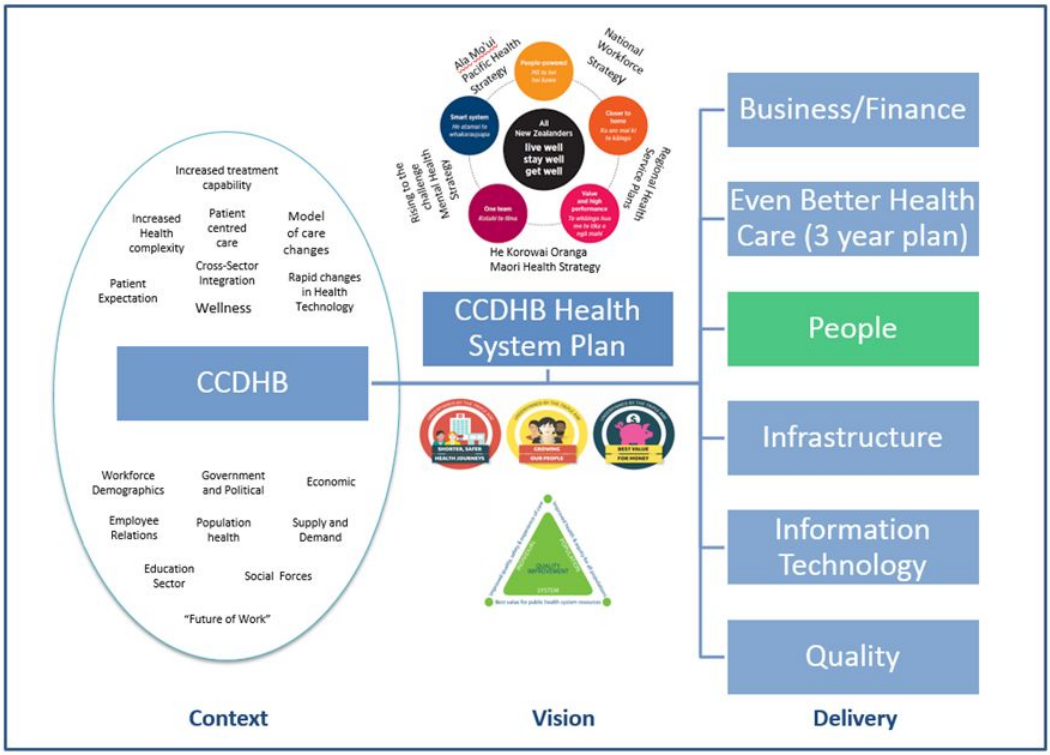


Figure 1: Context of CCDHB People Strategy Development

3.0 Background – why create a people strategy?

In 2017 the 20 DHB Workforce Strategy Group developed a People Force Strategy intended to support people to live well, get well and stay well to 2025 (see Appendix 1). The role of a people strategy is to provide a shared formulation from which we can confidently reach for our goals, decide priorities for action and deliver on commitments. Put simply, a people strategy brings together our understanding of our people and what is important to them, with our vision for the future and our knowledge about how best to get there.

The traditional focus of people management has been to provide a transactional Human Resource service for an organisation, doing things for it and for the staff. A contemporary approach emphasises the value of people strategy work to support a step forward in organisation maturity. By building an approach to people management that is strategic, future focussed and based on robust data, the people strategy can positively influence outcomes.

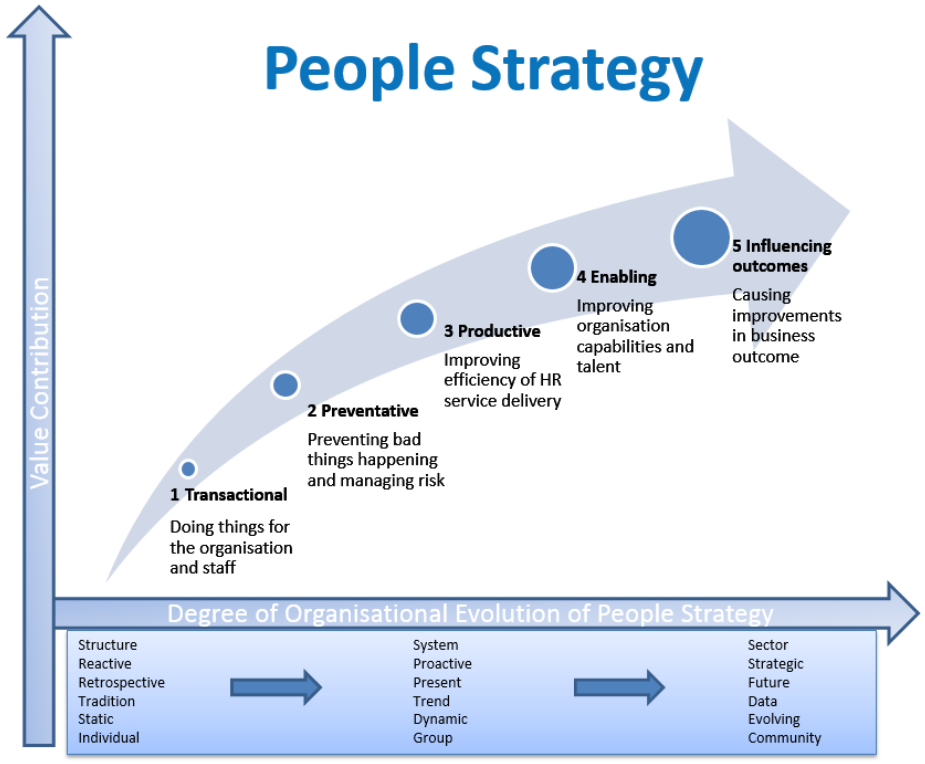


Figure 2: Value Contribution of People Strategy[3]

Figure 2 illustrates how as an organisation matures, people management develops through a number of stages to eventually create significant improvements to business outcomes. At CCDHB, different people management activities are at different points of evolution. As we work towards our health system vision for 2030, there is a need to think about the organisation as one part of a broader sector. Our organisation will require an agile and flexible workforce that is constantly evolving in response to changing health needs, demographics and technologies. Understanding our people as a community of individuals coming together to work for a common purpose, in the context of their broader lives, is a key aspect to optimising organisation functioning.

[3] This model was developed from a framework by Axiom Consulting Partners.

4.0 Development of our people strategy

4.1 Participants

A significant number of our people contributed to the people strategy and we are extremely grateful for their energy and support. The engagement survey was completed by 2999 Capital & Coast District Health Board staff and more than 200 staff from across Capital & Coast District Health Board and Mental Health, Addiction & Intellectual Disability Services (3DHB) have helped us to develop the emerging themes into a cohesive people strategy.

Co-design workshop participants (n=186) came from a diverse range of occupational groups (figure 3). The largest group represented was nursing (17%), and most attendees in this occupational group held senior nursing roles (82%). Participants working in management administration were the second largest group represented (e.g. receptionists, ICT, finance). Due to the small number of doctors attending the workshops we attended clinical director meetings to ensure a medical perspective was included.

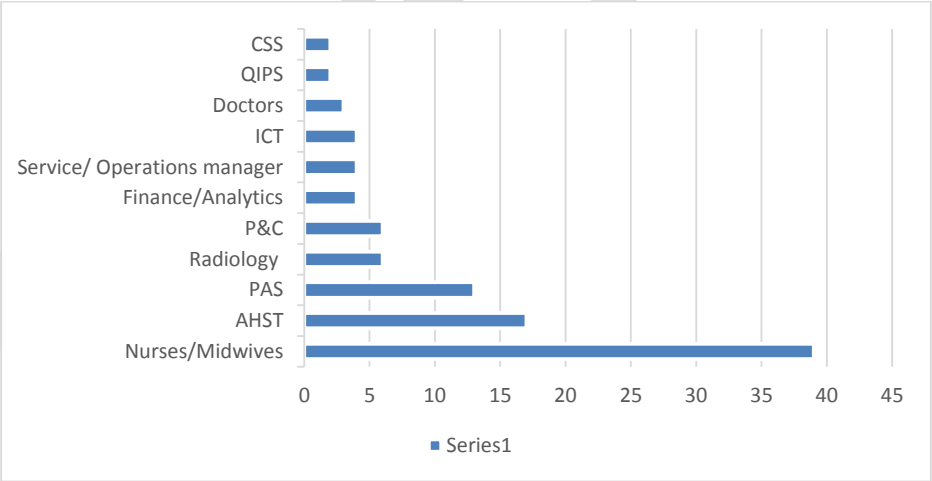


Figure 3: percentage of participants by occupational group (self-identified)

Although the majority of participants came from the Wellington main campus, workshops on other sites were well attended (figure 4), and all directorates were represented.

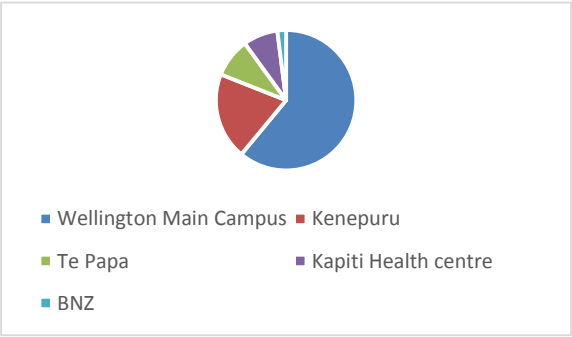


Figure 4: Percentage of participants by workshop site

4.2 What is important to our people? – Values expressed

A number of values statements emerged consistently through the text comments in the Staff Engagement Survey and through the Co-design workshops.

Figure 5: Values expressed by staff in people strategy workshops 2017

These form a sound basis for planned work to refresh the CCDHB values, with confidence that these are values that reflect what is important to our people.

4.3 Themes from the staff engagement survey

The first stage in development of the people strategy began following results of the 2017 staff engagement survey. The results of the survey are not reprised here and can be accessed via the CCDHB staff intranet.

Results from the staff engagement survey were then analysed by the People & Capability team. Eight organisation wide themes were identified for further exploration. It is important to note that underpinning all, are the concepts of respect and kindness. Our staff indicated a belief that a base of respect and kindness is important for all, but also increases the likelihood of success in any aspect of everyday work.

Figure 6: Key themes from the Staff Engagement Survey 2017

The key themes identified in the survey form clear focus areas for action to optimise how our people experience their everyday work. However, the survey alone gave a broad but surface level view of what is important to our people. The next stage of the people strategy development involved a more in-depth analysis of each of these eight focus areas.

4.4 Work as experienced and Work as imagined - Co-design workshops

The second stage of our people strategy development consisted of co-design workshops, which were held In October/November 2017 on all DHB sites. Nearly 200 staff, in 20 workshops, explored each theme in small groups, against a set of open questions e.g. *"what is important for you…."*, *"do you have any ideas for how we create a culture of high performance?"*, *"how can we make working here smart and simple?"* and "*what does a healthy workplace look like for you?"*

Thematic analysis[4] of workshop data developed frameworks that helped build a picture of '*Work as experienced*' and '*Work as imagined',* from the reality of everyday work in our organisation to the possibility of making every day a great day to work here.

Table 1: How staff would like to experience working here

Survey theme	How staff would like to experience working here:	Key elements
Meaningful Communication We understand, share and create together	Seamless, reciprocal communication from board to ward.	Authentic Timely Mobile Tools are fit for purpose Reciprocal
Future Thinking We look to the horizon in everything we do	Strategies are proactive, build resilience and account for fundamental human needs.	Proactive planning Resilience and agility Equity Building blocks of holistic care for staff
Healthy Workplace We care for each other to ensure a safe and supportive workplace	The health and wellbeing of every employee matters. Our organisation rewards people who speak up and treat others well.	Health promotion Psychological safety Effective partnerships Work-life balance

[4] **Thematic analysis** is one of the most common forms of **analysis** in qualitative research. It emphasizes pinpointing, examining, and recording patterns (or "themes") within data.

High Performance We are able and motivated to do our best	Individuals and teams are trusted to deliver safe patient care and excellence and innovation is recognised and rewarded.	Altruism Collaboration and trust Balance Recognition Incentives
Inspirational Leaders We inspire and enable our people to do their best work	Leaders are trusting, respectful and empathetic. They value every contribution and plan for the future.	Visible Authentic Strategic Humanitarian
Continuous Learning Every day we learn, reflect and review	Personal development is encouraged and supported. Encouraging continuous learning and innovation ensures individual, team and organisational goals are delivered.	Self-managed Diverse Accessible
Smart and Simple Ways of Working We make it easy to do great work here	The work environment enables staff to excel in the role they were employed for.	Distribute decision making Declutter Integrated, reliable IT Future proof

As can be seen in Table 1 above, staff identified a set of key elements which represent how they would like to experience working here. Importantly, these elements bring together some very practical system and process aspects, with a values base or intentional way of applying those systems and processes in the everyday context.

4.4.1 Workshop participant cohorts

Some of the co-design workshops were organised to include specific staff cohorts, to explore the possibility that unique perspectives exist for these different groups. Cohorts included staff new to the organisation (started within 6 months of the invitation), staff in transition within the organisation within the last 12 months (e.g. change of role, restructure, parental/study leave/sabbatical), and long serving staff (20 years +). We also analysed staff groups by their geographical base. Although themes were similar across all groups there were some key differences, which are summarised in the following table:

Table 2: Key issues for each staff cohort

Staff Cohort	Key issues	Elements
Staff new to the organisation	The local team welcomed me, but it took ages to work out how I could access the tools to do my job. There are different expectations regarding the role I was employed for and what I am allowed to do/what is custom and practice.	Hierarchical nature of organisation IT systems are complex and don't talk to each other On boarding was not consistently experienced by different staff members Did not have access to tools to do my job People do an awful lot with little There are some great people working here
Staff in transition	I moved roles because I like the organisation but I wasn't happy in the team/with the leadership I had. I am much happier where I am now.	Variability of leadership, development opportunities, teams
Long serving staff	Some fantastic people work here but we are too siloed. There is an unacceptable level of unwarranted behaviour. We are fatigued by demand, constant change and the message about our fiscal climate. There is no opportunity to recover. The structure of the organisation prohibits innovation and makes us feel disempowered.	Poor collaboration outside of local teams Bureaucratic systems and processes Lack of autonomy Change processes Workload Speaking up
Staff based off the main Wellington hospital site	We don't feel we are an equal part of CCDHB and we get forgotten.	Communication Being inclusive

4.5 Work as imagined – Expert panels

In stage 3, the frameworks were augmented by discussions with expert panels. Eight panels occurred and these were designed to bring together strategic thinkers, subject matter experts, pragmatists (the people who would be charged with delivering future actions to develop from the strategy) and lived experts (people who are seen as exemplars of best practice in the organisation). Each panel considered one of the eight themes of the people strategy.

The panels were to some extent an experiment, to address two common challenges for organisation wide strategies. The first being a lack of connectedness between strategy and implementation and the second being the impact of silo conversations – where frequently a team or service discusses within its own and known group and can miss the opportunity to learn from excellence across the organisation.

In addition to reviewing the 'work as experienced' and 'work as imagined' feedback from the staff workshops, our panels discussed the principles of the Health System Plan and reflected on current practice at CCDHB and around the world. The panel discussions enabled us to understand what managers and subject matter experts believe should and could happen now and and in the future defined as '*work as imagined'*.

Similarities and differences between how work is imagined and how staff experience everyday work were synthesised to explore areas of focus for each theme in detail. The following sections bring together the expert panel discussions for each of the eight areas of focus.

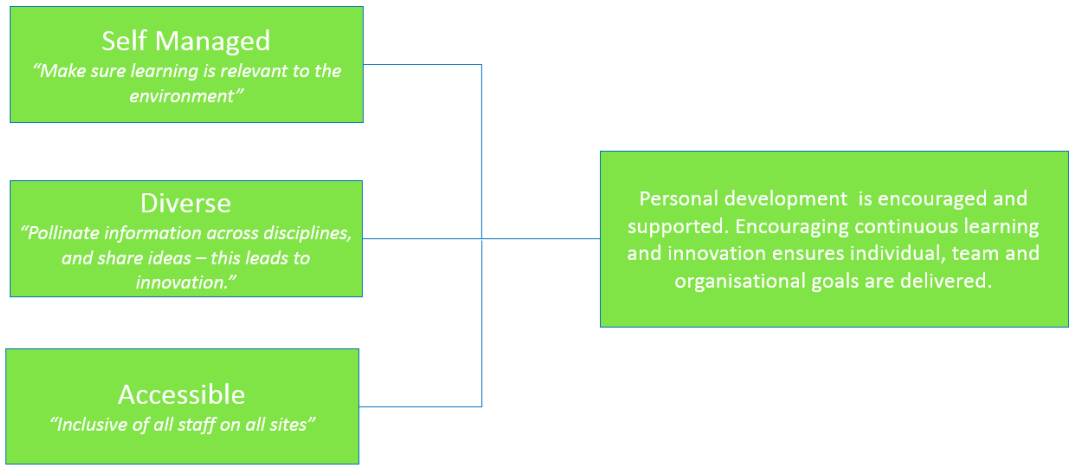
4.5.1 Continuous Learning

Continuous Learning

Every day we learn, reflect and review

Work as Experienced

Staff indicated that work as experienced does not always support continuous learning. Common perceived barriers include access inequity, complex hierarchical upstream processes, a lack of autonomy to be innovative and poor support for learning in day to day work.



Self-managed learning incorporates autonomy for the individual to choose their development priorities within a career development framework. Clinical staff indicated they wanted local involvement in the decision making process for prioritising quality and service improvement work, as they view this as a learning opportunity. Staff suggested these opportunities and other incentives, are important alongside a culture that supports research and innovation. The preferred learning model was described as one of mentorship or coaching alongside more formal teaching where skills are shared willingly.

Staff described a range of technical and non-technical skills that make up **diverse learning.** They indicated that an inter-professional learning environment is important but does not currently exist in most areas. Learning tailored to individuals and teams was viewed as essential, as was providing or capitalising on external opportunities for skill development, rather than relying on in-house training.

Accessible learning across sites and all staff groups was viewed as essential, particularly for those in non-clinical roles. Staff felt that the organisation has a responsibility to ensure that they have access to training. Examples of how this could be achieved included incorporating mandatory training days into roster models and allocating funding for external courses.

Work as Imagined

The expert panel identified the following priorities for continuous learning in the context of the healthcare strategy and staff feedback:

- A shared understanding of what a learning organisation looks like is required. Rather than a focus on training delivery this should include (1) commitment to innovation and critical thinking in clinical practice (2) focus on opportunities to learn in day to day work e.g. meetings, projects and (3) provision of communication and technology tools to facilitate learning opportunities.

- A learning strategy must be cohesive with a workforce planning strategy. The learning strategy can consequently mitigate emerging risks such as increased roles for unregulated staff, low levels of Māori and Pacifika staff and optimise interdisciplinary cohesion.

- A learning strategy should include the perspective of service users and their family/whānau. It can usefully identify how our community learns about changes in the healthcare system and what this means for them and therefore what capability our staff need to have to deliver care effectively in this context.

- Responsibility for aspects of learning need definition that is shared between health education providers, healthcare institutions and entities, CCHDB, professionals and individuals. This will provide clarity, increase the likelihood of work-ready graduates and identify opportunities for cooperation, synergies and efficiencies.

- A CCDHB continuous learning strategy must take a healthcare system approach as opposed to a hospital focus. Learning opportunities should identify potential for cross pollination e.g. staff rotation programmes, inter-professional learning opportunities.

- We need to understand if current systems and processes are appropriate and meet organisational and staff need. It is likely that any strategy will require investment in technology and people.

Where to from here?

Expert panels and staff groups generally agreed how the organisation should approach continous learning. Perceived barriers to a learning culture were identified as complex funding and decision making processes, siloed thinking in departments or professional groups, and a lack of organisational commitment to the principles of the Treaty of Waitangi.

Our people suggest that a strategy for continuous learning should include:

- Core principles - fostering a culture of critical thinking, inter-professional learning and collaboration, coaching and mentorship, research and innovation and individual choice.

- Developmental frameworks for all occupational groups that account for workforce planning, national strategy, known risks and individual career aspirations. The frameworks must be self-directed and meet organisational and individual needs. Frameworks should account for long term aspirational goals and be shared with educational providers.

- Employment opportunities that include rotating posts across the healthcare system to create workforce flexibility and improve staff retention. An adjustment to how FTE is utilised and funded across the organisation/health sector would be required.

- Prioritising and supporting learning in everyday work. This requires a change in how learning opportunities are perceived and operationalised by our managers and the creation of mechanisms that support easy and equitable access.

- Organisational decision making process that allows all staff to easily submit proposals for development/quality assurance/research and innovation to a central point. The aim of this process would be to identify opportunities for inter-professional/departmental collaboration and maximise effective use of resources. To achieve this a change in structure/funding would be required. This approach would maximise organisational learning opportunities presented e.g. by our partnership with the Cognitive Institute.

- Learning is supported by our technology, our systems and our structure. Current authorisation processes are simplified and there are key transparent accountabilities. Systems are paperless and all mediums (external and internal) are accessible.

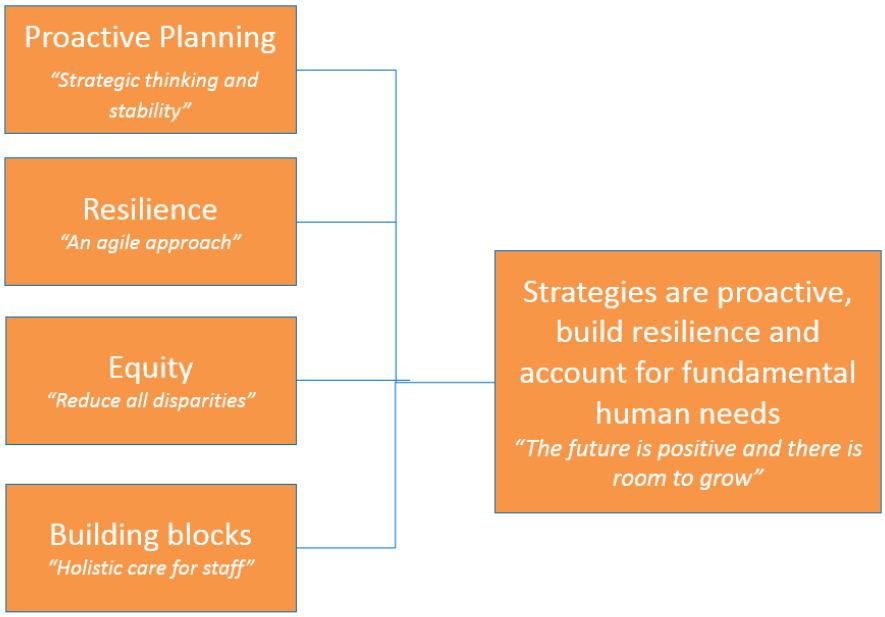
4.5.2 Future Thinking

Future Thinking

We look to the horizon in everything we do

Work as Experienced

Staff indicated that work as experienced does not always support future thinking. Common perceived barriers include a lack of strategic thinking or consistency in pursuit of goals and a lack of recognition of the core building blocks needed to future proof the workforce.



Our people said that future thinking requires **proactive planning** and system co-design. Staff suggested a proactive approach was more likely to develop **resilience** and sustainability. Recognition of increasing complexity in the health system and the community was viewed as extremely important. They indicated that **innovation** was required for future success, especially in workforce planning and service delivery as healthcare requirements, delivery and technology increase in complexity.

Our people proposed that achieving **equity** is essential, especially living the Treaty. Increasing the capability of all staff to meet the needs of our community is an important aspect, alongside increasing the proportion of Māori staff to reflect the community. Staff suggested areas of focus within our organisation include eradicating racism, sexism and silos. They noted the impact of unconscious bias in hiring and development decisions, which impacts on staff of different ethnicities. More broadly they suggested promoting equity by accounting for the social determinants of health in our community, for both patients and staff. B**uilding blocks** that staff viewed as essential to future proof the workforce included facilitating work life balance and ensuring staff have the skills and tools to do the job.

Work as Imagined

The expert panel identified the following priorities in the context of the healthcare strategy and staff feedback:

- Ensuring that everyone can see their role and contribution to the big picture of the Health System Plan. It is important to have a clear vision to get behind. Workers need to be able to identify how they add value and have mechanisms to build service, team and individual level plans that contribute to that big picture. Honest communication about positive and negative aspects is important in building acceptance of plans for future change/development.

- Connections are an essential focus – how we interact with each other across the system.

- Communication about the future and future strategy needs to be targeted for different roles and service areas. Blanket statements about 'the future of healthcare' or focus on one element can disengage sections of the workforce (e.g. focus on community integration can lead hospital based staff feeling disconnected from the strategic priorities, focus on automation can raise anxiety for different workforces). Clear communication which connects to the strategic priorities is really important. Utilising personal stories – to engage people emotionally in the rationale for change - can be powerful motivators.

- The processes for planning and strategy development are components of future thinking. Taking time to identify priorities, plan and deploy resources, as part of ensuring future thinking, has usefulness.

- Change is an ongoing process into the future and how language for change is used is very important. Working with people for change, rather than change being done to people has higher likelihood of successful outcomes.

- Need to equip managers to support people to be the best they can be and help them have a sense of forward momentum and direction. Strengthen managers and leaders to support development, to view a staff member growing and moving on and up as a success, rather than as a failure to retain the staff member.

- Healthcare is a complex business, so reasoning and decision making systems need to be fit for this context. Complicated systems and structures often overwhelm decision making and stifle future focussed initiatives. Agility is an important component for future thinking. Being able to prioritise quickly and respond to changing drivers, deciding where and when to innovate, with systems to allow upfront investment and support for change and development. Being a big organisation should aid the ability to flex and be agile.

- Leaders need to have courage to make choices, prioritise and be able to explain why some activities will not be taken up. Collective ownership of decisions is essential, with visible leadership across silos to give confidence to staff and reinforce the concept of system based thinking and decision making.

- Pragmatic responses to challenges such as the ageing workforce are needed. Taking a life course approach to our staff to enable a longer career with us. Recognise that our workforce are also our service users – how do the social determinants of health impact on productivity and engagement for our workforce?

- Utilisation of data and predictive modelling to identify the workforce skill mix needed so that development of the workforce can be underway for future state, is also an important component of future thinking. People management planning is needed in parallel to asset planning.

- Need to market CCDHB as a destination workplace is essential in light of increasing shortages of skilled health workforces both nationally and internationally.

Where to from here?

Expert panels and staff groups generally agreed how the organisation can ensure we are always future thinking.

Our people suggest that a strategy for future thinking should include:

- Being strategic, with a clearly communicated and shared vision.

- An expectation of continuous change, with proactive and agile systems to support and encourage innovation.

- Recognition of our people as our greatest asset, requiring a life course approach to optimising their ability to contribute to achieving our strategic aims.

- Utilisation of data and predictive modelling.

- Leaders and managers who are constantly looking for opportunities for growth and development, change and innovation.

- Systems that allow decision-making, trial and error and empowerment of individuals and teams.

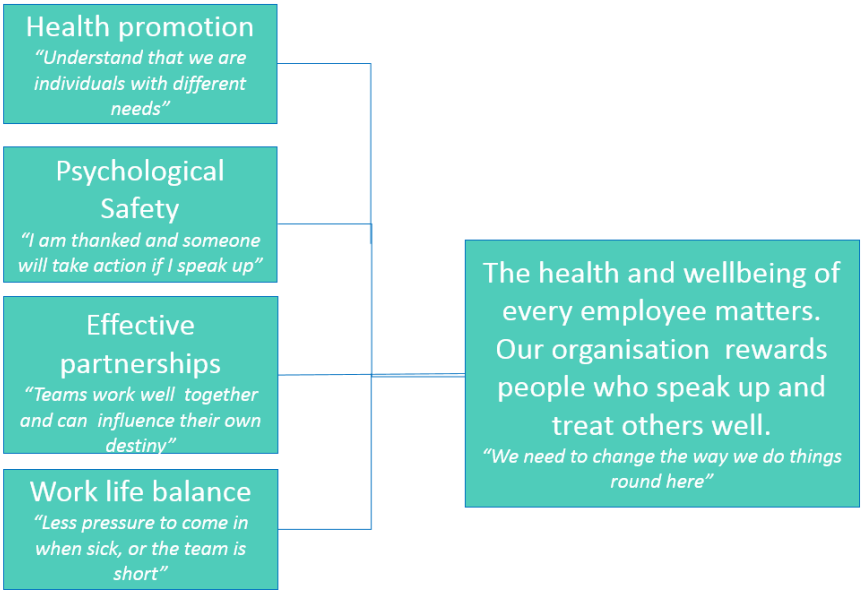
4.5.3 Healthy Workplace

Healthy Workplace

We care for each other to ensure a safe and supportive workplace

Work as Experienced

Staff indicated that work as experienced does not always support a healthy workplace. Common perceived barriers include; bullying and unacceptable behaviours that are known and not addressed, a lack of trust in organisational processes regarding these behaviours, negative consequences when people speak up, sub-optimal staffing levels and a focus on money over people.



Our people suggested a wellness approach should focus on **health promotion**. Staff indicated they would like individual needs such as flexible working, ergonomic assessment and subsidised programmes considered in a holistic framework. A zero tolerance to bullying and unacceptable behaviour was viewed as essential for **psychological safety**. Staff indicated a safe process to raise concerns was required. The preferred model was described as transparent, consistent and proactive, with staff thanked for speaking up, across all areas of the organisation.

Staff described **effective partnerships** as respectful, equal and supportive, with clearly defined roles**.** An environment that supports inter-professional collaboration with internal and external partners, including the unions, patients and other units was highly regarded. Staff indicated that effective partnerships are not routinely developed in day to day work in our organisation.

A work life balance was described as essential across all sites and staff groups. Our people noted that the organisation has a responsibility to acknowledge the stress and burnout prevalent here. Prevention strategies suggested by staff included being able to take annual leave or meal/tea breaks, workload that is doable within contracted hours and safe staffing levels. Staff indicated these

strategies would ensure the organisation retains talent and would build resilience by allowing time for individual and team recovery.

Work as Imagined

The expert panel identified the following priorities in the context of the healthcare strategy and staff feedback:

- Approximately 15% of SMO burnout is patient related, the remainder is associated with perceived or actual organisational conditions. Organisations that invest only in personal resilience are unlikely to be successful as they create individual resilience to a toxic workplace, so a multi-faceted approach is required.

- The evidence suggests that a culture of wellness and support is underpinned by commitment to organisational values that promote workplace civility and kindness. Other DHBs are developing this approach e.g. Hutt Valley DHB.

- An overarching strategy for wellness is important alongside locally based solutions. Situational context must be considered to promote health in everyday work. Roles and settings vary, as will the needs of teams. We need to keep our people connected when they are spread out across the system and ensure strategies are effective for people in different work contexts of healthcare delivery (e.g. how we support lone workers and staff in the communities to stay safe – police have radio and working phones yet our community staff do not all have cell phones).

- People's health is related to our leadership, specifically how willing/able managers are to address difficult issues e.g. team work, dynamics, relationships, unacceptable behaviours and culture. We need to focus on recruiting and retaining leaders with these skills and to develop those skills in our current leaders.

- Promote networking. For example in the NHS an organisational development expert facilitates inter-professional groups across organisational structures. People feel safe to express their views about what is/isn't working and develop action points for the executive leadership team.

- Our staff referral rate to the Employee Assistance Programme for bullying and anxiety is high in the national context. How managers respond to and support staff experiencing stress or allegations of bullying and bad behaviour is inconsistent and staff do not trust the process. Managers should support and role model value driven expectations of behaviour and remove roadblocks for this.

- The CEO and board will need to support a culture of wellness and appreciation. This will require a shift in focus from fiscal responsibilities and targets to people.

- There are too many control measures in place preventing innovation to create more efficient and effective ways of doing things. Our people work within a context of fiscal deficit and resultant layers of bureaucracy whenever resource is required for innovation. Simple issues are now perceived by managers to require a battle, creating burnout and reducing their ability to be innovative.

- Many of our senior staff work significantly over their contracted hours. This is not demonstrating that the organisation values looking after our staff and their families. Stress at work impacts on the family/whānau of our staff and ultimately impacts the health of our community.

Where to from here?

Experts and staff groups generally agreed how the organisation should approach creating a healthy workplace. Managing workload, burnout and unacceptable behaviour were identified as key priorities. Perceived barriers to a healthy workforce included control processes, lack of capacity and skill to deal with unacceptable behaviours, stress and burnout from high workloads and lack of high level support for innovation.

Our people suggest that a strategy for a healthy workplace should include:

- A definition of a healthy workplace that is shared and supported by all our people including the executive and our Board. Support is likely to require financial investment as staff in many areas of our organisation suggested they are currently unable to take breaks, leave and often work long hours.

- Agreement of the core values that underpin our day to day work and interactions.

- A suite of measures to manage internal and external stressors, bringing together aspects of personal resilience, organisational practice and a culture of wellness e.g. self-care workshops, a healthcare workers 'warrant of fitness', job sizing, care capacity and demand management, speaking up for safety.

- An overarching framework for health care provision that is flexible and applicable at community, organisation, team and individual level. This will ensure that a consistent strategy is applied which accounts for situational context.

- Co-design of processes relating to psychological safety between front line staff, internal experts, patients and unions. Co-design aims to nurture trust and tailored interventions that account for the situational context.

- Organisational systems and processes for assessing and responding to stressors that are perceived to be related to job size, workload or situational context.

- Recruitment strategies that attract people whose behaviours align with our core values. Development of skills in dealing with difficult people and situations and in having courageous conversations with existing staff, especially for leaders and managers.

4.5.4 High Performance

Work as Experienced

Staff indicated that work as experienced does not always support high performance. Common perceived barriers include feeling overworked and under pressure, hierarchical and opaque decision making processes, a blame culture, insufficient resources and limited coaching, positive feedback and/or development opportunities.

Our people indicated through the engagement survey that for many **altruism**, having a purpose and meaning to the work they do for our community, is the most important thing about working for CCDHB. Reflecting this in the way our organisation employs our people was a clear theme in the workshop discussions. Engaging our teams in **collaborative** endeavour, with **high trust** was seen as an essential ingredient to achieve high performance.

Many described the importance of **balance** throughout the work day to their ability to deliver high quality work, noting that a 'fair' workload, with sufficient resources to be able to do their work efficiently and to take breaks, enables the energy and mental space to put in the extra mile.

The role of **recognition** as a motivational factor for high performance was highlighted by many. At a local level, being thanked and given positive feedback is highly valued, along with recognition and showcasing of great practice and achievements. Encouragement to innovate, with practical support to remove constraints, and celebration of success were also identified as key ingredients.

While **incentives** such as pay and advancement were part of the discussion, many staff indicated that fun and supportive peer and leader relationships also incentivise them to do their best. Some very basic elements such as access to 'decent' tea and coffee, breaks, stationery, technology and equipment can be powerful in supporting high motivation or conversely demotivating when unavailable.

Work as Imagined

The expert panel identified the following priorities in the context of the healthcare strategy and staff feedback:

- Clear communication of the Health System plan to the organisation, helping staff to connect to their role in achieving the plan and inspiring them to see their role in its success.
- Utilise the sub-regional and regional context to leverage gains in performance.
- A strengths based approach to development.
- Currently communication in team meetings tends to be issue focussed, need to share stories of success to inspire and motivate for high performance, plus to recognise high performing teams.
- How we define the term 'team' can enable or obstruct high performance in the broader system. What does it mean in a more system focussed service delivery model?
- Focus on relationships and connectedness. Currently funding and resourcing is very siloed, encouraging competitive rather than cooperative inter-team dynamics.
- Need to create the information systems and processes to support seamless care provision.
- Develop a culture of innovation – rapid cycle – try, fail, learn, move on. Agile and experimental, prepared to take calculated risks. However this needs to occur conjointly with activity/investment for large scale transformational change.
- Customer focus/patient focus. Patient centred is frequently articulated, but what does 'customer focus' mean – e.g. for corporate services.
- Prioritise allocation of high skill/ability to high performance activities. We try to do too much and are spread too thin, so don't complete or aren't robust in change/innovation.
- Invest in mechanisms to support high performance – e.g. coaching, development frameworks.
- Evaluation is often missing – reflecting and recognising when something is not right and fixing/amending/re-directing.
- Need to empower teams and individuals to innovate. Have clear but non-restrictive boundaries, give autonomy and time to innovate.
- Staff need to feel engaged and that they have a sense of ownership, before they will feel motivated to go the extra step to high performance.

The panel also discussed activities already commenced (or in place) to build high performance – leadership development frameworks, the Improvement Movement, Qlik project for better data/information, Service Reviews, and introduction of ICT relationship managers – all intended to connect across the organisation and identify opportunities for innovation.

The panel reflected that we are not very good at telling our positive stories and celebrating success and high performance. A challenge is how to make improvements and achievements visible – acknowledgement, shared learning, leverage, cross pollination. This needs a sustained effort to create visibility and provide a reference point for future initiatives.

Where to from here?

Expert panels and staff groups generally agreed how the organisation can achieve high performance:

- High trust, high accountability approach.
- Recognise, publicise and learn from excellence.
- Empower and support teams and individuals to innovate.
- Build relationships and networks for shared responsibility and collaborative opportunities.

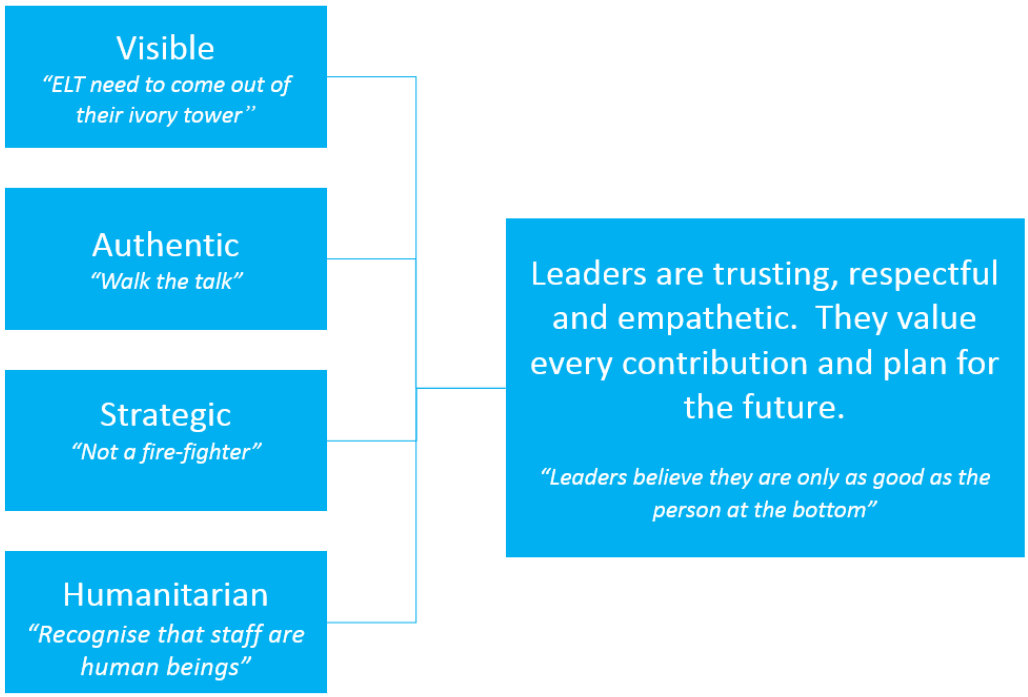
4.5.5 Inspirational Leaders

Inspirational Leaders

We inspire and enable our people to do their best work

Work as Experienced

Staff indicated that work as experienced does not always include inspirational leadership. Common perceived barriers include micromanagement, favouritism, hidden agendas and personal ambition. Also noted were the challenges for managers and leaders caused by lack of time to lead effectively, which can result in limited communication, lack of follow through on promised actions and lack of focus on team/individual development.



Visible leadership incorporated the concept of being approachable and actively involved with staff, particularly in challenging times. Inspirational leaders were seen as valuing staff, both in terms of listening to them and by acknowledging their hard effort and commitment.

Staff highlighted the importance of a leader being **authentic**. Honesty and fairness were identified as key attributes. Being credible in terms of the area of work was seen as important, but also by walking the talk in terms of consistency of words and actions. Having a belief that staff are valuable and that staff development is a priority was also seen as essential. Connected to this is the idea that credit is distributed and that opportunities are offered equitably across the team.

Balancing the ability to muck in with the team with providing a **strategic perspective** – one that has a vision and clear direction - is important for the inspirational leader. Our staff talked about the

importance of a leader who reflects on mistakes, is open to new ideas and approaches and is proactive in creating and providing opportunities for growth.

Finally, and certainly importantly for staff, is that the leader is able to relate to their people in a very **human** way. This includes two components; the leader's ability to view others with respect, integrity and a level of humility, but also their ability to be a whole person who is passionate, courageous, vulnerable, and fun.

Work as Imagined

The expert panel identified the following priorities in the context of the healthcare strategy and staff feedback:

- A values base for leaders was identified as critical. Inspirational leaders have values congruent with the values of the organisation and are in leadership for the right reasons. They are able to reflect on their biases and work actively to encourage diversity and equity in everything they do.

- The group noted that there is no single evidence based model or framework for leadership. While some frameworks such as the State Service Commission Leadership Success Profile framework can be helpful, leadership is not a unitary construct. Leadership development therefore is not a course, it is an ongoing process which combines the personal attributes and experiences of the leader with the context in which they are leading.

- The concepts of being authentic and of being a reflective leader come through as common themes in current thinking on leadership. This points us to activities such as mentoring and coaching as supportive of leadership development.

- Strategic priorities point to the need for leaders to understand the broader health continuum and have line of sight across the sector. This needs to be paired with the ability to be proactively creating partnerships across professions, in the health, social and community settings.

- Leaders also need to be able to articulate "the grand plan" with a clear vision for the future, combined with the practical ability to adapt and lead change. This overlies attributes of curiosity and openness, courage and a desire for continuous learning and development.

- On a practical level, leaders need to be able to manage resources effectively, including human, financial and system resources. This will include a variety of aspects according to business need in the area and a constant desire to reduce inefficiencies and bureaucracies.

- Rigorous recruitment of leaders with the right attributes and values was identified as a core activity to ensure inspiring leadership. This involves comprehensive induction to leadership roles, which includes the aspects identified above.

- Applying a 'growing our own' philosophy to create opportunities for people to try out leadership roles. This highlights the need to equip current leaders with strategies for how to develop/mentor the next tier of leaders and the need to nurture and support our leaders to continue to develop.

- The ability to assist people to exit from a leadership role, where the fit is not successful and subsequently performance is poor, was discussed by the group as essential in ensuring inspirational leadership at CCDHB.

Where to from here?

Expert panels and staff groups generally agreed how the organisation should develop inspirational leadership.

Our people suggest that a strategy for inspirational leadership should include:

- Be clear about what we value in leaders (e.g. authenticity, vision, approachability, capability, humanity) and recruit and support those attributes.

- Ensure leaders are supported to develop necessary skills and expertise for their role.

- Provide context to enable leaders to be aware of the wider health system aims and their role in the bigger picture.

- Create opportunities for growth and development, through mentorship and coaching and in so doing grow our own next generation leaders.

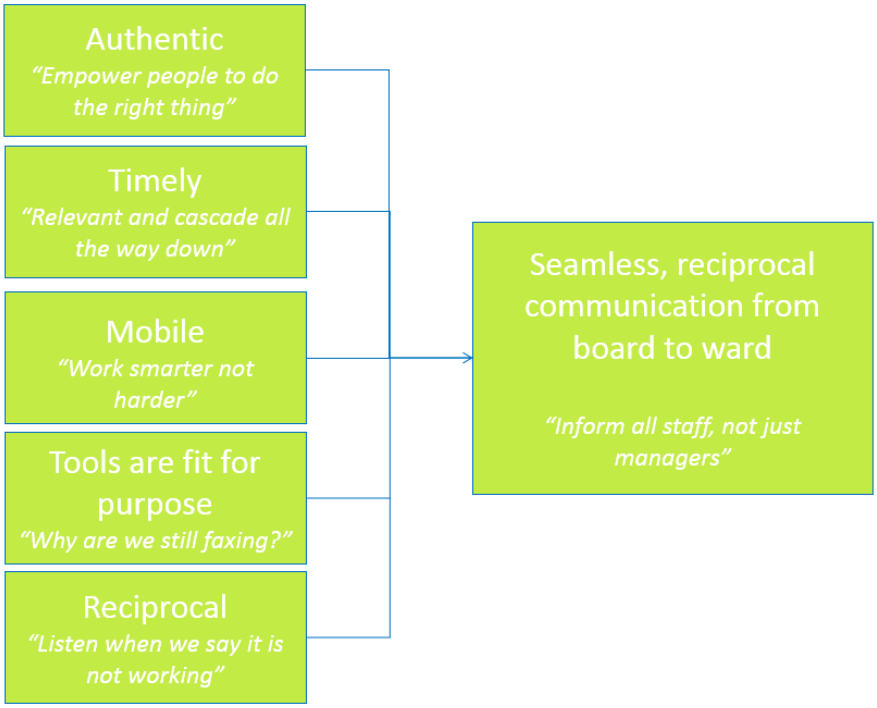
- Create time and space for leaders to be successful.

- Manage poor performance effectively.

4.5.6 Meaningful Communication

Work as Experienced

Staff indicated that work as experienced does not always support meaningful communication. Perceived barriers commonly cited were non-transparent hierarchical control structures, lack of reciprocity, reactive and/or judgemental response, and bad behaviour.



Our people said that meaningful communication thrives when staff are thanked for speaking up. Staff indicated that **reciprocal** communication, underpinned by respectful, restorative and kind behaviours between inter-professional groups is essential. Common examples of **tools fit for purpose** included technology that supports reciprocal communication and skill development for managers to have difficult conversations and address unacceptable behaviour.

Meaningful communication was described as **authentic,** especially in hierarchical relationships. Collaboration, honesty, confidentiality, trust and transparency characterised authenticity. Staff supported timely **communication**, which was depicted as proactive, regular, and meaningful. Our people noted communication should outline milestones, allowing time for considering options and responding to requests for input.

Mobile communication was viewed as essential for CCDHB to be a modern healthcare organisation. Staff suggested mobile communication requires several different mediums. Two way conversation regardless of role, location or time of day was an overwhelming staff priority. Common examples included DHB apps/social media and increasing face to face communication between managers and

teams. Staff indicated that mobile and visible leadership increased their confidence that they were being heard.

Work as Imagined

The expert panel identified the following priorities for meaningful communication in the context of the healthcare strategy and staff feedback:

- A system approach is important for any communication strategy to align with the healthcare strategy and ensure information flows across the DHB community.

- Modernisation of IT systems/devices is required to support mobile communication. This will require investment and executive support. Modernisation of the intranet including updating the contact directory is planned and could replicate effective DHB models e.g. Hutt Valley DHB contact directory.

- In the current cascade model, messages are filtered and inconsistent in both directions, eroding trust and opportunities for collaboration and efficiency. Strategies that focus on increasing reciprocal communication through multiple media are important. Social media platforms are used by other DHBs effectively and have supporting systems. Standardised toolkits and team briefing models may also improve consistency.

- A core message from staff is a lack of visibility for senior leaders. The link between staff safety and leadership is supported by international literature. Senior staff need to commit to walk rounds on all sites and role-model meaningful communication.

- Communication should be consistent and link the message to our goals and values. We need to maximise our touch points for communication face to face e.g. bed meetings, clinical champions, leaders visiting team meetings.

- Communication between all members of our organisation must be underpinned by a culture of kindness and respect. Expectations around how our people communicate and relate to each other should be embedded in job descriptions, core training and competency frameworks for all staff.

- Organisational investment should focus on programmes that create insight into individual communication skills and behaviour in order to produce the required change. Communication training should incorporate a customer service focus, be relevant to teams' situational context, understand the technological barriers and skills to overcome them and have follow up in the workplace e.g. supervision, problem dumping sessions, simulation.

Where to from here?

Expert panels and staff groups generally agreed as to how the organisation should approach meaningful communication.

Our people suggest that a strategy for meaningful communication should include:

- Investment in technology, systems and processes that support mobility, for example enabling staff to use their own devices. Communication strategy should expand beyond email and the intranet to encompass modern platforms such as social media and DHB mobile APPs.

- Systems that promote more interactive functionality from ward to Board so that strategy can be built on and responsive to insight. Staff should be thanked for speaking up about unacceptable behaviour or poor communication.

- Language should reflect the needs of our population, and communication should be provided in Te Reo Māori and English. Te Reo should be visible in communication.

- Best practice principles for communication embedded in the way we communicate with all stakeholders. Principles should include communication that is reciprocal, timely, honest, inclusive and authentic. Communication to keep staff informed and engaged, feeling valued, involved and clear about how their work experience connects with broader health strategy and vice versa.

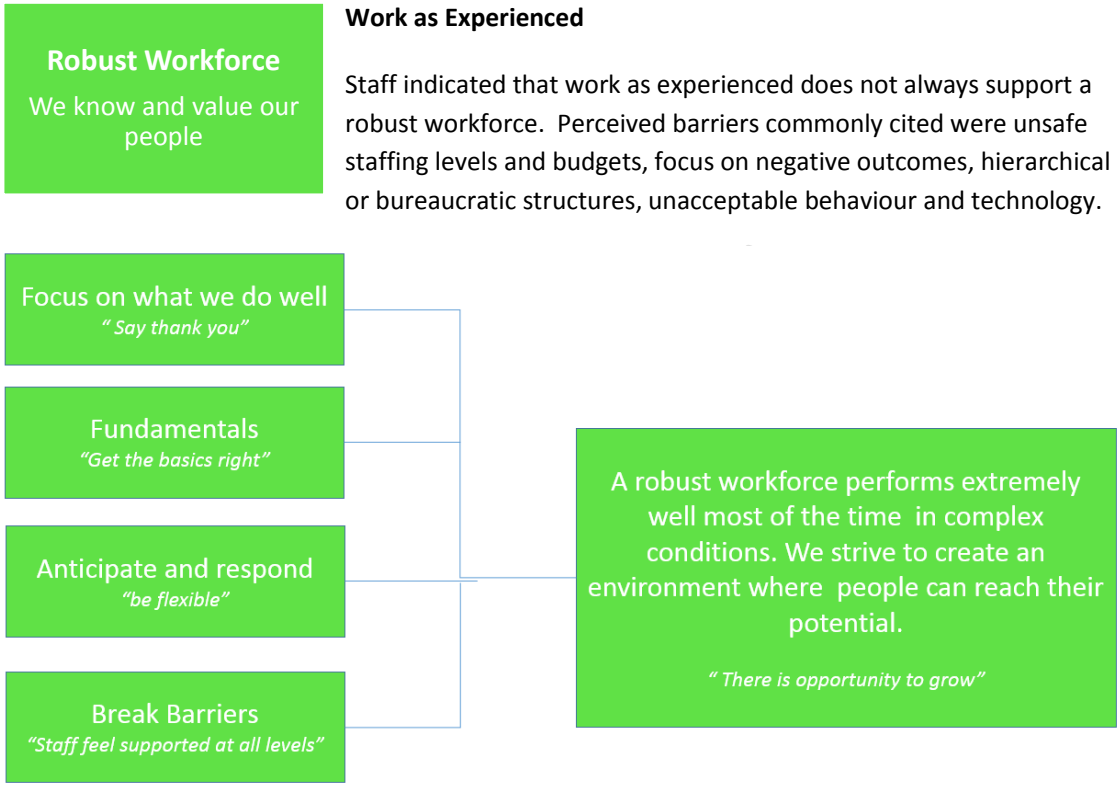
- An approach consistent with the DHB's espoused values and expected behaviours. The approach should be linked to strategic priorities and/or the priorities of our people. This will require a commitment for visible leadership that role models best practice and investment in training that supports all our staff to develop the required skills.

- Explicit responsibilities and accountabilities for internal groups and individuals. Toolkits should be provided so managers are supported and accountable for consistent messages in communications, meetings and one to ones.

- Strategies to build thought leadership by understanding our broader networks. A number of senior and clinical staff are involved in national forums and this internal expertise is currently invisible and under-utilised.

- Agreed measures of success. For example increase in the percentage of staff agreeing that communication between senior staff and management is effective in the engagement survey.

4.5.7 Robust Workforce



Work as Experienced

Staff indicated that work as experienced does not always support a robust workforce. Perceived barriers commonly cited were unsafe staffing levels and budgets, focus on negative outcomes, hierarchical or bureaucratic structures, unacceptable behaviour and technology.

Our people said that the **fundamental** building blocks for a robust workforce are adequate numbers of skilled staff and the tools to do the job for which they were employed. Flexibility was viewed as an important characteristic. Staff suggested realistic budget setting should include a buffer to **anticipate and respond** to the unexpected. In their view a long-term approach to workforce development was required incorporating; succession planning, training and development and innovative workforce models.

Staff indicated that **breaking barriers** to collegial relationships was essential. The ideal workforce was described as respectful with a minimal hierarchy and with time built in for inter-professional collaboration. Management of unacceptable behaviour and team mentorship were viewed as important roles of executive leaders and managers. Our people noted that celebrating success, voicing appreciation and promoting self-management are important to retain effective staff. They suggested a **focus on what we do well** would be more likely to generate trust than approaches that focus on negative outcomes. Siloed hierarchies and bureaucratic systems are also identified as barriers to trusting relationships**.**

Work as Imagined

The expert panel identified the following priorities for a robust workforce, in the context of the healthcare strategy and staff feedback:

- Clarity regarding the core skills and knowledge required for all members of our workforce. Clear frameworks are lacking for non-clinical roles with some notable exceptions e.g. orderlies. Frameworks are currently too hospital focussed.

- Organisational skills training is too generic for specialist staff. Conversely, opportunities to capitalise on skills/training provided by local specialists are under-utilised. This leads to both repetition and to essential skills gaps.

- Future proofing requires workforce planning that supports system integration and will need to reflect/consider diversity, growing needs in the community, involvement of inter-professional groups at the planning stage (i.e. NGOs, hospital/community), challenging traditional leadership models and workforce planning in parallel with models of care revision.

- Local services need to be given permission to be proactive, innovative AND link workforce planning to funding streams. However senior leadership will need to support the local initiatives for long term change and innovation to prevent misalignment of systems and people. For example, high level support is required to create rotational posts where hospital staff can work in different environments across the sector or a specialism e.g. funding a two-year acute nursing programme or a community/hospital rotation for Allied health staff. However, local services need to drive the programmes, as the impact and management occur at the local level.

- Organisational investment should focus on programmes that produce the required change. Robust workforce planning should promote equity, a customer service focus, be relevant to a team's situational context, understand technological barriers and support the skills to overcome them, and have follow up in the workplace e.g. performance management, promoting the right to manage, slicker recruitment processes and integration of staff information in one place.

- The changing profile of our community is a significant challenge. For example approximately 40% of the nursing workforce will reach retirement age in the next 10 years, and the ethnic profile is diversifying. We do not have a workforce plan that takes the ageing workforce into account or reflects our Māori and Pacific population, and we are increasingly recruiting from overseas rather than growing our own e.g. over-recruiting NETP nurses would support more positive long-term outcomes.

Where to from here?

Expert panels and staff groups generally agreed on how the organisation can achieve a robust workforce. Front line staff focussed on the importance of having the right number of staff with the skills and tools to support positive outcomes. They indicated that relationships and effective leadership behaviours and structures were also important. Our experts discussed the importance of innovation and long-term planning, indicating that achieving a robust workforce would support

systemic change and reflect community diversity. Both groups agreed that current systems and structures are fragmented, making robust workforce planning challenging.

Our people suggest that a strategy for a robust workforce should include:

- Develop a sophisticated understanding and approach to workforce, with robust and real time analytics and strategic planning for future workforce needs aligned to the Health System Plan. This would result in a workforce plan.

- Understand our workforce market context and the value proposition which makes CCDHB an attractive destination for our health workforces.

- Prioritise strategy that encompasses the whole healthcare system and provides opportunities to grow our workforce over the next ten years, to deliver healthcare across community and hospital settings. Maximise support from education providers alongside this strategy, so our pipeline supports inter-professional working.

- High level leadership to challenge traditional models of healthcare delivery and integrate budgets i.e. medicine, nursing and allied health, in-patient and community is required. This will maximise opportunities for effective and efficient workforce planning currently prevented by siloed systems and structures.

- A long-term view, with provision of financial investment to grow our own workforce for 2030 and beyond. This strategy will require leaders to support budget planning beyond annual planning cycles.

- Develop innovative models that create an adaptive healthcare system and anticipate fluctuation. This incorporates models supporting an agile and flexible workforce.

- Consider the social determinants of health in line with the healthcare strategy e.g. inequity, the ageing population, family violence. Consider the ethnic profile of our community and create opportunities to increase the numbers of Māori and Pacific staff in our workforce.

- Recruit and retain staff who align with our core values and who can role model authentic leadership, collaboration, equity focus, self-management and inter-professional working. Provide an organisational structure that supports staff to work within a values framework.

- Broader competency and career development in all occupational groups incorporating opportunities such as core skill development, mentorship in day to day work, apprenticeship models, rotational posts and investment in post graduate education.

- Maximise opportunities for organisational learning and development of workforce planning though effective entry and exit processes including values based recruitment, on-boarding and exit engagement.

- Strategies that ensure our people feel cared for, recognised and appreciated. Create opportunities to celebrate what goes well and learn from excellence.

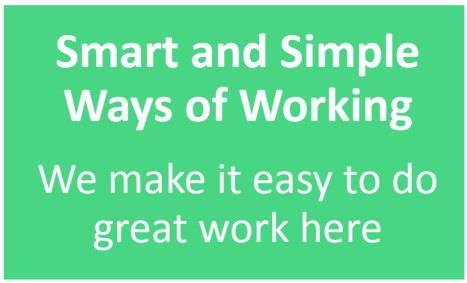
- Attend directly to diversity and inclusion aspects of recruitment and development of our workforce, to ensure increased ability to address inequities in access to services and consequent health outcomes.

- Opportunities for our people to be fulfilled in their roles and across the life span of work.

- Provide an environment in which committed and caring professionals can flourish.

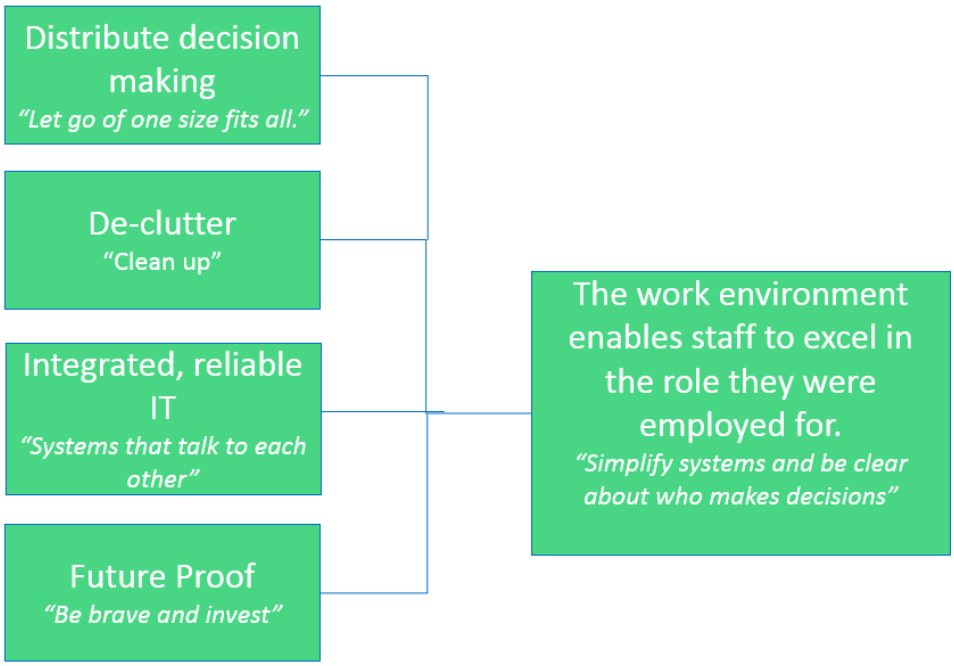
- An underlying remuneration and reward structure which feels fair and appropriate for the professional skills, dedication and complexity implied in the role.

4.5.8 Smart and Simple Ways of Working



Work as Experienced

Staff indicated that work as experienced does not always support smart and simple ways of working. Perceived barriers commonly cited were hierarchical structures, bureaucracy, disempowerment, poor access to information/data and technological barriers.



Our people said that smart and simple working requires **distributive decision making,** where tasks are delegated to competence and job role**.** Staff indicated that a **de-clutter** of the bureaucracy was required. They suggested that an increase in productive, effective work would result from increased autonomy and accountability in the role they had been employed for. Our people suggested a review of hierarchies and bureaucratic systems frequently described as siloed and obstructive. Staff indicated simple decisions are hampered by complex and disempowering structures and important decisions were complicated by disagreements about data authenticity and complex sign off processes. Our people advocated for a common-sense approach to decision making characterised by clear expectations about what is required, with authorisation and timeframes that are the same in each directorate, service and team.

Staff also described smart and simple systems as needing to be **future proofed.** Automation, mobile data and integration across the health system were key investment areas identified. Staff supported **integrated reliable information**, including ICT systems that communicate with each other, provide easily accessible data and reflect a consumer focussed design. Our people noted an effective change process and training was important for new technology to be successfully embedded.

Work as Imagined

The expert panel identified the following priorities in the context of the healthcare strategy and staff feedback:

- Connecting individual teams with the organisational plan is important. There is a lack of understanding of who people are and what their role is, which impedes effective interdisciplinary working. We need to understand what success looks like at every level of the organisation and create timely relevant measures of success.

- Future proofing beyond 2030 requires system integration, connection of regional services (e.g. tele-paeds/telehealth networks) and sharing information/IT across the 3DHB platform. Promoting the use of personal devices, booking systems and self-management of personal information in contact directory and HR systems are also important. To achieve these goals IT investment and strategy across the system will be priority, as will working effectively with other DHBs and policy makers.

- Decluttering is important in IT systems e.g. one event in Square generates four reports, different passwords are required across systems, patient information is held in multiple places e.g. EDIS, Concerto. Additional IT systems we are considering purchasing should interface with current systems e.g. e-prescribing, patient track.

- Choosing wisely in the corporate world is important. Transparent systems for prioritising spending, allocating resources and agreeing systemic changes are needed. Achieving this will require a reduction in the layers of approval, with distributed responsibility/ accountability to local areas within a consistent organisational framework. For example, current ATR process and recruitment are very complex.

- Organisational investment should focus on programmes that produce the required change. Smart and simple systems should promote (1) a customer service focus (2) be relevant to team's situational context (3) understand technological barriers and provide skills to overcome them (4) follow up in the workplace e.g. performance management, promoting the right to manage, slicker recruitment processes, (5) integrate staff information in one place.

Where to from here?

Expert panels and staff groups generally agreed as to how the organisation should approach smart and simple systems. Front line staff were very focused on empowerment, distributed leadership and decision making. Our experts discussed the importance of balancing these concepts with organisational responsibilities and finite spending. Both agreed that current systems and structures are overly complex and bureaucratic.

Our people suggest that a strategy for smart and simple systems should include:

- Investment in technology, systems and processes that support integration and mobility. The goal should be one patient management and one staff management system with a graded roadmap on how the DHB will achieve this with transparent, realistic, measurable, agreed milestones. Strategy should be visible so all staff can contribute.

- All systems should incorporate co-design principles with the end user e.g. inter-professional staff groups, patients and IT, involved in the design and development phase. Inclusion of consumer advocates linked to networks within and outside our organisation is essential, rather than only using them in discrete areas.

- Agree and make visible the ownership of systems at senior level e.g. contact directory, ATR process, Square. Make the lead accountable for required system changes and create a mechanism where staff can make suggestions for improvement.

- Commitment to support a high trust, high accountability model with distributive decision making. Job role should determine accountability for performance and KPIs e.g. budgets, quality and safety initiatives and provided with resources to achieve local outcomes. Staff feedback suggests this would require significant change in systems and leadership approach.

5.0 Key principles

Our analysis identified 4 key principles for positive change.

The key principles of our people strategy are:

A. Strong foundations
Investment in the fundamental building blocks that ensure our people have the skills and tools to excel and to lift health outcomes for our whole population, with a focus on Māori and Pacific peoples.

B. Trust and partnership
Open respectful communication, shared decision making, easy processes, transparency and individual accountability.

C. Promoting wellbeing
Working together for the health and wellbeing of our people and the community we serve.

***D.* Learning from excellence**
Fostering innovation to ensure we do more of what we do well. Recognising the efforts and contribution of individuals, teams, leaders and managers.

A number of strategic intentions underpinning each of the four principles have been identified which:

- Reconcile the gap between *work as experienced* and *work as imagined*.
- Ensure we are an employer of choice; attracting, developing and retaining staff from local, national and international markets to achieve a workforce that reflects our community.
- Ensure our people are excited to work here and to come to work here every day.

- Ensure every individual is supported, empowered and happy in our organisation, where their talents are promoted, developed and respected. Our people can do their best work here.
- Align strategy with our culture and our actions, so that great team work is the norm within and across departments and the organisation. Our people are proud to say they work here.
- Ensure that decision making, prioritisation and investment in our people have a shared reference point and intent.

The following sections outline the strategic intentions underlying each of our four key principles.

6.0 Strategic Intentions: Strong Foundations

Table 3: Strategic Intentions: Strong Foundations

A.Strong foundations	***Investment in fundamental building blocks to ensure our people have the skills and tools to excel and to lift health outcomes for our whole population, with a focus on Māori and Pacific peoples.***
The Treaty of Waitangi is integrated into strategy	The principles of te Tiriti o Waitangi are genuinely incorporated and we actively seek out to safeguard Māori cultural concepts, values and practices. We actively seek to increase the numbers of Māori and Pacific staff in all roles and professions. Attempts to measure or manage organisational culture recognise and respect Māoritanga and actively engage with Māori in the development of initiatives and interventions.
Be recognised as an exceptional employer of choice	Our people are our greatest asset and our approach optimises their ability to contribute to achieving our strategic aims. Our organisation values diversity and actively works to ensure barriers to achieving diversity in our workforce are removed.
Recruit and retain staff who align with our core values	Our people role model authentic leadership, collaboration, self-management and inter-professional working. Our organisational structure supports work to be delivered in our values framework which is supported and modelled by our leaders.
Be proactive and agile.	We are future focussed and our proactive strategies have a long-term view. We invest in long term plans for the future so we can grow our own workforce to meet the future needs of our community. We create employment opportunities that create flexibility and retain staff across the healthcare system in all roles.
Support our workforce to perform well in complex conditions.	We strive to be a high reliability organisation*. We anticipate and plan for unpredictable fluctuations and support strategies that allow us to adapt in complex conditions. There is an expectation of continuous change and proactive, agile systems which acknowledge the complexity of everyday work. We de-clutter bureaucratic rules and processes that make it hard for our people to perform at their best.
Proactive workforce strategy	Our people have the skills, tools and resources they need to deliver fundamental care. We recognise the need to create opportunities for recovery to maintain our people's resilience and work life balance.
Every day work is supported by integrated reliable systems	We invest in IT systems that are easy to use and talk to each other. Our goal is one mobile patient management and one staff management system
Prioritise and support continuous learning in everyday work.	Our organisation provides supportive mentorship and knowledge and skills frameworks for all our people. Most learning occurs in every day work to account for the situational context. Learning is supported by our systems, our leaders and managers. We build strong relationships with our local education providers to attract a pipeline of talent for the future that is reflective of our community.

*High reliability organisations are organisations that operate in complex, high-hazard domains for extended periods without serious accidents or catastrophic failures e.g. aviation.

7.0 Strategic Intentions: Trust and Partnership

Table 4: Strategic Intentions: Trust and Partnership

B.Trust & Partnership	***Open respectful communication, shared decision making, easy processes, transparency and individual accountability.***
Individuals are trusted to safely care for patients and each other.	We trust our people, our leaders and our managers to make effective decisions. We agree outcomes and hold each other accountable using an agreed framework. Our systems, structures, resources and leadership support this distributive approach.
Seamless, reciprocal communication from board to ward.	We actively seek out ideas and feedback from our people. We talk to each other in person and invest in modern technology, systems and processes that ensure reciprocal communication is mobile, easy, consistent and transparent. Our communication reflects the needs of our population and is provided in Te Reo Māori and English.
Recruit and promote trusting, empathetic leaders	Our leaders are authentic and visible and set clear expectations of behaviour. They actively seek out opportunities for individuals, teams and the organisation to collaborate and innovate. Our leaders involve our people in decision making and ask how we can improve how we do things round here. They develop talent and they listen and respond to concerns.
Co-design underpins how we approach change	Our staff, community and patients are partners. We value input into design and recognise that a diverse range of perspectives are required to ensure healthcare provision meets the needs of our community, connects across the health system and accounts for differences in situational context.
Decisions are evidence based, consistent and transparent.	Our strategy, risks and change processes have an allocated executive leader. Graded roadmaps outline how our organisation will deliver strategic objectives with realistic, measurable, agreed milestones. Strategy is visible so all staff are able to contribute and provide feedback which will be responded to using simple mobile technology.
We make it easy for people to do the right thing	A cohesive organisational structure supports teams and individuals to work together. Our processes are smart and simple, and we strive to remove unnecessary bureaucracy and rigid rules. We prefer to defer to the 'expert on the spot' and expect our experts to escalate barriers or potential risks to safe, effective everyday work so they can be removed.

8.0 Strategic intentions: Promoting Wellbeing

Table 5: Strategic Intentions: Promoting Wellbeing

C. Promoting Wellbeing **Strategic actions**	*Working together for the health and wellbeing of our people and the community we serve.*
The health and wellbeing of every employee matters.	Our board, executive and our people support a healthy workplace, such as that defined by the World Health Organisation.[5] Our staff are individuals with different needs and a number of strategies support and promote wellness. Risks to the health, safety or wellbeing of our staff are identified and removed in a timely manner.
Investment in wellness for long term gain.	A wellness approach underpins financial decisions about our workforce. Decisions are evidence based and we seek to understand how work is experienced by our staff using metrics and methods that involve us talking to our people to understand what matters to them in their day to day work.
Treating each other well.	We treat each other with respect and our core values underpin our day to day work interactions and how we raise and respond to concerns. There is a clear process to hold individuals accountable if their behaviour does not match our values which applies to everyone in our organisation.
Courageous conversations are encouraged.	We listen to others and provide our people with the skills to feel confident to speak up, deal with difficult people and situations and provide constructive feedback.
Social determinants of health are accounted for.	A number of tailored strategies promote the health of our workforce, acknowledging it is reflective of our wider community including the ageing population, family violence and social inequity.

[5] A healthy workplace is one in which workers and managers collaborate to use a continual improvement process to protect and promote the health, safety and well-being of all workers and the sustainability of the workplace by considering the following, based on identified needs: • health and safety concerns in the physical work environment; • health, safety and well-being concerns in the psychosocial work environment including organization of work and workplace culture; • personal health resources in the workplace; and • ways of participating in the community to improve the health of workers, their families and other members of the community – WHO 2010 Healthy workplace: A framework and model

9.0 Strategic intentions: Learning from Excellence

Table 6: Strategic Intentions: Learning from Excellence

D. Learning from Excellence **Strategic actions**	*Fostering innovation to ensure we do more of what we do well. Recognising the efforts and contribution of individuals, teams, leaders and managers.*
Learn from what we do well.	Every day work is complex and we celebrate how much our people achieve every day. We learn from good outcomes so we can replicate and share what we do well.
Foster innovation.	A partnership between front line services and leadership provides the basis for us to understand our organisation. We encourage innovation and support and resource frontline innovation, testing and redesign – scaling innovations that work and sharing success. We back our staff to try new things, with 'fast fail' initiatives providing us with new opportunities to learn.
Develop and encourage talent.	Our organisation welcomes every individual and provides opportunities for our people to utilise and share all the skills they have to offer and learn new ones. Our people excel in their role today, and are supported to achieve their aspirations for tomorrow. We promote self-management and expect individuals to invest in their future.
Build, publicise and celebrate excellence.	We understand our broader networks and create effective partnerships. We utilise and make visible the experts that work in our place and across national and international platforms. We encourage research and publication. We are proud of our people and their innovation and support them to spread and share their results.

10.0 The future at CCDHB…

Our people have provided us with clear guidance as to what is important for them, how they experience work and how they imagine work could be.

This document brings their perspective together with our long term Vision 2030 and the knowledge of our subject matter experts to provide us with a wealth of understanding.

It represents an important chapter in an ongoing conversation with our people, creating depth of understanding from the broad brush information we obtained from the staff engagement survey.

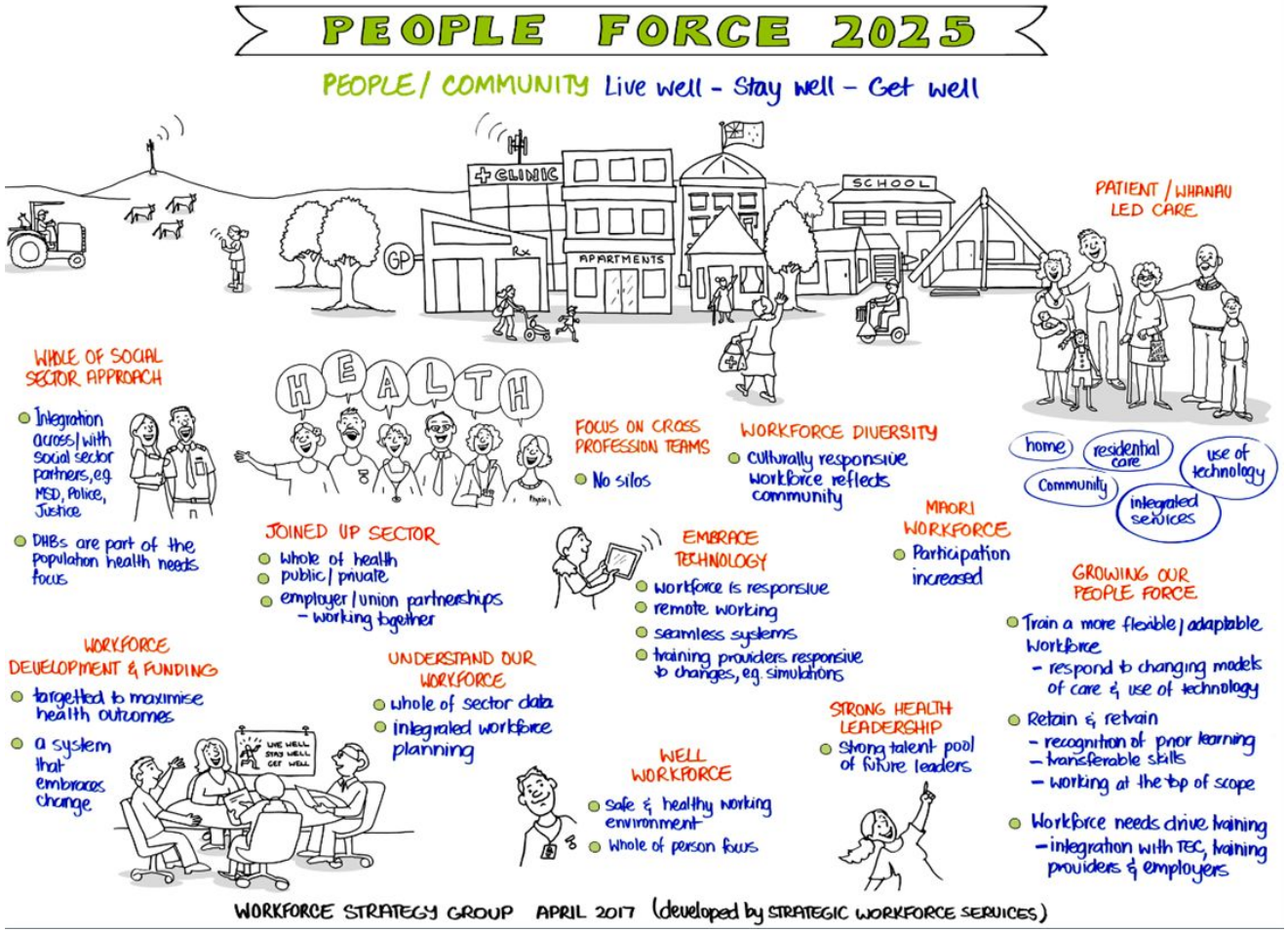
So what is the next chapter? The discussion in this document points us to a conversation about values. A significant theme throughout the conversation to date has been the desire for clarity and confidence in the quality of decision making at all levels of the organisation. Every day, in every situation, our people make decisions and choices. Those choices involve weighing up a range of factors, at times conflicting and almost always complex. Working together to refine and refresh CCDHB values, provides the opportunity to lift both the quality of decision making, and to strengthen confidence in our efforts to provide best outcomes for patients and best experience for staff.

- The principles described in this people strategy provide a sound base for us to explore and identify our shared values over the coming months. We would propose that the next chapter involves establishing share values and behaviours to guide decision making, our interactions with each other and our patients and how we act to achieve our goals and aspirations.

- The information in this paper, provides a rich knowledge base for our senior leadership to use in thinking about future directions and priorities for action. Some of our senior leaders have been involved in the development of this strategy and we propose a workshop process, aligned with the values work to encompass all our leaders, to identify how we will turn the principles of the strategy into planning and action.

- Our people have contributed energy, time, laughter and a few tears to the development of this strategy. The passion, dedication and hopefulness of our staff is inspirational. An essential next step is continuation of the conversation we began with the staff engagement survey. Honouring that contribution and showing that we have heard and value all voices, will be an ongoing call to action for us all.

11.0 Appendix 1: National Workforce Strategy Group – People Force 2025



Supporting safety culture: Research and evaluation

1.0 Introduction

This paper proposes a number of different methods are utilised to understand and evaluate our organisational culture within a research and evaluation framework. An internationally recognised model of organisational culture and its relationship with safety culture will be described. Examples of research that has attempted to understand, measure and evaluate safety culture will be discussed. Any study of culture in a NZ setting must consider Maoritanga, and the proposal attempts to incorporate the principles of the Treaty of Waitangi.

2.0 What is organisational culture?

Organisational culture is comprised of values, beliefs and behaviours that are practiced because of shared subconscious assumptions and tacit beliefs. It is widely recognised that multiple sub-cultures exist in organisations, including healthcare environments (Travaglia *et al*. 2011, Schein 2004).

Edgar Schein, a key author and former MIT professor, defines organisational culture as:

"A pattern of shared basic assumptions that the group has learned as it solved its problems that has worked well enough to be considered valid and is passed onto new members as the correct way to perceive, think and feel in relation to these problems." (Schein 2004)

Schein's model illustrates the complex and multilayered nature of organisational culture. Culture is depicted as an iceberg where much lies below the surface, making culture difficult to examine or observe.

Figure 1: Schein's model of culture

Wailling J Supporting safety culture research strategy for Capital and Coast DHB March 2018

3.0 Safety culture

Safety researchers began to study the relationship between organisational culture and safety in high reliability organisations (HROs), after the Chernobyl disaster[1]. In HROs, such as aviation and nuclear power, safety culture is characterised by communications founded on mutual trust, shared perceptions of the importance of safety and confidence in the efficacy of preventive measures.

Theorists have proposed different models and approaches to shape, understand and evaluate safety culture (e.g. Reason 1997, Weick and Sutcliffe 2001, Westrum 2004). It isdescribed as both a subset of organisational culture (Weick and Sutcliffe 2001) and a phenomenon in its own right (Reason and Hobbs 2003). These differences in how safety culture is defined and evaluated may explain why the relationship between culture and patient outcomes is poorly understood (Braithwaite et al 2018). International (Dixon-Woods, Suokas and Tarrent, 2009, Waring, 2005) and NZ research (Hardy 2013, Wailling 2016) indicates that multiple safety sub-cultures exist in healthcare environments. The research and evaluation strategy we propose attempts to account for these different perspectives by utilising a mixed methods approach.

4.0 How has safety culture been measured?

The problem with trying to assess or evaluate highly complex phenomena like safety culture is that experts rarely agree on the essential dimensions to measure. A significant body of international survey research has attempted to evaluate **exposed beliefs and values** using surveys. Survey tools have examined components that have worked well in HROs in healthcare environments. The approach assumes values and rules of behaviour about safety are shared by all individuals and can be measured. Findings from international survey research indicate that professional groups may have different values and rules of behaviour about safety. (Singer et al 2009, Wagner et al 2013, Robb and Seddon 2010). A growing body of evidence has attempted to understand **basic underlying assumptions** about safety culture using qualitative methods, and a small number of studies have also attempted to incorporate cultural **artefacts** (Dixon Woods et al 2000). This research has revealed new insights into the unconscious behaviours and actions of employees that are deeply integrated in organisational cultures (Brooks and Bosk 2012, Wailling 2016, Waring 2005).

5.0 Safety culture in our place

The aim of the supporting safety culture programme is to understand and influence safety culture in CCDHB over a three-year period. A mixed methods approach will best achieve this aim as it acknowledges the complex and multi-dimensional nature of culture. The triangulation of multiple data sources will increase confidence in our conclusions and will assist in identifying potential confounding variables, such as coincidental improvements. Achieving triangulation will require central oversight and multiple research and evaluation projects provide the opportunity for staff engagement and involvement. An organisational research network has been established, with 26 staff expressing interest in contributing to the research and evaluation programme.

[1] The Chernobyl disaster was a catastrophic nuclear accident in the Ukrainian Soviet Socialist Republic 1986.

6.0 The research and evaluation framework

The framework has been developed by the organisational development team in partnership with experts from capability and development and the quality improvement patient safety team.

It is anticipated that findings from the supporting safety culture research and evaluation framework will:

- Ensure organisational oversight and identify opportunities for development at the macro, micro and meso level.[2]
- Identify, create or empower structures that will ensure sustainability
- Empower local units (staff group, service etc.) to be involved in evaluating and researching safety culture.
- Contribute to the literature on safety culture and raise the organisational profile by aiming to publish research
- Raise the profile and awareness of staff and patient safety

Key organisational projects that may impact on the results of the evaluation and research strategy have been identified and an awareness of the influence of ongoing projects will continue during the life of the program. Examples include the people strategy, welcome project, training and leadership programs, CCDM, acute flow and the ward innovation projects.

The research and evaluation framework uses a traffic light identification system to demonstrate which projects can be achieved through business as usual and the research network, and which will require additional support. Additional resource would be required if there is a requirement to amalgamate projects into a case study.

There is requirement for IT/analytics support to develop a people and capability dashboard and an easy to use staff led database to capture innovation and provide opportunities to learn from excellence.

7.0 Treaty of Waitangi

The influence of unique aspects of NZ culture will be considered and each project team will consult with an Maoritanga expert. Data analysis will include strategies to identify factors that require further consideration in patients or staff groups who identify as Maori or Pasifika.

[2] **Micro**-, **meso**-, and **macro**-**levels** refer to the patient interaction **level**, the **health care** organization and community **level**, and the policy **level**, respectively.

Waillling J Supporting safety culture research strategy for Capital and Coast DHB March 2018

Study Topic	Aim	Data Source	Metrics/Methods	Frequency	Analysis	Requirements
CCDHB Safety culture: Espoused beliefs and values	To determine any change in CCDHB safety culture over a three-year period	Safety attitudes questionnaire https://psnet.ahrq.gov/resources/resource/3601/the-safety-attitudes-questionnaire-psychometric-properties-benchmarking-data-and-emerging-research-- Inclusion criteria: All CCDHB and MHAIDS staff will be sent a link via survey monkey to survey.	6 Factors Teamwork climate, safety climate, perceptions of management, job satisfaction, working conditions, stress recognition Limitations: only accounts for espoused beliefs and values	Baseline (August 2018) Formative assessment (Nov 2019) Summative assessment (March 2021) May not be able to achieve formative assessment here	OD SPSS.	OD Business as usual (BAU) Potential database of SAQ data for comparison
CCDHB safety culture: Basic underlying assumptions and artefacts	To determine barriers and enablers to a positive safety culture in CCDHB	Semi structured interviews using the critical incident technique. Inclusion criteria: units (n=4-6) identified as having an extremely positive or negative attitude to safety as identified by the SAQ. May include observational work	Mixed methods. Analysis of survey data and qualitative data	Once	Thematic analysis in Vivo software	OD BAU Support from leaders to establish and enable access to departments. Access to in Vivo software.

Organisational Development: Supporting safety culture March 2018

Study Topic	Aim	Data Source	Metrics/Methods	Frequency	Analysis	Requirements
CCDHB Safety culture: Espoused beliefs and values and basic underlying assumptions	To determine enablers and barriers patient identify for a positive safety culture in CCDHB	Modified SAQ and semi structured interviews of patients in units identified in the staff SAQ survey as having an extremely positive or negative attitude to safety	Mixed methods. Analysis of survey data and qualitative data	Once opportunity to incorporate into ward project	Thematic analysis in Vivo software SPSS	DONM office/QIPS Would require FTE interest in research network
Professional accountability: artefacts	To determine any change in the frequency of alleged staff unprofessional behaviours that are formally reported	Unprofessional behaviours reported to HR, HDC, complaints, unions, square, exit interview data. EAP referral rates for B&H and anxiety. OH referrals relating to B&H. SAQ data. Data from medical council and MPS also available via open disclosure Inclusion criteria: all CCDHB staff	Analysis of data from multiple sources. B&H review has identified that HR and OH data is limited and needs work to be useful to organisation	Monthly	Internal data sets audit SPSS	OD BAU FTE support from analytics to establish database and reporting regarding our people.
Staff engagement and staff safety: Espoused beliefs and values and artefacts	To determine if there is a change in staff safety, engagement, satisfaction and retention	Routinely collected staff and satisfaction data and staff SAQ data. Inclusions: all CCDHB staff	Occupational injury data, ACC related staff claims, EAP data, turnover, exit interview trends sickness rates, OH referrals for stress related issues, SAQ data (i.e. I like my job)	Month data collection of all data except SAQ which will be annual/bi-annual	Internal data sets audit SPSS	OD As above Analytics required External data for EAP External provider for exit data?

Organisational Development: Supporting safety culture March 2018

Study Topic	Aim	Data Source	Metrics	Frequency	Analysis	Requirements
Quality and safety of care: basic underlying assumptions	To determine how safe care delivery can be enhanced by learning from what we do well	Standard Performance Expectations 1/4 report Patient Experience MOH	Patient experience data already collected via survey	Quarterly	Current reporting	QIPS BAU
Quality and safety of care: basic underlying assumptions	To determine how safe care delivery can be enhanced by learning from what we do well	Learning from excellence	Needs research framework to be identified March 2018	Pilot in ED underway. Other sites may be included	TBA march 2018	Current local ownership in ED BAU. Would need FTE to coordinate more broadly.
Compliance with CCDHB protocols: artefacts	To determine if there is change in compliance with CCDHB protocols	Routinely collected care process audit that observes best practice	Care Process audits - PADP,MADP, Paed ADP EWS, Falls, PI, Documentation etc.	Already visible electronically BIA portal	Current reporting	QIPS BAU
Compliance with CCDHB protocols: artefacts and basic underlying assumptions	To determine if compliance with CCDHB HH protocol is possible	Observational study: repeat of CMDHB study relating to HH to identify artefacts. Uses safety II lens.	Qualitative study (could incorporate HH compliance rates as well for mixed methodology)	Once	Observational study	Would need FTE resourcing – ICU/QIPs

Organisational Development: Supporting safety culture March 2018

Study Topic	Aim	Data Source	Metrics	Frequency	Analysis	Requirements
Cognitive institute workshops	To determine the effectiveness of the workshops and if staff report a perceived change in awareness, abilities, confidence or behaviours following attendance	CI own evaluation framework (Likert) Kirkpatrick framework (C&D)	Mixed methods. Analysis of survey data and qualitative data	Following workshops	TBC	CI to confirm
Safety Leadership: Espoused beliefs and values and basic underlying assumptions	To understand leader's perceptions of their role in safety leadership and identify organisational interventions	SAQ subset group – formal leadership Semi structured interviews using the critical incident technique. Inclusion criteria: units (n=4-6) identified as having an extremely positive or negative attitude to safety as identified by the SAQ.	Mixed methods. Analysis of survey data and qualitative data	Once	Thematic analysis in Vivo software SPSS	OD to provide SPSS BAU Qualitative research BAU for C&D leadership program
Quality and safety of care: artefacts	To determine if there is a change in the quality and safety of patient care delivered to patients	Routinely collected data via the CCDHB incident reporting system. Inclusion: only CCDHB data	SPE - Falls /PI/Medications Quality Safety Measures	Monthly	Current reporting	QIPS BAU

Organisational Development: Supporting safety culture March 2018

Study Topic	Aim	Data Source	Metrics/Methods	Frequency	Analysis	Requirements
Sustainability: basic underlying assumptions and espoused beliefs and values	-To determine how safety champions influence safety culture by examining changes in their network relationships and attitudes. -To identify the components essential for successful brokers in a safety network -To utilise network information for organisational intervention/support	Social networks of safety champions SAQ Semi structured interviews using the critical incident technique of safety influences champions identify. Inclusion: safety champions (n=15)	Social network analysis (SNA) SPSS analysis of SAQ data Qualitative interviews	SAQ (annual) SNA questionnaire (annual) Interviews (once)	OD SPSS. Thematic analysis in Vivo software	OD (BAU) Proposal has been reviewed by SNA experts from Australian Institute for health innovation. Ethics approval sought from Vic Locality approval complete All champions have consented to be included in study
Patient experience: espoused beliefs and values	To determine if there is any change in patient experience	Routinely collected patient experience data. Inclusions criteria: - Adult inpatients national	Monthly own survey and 1/4 national using Likert	Own monthly Nationally 1.4	Difficult to drill down by area currently – needs review	QIPS BAU

Organisational Development: Supporting safety culture March 2018

Study Topic	Aim	Data Source	Metrics/Methods	Frequency	Analysis	Requirements
Sustainable reliable systems: TBA	To determine if reliability science strategies have been integrated into improvement projects and ward processes as part of the CI program	Need to understand program before can determine i.e. what/who specifically do they determine they can influence in terms of high reliability thinking?	S&R tools currently exist in CCDHB which have considerable data sets for examination -CCDM -EWS	TBA	TBA	Likely to be significant as will involve multiple parties including OD/QIPS/GMHSS/GMMHAIDS/CEO/SIPS

Organisational Development: Supporting safety culture March 2018

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PUBLIC

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**BOARD DECISION**
	Date: 13 June 2018
Author	Rachel Haggerty, Director, Strategy, Innovation and Performance
Endorsed by	Ashley Bloomfield, Interim Chief Executive
Subject	**HEALTH SYSTEM COMMITTEE RECOMMENDATIONS**

The full papers and recommendations of the 30 May meeting are available on Board books for Board members to review.

RECOMMENDATIONS

It is **recommended** that the Board receives and **endorses** the advice of HSC as considered at their meeting on 30 May, and:

Terms of Reference

(a) **Noted** that it can be challenging at times to meet the quorum but it shouldn't impede the progress of the meeting.

(b) **Endorsed** the importance of the attendance of the Executive Leadership Team, including GM, Corporate Services and the CFO join future HSC meetings given that the discussions do centre on the investment in the health system.

(c) **Endorsed** the opportunity to invite a representative from Otago University to assist in the areas of population health and regional health and also other areas of research in an effort to strengthen relationships and increase collaboration.

2018 Work Programme

(d) **Noted** the approved Work Programme for 2017/18 with a focus on health system investment and prioritisation, system and service planning, system performance reporting and provider performance.

2018/19 CCDHB Planning Progress update

(e) **Noted** the Minister of Health's Letter of Expectations, outlining the Government's priorities and areas of focus.

(f) **Noted** the Government's Budget was announced on 17th May and the Chief Financial Officer will present a paper outlining the CCDHB 2018/19 budget to 27 June FRAC meeting.

(g) **Noted** the initial draft MOH Annual Plan using the 2017/18 template was approved by the Board in March. This pro-active approach enabled CCDHB to deliver draft a Statement of Performance Expectations (SPE) and Service Change Schedule to the Ministry of time and at short notice, which has been noted by Ministry officials.

(h) **Noted** the MOH Annual Plan and Planning Guidance has now been issued. Management is updated the March draft Annual Plan for presentation to the HSC and Board for approach on the 27th June and 11th July respectively.

(i) **Noted** the dates for the SPE must be submitted to the Ministry by the 29th June; the final draft SLM must be submitted to the Ministry by the 2nd July; and the draft Annual Plan must be submitted to the Ministry by the 16th of July. No Statement of Intent (SOI) will be required in 2018/19. This will be refreshed in 2019/20.

Investment in and Performance of CCDHB NGO Providers for Child Services

(j) **Noted** the Ministry of Health contracts Plunket at a national level for the balance of the well child checks. The Ministry of Health is collating well child check information at a national level which will be available to DHBs in 2018/19 for the first time.

PUBLIC

(k) **Noted** the 2017/18 CCDHB investments in local providers for Well Child Tamariki Ora, Before School Check services; green prescriptions; Porirua Ear Van Service; Kenepuru Accident and Medical centre for services providing free under 13s care in after hour clinics; Project Energise; vision and hearing screening for school aged children and secondary school based health services (SBHS);

(l) **Noted** the initial dashboards for children 0 to 4 years and school aged children presented at this meeting.

(m) **Noted** that persistent inequalities occur for Māori and Pacific children and require significant focus.

(n) **Noted** the opportunities to improve services for young children through working with local WCTO providers and Plunket to improve our understanding to improve our data and our understanding of how children are using the services to improve coverage for our high need populations.

(o) **Noted** the opportunities to improve services for youth through the actions of the youth SLA-improving sex and gender diverse young person's access to care and health outcomes; establishing an Alcohol and Other Drug / Co existing Problems (AODCEP) service to better support young people experiencing AODCEP; developing and implementing a plan for integrated youth services in Porirua (2018/19).

(p) **Endorsed** the SIP team working with the DHB Pacific and Māori teams PHOs, child service providers and other providers to develop an approach to achieving equity which will be linked to the improvement in equity in the use of primary care services (agenda item 3.1 2 May 2018 meeting).

MHAIDS Bi-Monthly Performance Report

(q) **Noted** a final report has been presented by the MHAIDS Advisory group to the 3CEs and is documented in this report;

(r) **Noted** that Phase 1 of the Client pathway/Digital Client Records is now complete;

(s) **Noted** that the National Mental Health Inquiry has begun with various meetings with the Panel taking place during May 2018;

(t) **Noted** that ICAFS launched two new teams on 30th April, as per the review;

(u) **Noted** that there are acute on going demands and pressure for the Intensive Recovery Sector.

Regional Public Health Bi-Monthly Report

(v) **Noted** RPH provided both a written and oral submission on the Sale and Supply of Alcohol (Renewal of Licenses) Amendment Bill (No 2).

(w) **Noted** RPH completed submissions on Councils' Long Term Plans.

(x) **Noted** RPH activity with Councils in the Central Region on "Healthier Food and Drink Environments." RPH is working alongside Councils to improve health food and drink environments.

(y) **Noted** RPH is collaborating with the Institute of Environmental Science and Research (ESR) with research on the impact of repeat vaccination on response to influenza virus infection.

(z) **Noted** RPH is organising the 2018 Australasia Tuberculosis Conference for 30 - 31 August 2018.

(aa) **Noted** RPH is supportive of and participated in the annual Creekfest 2018 festival.

(bb) **Noted** RPH provided the evaluation of the Porirua Whānau Centre Ko wai au Programme 2016.

(cc) **Noted** the RPH Public Health Nurse activity in primary and intermediate schools January – March 2018.

(dd) **Noted** the Public Health Nurse activity based at Porirua Work and Income.

(ee) **Noted** the Human Papilloma Virus (HPV) vaccination (Gardasil) progress for 2018.

(ff) **Noted** RPH has commences planning for a Centreport Pandemic Preparedness Exercise in May 2018.

CAPITAL AND COAST DISTRICT HEALTH BOARD
DRAFT Minutes of the Health System Committee (HSC)
Held on Wednesday 30 May 2018 at 9.30am
Board Room, Level 11, Grace Neill Block, Wellington Regional Hospital

PUBLIC SECTION

PRESENT:

BOARD	Dame Fran Wilde (Chair) Ms Sue Kedgley Dr Roger Blakeley Ms 'Ana Coffey Ms Eileen Brown Ms Sue Driver Dr Tristram Ingham
STAFF:	Ms Rachel Haggerty (Director, Strategy Innovation and Performance) Ms Chris Lowry (General Manager, Hospital and Healthcare Services) Ms Catherine Epps (Executive Director, Allied Health, Technical and Scientific) Ms Taima Fagaloa (Director, Pacific People's Health) Ms Catherine Khoo (Minute Secretary)
PRESENTER:	Nigel Fairley (General Manager, 3DHB MHAIDS); item 4.1
GENERAL PUBLIC:	1 members of the public was present

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1 PROCEDURAL BUSINESS

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

1.2 APOLOGIES
Apologies was received from Andrew Blair, Fa'amatuainu Tino Pereira, Ashley Bloomfield,

1.3 INTERESTS
1.3.1 REGISTER OF INTERESTS

Action:
1. Committee Secretary to update the Conflicts Register.

1.4 CONFIRMATION OF PREVIOUS MINUTES
The minutes of the CCDHB Health System Committee held on 2 May 2018, taken with public present, were confirmed as a rue and correct record.

Moved: Roger Blakely **Seconded:** Eileen Brown **Carried**

1.5 MATTERS ARISING

1.6 ACTION LIST

Eileen **noted** in item 3.1 the word equity is missing. Other reporting timeframes on the other open action items were **noted**.

Tristram arrived at 9.36am

1.7 TERMS OF REFERENCE

The Committee **noted** that it is challenging at times to meet the quorum but it shouldn't impede the discussion.

1.8 The Committee **endorsed** the importance of the attendance of the Executive Leadership Team, including GM, Corporate Services and the CFO join future HSC meetings given that the discussions do centre on the investment in the health system.

1.9 The Committee **endorsed** the opportunity to invite a representative from Otago University to assist in the areas of population health and regional health and also other areas of research in an effort to strengthen relationships and increase collaboration.

The Committee **approved** the Terms of Reference.

Moved: Roger Blakely **Seconded:** 'Ana Coffey **Carried**

1.10 2018 WORK PROGRAMME

The Committee **approved** the 2018 Work Programme**.**

2 FOR INFORMATION

2.1 2018/19 CCDHB PLANNING PROCESS UPDATE

The paper was taken as **read**.

The Committee:

a) **Noted** the Minister of Health's Letter of Expectations, outlining Government's priorities and areas of focus;

b) **Noted** the Government's Budget was announced on the 17th May and the Chief Financial Officer (CFO) will present a paper outlining the CCDHB 2018/19 budget to 27 June FRAC meeting;

c) **Noted** the initial draft MOH Annual Plan using the 2017/18 template was approved by the Board in March. This pro-active approach enabled CCDHB to deliver draft a Statement of Performance Expectations (SPE) and Service Change Schedule to the Ministry of time and at short notice, which has been noted by Ministry officials;

d) **Noted** the MOH Annual Plan and Planning Guidance has now been issued. Management is updating the March draft Annual Plan for presentation to the HSC and Board for approval on the 27th June and 11th July respectively;

e) **Noted** the dates for the SPE is prior to the Annual Plan for statutory compliance reasons. The final SPE must be submitted to the Ministry by the 29th June; the final draft SLM must be submitted to the Ministry by the 2nd July; and the draft Annual Plan must be submitted to the Ministry by the 16th of July. No Statement of Intent (SOI) will be required in 2018/19. This will be refreshed in 2019/20.

Action:

1. SIP to bring an organisational approach on equity to the Committee. This approach is being developed by the Māori Health team.
2. SIP to present to the Committee at a future HSC meeting the development of suicide prevention approach and the DHB role as a health system.
3. SIP to share the School Based Health System strategy with the Committee at a future HSC meeting.

3 FOR DECISION

3.1 INVESTMENT IN AND PERFORMANCE OF CCDHB NGO PROVIDERS FOR CHILD SERVICES

The paper was taken as **read**.

The Committee notings were summarised. The Committee:

a) **Noted** the Ministry of Health contracts Plunket at a national level for the balance of the well child checks. The Ministry of Health is collating well child check information at a national level which will be available to DHBs in 2018/19 for the first time;

b) **Noted** the 2017/18 CCDHB investments in local providers for Before School Check services; green prescriptions; Porirua Ear Van Service; Kenepuru Accident and Medical centre for services providing free under 13s care in after hour clinics; Project Energise; vision and hearing screening for school aged children and secondary school based health services (SBHS);

c) **Noted** the initial dashboards for children 0 to 4 years and school aged children presented at this meeting;

d) **Noted** that persistent inequalities occur for Māori and Pacific children and require significant focus;

e) **Noted** the opportunities to improve services for young children through working with local WCTO providers and Plunket to improve our understanding to improve our data and our understanding of how children are using the services to improve coverage for our high need populations;

f) **Noted** the opportunities to improve services for youth through the actions of the youth SLA-improving sex and gender diverse young person's access to care and health outcomes; establishing an Alcohol and Other Drug / Co existing Problems (AODCEP) service to better support young people experiencing AODCEP; developing and implementing a plan for integrated youth services in Porirua (2018/19);

g) **Endorsed** the SIP team working with the DHB Pacific and Māori teams PHOs, child service providers and other providers to develop an approach to achieving equity which will be linked to the improvement in equity in the use of primary care services (agenda item 3.1 2 May 2018 meeting).

Action:

1. SIP to report on the integration progress of the different programmes at a future HSC meeting.
2. SIP to present the investment planning approach at the next meeting in June:

a. Whole system approach
b. Life course investment
c. How we use investment planning to redirect our current investment
d. How do we get public health to be a part of DHBs
e. Development of new performance framework based on our new investment models

3. SIP to continue to provide examples in the system for future papers. Board members need to be better informed in terms of context rather than just facts.
4. Reconsider the use of BMI as an indicator (item 6.5) as the Māori and Pacific population doesn't fit in with the standard body type.
5. Housing issues to be discussed at a future HSC meeting and SIP will bring back information to the Board regarding what actions they will be taking.

The Committee took a break at 11am and resumes at 11.10am.

4 FOR DISCUSSION

4.1 MHAIDS BI-MONTHLY PERFORMANCE REPORT

The paper was taken as **read**. Eileen endorsed the organisation of the Mental Health Inquiry and acknowledged recommendation point e.

The Committee:

a) **Noted** a final report has been presented by the MHAIDS Advisory group to the 3CEs and is documented in this report;

b) **Noted** that Phase 1 of the Client pathway/Digital Client Records is now complete;

c) **Noted** that the National Mental Health Inquiry has begun with various meetings with the Panel taking place during May 2018;

d) **Noted** that ICAFS launched two new teams on 30th April, as per the review;

e) **Noted** that there are acute on going demands and pressure for the Intensive Recovery Sector.

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

4.2 REGIONAL PUBLIC HEALTH BI-MONTHLY REPORT

The paper was taken as **read**.

The Committee:

a) **Noted** RPH provided both a written and oral submission on the Sale and Supply of Alcohol (Renewal of Licenses) Amendment Bill (No 2);

b) **Noted** RPH completed submissions on Councils' Long Term Plans;

c) **Noted** RPH activity with Councils in the Central Region on "Healthier Food and Drink Environments." RPH is working alongside Councils to improve health food and drink environments;

d) **Noted** RPH is collaborating with the Institute of Environmental Science and Research (ESR) with research on the impact of repeat vaccination on response to influenza virus infection;

e) **Noted** RPH is organising the 2018 Australasia Tuberculosis Conference for 30 - 31 August 2018;

f) **Noted** RPH is supportive of and participated in the annual Creekfest 2018 festival;

g) **Noted** RPH provided the evaluation of the Porirua Whānau Centre Ko wai au Programme 2016;

h) **Noted** the RPH Public Health Nurse activity in primary and intermediate schools January – March 2018;

i) **Noted** the Public Health Nurse activity based at Porirua Work and Income;

j) **Noted** the Human Papilloma Virus (HPV) vaccination (Gardasil) progress for 2018;

k) **Noted** RPH has commences planning for a Centreport Pandemic Preparedness Exercise in May 2018

Action:

1. Peter Gush to join the meeting when the next Regional Public Health Bi-Monthly Report is presented.
2. It is important for RPH integration to occur across the DHB services and strategies.

The meeting closed at 12.05pm.

5 DATE OF NEXT MEETING

27 June 2018, 9.30am, Moa Room, Ratonga Rua o Porirua, 20 Upper Main Drive, Kenepuru.

PUBLIC

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**BOARD DISCUSSION**
	Date: 13 June 2018

Author	Peter Guthrie, Manager Planning & Performance
Endorsed by	Rachel Haggerty, Director Strategy Innovation & Performance Ashley Bloomfield, Interim Chief Executive
Subject	**CCDHB JANUARY- MARCH 2018 QUARTERLY PERFORMANCE MONITORING REPORT**

RECOMMENDATIONS

It is **recommended** that the Board:

(a) **Notes** that CCDHB had one national target ranked outstanding performer/sector leader (Raising Healthy Kids), three achieved, two partially achieved and one not achieved;

(b) **Notes** we achieved the Better Help for Smokers to Quit (Primary) (90%), Improved Access to Electives (+144), Faster Cancer Treatment (91%) and Raising Healthy Kids targets (97%);

(c) **Notes** there are specific action plans in place to improve performance on the remaining two priority health targets, Increased Immunisations (95%) and Shorter Stays in Emergency Departments (90%);

(d) **Notes** the Better Help for Smokers to Quit (Maternity) (84%) was not achieved due to a data interpretation issue at the Ministry of Health, which we expect to resolve;

(e) **Notes** that in quarter three, of the wider performance targets that we report on to the Ministry of Health 26 were achieved, 15 were partially achieved, 1 was not achieved (Better Help for Smokers to Quit (Hospital)) and 1 received 'no rating' (Reducing Rheumatic Fever).

(f) **Notes** that there are focused areas for improvement to improve results in those wider performance targets that are partially achieved;

(g) **Notes** that the Ministry of Health (MoH) dashboards are for quarters one and two as the quarter three dashboard (the subject of this report) had not been received at the time of writing.

APPENDICES

1. MOH Dashboard: Quarter One 2017/18 Performance for the DHB Population of Capital & Coast
2. MOH Dashboard: Quarter Two 2017/18 Performance for the DHB Population of Capital & Coast.

1. PURPOSE

To update the Board on the District Health Board's (DHB) quarter three 2017/18 priority health target results and other indicators that are part of the quarterly reporting to the Ministry of Health (MoH), and to note the action plans to achieve the two health targets that have a partially achieved status.

To provide the Board with the MoH dashboards summarising DHB performance for 2017/18 quarters one and two. The information in the dashboards aligns with that reported to the Board by management in December 2017 and March 2018.

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2. OVERVIEW OF PERFORMANCE

In quarter three 2017/18, Capital & Coast District Health Board (CCDHB) achieved one outstanding health target, three achieved health targets, two partially achieved health targets and one not achieved health target. This maintains the improvement seen in quarter two 2017/18 and is a significant improvement on quarter three 2016/17 when only one target was achieved and six were partially achieved.

In the comprehensive assessment of 43 targets reported in quarter three CCDHB has delivered a solid performance with 26 'achieved' targets and 14 'partially achieved' targets. One target remains a focus for intensive work being 'Better Help for Smokers to Quit in Public Hospitals'. Performance on this target continues to be difficult to improve. The MoH has not recorded a result for one indicator (rheumatic fever).

Overall performance is being maintained or improving. There are areas of focus for improvement including improving wait times for services including youth mental health and colonoscopy, mental health wellness transition, healthy ageing strategy. There are also opportunities that have been reviewed by the Health System Committee including equity in breast and cervical screening, immunisation for Māori and cardiovascular health.

Strategy Innovation and Performance (SIP) is developing an integrated approach to performance monitoring for implementation, which covers all Government indicators, not just those covered by this report. A paper on this system and how to implement it is scheduled to be put to the Health Systems Committee in June. This tighter focus will help to ensure gains made are retained in coming years.

3. CCDHB COMPREHENSIVE PERFORMANCE

In addition to the seven Health Targets, there were 43 non-financial performance indicators the DHB was required to report on to the Ministry of Health in quarter three 2017/18. These indicators include Government Policy Priorities, Crown Funding Agreement activities and System Integration obligations.

- 26 indicators have an "A" (achieved) or for Crown Funding Agreements "S" (satisfactory) status
- 15 indicators have a "P" (partially achieved) or for Crown Funding Agreements "B" (further work required)
- 1 indicator has an "N" (not achieved – escalation required) status
- 1 indicator has no result recorded

All 15 "P" indicators have resolution plans in place to ensure "A" status is attained. The single "N" indicator also has a resolution plan in place, although improvement to "P" or "A" status continues to prove difficult. CCDHB has reached a status of 'achieved' or 'satisfactory' in the following 28 indicators:

MoH Descriptor	Indicator
Delivery	Improving Patient Experience
Outputs	Mental Health Output Delivery Against Plan
Ownership	National Health Index
	National Collections
	Improving the Quality of the Programme for the Integration of Mental Health Data
	Inpatient Average Length of Stay (ALOS) Acute
	Reducing Acute Readmissions to Hospital
Policy Priority	Long Term Conditions
	Diabetes Services
	Acute Heart Services
	Oral Health DMFT Score at Year 8
	Improving System Integration and System Level Measures
	Implementing the Healthy Aging Strategy
	Mental Health Prime Minister's Youth Mental Health Project
	Mental Health Primary Mental Health
	Mental Health District Suicide Prevention and Post-vention
	Mental Health Improving Crisis Response Services
	Mental Health Improving Outcomes for Children

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	Mental Health Improving Employment and Physical Needs of People with Low Prevalence Conditions
	Supporting Vulnerable Children
	Faster Cancer Treatment – 31 Day Indicator
Crown Funding Agreement	Appoint Cancer Psychological and Social Support Workers
	Appoint Regional Cancer Centre Clinical Psychologists
	B4 School Check
	Disability Support Services Funding Increase
	Elective Initiative and Ambulatory Initiative
	Well Child/ Tamariki Ora Services
Health Strategy	Supporting Delivery of the New Zealand Health Strategy

CCDHB has reached a status of 'some aspects still need development / or the DHB is not tracking to target but has an appropriate resolution plan' in the following 15 indicators. Focused effort across all of these areas is progressing.

MoH Descriptor	Indicator
Ownership	Inpatient Average Length of Stay – Elective
Policy Priority	Implementing the Healthy Ageing Strategy
	Children Caries Free at 5 Years of Age
	Improving the Number of Children enrolled in DHB Dental Services
	Cardiovascular Health (previous CVD Health Target)
	Immunisation Coverage at 24 Months and 5 Years Old
	Improving Waiting Times for Diagnostic Services – Colonoscopy
	Improving Waiting Times for Diagnostic Services – Coronary Angiography
	Improving Waiting Times for Diagnostic Services – CT/ MRI
	Reduce the rate of Maori under the Mental Health Act section 29 Community Treatment
	Improving Breast Feeding Rates
	Improving Mental Health Services using Transition Discharge Planning
	Shorter Waits for non-Urgent Mental Health and Addiction Services for 0-19 Year Olds
System Integration	Delivery of Regional Service Plans
	Standardised Intervention Rates

CCDHB has reached a status of 'DHB is not on track to meet the target and does not have an appropriate resolution plan' in the following indicator:

MoH Descriptor	Indicator
Policy Priority	Better Help for Smokers to Quit in Public Hospitals (previous Health Target)

This indicator has been escalated for implementation by HHS. Achievement is a priority.

4. PRIORITY HEALTH TARGETS

The table below outlines the performance of CCDHB on the seven Health Targets. CCDHB has achieved the 'Better Help for Smokers to Quit (Primary)', 'Faster Cancer Treatment Times', 'Improved Access to Elective Surgery' and 'Raising Healthy Kids' targets. It has two partially achieved targets and one not achieved target.

Incremental improvement has been made against the difficult to achieve 'increased Immunisation' target. We achieved the total population target of 95%, but did not meet the target for Maori where performance declined by 7% on quarter two. CCDHB is ranked as the third DHB nationally on performance for this target. The 'Better Help for Smokers to Quit (Maternity)' target was not achieved with performance recorded as falling from 96% to 84%. We believe this to be a data interpretation issue by the MoH and have followed up with them for an explanation. CCDHB expects to gain or maintain 'achieved' for all targets in quarter four except the 'Shorter Stays in Emergency Department' target, which remains a challenge. Work to identify and implement further efforts to achieve this target is being continued as per the summary below.

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4.1 Quarter Three 2017/18 Health Target Results

Health Target	Target	Quarter One Result	Quarter Two Result	Quarter Three Result	Quarter Four Result	Change from Previous Quarter	DHBs Achieving Target out of 20	CCDHB Rank out of 20 DHBs	Action Plan
Better Help for Smokers to Quit (Primary)	90%	91% (A)	91% (A)	90% (A)		-1%	12	8	Achieving target. Maintain performance.
Faster Cancer Treatment*	90%	88% (A)	89% (A)	91% (A)		3%	16	11	Achieving target. Maintain performance.
Improved Access to Elective Surgery	Achieve Volume Target	27 (A)	93 (A)	144 (A)		51	11	11	Achieving target. Maintain performance.
Raising Healthy Kids	95%	84% (P)	98% (O)	97% (O)		-1%	information not available	information not available	Achieving target. Maintain performance.

* Note achievement criteria changed from quarter four 2016/17 to quarter one 2017/18.

Health Target	Target	Quarter One Result	Quarter Two Result	Quarter Three Result	Quarter Four Result	Change from Previous Quarter	DHBs Achieving Target out of 20	CCDHB Rank out of 20 DHBs	Action Plan
Better Help for Smokers to Quit (Maternity)	90%	97% (A)	96% (A)	84% (N)		-12%	12	16	Moving towards target. The MoH record does not align with the data submitted. We have escalated the issue with the MoH for resolution. We expect an achieved result.

PUBLIC

Increased Immunisation	95%	94% (P)	94% (P)	95% (P)		1%	2	3	Moving towards target. This target is now consistently being achieved for our general population, but not for our Maori population. The equity focus of the PHO is: PHOs are following up a list of Maori children - The list is compiled from the PHO birth cohort turning 8 months this quarter and due for 5 months vaccinations. - All of these tamariki have been referred to OIS - Outreach Immunisation Service (OIS) are prioritising Maori - OIS will complete a minimum of 3 home visits to locate a child and their whanau. - They also use their extensive community networks to try and locate whanau.
Shorter Stays in Emergency Departments	95%	89% (N)	92% (P)	90% (P)		-2%	7	14	Challenged by target. Over quarter four 2017/18 management is implementing the actions listed below to improve compliance with the target: - A new Acute Flow project has begun led by the Even Better Health Care team. Decision making on solutions is informed by a dynamic modelling tool which allows the DHB to understand the impact of changes to models of care at a health system level. The Board can expect a report on the recommendations generated by this work in in quarter one 2018/19. - Process improvement projects are continuing across the ED and the specialty departments. - Winter demand presents some threat to the achievement of this target as demand is anticipated to grow.

PUBLIC

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**BOARD INFORMATION**
	Date: 29 May 2018

Author	Valentino Luna Hernandez, Sustainability Manager
Endorsed by	Gina Lomax, Executive Director, Clinical and Support Services Ashley Bloomfield, Interim Chief Executive
Subject	**ENVIRONMENTAL SUSTAINABILITY UPDATE**

RECOMMENDATIONS

It is **recommended** that the Board:

(a) **Notes** that there is a significant programme of work underway to reduce the impact of CCDHB's activities on the environment and support environmental sustainability;

(b) **Notes** that the Minister's Letter of Expectation for 2018/19 included a clear indication that DHBs should be undertaking work on environmental sustainability;

(c) **Notes** that management is proposing to participate in a scheme to measure and reduce the DHB's carbon emissions and will keep the Board updated on this;

(d) **Notes** that CCDHB was a category winner for the Wellington Region in the annual Aotearoa Bike Challenge.

APPENDICES

1. Environmental Sustainability Policy
2. Sustainability Stories, Awards and Coverage.

1. INTRODUCTION

1.1 Purpose

The purpose of this paper is to inform the board of activities related to environmental sustainability.

1.2 Previous Board Discussions/Decisions

This is the first written update on environmental sustainability.

2. BACKGROUND

2.1 Environmental sustainability at CCDHB

The focus on environmental sustainability at Capital and Coast District Health Board (CCDHB) grew organically reflecting increased awareness of environmental and climate change issues among staff. The current team began as a staff-led Green Ideas Group working in a variety of waste and energy saving initiatives in 2009.

A Sustainability Steering committee was later established. The committee is the strategic backbone of our work in environmental sustainability. In June 2016 CCDHB appointed its first Sustainability Officer signalling a commitment to work in reducing its environmental footprint.

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During this growth phase, the values of the staff working in environmental sustainability continue to be helping CCDHB deliver its mission of healthier communities by also contributing to a healthy environment.

2.2 Minister of Health's Letter of Expectations 2018/19

The Minister's Letter of Expectations includes the following:

> The Government also wants to support our health system to implement a strong response to climate change, this will include working with other DHBs, other agencies and across Government. Plans to address climate change and health, need to incorporate both mitigation and adaptation strategies, underpinned by cost benefit analysis of co-benefits and financial savings.

The current and proposed activities outlined in this report support this direction.

2.3 Activity since the appointment of the Sustainability Officer

The Environmental Sustainability Policy (Attachment 1) lists the following target areas:

- Material and waste flows
- Sustainable energy management
- Sustainable Journeys
- Design for sustainability
- Sustainable water management
- Carbon management and reduction.

Many initiatives in the waste, transport and energy fields were implemented across departments since the appointment of a dedicated person to coordinate activities. The Sustainability Officer leads the on-going management and implementation of the CCDHB Environmental Sustainability Policy by developing, planning, implementing and evaluation of sustainability initiatives.

The list of projects outlined below cover the first steps taken to improve the environmental performance of CCDHB's operations and the benefits (environmental, social or financial) achieved.

Impact area	Project description	Outcomes (Environment, Budget, Risks)
Material and waste flows	Recycling of used IV fluid bags – clean IV fluid bags are segregated from waste stream and sent for recycling locally	- Reduced 3,000 kg of plastic waste to landfill per year - $300-400 less disposal fees - Supports regional recycling industry - Very popular among staff, high engagement. Most liked post in the CCDHB facebook page when published in 2017.

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Impact area	Project description	Outcomes (Environment, Budget, Risks)
Material and waste flows	Waste Audit through WCC Waste Minimisation Grant	- Independent evidence of Wellington Hospital waste footprint - Supports local NGO (Sustainability Trust was the provider) - Identified savings in food waste ($50k if fully realised) from single serves of milk, butter, etc) - Positive coverage by the Dominion Post
Material and waste flows	Hosted the quarterly Regional Waste Forum (all councils from the Wellington Region)	Established CCDHB as an active stakeholder in regional waste minimisation
Material and waste flows	Worm Farm at Kapiti Health Centre – Obtained through grant from Kapiti Coast District Council	- Reduced food waste by an estimate 500kg/year - Circa $500 financial savings - Popular with staff
Material and waste flows	Trial of new reduce and recycling technologies: - Longopac bagging system (Kenepuru, Kitchens) - Food waste processing (Kitchens) - Biocharring paper cups - Stainless Steel and other metal instruments recycling - Pallets recycling - Free for all - Textiles	
Material and waste flows	Collection of sharps in the community – Used funds from WCC grant to increase awareness and user uptake for existing regional collection scheme of sharps waste.	- Minimised harm from waste in the region (reduced reports of waste collection workers struck by sharps) - Well received by local councils (Wellington, Hutt)
Material and waste flows	Furniture recycling - Established a single point of contact for furniture reuse-recycle-disposal	- Repurposed estimated $70,000 worth of furniture items - Saved $7,000/year in skip bin hire and disposal costs - This scheme is well used by staff
Material and waste flows	Work with Charities and NGOs – established arrangement with local and international NGOs to find alternative uses to equipment no longer available for use in Wellington Hospital - Surgical instruments donated to SPCA - 50 Beds donated to Healthcare facilities in Pakistan and Solomon Island - Surgical instruments, and expired supplies to Wellington Zoo - Obsolete equipment donated to Props companies - Textiles donated to Schools for projects	- Reduced disposal costs - Enhanced links with local organisations - Positive stories in local press

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Impact area	Project description	Outcomes (Environment, Budget, Risks)
Sustainable Journeys	Developing a staff travel plan to increase uptake of sustainable travel options - Sustainable transport information days in Wellington and Kenepuru	- Well received by staff (circa 10% of staff has had 1:1 discussions about sustainable travel with trained staff from Greater Wellington Regional Council)
Sustainable Journeys	Establishing CCDHB as a local and regional stakeholder for transport-related projects (Get Wellington Moving, Cycling infrastructure projects, Public transport projects)	-
Sustainable Journeys	Supporting cycling awareness by participating in Aotearoa Bike Challenge	- Increased staff engagement, over 150 staff taking part. - Won 'Large employer' category, with 3.1% staff participation - 2,230 Kg of CO2 emissions reduced
Sustainable Journeys	Sign MoU with Greater Wellington Regional Council for work in sustainable transport	$20,000 savings in consultancy fees savings to the CCDHB due to access to GW's expertise and grants for specific outputs (Travel Plan)
Sustainable Journeys	Build more secure bicycle parking, storage and changing facilities in response to staff demand	Increased staff engagement
Sustainable Energy Management	Enter CCDHB in Sustainable Business Network awards (2016) for energy saving-related projects delivered in 2013-15	- Established CCDHB as one of the leading DHBs working in Sustainability - Finalist project in the Mega-Efficiency (impact) category - Project Savings were approximately 6,000,000 Kilowatt hours ($ 0,5M in reduced energy costs) and 850 tonnes of CO2 Emissions
Sustainable Energy Management	Sign a collaboration agreement with EECA that allows access to funding and crown loans. Current opportunities: - Funding for a graduate engineer to support energy-saving projects - Funding for energy efficiency review of new builds design - Crown loan for large scale LED deployment - 40% funding for new technologies. Currently supporting LED cyanosis lights in theatres -	- $20,000 savings from EECA's contribution for Theatre LED project - EECA contribution up to $15,000 for new builds energy efficiency design
Sustainable Energy Management	Procure new software to reconcile billing and identify over charges and energy-intensive areas for future work When set-up is finished there will be 2 years' worth of billing data for all energy, bulk fuel, air travel and transport-fuel. This can be used to model future interventions	-

PUBLIC

Impact area	Project description	Outcomes (Environment, Budget, Risks)
Promotion/Community	Deliver targeted waste education talks to individual departments.	Increased staff satisfaction as able to recycle more waste in wards
Policy	Developing and implementing the Environmental Sustainability Policy	National leadership, CCDHB is one of 6 DHBs where Environmental Sustainability Policy has been adopted by the Executive

3. DISCUSSION

3.1 Risks and opportunities

3.1.1 Scope and scale

The potential scope and scale of sustainability opportunities in CCDHB is still being elaborated. All the projects listed above were possible because staff involved (from frontline to functional managers) were willing to try new ways of doing their business with existing resources. Scaling up work in this area will likely require additional resources (and budget), which could be prioritised from savings made from implementing sustainability initiatives.

The Sustainability Officer is currently developing a strategic implementation plan based on Treasury's 'Better Business Case' process. The draft plan will provide a five year work plan and indicative budget.

3.1.2 Measuring and managing

After two years of work across the many domains, CCDHB now has the knowledge and capacity to start a formal scheme for measuring and managing its carbon emissions. Carbon measurement by an independent scheme such as CEMARS provides an evidence-based and comparable metric that can be used to outline progress of work in climate change mitigation.

While there are costs to participating in such schemes (about $30,000/year), these are recovered by savings in reductions in electricity, fuel, travel or waste disposal. Other DHBs have achieved 20% carbon footprint reductions and financial savings that easily cover the costs of the CEMARS scheme. Management will continue to progress this and keep the Board informed.

3.1.3 Devolved and Centralised procurement

CCDHB has been able to advance environmental initiatives through having control or influence over certain areas such as the integrated services of Kitchen, Waste and Cleaning. For example, there is a current project to minimise food waste. This can be done because CCDHB manages its own kitchens for staff and patients meals. However, centralised procurement such as the drugs and devices procured by PHARMAC create environmental challenges. Currently, DHBs in general have little influence over these centralised processes and are left with the waste disposal challenges (excess packaging, unrecyclable single-use devices etcetera)

There is a strategic opportunity to advocate for more sustainability in procurement both internally and externally. Work in this area will be included in the five-year plan.

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CONGRATULATIONS
1st
AOTEAROA BIKE CHALLENGE
CATEGORY WINNER 2018 – Wellington Region
Capital & Coast District Health Board
For encouraging 3.1% of your staff to ride.
You rode 23,087 km and saved 2,230 kg of CO_2.
2000+ STAFF CATEGORY
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REGIONAL COUNCIL
Te Pane Matua Taiao

Document facilitator: Sustainability Officer

Senior document owner: Executive Director Clinical & Support Services / ELT Committee

Document number: 1.103421 **Issue Date** 25 Sept 2017 **Review Date** 25 Sept 2020
Version 1

Type: Policy

Name: Environmental Sustainability Policy

Purpose

In delivering its work, Capital and Coast District Health Board (CCDHB) has the potential to impact on the local natural environment, society and economy. The purpose of this policy is to lead CCDHB towards a sustainable and environmentally responsible practices.

Scope

Includes:

This policy is applicable to all CCDHB employees, all associated personnel including contractors, visiting health professionals and students working for or on behalf of CCDHB, as well as CCDHB tenants.

In the context of this policy, sustainability refers to environmental sustainability; understanding the environment is not separate to the society and economy we live in. We aim to live within our means, and limit the use of natural resources in order to improve the environment whilst ensuring the goals of CCDHB are achieved.

Definitions

Term/Abbreviation	Description
Sustainability	Living within and respecting environmental limits and preventing environmental harm while providing for our society now and for future generations.
Carbon footprint	The total amount of greenhouse gases produced to directly and indirectly support human activities, usually expressed in equivalent tons of carbon dioxide (CO2)
CEMARS	Certified Emissions Measurement And Reduction Scheme certification is the first of a two stage carboNZero certification process (measure and manage). each step will be independently verified then certified.

Document facilitator: Sustainability Officer

Senior document owner: Executive Director Clinical & Support Services / ELT Committee

Document number: 1.103421 **Issue Date** 25 Sept 2017 **Review Date** 25 Sept 2020
Version 1

NZ Legislation /Standards	Waste Minimisation Act 2008 New Zealand Public Health and Disability Act 2000 Resource Management Act 1991 Health & Safety at Work Act 2015 Hazardous Substances and New Organisms Act 1996 Land Transport Act 1998 Land Transport Rule: Dangerous Goods 2005 Councils of the Wellington Region Waste Minimisation and Management Plan 2012 Wellington Trade Waste Bylaw 2016 Wellington Water Conservationand Efficiency Plan 2011

Policy content and guidelines

CCDHB recognises that a healthy environment (including a stable climate) is a key factor for supporting the health and wellbeing of its population. Environmentally sustainable operational practices often result in cost savings; environmental sustainability also reflects prudent stewardship of limited financial resources. CCDHB will work to establish itself as a local leader in protecting the environment and public health.

CCDHB will foster a culture of environmental sustainability and encourage leadership in sustainability throughout the organisation. It will commit to keeping sustainability in mind in the practice of healthcare. CCDHB will also encourage staff to practice sustainability at work, at home, and whilst commuting.

Behaviours

- Measure and manage
- Collaborate
- Be a good neighbour
- Learn together
- Manage risks
- Own the environmentally sustainable solutions
- Evaluate and share good practice
- Lead by setting an example within the sector.

CCDHB will realise its commitment to continuous improvement of environmental practice by:

- ensuring an appropriate administrative structure to achieve institutional compliance with this policy
- developing and implementing strategies, programmes and initiatives with specific goals and regular reporting on progress towards these goals.

- the Sustainability Steering Group will oversee the policy and programmes, set long term goals for continuous improvement of its environmental performance, and review the results
- obtaining CEMARS Certification (or equivalent) and audit requirements and implementing the CEMARS Management and Reduction Plan
- ensuring compliance with environment and government laws and regulations
- minimising waste by considering the waste hierarchy before disposal and having a whole-of-life-view on the products and services procured by the DHB
- reducing the consumption of raw materials and redundant packaging
- improving energy efficiency within buildings we own throughout the organisation
- encouraging sustainable travel practices and reviewing the staff travel plan
- ensuring that the design of all refurbishment in leased or owned buildings takes into account sustainable design and construction principles where practicable
- avoiding, remedying or mitigating harmful emissions
- purchasing goods and services that are manufactured, used and disposed of in an environmentally responsible way
- engaging and partnering with our campus neighbours and the wider community, research, higher education and healthcare, to promote environmental best practice
- increasing the use of smart-metering technologies for water and energy.

CCDHB will seek to improve environmental sustainability in the key areas of material and waste flows, energy management, travel/transport, water conservation, buildings and procurement in order to reduce its ecological and greenhouse gas emissions' footprint. CEMARS certification (or equivalent) is the framework chosen to measure and monitor progress.

Initial Target areas

- Materials and waste flows (environmentally sustainable procurement, Reduce-Reuse-Recycle, environmentally responsible providers)
- Sustainable energy management
- Sustainable journeys - for staff, patients, goods and services
- Designing for sustainability (Site masterplanning)
- Sustainable water management
- Carbon management and reduction (CEMARS)

stuff

Wellington hospital beds donated to charity to help needy in Pakistan, Solomon Islands

RACHEL THOMAS
Last updated 09:46, March 28 2018

SUPPLIED/CCDHB

Beds recycled from Capital & Coast District Health Board are loaded into a container for shipping to Pakistan, through the charity Take My Hands.

Amputees in Pakistan and patients in the Solomon Islands may soon be sitting on Wellington beds.

Fifty-one working hydraulic and electric beds, which have reached the end of their usable life for Capital & Coast District Health Board (CCDHB), have been diverted from landfill to Kiwi charity Take My Hands.

The group collects usable medical equipment and resources that can no longer be used in New Zealand and redistributes them to organisations that work with those in need in the Asia Pacific Region.

SUPPLIED/CCDHB

Capital & Coast District Health Board contractor Rick Kraus, helps to load recycled beds onto a container for shipping to Pakistan.

A container packed with 25 of the beds, 36 meal trolleys and two drip poles headed off last weekend, destined for the Hope Rehabilitation Society in Lahore, which specialises in artificial limbs, Take My Hands managing trustee Janette Searle said.

READ MORE:
* **DHB tackles waste mountain**
* **Schools get behind charity campaign**
* **Take a night off to help those in need**

It's likely the rest will end up in the Solomon Islands, where beds of any kind are in short supply, Searle said.

SUPPLIED/CCDHB

Kenny McCaul, Capital & Coast DHB contracts manager, says the DHB sent 51 beds to Pakistan as part of a mission to reduce hospital equipment going to landfill.

"Some health clinics just don't have beds. They have patients on the floor. In paediatric departments there are women who have just given birth who were in blankets on the floor.

"It's not about shoddy equipment it's that there's no equipment," Searle said.

CCDHB contracts manager Kenny McCaul said the move was part of the hospital's new waste minimisation policy, which came out of a waste audit conducted last year.

"We decided the traditional way of disposing of these beds wasn't going to suit the way we wanted to operate as a DHB any more."

Most of these beds have a shelf life of about 10 years, then it becomes too hard to get parts, McCaul said.

"They were past the age where they could operate in a hospital environment."

They were all in a working state when donated, which Searle said was important.

"We don't want our junk just to end up in thier landfills. It's important to send stuff that's easy to maintain or they can get parts."

On top of the donation to Take My Hands, the DHB had also sent beds to propmakers and the Wellington Menzshed, where they were used as portable workstations, he said.

"You can get them to a decent height to be able to lean over a project and raise it up, so you're not having to reach in the middle of something."

Some would have arrived with the regional hospital in 2008, while some were even older, McCaul said.

Searle said Take My Hands, officially established in 2012, was made possible through the use of small contributions of transport and logistics companies and DHBs that no longer needed medical equipment.

"It's when small contributions that make sense come together."

Anyone who wants to help Take My Hands, can visit onepercentcollective.org/take-my-hands.

- Stuff

more from stuff

LOVE TO RIDE

CONGRATULATIONS

AOTEAROA BIKE CHALLENGE

CATEGORY WINNER 2018 – Wellington Region

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For encouraging 3.1% of your staff to ride.
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stuff

Capital & Coast DHB tackles waste mountain in a bid to improve recycling

ROSS GIBLIN/FAIRFAX NZ

Thom Adams from the Sustainability Trust is auditing the recyclable waste from Wellington Hospital.

In the muggy basement of Wellington Hospital, between the pipes and the plumbing, two people in contamination suits have been sorting through mountains of rubbish.

Syringes and human offcuts, or related gore, are nowhere in sight as bags of general rubbish are slung on to a sorting table in an effort by the capital's district health board to address its waste.

"There are no body parts ... and there's no way we should be dealing with anything that's soaked," according to Thom Adams, lead educator for The Sustainability Trust.

ROSS GIBLIN/FAIRFAX NZ

Capital & Coast DHB produces thousands of kilograms of waste each day. The DHB has carried out its first waste audit to see if there's room for improvement.

These things are a health hazard and must be shipped off to Brisbane in refrigeration containers and destroyed in an incinerator, under order of the Environmental Protection Authority.

READ MORE:
* **Wellington businesses go through the trash to save cash**
* **Kaikoura waste audit underway**
* **Missing gowns and towels cost hospitals dearly**
* **New hope for recycling plastic bags in Wellington in soft plastics**

Capital & Coast DHB (CCDHB) generates between 4000 and 5000 kilograms of waste every day. That includes biohazardous materials, recyclable materials and general waste.

ROSS GIBLIN/FAIRFAX NZ

Capital & Coast DHB generates between 4000 and 5000 kilograms of waste every day.

Valentino Luna, the health board's sustainability officer, said a lot of hospital waste is subject to health and safety protocols and cannot be helped.

But there may be room for improvement around recycling packaging, or dealing with food waste.

This audit marks the first time the health board has done a stocktake of its waste. Adams and his co-worker, Deepa-Rose Sealy, have been underground at the hospital for six days.

For surgeons dealing with critical situations, it is understandable if their first priority is not taking a moment to recycle, Luna said.

"We have a workforce that is here to look after people's health. They are very time poor ... [for example] the emergency department - trying to deal with life or death situations - getting into their habits to recycle, it takes a bit of time.

"Making the default to recycle instead of throwing something away - it's a behaviour change."

Two months ago the health board began recycling plastic bags from intravenous treatments, such as saline, glucose and iron. They are being trucked to Otaki and recycled into equipment used in children's playgrounds, Luna said.

The health board goes through about 300,000 of these bags a year. About 500kg of plastic has been diverted from landfill already.

"Surprisingly, the biggest uptake of this is in [the] ED and intensive care unit. So high stress situations, but there's a very dedicated pool of nurses who want to do it," Luna said.

The Sustainability Trust will come back to the health board with a report on what they have found, then it is up to the health board to decide what steps to take.

In recent times The Sustainability Trust has done waste audits for Wellington Chocolate Factory, Victoria University and Rimutaka Prison -- all of which are making efforts to catalogue their waste habits.

- Stuff

more from stuff

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Capital & Coast District Health Board (CCDHB) is with Valentino Luna Hernandez.
7 February 2017 ·

It's Go by Bike day and here at Capital & Coast District Health Board we have hundreds of staff who bike. Cycling for recreation and commuting saves millions of dollars per year in health costs – and it's lots of fun!

26 Likes 1 Comment 5 Shares

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Capital & Coast District Health Board (CCDHB)
17 August 2016 ·

Recycling our used IV bags into plastic playground mats means we're now turning tonnes of trash to tonnes of fun!

324 Likes 19 Comments 31 Shares

Transformation Areas

This story reflects success in the highlighted areas.

community | **mega-efficiency** | renewables | restorative

Capital & Coast District Health Board.

Hospital buildings are a 24/7, energy-intensive operation. Sterilisation, heating, cooling, lighting and ventilation don't ever stop running.

Capital & Coast District Health Board (CCDHB) is showing leadership by investing in management systems to reduce energy consumption, providing savings to the organisation and reducing overall energy demand.

In 2013 CCDHB began a strategic energy management programme to reduce its utilities use and costs. The following year, it initiated a number of projects that significantly reduced overall utilities use at Wellington Regional Hospital.

From 2014 to 2016, electricity use was reduced by 5 million kWh, equivalent to savings of 785 tonnes of CO_2 per year.

Key projects contributing to this success include: a new building management system in Wellington Regional Hospital which reduced energy consumption by over 10%; the replacement of over 4,000 fluorescent tubes with modern LEDs which reduced electricity costs by approximately $37,000; and savings on gas with a burner replacement project, which is forecast to offset 1.2GHW per annum.

Capital & Coast District Health Board is a finalist in the Mega Efficiency Impact category of the 2016 NZI Sustainable Business Network Awards.

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Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**BOARD INFORMATION**
	Date: 6 June 2018
Author	Trish Davis, National Operations Manager, ID Services (Seconded to Inquiry project)
Endorsed by	Rachel Haggerty, Executive Director, Strategy, Innovation and Performance Nigel Fairley, General Manager, Mental Health Addiction & Intellectual Disability Services 3DHB Ashley Bloomfield, Interim Chief Executive
Subject	**MENTAL HEALTH AND ADDICTIONS INQUIRY UPDATE**

RECOMMENDATIONS

It is **recommended** that the Board:

(a) **Notes** the Inquiry consultation process in the CCDHB rohe was completed successfully;

(b) **Notes** the feedback from the Pacific attendees included in this report, as requested;

(c) **Notes** the feedback from the MHAIDS staff members who attended a session with the Inquiry Panel;

(d) **Notes** the final submission made to the Inquiry by Wairarapa, Hutt Valley and Capital & Coast District Health Boards.

APPENDICES

1. Feedback from discussion with the Mental Health Inquiry Panel by Pacific attendees
2. Government Inquiry into Mental Health and Addictions – Final 3DHB response

1. BACKGROUND

Members of the panel conducting the Government's Inquiry into mental health and addiction visited the Wellington, Hutt Valley and Wairarapa regions on May 17, 18 and 22. In May, we advised you that a 3DHB approach had been adopted to providing input into the Mental Health Inquiry (Inquiry).

Two joint written submissions were made and meetings with the Inquiry panel were coordinated across the three DHBs to ensure opportunity for consumers, the community and NGO sector, the workforce and the MHAIDS provider to make representation to the Inquiry panel.

2. 3DHB RESPONSE

The 3DHBs have submitted two written submission, two presentations at the panel meeting with senior executives, and feedback from MHAIDS staff. The initial submission and presentationsw ere made available to the Board via Boardbooks. The final response and staff feedback are attached as appendices two and three.

2.1 Initial Responses

The initial response and stocktake was submitted to the Inquiry on 4th May 2018. This response outlined the DHBs' insights into this area, a stocktake of programmes/services, challenges and potential solutions. This 3DHB response recommended the following seven key solutions:

- Addressing equity issues for those populations with greatest need including Māori, youth, Pacific,

- Broadening service scope to mental health and mental distress with emphasis on prevention and early intervention,
- Increasing access to talk therapies,
- Workforce development,
- Creating multi-disciplinary therapeutic hubs around clusters of schools,
- Increasing integration across primary/community and specialist mental health services by developing community wellbeing networks, and
- Commissioning integrated services.

2.2 Final Written Submission

A final brief submission, submitted on 5 June 2018, focused on the importance of prevention and early intervention and DHBs using commissioning for populations and outcomes. At the same time it reiterates that change is important but disinvesting from secondary mental health and addiction services to reinvest in other areas is not an option in the current funding constrained environment and strengthening prevention and community responses will require additional investment.

3. MEETINGS WITH THE MENTAL HEALTH INQUIRY PANEL

Engagement with the panel members occurred on **May 17, 18 and 22**. The Inquiry panel met with senior DHB leadership, the public and consumers, provider stakeholders and the workforce. The team met with the chief executives from the three DHBs, 3DHB senior leaders, and senior clinical and management staff from MHAIDS. The range of presentations gave the Inquiry panel insights into current mental health and addiction services, challenges and possible solutions for the future.

The public meeting held in Porirua on 17th May was attended by approximately 120 people. Many family members spoke about their individual circumstances and what had worked or not worked well for them. Key themes emerged about: the lack of early supports for people with mental distress; families/whānau seeking more involvement in the support processes for their family member; the impact of methamphetamine in the community and the need for an increased range of supports for Māori and Pacific.

Eleven stakeholder meetings were held with the following groups: consumers, Māori, Pacific, NGOs (mental health and addiction), community, Te Ara Pai collective, PHOs and GPs. Out of the eleven meetings, three were dedicated for MHAIDS staff working in Capital and Coast and Hutt Valley areas.

The general feedback we received was that everyone was grateful for the opportunity to be able to talk about their areas, the challenges they were facing and they submitted a range of solutions for change. (See appendix 3.2.1 for the feedback from the Pacific attendees who met with the Inquiry panel on 18th May 2018).

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APPENDIX 1

Pacific Fono: Mental Health Inquiry Feedback

1 PACIFIC ISLAND ENGAGEMENT WITH THE MENTAL HEALTH INIQUIRY

Approximately 30 members of the Pacific Island community across Capital and Coast, and Hutt Valley DHBs attended the Pacific fono. The Pacific members of the Mental Health Inquiry panel To'oa Dr Jemaima Tiatia and Josiah Tualamaleali'i met with Pacific leaders and consumers to listen to their views and experiences of mental health services.

Prior to presenting their issues, Pacific leaders and consumers expressed their appreciation for the opportunity to be engaged in the Mental Health Inquiry. A follow up Pacific focussed consultation has been arranged for the 5th July in Wellington of which details will be disseminated to participants and those leaders and consumers who could not attend.

Participants reinforced that their ultimate goal was to see Pacific families and communities flourish by establishing strong connections to their cultural identity, heritage and language, and achieving the dreams and aspirations for their aiga / families.

Across the board, participants felt that the barriers to progression are systemic and attitudinal. Participants expressed grave concerns about the current state of mental health services and a have made a call to the Mental Health inquiry for immediate action to curb the significant risk and danger posed on consumers, their families and communities;

The following feedback was provided:

1.1 Service delivery, utilisation and integration

- Pacific leaders expressed concerned that the data available does not define a clear problem definition and as a consequence, the investments in services does not accurately reflect the needs of Pacific consumers and their families;
- There is a sense that mental health services are fragmented, lack alignment, and collaboration within secondary and primary mental health services, making access and utilisation of services challenging for Pacific people;
- The services for Pacific people do not cater for co-morbidities across mental and physical health, e.g. Pacific people with mental health who have diabetes, obesity and long term conditions;
- There is a lack of integration between Pacific providers across community and secondary services. This issue is a reflection of the funding models and lack an understanding of Pacific consumers needs to have a seamless service from being discharged from acute / secondary services to community, and that avoids readmission;
- As much as possible, services need to be based and delivered within the communities and across the NGO sector.[iii]

1.2 Models of care

- Pacific populations are evolving yet the current models are poorly equipped to deal with the growing challenges being experienced by Pacific communities in particular young Pacific people in society today;
- Cultural assessment frameworks are still relevant for Pacific consumers yet they are not readily available, developed or reviewed for practitioners to utilise nor is appropriate training responsiveness programmes available;

- There is a lack of cultural assessment frameworks supporting wellbeing of Pacific consumers being integrated in service delivery[iii];

1.3 Workforce

- Despite the efforts to grow the Pacific mental health workforce in CCDHB and HVDHB, and the significant investment by organisations like Le Va, Te Pou, and the DHBs, the Pacific workforce continues to be under-represented in the clinical, management and leadership areas, across CCDHB and HVDHB.
- Pacific people appear to be over-represented within entry level roles such as support workers and front line roles in NGOs such as navigators with little understanding of how Pacific people can progress into clinical / management roles;
- There is no leadership pipeline to support senior clinicians and staff in leadership roles within Mental health services and the NGO sector[iv];

1.4 By Pacific for Pacific

- Pacific participants continue to be concerned about the perceived 'taker-over' of Pacific providers and services by mainstream services without due consideration of the relevance of by Pacific for Pacific services.[v]

[i] Pacific Perspectives (2011) Primary Care for Pacific People: A Pacific and Health Systems View. Wellington: Pacific Perspectives.
[ii] "Inequity is built into health systems..." (Starfield, 2011) and equity is achieved only by good policy and managing to that policy (Sheridan, 2011).
[iii] Tiatia J. 2008. *Pacific Cultural Competencies: A literature review*. Wellington: Ministry of Health. Published in February 2008 by the Ministry of Health PO Box 5013 Wellington, New Zealand
[iv] Betancourt, J.R., Green, A.R., Carrillo, J.E., Ananeh-Firempong II, O. (2003) Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. Public Health Reports 118(4): 293-302
[v] Ryan, D., Beckford, N., & Fitzsimons, M. (unpublished, 2010) Lalaga: Pacific providers making a difference. Wellington: Ministry of Health

APPENDIX 2

June 5 2018

Professor Ron Patterson
Chair
Government Inquiry into Mental Health and Addiction
mentalhealthinquiry@dia.govt.nz

Dear Ron

3DHB final submission to Government Inquiry into Mental Health and Addiction

Background to submission development

This letter forms our final submission to the Government Inquiry into Mental Health and Addiction. In addition to this letter, please also refer to the following:

- The initial response and stocktake on behalf of the 3 DHBs as funders, and MHAIDS as the 3DHB provider arm of mental health and addiction services in our area, sent to the Inquiry on **Friday May 4**.
- Engagement with the panel members on **May 17, 18 and 22**, including the two presentations provided by the 3 CEs and the 3DHB senior leadership team.

District Health Boards (DHBs) have a contribution to make. Approaches need to change, and leadership from the centre of the system needs to support us to take the initiative in that change.

We acknowledge our mental health and addiction services play an important role in the provision of services and require appropriate funding to support ongoing service development and delivery. Our service provision and investment is dominated by specialist mental health services. With significant funding pressure investment in prevention, early intervention and support for mental distress and trauma is very limited.

However; the major changes have to take place outside of services, at a societal level, if services are able to respond differently to need and have the space required to focus on the recovery and wellbeing of their clients and their families.

From the perspective of a services provider, the combined DHBs would like to see a society where wellbeing and freedom from addictions are supported in our society and issues affecting mental health and wellbeing are recognised and acted upon ***before they require an intensive (and expensive) health system response.***

Furthermore, internationally there is wide discussion on a population health approach prevention and promotion of mental health and wellbeing. The World Health Organisation, along with others have promoted these approaches. In our New Zealand context we have the learnings of whānau ora to

inform our approach to approaches, programmes and partnerships that will support mental health, wellbeing and freedom from addictions. Critically, ensuring the relevant government agencies are on board and the right systems, budget appropriations and capability are in place is essential to this transformational change.

The issue of funding streams that support mental health and wellbeing is also a critical discussion. As we verbally outlined; disinvesting to reinvest remains an unsuccessful approach in a funding constrained environments with significant competing demands; that redirecting increases in population based funding streams is possible (and the current focus of Capital and Coast DHB) is possible but will be slow to achieve the change we need, and finally the development of a focused investment for mental health and wellbeing could be the most effective model of funding.

Specific contributions from DHBs to the change required

In our earlier responses we had listed integrated commissioning as the seventh in a list of possible solutions. The process of engaging with the panel has helped us refine our ideas: we see that addressing commissioning is the fastest lever by which New Zealand as a whole can address the issues outlined in this submission, and our earlier responses and presentations.

MOH published a commissioning framework for Mental Health and Addiction in 2016. It also commenced the development of a population based approach to outcomes that recognises that diversity requires differing responses to support mental health and wellbeing. Neither of these frameworks have been implemented consistently nationally[1].

In addition to tackling commissioning, DHBs have other significant contributions to make in effecting the systemic change described earlier in this letter. These are strategic level solutions, and complement the practical solutions we provided in our earlier response and presentations. They include ensuring that:

- Accountability mechanisms to the Crown/MOH for mental health and freedom from addiction reflect drivers of wellbeing and facilitate investment in wellbeing models;
- DHB commissioning models that focus on the mental health and freedom from addictions of ethnographically identifies population groups, requiring integration of health services across the life course;
- Services for those who are experiencing illness are also focused on achieving wellbeing and specifically focusing on removing risk based approaches;
- Clinical expertise is focused on supporting wellness through focusing on life outcomes as well as clinical results.
- Workforce development focuses on delivery of redesigned models of care that are specific and not general.

[1] See last paragraph, p 4, *Commissioning Framework for Mental Health and Addiction: A New Zealand guide*, 2016

In addition to the last point above on workforce, our May 4 response inadvertently missed addressing the registered nursing workforce, easily the largest group of our staff. We recognise better workforce planning is required for this vital group, including creating a 3DHB approach, significantly increasing the new entry to specialist practice (NESP) intake and take practical approaches to address the gender and cultural imbalances.

Conclusion

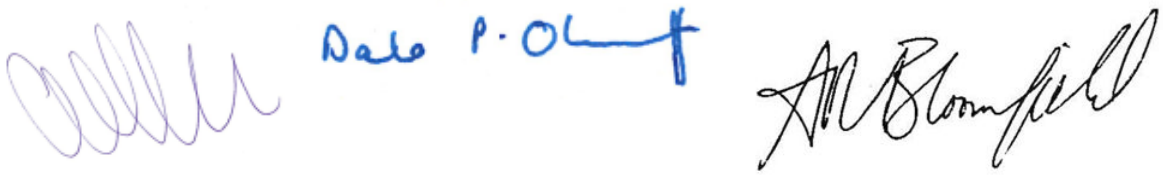
In conclusion, a future society will still need a strong, capable and committed mental health sector that can help individuals in greatest need, and it is essential that we do not disinvest in that sector in order to reinvest elsewhere. But we stand a far greater chance of success if the current flood tide can be stemmed by a society that gives ***greater priority to managing the determinants of mental health.***

As DHBs, we have a contribution to make to implementing recommendations for a cohesive mental health and addiction approach for Aotearoa, New Zealand, an anticipated outcome of this Inquiry.

We believe we are at a point of opening the door to a very different approach with our community partners – embarking on deliberate, transformational change. We trust the panel will recognise the system-level changes required to enable this to happen in a meaningful way.

We thank you again for the opportunity to make our submission. Please let us know if you have any questions.

Yours sincerely



Adri Isbister	**Dale Oliff**	**Ashley Bloomfield**
CEO	Acting CEO	Interim CEO
Wairarapa DHB	Hutt Valley DHB	Capital & Coast DHB

PUBLIC

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**BOARD DECISION**
	Date: 6 May 2018
Author	Andrew Blair, Capital & Coast District Health Board Chair
Subject	**RESOLUTION TO EXCLUDE THE PUBLIC**

RECOMMENDATION

It is **recommended** that the Board:

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
Public Excluded Minutes	For the reasons set out in the respective public excluded papers.	
Public Excluded Matters Arising from previous Public Excluded meeting	For the reasons set out in respective public excluded papers.	
Chair's report CEO's report FRAC Recommendations Risk Report Spotless Integrated Services Contract Extension New Zealand Health Partnership's Statement of Performance Expectations 2018/19 Children's Hospital Update DHB's National Work Programme	Papers contain information and advice that is likely to prejudice or disadvantage commercial activities and/or disadvantage negotiations	9(2)(b)(i)(j)
Overview of Budgeting and Funding Final 2018/19 Statement of Performance Expectations	Subject to Ministerial approval	9(2)(f)(v)
Copper Pipes Update	Maintain legal professional privilege	9(2)(h)

* Official Information Act 1982.

CAPITAL & COAST DHB STAFF NEWS

ISSUE 37 • MAY 2018

Health Matters

In this issue:

Win movie tickets!

See page 5 for details

Compliments

OPHTHALMOLOGY OUTPATIENTS

A well organised department, staff are courteous and very informative. Patient care is respectful and the environment is clean.

INTENSIVE CARE UNIT & WARD 7 NORTH

I have been highly impressed with the care, co-ordination of care, respect and dignity shown to my father. The nurse phoned me at home, and involved me in his care coordination. The pain team were thorough in their assessments and the interventions suited the patient.

He was educated at every opportunity to express his pain and nausea. He has recovered well and is home now but I feel strongly the need to express mine and our families gratitude for all the care he has received. What an amazing team.

INTERVENTIONAL RECOVERY WARD (IRW)

Thank you for the amazing care I recently received when I was in Wellington for an angiogram. IRW is very small but the care, professionalism and competency shown by staff, across the board, was faultless which makes a fairly harrowing time a lot less stressful. Keep up the good work.

PAEDIATRICS

The paediatric service is amazing. My 15 year old daughter has chronic co-morbidity issues. When we presented to ED they were quick to grasp the presenting issues and by the time we were discharged there was a plan in place and the follow through has been amazing. The most important thing is that my daughter has felt supported and there is a clear plan to manage her needs.

I just wanted to thank your service for the wonderful support and the way forward. CCDHB have a wonderful paediatric team – you have made a big difference to our daughter and to us as a family.

WARD 5 NORTH/EMERGENCY DEPARTMENT (ED)

Over the last four years I have been a regular patient to ED because of my special cancer treatment, which brings on unbearable headaches. The quick, efficient and immediate medical attention I receive is so helpful. Often my wife and I have telephoned and spoken to many nurses from 5 North or the Cancer Unit before coming into ED. They promptly pass information onto ED doctors to ensure that my management plan is administered.

You are all very special and valuable and CCDHB should be grateful to have you. I know we are grateful and really thankful you have looked after me well.

COVER PHOTO: Our Speaking Up for Safety trainers are ready for action.

From the interim CE

Thanks to everyone who has made the past five months at Capital and Coast DHB so rewarding. I came on secondment from Hutt Valley DHB and next month I take up the role of Director-General of Health. While this was only an interim role, in the short time I've been here I've been made to feel welcome and part of the team - so thank you. I am impressed at how focused everyone is on ensuring that we deliver high quality care to all our patients and support wellbeing across our community.

Some of the highlights of the last few months fall squarely in the health sector's most challenging and important areas. This includes a focus on our mental health services through supporting the work of the Government-led Mental Health and Addiction Inquiry, and the launch of Speaking Up for Safety (see P.3). Managing the ongoing increase in demand for services is a key challenge. It may take time to address all of these issues, but by working together we can make a big difference and deliver the best possible health outcomes - equitably for all - with the available resources, and also plan and develop the services our population will need in future.

As I depart for my new role it is good to know that I'll still have contact with many of you and leave the organisation in the very capable hands of Julie Patterson, former Whanganui DHB chief executive and an experienced health sector leader. I have welcomed all your feedback and tried to respond to all your emails – apologies if you were missed. Keep in touch and keep up your great work!

Nga Mihi,
Ashley Bloomfield
Interim chief executive

Speaking Up for Safety at our place

Melita Macdonald, Senior Capability Development Advisor, is one of 16 newly qualified Speaking Up For Safety trainers who will be leading staff sessions as part of CCDHB's new three-year Supporting Safety Culture programme.

Whether it's addressing concerning behaviour, or dealing with a potential safety hazard, we need to cultivate an environment where people feel empowered to say something and know they will be listened to when they speak up, says Interim Chief Executive Ashley Bloomfield

Melita, Portfolio Lead for Allied Health, Scientific, and Technical, is excited about the opportunity the programme presents.

Before moving into capability development Melita was an Occupational Therapist. "I put my hand up to be involved because I have been a clinician and a team leader. I understand, and have experienced, the challenges of 'speaking up' in relation to both clinical and non-clinical concerns."

She uses her own experience, when she was a new graduate involving a patient with a spinal cord injury, as an example of the importance of speaking up for safety. "t was a wake-up call as to how serious impacts can be."

The hour-long session will provide a framework to support people who speak-up about safety concerns, which focuses on valuing feedback and acting on it.

"Our SUFS T-shirts say: 'I have your back'. It means we have each other's backs. We understand each other's roles and responsibilities and we support each other the best way we can."

Melita says we need to acknowledge that we're all human and make mistakes occasionally. What's important is how we respond to a situation.

'Every person in CCDHB, regardless of role or position, has an equal right and responsibility to speak up – I strongly encourage you to work together to support each other on this,' Ashley says.

Key Principles of Speaking Up For Safety:

- Safety is a shared responsibility - we are all accountable for the safety of patients and each other.
- Every person is part of the health team, regardless of role or position, and has an equal right and responsibility to speak up for safety.
- When anyone raises a concern, we all need to strive to listen and thank them for speaking up.
- Managers and leaders take the time to follow up and feedback about concerns raised.

How to get involved:

- Make a practice of talking about safety in the workplace. Managers can start the conversation with teams. You can find resources on the intranet, under the homepage quick links.
- Go to ConnectMe to book your team in for training, or email RES-ItsAboutOurPlace@ccdhb.org.nz to arrange a trainer to come to you.

New patient & visitor behaviour charter

Safety across the DHB is a shared responsibility. We have a number of initiatives in place and underway to protect the safety of our staff and patients. As part of this, we have developed a patient and visitor behaviour charter.

The aim of the charter is to ensure that patients and visitors are aware of what is expected of them and what they can expect of us whilst visiting our hospitals.

We know that caring for sick and injured people can sometimes be very difficult and distressing for all those involved – patients, whānau and staff. But we all share the same goal to care for patients.

It's important that patients, staff and visitors all treat one another with respect and dignity. The charter makes it clear that the DHB has zero tolerance to violence, aggression or harassment of any kind towards staff, patients or visitors. This includes intimidation or threats, swearing, shouting, racial or sexual comments, or physical aggression towards people or things.

The charter also encourages visitors to talk to staff if they're feeling frustrated or stressed.

We have created a series of posters that outline our expectations as part of our patient and visitor charter. These posters, and the charter, are available now on our intranet or from the communications team.

HAVE YOU OR YOUR TEAM GOT NEWS TO SHARE WITH STAFF?

Tell us about it. Email: healthmatters@ccdhb.org.nz

CELEBRATING OUR NURSES

The Medical Day Ward

Throughout May, we celebrated our nurses and unregulated healthcare workers, and the incredible work they do. May 12 was International Nurses Day, and as part of this campaign we awarded Certificates of Recognition as a way of paying tribute to how much this profession contributes to the health sector.

More than 170 individuals and teams were awarded a Certificate of Recognition, acknowledging their efforts and the different ways they go above and beyond to deliver care.

Over the next few months, we'll be profiling some of the certificate recipients. In this edition, we talk to charge nurse manager, Mikaela Shannon, about Kenepuru Community Hospital's medical day ward.

Mikaela nominated Pamela Bowers and the nursing team for a Certificate of Recognition largely because of their unwavering dedication.

"The medical day ward is a nurse led service, and the nurses carry the patient load and administer treatments as required. And despite a significant increase in patient numbers over the last year, the nurses in this ward have taken it in their stride. They work so hard, and are always so enthusiastic and flexible," Mikaela says.

"Because there is no doctor cover in that ward, the nursing team must have comprehensive procedural knowledge of clinical practice and policy changes, and are often making clinical decisions and dealing with issues that arise during the course of the day."

The team work collaboratively with Wellington Blood and Cancer to care for chemotherapy patients, and with General Practices who have referred patients to the ward. They also work closely with a range of medical specialties.

"They really are a jack of all trades when it comes to directing and delegating care, and they do it in a really positive and unassuming way," Mikaela says.

Answer three questions correctly and go into the draw to win two Embassy theatre tickets donated by the Wellington Hospital's Foundation. This month's questions are:

1. Name two of the key principals of Speaking Up for Safety
2. How can you get involved in Speaking Up for Safety?
3. What is the aim of the patient & visitor behaviour charter?

Email your answers to us at: healthmatters@ccdhb.org.nz with the subject line "Health Matters Competition" before 21 June. We'll announce the winner each month in Health Matters and in Daily Dose.

Congratulations to last month's winner - Helen Hiko, Mental Health Support Worker.

WIN MOVIE TICKETS

Live well, stay well, get well with Allied Health

The National Allied Health, Scientific and Technical conference was held at TePapa in Wellington this month. It was a highly successful event where numerous professions contributed, and took the opportunity to share their achievements from across all parts of New Zealand. CCDHB was particularly well represented, and between us we delivered nine presentations.

Emma Felix, and Sally Jackson, Genetic Counsellors

Jo Stewart, Professional Leader for Dietetics

if you would like a copy of any of the presentations, contact catherine.epps@ccdhb.org.nz

By way of background, the Allied Health, Scientific and Technical workforce encompasses over 50 professional groups working across all health and disability services, employed in the public and private sector. The workforce comprises at least 30,000 individual professionals and accounts for 16% of DHB employees, as compared with 13% medicine and 38% nursing (2016 figures).

The theme made use of the NZ Health Strategy; “live well, stay well, get well with Allied Health.” Presentations from CCDHB at the conference were as follows, and are available on request.

- Growing Collaboration and integration across allied health scientific and technical professions and further afield: a multi-work stream approach.
- Delivering a Primary care model with integrated specialist services including Allied Health to enhance health care in the Wellington community.
- Genetic Counsellors help patients stay well: personalising breast cancer risks and screening.
- Reinventing the Incident Framework - a chance to learn.
- Unleashing the potential of Telehealth for Allied Health, Scientific and Technical Services
- Allied Health Choosing Wisely to help people live well, stay well, and get well.
- A new model of Care for patients undergoing radiation treatment at Wellington Regional Hospital.
- Breaking Barriers and improving Communication with MORSim.
- Appropriate Parentral nutrition useage in Adults: A Choosing Wisely initiative involving Dietetics.

CONGRATULATIONS

Wards 5 south, 5 north, ED, renal, ICU, women’s clinics, 7 south, 7 north and wards 1 and 2 have achieved an over 80 percent vaccination rate. Thank you to everyone who has played their part and had their vaccination.

Ward 5 south (left) and ED (right) teams celebrate their 80% vaccination result with cake!

NEW INFLUENZA TEST TO IMPROVE PATIENT OUTCOMES

As part of our winter planning this year, a point of care influenza test has been rolled out across the emergency department, the medical assessment planning unit, the intensive care unit and the delivery suite.

The test, aimed at improving bed allocation and isolation to prevent staff and patient infection, was trialled in ED last winter. It takes around 15 minutes from start to finish, and is performed by senior nursing staff.

The point of care test (POCT) involves the use of early rapid testing using a point of care diagnostic device, rather than sending a patient swab to the lab for testing - which, in some cases, can take more than 24 hours for results.

“Data from last year’s trial showed that patients get allocated the right hospital bed more quickly, and this helps reduce ED waiting times and winter bed block. The test is 95 percent sensitive and 100 percent specific, and is therefore almost as reliable as a lab test, but the results are much faster,” says infectious diseases physician Tim Blackmore.

Influenza testing by POCT is indicated for those with influenza-like illness presenting for admission, with a symptom onset of less than 5 days.

“This means that we can also make treatment decisions much more accurately, and offer treatment within 48 hours to patients that present with flu-like symptoms.

“There’s evidence to suggest that treatment reduces complications and length of stay. Because POCT allows us now to diagnose influenza quickly enough to be able to use medications effectively, we hope that this will improve patient care, increase timely discharge rates and shorten length of stay,” Tim says.

CCDHB Board chair, Andrew Blair

Peer vaccinators

Director of nursing Andrea McCance and nurse Sarah Christensen with chief medical officer, John Tait.

Staff Profile

Barbara Kelly

Personal assistant for the operations manager for the Kenepuru, Kapiti and Community Team.

What's your role here?

I am the Personal Assistant for the Operations Manager for the Kenepuru, Kapiti and Community Team based at Kenepuru Hospital.

I have been in this role for 12 years. I originally came from working in the private sector (engineering and insurance) before obtaining a role in the health sector. This was a big change in the way I worked but after 12 years I feel I have adjusted very well into my role.

Who's in your team?

There are seven people in our team which includes our Service Managers and Operations Manager. We have two managers working in Wellington, four Kenepuru and one in Kapiti. Our team includes Accident & Medical, ORA Allied Health, ORA Inpatients and Community Health Services.

What's the best part of your job?

Having a great team, working face to face with staff and external visitors, helping solve IT problems associated with the Education Centre and helping staff with learning/education about the new systems that are introduced to us all.

Tell us something most staff wouldn't know about you

I am Australian and don't have a Kiwi passport even though I have lived here longer than I lived in Australia.

Thanks

Special thanks and recognition to the following staff

5 Years

Rebecca Miles, *registered nurse*
Tracey Badcock, *allied health assistant*
Helen Patea, *clinical nurse specialist*
Pelenato La'auli, *mental health support worker*
Stephen Mackley, *security orderly - Kenepuru*
Joanne Mills, *paediatric physiotherapist*
Kathryn Hedley, *occupational therapist*
Jonathan Marks, *health care assistant - casual*
Darren Santos, *analyst programmer*
Bettylene Padilla, *health aare assistant - casual*
Julie Folster, *registered nurse*
Karen Woods, *clerical assistant*
Richard White, *registered nurse*
Paula Craig, *sterilization technician*
Victor Philpott, *plumber*
Anthony Philpott, *plumber*
Susana Ybas, *midwife*
Virginia Dimayuga, *health care assistant*
Tyronne van Schalkwyk, *system engineer*
Lynne Gledstone-Brown, *associate charge nurse manager - Emergency Department*
Stewart Borland, *pharmacy technician*
Tina Jones, *registered nurse*
Ellie Meier, *registered nurse*
Deborah Davenport, *registered nurse*
Robyn Miskimmin, *registered nurse*
Kristy Wilson, *rersonal assistant*
Pierre Marsters, *mental health support worker*
Rosalind Clewley, *registered nurse*
Mylene Lugtu, *registered nurse*
Silvia McNamara, *provisional cardiac physiologist*
Maria Magadia, *dental assistant*
Robert Veale, *violence prevention coordinator*

10 Years

Julie Bate, *clinical nurse speclialist - diabetes*
Janey Quaine, *clinical nurse speclialist - diabetes*
Brigitte Stravens, *registered nurse*
Abigail Cunanan-Banlawi, *registered nurse*
Carolynn Farrow, *social worker*
Jane Siaosi, *child protection team Admin Support*
Philip Just, *mental health support Worker*
Norberto Nillo, *registered nurse*
Douglas Mein, *specialist*
Joanne McNamara, *social worker*
Evelyn MacDonald, *senior medical officer*
Eric Yee, *ICT systems trainer*
Fiona Cameron, *registered nurse*
Rajeshni Naidu, *receptionist*
Kessell Lewis, *electrician*
Emma Samuel, *registered nurse*
Purnima Panchal, *health care assistant*
Andrew Swain, *senior medical officer*
Tania Mitchell, *registered nurse*

15 Years

Fiona Houghton, *associate director of nursing*
Sonia Parker, *systems analyst*
Susanna Every-Palmer, *clinical director*
Bridgette McPhail, *registered nurse*
Linda Peat, *clinical typist*

25+ Years

Lauren Wilkinson, *project manager*
Ann O'Leary, *physiotherpist*
Suzanne Alexander, *staff radiation therapist coordinator*
Diane Kilpatrick, *registered nurse*
Smita Kapadia, *scientific officer*

DAY IN THE LIFE

JAMES CRAWFORD, PROJECT DIRECTOR FOR CORPORATE SERVICES

It's been nearly a year since Wellington property developer Mark Dunajtschik publicly announced that he would pay for, build, and gift a new $50 million children's hospital to Capital & Coast DHB.

Since then, progress has been made at a steady pace – with the past 10 months having seen designs drafted, consents obtained, buildings demolished to make way for the new building, and more.

With the new hospital aimed to be completed and operational in the next couple of years, maintaining momentum on the children's hospital project is crucial.

That's where corporate services project director James Crawford and his team – based in the children's hospital project office on level four of the WSB at Wellington Regional Hospital – come in.

"The team is made up of both internal and external people. We work with various parties to plan, manage and deliver a number of capital investment projects related to the new Children's Hospital programme of work," James says.

"At this stage, much of our focus is around the key challenge of ensuring that the designs – which are becoming increasingly refined – for the new hospital align with the needs of staff and the children and families who will use it."

Working in this sort of environment isn't new, however. James was previously the project director on the redevelopment of Bay of Plenty DHB's Tauranga Hospital.

When the project began in 2005, it was the largest public health project in the Bay of Plenty since the previous hospital was built during the 1960s. It was a five-year capital investment programme that involved staff, patients and families and was focused on providing facilities to best meet existing and emerging needs of the community and staff.

Like that work, helping bring the children's hospital to fruition is a wide-reaching project. This means it can be a challenge to make sure that communication with all the people involved is always proactive and timely.

"It is immensely satisfying to be working with such diverse and dedicated teams of people to ensure the designs are correct, and that capital investment projects are successfully managed and delivered.

"Mark – the benefactor who we all greatly respect for his significant donation and experience – also has a great team, and our team continues to work very well and collaboratively with them."

Improving inpatient diabetes management in our hospitals

Practice changes in how we manage our inpatients with diabetes have likely contributed to a reduction in hypo and hyperglycaemic episodes, and a reduction in the use of IV insulin.

A new inpatient diabetes management package was launched across the DHB in November last year to improve outcomes and reduce harm for people with diabetes in our hospitals. It included six new policies around changes to insulin prescribing and monitoring, and clearer guidance around insulin correction scales, hypo and hyperglycaemia, and managing insulin while fasting for surgery or procedures. It also included the roll-out of new supplementary medication charts for insulin.

The work involved nurses, doctors, pharmacists, and data analysts across a number of departments including endocrine, surgical, medicine, PACU, pharmacy, laboratory, emergency and intensive care.

"These changes were significant and required a huge amount of work from our staff to familiarise themselves with the new policies," says diabetes inpatient nurse and project lead Miranda Walker.
However, it appears that staff willingness to embrace these changes and to implement them into practice has resulted in some tangible improvements for people with diabetes in our hospitals.

An audit of Point of Care Testing (POCT) data found a 43 percent reduction in hypoglycaemic episodes in February this year from February last year – even with the same average bed occupancy.

"We expect to see fewer hypo and hyperglycaemic episodes across the board as a result of the improved monitoring chart and altered target range," Miranda says. "Ongoing monthly analysis will allow us to see any prominent patterns emerging.

"We've also had fewer referrals from clinicians asking for advice prescribing correction scales, and less use of IV insulin in preparation for surgery."

Miranda says she is delighted to be seeing such positive outcomes four months since the changes came into effect, and congratulates all the clinical staff who have worked so hard to produce these improvements.
The next steps are to launch the accompanying eLearning modules that are being developed to support staff to familiarise themselves with the policies and charts, and to roll-out the changes to Wairarapa DHB.

In addition to fielding enquiries from other DHBs, Miranda also recently presented the project at the Annual Scientific Meeting of the New Zealand Society for the Study of Diabetes, winning the prize for the best nursing and allied health presentation.

NEW ANTIBIOTIC APP TO ASSIST CLINICAL DECISION-MAKING

A mobile app of our empiric antibiotic guidelines has been developed to make it easier for doctors, nurse prescribers and pharmacists to access hospital antibiotic guidelines.

The development of the app, which can be downloaded from the CCDHB app store for use on iPhones or Android phones, was led by infectious diseases registrar Olivia Bupha-Intr.

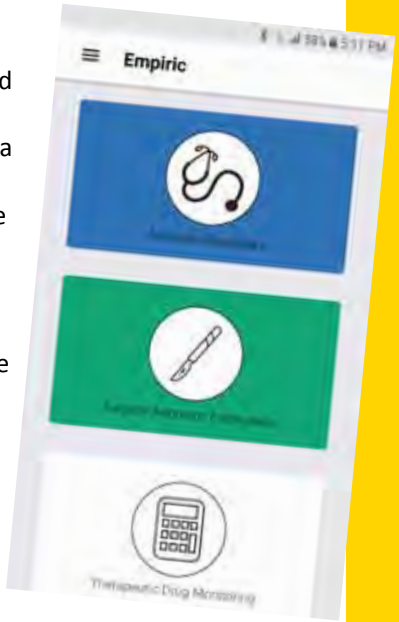
She joined forces with computer science students from Victoria University to create an easy-to-use mobile platform that provides step-by-step guidance around antibiotic prescribing.

"Not only does the app allow prescribers to have our antibiotic guidelines at their fingertips, it also assists with clinical decision-making," Olivia says.

Unlike other antibiotic guideline apps, the CCDHB app takes prescribers through a set of questions, producing a personalised recommendation for antibiotic prescribing, rather than a generic one.

"The app has some really helpful features, including clinical scoring systems, and options for when a patient has an allergy or if there is a risk of multi-drug resistant organism, as well as dosage calculators for vancomycin and gentamicin."

empiric



More information on the app, including a video guide on how to use it, will be on the intranet this week.

You can see the video here: https://youtu.be/AIK9_DJMy9I.

GENEROUS DONATION TO SAVE TINY LIVES

New cutting edge training manikins are helping doctors and nurses hone their resuscitation skills and save tiny lives.

The 'Premature Anne' is a state-of-the-art, realistically-proportioned, 25-week premature manikin designed to be used in simulation training.

Two models – worth a combined total of almost $9000 – were recently donated to the neonatal intensive care unit (NICU) at Wellington Regional Hospital.

They were gifted by the Neonatal Trust with funds from the 2017 New Zealand Financial Markets Association (NZFMA) Thomson Reuters Charity Golf Classic.

Wellington's NICU cares for more than 1100 neonatal babies each year – some as small as 500g, the equivalent of a block of butter – and having these manikins to train with will help doctors and nurses give these babies an even better fighting chance.

NICU nurse manager Rosemary Escott demonstrates use of the 'Premature Anne' for Maria Chandler from the New Zealand Financial Markets Association and her daughter Grace Chandler.

Celebrating our midwives

On 5 May, we celebrated International Midwives Day and acknowledged the significant role played by midwives in the health of women and their children. This year's theme – midwives leading the way with quality care – paid homage to the important contribution made by midwives to the health and wellbeing of mothers, babies and families. International Midwives Day also provided us with an opportunity to celebrate the outstanding midwives we have working within our region.

Congratulations to this year's recipients of the International Midwives Day awards.

Marg Hadley
Midwife of the Year

Marg has worked in ward 4 north and the delivery suite, but has recently stretched her wings to include community and Kenepuru Community Hospital. Marg is unflappable under duress, infinitely wise and just gets on with the job. She provides excellent care and always nurtures new graduates and staff members. Marg is everything a midwife should be – generous, wise, and pragmatic, with a great sense of humor.

Ward 4 north associate charge midwife managers - *Supportive Midwives of the Year*

The Associate Charge Midwife Managers (ACMMs) do a fantastic job supporting the charge midwife manager and the core staff and students who work on ward 4 north. They co-ordinate a very busy ward with high patient acuity, using their expert clinical skills and knowledge. They are resourceful and reliable and undertake extra portfolios, roles and responsibilities that all contribute towards a great dynamic team culture and a great place to work.

Anne MacMillan and Rachel McTavish *Joint winners of the Supportive Midwife of the Year*

Rachel has offered her exceptional midwifery services to the women of Newlands to Ngaio and Karori. She is especially caring for those women who are vulnerable or don't have the support in their community.

When the delivery suite is busy, Rachel is known to stay beyond hand-over, without any complaint. She is a true team player, with a contagious sense of humour.

Anne is an excellent role model – mentoring students and new graduates. She is always happy to share her clinical experiences, so that others can learn, and she demonstrates an unfailing commitment to ensuring women receive the best antenatal, intrapartum and postnatal care.

RESEARCH

BLOOD TRANSFUSION RESEARCH FOR PREM BABIES

Research at Wellington's neonatal intensive care unit (NICU) could change how red blood cells are treated at hospitals around the world.

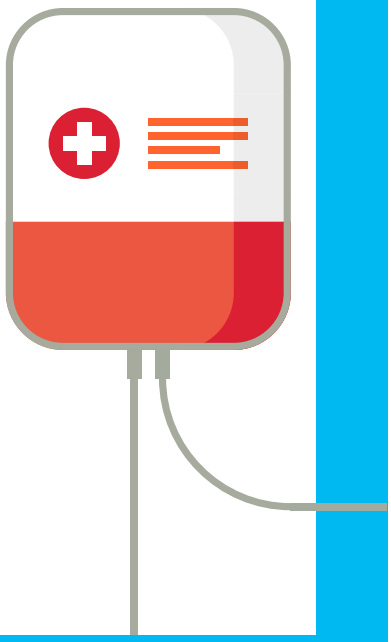
Cells for neonatal patients are irradiated - treated with radiation - and stored until needed for a transfusion. Multiple transfusions take place in NICU each week.

However, a pilot study on the effect of the cells' transfusion on brain oxygenation in premature babies found the cells become less useful for carrying oxygen the longer they are stored after irradiation.

That led to the current study on how the treatment of cells affects their oxygen-carrying abilities in the bodies of very premature babies, and specifically if changing irradiation practice results in more oxygen getting to the brain.

"If we can confirm the pilot's findings, then practice could change overnight and cells would only be irradiated when we need them," said Consultant Neonatologist and Senior Lecturer Dr Max Berry.

"We would tell the blood bank when we wanted the cells, and they would be irradiated freshly for us – they wouldn't sit in the lab, and the baby would get the maximum benefit of the transfusion. It's really gratifying that just by changing custom you can potentially improve outcomes for patients."



The study is the first of its kind and data is expected to be analysed and published before the end of the year. It is a collaboration between Capital & Coast DHB and the University of Otago Wellington, and is one of a number of research projects supported by NICU.

ICT/PRIVACY ETC

WINDOWS 10 UPGRADE

During June we will start upgrading PCs and laptops across the DHB to the latest Microsoft operating system – Windows 10.

The upgrade will ensure that we continue to have a supported operating system, improves security, and provides support for the increased use of portable devices with touch-enabled applications.

The Windows 10 upgrade will be deployed to all staff PCs and laptops over several months from mid-June.

Windows 10 looks different to Windows 7. There will be a number of options available to staff so they can familiarise themselves with Windows 10 and the location of the applications they use.

If you are a PC or laptop user, and have not used Windows 10 on a personal or home device, it is recommended you attend one of three brief training options prior to the upgrade taking place.

We are in the process of checking all PCs, laptops and applications to ensure they work with Windows 10. Once we have completed this staff will be prompted with a pop-up message on their screen inviting them to book into one or more of the training options. At the completion of the selected training, staff will be guided on the steps they need to take for their PC or laptop to be upgraded.

If you have any questions regarding the Windows 10 upgrade, please contact the Windows 10 Project Team at ICTWindows10Project@ccdhb.org.nz.

RADIOLOGY

BREAKING DOWN LANGUAGE BARRIERS

Improved signs and new information sheets are helping break down language barriers at Wellington Regional Hospital's Radiology Department.

The brainchild of senior project manager Emma Morrow, the project has involved making Radiology's materials more relevant to the patients of different ethnicities that the department sees.

"The aim is to have a stronger focus on communicating with patients from different cultural backgrounds, and helping improve their awareness of what to expect," she said.

"As part of this, I looked at the top 10 ethnicities of the patients who come through Radiology and had one of our key information sheets translated into those languages."

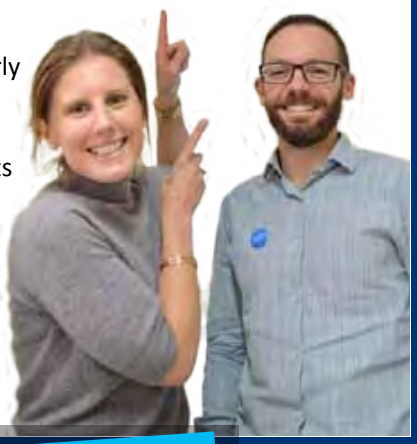
The sheet includes information about where patients can wait for their appointment, how long they may to wait, what to do if they feel unwell, and when they can expect to receive their results.

As well as English the sheets are now available in Arabic, Burmese, Hindi, Khmer, Korean, Mandarin Chinese, Māori, Samoan, Somali and Vietnamese.

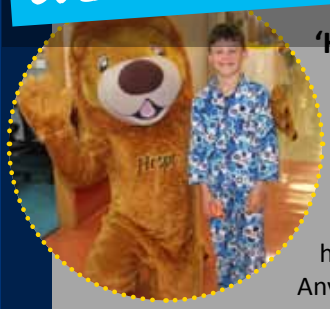
Translations in Mandarin, Māori and Samoan translations have also been added to signs and a number of children's books in the same languages have been purchased for the waiting area.

"It's been a really good opportunity to think about these things more than we usually do," said radiology operations manager Tim McElroy.

"Having these resources, particularly the signs and the books, make a real difference to patients – especially in terms of making them feel more comfortable, which is really important."



WELLINGTON HOSPITAL FOUNDATIONS UPDATE



'Hospi's Pyjamas for Winter Appeal'

We have launched a new appeal to provide new pyjamas for kids in the Children's Hospital, and kids visited at their homes by Community Nurses. Anyone can donate a pair of new, size 2-10 flannelette pyjamas, or make a donation here: whf.org.nz/pyjamaappeal

New mums gift packs on Mother's Day

Thanks to an amazing team of volunteer quilters, we were delighted to give a special Mother's Day gift pack to new mums. All mothers and babies in the Neonatal Intensive Care Unit received a gift pack, as well as all babies born on Mother's Day at Wellington, Kenepuru and Kapiti Coast Delivery Suites. Each gift pack contained a beautiful handmade quilt, a beanies and bootees set, and a soft toy Hospi.

Seido karate charity quiz night

South Wellington Seido Karate recently held a very successful quiz night to raise funds for the New Wellington Regional Children's Hospital. This group have been supporting Wellington Hospitals Foundation for over five years! Thank you to Dr Andrew Marshall for giving thanks on the night on behalf of Wellington Regional Children's Hospital.

Jayne Coombes, community mental health operations manager and Ashley Bloomfield, interim chief executive at the new Adelaide Road location.

This month in Mental Health, Addictions & Intellectual Disability Services

It has been a busy month for Mental Health, Addictions and Intellectual Disability Services (MHAIDS) with a lot happening across our services.

The Government Inquiry for Mental Health and Addictions visited our region at the end of the month and heard from people across the region. The Inquiry Panel also met with the chief executives from the three DHBs, along with our senior clinical and management staff from MHAIDS, and colleagues from funding and planning. We presented insights into our mental health services and focused on a solution based discussion. We're looking forward to seeing the recommendations from the Panel in October.

The single client pathway and digital client record for MHAIDS is live and tracking well, allowing for streamlined, consistent and up-to-date client information. Read/write access to electronic progress notes has now been set-up for non-MHAIDS clinicians, and instructions for use has been circulated via the intranet. The feedback has been good so far, we are continuing to address opportunities for improvement with teams across the region, as we work towards the next phase of the project.

At the end of last month we celebrated the official opening ceremony of the new Wellington Community Mental Health and Addictions Services location at 113 Adelaide Road in Wellington. The new location provides a more centralised and modern environment for clients – boasting increased space, improved access, and a comfortable and welcoming setting. Our teams are settling in well and hundreds of people with mental health and addictions needs from across the city are now benefiting from the improved location.

This month we also celebrated International Nurses Day across the region. We have around 600 nurses and support workers working across MHAIDS, and the day was devoted to celebrating each and every one of them. They are a crucial part of our services and represent the largest number of employees in MHAIDS.

NEWSinBRIEF

Tracking the flu this winter

A new online tool will help track the spread of influenza this winter.

The 'FluTracking' initiative sends participants a weekly ten second survey asking if they've had a cough or a fever in the past week and whether they've been vaccinated

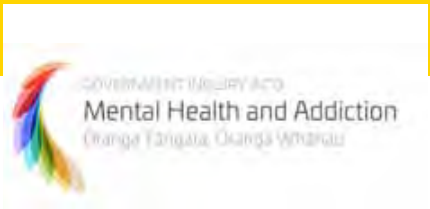
If more people join 'FluTracking', more information becomes available to better track the flu. Sign up at: http://www.flutracking.net/.

More funding for DHBs in latest Budget

Budget 2018 saw an additional $2.2 billion allocated to DHBs.

It also allocated $100 million in deficit support for DHBs, and $126 million for planned care to keep up with demand for elective surgeries and other procedures.

Health Minister Dr David Clark has described it as the largest DHB funding increase in a decade.



Mental health enquiry visits region

This month, the Government Inquiry into Mental Health and Addiction panel visited our region.

Two public meetings were held – in Porirua and Masterton – so people could say what they think works well, what doesn't, where gaps are, and what potential solutions might be.

The meetings were constructive, and the three DHBs will submit a formal response on 5 June.

Wellbeing for Health website

TAS, the agency that provides financial, governance, service delivery and quality management services to DHBs, has set up the Wellbeing for Health website.

This is a central place for tools and resources related to workplace wellbeing. Key topics include tikanga (culture and values), kōrero (communication and engagement), better work practices, ārahitanga (leadership) and personal wellbeing. Visit www.wellbeingforhealth.nz.

NZ Health App library

Studies show that some health apps can improve health and wellbeing, but with over 300,000 out there, it's impossible to identify the best ones.

The team behind the Health Navigator website is reviewing health apps and adding them to the NZ Health App Library. This library uses a simple scoring system to help people accessing the information. Go to www.healthnavigator.org.nz/app-library/a/app-library/.

CCDHB medical photographer's graphic photos on cigarette packets

Cigarette packets new pictorial health warnings, comprising graphic images and explanatory messages, feature the work of our very own medical photographer, Louise Goossens.

You can see the photos Louise took on the Ministry of Health website under tobacco-packaging-warnings.