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- Diane Anderson
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- Karen Naylor
- Oriana Paewai
- Barbara Robson

Management Team
- Kathryn Cook, CEO
- Craig Johnston, General Manager, Strategy, Planning & Performance
- Mike Grant, General Manager, Clinical Services & Transformation
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Next Meeting Date 21 March 2017
Deadline for Agenda Items 3 March 2017

MidCentral District Health Board

A g e n d a

Healthy Communities Advisory Committee

Part 1

Date: 7 February 2017

Time: 1.00pm

Place: Board Room
Board Office
Heretaunga Street
Palmerston North

MidCentral District Health Board

Healthy Communities Advisory Committee Meeting

Tuesday, 7 February 2017

Part 1

Order

1. APOLOGIES

Brendan Duffy

2. NOTIFICATION OF LATE ITEMS

3. CONFLICT AND/OR REGISTER OF INTERESTS

3.1 Amendment to the Register of Interests

3.2 Declaration of Conflicts in Relation to Today's Business

4. MINUTES

4.1 Minutes

Pages:	5-19
Documentation:	minutes of 22 November 2016 and 11 October 2016
Recommendation:	that the minutes of the previous meeting held on 22 November 2016 and 11 October 2016 be confirmed as a true and correct record.

4.2 Recommendations to the Board

To note that all recommendations contained in the minutes were approved by the Board.

4.3 Matters Arising from the Minutes

To consider any matters arising from the minutes of the meeting held on 22 November 2016 and 11 October 2016 for which specific items do not appear on the agenda or in management reports.

5. GOVERNANCE

5.1 Work Programme

Pages:	20-23
Documentation:	report from General Manager, Strategy, Planning & Performance dated 31 January 2017
Recommendation:	the progress against the 2016/17 work programme be noted

6. STRATEGIC & OPPERATIONAL PLANNING

6.1 Regional Service Plan – Planning Priorities for 2017/18

Pages: 24-29
Documentation: report from Manager, DHB Planning & Accountability dated 30 January 2017
Recommendation: that this report be received

6.2 2017/18 Budget - Update

Pages: 30
Documentation: report from Finance Manager dated 24 January 2017
Recommendation: that it be noted that further information will be supplied with which to quantify the DHB level funding, and that budgeting continues to be based on the assumption of 1.7% funding increase

6.3 A Locality Approach

Pages: 31-39
Documentation: report from Project Manager dated 17 January 2017
Recommendation: that this report be noted; and

that the proposed approach to locality plans be endorsed

6.4 Strategic and Operational – Maori Health Update

Pages: 40-42
Documentation: report from General Manager, Maori & Pasifika Health dated 20 January 2017
Recommendation: that this report be noted

6.5 Older Persons Healthy Aging Strategy Update

Pages: 43-48
Documentation: report from Senior Portfolio Manager, Health of Older People dated 18 January 2017
Recommendation: that this report be received

6.6 Disability Strategy Update

Pages: 49-53
Documentation: report from Senior Portfolio Manager, Health of Older People and General Manager, Enable New Zealand dated 16 January 2017
Recommendation: that this report be received

6.7 Drinking Water in MDHB District

Pages: 54-58
Documentation: report from Manager, Public Health Services dated 30 January 2017
Recommendation: that this report be received

7. PERFORMANCE REPORTING

7.1 Performance Reporting – Whanau Ora Collectives Update and Equity Dashboard

Pages: 59-62
Documentation: report from General Manager, Maori & Paskifika Health dated 20 January 2017
Recommendation: that this report be noted

7.2 Strategy, Planning & Performance Operating Report

Pages: 63-68
Documentation: report from General Manager, Strategy, Planning and Performance dated 27 January 2017
Recommendation: that this report be received

8. CONSUMER & DISABILITY

8.1 Accessibility Self Audit Update

Pages: 69-82
Documentation: report from Director, Patient Safety and Clinical Effectiveness dated 20 January 2017
Recommendation: that this report be received

8.2 Patient Experience Survey

Pages: 83-86
Documentation: report from Director, Patient Safety and Clinical Effectiveness dated 13 January 2017
Recommendation: that this report be received

9. INTEGRATION

9.1 Raising Healthy Kids Update

Pages: 87-94
Documentation: report from Senior Portfolio Manager Children, Youth & Intersectoral Partnerships dated 26 January 2017
Recommendation: that this report be received

10. LATE ITEMS

To discuss any such items as identified under item 2

11. DATE OF NEXT MEETING

21 March 2017 (Shared matters of interest)
2 May 2017

MidCentral District Health Board

Healthy Communities Advisory Committee

Minutes of meeting held on Tuesday, 22 November 2016 at 9am at MidCentral District Health Board Offices, Board Room, Gate 2, Heretaunga Street, Palmerston North

The shared matters of interest section of the meeting commenced at 9.00am.

This section of the meeting was chaired by Diane Anderson, Chair, Healthy Communities Advisory Committee.

PRESENT

HCAC Members
- Diane Anderson (Chair)
- Adrian Broad
- Ann Chapman
- Nadarajah Manoharan
- Phil Sunderland (ex officio)
- Vicki Beagley
- Donald Campbell
- Jonathan Godfrey
- Tawhiti Kunaiti

QEAC Members
- Barbara Robson (Chair)
- Lindsay Burnell (Deputy Chair)
- Karen Naylor
- Phil Sunderland (ex officio)
- Duncan Scott
- Cynric Temple-Camp
- Dennis Emery

IN ATTENDANCE

Kathryn Cook, Chief Executive
Craig Johnston, General Manager, Strategy, Planning & Performance
Mike Grant, General Manager, Clinical Services & Transformation
Janine Hearn, General Manager, People & Culture
Neil Wanden, General Manager, Finance & Corporate Services
Megan Doran, Committee Secretary
Stephanie Turner, General Manager, Maori & Pacific
Gabrielle Scott, Executive Director, Allied Health
Ken Clark, Chief Medical Officer

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Vivienne Ayres, Manager, DHB Planning and Accountability
Barb Bradnock, Senior Portfolio Manager, Children, Youth & Intersectoral Partnerships
Gopy Sundararajah, Portfolio Manager, Clinical Support
Jo Smith, Senior Portfolio Manager, Health of Older Persons
Claudine Nepia-Tule, Portfolio Manager, Mental Health & Addictions
Lyn Horgan, Operations Director, Hospital Services
Nicholas Glubb, Operations Director, Specialist Regional & Community
Chris Nolan, Service Director, Mental Health Services
Muriel Hancock, Director, Patient Safety & Clinical Effectiveness
Kelly Isles, Project Manager
Greig Russell
Dennis Geddis, Communications Team Leader

OTHER

Public: (4)
Media: (1)

The HCAC Chair opened the meeting and noted that it was Lindsay Burnell's final meeting. The committees acknowledged the considerable contribution Lindsay has made over his time with the District Health Board. The Chair also noted that it is the last meeting of the committees and the board of the 2013-2016 triennium.

1. APOLOGIES

There were apologies from Oriana Paewai and Kate Joblin.

2. CONFLICT AND/OR REGISTER OF INTERESTS UPDATE

2.1 Amendment to the Register of Interests

There were no amendments to the Register of Interests.

2.2 Declaration of Conflicts in Relation to Today's Business

Ann Chapman declared a potential conflict with regards to the Regional Service Plan report because her grandson works at Central TAS. Karen Naylor declared a conflict in regards to the Maternity Review. Tawhiti Kunaiti declared a conflict as he works for both Central PHO and Te Tihi. Barbara Robson declared a conflict as she is a consumer representative on the Ministry of Health's national Electronical Oral Health Record Programme Design Group.

It was agreed that these interests did not constitute a conflict of interest with respect to today's business.

2.3 Statement from Mr Hume

The Chair then advised that Mr Hume wished to make a short address to the committees before the meeting started. Mr Hume raised two key points. Firstly, Mr

Unconfirmed Minutes

Hume requested that in future enough information and detail about the Erica Hume Action Plan be included in the narrative section of the Mental Health Report to give transparency about progress.

Secondly, Mr Hume inquired about DHB commitment to the rebuilding of Ward 21. The General Manager, Clinical Services & Transformation thanked Mr Hume and advised that because the cost of the rebuild is significant, there are regional and national capital processes that have to be worked through, including the development of an Indicative Business Case. These take time. At any rate, the DHB's commitment to the Ward 21 facility has been included in MidCentral DHB's Long Term Investment Plan, which was approved at the last Board meeting.

3. GOVERNANCE

3.1 Work Programme

The General Manager, Strategy, Planning & Performance advised that the workshop with Dr Gloria Johnson that was schedule for today's meeting would now take place in February 2017 at the Quality & Excellence Advisory Committee. The mental health workshop, which is focused on community mental health services, will proceed as planned at the joint committee meeting on 21 March 2017.

The Committees agreed with these arrangements. Member Robson expressed her strong disappointment that the workshop had not been arranged for 2016 and requested this be recorded.

There was discussion about the Annual Plan Assumptions report, which has been provided to both the Board and FRAC. It was agreed that committee members who were not board or FRAC members would have access to the report through the sharednet website now. There will be a report on the Funding Envelope in February.

A committee member commented that more focus needed to be applied to disability issues in the Annual Plan as well as future committee meetings.

It was recommended:

that progress against the 2016/17 work programmes be noted.

4. PERFORMANCE REPORTING

4.1 Health Targets – Quarter 1, 2016/17

Vivienne Ayres, Manager, DHB Planning & Accountability introduced this report. It was noted that the new Raising Healthy Kids health target was tracking well.

There was discussion about the healthy eating and physical activity as essential components of raising healthy children. It was noted that the DHB funds a number of these programmes, with more funded and provided by intersectoral partners. It was agreed that a paper on the healthy eating and physical activity target would be provided at the February 2017 Healthy Communities meeting.

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In response to a member's inquiry, management confirmed that Central PHO has provided extensive support to its general practice teams around the Winter Warrant of Fitness Programme. This is in addition to the PHO's more general work on long term conditions.

In regards to Shorter Stays in the Emergency Department, the committee noted the comment that Maori and Pacific people generally have slightly better shorter stay rates than other ethnicities (noting the smaller numbers involved). A member inquired as to whether this was due to the "conveyor belt" affect or some other kind of ethnicity based bias. Management advised that data had been analysed over a four to five year period and it showed no particular differences in outcomes from ED attendance between ethnicity groups.

A request was made that future narrative reports explain how as a DHB we will reach the target when we are currently not tracking.

It was recommended:

that this report be received

4.2 Central Regional Service Plan Implementation – Report for Quarter 1, 2016/17

Vivienne Ayres, Manager, DHB Planning & Accountability introduced this report. It is the full report for quarter 1 and contains nothing unexpected for this period.

It was noted that the contingency plan for acute cardiac services is to send patients to Nelson-Marlborough DHB, and that this would involve transport and accommodation costs for the DHB of domicile.

The committee noted that cardiac intervention rates for the MidCentral district have increased and are now not significantly different from the national target. This was not the case in the past.

A question was raised by a member around the Clinical Portal and had the problems encountered by Whanganui DHB during implementation been factored into roll-out planning for MidCentral. The Chief Executive confirmed that there is a robust system for recording and addressing implementation issues which has the express purpose of ensuring subsequent roll-outs are smooth and trouble free. The Regional Chief Executives have oversight of this process.

It was noted that volumes and waiting times for Forensic Mental Health assessments for people in prison have been rising steadily, particularly in Whanganui and Rimutaka prisons. There is no current data showing the rates for Manawatu Prison however.

Barbara Cameron entered the meeting.

It was recommended:

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that this report be received.

4.3 2016/17 Maori Health Plan Update

The General Manager, Maori & Pacific presented this paper to the committees and thanked Wayne Blissett, Manager Maori Health Strategy & Support, Vivienne Ayres, Manager DHB Planning & Accountability and the Portfolio Managers for their input to this report.

There have been a number of improvements since the last update. This includes securing a major contributor to be able to achieve the Kainga Whanau Ora initiative – social housing for 100 households in Palmerston North City. The involvement of the DHB & Pae Ora in this initiative has been very valuable and the committees wished to thank the DHB.

It was noted that there has been an increase in Ambulatory Sensitive Hospitalisations (ASH) presentations.

A member questioned the increase in hospitalisations and asked if that was caused by an increase in presentations or as a result of other factors. The Chief Executive advised that there was currently a piece of work being done analysing data from practice to practice in our region.

The committees requested that in future reports include both numbers and percentages so that members could appreciate scale as well as proportion.

It was noted that the Regional Interagency Network (RIN) has been very effective as an intersectoral forum in the Manawatu, but that it has not met since March. There are plans to meet again in the New Year with the possibility of a redesign to better meet the needs of the group going forward.

It was recommended:

that this report be received.

4.4 2016/17 Annual Plan Update: Maternal, Child & Youth Health

Barb Bradnock, Senior Portfolio Manager Children, Youth & Intersectoral Partnerships introduced this paper.

The committees were advised that at present the Ministry of Social Development is working through a complex process of establishing Oranga Tamariki, the new Vulnerable Children agency. The, Senior Portfolio Manager Children, Youth & Intersectoral Partnerships, has been part of the discussions and has been providing feedback as and when required on behalf of the DHB. It is very important that the DHB remains part of this.

The committees noted the good work being done, especially in deprived areas.

A member provided positive feedback on the new Pregnancy & Parenting service and the impact it is having on the community.

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The Senior Portfolio Manager Children, Youth & Intersectoral Partnerships, provided an update on the disestablishment of the Social Sector trial in Horowhenua. The Ministry has recently confirmed that one of the funding lines attached to the Social Sector Trial will continue directly to Life to the Max. This will be critical in order to sustain the youth workers in schools in the Horowhenua.

There was discussion about whether the Children's Team programme has or will be subject to a formal evaluation. The Senior Portfolio Manager Children, Youth & Intersectoral Partnerships, confirmed that this is on the horizon at a national level.

It was recommended:

that this report be received.

5. INTEGRATION

5.1 Renal Services Review Update

This report was for information only purposes. The Renal Services plan was approved some months ago. The DHB is now in the process of drafting an implementation plan which is to include costs, resources etc. At present a small advisory group has been set up.

The implementation plan will focus on establishing dialysis capacity at Horowhenua Health Centre and the redesign of the pre-dialysis training programme including home dialysis.

A member asked if there was a specialist clinician leading the in-home dialysis work. This is aimed at improving current pre-dialysis processes and the information packages provided to patients and whanau to ensure their better understanding of options and engagement during the pre-dialysis process. The committees were advised that Norman Panlilio, Medical Head for the Renal Service, is the lead clinician for this piece of work.

It is envisaged that the three dialysis chairs for Horowhenua Health Centre will be in place by the first quarter of the next calendar year.

It was recommended:

that this report be received.

5.2 Integrated Service Model (Clusters)

The General Manager, People & Culture presented this report.

The integrated service models will link in with our strategy and the strategic imperatives.

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It was noted that Child Health and Palliative Care are making some progress towards this approach.

Workshops will be held before and after Christmas. This will need strong leadership and everyone will need to work together to ensure that the integrated service models are a success. A member sought assurance that there would be community involvement in planning. The Committees were advised that Locality plans will also be created which will include priorities for each locality and engagement from the community will be sought. Locality Plans will shape Service Plans.

It was recommended:

that this report be received.

5.3 Mental Health & Addictions Update

Claudine Nepia-Tule, Portfolio Manager Mental Health & Addictions and Christopher Nolan, Service Director, Mental Health and Addictions Clinical Services introduced this paper. This is the first combined report aiming to provide a more informative and balanced approach to what is occurring across the district and within the clinical services.

This report provided an update to the committees on a number of activities across the district in line with the Rising to the Challenge Mental Health and Addictions Service Development Plan, that ends in 2017, alongside the introduction of the newly established Ministry of Health's Commissioning Framework for Mental Health.

A member inquired about local authority representation at the Mental Health Hui and management confirmed that invitations had been sent to all local councils within the MidCentral region.

The Chief Executive advised that with the changes in councils due to the local elections, the Chief Executive and the Chair of the Board would be holding more meetings with local councils in the New Year.

There was discussion around people with disabilities and if they were included in the current workstreams or was it just NGOs and other agencies that participated. There were some consumers with disabilities involved who did feed back to their own agencies. A member suggested that that hearing impaired seemed to be missing from the list and should be involved.

It was noted that the support and commitment from Police in relation to Mental Health services and for the DHB overall has been outstanding.

The popular hui works stream – whanau ora "TED Talks" was a great success. In response to the committees' inquiry, management confirmed that these would be made available to all committee members.

A member asked for examples of where there had been reduction of duplication and cost around contract management and compliance costs for NGOs. One example was the merger of two small NGOs, which had been achieved without disruption to

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services. Another example is the support MidCentral DHB's largest mental health provider is now providing to some of the district's small providers (without charge) for their back office functions such as the Programme for the Integration of Mental Health Data (PRIMHD) reporting to the national collection.

The national commissioning framework for Mental Health was discussed and the committees were advised that it will be adopted and implemented at MidCentral DHB. In the meantime, MidCentral has been working with MASH Trust to develop an outcomes agreement contract. It is expected that this will map very well to the new Mental Health commissioning framework.

A member inquired about the sustainability of the Dialectical Behavioural Treatment programme. Management outlined the investment that had gone into additional capacity and capability for this service. Assurances were given that the service was available in the major centres throughout the district.

It was agreed that the Quality & Risk Dashboard Summary should continue to be reported to the joint committees, although over time it will change as service improvements across mental health and addictions services are embedded. With regard to the Mental Health Scorecard, the meeting noted and was concerned that MidCentral Health is still some way from achieving the 'Post-discharge community care' target. Management were mindful of the weakness in this area and are working to see improvements. Reference was made to the additional investment in community mental health teams. This is an indicator that management and governance will continue to watch in the coming months.

It was recommended:

that this report be received.

6. DATE OF NEXT MEETING

7 February 2017
21 March 2017 (Shared matters of interest)

The meeting closed at 11.20am.

Confirmed this 22nd day of November 2016

.....
Chairperson

Unconfirmed Minutes

MidCentral District Health Board

Healthy Communities Advisory Committee Meeting

Minutes of meeting held on Tuesday, 11 October 2016 at 1pm at MidCentral District Health Board Offices, Board Room, Gate 2, Heretaunga Street, Palmerston North

PRESENT:
Diane Anderson (Chair)
Barbara Cameron (Deputy Chair)
Adrian Broad
Ann Chapman
Nadarajah Manoharan
Oriana Paewai
Phil Sunderland (ex officio)
Vicki Beagley
Donald Campbell
Jonathan Godfrey
Tawhiti Kunaiti

IN ATTENDANCE:
Craig Johnston, General Manager, Strategy, Planning & Performance
Megan Doran, Committee Secretary
Janine Hearn, General Manager, People & Culture
Gabrielle Scott, Executive Director, Allied Health
Deborah Davies, Nurse Director, Primary & Integration
Barbara Robson
Barb Bradnock, Senior Portfolio Manager, Children, Youth & Intersectoral Partnerships
Jo Smith, Senior Portfolio Manager, Health of Older Persons
Gopyraj Sundararajah, Portfolio Manager, Clinical Support
David Jermey, Portfolio Manager, Primary Health Care
Mahashweta Patel, Intern Portfolio Manager
Steve Tanner, Finance Manager
Dr Rob Weir, Medical Officer of Health/Public Health Physician
Lydia Kirker, Communications Officer

OTHER:

Public: (1)
Media: (0)

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Opening the meeting, the Chair formally acknowledged the contribution that former committee member Andrew Ivory made to the CPHAC committee, and welcomed two new members of the Strategy, Planning & Performance Team, Gopy Sundararajah, Portfolio Manager Clinical Services, and David Jermey, Portfolio Manager, Primary Health Care.

1. APOLOGIES

There was one apology from Kathryn Cook, CEO.

2. NOTIFICATION OF LATE ITEMS

There were no late items.

3. CONFLICT AND/OR REGISTER OF INTERESTS UPDATE

3.1 Amendment to the Register of Interests

Vicky Beagley advised she was on the City Council District Licensing Committee.

3.2 Declaration of Conflicts in Relation to Today's Business

Jonathan Godfrey advised that he sits on the Disability Data and Evidence Working Group – a joint working group of the Office for Disability Issues and Statistics NZ and is also supervising a Massey Student on interRAI, and that there was a potential conflict with item 7.1 Disability Strategy & Aged Care in MidCentral.

It was agreed that these interests did not constitute a conflict of interest with respect to today's business.

4. MINUTES

4.1 Minutes HCAC 30 August & 19 July 2016

It was recommended:

that the minutes of the previous meeting held on 30 August & 19 July 2016 be confirmed as a true and correct record.

4.2 Recommendations to the Board

It was noted that all recommendations contained in the previous minutes were approved by the Board.

4.3 Matters Arising from the Minutes

The Chair of the Board advised that consideration had been given to the issue raised about the Committee's Terms of Reference and the extent to which they covered off the Board's obligations under the Health and Disability Services Act. The conclusion

Unconfirmed Minutes

was that this is well covered by the current wording. The Committee accepted this conclusion.

4.4 Minutes DSAC 7 June 2016

It was recommended:

> *that the minutes of the previous meeting held on 7 June 2016 be confirmed as a true and correct record.*

4.5 Recommendations to the Board

It was noted that all recommendations contained in the previous minutes were approved by the Board.

4.6 Matters Arising from the Minutes

There were no matters arising from the previous minutes.

5. GOVERNANCE

5.1 2016/17 Work Programme

Management noted that the work programme is in a different format from previous reports and it is hoped it is easier to understand. The Committee was alerted to the fact that the November meeting is a joint meeting and has a large number of reports.

The Chair asked the committee to think of presentations that they would like to see in the 2017 year. There are only four Health Communities Advisory Committee meetings so the committee needs to be mindful of timing.

Barbara Robson, Chair of the Quality & Excellence Advisory Committee advised the Quality and Excellence Committee had recommended the PHARMAC presentation be postponed until June so that the Mental Health presentation could be held in March. This was agreed.

It was recommended:

> *that progress against the 2016/17 work programme be noted.*

6. PERFORMANCE MONITORING

6.1 Equity Snapshot & Dashboard Development Approach

A committee member requested a copy of the Equity Report from the Hawkes Bay District Health Board.

A member raised the issue of the extent to which disability issues are covered under the equity heading. There are issues with the measurement of disability. There is no

Unconfirmed Minutes

single standard definition, with various different approaches in play (eg, in the Census). There is a national group working on developing a standard approach, which will greatly help service planning and service development.

"If you're not counted, you don't count."

It was recommended:

that this report be received.

7. DISABILITY MATTERS

7.1 Disability Strategy & Aged Care in MidCentral

Jo Smith, Senior Portfolio Manager, Health of Older People introduced this paper. Broadly the paper provides an update on the national strategic direction across the disability spectrum and then provides information out of the interRAI tool about disability needs of our older population.

In response to an inquiry from a member, the General Manager, Strategy, Planning & Performance, explained that MidCentral DHB is not responsible for the planning and funding of disability services for children and adults; these lie with the Ministry of Health. The DHB has planning and funding responsibility for health care for children, adults and older people and is also responsible for the disability needs of the older population.

The interRAI data is a snap shot taken on the day of the assessment and is mainly self-reported. Assessments are completed by trained staff within the Needs Assessment and Service Coordination services (e.g, Supportlinks). There is significant data now available for analysis. A number of interested parties and academic groups are starting to explore aspects of the data, recognising this is just one subset.

A member commented on the needs of older people living in smaller communities – particularly people migrating into these communities for economic reasons and then becoming immobile/dependent. The Portfolio Manager advised that there are a range of community programmes run by providers across the district, including in smaller towns and in people's homes.

The chair questioned if transport was made available to those who require it to get to these services, particularly in smaller towns. It was explained that transporting patients is not part of these services, and it is sometimes an issue, but that some communities have quite well developed networks and services that can address access problems.

It was recommended:

that this report be received.

Unconfirmed Minutes

8. OPERATIONAL REPORTS

8.1 Immunisation Stakeholder Group Work Plan 2016/17

Barb Bradnock, Senior Portfolio Manager Children, Youth & Intersectoral Partnerships and Dr Rob Weir, Medical Officer of Health/Public Health Physician provided the Committee with a brief overview of the Immunisation Stakeholder Group Work Plan 2016/17. The outstanding work of the team was noted.

The Committee was advised that as of next year (2017) boys would also be eligible to receive the HPV vaccination and that this would impact on the Public Health Team.

In response to a member's inquiry, Dr Weir advised that at present there is a global shortage of the BCG vaccine, and that there are 180 children on a waiting list to receive their BCG vaccination.

It was noted that members of the Immunisation team had been invited to Northland and Bay of Plenty to provide support on how those districts could improve their immunisation coverage rates.

It was recommended:

that this report be received.

8.2 Health Shuttles Arrangements MidCentral DHB

The General Manager, Strategy, Planning & Performance advised this paper was originally a briefing for the Chief Executive but was provided to the Committee because it contains a lot of usefully material and is relevant to the Committee's brief.

Mahashweta Patel, Intern Portfolio Manager, provided further background to this paper and noted that recently a meeting had been held with Horizons, Whanganui DHB and MidCentral DHB to try and gain a unified funding approach.

In response to a member's inquiry, the General Manager, Strategy, Planning and Performance explained that the reason MidCentral provides direct funding to the Horowhenua shuttle service is that MidCentral had required additional shuttle runs to accommodate Renal dialysis patients on a Saturday. The funding for this service may be looked at once the renal chairs are set up in Horowhenua.

The committee was supportive of the suggested approach and also of a more balanced and equitable approach to the allocation of the available funding across the district.

It was recommended:

that this report be received.

Unconfirmed Minutes

8.3 Consumer Council

The General Manager, Strategy, Planning & Performance introduced this paper.

It is envisaged that the Consumer Council will link to the Healthy Communities Advisory Committee. It will be developed using a co-design approach similar to what was used for the master health services plan and similar to the Clinical Council.

The Consumer Council will be utilised for future projects and in some instances they may be able to provide users where they can find the information rather than managing the project directly.

There will be a formal relationship with a reporting process to the Healthy Communities Advisory Committee, and potentially the Quality & Excellence Advisory Committee when appropriate.

There is still more work to be done including how to recruit people, training they require and remuneration.

It was important to ensure that there was a focus on including people with disabilities as well as pacific people.

It was recommended:

that this report be received.

8.4 Strategy, Planning & Performance Operating Report

Item 5.3.2 Change at City Doctors, Palmerston North
The General Manager, Strategy, Planning and Performance explained that City Doctors has no direct contractual link to either the DHB or Central PHO. The DHB and Central PHO contract with local GPs for a 24/7 service, and the GPs in turn have an arrangement with City Doctors to provide after hours services.

It was noted that the General Manager met with White Cross and City Doctors management and has set out the DHBs expectations. A good interaction occurred and it is hoped that once it's established, White Cross's interest in Accident and Medical care can be used to the advantage of the district.

It was recommended:

that this report be received.

9. LATE ITEMS

There were no late items for this section of the meeting.

Unconfirmed Minutes

10. DATE OF NEXT MEETING

Tuesday, 22 November 2016 (Shared matters of interest)

The meeting closed at 2.50pm.

Confirmed this 11th day of October 2016

.....
Chairperson

Unconfirmed Minutes

TO Healthy Communities Advisory Committee

FROM General Manager, Strategy, Planning & Performance

DATE 31 January 2017

SUBJECT **Committee's Work Programme**

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

MEMORANDUM

1. PURPOSE

The report updates members against 2016/17 work programme for the Healthy Communities Advisory Committee. It is for the Committee's interest and consideration. No decision is required.

2. SUMMARY

Reporting is generally occurring in accordance with the work programme.

The establishment of a Consumer Council is underway and the first workshop was held in December 2016. This was with the group of consumers involved in the Health Charter development, and we canvassed the potential role, scope, aspirations, and membership of a Consumer Council. Further work is being done and it is expected we will be in a position to provide a briefing paper for the Committee at its next meeting. The Board, at its meeting in December, appointed Mr John Hannifin to chair the new Council and he will play a lead role in the establishment process. Concurrently, the development of a Clinical Council is also occurring.

The regular review of our Health Needs Assessment has been delayed and we now expect to present this to the Committee in June. The current focus is on updating the Health Equity data, and health needs assessments in relation to locality plans and integrated service models. Our clinical advisor who completes this work has just returned from extended leave and will be giving it his priority.

A copy of the Committee's work programme is attached. These are still a work in progress and will be further refined as new the Board term gets underway.

3. RECOMMENDATION

It is recommended:

that progress against the 2016/17 work programme be noted.

Craig Johnston
General Manager
Strategy, Planning & Performance

HCAC Meeting Work Plan 2016/17				
Strategic & Operational Planning	**Performance Reporting**	**Consumer & Disability**	**Integration**	**Meetings**
October 2016				
• Equity snapshot & dashboard development approach • Health shuttle arrangements • Immunisation stakeholder group workplan 2016/17 • Disability & aged care	• Operational report (inc financials) – C Johnston	• Consumer council NB: refer also "strategic/operational planning" re disability priorities		• Minutes • Matters arising • Work programme
November 2016				
• Planning priorities & financial assumptions 2017/18*	• Health target results* • 2016/17 RSP update* • centralAlliance update* • 2016/17 Maori Health Plan update* • 2016/17 Annual plan update maternal, child & youth*		• Integrated service arrangements (clusters) workshop* • Renal health implementation plan* • Mental health review (& G Johnson)* • Portfolio updates:* o Maternal/maternity Child & youth	• Minutes • Matters arising • Work programme
February 2017				
• Health service plan/priorities for Central Region • Funding envelope & CFA variations • Locality plans (approach & timeline) • Iwi plans (approach & timeline) • Maori health priorities 2017/18 • Disability priorities 2017/17 • Funding envelope	• Operational report (inc financials) • Health equity dashboard results • Whanau ora collectives update	• Disability self-audit update • Disability consumer feedback NB: refer also "strategic/operational planning" re disability priorities	Raising healthy kids – update 2 re approach being taken	• Minutes • Matters arising • Work programme
March 2017				
• Draft 2017/18 Annual Plan* (inc funding envelope) • Planning workshop* • Statement of intent & performance expectations*	• Health target results* • 2016/17 RSP update* • centralAlliance update* • 2016/17 Annual Plan update health of older people, mental health & addictions*	• Establishment and role of Consumer Council – c/f Feb 17	• Mental health review* • Portfolio updates:* o Health of older people o Workshop re community mental health*	• Minutes • Matters arising • Work programme

May 2017				
• 2017/18 Regional Service Plan • 2017/18 Funding Arrangements 2017/18 Annual Plan • 2017/18 Maori Health Plan • Contracting/commissioning plan 2017/18 • Ward 21 indicative business case*	• Operational report (inc financials) • Health equity dashboard results	• Consumer Council report and meeting • Disability	• Meeting with Health Promotion Agency	• Minutes • Matters arising • Work programme
June 2017				
• Health needs assessment – c/f Feb17	• Health target results* • 2016/17 RSP update* • centralAlliance update* • 2016/17 Maori Health Plan update* • 2016/17 Annual Plan update general & specialist*	• Consumer Council report	• Mental health review* • Portfolio updates* o General & specialist assessment & treatment o Cancer services & palliative care • Meeting with Central PHO* • Meeting with Pharmac*	• Minutes • Matters arising • Work programme

*area of shared interest with Quality & Excellence Advisory Committee

TO Healthy Communities Advisory Committee

FROM Vivienne Ayres
Manager
DHB Planning and Accountability

DATE 30 January 2017

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

MEMORANDUM

SUBJECT **REGIONAL SERVICE PLAN – PLANNING PRIORITIES FOR 2017/18**

1 PURPOSE

To provide the Committee with an update on the development of the 2017/18 Regional Service Plan and the Ministry of Health planning priorities.

This update is for information – no decision is required.

2 SUMMARY

A working draft Regional Service Plan (RSP) has been prepared for the 2017/18 year in accordance with the planning guidelines issued by the Ministry of Health. Development of the Regional Service Plan (RSP) is coordinated by the Central Technical Advisory Service on behalf of the six District Health Boards (DHBs) with input from the regional networks.

The 2017/18 RSP clinical service priorities build on the current year's priorities and are noted below.

- Electives
- Cardiac Services
- Mental Health and Addictions
- Stroke
- Healthy Ageing
- Major Trauma
- Hepatitis C

Implementing the priorities of the *New Zealand Cancer Plan: Better, faster cancer care 2015-2018* continues to be the priority for regional planning through the Regional Cancer Networks.

For MidCentral DHB, the key planning clinical service priority is in the development of interventional cardiology services, including related diagnostic services, with a business case being established in the first part of the 2017/18 year. Another new development will be the planned response – regionally and locally – to develop addiction service capacity and capability for implementing the Substance Abuse Compulsory Assessment and Treatment (SACAT) Bill.

The Ministry of Health advises that in 2017/18, regions are expected to strengthen their focus on the regional enablers (Workforce and Information Technology). The Government ICT Strategy and Health Workforce Regional Work Plan outline the strategic focus for these areas, and include key priorities and programmes that are expected to be implemented regionally by DHBs. These priorities for 2017/18 are outlined below.

- Digital Health 2020 – Digital Hospital maturity with regionally aligned solutions and integration with the wider sector
- Regional IT Foundations – eReferrals, eDischarges, Hospital Patient Administration, access to integrated clinical records (primary and secondary services), Hospital Pharmacy and Hospital Radiology

The 2017/18 Regional Service Plan is to include the prioritised four year plan of all local, regional and national IT initiatives with specific details for each initiative.

Specifically for MidCentral, the Ministry of Health expects the DHB to demonstrate how the DHB is regionally aligned and where it is leveraging digital hospital investments, state when Order Entry, ePrescribing and Administration, Nursing Documentation and CPOE will be implemented (not all expected in 2017/18), and to complete implementation of ePharmacy.

The workforce plan is to build upon work from previous RSPs and identify workforce priorities specific to the region. DHBs are expected to work in collaboration with Regional Training Hubs and in conjunction with the Ministry of Health to achieve agreed regionally-based solutions for the following areas: workforce planning, workforce diversity, healthy ageing and mental health and addictions.

The working draft 2017/18 RSP action plans were subject to a moderation process conducted with each of the six District Health Board (DHB) planners and TAS planning team on 27 January 2017. Subsequently, the action plans are to be refined with more attention given to streamlining and lifting the programme plans with fewer high impact projects, noting the implications for change (including cost) and documenting what is expected to change with measureable results and realistic timeframes. There is also to be more emphasis on lifting equity of access and health outcomes for Māori.

Currently, it is expected that the Committees and Board will receive a copy of the draft RSP for their meetings in late February and March. The first draft RSP is to be submitted for review by the Ministry of Health on 31 March 2017.

3 RECOMMENDATION

It is recommended:

that this report be received

Vivienne Ayres
Manager, DHB Planning and Accountability

4 BACKGROUND

The purpose of a Regional Service Plan (RSP) is to provide a mechanism for District Health Boards (DHBs) to document their regional collaboration efforts and align service and capacity planning in a deliberate way. The RSPs include national and local regional priorities, and outline how DHBs intend to plan, fund and implement these services at a regional or sub-regional level. The plans have a specific focus on reducing service vulnerability, reducing costs and improving the quality of care to patients. As for DHB Annual Plans, the 2017/18 RSPs must reflect the New Zealand Health Strategy's direction, and in particular should clearly align to the themes of People powered, Closer to home, Value and high performance, One team, and Smart system.

The regional services planning process is managed by the Central Technical Advisory Services (TAS) programme management office, and overseen by the regional Chief Executives. The work plans are developed with input from the regional clinical networks. Each of the service programmes has an Executive Sponsor, Project Manager and Clinical Lead (where applicable).

MidCentral's contribution to the Regional Service Plan is principally through clinical and non clinical staff representatives participating in the various regional networks. From a DHB annual planning or sub-regional perspective it will otherwise be coordinated through the Strategy, Planning and Performance group in collaboration with the centralAlliance where appropriate.

At this stage regional planning activities continue to revolve around MoH priorities. Central Regional DHBs, led by the CEs have been developing a strategic direction for the region. At this stage it is a work in progress and is not incorporated in the draft RSP to a significant extent, but it is expected that it will drive the RSP in future years.

5 UPDATE

Implementation planning for each of the regional work programmes for the 2017/18 year is underway. Each of the work programmes builds on current and prior years' work and achievements guided by the relevant regional networks and Ministry of Health Planning Guidelines for RSPs. MidCentral DHB has a number of clinical and non-clinical staff involved in the regional networks, so is contributing to the development of the 2017/18 work programmes through those fora.

The regional programmes of work are:

- Elective Services
- Cardiac Services
- Mental Health and Addictions
- Stroke Services
- Healthy Ageing
- Major Trauma
- Hepatitis C
- Information Technology (Health Informatics)
- Workforce

As for this current year, cancer services will be included in the RSP under the umbrella of the Regional Cancer Networks' work programme. This will include implementing priorities of the *New Zealand Cancer Plan: Better, Faster cancer care, 2015 – 2018* as

the priority for regional planning. The draft action plan to date has a focus on improving equity of access to cancer services, timeliness of services across the whole cancer pathway and the quality of cancer services delivered.

A clear 'line of sight' between the outcomes and objectives of Government priorities (including the New Zealand Health Strategy), the Regional Service Plans and DHB Annual Plans is expected to be shown in each of the documents. This will be demonstrated in MidCentral's Annual Plan and the RSP by clear referencing of the linkages between the respective programme plans.

Draft work plans for each of the regional programmes were considered by DHB planners and the TAS planning team at the end of January 2017 before being updated and submitted as working drafts for consideration by the regional executive and governance groups followed by DHB Boards/Committees in February and March.

6 2017/18 REGIONAL SERVICE PLAN – PROGRAMME PRIORITIES

The current priorities and regional objectives for which action plans are being developed for the Regional Service Plan are outlined below.

6.1 Regional Clinical Services

Elective Services

- Improve access to elective services
- Maintain reduced waiting times for elective first specialist assessments and treatment
- Improve equity of access to services, so patients receive similar access regardless of where they live
- Identify the actions that the region will undertake to support improved information management
- Identify the actions that the region will undertake to maximise workforce resources

Cardiac Services

- Improve access and timeliness of cardiac services
- Patients with a similar level of need receive comparable access to services, regardless of where they live
- More patients survive acute coronary events and the likelihood of subsequent events is reduced
- Patients with suspected Acute Coronary Syndrome receive seamless, coordinated care across the clinical pathway
- Patients with heart failure are optimally managed at admission, reducing the need for further readmission
- Reviewing and auditing Accelerated Chest Pain Pathways in Emergency Departments

Mental Health and Addictions

- Improve access to the range of eating disorder services
- Youth forensic service capacity and responsiveness
- Develop addiction service capacity and capability for implementing the Substance Abuse Compulsory Assessment and Treatment (SACAT) Bill
- Improve the physical health of people with low prevalence disorders

Stroke Services

- Improve primary and secondary stroke prevention and reduce stroke related disability and mortality
- Improve access to quality assured organised acute, rehabilitation and community stroke services (including 24/7 thrombolysis services)
- Ensure all stroke patients have access to high-quality stroke services regardless of age, gender, ethnicity or geographic domicile

Healthy Ageing

- Continue strengthening dementia pathways, dementia awareness, education and support programmes across primary, secondary and community settings and in supporting informal carers
- Proactive use of interRAI data across primary and secondary care to identify equity, population and service trends

Major Trauma

- Implement a regional trauma system that will result in a reduction of preventable levels of mortality, complications and lifelong disability of patients who have sustained a major trauma (as defined by the National Trauma Network). Includes reporting national minimum dataset to regional registries, clinical guidelines and Regional Destination policies for major trauma patients

Hepatitis C

- Implement a single clinical pathway for Hepatitis C care across all regions in order to provide consistent services (including minimum requirements, minimum standards and data collection)
- Implement integrated hepatitis C assessment and treatment services across community, primary and secondary care services in the region (includes HCV testing and care that will include Fibroscan services)

Cancer services

As for this current year, cancer services will continue implementing priorities of the New Zealand Cancer Plan: Better, Faster cancer care, 2015 – 2018. The plan is expected to focus on improving equity of access to cancer services, timeliness of services across the whole cancer pathway and the quality of cancer services delivered.

6.2 Regional Enablers

Workforce

Work regionally and in collaboration with DHB Shared Services and the Ministry of Health to:

- identify workforce data and intelligence that is collected across services and DHB areas, understanding workforce trends to inform workforce planning
- understand the workforce data and intelligence requirements that best supports regions and DHB areas in order to undertake evidence based work force planning
- ensure each region is aware of the number of eligible new health professional graduates for their regions DHBs (PGY1 and PGY2, nurses, allied health, scientific and technical) and plans for where they will be based.
- build cultural competence across the whole workforce
- increase participation of Māori and Pacific in the health workforce

- form alliances with educational institutes (including secondary and tertiary) and local iwi to identify and implement best practices to achieve the Māori health workforce that matches the proportion of Māori in the population
- ensure all DHB employed workforce data on ethnicity is updated and collected in accordance with Ministry guidelines on ethnicity for 95-100 percent of the workforce by 30 June 2018.

Healthy Ageing Strategy and Review of Adult Palliative Care Services in New Zealand

- identify the workforces working with older people and with clients requiring palliative care services and their family / whānau and informal carers
- develop workforce plans to ensure that those working with older people and with clients requiring palliative care services have the training and support they require to deliver high-quality, person-centred care
- develop a sustainable mechanism for collecting a minimum workforce data set on the health workforce working in health of older people outside the DHB provider arm by 30 June 2018

Implement the actions set out in the Mental Health and Addiction Workforce Action Plan 2016-2020.

Information Technology / Health Informatics

sThe Government ICT Strategy outlines the strategic focus for Information Technology and includes key priorities and programmes that are expected to be implemented regionally by DHBs. The regional priorities for 2017/18 for IT are:

- Digital Health 2020 – Digital Hospital maturity with regionally aligned solutions and integration with the wider sector
- Regional IT Foundations – eReferrals, eDischarges, Hospital Patient Administration, access to integrated clinical records (primary and secondary services), Hospital Pharmacy and Hospital Radiology

The 2017/18 Regional Service Plan is to include the prioritised four year plan of all local, regional and national IT initiatives with specific details for each initiative.

Specifically for MidCentral, the Ministry of Health expects the DHB to demonstrate how the DHB is regionally aligned and where it is leveraging digital hospital investments, state when Order Entry, ePrescribing and Administration, Nursing Documentation and CPOE will be implemented (not all expected in 2017/18), and to complete implementation of ePharmacy.

TO Healthy Communities Advisory Committee;
Quality & Excellence Advisory Committee

FROM Finance Manager
Funding and Planning

DATE 24 January 2017

MEMORANDUM

SUBJECT 2017/18 BUDGET - UPDATE

1. PURPOSE

This report updates the Committees on the 2017/18 Funding Envelope.

2. 2017/18 FUNDING STREAMS – THE FUNDING ENVELOPE

In mid to late December DHBs normally receive detailed information on the funding allocation for the next financial year. This is a key input to the planning process. This year DHBs have received only a high level 'indicative funding signal' which provides only national funding information.

The letter from the Ministry indicates that DHBs should assume a national increase of $400 million. This is the same as the previous year. To measure the implication on MidCentralDHB of the indicative funding signal requires further information, which is not yet available.

It is not yet clear when DHBs might expect to receive the further information. Pending the arrival of this information, the Annual Plan and Budget are proceeding on the basis of the previously agreed assumption of 1.7% funding increase.

3. RECOMMENDATION

It is recommended:

- *that it be noted that further information will be supplied with which to quantify the DHB level funding, and that budgeting continues to be based on the assumption of 1.7% funding increase;*

Steve Tanner
Funding and Planning

TO Healthy Communities Advisory Committee

FROM Kelly Isles, Strategy Planning and Performance

DATE 17 January 2017

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

Memorandum

SUBJECT A LOCALITY APPROACH

1. PURPOSE

This report provides an overview of the proposed approach to the development of locality plans (Health and Wellbeing plans). It is for noting.

2. SUMMARY

The next step in the implementation of the MidCentral Strategy is the development of locality plans across the district. These plans will be 'Health and Wellbeing plans' and will be closely aligned to the Health Charter. They will identify the current and future health and wellness needs of each locality, local priorities for change, and actions to address these.

Locality planning is a population health approach which puts people, families/whānau at the centre of planning decisions and design to best meet the needs of their communities. It looks wider than health, driving better connections and integration of health and other services to ensure people live well, stay well and get the help they need when they need it no matter who you are or where you live.

A standardised framework will be used to develop each locality plan; however each plan will be unique in how it addresses the prioritised needs identified in each locality in order to meet the communities' specific needs. They will comprise three components; population intelligence, community engagement, and information on service provision. These components will roughly correspond to the phases of development. The final plans are expected to be brief and largely pictorial (following the lead of the MidCentral Strategy). They will identify priority projects and outcome measures. These are expected to involve a range of agencies and sectors.

Initially, it is intended that plans be developed for Manawatu, Tararua, Horowhenua and Otaki. In time there will also be a locality plan for Palmerston North.

3. RECOMMENDATION

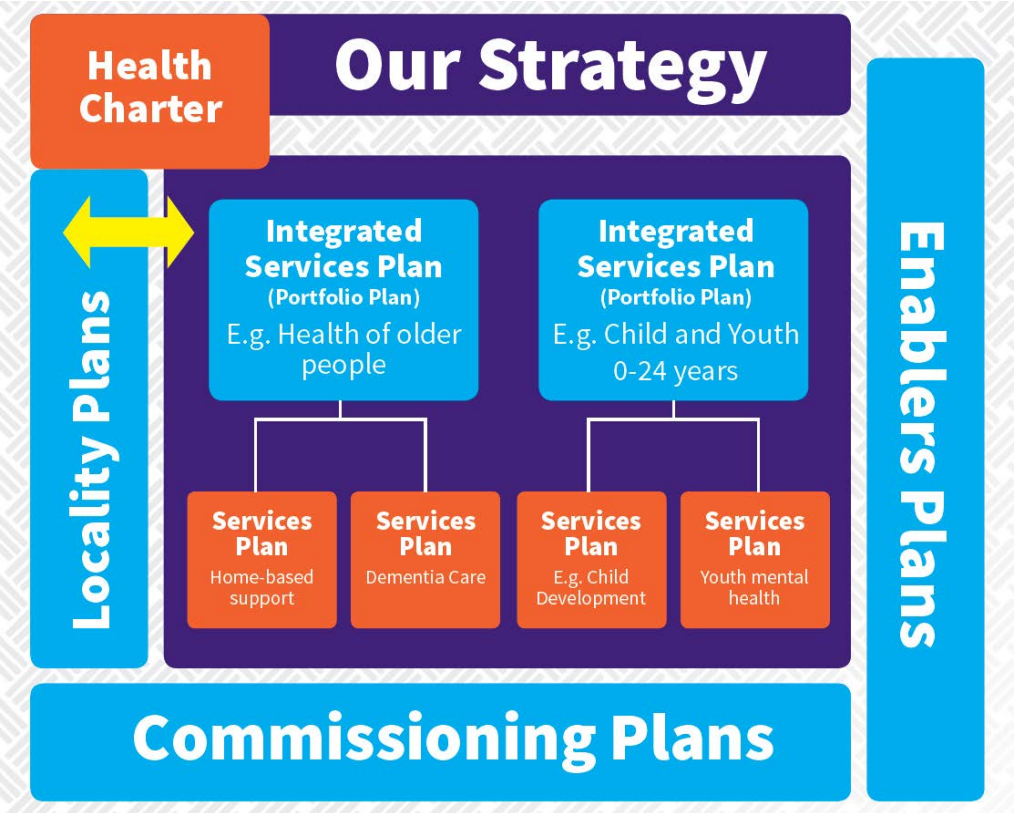
It is recommended:

that this report be noted
that the proposed approach to locality plans be endorsed

4. BACKGROUND

The MidCentral Strategy is now in place and the Health Charter is largely complete. These two documents provide the major strategic platform for MidCentral DHB. It is anticipated that flowing out from these overarching strategies there will be a range of increasingly detailed and concrete strategies and plans. These include plans for our enablers, for our Integrated Service Teams, and for our localities. Taken together, these strategies and plans will achieve the implementation of the MidCentral Strategy and Health Charter.

The following picture represents how these strategies and plans relate.



Example of differences between plans

	Needs Assesment	Models of Care	Timeframe	Leadership	Scope	Integrated Service Model Approach	Level	Priority
Locality Plans	✓		1 – 5 years	Cross sector leadership	Specific Communities	✓	High Level Sets priorities for Communities	Horowhenua and Otaki, Tararua and Manawatu
Integrated Service Plans	✓		3 - 5 years	Service Leadership Team	Population Focus Continuum of Care	✓	High Level Sets priorities for target groups	Mental Health and Addiction
Services Plans	✓	✓	1 - 3 years	Service Leaders and Manager	Service Specific	✓	Operational Focus	Child and Youth Learning and Behaviour

5. WHAT IS A LOCALITY PLAN

Locality plans cover a defined geographical area. It is proposed that these be based on Territorial Local Authority (TLA) areas. The plans will encompass all people usually resident in the area (not just those enrolled with local general practice teams). Localities are strong natural communities of interest, and health services are predominately geographically located and deliver services within a locality.

Basing locality planning on TLAs allow for meaningful population data analysis and intersectoral working.

Locality service provision and development is about improving the coordination and integration of health and attributed services at a locality level. As providers and networks are spread across the district and people may have to travel to receive care locality service provision is not bound by TLA boundaries.

Locality Plans will have a strong integration flavour and also an intersectoral component, but the key focus is on achieving health gains for and with the community of interest.

Our intent is to build on the foundation of work already developed to deliver plans unique to each locality with actionable commitments that move us clearly towards delivering on our strategic intentions. Taking a Locality approach to planning is **one** way we can do this; there will still need to be a broader district and regional approach.

6. WHAT ARE THE ADVANTAGES OF A LOCALITY APPROACH?

Why do we want to take a locality approach?

- Provides a voice for communities, acknowledging different needs, cultures and priorities
- Places people, families/whānau at the centre of planning decisions and design to best meet the needs of their communities
- Empowers people to take greater control of their own health and wellbeing and enhance their quality of life
- Engages other sectors in common community health and wellbeing agenda to reduce inequalities and improve health outcomes
- Helps to develop active partnerships with people and communities, and other agencies who work within or across health, at all levels
- Will help inform investment decisions and focus for future planning
- Helps to Identify change in population health and future needs

Impact for people and communities

- Health care that is flexible, responsive and adaptive to meet their needs
- People having evidence-based, clinically effective health care services delivered on time, closer to home where possible
- People have a positive experience of care from a joined up health system.
- Health and wellbeing of all people in our community is improved as a result of collaborative work between health, social services, and community agencies

Example of Outcomes

- **Partnering with people to co- design services**: improving community health and wellbeing
- **An intersectoral approach** with providers of health and non government agencies who have an influence on health and wellbeing and its determinants
- **Reduce inequalities** in health across communities
- **A community that feel well informed and supported:** to make healthy choices and understand where to go to get help

7. MODELS OF BEST PRACTICE

Locality plans have been used in a variety of health settings, both in New Zealand and internationally. Two specific examples have been referred to in developing our model. These are:

- 'Health and Healthcare where it Matters' A locality approach for Auckland and Waitemata DHB
- 'Health and Social Care Strategic Plan' Dumfries and Galloway (Scotland) by Dumfries and Galloway Integration joint Board

The Auckland experience is of particular interest. Waitemata DHB took a number of years to develop its locality plan. Key learning's include the following:

- Having a lead group for each locality made up of a representative from the following worked well: DHB, PHO, NGO, Alliance and Board member
- Taking time to build strong meaningful relationships
- Being transparent in any communication with the community about what the DHB can and cannot help with / commit to
- Meaningful community engagement takes time and requires a multiple pronged approach
- A member of the team placed in the locality throughout the process
- To an extent it's an organic process, you cannot predict what the community will say and what are their priorities

8. MIDCENTRAL'S APPROACH

It is intended that in the first round, plans be developed for the following localities:

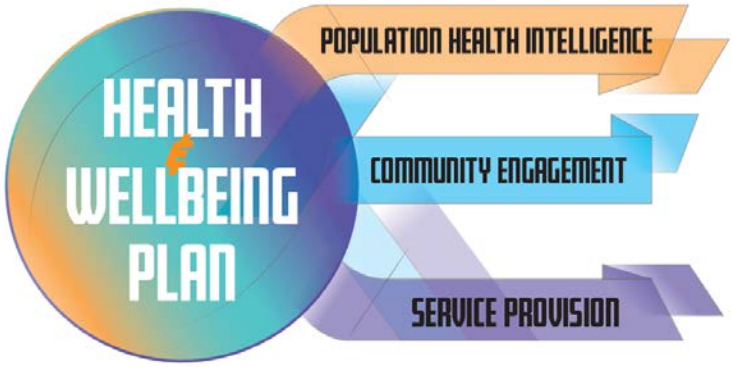
- Manawatu
- Tararua
- Horowhenua and Otaki

A plan will also be developed for Palmerston North, but this will come later.

A standardised framework will be used to develop each locality plan; however each plan will be unique in how it addresses the prioritised needs identified in each locality in order to meet the communities' specific needs. This will ensure consistency between the plans (and with other planning processes) and will assist with workload management. During the early planning stages it will be important to work together across teams on Locality Planning and Integrated Service Planning, ensuring the plans complement each other, avoiding any duplication in work as well as duplication of engagement in the community.

Locality Plans will essentially have three components, which generally correspond to phases of development.
These are as follows:

- Population Health Intelligence
- Community engagement
- Service Provision



Population Health Intelligence

The abundance of data available is spread across many areas, in order to gain a clearer understanding of each locality and its uniqueness we will pull this information together and translate it into meaningful information. This information will help inform future planning to better respond to the health needs of different population groups, including addressing health inequities and improving health outcomes.
Analysis will include relevant information from local, regional and national data sets, such as;

- Nationally generated data sources e.g. NZ Census, National Minimum Data Set, New Zealand Health Survey
- District-wide data sources e.g. hospital utilisation data, PHO data sets, referred services data sets (e.g. laboratory and pharmaceutical data)
- Locally derived data sources e.g. enrolled population information at practice level, territorial local authority level data

A member from the Planning Group will lead and develop this component with appropriate support from additional MDHB staff as and when needed.

An equity lens will be applied throughout this process, and the development of an equity snapshot will identify the current and future needs and priorities of each locality, based on population health information and data from each community. The equity snapshot will highlight the unique differences between localities as well as the similarities.

Community engagement

Community engagement is a key component to the success of the locality plans, an engagement plan will be developed for each locality. Development of engagement plans will include input from identified key representatives from each locality, including a consumer voice as well as the support and input from the MDHB communications team.

To be successful with the engagement process we need to facilitate genuine conversation within each locality with a diverse range of residents including; rural and urban, families, iwi,

community agencies, service providers, Manawhenua Hauora and intersectoral partners. This approach is more than a one off opportunity to gain feedback; it's about building an ongoing partnership with the community.

The engagement plan will include doing appropriate Stakeholder Mapping which will be broken down into four phases:

1. Identifying: listing relevant groups, organisations, and people
2. Analysing: understanding stakeholder and peoples perspectives and priorities
3. Mapping: visualizing relationships to objectives and other stakeholders, people and the community
4. Prioritising: ranking peoples and stakeholder relevance and identifying issues and priorities
A variety of mechanisms will be running simultaneously within each locality to engage different groups, these may include but are not limited to the following:

- World café forums and open community forums (multiple forums both targeted and open to all)
- Marae visits , iwi, specific visits to priority settings
- A working group / project team member residing within each locality available for feedback throughout the engagement phase (approximately 2 month period)
- Workshops set up with priority groups (multiple workshops with identified groups)
- Ability to feedback online (available throughout process)
- Meetings with service providers, intersectoral partners and other stakeholders (multiple meetings / opportunities throughout process to maintain engagement)
- Social Media, videos, and other tactics to engage youth and other groups
- Surveys
- Meetings and /or workshops with Integrated Family Health Care Centres in each locality

All workshops and forums will be lead and facilitated by the Steering Group and Planning Groups allocated to this project. Discussions with each community will be targeted around what the communities' health priorities are.

The engagement process will run over a number of months and involve multiple opportunities for the community to engage at each stage of the process. The engagement plan will include how sustainable linkages with each locality will be maintained to ensure engagement on an ongoing basis.

The community engagement plan will also contain a communications strategy which will help to manage community expectations and ensure all communication with localities is consistent in its messaging. Key messaging of the communication strategy will include, but not limited to:

- MDHB will be transparent in its communication from the beginning with all involved, stating locality planning is about how, within the current resources available, we can better meet the identified health priority needs within each locality.

It is important that time is taken to engage as the quality of the feedback is dependent on the quality of the process.

Service Provision

The service provision component of the approach is in alignment with the Health Charters philosophies, looking to achieve a more integrated cross sector system providing collaborative

health and social services. It's about intersectoral collaboration and communities working together to enhance lives, designing and delivering services collaboratively, creating positive impacts on the community and reducing inequalities across communities.

This component looks at the opportunities to design and deliver services in a more collaborative way across sectors in partnership with the community.

There are four main sections:

- A stock take, within the identified scope, of current community health and social services within each Locality
- Looking at what are the opportunities that exist across community health and social services available in each locality to work more collaboratively together to tackle the identified priorities
- How hospital care is provided and the opportunities that exist to ensure no matter who you are or where you live you can get the help you need when you need it in regards to the identified priorities

This component will be strongly supported and lead by the portfolio managers within the established Planning Group.

There are a number of established committees and groups within each locality with representatives from a broad range of providers, for example the Horowhenua Community Wellbeing Group convened by the Horowhenua District Council. MidCentral DHB has strong relationships with this group and it will be vital that we work collaboratively with them during the development, design and implementation of the locality plans. Working collaboratively with social service agencies and areas wider than health broadens our sphere of influence and impact we can collectively have on reducing inequalities and improving health outcomes.

The Health and Wellbeing Plan will be produced by looking at all three components above. It will identify a maximum of 5 priorities for each locality and actionable steps or commitments will be made to tackle the priorities in partnership with each community over a 1 – 5 year period.

9. OVERVIEW OF PROCESS AND TIMELINES

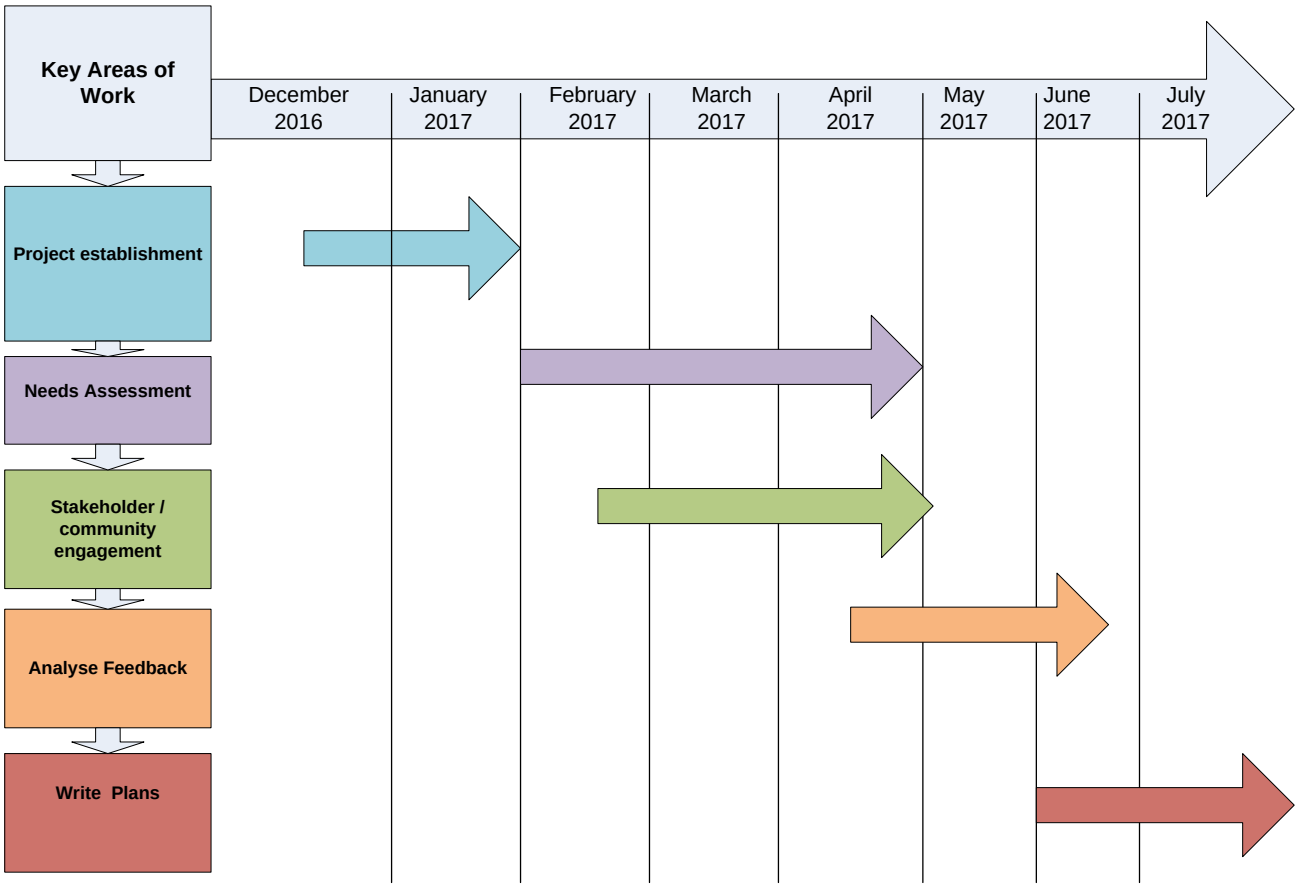
The process to create, develop and implement this approach has a number of stages. To have a positive impact on each locality it is important that time is put into each stage.

Please see below and overview of the stages involved.

Timeframe

The proposed timeframe is an approximation and will guide the process. Although there needs to be time limitations on this piece of work it, also important that there is flexibility to ensure each stage of the process has adequate time to be completed, particularly in regards to community engagement.

Approximate timeline



10. STRUCTURE

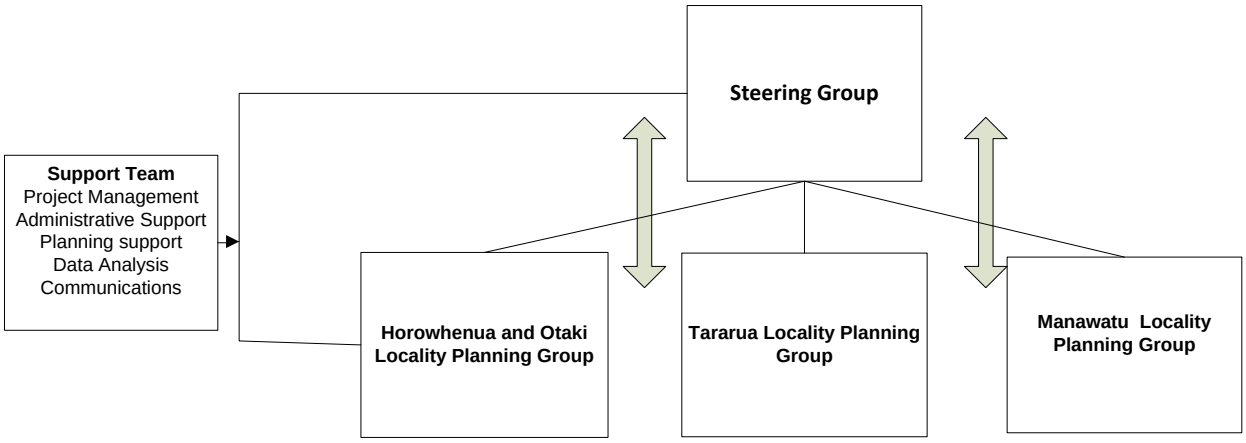
For each locality it is proposed we establish a Planning Group made up of MDHB staff (both clinical and non clinical) Central Primary Health Organisation (CPHO), Iwi, Non Government Organisation (NGO) and other identified representatives from each community, including a consumer representative. This group will help design, develop and implement each of the three components outlined above.

The Working Group/Project Group will report to a Steering Group made up of key representatives from, the DHB, CPHO, iwi, consumer representation and other key representatives identified from across the district. This group will approve the project and engagement plans, help to provide direction, leadership and governance support.

One of the successes highlighted in the review of the Task Force Groups developing our Strategy was having appropriate administrative and project support in place. It is proposed that a support team be established, this team will be the background support for all elements of the

locality planning, and this will also ensure a consistent approach is taken in the design, development and implementation of each unique locality plan.

Proposed structure:



11. NEXT STEPS

- Establish appropriate Planning and Steering Groups. Engaging the community and cross sector representation at an early stage in the design and development stages affirms our commitment to a collaborative approach, rather than a DHB driven approach. This group will be responsible for the further development of defining the project brief and scope.
- Develop an engagement plan to ensure people, families/whānau, iwi, key partners, service providers and the wider sector agencies actively contribute to determining the indentified priorities within their respective localities.
- Maintain communication with Auckland DHB throughout the process and visit DHB if possible.
- Create an Equity Snapshot and health profile for each locality. Strategy Planning and performance will work with the Pae Ora Team to develop this. The Pae Ora team will remain an important partner and voice throughout the locality plan development and implementation process.
- Ministry of Social Development are about to embark on a mapping exercise in Horowhenua, there is an opportunity to work with them during this process, gaining valuable knowledge and building stronger relationships.

TO Healthy Communities Advisory Committee

FROM Stephanie Turner
General Manager Māori and Pasifika Health

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

MEMORANDUM

DATE 20 January 2017

SUBJECT STRATEGIC AND OPERATIONAL - MĀORI HEALTH UPDATE

1. PURPOSE

This report updates the Committee on Māori Health Priorities for 17/18 identified by Manawhenua Hauora to actively improve Māori health gains across the DHB and the development of Ka Ao Ka Awatea as the Strategic Framework for Iwi Health Plans.

2. SUMMARY

The changes to the Annual Planning Processes from the MOH in removing the stand alone Māori Health Plan to clearly articulating Māori Health measures across every aspect of the Annual Plan for the DHB has created the potential for a more collaborative and integrated planning and reporting process for 2017-2018. The challenge across the DHB is to ensure that all areas of care ensure that they continue to build their focus and reporting on Māori health gains as a discrete component of work. There is a risk that has been identified by Tumu Whakarae – the Māori DHB General Manager network – that the targeted focus that has been achieved through a standalone Māori Health Plan may be diluted with the integration into one Annual Plan. While we share this concern, we also have confidence with MDHB's focus on equity of health outcomes, partnering with whanau, excellence by design and the transformation of primary and secondary care, this risk can be adequately mitigated.

This is further supported with the development of the Māori Health Strategy across the district – Ka Ao Ka Awatea, The development of this Strategy has been a partnership between Central Primary Health Organisation (CPHO) Māori Health Unit, Te Tihi o Ruahine Tuahiwi, and Pae Ora the MDHB Māori Health Directorate. Ka Ao Ka Awatea will sit as part of the Manawhenua Hauora Strategic Framework and identifies the Māori Health Priorities for the Māori Community for the next five years.

A primary focus of the Māori Health Directorate is the development of the Equity Snapshot across the District. This is a key piece of strategic work that will actively inform the planning, design and operation of the DHB over the next 5 years. The Equity Snapshot is also central to informing Locality Plans. The MDHB Equity Snapshot will provide clear methodology and approach to improving access and equity of outcomes across our communities. Pae Ora Māori Directorate is also partnering in the development of the Locality Plans which will comprise three components: population intelligence/health information, community engagement,

and information on service provision. It is intended that the Equity snapshot will be utilised to inform across the phases of development.
Both the Equity Snapshot and the Locality Plans are expected to be succinct, pictorial (following the lead of the MidCentral Strategy) and informative. They will identify priority projects and outcome measures.

3. UPDATE

3.1 Annual Planning

In December we received advice from the Minister that there is no longer a requirement for a standalone Māori Health Plan. The Māori health priorities are integrated as part of an integrated Annual Plan. The Minister was clear in his Letter of Expectation that MDHB must continue to focus on Māori health priorities and equity of health outcomes for Māori, Accordingly the Annual Plan for 17/18 will have both Māori and non-Māori health targets integrated across service areas. Service areas will have an increased focus on reporting against both Māori and non-Māori health targets. Further advice from the MOH is expected in February to further refine and develop the Māori specific targets for 17/18. The Māori Health Directorate has been invited and active in all Annual Planning Areas across the DHB except Mental Health to date.

3.2 Ka Āo, Ka Awatea – Māori Health Strategy 2017 – 2022

The Māori Health Directorate has been an active partner in the development of Ka Āo, Ka Awatea – Maori Health Strategy for the district. This strategy builds on Ka Pō Ka Āo, Ka Awatea which was the Regional Maori Health Plan for Compass Health in 2011 – 2016. As a part of Maori Health's commitment and focus on integration the Māori Health Unit – CPHO, Te Tihi o Ruahine – Te Tuahiwi and Pae Ora the Maori Health Directorate MDHB have actively worked together with Manawhenua Hauora and the community to freshen and build an approach to address health inequities and create pathways to wellbeing for whanau. Ka Ao Ka Awatea will provide the context and strategic framework for Iwi Health Plans moving forward.

Key to this development has been the Māori Health Priorities workshop held with Manawhenua Hauora to guide the Strategy for the next 5 years. Manawhenua Hauora identified the following seven priorities that they would like to see given a concentrated focus in the following five to ten year period, in order to make significant gains in Māori Health. These seven priorities, combined with the seven goals from the Whānau Ora Outcomes Framework provide the foundation that underpins Ka Ao, Ka Awatea 2017-2022.

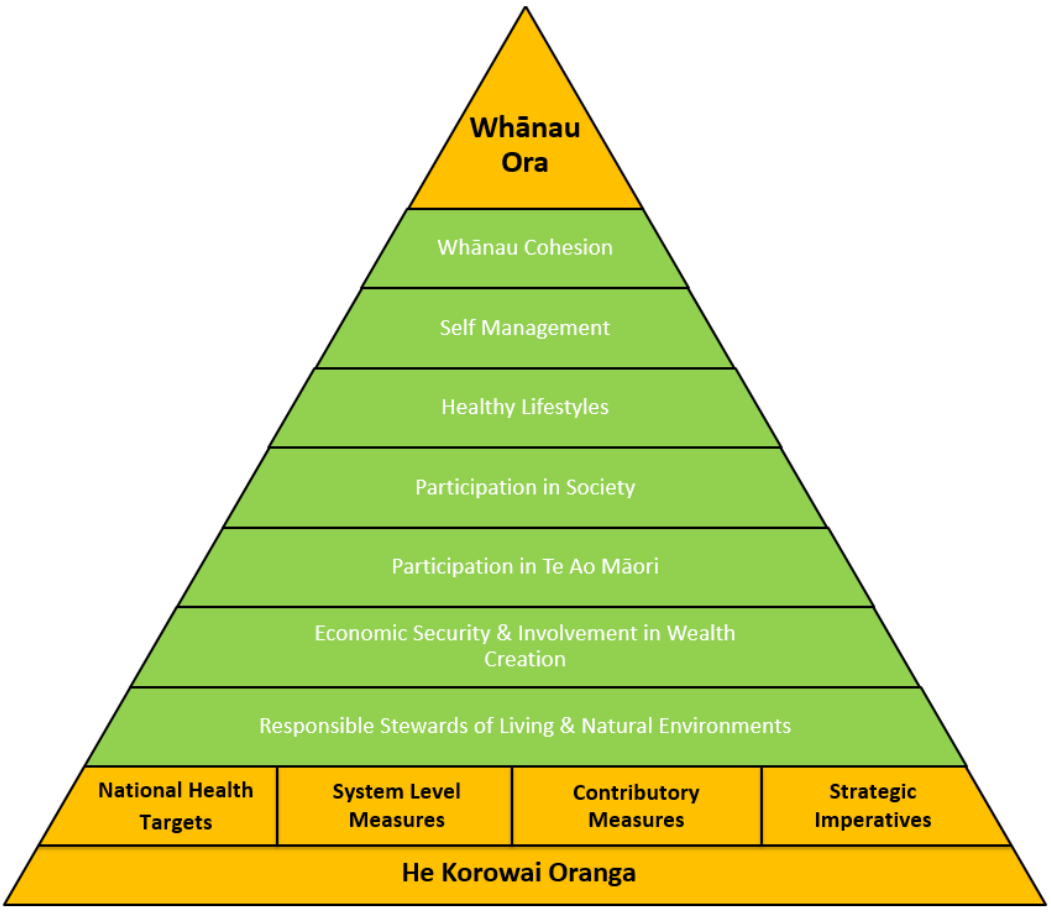
The seven priority areas are;

- Whānau free of Violence,
- Women's Health,
- Mental Health and Addictions,
- Elder People,
- Child Health,
- Maori Workforce Development, and
- Investment and Development in Iwi/Māori Providers.

These will provide the local Māori Health Priorities for the MDHB Annual Planning process for 17/18 onwards as we seek to be a meaningful contributor to building a Māori Health Strategy that embraces Whanau Ora as both a methodology and practice approach to Māori health and wellbeing. The current draft builds on the System Level Measures, Whanau Ora Strategic Outcomes and Māori health priorities alongside the aspirations of whanau, hapu and iwi to challenge health inequities and create pathways to wellbeing

The Draft Framework is currently captured in the figure below, as an attempt to demonstrate the integration and alignment with systems, structures and aspirations of whanau.

Figure One: He Anga: Te Framework



Ka Ao Ka Awatea will be completed at the end of March 2017 for ratification through Manawhenua Hauora. Following ratification presentations will be made across the district explaining the Strategy and the key activities to provide support and guidance assisting to make Maori health gains though a collective and integrated approach.

4. RECOMMENDATION

It is recommended:

this report be noted

TO Healthy Communities Advisory Committee

FROM Senior Portfolio Manager
Health of Older People

DATE 18 January 2017

Memorandum

SUBJECT **OLDER PERSONS HEALTHY AGING STRATEGY UPDATE**

1. PURPOSE

This report provides an overview of the current revision of the National Healthy Aging Strategy and its application to MidCentral's district. It is for information and discussion; no decision is required.

2. SUMMARY

The National Health of Older People Strategy underwent a refresh led by the Ministry of Health in 2016. The Strategy was finalised and released in December and is now renamed the Healthy Aging Strategy. The new Strategy is intended to provide a whole of Government approach to responding to the growing and aging population. The Strategy is not intended to be a one size fits all, nor able to address all issues or areas of concern to consumers and their services.

There are five outcomes identified in the proposed strategy all related to healthy aging, acute and restorative care, living well with long term conditions, support for people with high and complex needs and respectful end of life.

Locally, there are many examples of current and planned work that reflect the intentions of the Strategy. It is intended that future integrated service planning will build on this as we develop specific actions for services to give effect to the four strategic imperatives of our own Strategy and develop locality plans.

We anticipate that the strategies and key activities for older people will build on current work and an assessment of gaps once the more detailed action plan is released, together with advice from the Clinical Council and Consumer Council, both currently being established and the relevant district groups and other services locally.

In addition, our direction this year implementing integrated service models focused on service and locality planning will ensure MidCentral's contribution is consistent with and supported by the refreshed Strategy.

3. RECOMMENDATION

It is recommended:

that this report be received

Jo Smith
Senior Portfolio Manager
Health of Older People & Palliative Care
Strategy, Planning & Performance

4. INTRODUCTION

The New Zealand Health of Older People Strategy was revised in 2016 led by the Ministry of Health. The new Healthy Aging Strategy sets out a pathway for the next ten years and provides a framework for government agencies to improve the health outcomes and independence of older people in a sustainable way.

New Zealand has an ageing population which will result over time in an increasing incidence of disability and call on resources. Older people are living longer, and there will be an increasing number of people with age-related disabilities. This is a global trend and one that is drawing greater attention to the costs of services.

People age in different ways and do not necessarily become 'old' when they reach the age of 65. The Healthy Aging strategy recognises the diversity of older people, and seeks to maximise health and wellbeing into and throughout people's older years.

The Strategy centres on a number of outcome areas which include healthy aging, acute and restorative care, living well with long term conditions, support for people with high and complex needs and respectful end of life.

The strategy has a strong focus on prevention, wellness and support for independence. It recognises the importance of family, whanau and community in older people's lives and gives greater priority to equity and supporting the most vulnerable.

5. TURNING THE STRATEGY INTO ACTION

A whole of government response is required to turn the national strategy into action. This includes a partnership approach with the health and social system, working with NGOs, communities' older people and their families and whanau.

5.1 Aging well

This outcome is about

- maximising people's physical and mental health and wellbeing through their lives
- developing health-smart and resilient older people, families and communities to help older people age positively
- achieve equity for Maori and other population groups with poorer health outcomes
- taking actions to improve the physical, social and environmental factors of healthy aging
- supporting the development and sustainability of age-friendly communities that enable older people to age positively.

These outcomes are important for people to be able to live well, age well and continue to participate in family and community life. There is increasingly clear evidence that healthy lifestyles and physical and mental resilience are determinants of health in older age.

5.2 Acute and restorative care

This outcome is about

- Ensuring appropriate admissions to hospital for older people with acute or urgent/care needs
- Coordinating care across specialities and between ACC and the health sector
- Ensuring hospital stays are safe for older people who are frail, vulnerable or have dementia
- Helping older people to regain, maintain or adapt to changed levels of function after an acute event
- Looking for ways to weave family or whanau and wider community support into an older person's recovery and ongoing functioning.

Once in hospital, older people can be especially vulnerable to rapid deterioration putting them at risk of further harm such as acquiring an infection. There is further risk of decline in health associated with reduced physical activity, stress leading to increased confusion, and inappropriate medication. Slower recovery and increased stress are impacts on health systems and for families. Implementing system wide services, follow-up care in the community and health sector integration are aspects within this outcome.

5.3 Living well with long term conditions

This outcome is about

- Giving individuals the tools and support they need, including guidance, information and access to technology, to manage their long-term conditions to a comfortable level and reduce the impact of those conditions on their lives
- Ensuring all health professionals and social services have the tools and support they need, including information and resources, training , models of care and access to technology, to detect long-term conditions at the early stages and treat, rehabilitate and manage them well
- Improving social assistance, primary health care and home and community services and supporting family and whanau carers to help older people with long-term conditions live well
- Improving our ability to slow or stop the progress of long-term conditions towards frailty.

Long term conditions (LTC) are more prevalent and are more common among older people. The focus is on reversing or slowing declines in health and function, and promoting and supporting the behaviours and other factors that enhance people's capacity. The intent is to improve the detection of LTC, support New Zealanders to become more health smart, focus on workforce and strengthen home and community support services to be better equipped to support people, their family and whanau.

5.4 Support for people with high and complex needs

This outcome is about

- Ensuring people are in the right place to receive the care and support that most appropriately meets their needs while maintaining choice and control and irrespective of their financial position

- Helping families and whanau to provide the best support they can while maintaining their own wellbeing
- Coordinating, integrating and simplifying health and social services
- Providing flexible home and aged residential care services that suit the needs of the increasingly diverse older population
- Reducing avoidable visits to emergency departments and acute care among a group of potentially high users
- Promoting innovative models of complex care that better support older people, their family and whanau and carers
- Ensuring values and high performance for services that use a large proportion of the health budget.

People with high and complex needs are more likely to become 'frail' and deteriorate markedly after an event that the rest of us might experience as minor. Actions to support this outcome will consider value and high performance and include ensuring Maori and Pacific groups have services tailored to provide better support. The approach will consider health and social systems, people's experiences, service quality and the impact of services on whanau.

5.5 Respectful end of life

This outcome is about

- Respecting the goals and preferences of people in their last stages of life
- Tailoring care to the physical, emotional, social and spiritual needs of the individual and their family and whanau
- Continuing to provide high-quality palliative care and preparing the health system for future palliative care needs
- Providing coordinated care that meets all individuals' needs, wherever they are
- Supporting family and whanau and friends to support dying older people.

This section builds on the four other outcomes and increases the emphasis on primary palliative care, improving quality across all settings, and growing capability of carers and communities. Ensuring a dying person's goals and wishes have been well articulated, understood and respected by all involved in their care at every level is important to consumers.

6. NEXT STEPS

The actions to achieve the outcomes are set out over a ten year period with various government organisations taking a specific lead. The actions take a life course approach focused on information, tools and resources and other enablers and include referral pathways and aspects for a system wide approach to integration.

Further work will refine the finer details of the actions, including timing, sequencing, and responsibilities and resourcing. We will pick this work up through the annual planning process, the work of the relevant district groups and integrated service models. Our focus on service and locality planning over the coming months will ensure the key actions align.

In the short term, examples of actions within the next two years of the strategy include:

- Concepts of age friendly communities
- Healthy aging initiatives and healthy lifestyles
- Increasing mental and physical resilience
- Family violence
- Inter agency rehabilitation partnerships (across sector)
- Improvement on patient journey experiences
- Regularise and improve training for the kaiawhina workforce
- Enhance workforce capability
- Development of health apps
- Technology options around social isolation
- Frailty identification tool
- Actions around end of life care.

Many of our local activities already line up with the intent of the Strategy. Future planning activities will give effect to our strategic imperatives and implementation of the various integrated service plans that are to be progressively developed over the next year or two. We anticipate that the strategies and key activities for older people will build on current work and an assessment of gaps once the new Strategy is socialised locally, together with advice from the Clinical Council and the yet to be developed Consumer Council, relevant district groups and other stakeholders.

Priorities for 2017/18 are in the early stages of being gathered and more will come on this front.

Locally, our key priorities align to the Healthy Aging Strategy. For example:

- Dementia activity, raising awareness, primary care capacity/capability
- Advanced care planning, what does the consumer want?
- End of life care, improving primary care capacity/capability
- Use of interRAI data in planning for future services
- Responsive to communities with assessment
- The development of primary care workforce around older people

The opportunity for this committee as a governing body is to overview our response to the national Strategy as it is finalised and implemented and provide any additional commentary on specific areas of need for our district.

TO Healthy Communities Advisory Committee

FROM Senior Portfolio Manager
Health of Older People
General Manager
Enable NZ

DATE 16 January 2017

Memorandum

SUBJECT DISABILITY STRATEGY UPDATE

1. PURPOSE

This report follows a paper tabled at the previous October meeting on an overview of the revision of the New Zealand Disability Strategy and its application to MidCentral's district. It is for information and discussion; no decision is required.

2. SUMMARY

The New Zealand Disability Strategy 2016-2026 was launched in November 2016 from the Office for Disability Issues. The new Strategy provides a whole of Government approach to responding to the growing population affected by disability, enabling New Zealand to better support disabled people to achieve their potential and improve the lives of disabled New Zealanders and their families.

There are a number of themes in the Strategy, all related to accessibility: accessibility to health and social services; inclusive education; meaningful and appropriate employment; accessibility of information through accessible formats; accessibility of built environments including facilities and buildings; accessibility to transport in communities and better attitudes towards disabled people.

Along with the themes are outcome areas which over time will be developed and which will set targets and measures for the Strategy. Annual reporting on the outcomes will be published on the Office for Disability Issues website and the Disability Action Plan will be the vehicle for implementing the Strategy.

Locally, there are many examples of current and planned work that reflect the intentions of the revised Disability Strategy. Future integrated service planning will build on this as the Ministry develop specific actions for services to give effect to the four strategic imperatives of the Strategy. This will cover the population health continuum from prevention and early detection through to rehabilitation and support.

We anticipate that the strategies and key activities for people with disabilities will build on current national work and a national assessment of gaps together with advice from our own Clinical Council and Consumer Council, both currently being established.

3. RECOMMENDATION

It is recommended:

that this report be received

Jo Smith
Senior Portfolio Manager
Health of Older People & Palliative Care
Strategy, Planning & Performance

Scott Ambridge
General Manager
Enable New Zealand

4 BACKGROUND

This report updates the previous tabled report, acknowledges that the revised national disability strategy has now been released and will form part of our local response to disability issues and future planning priorities.

> *"Disability is something that happens when people with impairments face barriers in society; it is society that disables us, not our impairments, this is the thing all disabled people have in common."*

Nationally, a number of organisations are tasked with activity to improve the life of New Zealanders; this can be from the Office for Disability Issues, District Health Boards, other Ministries including Justice and Social Development. Cross Government action is a stronger response to thinking about how the various organisations can contribute to better lives for all New Zealanders.

Disability services and actions extend across the whole lifespan to the lives of babies and young children, families, those who have had a life changing event (e.g. through an accident), developed an impairment as they have aged or those that have reached retirement and into their latter years who often have multiple impairments.

The new New Zealand Disability Strategy 2016-2026 can be found at:

http://www.odi.govt.nz/nz-disability-strategy/

The new Strategy centres on a number of broad outcome areas which include education, employment, health and wellbeing, justice, accessibility, attitudes, choice and control and leadership. The national existing Disability Action Plan (DAP) will be the primary vehicle for implementation of actions to support the achievement of the Strategy.

The Disability Strategy is required to:

- have person-directed participation
- provide a longer-term direction to address the barriers to social and economic participation faced by disabled people
- consider a social investment approach across government to improve economic and social outcomes for disabled people
- align with the obligations and principles of the [1]UNCRPD
- allow for the strategic direction to translate into actions through the DAP.

An Action Plan will be adapted in time, to become the main mechanism for implementing the Strategy.

The Action Plan approach can be built on by extending its coverage to include high priority, or significant actions that are the responsibility of a single government agency. This change will ensure that the plan provides a mechanism to identify priorities and measure progress against the Strategy outcomes.

The current Disability Action Plan follows the example of Better Public Services, the Plan focuses on action to achieve shared results. Progress against this work is reported through the Minister of Disability Issues annual report to Parliament.

[1] UNCRPD – United Nations Convention on the Rights of Persons with Disabilities

5. OUR LOCAL RESPONSE TO DISABILITY

Disability has become the business of all. The National Strategy takes a stronger intersectoral approach and includes disability action on a number of fronts, for example district councils have a disability plan which health services feed into as part of broader consultation.

Closer to home, MidCentral Health reports regularly to this committee on aspects such as the Accessibility Self Audit Update and the Patient Experience Survey reported this meeting. Strategy, Planning and Performance have reported annually a *contracts update*, giving assurance that national policy changes filter down to community providers supported by DHBs.

Last committee meeting, our current key priorities were reported on. Examples included the EASIE Living and Demonstration Centre, information packs to support people, their family and whanau living with dementia and a number of other activities.

Several initiatives are included in the current Annual Plan and further planning is underway for the 2017/18 year. Future planning activities will give effect to the strategic imperatives of our Strategy through implementation of the various integrated service plans that are to be progressively developed over the next year or two.

We anticipate that the strategies and key activities for people with disabilities will build on current work and an assessment of gaps once the action plan for the New Zealand Disability Strategy is finalised together with advice from the Clinical Council and the yet to be developed Consumer Council. This will ensure MidCentral's contribution is consistent with and supported by the revised New Zealand Disability Strategy as well.

The priorities for 2017/18 are in the early stages of being gathered. The Maori Directorate has identified Elderhealth as a priority and is narrowing this to specific areas of focus over the coming months. The Older Persons District Group is focused around dementia, frailty and advance care planning as responses to the impact of disability. Children with disabilities are a priority group for further service development as well and the hospital recognises medication information on discharge as a worthy action area.

5.1 Older Persons NASC Update

With the aging population and incidence of disability, the older persons NASC service continues to respond to the tension of supports that are enough to enable people to live independently without enabling dependence. Numbers have remained somewhat stable as a shift towards focusing on those with high and complex needs has occurred over time.

In 2016, interRAI data reported 40 percent of people who are Needs Assessed have the potential to do more things for themselves such as showering, eating and walking.

Individualised funding; a new service, has been taken up by seven families whose preference is to have caregivers of choice working hours better suited to the individual rather than the contracted agency. This option is well embedded with younger persons services and is gaining favour in those receiving older person's services.

By and large, the needs of the community are being met well and few gaps are seen to exist. Forums with NGO's occur regularly and feedback is positive with opportunistic service improvement strategies and case reviews as the basis to improve consumer journeys.

5.2 Enable NZ specific Activity

Enable New Zealand provides a range of Disability Support Services via local, regional and national contracts held with the Ministry, ACC and District Health Boards. The local disabled and ageing population seeking independence and support will continue to increase demand for these services, specifically for equipment and housing modifications, information and other support services.

Below is a summary of key activities within the MDHB district:

- The EASIE Living and Demonstration Centre provide a range of DIAS services and continues to enjoy a positive profile within the community. Future planned activities include continued community engagement, further developing disability awareness education programs, building a specialist incontinence service and implementing our mobile outreach service to the more remote MDHB areas.

- The under 65 Needs Assessment and Service Coordination service continues to experience increased demand on services (up 10% on prior year). The service is currently dealing with a small number of clients with very complex, challenging behaviours. These clients are historically very difficult to place, requiring multi-agency support and funding. The process can sometimes take months and there is currently limited access to any kind of temporary placement in the region whilst a more permanent solution is found. A proposal to address this will be going to the Ministry in the next few months.

  NB: Enable New Zealand holds one of seven national DIAS contracts, and provides Under 65 Needs Assessment and Service Coordination services for the MDHB district. Both services are funded by the Ministry.

- Enable New Zealand is contracted to provide online Disability Information Services via its WEKA (What Everybody Keeps Asking) Website. Given the growing demand on disability support services disabled people are more likely to see web based access as a way to easily access information and support. To better support this population a new information website FIRSTPORT (previously WEKA) is being developed. This is being done in collaboration with the New Zealand Federation of Disability Information Centres to become the **New Zealand disability hub** offering a multi-channel information model for the provision of information, services and support throughout the country. Development is underway, the new baseline functionality will be in place by June 2017.

TO Healthy Communities Advisory Committee

FROM Robert Holdaway
Manager, Public Health

DATE 30 January 2017

SUBJECT Drinking Water in MDHB District

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

MEMORANDUM

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1. PURPOSE

This report provides an update regarding the status of drinking water supplies in the MDHB District, including arrangements for fluoridation. It is for members' information and does not require a decision.

2. SUMMARY

Territorial Local authorities are responsible to ensure communities are supplied with safe drinking water. DHBs provide specialist advice and recommendations to TLAs over the status of their drinking water supplies, and can order the closure of water supplies if a serious health risk situation arises.

Our Public Health Service is actively working with all of the water suppliers in the MDHB district, to support them in meeting their responsibilities to improve their drinking water quality and to facilitate their meeting the standards.

Drinking water will be a topic for discussion with all councils as part of the upcoming Chair and CEO meetings with councils in our district.

3. RECOMMENDATION

It is recommended:

that the report be received

4. BACKGROUND

Three organisations are concerned with the provision of safe drinking water.

The territorial local authority (TLA), district or city council extracts the source water, runs the treatment plant to remove risks or contaminants, and pipes the water to the population. Under the *Drinking-Water Standards for New Zealand 2005*, they are expected to test the water regularly to demonstrate that it is safe. The TLA has the accountability to ensure that drinking water is safe and to implement any actions necessary to ensure this.

The drinking-water standards were produced by the Ministry of Health, which has a national function to ensure appropriate regulations are in place. The Ministry of Health does not check on the local authorities directly, but instead works at the regional level through the District Health Boards (DHBs). Each DHB is expected to oversee the TLAs in its area and ensure (audit) that they maintain appropriate water quality.

In a serious health risk situation, the DHB can, through the health district's Medical Officer of Health, order a water supply to close, but generally it works effectively through persuasion rather than coercion. DHBs also report to the Ministry so that a national picture can be maintained of the state of all community drinking-water supplies.

Drinking-water responsibilities of the DHBs are undertaken by Drinking-Water Assessors (DWAs). Formerly this work was covered by Health Protection Officers, but the Health (Drinking-Water) Amendment Act 2007 provides for the more specialised DWA role.

In addition, regional councils are responsible for the management of source catchments (under the Resource Management Act), while water suppliers (Local Authorities) are responsible for the water supply from the point of abstraction to the property.

5. STATUS UPDATE

5.1 Drinking Water Safety in the MidCentral District Health Board region.

As a function of MDHB's Public Health Service, the Palmerston North Branch of the Central North Island Drinking Water Assessment Unit actively assesses compliance with the Drinking-water Standards for New Zealand 2005 (Revised 2008). Each Council receives a report annually that summarises their compliance.

Each of these compliance reports includes a statement of confidentiality, required under the terms of CNIDWAU accreditation. "With the exception of the Ministry of Health, this report shall not be reproduced without the approval of the Central North Island Drinking Water Assessment Unit and <<water supplier name>>."

The Drinking-Water Standards define minimum standards to protect public health. Water suppliers are required to take all practicable steps to comply with the Drinking-water Standards under Section 69V of the Health Act 1956.

The current status of the water supplies is as follows:

Horowhenua District Council

- Five drinking water supplies. Foxton, Foxton Beach, Levin, Shannon, Tokomaru.
- No water supply fully complied with all aspects of the Drinking-water Standards.
- Feedback was provided regarding Council's publication of a required notice that affected two supplies.
- Three supplies (Levin, Shannon and Tokomaru) did not meet the protozoa criteria over the 12 months from 1 July 2015 – 30 June 2016.
- Overall trend is towards improving compliance.

Manawatu District Council

- Six drinking water supplies. Feilding, Halcombe-Stanway, Himatangi Beach, Rongotea, Sanson, Waituna West.
- No water supply fully complied with all aspects of the Drinking-water Standards.
- Council has reported a number of monitoring failures over the 12 months from 1 July 2015 – 30 June 2016. The infrastructure is in place for compliance to be achieved.
- One supply (Waituna West) did not comply because one required test has not been performed.
- Four supplies (Feilding, Halcombe-Stanway, Himatangi Beach and Sanson) did not meet bacterial compliance requirements due to inadequate monitoring over the 12 months from 1 July 2015 – 30 June 2016.
- Five supplies (Feilding, Halcombe-Stanway, Himatangi Beach, Rongotea and Sanson) did not meet the protozoa criteria over the 12 months from 1 July 2015 – 30 June 2016.

Palmerston North City Council

- Four drinking water supplies. Palmerston North City, Ashhurst, Bunnythorpe, Longburn.
- All supplies fully compliant with all aspects of the Drinking-water Standards up to end July 2016.

Tararua District Council

- Seven drinking water supplies. Akitio, Dannevirke, Eketahuna, Norsewood, Pahiatua, Pongaroa, Woodville.
- No water supply fully complied with all aspects of the Drinking-water Standards.
- Council lacks the infrastructure to demonstrate compliance for some supplies.
- Five supplies (Akitio, Dannevirke. Norsewood, Pahiatua, and Pongaroa) did not meet bacterial compliance requirements due to inadequate monitoring over the 12 months from 1 July 2015 – 30 June 2016. *E. coli* (bacteria from faeces) was detected in an excessive number of samples in Akitio, Norsewood, Pahiatua and Pongaroa)
- Six supplies (Akitio, Dannevirke, Eketahuna, Pahiatua, Pongaroa, and Woodville) did not meet the protozoa criteria over the 12 months from 1 July 2015 – 30 June 2016.

Kapiti Coast District Council (Otaki water supplies are assessed by Regional Public Health, Hutt Valley District Health Board.)

- Ōtaki has two groundwater source sites near the Ōtaki River serving Ōtaki beach and town. The groundwater is chlorinated, high-intensity UV treated and pH corrected to ensure clean safe water is available for distribution to Ōtaki and the surrounding area.
- Council has resource consent to take a total of 11,233 cubic metres of water (from all Ōtaki water supply sources combined) per day.

All of the water supplies (all Councils) are currently chlorinated. This mitigates some of the risk. We are actively working with all of the water suppliers, looking at ways by which they can improve their drinking water quality.

5.2 Fluoridation

The status re fluoridation of community water supplies in our district is:

Fluoridated

- Palmerston North City (including Linton town) – Five treatment plants in city
- Ashhurst
- Linton Military Camp
- Manawatu District Council (Feilding water supply) reported fluoridating for 22/52 weeks in the period 1 July 2015 – 30 June 2016.)

Not Fluoridated

- Horowhenua (includes Levin, Foxton, Foxton Beach, Shannon and Tokomaru)
- Tararua (includes Dannevirke, Woodville, Pahiatua, Eketahuna, Norsewood, Pongaroa and Akitio). Mangatainoka doesn't have a water supply.
- Manawatu District (includes Rongotea, Sanson, Himatangi Beach, Halcombe, and Waituna West). Kimbolton is privately run. (
- Otaki - Water assessment for Otaki is covered by Regional Public Health (Lower Hutt).

MidCentral DHB's position on fluoridation, as endorsed by the Board, is as follows:

> *The Ministry of Health and the MidCentral District Health Board strongly support water fluoridation as a safe, effective and affordable way to prevent and reduce tooth decay across the whole population. Most tooth decay is preventable, and water fluoridation is a simple way to help prevent it.*
>
> *Water fluoridation has been shown to have positive beneficial outcomes on dental health. A 2014 review by Sir Peter Gluckman and the Royal Society of New Zealand identified water fluoridation as the safest and most appropriate approach for promoting dental public health, and found no adverse effects of any significance associated with its use at the levels used within New Zealand.*

The benefits of community water fluoridation are most pronounced for those at risk of poor oral health. In New Zealand, Maori and Pacific people, and people living in more deprived areas, experience poorer oral health outcomes compared to other New Zealanders.

Robert Holdaway
Manager
Public Health Service

TO Healthy Communities Advisory Committee

FROM Stephanie Turner
General Manager Māori and Pasifika Health

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

MEMORANDUM

DATE 20th January 2017

SUBJECT PERFORMANCE REPORTING – WHANAU ORA COLLECTIVES UPDATE AND EQUITY DASHBOARD

1. PURPOSE

This report updates the Committee on the developments of Whanau Ora Collectives in our District and an Equity Dashboard as to how MDHB compares to other DHBs in the Māori Health Priorities

2. SUMMARY

2016 was significant in terms of the amount of development and initiatives within the Whanau Ora Collective environment across the District. The Pae Ora Māori Health Directorate, MDHB was an active participant and partner in the Whanau Ora Collective's achievements during 2016. This occurred through the investment of our time, resources and information and has further consolidated the integration of systems and processes to support Whanau Ora now being realised across the District.

Raukawa Social Services changed their legal identity and trading name to Raukawa Whanau Ora Services and appointed a new CEO. The Māori Health Directorate attended the Pōwhiri for the new CEO and has established a strong working relationship with Raukawa Whanau Ora Services. Raukawa Whanau Ora Services are also an active participant on WOSIDG (Whanau Ora Strategic and Innovation Development Group). WOSIDG meets monthly as a joined up inter-sectoral forum hosted by Te Tihi o Ruahine Whanau Ora Alliance. WOSIDG is a useful and powerful forum to address barriers and system blocks for whanau across multiple sectors.

Muauoko Tribal Authority joined the Te Tihi o Ruahine Whanau Ora Alliance as another Iwi member joining Whakapai Hauora, Rangitāne o Tāmaki nui a Rua, Ngā Kaitiaki o Ngāi Kauwhata, Te Roopu Hokowhitu Charitable Trust, He Puna Hauora, Te Wakahuia Manawatu Trust, Māori Womens Welfare League – (Kauwhata and Rangitāne o Manawatu branches) and Raukawa Maori Wardens.

Te Tihi o Ruahine Whanau Ora Alliance was successful with the Better Public Services (BPS) Application for a Social Housing initiative in Palmerston North. This was a significant achievement that has the potential to change the landscape of social housing in Palmerston North. Thanks to the foresight and commitment of MDHB CEO in signing the Memorandum of Agreement, MDHB is an active partner in this important social and health initiative. Te Tihi o Ruahine Whanau Ora Alliance is the

first non-State entity to be successful in such a bid to Treasury and this is an exciting opportunity for inter-sectoral collaboration directly with whanau.

3. UPDATE

MDHB is fortunate to have one of the leading Whanau Ora Collective environments nationally. Since the development a stage of the Collectives in 2011 – 2012 the Collectives have continued to develop and deliver a Whanau Ora model of care and supports that challenge the status quo. Whanau Ora requires services and organisational; structures to focus on the aspirations of whanau rather than the systems and processes being about what is most convenient to the organisation itself.

Te Tihi o Ruahine Whanau Ora Alliance provides a unique approach not undertaken anywhere else, where a number of Iwi and Māori providers came together under an Alliance Approach rather than forming a traditional Collective model. The Alliance has been in place since 2011, with Muaupoko Tribal Authority joining towards the end of last year. Currently Te Tihi o Ruahine is forming itself into a discrete legal entity that sits under the Te Tihi o Ruahine Alliance Governance Board. This is a natural next step and provides increased opportunity for Te Tihi o Ruahine to access MOH Māori Provider Development Scheme funding and other supports moving forward.

3.1 Te Tihi o Ruahine

Te Tihi o Ruahine hosted a series of TED style talks on Whanau Ora last year, following the Mental Health Sector Workshop in April last year. As an action from the workshop it was agreed that a better understanding of Whanau Ora as a concept and practice was required to ensure people across sectors are familiar with and have a shared understanding of what Whanau Ora means across the District. The talks were well attended and very successful for their purpose. The presentations are available to view on youtube: **www.youtube.com**/watch?v=KrTbt1q8jXE

3.2 Kainga Whanau Ora

Te Tihi o Ruahine Whanau Ora Alliance has also embarked on a social housing initiative, Kainga Whanau Ora which Pae Ora the Māori Health Directorate is an active partner in. This initiative is focussed on 100 Households in Palmerston North City and creating new pathways to wellbeing for these 100 households. This is an inter-sectoral initiative with Housing NZ, Ministry of Social Development, Ministry of Education, MDHB, Ministry for Vulnerable Children, Police, Corrections and Palmerston North City Council. Kainga Whanau Ora was further strengthened with the achievement of Te Tihi o Ruahine's BPS application to Treasury. This was successful and creates new funding and pathways to housing and wellbeing for whanau in Palmerston North City. It is being run as a pilot for the next year and may well provide a blueprint for further opportunities and experience on transforming systems and processes to be focussed on whanau rather than organisations.

3.3 Raukawa Whanau Ora Services

Following an organisational redesign Raukawa Social Services Inc have formally rebranded and structured to become Raukawa Whanau Ora Services. A new CEO,

Betty-Lou Iwikau was appointed in October. Pae Ora attended the Pōwhiri for the new CEO and we have developed a strong working relationship. Raukawa Whanau Ora Services continue to provide follow up and follow through with whanau creating fresh opportunities for wellbeing. This has included working with the Pae Ora Team to develop discharge/referral pathways from MidCentral Health back into Horowhenua – Ōtaki for whanau.

3.4 WOSIDG - Whanau Ora Strategic and Innovation Development Group

WOSIDG – The Whanau Ora Strategic and Innovation Development Group continues to be the leading integrated sector forum for the District. WOSIDG meets monthly as a joined up inter-sectoral forum hosted by Te Tihi o Ruahine Whanau Ora Alliance. WOSIDG is a useful and powerful forum to address barriers and system blocks for whanau across multiple sectors. It has all Iwi and Māori providers represented as well as the Ministry of Education, Ministry of Social Development, Ministry for Vulnerable Children, Palmerston North City Council, Police, UCOL, Housing NZ, DHB and CPHO. As a key initiative of WOSIDG, Pae Ora is currently working in partnership with the Police to develop a 'Sudden Unexpected Death Package' for whanau. This package provides information about Police and Coroner processes to prepare whanau for unexpected deaths and some practical supports to assist whanau during this difficult time.

Another key initiative within WOSIDG currently is the Alternative Family Violence Response that is being developed between the Police, Te Tihi o Ruahine and Muaupoko Tribal Authority. This Alternative resolution approach builds on the success of the WOWARM model that was undertaken in 2015 which was an alternative pathway for low offending, creating the opportunity for individuals to undertake Te Ara Whanauora as an alternative to being charged for low level offending. The success of the Whanau Ora Whanau Alternative Resolution Model (WOWARM) provided a sound platform to develop a fresh approach to working with whanau at risk of family violence. This is to be piloted in Horowhenua over the next 6 months with the Horowhenua Police and Muaupoko Tribal Authority.

3.5 Equity Dashboard

As a direct outcome of the strategic imperative work last year, the Māori Health Directorate has been charged with leading the development of an Equity Snapshot across the district. The Equity Snapshot will provide the baseline challenges for MDHB to address inequities across our communities to actively support better health outcomes for all. Pae Ora Māori Directorate initially completed a review and document scan of other DHBs to see if any were taking a similar approach. Most utilise the Māori Health Profiles funded by MOH and developed through Te Roopu Rangahau Hauora A Eru Pomare & University of Otago. Some individual DHB's utilise district focussed Health Needs Assessments. Hawkes Bay was the only obvious DHB to have developed an equity-focused population health needs assessment.

Technical requirements for the Equity Snapshot have been scoped including access to necessary national and local data sources, ensuring availability of relevant analytical expertise, and consideration of the necessary skills and resources for meaningful interpretation, presentation and dissemination of the Equity Snapshot

findings. The base methodology has been developed and the schemata for the technical data collection and analysis are in its final stage. Dr Janine Stevens –Public Health Physician, Māori Health Directorate is leading this piece of work with the support of Richard Fong from Information Services.
The national data collection platform Trendly which reports against all current Annual Māori Health Plan indicators will also be utilised to develop the Equity dashboard for the DHB.

The technical data report will be completed by the end of February while concurrently holding focus groups around the district to ensure a community narrative sits as an integral part of the data analysis. The completion date is for late March. The Equity Snapshot will provide the data basis and narrative platform for the Locality Plans which will follow and be led out by Strategy, Planning and Performance.

The Equity Snapshot is intended to be a meaningful and useful document for all our community, capturing and interpreting numerous data sets and presenting the information in a way that makes sense as to why there are differences in health outcomes and to stimulate our thinking as to what can be done differently to address these inequities.

It is intended that the MDHB Equity Snapshot will ensure intelligibility and focus on actions to address the current inequities occurring within our district.
The Equity dashboard will be the reporting framework against which progress on district wide equity of outcome actions will be measured. Equity Dashboard reports will be generated and scheduled within Board and relevant committee work plans for 2017-18.

4. RECOMMENDATION

It is recommended:

this report be noted

TO Healthy Communities Advisory Committee

FROM General Manager
Strategy, Planning & Performance

DATE 27 January 2017

Memorandum

SUBJECT **STRATEGY, PLANNING & PERFORMANCE OPERATING REPORT**

1 PURPOSE

This report provides the Committee with an update on the activities of Strategy, Planning and Performance group. It is for the Healthy Communities Advisory Committee's information and discussion – no decision is required.

2 SUMMARY

The Annual Planning process is underway for the 2017/18 period. Work has begun to look at the development of locality plans for the district, initially focusing on the Horowhenua/Otaki, Manawatu and Tararua localities. We have been looking at the model being utilized in Auckland as an initial basis for our work.

In the Health of Older Persons' portfolio the Ministry is leading a piece of work which aims to identify and implement future models of Home and Community Support Services. The sector continues to see growing demand for residential care at around 2.8 percent.

In the Primary Care portfolio work has started to review the service provision for patients with long term conditions, with a view to assess the extent to which we are achieving value and quality from our current investment.

3 RECOMMENDATION

It is recommended:

that this report be received

Craig Johnston
General Manager,
Strategy, Planning & Performance

5. LOCAL PORTFOLIO MATTERS

5.1 Health of Older People

The National Strategy for Healthy Aging has now been released. Planning for 2017/8 will include aligning cohesive activity with direction aligned in the strategy. The strategy is discussed more fully in other narrative to the committee and will be reported back to the committee as required.

Other key work in the sector includes the home and community support services. The Ministry is taking a lead on a programme of work which aims to identify and implement future models of Home and Community Support Services (HCSS) that will support New Zealanders to live well, stay well and get well in their homes and communities. A review of the Needs Assessment/Service Coordination (NASC) guidelines is included in the programme of work.

The release of the new New Zealand Health and Healthy Aging Strategies provides an opportunity to continue to move forward and design at the national level the framework for HCSS that will meet the needs of New Zealanders in the future.

DHBs will take a lead role in supporting this work. The programme of work includes regularisation of the workforce, and the TerraNova Equal Pay negotiations implementation. Models of HCSS are closely linked to NASC services therefore a review of the NASC guidelines has been incorporated into future models work stream.

Our local approach to procuring HCSS for the future is contingent on the completion of the national work. In addition, our intended locality planning will consider the role Providers play in a joined up health system. We will shape our local services alongside our planning and community requirements.

5.1.1 Rewarding Excellence

A new dementia service in Horowhenua was launched in November 2016. Summerset By The Ranges facility opened a new dementia wing incorporating ten standard rooms and ten own your own/licence to occupy apartment style rooms. The application of technical detail incorporating dementia design, colour/contrast and a myriad of other important features for people with dementia is world class. This sets a new benchmark for housing people with dementia.

5.1.2 Growing Demand

A new facility will open in Feilding in February/March housing 50 resthome level care residents. The previously used facility 'Ranfurly Manor', has been refurbished and will cater to an overall demand in the sector for more dedicated 'stand alone' resthome level beds. Through 2010 to current date demand for 'stand alone' resthome level had reduced significantly as more people are able to be kept at home for longer. Facilities responded to the change in demand and by and large reduced 'stand alone' resthome level beds and instead are certified to cater to dual beds accepting mainly hospital level care residents which requires 24/7 registered nursing staff. Demand for residential care continues to grow at around 2.8 percent.

5.2 Mental Health and Addictions

5.2.1 Mental Health and Addiction Non-Government Organisation (NGO) Sector

Over the last several months the NGO Alcohol and Drug Services have undertaken a planning approach for the increased client volumes due to the service reviews being undertaken by MidCentral Health. These service reviews by the clinical Alcohol and Drug Service and adult Mental Health Services will essentially focus the service criteria to those with severe mental health only. This approach aligns to Goal Two Objective 2.2 'Working together as a single system of care', Mental Health and Addiction Strategy (MDHB).

Discussion with several NGO providers in relation to this new approach by MidCentral Health has demonstrated over the last few months not only an increase in referrals to their services, but the levels of complex client issues have also been notable. These services are looking to review the current models of approach to work within their current capabilities and resources. This added pressure on the sector provides opportunity to enhance the capacity, development and delivery of the mental health and addiction services provided across the continuum of care. Key areas for strengthening NGO addiction services include:

- Development of more peer run services across the continuum
- Use of more flexible service delivery models, such as mobile services
- More differentiated services for children, young people and older people
- Establishment of a mechanism for NGOs to collaboratively develop and implement strategies for improving mental health and addiction services within community based services.

The advancement of a commissioning approach for population health outcomes and Service Plans will assist in the achievement of a well-designed continuum of care for people with addiction issues.

5.3 Primary Health

5.3.1 Horowhenua Urgent Community Care (UCC) Service

In 2013 MDHB and St John Ambulance entered into a pilot program based in Horowhenua, in which a UCC paramedic would triage, assess and refer patients to an agreed health provider appropriate to the patient's needs. The service is available to any patient who requires urgent and unplanned care and/or advice that can be provided in the community or primary health care setting. Patients access the service by contacting the Ambulance Communications Centre.

The key objectives of the UCC service is to improve access to clinical care and improve management of patients who require urgent and unplanned care, who would otherwise experience barriers to timely access to normal primary health care services.

In November 2016 the National Ambulance Sector Office (MOH) agreed to have an agreement directly with St John for the ongoing funding of the UCC service.

The current arrangement with MDHB expires on 30 June 2017, the new direct

arrangement with St John will come in to effect 1 July 2017. The Ministry expects that St John continues to work closely with primary care to ensure ambulance patients receive the most appropriate care.

5.3.2 Long Term Conditions Review

A review of the Long Term Conditions (LTC) service provision across the district has been started. An initial review of current population trends and resourcing levels is underway, encompassing data from both Central PHO and MidCentral Health. Whilst the full scope of the review is yet to be determined, this initial review will be used to inform the future scope of the work undertaken. One of the aims of the review will be to assess the extent to which we are achieving value and quality from our current investment.

5.3.3 Ministry of Health (MoH) Visit to MDHB Regarding Services for People with Diabetes – November 2016

In November 2016 Dr. Paul Dury (Clinical Advisor Diabetes, MoH) and Gabrielle Roberts (Diabetes Prog. Manager, MoH) visited MDHB to discuss diabetes service provision across the district within the context of *Living Well With Diabetes* and the associated *Quality Standards for Diabetes Care*.

They were pleased to hear about MDHB's progress with primary care and community services for people with diabetes and appreciated the integrated approach between the DHB, Central PHO, the Diabetes Trust and within Kauri Integrated Family Health Centre(IFHC). The level of engagement described with multi disciplinary teams working together in primary settings was impressive, as was the primary care focus on high-need populations - including youth and refugees.

They highlighted that MDHB faces some capacity and resourcing issues in relation to specialist service provision for people with diabetes. Since their visit we have had a new physician join the diabetes team, Dr. Manoj Mishra, who replaces Dr. Owais Chaudri who left MDHB earlier in 2016.

There was also an issue raised around the effective delivery of the community retinal screening programme being hampered by process issues and the requirement for GP approval, although the MoH is aware that MDHB is working to address this and is in the process of reviewing the contract.

MDHB was aware of the issues highlighted prior to the MoH visit. The MDHB Diabetes Leadership Group is currently working to finalize a diabetes model of care for the district, subject to available resourcing and capacity.

A follow-up visit is planned for 2017.

5.3.4 Health Hub Project

A new medical centre, called the Health Hub Project, plans to open in Downtown on Broadway from May 1 2017. The centre will occupy the space previously filled by the Cinema Gold movie theatre. The new clinic will contain 15 consulting rooms, with space for acute procedures, basic pathology and radiology, as well as acting as a base for staff to go out into the community. The existing site at 174 Featherston Street will become an outreach centre for the hub. Initial funding for the centre is being provided

by the founders as well as from loans, with an intention to turn the company into a charitable trust once the centre is established.

The Health Hub intends to provide a new approach to community general practice with services that will be increasingly social care oriented. The centre plans to have capacity to serve 7000 patients. It aims to develop and use both new and re-designed healthcare processes and systems such as multidisciplinary care teams, professional collaboration internally and externally, and a culture of practice, overall, which is proactive and inclusive, respectful and supportive.

6. Child and Youth Health

6.1 Well Child Tamariki Ora Health Forum:

For more than twenty years now clinicians interested in child health have met quarterly at the Well Child forum. This forum started as an avenue for professional development, to learn what each organisations core business was and to learn of any new initiatives alongside networking opportunities. The forum has been held at Addis House for many years and has an official Chairperson, Treasurer and Secretary who run the meetings and organise speakers etc.

On 13 December 2016 the Portfolio Manager responsible for child health was asked to give an annual overview of child health to the forum. Having been involved in these forums sporadically for over twenty years it was with some surprise that on arrival there were more than fifty child health professionals in attendance from a range of clinical settings and agencies. The forum was focussed, well run and speakers interesting and informative.

Given the beginning of a new year it seemed timely to reflect on some great treasures like this forum that are working well in the community, run by people within their own existing roles and that do not require any funding. These work because they are responsive to clinical need and effectively and efficiently improve the knowledge, skills and efficiency of the child health sector.

6. FINANCE REPORT

6.1 Summary

Income and Expenditure for the period ended 31 December 2016 was as follows:

$000	Dec-15	Dec-16			Dec-15	Year to date		
	Actual	Actual	Budget	Variance	Actual	Actual	Budget	Variance
Revenue	44,661	47,216	45,686	1,530 ✓	266,434	276,021	274,114	1,906 ✓
Expenditure								
Other Outsourced Services	205	484	484	0 ✓	1,228	2,901	2,901	0 ✓
Provider Payments	43,804	46,044	44,985	(1,058) !	266,233	273,990	273,613	(377) !
Total Expenditure	**44,009**	**46,527**	**45,469**	**(1,058)** !	**267,461**	**276,892**	**276,514**	**(377)** !
Surplus/(Deficit)	**652**	**689**	**217**	**472** ✓	**(1,027)**	**(871)**	**(2,400)**	**1,529** ✓

✓ Favourable to Budget ! Unfavourable to Budget but within 5% ✗ Unfavourable to Budget outside 5%

6.2 Financial Performance

The Funding result for the month of December 2016 was a $689k surplus, which was positive in variance against budget by $472k. This brought the Funding result year to date to a $1,529k positive variance against budget. This is consistent with the revised financial forecast of the Funding division.

6.3 Inter-District Flows (IDF)

The Inter District Flows (IDF) inflows and outflows were on budget for the month. To 31 December 2016 a total of $291k has been accrued and paid to MidCentral Health in anticipation of the year end National IDF wash up for RCTS.

6.4 Financial Impacts

The Ministry confirmed payment of the 15/16 wash up of In Between Travel costs in relation to payments made by DHB's for carer support travel costs. MidCentral DHB received $260k which has been recognised this month.

During the month MidCentral DHB incurred a reduction of Ministry funding of $706k as a result of the change in funding in relation to the Capital Charge reducing from 8 per cent to 7 per cent. There is a corresponding reduction in cost and therefore a net nil impact.

The Funding and MidCentral Health teams continued to work closely together to monitor progress on securing Elective Income as the revenue is dependent upon budgeted volumes being achieved.

6.4 Financial Forecast

The financial forecast of Funding division for the year to 30 June 2017 is consistent with core components of the annual plan. Through careful prioritisation and cost saving initiatives the current favourable variance will be maintained and improved to offset other cost pressures.

TO Healthy Communities Advisory Committee

FROM Muriel Hancock
Director
Patient Safety and Clinical Effectiveness

DATE 20 January 2017

SUBJECT **Accessibility Self Audit Update**

MIDCENTRAL HEALTH

MEMORANDUM

1. PURPOSE

To provide an update on the accessibility self audit, progress on the work programme, an evaluation of outcomes from the four completed audits and to describe the next steps.

2. SUMMARY

- Quarterly audits were completed over the period July 2015 to July 2016 in the following services:
  - Child and Adolescent Oral Health (CAOH);
  - Wards 26 and 29;
  - Child Development Service;
  - Social Work in Therapy Services.

- Findings include low numbers of staff undertaking customer service training and low levels of awareness relating to the Health & Disability Commissioner's (HDC) Health Passport and the Pink Passport.

- Staff are supportive of this audit process and readily participate.

- To ensure further development of accessibility related improvements the audit questions and process will be reviewed.

- An online learning module relating to disability responsiveness will be trialled.

- A further work programme is yet to be developed.

3. RECOMMENDATION

It is recommended:

that this report be received.

4. BACKGROUND

In 2013 Be.Accessible and Enable New Zealand, on behalf of MidCentral District Health Board (MDHB), developed an Accessibility Review Self Assessment tool in order for the organisation to complete a stocktake of accessibility for patient/consumers of health and disability services within MDHB. Part of this process involved consumer focus groups as well as working with MDHB staff including the Child Health Service. This is a local audit rather than regional or national.

MDHB's vision for "*Quality living – healthy lives – well communities*" for all, together with a desire to create a "*more unified, improved health and disability system*"..... "*that can be accessed by all in a trusted and confident way*" are objectives which were identified in the Be.Accessible MDHB report in 2012.

Be.Accessible is about having patients/consumers at the centre of our thinking and actions. It is about creating greater accessibility for our patients/consumers who have access needs. Patient/consumer accessibility goes well beyond the obvious one of accessible environments. The philosophy of accessibility self audits is the patient/consumer being at the centre of our thinking, and actions that need to be woven into the culture of the organisation, both in day to day operations and its future planning and development.

5. WORK PROGRAMME

The work programme, in the table below, was developed to show scheduling of the services identified for audit over 12 months, equating to one per quarter. Each service has an action plan regarding audit findings which they have reported against.

Service to Complete Accessibility Survey	Month Scheduled	Completion Date
Child and Adolescent Oral Health	July 2015	6 July 2015
Ward 26 and Ward 29	December 2015	1 December 2015
Child Development Services	March 2016	15 March 2016
Social Work Therapy Services	June 2016	15 July 2016

The process for the audit includes a brief introduction to the objective of working toward a stronger accessibility culture, completion of the self assessment audit, collection and collation of all responses, results provided back to the service, key findings/themes identified and actions agreed and allocated.

We have now completed the above annual work programme and have analysed the overall results. A new work programme will be developed when we have reviewed the process, audit questions and on-line education.

6. AUDIT UPDATE

The accessibility self audit summary of findings from the Social Work Therapy Services Team is shown below. The Therapy Services Social Work Team is based in the STAR Centre and covers in-patients and also works within the community.

The audit was undertaken at a staff meeting with the pool of staff available to complete the survey being 19. The audit questions are attached as Appendix 1.

Service	Audit Date	Findings
Therapy Services Social Work Team	15 July 2016	• Eighteen staff have attended staff orientation day but only three staff have attended customer services skills training. • Seventeen staff responded that they were aware and prepared to bring in an appropriate communication consultant/interpreter or support person at no cost to the family. • Ten staff did not know what the HDC Health Passport or the Pink Passport was. • Fifteen respondents answered yes to 'Has your service discussed different cultures and the impacts for your service'.

6.1 Progress on Implementing Audit Findings

The report against the action plans for Accessibility Self Assessment Audits is attached as Appendix 2.

Progress with implementing the key findings/themes from the self assessment audits will continue to be reported by the audited services quarterly until completed.

Each service taking part in the self assessment audit had the opportunity to add two extra questions pertinent to their specific service; to date no service has taken up this offer.

We have gathered 12 months findings from Accessibility Self Assessment Audit, see graph at Appendix 3 this shows combined results from all surveys.

6.2 Key audit findings

Across all services audited there was commonality around what staff assessed themselves as doing well and also similar areas where education was needed.

Positive accessibility themes:

- 86 per cent of staff have attended staff orientation day;
- 83 per cent of staff say that they are aware that patients can access an interpreter at no cost to themselves;
- 82 per cent say that they explain who they are and what their role is when meeting a patient;
- 79 per cent of staff say everyone in their service wears a uniform and/or has a clearly visible identification badge;

Identified areas for improvement:

- 35 per cent of staff say their service uses our Pink Passport or the HDC passport;
- 29 per cent of staff have attended Customer Service Skills training sessions;
- 24 per cent of staff have seen positive access stories;
- 17 per cent of staff have shared positive access stories.

As can be seen from the results obtained over the last 12 months, the questionnaire has not assisted us to fully assess our accessibility awareness to the level anticipated.

Whilst it is pleasing to have an increased knowledge in 'customer service skills' and 'passports', further opportunities need to be identified for improvements related to accessibility issues.

7. NEXT STEPS

As previously reported to the Disability Support Advisory Committee in October 2014, there is a need for educational resource, either on-line or hard copy that covers disability awareness.

Waitemata District Health Board has designed a Ko Awatea LEARN "Disability Responsiveness" course which we are now able to access.

We will trial this on-line course with the Therapy Services Social Work Team during a team meeting in February. Once we assess this module it is possible that we would look to include it in the new staff induction programme or as part of a regular programme across services to help build accessibility awareness within our staff. As part of assessing the value of the on-line course we will consider if a further add-on module is required given this one is primarily focused on physical disability.

The audit questions will be reviewed in parallel to considering the on-line course and other options. This will enable us to gain a clearer understanding of where our staff see we could make improvements to accessibility for our patients and families to attend our services.

Muriel Hancock
Director
Patient Safety and Clinical Effectiveness

Appendix 1

SELF AUDIT SURVEY

To build on the MDHB's vision for **"Quality living – healthy lives"** for all, there is a desire to create a **"...more unified, improved health and disability system... that can be accessed by all in a trusted and confident way...",** the MDHB engaged Be.Accessible to co-create a self assessment tool that would enable MidCentral Health (MCH) to develop a truly inclusive and accessible health and disability service in the region.

The audit has been designed to enable teams, who are instrumental in delivering MDHB's services throughout the region, to understand what they need to do to provide for a fully accessible and inclusive health and disability service.

A group of New Zealanders have been identified for whom this audit supports. This group has been identified as the access client.

This group makes up at least 20 per cent of our population and members of this group are people who:

- Are an older person or part of the growing Baby Boomer generation.
- Are blind or have difficulty reading small print.
- Are deaf or have trouble hearing in noisy places.
- Are from a different country with a different language.
- Find it difficult to read and understand things.
- Are carrying a child or has to manoeuvre a stroller or pram.
- Are unable to walk easily or uses a wheelchair.
- Are caring for a child or person with access needs.

By improving the experience for people with access needs, organisations create greater accessibility for all citizens and clients, enabling these services to build and develop better performance and results from their work.

The following questions form an accessibility review to be completed by teams and agencies.

Questions	Yes	No	N/A	Comments
• Have you attended a staff orientation day? • If so was there information / discussion on delivery of accessible health services?				
• Since beginning work here, have you attended any Customer Service Skills training sessions? • If so did you learn about dealing with accessibility issues?				
• Have you seen any patient positive access stories (which story and where did you see it)? • Have you shared any patient positive access stories (which story and how did you share it)?				
• Any communications you send are created using minimum of 12 point font.				
• Photos and pictures are used in any information you give out to patients and are in accordance to MDHB policy.				
• When patients receive appointment information do they get maps and information about how to change an appointment? • Does this information let patients know they can have a support person or interpreter attend the appointment?				

Questions	Yes	No	N/A	Comments
• Patient information on their discharge or further treatment is given to them in an easy to read and understand format? • Do you check that they have understood what happens next?				
• All staff in your unit (including administrative) have been trained and are confident in accessibility awareness? • If yes who did this training for your team?				
• Staff in your unit clearly communicate to patients the access features and hazards that exist on your site/s?				
• Everyone in your unit either wears a uniform or has a clearly visible identification badge? • Everyone in your unit explains who they are and what their role is when meeting a patient?				
• All staff in your unit are aware and prepared to bring in an appropriate communication consultant/interpreter or support person when and if required at no cost to the patient?				
• Suitability of appointment time and all decisions relating to patient care are made in partnership between the health professional and the patient or their representative?				

Question	Yes	No	N/A	Comment
• We ask our patients whether they need more information.				
• Do you know what the Pink Passport or HDC Health Passport is? • Does your unit use the Pink Passport or HDC Health Passport?				
• Has your service discussed different cultures and the impacts for your service?				
• Do your patients have quick, timely appropriate access to practitioners and specialists with multi-disciplinary responses available?				
• Access to interpreters (NZSL/multilingual) is made available at no extra cost to the client/patient/care-giver.				

ACCESSIBILITY SELF AUDIT FEBRUARY ACTION PLAN REPORT

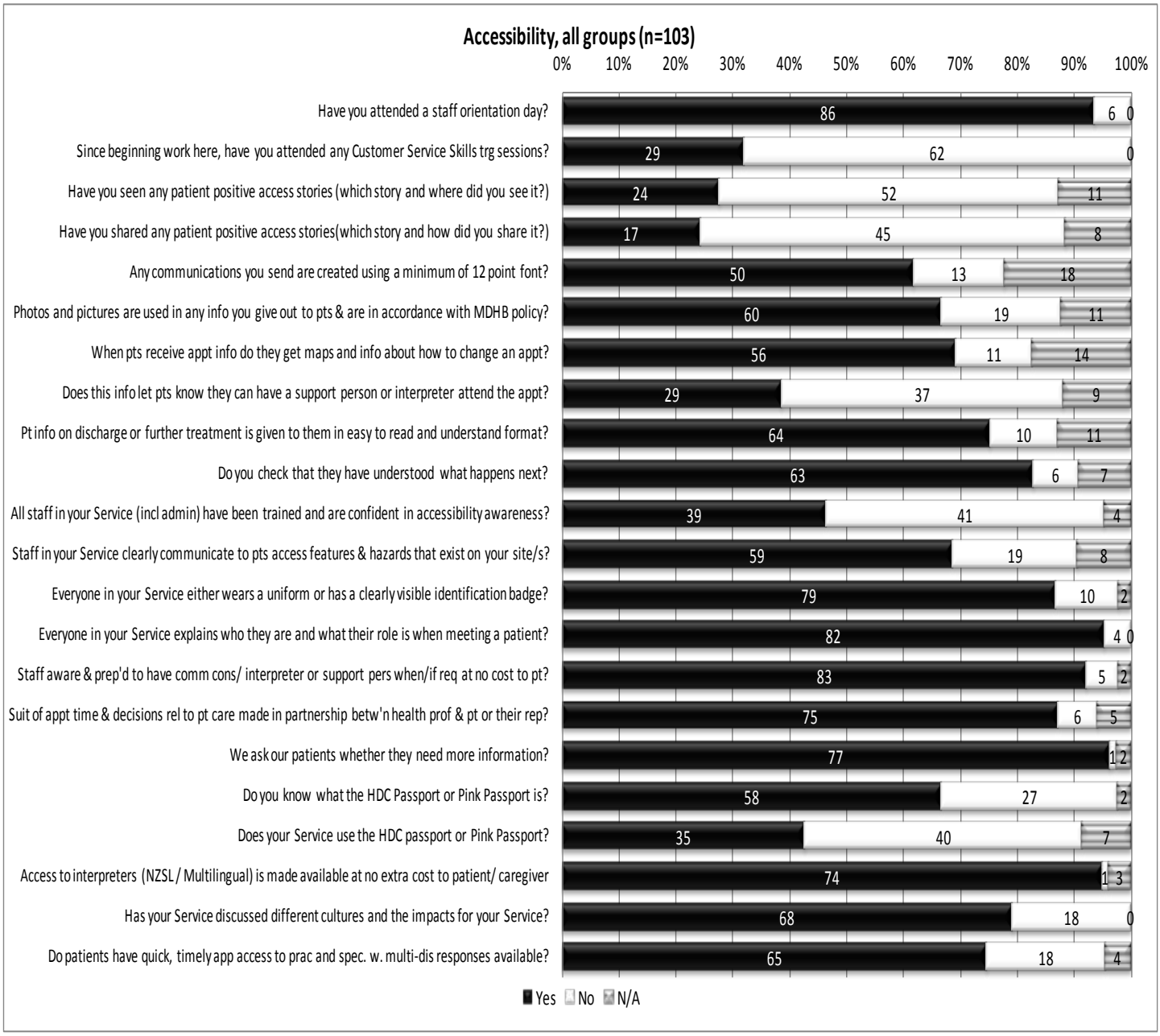
Service	Findings	Action	Who	By when	Progress reported
CAOHS	Sharing of positive access stories at team meetings.	Staff to take the opportunity to share positive access stories at regular team meetings.	CAOH Service staff	Completed	Staff are encouraged to share positive access stories at regular service Quality and Clinical Risk meetings and at local team level.
CAOHS	Staff who have not attended a Customer Service Skills training session have this built into their performance development schedule.	As staff complete performance development – staff are routinely scheduled to attend available Customer Service Skills training.	CAOH Service staff	Completed	Sixteen staff have been registered to attend course on 25/02/16. Remaining staff are registered to attend next available course on 06/09/16. Staff have all attended the Customer Services Course.
CAOHS	Educate/ remind staff of the use of HDC Heath Passport and Pink Passport.	Discuss HDC Health Passport and Pink Passport use at regular team meetings.	CAOH Service staff	Completed	Staff completed online learning legislative compliance module February 2016, this has a component on HDC. Staff updated on Pink Passports, at meeting 29/03/16.
Ward 26	Educate / remind staff about accessibility issues and the use of Pink Passport / HDC Health Passport.	Discuss accessibility at team meetings, including use of Pink Passport and HDC Health Passport.	Charge Nurse Ward 26	Completed	Discussed at team meeting.

Service	Findings	Action	Who	By when	Progress reported
Ward 26	Staff who have not attended a Customer Service Skills training session have this built into their performance development schedule.	As staff complete performance development – staff are routinely scheduled to attend available Customer Service Skills training.	Charge Nurse Ward 26	In progress As identified at performance development sessions.	Customer Service Skills training session is fully booked for February; next scheduled session is September 2016. It is recommended that Customer Service Skills training be added to induction courses.
Ward 26	Staff to ensure patients and families are aware of what happens at and after discharge.	Consider use of brochure under development by Ward 29, once trial is completed.	Charge Nurse Ward 26	Completed	Brochure given to patients.
Ward 29	Staff who have not attended a Customer Service Skills training session have this built into their performance development schedule.	As staff complete performance development – staff are routinely scheduled to attend available Customer Service Skills training.	Charge Nurse Ward 29	In progress as identified at performance development sessions.	Customer Service Skills training session is fully booked for February; next scheduled session is September 2016. It is recommended that Customer Service Skills training be added to induction courses.

Service	Findings	Action	Who	By when	Progress reported
Ward 29	Staff to ensure patients and families are aware of what happens at and after discharge.	A brochure was developed on Ward 29 as part of the Enhanced Recovery after Surgery (ERAS) project that covers off what a patient can do to prepare for discharge and once at home. The brochure is currently being finalised.	Charge Nurse Ward 29	Completed	Brochure given to patients.
Ward 29	Educate / remind staff about accessibility issues and the use of Pink Passport / HDC Health Passport.	Discuss accessibility at team meetings, including use of Pink Passport and HDC Health Passport.	Charge Nurse Ward 29	Completed	Discussed at team meeting.
Child Development Service	Fourteen staff have attended staff orientation day but only four staff have attended Customer Services Skills training.	Child Development leadership team to discuss at team strategy meeting.	Coordinator Child Health – Child Develop-ment	Completed	
Child Development Service	Thirteen staff answered that they had not seen any patient positive access stories and only one staff member had shared a positive access story.	Feedback from customers is now being shared monthly.	Coordinator Child Health – Child Develop-ment	Completed	Customer feedback is an agenda item at monthly meetings.

Service	Findings	Action	Who	By when	Progress reported
Child Development Service	Ten staff did not know what the HDC Health Passport or the Pink Passport was.	HDC Health Passport and Pink Passport have been re-socialised with the team.	Coordinator Child Health – Child Develop-ment	Completed	Discussed at team meeting.
Therapy Services Social Work Team	Ten staff do not know what the Pink Passport or HDC Passport is.	Discuss Pink Passport & HDC Passport at team meeting; provide examples of each for team to view.	Social Work Clinical Coordinator	Completed	Discussed at team meeting.
Therapy Services Social Work Team	Sixteen staff have not attended Customer Services Skills sessions.	This topic is studied as part of the degree Social Workers hold. Discussion between the Team Leader and staff will uncover whether additional training is required by this team.	Social Work Clinical Coordinator to discuss with individuals at appraisal time.	Ongoing	It has been agreed that this team will trial the KoAwatea disability responsiveness on-line training module during a team meeting in February 2017.

TWELVE MONTHS FINDINGS FROM THE ACCESSIBILITY SELF ASSESSMENT AUDIT



TO Healthy Communities Advisory Committee

FROM Muriel Hancock
Director
Patient Safety and Clinical Effectiveness

DATE 13 January 2017

MIDCENTRAL HEALTH

MEMORANDUM

SUBJECT **Patient Experience Survey**

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1. PURPOSE

To provide an update on findings from the patient experience surveys for those who self identified as having a disability or long term impairment.

2. SUMMARY

- A national inpatient experience survey was implemented in August 2014.
- Nine survey rounds have been completed.
- The survey is mailed to 400 inpatients each time.
- The response rate to the most recent survey was 47 per cent. Thirty three per cent of these respondents self identified as having a disability or long term impairment.
- Comparisons cannot be made with other District Health Boards (DHB) as they did not include the disability question.
- The average overall scores for the performance dimensions of Co-ordination and Physical and Emotional were much the same for disabled and all respondents. In the Communication and Partnership dimensions respondents with a disability provided a lower rating than all respondents.
- Aside from Communication the trends in ratings by disabled respondents is similar to the all respondents trend.
- The trend with all ratings is broadly stable.

3. CONCLUSION

The survey continues to be administered quarterly and analysis of all results will continue both by all respondent results and by respondents identifying as having a disability. Trending information and service improvements action will be identified and reported when adequate data is available for this to be meaningful. Response rates are pleasing.

4. RECOMMENDATION

It is recommended:

that this report be received.

5. BACKGROUND

In August 2014 all DHBs implemented a new national Inpatient Experience Survey. The survey is intended to fill the gap of providing a nationally consistent data source for the Health Quality and Safety Commission's (HQSC) quality and safety indicator set and the Ministry of Health's (MoH) accountability metrics. Implementation of the survey was identified as a priority in the MoH's letter of expectation and the requirement to report against it was stipulated in the 2014/15 DHB non-financial monitoring framework and performance measures document.

This survey was designed by the HQSC following a period of consultation with DHBs. This survey drew upon the PICKER library of questions and was structured to cover the four domains of the patient experience:

- Communication
- Partnership
- Co-ordination
- Physical and emotional needs

The survey takes a random sample, every quarter, of inpatients aged 15 and older, who had an overnight stay in hospital in a selected fortnight and whose event ended with a routine or self discharge. Specific exclusions are patients admitted to a mental health specialty, patients who are transferred to another health facility, and patients who died in hospital. Respondents are guaranteed anonymity unless they choose to provide their contact details because they wish to contact someone at the DHB.

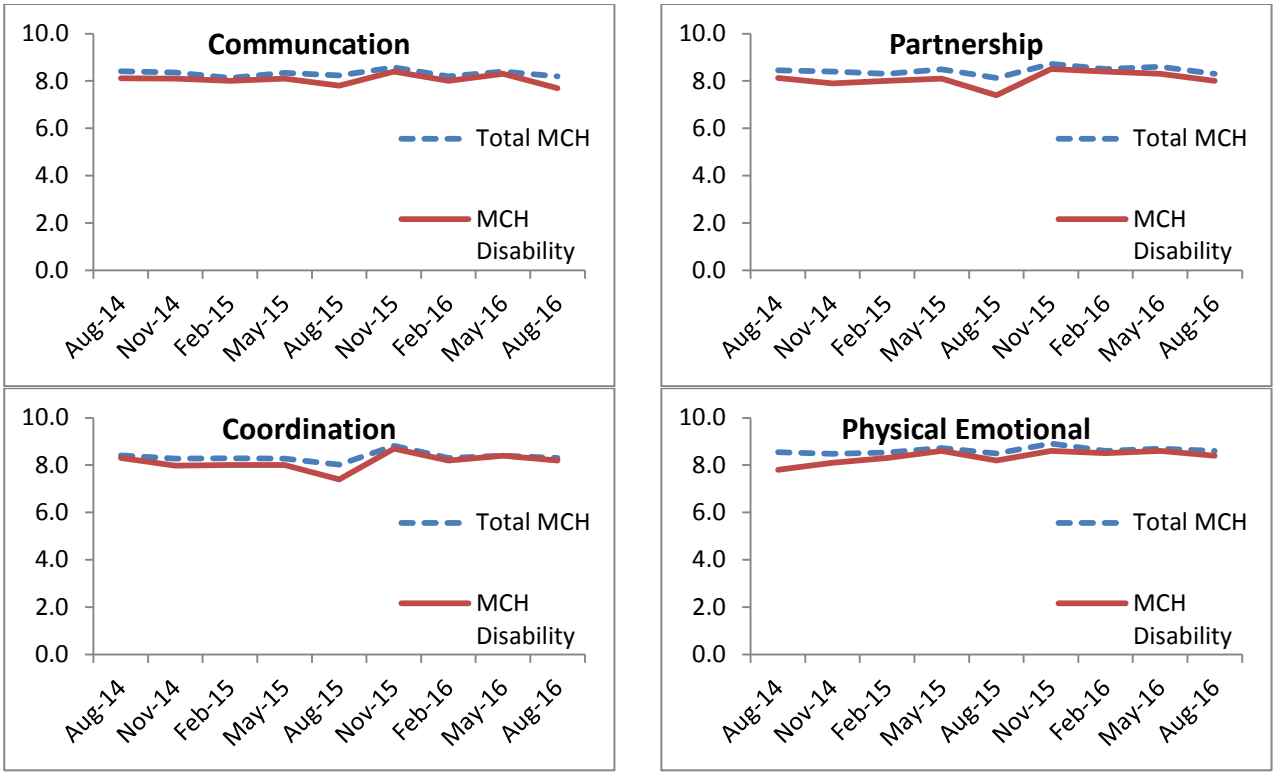
The national administrator of the survey is a contracted third party. They provide the random sample of patients, taken from the file provided by MidCentral District Health Board (MDHB) to be surveyed, and where electronic contact details are available send out the survey. They also provide the secure portal where respondents enter their responses. They then provide back to HQSC and DHBs a reporting portal with weighted responses to the survey questions. Each DHB also receives their own data file with all (anonymous) responses and comments.

The survey is intended to be conducted electronically by either email or SMS (text) with a unique survey link provided to enter response in a secure website. Reminders are sent to patients seven days after the initial contact. Respondents are given 21 days to respond. We predominantly conduct the survey by post however with the ongoing collection of email details 25 per cent were emailed in November. Recipients of these postal surveys are provided with information to enable them to complete the survey securely online if they prefer.

A core set of 20 questions is asked. In addition MDHB also chose to ask questions relating to whether patients felt they had enough privacy, whether their ward or room was clean, and whether they had religious or spiritual support when required. MDHB also added a screening question asking whether respondents had a long term disability or impairment.

6. SURVEY FINDINGS

The graphs below show the trends in overall score for each of the four domains for those respondents who self identified as having a disability compared to all respondents. A rating of ten (10) corresponds to very good and zero (0) to very poor.



It can be seen that ratings above, from respondents self identifying as having a disability, are usually similar to those from all respondents. In the most recent survey Communication was notably lower than the rating from all respondents. Questions in this dimension include whether clinical explanations were understood by the patient, whether side effects were explained or if adequate information on medication was provided.

Relative to all respondents those self identifying as having a disability were older, 76 per cent over the age of 65 compared to 53 per cent of all other respondents and they were more likely to have been through ElderHealth.

Comparisons are unable to be made with other DHBs as no other DHB chose to include a disability screening question. This has been raised at the Central Region Quality and Safety Alliance as well as at the National Quality and Risk Managers meeting with HQSC.

7. NEXT STEPS

- Continue administering the survey on a quarterly basis.
- Disseminate findings within MidCentral Health for discussion and learning.
- Continue to review anecdotal responses to identify any opportunities for improvement.
- Continue to collect email contact details so that surveys can be emailed.

- Work is being progressed to complete analysis of the responses to the communication dimension and to progress an improvement initiative based on these findings.

Muriel Hancock
Director
Patient Safety and Clinical Effectiveness

TO Healthy Communities Advisory Committee

FROM Senior Portfolio Manager Children, Youth & Intersectoral Partnerships

DATE 26 January 2017

Memorandum

SUBJECT Raising Healthy Kids Update

1. PURPOSE

This paper provides the Heathy Communities Advisory Committee (HCAC) with an update as requested at the joint committee meeting 22 November 2016. The paper outlines the direction MidCentral District Health Board has taken to manage the new Ministry of Health "Raising Healthy Kids" Target.

This paper is for information and discussion only.
Version

2. SUMMARY

In response to the growing obesity issue in New Zealand, the Government announced in October 2015 a package of initiatives to prevent and manage obesity in children and young people up to 18 years of age.

The Raising Healthy Kids Health Target is one of two targeted interventions in the Ministry of Health Childhood Obesity Plan that will reach at risk young children and their families directly.

The new National Health Target aims for 95 percent of obese children identified in the Before School Check (B4 School Check) programme to be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions by December 2017.

MidCentral DHB formed a working group to drive and provide clinical oversight of the childhood obesity initiative. The working group was developed in order to help mitigate the risks associated with childhood obesity using evidence based approaches, and not merely to meet the transactional requirements of the new target.

The group decided to use a Multi-Disciplinary Team (MDT) approach to support families of four year old children identified as "obese". The B4 School Check Team has the "difficult conversation" with the family/whanau and discusses referral options available to them. If the family wish to seek further guidance and support to help manage their child's weight they can either choose a referral to their General Practice Team or a consented referral is sent to the MDT, named the "Boost Team".

It is important to note that the family's GP Team can also refer to the Boost Team at any time if the family wish this to occur or they are looking for other options. It is expected MidCentral DHB will have around 200 four year old children each year identified as "obese", defined as BMI on the 98th centile or above.

The 'Boost' MDT provides a multi-disciplinary approach to the clinical oversight of referrals and makes recommendations and referral suggestions for managing preschool children identified as obese.

The Boost Team comprises of the B4SC Coordinator, Central Primary Health Organisation (CPHO) Clinical Dietitian, MidCentral Health Paediatrician and representatives from Sport Manawatu Active Families and Massey University Psychology Service. The Boost Team recommends the best single agency or combination of agencies for the child and their family. The family are then contacted by the appropriate agency/ agencies to arrange the appropriate intervention/s. The administrative process is supported by Sport Manawatu.

The system that has been established in our DHB is designed to be applicable for other children identified as obese, not just children identified during the B4 School Check. Already a number of older children have been referred with significant weight issues which are impacting on their health and wellbeing. The team accept these referrals but the children are coded separately.

The Boost Team meet once a month and are using a Plan-Do-Study-Act (PDSA) quality improvement methodology to addressing any issues in the system as they are identified.

Going forward, MidCentral DHB is keen to explore some research opportunities to identify if what we are doing is making a difference, and particularly to measure outcomes rather than just measure the process.

3. RECOMMENDATION

It is recommended:

that this report be received

Barb Bradnock
Senior Portfolio Manager Children, Youth & Intersectoral Partnerships
Strategy, Planning & Support

4. BACKGROUND

Obesity rates have increased in all ages, genders and ethnic groups over the last 30 years, with those born more recently becoming obese at a younger age. High Body Mass Index (BMI) has now overtaken tobacco as the leading risk to health in New Zealand.

Around one in nine children under the age of five in New Zealand are obese, with higher rates among Māori and Pacific children. Obesity is particularly concerning in children as it is associated with a wide range of health conditions and increased risk of premature onset of illness. It can also affect a child's immediate health, educational attainment and quality of life.

The new Raising Healthy Kids Health Target focuses on intervening in the early stages of life to ensure positive, sustained effects on health.

The target was selected as the existing B4 School Check focuses on early intervention to ensure positive, sustained effects on health. Children receive a comprehensive check after their fourth birthday before they start school and are referred to the services they need to support healthy eating and activity.

The target will ensure four-year-olds identified as obese while receiving their B4 School Check will be offered referral to manage any medical complication and any services they and their family may find helpful to support healthy eating and activity.

The Raising Healthy Kids health target is one of the suite of initiatives in the Ministry of Health "Childhood Obesity Plan".

The plan consists of a package of initiatives that aim to prevent and manage obesity in children and young people up to 18 years of age by focusing on:

- targeted interventions for those who are obese
- increased support for those at risk of becoming obese
- broad approaches to make healthier choices easier for all New Zealanders.

The emphasis is on food, behaviour change, the environment and being active at each life stage, starting during pregnancy and early childhood. The package brings together initiatives across government agencies, the private sector, communities, schools, families and whānau.

5. MIDCENTRAL DHB APPROACH

The DHB was given prior warning of the new target earlier in 2015. This allowed discussion to take place around the best way forward to ensure that MidCentral could manage and provide the best possible opportunities and support for children and their families/whanau in the target group.

A working group was established in the DHB to lead this new initiative and provide clinical oversight. The group consists of representatives from Public Health Services, the B4SC team, Sport Manawatu-Active Familes Programme, Massey University Psychology Services, hospital paediatrics, Central PHO dietitians and Maori Health Team.

The Ministry of Health has not provided any funding for this work but the DHB has reorganised some existing funding to support services to meet demand. The Child Health Tamariki Ora District Group supports this approach.

5.1 Preparation of the sector for the new Target

In order to prepare the Primary Care Community to manage the new Health Target and the referral process, the working group developed a Collaborative Clinical Pathway (Map of Medicine) to support particularly General Practice Teams to understand the process.

The pathway is available via the General Practice "Practice Management System" and allows the clinicians to access all the resources that might be required, including nutrition and physical activity information for families, referral pathways and guidance around BMI calculation. The pathway also maintains consistency of information for the family at whatever point they seek support.

In addition the DHB supported a professional development session delivered by Massey University Psychology Team around "having difficult conversations with families". This was well attended and supported by clinicians.

The professional development session was deemed essential by the B4 School Check nurses whom have found the greater majority of families struggle to even acknowledge their child is overweight let alone obese. The manner in which this very sensitive topic is approached and managed is the key to engagement with the families going forward and hence the engagement with Massey University Psychology Service to run the workshop.

The B4SC Coordinator has also visited and followed up by phone with many General Practice Teams to ensure they are familiar with how to access resources available to them and how to refer on to the Boost MDT.

5.2 The B4SC / Referral process

It was agreed by the working group that the B4 School Check Team would work through the "BeSmarter" resource with families during their B4 School Check visit. The resource has been purchased from Waikato DHB and is being used by many DHB's around the country. It is seen as best practice and has also been available to General Practice teams and MidCentral Health Child Health Service. A copy of the resource is provided in the Appendix.

During the B4SC if the child is identified as having BMI on or above the 98th centile then they will go through an informed consent process and will have 3 options:

- Decline referral
- Referral to their GP Team
- Referral to the Boost Team for discussion

5.3 Boost MDT Meetings

The Boost Team provides a multi-disciplinary approach to the clinical oversight of referrals and makes recommendations for managing preschool children identified as obese. The name of the Boost Team was developed by the childhood obesity working group and reflects encouraging children to be the best they can.

The Boost MDT takes a collaborative approach to referrals from the B4 School Check across the MidCentral District. These referrals are processed through a single point of entry model. The Boost team meet monthly for collaboration and case discussion. The administrator of the Boost Team sits within Sport Manawatu.

Members of the Boost Team include:

- MidCentral Health Secondary Service- Paediatrician
- Central PHO Clinical Dietitian- Team Leader
- B4 School Check- Coordinator
- Sport Manawatu- Active Families Advisor
- Massey University Psychology Services- Clinical Psychologist

Expert advisory members include:

- Māori/Pasifika team members
- Whanau Ora navigators

In order to start to mitigate the risks associated with childhood obesity, it is anticipated that the Boost Team will result in the following outcomes:

- Families are linked to key services to make lifestyle changes to help improve referred children's eating and activity
- Targeted interventions are provided for children who are obese
- Heightened awareness of the needs of families with children who are at or above 98th BMI percentile
- Streamlined access point by B4 School Check nurses and GP teams for families/ whanau with eating and activity concerns
- Coverage across the MidCentral district
- Integrated care for those experiencing medical complications
- Data collection and monitoring with regular review processes of child progress
- Strengthened collaboration for cross agency approach across sectors

The planning behind the establishment of the Boost Team commenced in mid 2016 and the first referrals were sent to the Boost Team November 2016. To date the Boost MDT meetings have seen some very complex cases for review but the opportunity to discuss these at length with all key players has been invaluable. Current feedback from service providers that are engaging with the families have expressed that families are eager and ready to make lifestyle changes to improve the health and wellbeing of their family. This is credited to the conversations had by the B4 School Check nurses and the implementation of the BeSmarter resource. It is too early to see any trends evolve but progress will be reported to the committee later in the year.

The Child Health Tamariki Ora District Group has also been clear that the opportunity for research alongside this programme of work is essential and this is being explored.

5.4 Health Target Monitoring

The data relating to the Childhood Obesity Health Target is collected by the B4 School Check Team with ongoing reporting to Ministry of Health. The MidCentral Childhood Obesity working group meet periodically and reviews progress towards the Health Target. As implemented by the effective Immunisation Team the Childhood Obesity working group take a PDSA quality improvement approach to correcting potential concerns.

The approach undertaken by MidCentral DHB is working well and is in line with other DHBs. Furthermore, this approach is aligned with the recently released Ministry of Health *"Clinical Guidelines for Weight Management in New Zealand Children and Young People (2016).*" Since the public reporting of the Health Target MidCentral is sitting amongst the top 5 DHBs nationally.

6. DISCUSSSION

Whilst the new Health Target has drawn considerable controversy across the child health sector as it was felt to be "too light", MidCentral DHB has taken a considered and quality improvement approach to meeting the needs of the children and families/whanau who fall into the target group.

Our approach to offer families the opportunity to have a range of dietitian, active families, psychology and paediatrician support is invaluable. General Practice Teams also seem more confident now they have been educated around resources, referral process and given tips on how to sensitively initiate these crucial conversations with families.

Finally, one very positive piece of work has also come from this new target. The Fielding Integrated Family Health Centre (IFHC) has been working with the Public Health Service, B4SC team and the DHB to implement the B4SC within the IFHC and then to manage their own children who meet the "obesity" threshold.

The DHB has supported the PHO dietitian and Active Families programme to work and connect with the IFHC and other services will be offered as and when required. The referral oversight will still remain with Sport Manawatu administration so that data is collected and reported consistently. This is truly exciting progress and all involved are prepared to use quality improvement methodology to ensure that this remains flexible, doable and seamless for the children involved and their families/whanau.

Appendix 1


FX006
basics
for healthy kids
be smarter
be bodywise
goal sheet
Not yet
Sometimes
Mostly
Always
breakfast every day
at 5+ a day
sleep 10-12 hours
match servings to hand size
activity 60 minutes daily
reduce sugary drinks
takeaways less than once a week
eat together as a family
reduce screen time < 2 hours
Name
Date
Goal
Tick your goals here:
Mon
Tue
Wed
Thur
Fri
Sat
Sun
Week 1
Week 2
Week 3
Week 4
bodywise@waikatodhb.health.nz
Today you were seen by:
WaiKids
sportwaikato

Here are some ways to be smarter

breakfast every day

Essential fuel for the body to start the day alert and ready to learn

- Choose a cereal with preferably less than 15 grams sugar per 100 grams, Weetbix or porridge are great choices
- Chop up some fruit and top with yoghurt
- Eat wholemeal toast or one with grainy bits that you can see. Fibre keeps you fuller for longer
- Find a buddy to eat breakfast with
- Stop eating /snacking after dinner so you wake up ready to eat healthy food
- Eat together as a family more often

eat 5+ a day

Vegetables and fruit are essential for vitamins that we need everyday

- Aim for at least 3 handfuls of colourful vegetables every day
- Eat a piece of fruit at breakfast and also pop one in the lunchbox
- Cut up fruit or carrot sticks for after school
- Thread bite size pieces of fruit onto a kebab stick
- Have a dip with raw carrots, broccoli, cauliflower pieces
- Add baby spinach and other greens to pizzas, mince and pasta dishes or make a hearty soup

Sleep 10-12 hours

Getting plenty of sleep helps with weight management, feeling good and learning

- Decide on a suitable bedtime to allow enough hours of sleep
- Have a regular bedtime routine
- Create a quiet space for sleep without distractions
- Remove electronics from the bedroom (tv, playstation, computers & phones)
- Aim for a gap between eating and bedtime. Two hours is best
- Plenty of physical activity during the day helps kids with sleep

match servings to hand size

For age appropriate portions

- Use child's hand to guide portion sizes: palm = protein (meat/meat alternatives), fist = carbohydrate (potato/ kumara/pasta/rice) and 2 cupped handfuls of colourful vegetables
- Try the ¼, ¼, ½ rule when serving the dinner meal (i.e. ¼ plate potato or rice or pasta (carbohydrate), ¼ plate meat or meat alternatives (protein), ½ plate colourful vegetables)
- If including bread in the dinner meal, reduce the other carbohydrate choice
- Choose smaller bowls and dinner plates if necessary

activity 60 minutes daily

Think huff 'n puff activity

- Join a club together, karate, squash, badminton, waka ama
- Do something active as a family in the weekend. Go for a walk around the lake or play at the playground
- Have a family game of soccer or softball
- Park further from the school or shops
- If the journey is less than 2km leave the car at home
- Plan ahead for next seasons sports
- Keep a bag of active equipment handy for outings or when visiting friends/whanau
- Activity can be broken into 10-15 min 'chunks'

reduce sugary drinks

Not for every day

- Take cordial, fizzy drink and sugary drink sachets off the shopping list
- Offer cold water from the fridge often
- Let friends know that your family are cutting back on drinks that are high in sugar and also caffeine
- Buy a new water bottle to keep water tasting fresh
- Flavour water with lemon or berries or mint
- Pack your own cold water when you go out
- Powdered chocolate drinks usually contain sugar and are not recommended as an everyday drink

takeaways less than once a week

Food not prepared at home

- Eat less than once per week
- Takeaways include bakery type lunches such as pies/ slices/savouries
- Talk with the family about what home-cooked meals are liked the most
- Plan a dinner menu
- Write a list for the food shopping
- Share the cooking duties
- Plan home-made lunch combos with the children
- Stick your combos menu on the fridge
- Keep to regular servings, avoid up sizing

eat together as a family

It's good being together

- Sit around a table (or together) for meals
- Decide on a time that will work best for everyone
- Consider after school /work activities
- Turn off the TV and phones
- Cook 1 meal to serve to everyone (no multi meal cooking)
- Eat together for good communication within families
- Remove the bread from the table
- Add a jug of water and a platter of raw vegetables

reduce screen time

Encourage the kids to be up and active

- Limit screen time to less than 2 hours a day
- Screen time includes: television, computer, game consoles, phones, i-pods etc
- Replace screen time with active time
- Plan screen time in advance. Talk about how much and when
- For every 30 min of screen time take a 10 min activity break
- Make the bedroom a screen free zone. This is a great way on monitoring what the kids are doing

www.healthnavigator.org.nz www.sportwaikato.org.nz www.heartfoundation.org.nz www.vegetables.co.nz www.5aday.co.nz www.feedingourfamilies.org.nz www.sportnz.org.nz

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