

DISTRIBUTION:

Committee Members

- ☐ Mr C Wade (Chair)
- ☐ Ms T Hodges (Deputy Chair)
- ☐ Mr B Simcock
- ☐ Ms S Webb
- ☐ Ms S Mariu
- ☐ Mrs P Mahood
- ☐ Ms C Beavis
- ☐ Ms TP Thompson-Evans (IMC representative)
- ☐ Mr F Mhlanga (Consumer Council to confirm)
- ☐ Mr J McIntosh (Consumer Council to confirm)
- ☐ Mr D Slone (Consumer Council to confirm)
- ☐ Mr R Vigor-Brown (Lakes DHB representative)
(Consumer Council to confirm)
- ☐ Mr M Arundel (BoP DHB representative)
(Consumer Council to confirm)

Management

- ☐ Dr N Murray, Chief Executive
- ☐ Mr B Paradine, Executive Director, Waikato Hospital Services
- ☐ Ms M Chrystall, Executive Director, Corporate Services
- ☐ Ms L Aydon, Executive Director, Public and Organisational Affairs
- ☐ Mr D Hackett, Executive Director, Virtual Care and Innovation
- ☐ Mr N Hablous, Chief of Staff
- ☐ Mrs S Hayward, Director of Nursing & Midwifery
- ☐ Ms L Elliott, Executive Director, Māori Health
- ☐ Dr T Watson, Chief Medical Advisor
- ☐ Mr I Wolstencroft, Executive Director, Strategic Projects
- ☐ Dr D Tomic, Clinical Director Primary and Integrated Care
- ☐ Dr D Wright, Executive Director, Mental Health & Addictions Service
- ☐ Mr M Spittal, Executive Director, Community & Clinical Support
- ☐ Ms M Neville, Director, Quality & Patient Safety
- ☐ Mrs B Garbutt, Rehabilitation and Allied Health
- ☐ Ms J Wilson, Executive Director, Strategy & Funding
- ☐ Prof R Lawrenson, Clinical Director, Strategy & Funding
- ☐ Ms T Maloney, Commissioner of the taskforce for the Women's Health transformation project
- ☐ Mr M ter Beek, Executive Director, Operations and Performance
- ☐ Mr C Cardwell, Executive Director, Facilities and Business
- ☐ Mr P Mayes, Ministry Of Health
- ☐ Minute taker
- ☐ Board Records

Contact Details:

Telephone 07 834 3600
www.waikatodhb.health.nz

Next Meeting Date: 13 December 2017



WAIKATO DISTRICT HEALTH BOARD

A g e n d a

Health Strategy Committee

Date: 11 October 2017

Time: 1pm

Place: Board Room
Level 1
Hockin Building
Waikato Hospital
Pembroke Street
HAMILTON



***Meeting of the Health Strategy Committee
to be held on Wednesday 11 October 2017, at 1pm
Board Room, First Floor, Hockin Building***

AGENDA

- 1 APOLOGIES**
- 2 LATE ITEMS**
- 3 INTERESTS**
 - 3.1 Schedule of interests
 - 3.2 Conflicts related to items on the agenda
- 4 MINUTES AND MATTERS ARISING**
 - 4.1 Waikato DHB Health Strategy Committee; 9 August 2017
 - 4.2 Lakes DHB Community & Public Health Advisory Committee; 14 August 2017 and Disability Support Advisory Committee; 14 August 2017
 - 4.3 Bay of Plenty DHB combined Community & Public Health Advisory Committee and Disability Support Advisory Committee; 7 June 2017 and 6 September 2017
- 5 WORKPLAN**
 - 5.1 Support for immigrants and refugees with disabilities
 - 5.2 Younger people in rethomes
 - 5.3 Interpreter Services at Waikato DHB
 - 5.4 Understanding our population profile
- 6 STRATEGY AND FUNDING OVERVIEW REPORT**
- 7 PAPERS FOR ACTION**
 - 7.1 Draft Suicide Prevention and Postvention Plan
- 8 PAPERS FOR INFORMATION**
- 9 STRATEGIC PROGRAMMES UPDATE**
 - 9.1 eSPACE (October)
 - 9.2 Mental Health and Addictions Model of Care (December)
 - 9.3 SmartHealth (December)
 - 9.4 Rural Project (December)
 - 9.5 Women's Health Transformation (December)
 - 9.6 Elective Services Improvement (December)
 - 9.7 Patient Flow (October)
 - 9.8 Medical School (December)
 - 9.9 CBD Accommodation Projects (October)
 - 9.10 Primary Care Integration (October)

10 PRIORITY PROGRAMME PLANS

11 GENERAL BUSINESS

12 DATE OF NEXT MEETING
13 December 2017

RESOLUTION TO EXCLUDE THE PUBLIC
NEW ZEALAND PUBLIC HEALTH AND DISABILITY ACT 2000

THAT:

- (1) The public be excluded from the following part of the proceedings of this meeting, namely:

Item 13: Interim Arrangements for Mental Health Supported Accommodation

- (2) The general subject of each matter to be considered while the public is excluded, and the reason for passing this resolution in relation to each matter, are as follows:

GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	REASON FOR PASSING THIS RESOLUTION IN RELATION TO EACH MATTER
Item 13: Interim Arrangements for Mental Health Supported Accommodation	Contract negotiations will be required.

- (3) This resolution is made in reliance on Clause 33 of Schedule 3 of the NZ Public Health & Disability Act 2000 and the grounds on which the resolution is based, together with the particular interest or interests protected by the Official Information Act 1982 which would be prejudiced by the holding of the whole or the relevant part of the proceedings of the meeting in public are as follows:

Item 13 Section 9(2)(j) of the Official Information Act 1982 – To enable the Waikato DHB to carry on negotiations without prejudice or disadvantage.

Item

13 INTERIM ARRANGEMENTS FOR MENTAL HEALTH SUPPORTED ACCOMMODATION

RE-ADMITTANCE OF THE PUBLIC

THAT:

- (1) The Public Be Re-Admitted.
(2) The Executive be delegated authority after the meeting to determine which items should be made publicly available for the purposes of publicity or implementation.



Apologies



Late Items



Interests

SCHEDULE OF INTERESTS AS UPDATED BY HEALTH STRATEGY COMMITTEE MEMBERS TO OCTOBER 2017

Clyde Wade

Interest	Nature of Interest <i>(Pecuniary/Non-Pecuniary)</i>	Type of Conflict <i>(Actual/Potential/Perceived/None)</i>	Mitigating Actions <i>(Agreed approach to manage Risks)</i>
Chair, Health Strategy Committee, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Board member, Waikato DHB	Non-Pecuniary	None	
Deputy Chair, Audit & Corporate Risk Management Committee, Waikato DHB	Non-Pecuniary	None	
Member, Maori Strategic Committee, Waikato DHB	Non-Pecuniary	None	Will not be taking any cases involving Waikato DHB
Member, Sustainability Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Board of Clinical Governance, Waikato DHB	Non-Pecuniary	None	
Shareholder, Midland Cardiovascular Services	Pecuniary	Potential	
Trustee, Waikato Health Memorabilia Trust	Non-Pecuniary	Potential	
Trustee, Waikato Heart Trust	Non-Pecuniary	Potential	
Trustee, Waikato Cardiology Charitable Trust	Non-Pecuniary	Potential	
Patron, Zipper Club of New Zealand	Non-Pecuniary	Potential	
Emeritus Consultant Cardiologist, Waikato DHB	Non-Pecuniary	Perceived	
Cardiology Advisor, Health & Disability Commission	Pecuniary	Potential	
Fellow Royal Australasian College of Physicians	Non-Pecuniary	Perceived	
Occasional Cardiology consulting	Pecuniary	Potential	
Member, Hospital Advisory Committee, Bay of Plenty DHB	Pecuniary	Potential	
Son, employee of Waikato DHB	Non-Pecuniary	Potential	

Tania Hodges

Interest	Nature of Interest <i>(Pecuniary/Non-Pecuniary)</i>	Type of Conflict <i>(Actual/Potential/Perceived/None)</i>	Mitigating Actions <i>(Agreed approach to manage Risks)</i>
Deputy Chair, Health Strategy Committee, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Board member, Waikato DHB	Non-Pecuniary	None	
Chair, Maori Strategic Committee, Waikato DHB	Non-Pecuniary	None	
Member, Remuneration Committee, Waikato DHB	Non-Pecuniary	None	
Member, Iwi Maori Council, Waikato DHB	Non-Pecuniary	None	
Director/Shareholder, Digital Indigenous.com Ltd (contracts with Ministry of Health and other Government entities)	Pecuniary	Potential	
Director, Ngati Pahauwera Commercial Development Ltd	Pecuniary	None	
Director, Ngati Pahauwera Development Custodian Ltd	Pecuniary	None	
Director, Ngati Pahauwera Tiaki Custodian Limited	Pecuniary	None	
Trustee, Ngati Pahauwera Development and Tiaki Trusts (Deputy Chair)	Pecuniary	None	

Note 1: Interests listed in every agenda.

Note 2: Members required to detail any conflicts applicable to each meeting.

Bob Simcock

Interest	Nature of Interest (Pecuniary/Non-Pecuniary)	Type of Conflict (Actual/Potential/Perceived/None)	Mitigating Actions (Agreed approach to manage Risks)
Chair, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Chair, Remuneration Committee, Waikato DHB	Non-Pecuniary	None	
Member, Performance Monitoring Committee, Waikato DHB	Non-Pecuniary	None	
Member, Health Strategy Committee, Waikato DHB	Non-Pecuniary	None	
Member, Audit & Corporate Risk Management Committee, Waikato DHB	Non-Pecuniary	None	
Member, Sustainability Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Maori Strategic Committee, Waikato DHB	Non-Pecuniary	None	
Member, Board of Clinical Governance, Waikato DHB	Non-Pecuniary	None	
Chairman, Orchestras	TBA	TBA	
Member, Waikato Regional Council	Pecuniary	Perceived	
Director, Rotorua LLC	TBA	TBA	
Trustee, RM & AI Simcock Family Trust	TBA	TBA	
Wife is Trustee of Child Matters, Trustee Life Unlimited which holds contracts with the DHB, Member of Governance Group for National Child Health Information Programme, Member of Waikato Child and Youth Mortality Review Group	Pecuniary	Potential	

Sally Webb

Interest	Nature of Interest (Pecuniary/Non-Pecuniary)	Type of Conflict (Actual/Potential/Perceived/None)	Mitigating Actions (Agreed approach to manage Risks)
Deputy Chair and Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Deputy Chair, Remuneration Committee, Waikato DHB	Non-Pecuniary	None	
Member, Performance Monitoring Committee, Waikato DHB	Non-Pecuniary	None	
Member, Health Strategy Committee, Waikato DHB	Non-Pecuniary	None	
Member, Audit & Corporate Risk Management Committee, Waikato DHB	Non-Pecuniary	None	
Member, Sustainability Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Chair, Bay of Plenty DHB	TBA	TBA	
Member, Capital Investment Committee	TBA	TBA	
Director, SallyW Ltd	TBA	TBA	

Crystal Beavis

Interest	Nature of Interest (Pecuniary/Non-Pecuniary)	Type of Conflict (Actual/Potential/Perceived/None)	Mitigating Actions (Agreed approach to manage Risks)
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2

Note 1: Interests listed in every agenda.

Note 2: Members required to detail any conflicts applicable to each meeting.

Deputy Chair, Performance Monitoring Committee, Waikato DHB	Non-Pecuniary	None
Member, Health Strategy Committee, Waikato DHB	Non-Pecuniary	None
Member, Sustainability Advisory Committee, Waikato DHB	Non-Pecuniary	None
Member, Remuneration Committee, Waikato DHB	Non-Pecuniary	None
Director, Bridger Beavis & Associates Ltd, management consultancy	Non-Pecuniary	None
Director, Strategic Lighting Partners Ltd, management consultancy	Non-Pecuniary	None
Life member, Diabetes Youth NZ Inc	Non-Pecuniary	Perceived
Trustee, several Family Trusts	Non-Pecuniary	None
Employee, Waikato District Council	Pecuniary	None

Pippa Mahood

Interest	Nature of Interest (Pecuniary/Non-Pecuniary)	Type of Conflict (Actual/Potential/Perceived/None)	Mitigating Actions (Agreed approach to manage Risks)
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Health Strategy Committee, Waikato DHB	Non-Pecuniary	None	
Member, Iwi Maori Council, Waikato DHB	Non-Pecuniary	None	
Chair, Waikato Health Trust	Non-Pecuniary	None	
Life Member, Hospice Waikato	TBA	Perceived	
Member, Institute of Healthy Aging Governance Group	TBA	Perceived	
Board member, WaiBOP Football Association	TBA	Perceived	
Husband retired respiratory consultant at Waikato Hospital	Non-Pecuniary	None	
Member, Community and Public Health Committee, Lakes DHB	Pecuniary	Potential	
Member, Disability Support Advisory Committee, Lakes DHB	Pecuniary	Potential	

Sharon Mariu

Interest	Nature of Interest (Pecuniary/Non-Pecuniary)	Type of Conflict (Actual/Potential/Perceived/None)	Mitigating Actions (Agreed approach to manage Risks)
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Chair, Audit & Corporate Risk Management Committee, Waikato DHB	Non-Pecuniary	None	
Chair, Sustainability Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Health Strategy Committee, Waikato DHB	Non-Pecuniary	None	
Director/Shareholder, Register Specialists Ltd	Pecuniary	Perceived	
Director/Shareholder, Asher Group Ltd	Pecuniary	Perceived	
Director, Hautu-Rangipo Whenua Ltd	Pecuniary	Perceived	
Owner, Chartered Accountant in Public Practice	Pecuniary	Perceived	
Daughter is an employee of Puna Chambers Law Firm, Hamilton	Non-Pecuniary	Potential	
Daughter is an employee of Deloitte, Hamilton	Non-Pecuniary	Potential	

Note 1: Interests listed in every agenda.

Note 2: Members required to detail any conflicts applicable to each meeting.

John McIntosh

Interest	Nature of Interest (Pecuniary/Non-Pecuniary)	Type of Conflict (Actual/Potential/Perceived/None)	Mitigating Actions (Agreed approach to manage Risks)
Member, Health Strategy Committee, Waikato DHB Disability Information Advisor, LIFE Unlimited Charitable Trust – a national health and disability provider; contracts to Ministry of Health (currently no Waikato DHB contracts) Coordinator, SPAN Trust – a mechanism for distribution to specialised funding from Ministry of Health in Waikato Trustee, Waikato Health and Disability Expo Trust	Non-Pecuniary	None	Refer Notes 1 and 2

David Slone

Interest	Nature of Interest (Pecuniary/Non-Pecuniary)	Type of Conflict (Actual/Potential/Perceived/None)	Mitigating Actions (Agreed approach to manage Risks)
Member, Health Strategy Committee, Waikato DHB Director and Shareholder, Weasel Words Ltd Trustee, NZ Williams Syndrome Association Member of Executive, Cambridge Chamber of Commerce Committee member, Waikato Special Olympics Wife employed by CCS Disability Action and Salvation Army Home Care, both of which receive health funding Disability issues blogger (opticynic.wordpress.com)	Non-Pecuniary	None	Refer Notes 1 and 2

Fungai Mhlanga

Interest	Nature of Interest (Pecuniary/Non-Pecuniary)	Type of Conflict (Actual/Potential/Perceived/None)	Mitigating Actions (Agreed approach to manage Risks)
Member, Health Strategy Committee, Waikato DHB Employee, Hamilton City Council Member, Public Health Association	Non-Pecuniary	None	Refer Notes 1 and 2

Te Pora Thompson-Evans

Interest	Nature of Interest (Pecuniary/Non-Pecuniary)	Type of Conflict (Actual/Potential/Perceived/None)	Mitigating Actions (Agreed approach to manage Risks)
Member, Health Strategy Committee, Waikato DHB Member, Iwi Maori Council Representative for Waikato-Tainui, Waikato DHB Iwi: Ngāti Hauā	Non-Pecuniary	None	Refer Notes 1 and 2

Note 1: Interests listed in every agenda.

Note 2: Members required to detail any conflicts applicable to each meeting.

Member, Te Whakakitenga o Waikato
 Trustee, Ngāti Hauā Iwi Trust
 Trustee, Tumuaki Endowment Charitable Trust
 Director, Whai Manawa Limited
 Director/Shareholder, 7 Eight 12 Limited

Rob Vigor-Brown
 Interest

	Nature of Interest <i>(Pecuniary/Non-Pecuniary)</i>	Type of Conflict <i>(Actual/Potential/Perceived/None)</i>	Mitigating Actions <i>(Agreed approach to manage Risks)</i>
Member, Health Strategy Committee, Waikato DHB Board member, Lakes DHB	Non-Pecuniary	None	Refer Notes 1 and 2

Mark Arundel
 Interest

	Nature of Interest <i>(Pecuniary/Non-Pecuniary)</i>	Type of Conflict <i>(Actual/Potential/Perceived/None)</i>	Mitigating Actions <i>(Agreed approach to manage Risks)</i>
Member, Health Strategy Committee, Waikato DHB Board member, Bay of Plenty DHB Armey Co Ltd – pharmacy locum services Armey Family Trust – property investments Member, Pharmaceutical Society of NZ Employee, Bethlehem Pharmacy Wife is an employee of Toi Te Ora (public health	Non-Pecuniary	None	Refer Notes 1 and 2

Note 1: Interests listed in every agenda.

Note 2: Members required to detail any conflicts applicable to each meeting.



Conflicts related to items on the agenda



Minutes and Matter Arising

**MEMORANDUM TO THE HEALTH STRATEGY
COMMITTEE
11 OCTOBER 2017**

AGENDA ITEM 4

COMMITTEE MINUTES

Attached are the following minutes from the Committee meetings:-

- Waikato DHB, Health Strategy Committee; 9 August 2017
- Lakes DHB, Community & Public Health Advisory Committee and Disability Support Advisory Committee; 14 August 2017
- Bay of Plenty combined Community & Public Health Advisory & Disability Support Advisory Committee; 7 June and 6 September 2017.

Recommendation

THAT

The minutes be noted.

**CLYDE WADE
CHAIR, HEALTH STRATEGY COMMITTEE**

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Health Strategy Committee held on 9 August 2017 commencing at 12.38pm

- Present:**
- Mr C Wade (Chair)
 - Ms T Hodges (Deputy Chair)
 - Ms S Mariu
 - Mrs P Mahood
 - Ms C Beavis
 - Ms TP Thompson-Evans
 - Mr J McIntosh
 - Mr R Vigor Brown
 - Mr M Arundel
- In Attendance:**
- Mrs MA Gill, Waikato DHB Board member
 - Ms J Wilson, Executive Director, Strategy & Funding
 - Mr B Paradine, Executive Director, Waikato Hospital Services
 - Mr D Hackett, Executive Director, Virtual Care and Innovation
 - Ms S Hayward, Director of Nursing and Midwifery
 - Mr D Tomic, Clinical Director, Primary and Integrated Care
 - Mr D Wright, Executive Director, Mental Health and Addictions Service
 - Mr M Spittal, Executive Director, Community and Clinical Services
 - Prof R Lawrenson, Clinical Director, Strategy and Funding
 - Ms T Maloney, Commissioner, Women's Health Transformation Taskforce
 - Mr M ter Beek, Executive Director, Operations and Performance
 - Mr A McCurdie, Chief Financial Officer
 - Ms E McKenzie Norton, Strategy and Funding
 - Mr W Skipage, Strategy and Funding
 - Mr R Webb, Strategy and Funding
 - Ms C Cresswell, Strategy and Funding
 - Ms N Arnet, Change Team
 - Ms B Wills, Elective Services
 - Ms J Hudson, Strategy and Funding

IN THE ABSENCE OF DELEGATED AUTHORITY ALL ITEMS WERE FOR RECOMMENDATION TO THE BOARD

ITEM 1: APOLOGIES

Apologies from Ms S Webb, Mr B Simcock, Mr D Slone, and Mr F Mhlanga were received.

Resolved

THAT

The apologies were received.

ITEM 2: LATE ITEMS

There were no late items raised at the meeting.

ITEM 3: INTERESTS

3.1 Register of Interests

There were no changes made to the Interests register.

3.2 Conflicts Relating to Items on the Agenda

No conflicts of interest relating to items on the agenda were foreshadowed.

ITEM 4: MINUTES OF PREVIOUS MEETING AND MATTERS ARISING

Resolved THAT

- 1) The minutes of a meeting of the Waikato DHB Health Strategy Committee held on 14 June 2017 be confirmed as a true and correct record.
- 2) The minutes of a meeting of the Lakes DHB Community & Public Health Advisory Committee held on 19 June 2017 be noted.
- 3) The minutes of a meeting of the Bay of Plenty DHB combined Community & Public Health Advisory Committee/ Disability Advisory Service Committee held on 1 March 2017 be noted.

ITEM 5: WORKPLAN

No discussion took place.

Resolved THAT

The Committee received the report.

ITEM 6: STRATEGY AND FUNDING OVERVIEW REPORT

The Strategy and Funding overview report was submitted for the Committee's information.

Key areas included:

Community Health Forum

A representative to attend and discuss the Community Health Fora at the October Committee meeting.

System Level Measures Plan

The Ministry of Health has approved the existing measures in the Waikato DHB plan.

An equity focus has been applied to each SLM.

Resolved**THAT**

The Committee received the report.

ITEM 7: PAPERS FOR ACTION**7.1 Child Health Matters**

Raising Health Kids measure is reported on and further comment will be included in future reports. Tools and resources cover all young people. An update report to be presented at the October meeting including the data to June 2017 where available. A discussion around the focus areas occurred, an understanding of what we want to impact will need to be further understood before the focus areas can be progressed.

Key areas include:

Early enrolment with Lead Maternity carers

The DHB is working closely with the Ministry of Health as LMCs are contracted to the Ministry of Health.

Smoking in pregnancy

A presentation at the October 2017 Performance Monitoring Committee will look at what is happening at cessation services in the Waikato. This will include a particular focus on pregnant women

Dental

A report will be presented to the October Committee meeting.

Resolved**THAT**

- 1) A paper providing a matrix of the key issues and what is currently planned for those issues to be presented at October Committee.
- 2) Health of Older People to be moved to December Committee meeting.

7.2 Alliances

Paper proposed moving to a single Waikato Alliance, inclusive of existing PHOs and alliances. Approval from the Ministry of Health will be required to change the alliancing. Concern has been raised from other regional DHBs about the impacts on contracting. Detail of these concerns has been sought and will be worked through regionally.

Close off for feedback is 17 August 2017. A full proposal and summary of feedback will be provided to a future Board meeting for consideration.

Resolved**THAT**

The Committee supported the alliancing paper.

ITEM 8: PAPERS FOR INFORMATION

8.1 Pacific Island People

Mr M Spittal attended for this agenda item.

An updated profile in the area of Pacific Health was submitted for the Committee's information.

Resolved

THAT

The Committee noted the report.

ITEM 9: STRATEGIC PROGRAMME PLANS

9.1 eSPACE

No updated at August meeting.

9.2 Mental Health and Addictions Model of Care

Mr D Wright attended for this agenda item.

An update report on the Creating our Futures programme was submitted for the Committee's information.

Of Note:

- The Strategic Assessment Tranche 1 has been closed;
- Tranche 2 of the business case has commenced. The timeframe is July 2017 – December 2017;
- A submission to Investment Ministers for approval to further develop a mix of project is scheduled for early 2018.
- A progress report may be presented at the October meeting

Resolved

THAT

The Committee noted the report.

9.3 SmartHealth

A presentation was given by Mr D Hackett and Dr D Tomic on the components of bringing together Virtual Health and its links with the New Zealand Health Strategy.

Resolved

THAT

The Committee received the presentation.

9.4 Rural Project

Mr M Spittal attended for this agenda item. Overall progress relative to the first year of the work programme is summarised in the attached appendix.

Resolved

THAT

The report be received.

9.5 Women's Health Transformation

Ms T Maloney attended for this agenda item.

Of note:

- Detailed report and progress against recommendations was provided to RANZCOG
- Areas of work for completion are due to be completed over the next five months
- The Commissioner and Transformation team are preparing for the RANZCOG accreditation review on 11 September.

Resolved

THAT

The Committee received the report.

9.6 Elective Services Improvement

Ms B Wills attended for this agenda item.

An update report on the progress in the area of elective services improvement was submitted for the Committee's information.

Of note:

- Year ending 16/17 to 98%, a lot outsourced;
- For 2017/18 a remodelling of funding was accepted from the Ministry of Health, which has resulted in funding shifted to outpatient areas where we had already been delivering but no funding has previously been allocated;
- The sustainability of the remodelling was done with a view to the future.

Resolved

THAT

The Committee received the report.

9.7 Patient Flow

No updated at August meeting.

9.8 Quality Account

No updated at August meeting.

9.9 Medical School

Prof R Lawrenson attended for the presentation of the Medical School progress update.

Queries were raised in relation to student loan benefits ending after 7 years. Fundraising for scholarship is possible and will be considered. The updated business case was submitted in May 2017. Provision for graduate pipeline has been asked to be considered from the government.

Resolved

THAT

The Committee received the presentation.

9.10 CBD Accommodation Project

No updated at August meeting.

9.11 Primary Care Integration

No updated at August meeting.

ITEM 10: PRIORITY PROGRAMME PLANS

10.1 Priority Programme Plan Project Update

Ms E McKenzie-Norton and Ms C Cresswell attended for this agenda item.

Of Note:

- A workshop has been scheduled for Priority 1.3 "Remove barriers for people experiencing disabilities" on 20 September.
- Nominations for workshop attendees to be received before Friday 11 August to Ms N Middleton

Resolved

THAT

The Committee noted the content of the report

10.2 PPP 1.4: Enable a Workforce to Delivery Culturally Appropriate Services

Ms E McKenzie-Norton and Ms S Hayward attended for this agenda item to provide a recap and update on the priority programme plan project. A presentation of priority 1.4 was given to the Committee

Resolved

THAT

- 1) The Committee approved the changes made to PPP1.4 'Enable a workforce to deliver culturally appropriate services'
- 2) The Committee noted ongoing reviews
- 3) The Committee noted that implementation will be staged to align with available funding
- 4) The Committee will be provided with a consolidated view at the conclusion of the PPP development;
- 5) PPP projects were approved for commencement.

ITEM 11: GENERAL BUSINESS

There were no general business items raised.

ITEM 12: DATE OF NEXT MEETING

11 October 2017



**MINUTES OF A MEETING OF THE COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE
HELD MONDAY 14th AUGUST 2017
TAUPO HOSPITAL LIBRARY, KOTARE STREET, TAUPO**

Meeting: [141]

Present: L Thurston (Chair), W Webber (Deputy Chair), D Shaw (Board Chair), M Raukawa-Tait, D Epp, J Morreau, B Edlin, P Mahood and S Te Moni

In Attendance: R Dunham, N De Witt, J Hanvey, B Bayne, M Watson, K Rex, L Pritchard (presenter) and B E Harris (Board Secretariat)

1.0 MEETING CONDUCT

The Chair welcomed everyone to the meeting. It was unfortunate that the presentation by Dr Johan Morreau did not eventuate due to technology difficulties.

1.1 Apologies: A Pedersen and M Davies

Resolution:

THAT the apologies be received.

L Thurston : D Epp

CARRIED

1.2 Schedule of Interests Register

The register was circulated during the meeting with no entries made.

1.3 Conflict of Interest related to items on the agenda : Nil

1.4 Items for General Business : Nil

1.5 Presentation on Breast Feeding by L Pritchard

The presentation given by L Pritchard highlighted:-

- Why breastfeeding is important to baby
- Before the service started
- Introducing the Lakes Breastfeeding service
- Our Kaupapa/Vision
- Our Goals and Objectives
- Provide specialist breastfeeding support in the community
- Workforce development
- Peer support programme
- Numbers in the first year and percentage in target populations
- How can we make a difference?

The Chair thanked Leonie Pritchard for her informative presentation, acknowledging the excellent work being provided to all women and babies in the Lakes region. Members looked forward to an update at some stage in the future.

2.0 SIGNIFICANT ISSUES

2.1. Public Health

2.1.1

Toi Te Ora Public Health Service

2.1.1.1 Toi Te Ora Public Health Service report : August 2017

2.1.1.2 Toi Te Ora Medical Officer of Health report : August 2017

Discussion covered:-

- The New Zealand Immunisation Schedule – 92-95% are supportive of immunisation
- Responding directly to posts rather than blogs
- Public Health view 95% coverage
- Have received feedback from those who have strong beliefs against immunisation
- Parents and health professionals who come through and who will be delivering messages to new families will have no experience in pre-vaccine world. Maybe far more graphic reminder to GPs with no experience of what this is about. How can we target and market this to GPs?
- Capturing experience from paediatricians is a good idea
- Strategy joined effort – Toi Te Ora and Lakes DHB work together

Resolution:

THAT Janet Harvey and Sue Wilkie work together to bring a strategy forward.

L Thurston : P Mahood

CARRIED

Resolution:

THAT the Public Health Services and Medical Officer of Health's reports be received.

L Thurston : M Raukawa-Tait

CARRIED

2.2

Primary Health

2.2.1

Pinnacle MHN Report for August 2017

2.2.2

Pinnacle MHN Quarter Report : October to December 2016

Discussion points raised were:-

- Health approach to addiction focuses focus on equity and legal approach on people suppliers and importers- A national approach is needed to quantify size of problem and its solutions
- 10 reported deaths in Auckland – need national insights
- Robust discussion is required – ask Midland if there is any national data available. Is a problem across the country.
- Formal approach be made to Midland – Chairs meeting in a couple of weeks' time in Hamilton. Feedback on National Health Strategy. CE and Chair to take this issue to Midland Chairs. Suggest drug and alcohol be an issue as well for discussion.

2.2.3

RAPHS report

Highlights were:-

- Extended care support team delivered to complex patients.
- As result of the fire in server room, this lent to building of relationships in ED
- K Rex shared feedback from MoH and read the complimentary letter she had received from the Ministry.

Resolution:

THAT the PHO reports be received.

B Edlin : P Mahood

CARRIED

The committee noted the value and importance of having the PHO representatives present at the meetings along with Toi Te Ora personnel which added a lot more depth to the meeting's conversation.

2.3 Maori Health**2.3.1 Maori Health report : July 2017****Resolution:**

THAT the Maori Health report be received.

L Thurston : M Raukawa-Tait

CARRIED

3.0 SECRETARIAL**3.1 Minutes of Community and Public Health Advisory Committee meeting : 19th June 2017**

Amendment: 3.3 Schedule of Tasks first bullet point replace "J Morreau" with "Dr Jim Miller"

Resolution:

THAT the minutes of the Community and Public Health Advisory Committee meeting of 19th April 2017 be confirmed as a true and accurate record.

L Thurston : D Shaw

CARRIED

3.2 Matters Arising:- Nil**3.3 Schedule of Tasks**

- RAPHs (M Watson) – update : timeframe 16th October 2017
- Drinking water : Dr Jim Miller to talk to S Goodin : 16th October

3.4 Copy of presentation slides on "A community survey of public health issues"

The above were provided for the information of the committee. Dr N de Wit spoke to this item and the members thanked him for his detailed verbal report

4.0 REPORTS**4.1 Reducing the incidence and impact of Diabetes**

The update was provided for the information of the committee and the excellent achievements and service for patients were noted.

Resolution:

THAT the update be received.

L Thurston : D Epp

CARRIED

4.2 Lakes DHB Live Births report up to 2016**Resolution:**

THAT the information be noted and received.

L Thurston : M Raukawa-Tait

CARRIED

4.3 News release – Free After Hours Immunisation Clinic : Noted.**4.4 Community representative reports : Nil****5.0 INFORMATION AND CORRESPONDENCE : Nil****5.1 Bay of Plenty appointee B Edlin to CPHAC****5.2 Waikato appointee P Mahood to CPHAC****Resolution:**

THAT the outwards correspondence be approved.

L Thurston : D Shaw

CARRIED

- 5.3 Asthma Rotorua – the Hailer August 2017 : Noted
5.4 BoP CPHAC/DSAC minutes 1st March 2017

Resolution:

THAT the minutes of 1st March 2017 be received.

B Edlin : D Epp

CARRIED

- 5.5 Waikato DHB Health Strategy Committee minutes for 14th June 2017

Resolution:

THAT the minutes of 14th June 2017 be received.

P Mahood : L Thurston

CARRIED

6.0 PUBLIC EXCLUDED

Resolution:

THAT the committee move into Public Excluded at 2.55pm

L Thurston : J Morreau

CARRIED

L Thurston QSO JP.....16th October 2017
Chair



**SCHEDULE OF TASKS FROM THE
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE
14th AUGUST 2017**

Agenda Item	Action	Responsibility of	Timeframe
PRESENTATIONS			
Pinnacle MHN	Source one or two mixed media speakers for a future meeting.	B Bayne	t.b.a.
Drinking water	"Drinking water to ensure it is safe"	Dr J Miller/Steve Goodin	16 th October 2017
ITEMS			
RAPHS	Update on RAPHS Retinal Screening Peer Review to be provided to next meeting.	M Watson	16 th October 2017
Immunisation	J Hanvey and S Wilkie work together to bring a strategy forward.	J Hanvey/S Wilkie	As convenient
National Strategy	Health The issue be taken to the Midland Chairs/CEs meeting for feedback and that drug and alcohol also be an issue for discussion.	D Shaw/R Dunham	Next Midland Chairs/CEs meeting



**MINUTES OF THE DISABILITY SUPPORT ADVISORY COMMITTEE MEETING
HELD IN THE TAUPO HOSPITAL LIBRARY MONDAY 14th AUGUST 2017 AT 10.00AM**

MEETING: [No. 138]

PRESENT: R Vigor-Brown (Chair), M Raukawa-Tait (Deputy Chair), D Shaw, D Epp, S Burns, J Horton, P Mahood, B Edlin, C Cockburn, S Westbrook and K Kaukau

IN ATTENDANCE: W Webber, R Dunham, V Russell, M Ranclaud, S Wilkie and B E Harris (Board Secretariat)

1.0	MEETING CONDUCT (Agenda Item 1.0)
	The Chair welcomed everyone to the meeting with special mention of the new members from the Midland DHBs, P Mahood and B Adlin. He asked for introductions to be made from around the table.
1.1	Apologies (Agenda Item 1.1) : D Sorrenson, M Watson, P Tangitu Resolution: THAT the apologies be received. R Vigor-Brown : D Epp CARRIED
1.2	Schedule of Interests Register – This was circulated during the meeting with deletions being made by S Westbrook.
1.3	Conflict of Interest related to items on the agenda - The Chair called for any disclosures from committee members. None were declared.
1.4	General Business
1.4.1	News media items on “smashing the taboo of mental health.”
1.5	The NZ Disability Strategy : 15 Objectives In noting the above objectives, the Chair highlighted Objective 1 “Encourage an education for a non-disabling society” and referred to the number of deaths in Auckland due to cannabis and the recent incident of the St John call-out. He asked members to consider possible solutions.
2.0	WORKPLAN : DISABILITY SUPPORT ADVISORY COMMITTEE
2.1	~ Disability Support Services
2.1.1	Access Taupo TDC minutes 12 July 2017
2.1.2	Rotorua Access Group minutes 14 th June 2017 C Cockburn reported that he was having discussions with the Tauranga City Council regarding beach access mats for wheelchairs. He was also pursuing a change to the reconstruction of shop frontage entrances to do away with the law requirement for entrances to have lips as he found this to be a hazard. Both minutes of the Access Taupo TDC and Rotorua Access group were received.
2.2	~ Health of Older People
2.2.1	Health of Older People and Disabilities update The update covered:- <ul style="list-style-type: none"> Health Passport is sitting with the Professional Development Unit – needs to be discussed. C Cockburn spoke of the work the Disability Advisory Group was working on in developing a simplified version of the

Disability Support Needs Form, a copy of which he tabled.

- Advanced and future care planning – G Lees working nationally on this.
- Pay equity settlement between MoH and unions. Process working reasonably well and sorting complex situations for providers who find themselves with insufficient funding
- Except for residential care, contracts increase by \$9 a day.
- Neutral to DHBs who are funded by MoH but required to pass it on. It is complicated due to a large number of low paid workers who are not in the scope. Some are in the mental health NGO sector. Current negotiations are occurring with the trade union and NGOs. R Dunham is the Lakes DHB representative driving to get the NGO sector included as well.

Resolution:

THAT the update be received.

D Shaw : S Burns

CARRIED

2.2.2

Live Stronger for Longer website

This is an announcement releasing a new website for older New Zealanders with a focus on reducing the incidence and severity of falls and fractures.

2.3 ~ Mental Health

2.3.1

Homecare Medical/National Telehealth Service update on key mental health support initiatives launched

The above item was provided for the information of members.

2.4 ~ Cancer Services

2.4.1

National Bowel Screening Programme : March 2017

The committee noted the overview of the National Bowel Screening Programme and its complexity and the implementation by 2019 by the Lakes DHB group.

3.0 SECRETARIAL

3.1

Minutes of previous meeting 13th February 2017

Resolution:

THAT the minutes of the previous DSAC meeting held 13th February 2017 be approved as an accurate and correct record.

J Horton : D Shaw

CARRIED

3.2

Matters Arising

3.3

Schedule of Tasks

- Members to consider measurement of the DSAC committee's performance as a committee and report back to the Chair or CE.
- *Community-based geriatric services* – difficulty in finding a compatible date with M Bloor to present to DSAC. At Lakes DHB Strategy Workshop on 5th September 2017 could inform DSAC's areas of focus.
- *Under 65 year old carer support* - change focus and look at a presentation or update on the service change.
- *DSAC Work Plan* – This work plan is seen as linking to the Strategic Planning Workshop. M Ranclaud's review around health services will be a key area of focus.
- *MoH DSS Carer Support* - Hold for 2018 to see details and have a presentation from DSS
- *Rotorua Dementia Friendly Community Initiative* - Awareness programme due in October. V Russell to provide an update. Excellent set of initiatives in helping people with dementia.
- Delete *presentation overview of Health of Older People Services in Lakes*.

- 3.4 Overview on Health of Older People, Rehabilitation, Palliative Care and Disability-related support services
The committee noted this item.

4.0 REPORTS

- 4.1 Community representative reports
This was delayed until later in the meeting.

5.0 INFORMATION AND CORRESPONDENCE

- 5.1 Community representative(s) on DSAC : Letters of appointment C Cockburn and C Reinders

Resolution:

THAT the letter of appointment of C Cockburn be received.

S Burns : J Horton

CARRIED

In noting the above, the meeting was advised that discussion on the appointment of C Reinders be held in Public Excluded.

- 5.2 Bay of Plenty appointee to DSAC : Letter 20.07.17 B Edlin
This appointment was noted by members.

- 5.3 Bay of Plenty DHB CPHAC/DSAC minutes dated 1st March 2017
The minutes of the BoP CPHAC/DSAC dated 1st March 2017 were received.

- 5.4 Waikato DHB Health Strategy Committee minutes dated 14th June 2017
P Mahood advised that Waikato had a structure change in that the Health Strategy Committee is focussing on strategic issues with a strategic refresh due soon. The new senior management team is proving to be of good value holding many workshops with free discussion occurring.

R Vigor-Brown found the presentation on the medical school excellent.

Other points raised were:-

- Deficit to retiring GPs and provision of GP services in future.
- Five year programme rather than a seven year one with placement in the community up to 12 months to gain a good understanding of GP work.
- Noted that Waikato DHB hasn't shared information with Lakes DHB.
- Auckland and Otago Medical Schools have just produced their rural proposals.
- D Shaw and R Dunham have had briefings and understood the business case is with Cabinet.
- Both medical schools attended the Midland meetings for the first time. This is seen as a positive move by the schools.
- Noted commitments the DHBs have to training

It was agreed that P Mahood provide a collection of papers from the Waikato Times on this subject to the Secretariat for circulation to members.

Resolution:

THAT the meeting move into Public Excluded at 11.55am.

P Mahood : D Shaw

CARRIED

6.0 PUBLIC EXCLUDED

- 6.1 2017.03.07 OIA 11214 Forensic Psychiatry Services
Members noted the above information.

6.2

Community Representative on DSAC

D Shaw reported that an email had been received from Cherie advising that she no longer worked for CCS Disability Action and is in fact working for the BoP DHB as a part time social worker in the Community Allied Health team. She commutes to Tauranga twice a week and was concerned that her employment with the BoP DHB would be a conflict of interest.

D Shaw requested this matter be placed before DSAC for discussion and to identify where any gaps were and whether additional membership would assist. He stated that Cherie's situation may not give the current insights into our community and it may be best to get someone closer to the coal face in Rotorua.

C Cockburn mentioned a friend Roger Loveless had recently moved to Rotorua from CCS in Hamilton. P Mahood agreed that R Loveless was a valuable person to have on the committee.

It was suggested the committee give some thought in looking for someone with good networks and insights into disability and the community and that recommendations be passed on to the Secretariat.

Resolution:

THAT the meeting move out of Public Excluded at 12noon

M Raukawa-Tait : J Horton

CARRIED

1.4

General Business

1.4.1 News media items on "smashing the taboo of mental health."

The meeting noted the papers handed out by R. Vigor-Brown relative to Prince William's mental health campaign.

In thinking of possible presentations on the subject, J Horton asked whether Mike King would be an option for consideration?

M Ranclaud spoke of Annette Bortray and the overview she gave on an international concept. M Ranclaud thought this concept would shape service delivery in New Zealand. She believed both presenters would cost a lot and this matter needed more thought in re-shaping our services.

D Shaw suggested that this matter would be discussed at the Strategy Workshop. R Dunham agreed it was a good suggestion despite Lakes having many priorities which needed to be sorted for further consideration.

4.1

Community representatives reports

Colin Cockburn

- A member of four advisory committees in Taupo.
- Disability Support Group to the CE, Ron Dunham which was formed in January 2014 under the Chair at the time, Dale Oliff, GM of Clinical Services. The group purpose is to provide a direct line of communication to service managers who can implement the purchase of equipment and influence staff training and procedures that assist the many and varied needs of the disabled. Meetings are quarterly and the next one is Thursday 7th September.
- Access Taupo 2005 with Taupo District Council
- Taupo Community Health Forum
- Community Advisory Group, Taupo branch.
- Funding to cover cost – new rules on minimum hours and minimum salary as of 1st July. Concerned that the funding given by government is

insufficient. As a service user, would hate to see the services cut.

Kim Kaukau

- Iwi workers affected by pay equity. 10 working in different respite care for older people struggling to collate. Kim to email V Russell regarding matter.

Karakia Whakamutunga/Closing

The meeting concluded at 12.15pm with Sue Westbrook leading the closing karakia.

DRAFT



LAKES DHB SCHEDULE OF TASKS : DISABILITY SUPPORT ADVISORY GROUP
14th August 2017

Item	Action	Responsibility	Time Frame
PRESENTATIONS			
Community-based geriatric services	<ul style="list-style-type: none"> • THAT a presentation be given to DSAC on community-based geriatric services and what this would mean for Lakes. 	Michelle Bloor	2017
	<ul style="list-style-type: none"> • THAT the Lakes DHB Strategy Planning Workshop be informed on DSAC's areas of focus. 	D Shaw	5 th September 2017
Under 65 year old carer support	THAT the MoH be invited to a DSAC meeting to present/update on under 65 year old carer support and hear the concerns of the committee.	V Russell	2017
TASKS			
DSAC Work Plan	<ul style="list-style-type: none"> • THAT the next draft version of the plan be placed before the November DSAC meeting. • THAT the review around Mental Health Services will be a key areas of focus at the Strategy Planning Workshop 	V Russell	November 2017 5 th September 2017
MoH DSS Carer Support	Hold for 2018 to see details and invite DSS to give a presentation.	V Russell	2018
Rotorua Dementia Friendly Community Initiative	Awareness programme due in October and that an update be provided to the final DSAC meeting for the year.	V Russell	13 th November 2016
Performance of DSAC	THAT measurement of the DSAC Committee's performance as a committee be considered by members and reported to the Chair or CE.	DSAC	As soon as convenient



Minutes

Combined Community & Public Health Advisory Committee/ Disability Advisory Services Committee Members

Venue: Tawa Room Education Centre

Date: Wednesday 7 June 2017 at 10:30am

Committee: Bev Edlin (Chair), Anna Rolleston, Ron Scott, Judy Turner

Attendees: Helen Mason (Chief Executive), Simon Everitt (GM Planning and Funding), Maxine Griffiths (Minutes)

Item No.	Item	Action
1	<p>Apologies</p> <p>Apologies were received from Marion Guy, Sally Webb and Mark Arundel</p> <p>Resolved that the apology from Marion Guy, Sally Webb and Mark Arundel be received</p> <p>Moved: B Edlin Seconded: R Scott</p>	
2	<p>Interests Register</p> <p>The Committee was asked if there were any conflicts in relation to the items on the agenda.</p> <p>As there were none – no further action required.</p>	
3	<p>Minutes</p> <p>Resolved that the Minutes of the meeting held 1 March 2017 be confirmed as a true and correct record.</p> <p>Moved: J. Turner Seconded: A. Rolleston</p>	

Item No.	Item	Action
4	<p>Matters Arising</p> <p>4.2 Regional HAC Committees - Regional Member not finalized</p> <p>A letter with nominations had been received from Lakes DHB. A response has been sent by GM G&Q. The letter advised that two appointees to the HSC had been made whereas one was thought appropriate. Awaiting finalisation of regional membership.</p>	
5	<p>5.1 Terms of Reference</p> <p>Committee approves TORs.</p> <p>Discussion as to whether the CPHAC/DSAC's two strategic objectives should provide stronger reference to the Disability sector was raised.</p> <p>CEO advised that this matter had been discussed with Execs. It was thought a strong disability focus is essential. It was suggested that a Board level discussion on Community members may be required. This matter will be on the next Board agenda.</p> <p>The Committee suggested that the impending formation of the Consumer Council should form part of the discussion.</p> <p>There was also mention of raising the matter of quorums. Updated TOR could be required.</p> <p>A query was raised regarding Runanga representation. CEO confirmed that the Runanga has been advised that status quo remains, i.e. same number of members on various committees.</p> <p>CEO clarified that the impending Consumer Council will be operationally focussed, as opposed governance focussed.</p> <p>5.2 Workplan</p> <p>Discussion on the workplan followed.</p> <p>Comment was made that liaising with the City Council as Council facilities are upgraded or replaced, would be beneficial and support Disability access.</p> <p>Homelessness and difficulty with finding suitable accommodation in the Eastern Bay was raised with mention that work is occurring with a variety of agencies to look at options.</p>	<p>GM G&Q</p> <p>GM G&Q</p>

Item No.	Item	Action
	<p>Comment was made as to how well run the male homeless shelter in Tauranga is. GM P&F advised that the DHB supports and funds a small part of that, as does the WBOPPHO.</p> <p>CEO noted items that require more in-depth focus, should be referred to Health Strategic Committee.</p>	
6	<p>Reports for Review and Discussion Empower Our Populations for Live Healthy Lives</p> <p>6.1 HSP Overview <u>6.1.1 HSP Overview Focus Area 1</u> - Sharlene Parry, Planning & Project Manager, Planning & Funding , updated the Committee.</p> <p>Sharlene presented a summary diagram providing an overview of the Strategic Services Plan and the two strategic objectives that form the intent of the CPHAC/DSAC Committee, highlighting a longer term view as opposed to previous annual basis. Her paper set out overall framework. Live well, Stay well, Get well were the themes. Five priority populations and infrastructure required to achieve objectives were also referenced.</p> <p>Discussion as to outcomes and key objectives followed with Sharlene explaining her table and the targeting of specific actions.</p> <p>A query was raised with regards to tracking and reporting actions. GM P&F advised that this is a work in progress, with actions to be monitored and feedback will be provided.</p> <p>GM P&F responded to a query around soundness of data, advising that System Level Measures are being developed in association with PHOs and the Provider Arm.</p> <p>CEO mentioned Communications plan development in response to a query in respect to educating communities.</p> <p>6.2 Increase our focus and investment on health improvement and prevention activities <u>6.2.1 Reducing Childhood Obesity Strategy</u> – Presentation – Dr Neil De Wet (Medical Officer of Health, TTO) presented, with Brian Pointon (P&F Portfolio Mgr) , Noelene White (B4 School RN) in attendance.</p>	

Item No.	Item	Action
	<p>Food environment changes were outlined with the biggest factors referred to as being the sugar epidemic, particularly sugary drinks and hidden sugar, e.g. cereals.</p> <p>Dr De Wet expressed that there is a need to change people's perception / understanding – thus schools play an important part in this process.</p> <p>He also outlined that a steering group has been established to develop a strategic approach. Representation from P&F, Toi Te Ora, Paediatricians, Plunket etc need to be involved and in this way a whole of community approach will be taken.</p> <p>The committee was advised that Toi TE Ora has a Childhood Obesity Prevention Strategy. Also advised that Children with over 98 percentile BMI are referred to GPs, that low rate of declines for referrals in BOP are being experienced and in younger children growth patterns can sometimes quickly change.</p> <p><u>The challenges include:</u></p> <ul style="list-style-type: none"> • Leadership • MOH Strategy expectations with no new funding • Effective intervention services • Developing ability to influence beyond health sector. <p>The Chair thanked Neil for the very informative presentation.</p> <p><u>6.2.2 Future Care Planning Implementation – Ellen Fisher</u> Future Care Planning (FCP) Implementation Manager, was in attendance at the meeting and updated the Committee on activities being undertaken to rollout FCP across the Bay of Plenty.</p> <p>This includes: engaging general practices, practice nurses and hospital teams and providing support across the health system to clients and practitioners</p> <p>The committee was advised that a survey based on a questionnaire was carried out involving the public at Bayfair. 45 questionnaires were given out, of which 16 people completed them – Results show that most people had not heard of FCP indicating that there is considerable work in community that is needed to assist the community to understand FCP. This will involve targeting particular population groups, with the aim of creating plans.</p>	

Item No.	Item	Action
	<p>Ellen advised the committee that there is currently no electronic form. Forms need to be scanned so she is working on a summary sheet for GPs – two page clinicians view rather than 12 pages.</p> <p>Ellen mentioned training for ACP – 60 people so far. Some have carried out the Level 2, 2 day course – ‘Teaching how to have the conversation’.</p> <p>Ellen advised the committee that she is currently seeking feedback as to what further training is needed. Clinicians do move on, but the committee was advised that at present there is a good network of people trained up to Level 2.</p> <p>A query was raised with regard to consultation within the Maori communities. Ellen advocated that ideally the plans should be completed while a person is in good health rather than in a health crisis so the matter of trying to educate/target the right audience at the right time is important. There is a template currently being reviewed by Maori Health Services for this purpose.</p> <p>The CEO advised that people often want to finalise such matters but their families find it more difficult to come to terms with such situations, so Ellen’s role is important and in representing FCP is fostering this approach.</p> <p><u>6.2.3 Population Health Survey</u></p> <p>The Committee received the paper</p> <p><u>6.2.4 Matters Arising for Health Strategic Committee</u></p> <p>There were no matters arising for Health Strategic Committee.</p> <p>6.3 Working more collaboratively to quicken the pace and scale of Health in all Policies</p> <p><u>6.3.1 HIAP Work Programme</u> – Sarah Davey, Portfolio Manager, Planning & Funding was in attendance and informed the committee of work being carried out, advising that a small team has been established for this purpose of developing the work programme.</p>	

Item No.	Item	Action
	<p>Sarah updated the committee as to activities and outcomes that have been achieved in the collaborative planning space highlighting that the DHB has been working with planners at Tauranga City Council and having an influence on urban planning matters. Adding that it has been good to be able to sit alongside and feed into plans and things like cycle ways, infrastructure, health services.</p> <p>Sarah commented on outcomes and the success of them and in addition what data is being gathered. This work has included working alongside Smartgrowth to develop a suite of 20 indicators to measure whether the approach making a difference and achieving Smartgrowth's strategic intent which is broad including environmental, social, cultural and some health aspects. The meeting was advised that data will be gathered from various sources.</p> <p>Copies of Tauranga City Council's Vision for the Future booklet were distributed to committee members which include aspects of health services.</p> <p><i>(A Rolleston left the meeting at 12.45).</i></p> <p><u>6.3.2 Matters Arising for Health Strategic Committee</u></p> <p>There were no matters arising for Health Strategic Committee.</p> <p>6.4 Targeting Investment to improve the lives of our most vulnerable</p> <p><u>6.4.1 Housing Paper</u> – Brian Pointon, Portfolio Manager, Planning & Funding.</p> <p>The committee was advised that housing is a strong determinant of health and the Paper is a summary of work occurring across the BOP.</p> <p>A lot of time is being spent considering all aspects of housing with homelessness being a big issue. Also looking at Hamilton's Wises programme and it's fit for Tauranga acknowledging that Emergency housing is being looked at by Salvation Army.</p> <p>Also looking at linkages e.g. homelessness and Mental Health services.</p> <p>Insulation projects are being looked at with Edgecumbe a current focal point.</p>	

Item No.	Item	Action
	<p>The committee was advised that the team is experiencing difficulty in collection, and availability of data around homelessness was raised particularly in relation to both Tauranga and Whakatane.</p> <p>The CEO conveyed to the Committee that management has been presented as to the work being carried out on HIAP and asked the Committee members to consider their views on anything further they saw as needing to be undertaken. GM P&F suggested this could be something to take forward to HSC.</p> <p><u>6.4.2 Psychosocial response for Edgecumbe</u></p> <p>The Committee received the paper. The Committee noted the information presented.</p> <p><u>6.4.3 Matters Arising for Health Strategic Committee</u></p> <p>The Committee indicated that it would like to defer discussion around Community projects/HIAP being undertaken and what further HIAP projects the Committee would like to see undertaken.</p>	GM P&F to add to next HSC Agenda
7	<p>General Business</p> <p>7.1 <u>Monthly CE report – Planning & Funding – GM P&F</u></p> <p>The Committee noted the report.</p> <p>7.2 <u>Correspondence BOPDHB and Deaf Action NZ</u></p> <p>The Committee noted the correspondence.</p> <p>7.3 <u>Report from Deaf Action NZ</u></p> <p>The Committee noted the report</p> <p>7.4 CEO relayed advice received on pay equity settlement - \$12m for 17/18: reflective of the emphasis BOPDHB places on HBSS and keeping people safely in their own homes, as well as demographics of BOP.</p>	

The meeting closed at 12.57 pm

These minutes will be confirmed as true and correct at the next meeting.



Minutes

Combined Community & Public Health Advisory Committee/ Disability Advisory Services Committee Members

Venue: Tawa Room Education Centre

Date: Wednesday 6 September 2017 at 10:30am

Committee: Bev Edlin (Chair), Anna Rolleston, Ron Scott, Judy Turner, Sally Webb, Matua Parkinson, Marion Guy, Mary-Anne Gill (Waikato DHB), Jennet Horton (Lakes DHB), Paul Curry, Mark Arundel, Margaret Williams (Runanga Rep) and Punohu McCausland (Runanga Rep)

Attendees: Mike Agnew (Planning and Funding), Gail Bingham (GM Governance & Quality), Sarah Davey (Planning & Funding), Janet Hanvey (Toi Te Ora)

Item No.	Item	Action
1	<p>Apologies</p> <p>Apologies were received from Judy Turner</p> <p>Resolved that the apology from Judy Turner be received.</p> <p>Moved: S Webb Seconded: R Scott</p>	
2	<p>Interests Register</p> <p>The Committee was asked if there were any conflicts in relation to the items on the agenda.</p>	
3	<p>Minutes</p> <p>Resolved that the Minutes of the meeting held 7 June 2017 be confirmed as a true and correct record.</p> <p>Moved: R Scott Seconded: A Rolleston</p> <p>Lakes CPHAC minutes were noted</p>	

Item No.	Item	Action
4	Matters Arising 6.4 Update provided on community nursing program.	
5	5.1 Workplan The question was asked what is occurring with the assessment of disability access.	GMGQ: What is the DHB doing to make the facilities and services accessible to disability clients – secondary and primary
6	Reports for Review and Discussion <i>Strategic Objective 1: Empower our population to live healthy lives</i> <i>Strategic Objective 2: Develop a smart, fully integrated system of care to provide care close to where people live, learn work and play</i> <u>Childhood Immunisations new model of care</u> Michelle Murray and her team gave a presentation on the immunisation collective operational plan to increase immunisation compliance. Agencies working as one team in a new regional approach across the PHO populations. Using a single IT system. Monitoring the use of existing tools and making people in the system accountable. National enrolment service is making it easier to locate children. The Committee thanked the presenters for their informative presentation. <u>BOP Healthcare Home Model of Care</u> Mike Agnew presented to the Committee on the concept of the health care home. It is not about a physical facility but the way practices work. Dimensions: virtual patient contact, front footing	

Item No.	Item	Action
	<p>care (being proactive), integrated model of care. The Committee noted that technology is key to efficiency.</p> <p><u>Community Care Coordination update</u></p> <p>Routine Care changes will commence this month. Based on referring patients back to their GP for post discharge follow-up for routine wound care. It was noted that the program has had a slow start; however it is now gathering support.</p> <p><u>Toi Te Ora Population Health update</u></p> <p>Neil DeWet presented to the Committee on Health for all. Looked at the effects of environment pollution on health. People are doing well at the expense of the environment. Discusses sustainable dietary patterns that support health and the environment. Discussed the development of biophilic cities.</p> <p>Janet Hanvey spoke to her report that was included in the agenda. COBOP has established a working group looking into development environmental friendly practices in BOP business community. Advised the Committee that Toi Te Ora now reports into Planning and Funding.</p> <p>The Committee discussed the increasing rate of smoking among Maori women.</p> <p><u>Matters to be referred to SHC:</u> Suicide prevention Muscular dystrophy prevalence</p>	<p>GMPE: Place on SHC agenda. Investigate the possibility of developing the DHB site into a biophilic site as a means of being a community leader in this development.</p>
7	<p>General Business</p> <p><u>Planning & Funding Report</u></p> <p>Taken as read</p>	

Next Meeting: Wednesday 6th December

The meeting closed at 1:00 pm

These minutes will be confirmed as true and correct at the next meeting.



Workplan

**MEMORANDUM TO THE HEALTH STRATEGY
COMMITTEE
11 OCTOBER 2017**

AGENDA ITEM 5.0

WORKPLAN 2017

The proposed Health Strategy Committee workplan for 2017 is attached for your information.

As discussed at the March Health Strategy Committee there will be standard items on the workplan in relation to

- updates around the DHBs strategic projects, and
- implementation of the strategy and development of priority programme plans.

There were however a number of other items the committee had indicated it would be seeking to include within a future agenda separate from these areas.

An initial workplan has been developed at attached. This recognises that a significant portion of the committee agenda will be focussed on the above items restricting other activity to one or two items per meeting.

Recommendation

THAT

The workplan be received.

**CLYDE WADE
CHAIR, HEALTH STRATEGY COMMITTEE**

HEALTH STRATEGY COMMITTEE FUTURE WORK PLAN 2017

	Report	When
1.	Prevention programme assessment Health of Older people Strategy Pharmacy Plan Tobacco Plan	December 2017

A joint workshop with the Performance Monitoring Committee is also proposed in relation to the following item:

- Managing demand

Items with date to be confirmed (subject to availability of presenters):

- Government Disability Strategy
- Improving access to primary care for the intellectual disability community.

*A – Ministry of Health will be invited to discuss these items



Verbal Presentation



Verbal Presentation

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE

11 OCTOBER 2017

AGENDA ITEM 5.3

INTERPRETER SERVICES AT WAIKATO DHB

Purpose	1) For information
----------------	--------------------

This paper provides further information about the current interpreter services available at Waikato DHB, and the national Government initiative developing interpreter guidelines. This paper is in response to a question raised at the March Health Strategy Committee.

Government guidelines for interpreter services

Currently there is a national project being undertaken by the Government in relation to interpreter services. This project is looking at language assistance services, such as interpreting and translations as these are essential to enable some people to access New Zealand's public services. They seek to support equitable access to public services by providing:

- best practice-based, consistent expectations across government agencies for the provision and use of language assistance in the planning, funding and delivery of services
- practical resources for the staff of government agencies and funded services.

Draft guidelines have been sent out for review and the Integrated Operations Centre have provided feedback on these on behalf of Waikato DHB.

These guidelines are part of a suite of inter-agency work being undertaken as part of the Language Assistance Services Project. As well as the guidelines, this inter-agency work is currently focusing on:

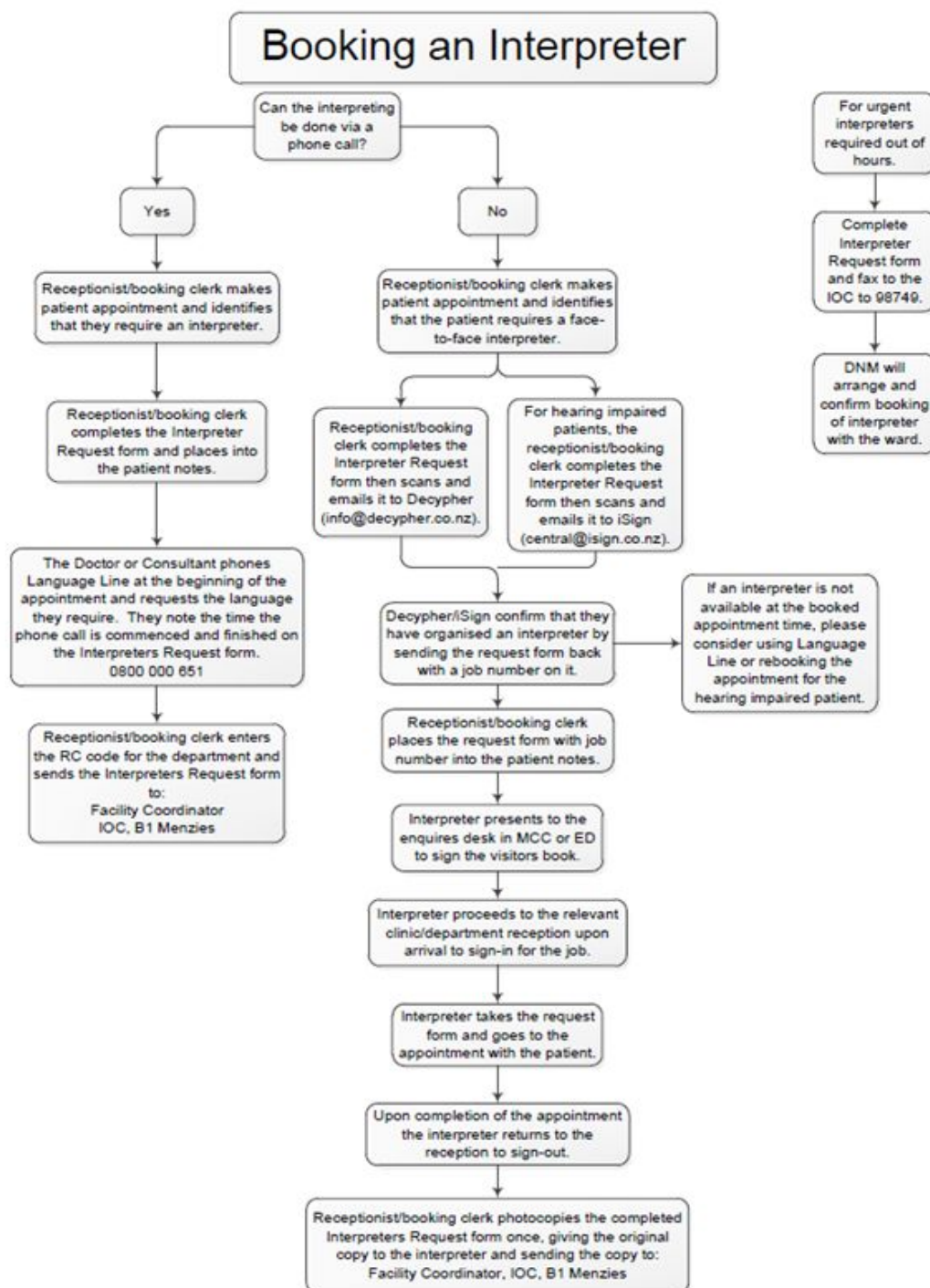
- a new model of procurement that will enable public sector agencies and government-contracted services to purchase language assistance from a pool of authorised language assistance providers
- the minimum standards expected (including certification) of interpreters and translators undertaking government work.

In relation to the draft guidelines, please note that:

- the guidelines will not apply to te reo Māori and New Zealand Sign Language because separate work programmes for these languages are being progressed by Te Taura Whiri i te Reo Māori (the Māori Language Commission) and the Office for Disability Issues.
- implementation costs will be assessed as part of a business case for the Government once the proposals have been finalised. As a result, you do not need to address the resource implications as part of your comments.

Current Waikato DHB interpreter services

The Waikato DHB current Interpreters and Translation policy (ID 0137) aligns well with the draft Government guidelines. This is the flow sheet describing the process for booking an interpreter at Waikato DHB:



Providers

For Waikato DHB, the authorised interpreters are:

- I-sign for New Zealand Sign Language
- Decypher Hamilton Multicultural Services Trust Interpreter / Translation Services (HMST)
- Language Line (Department of Ethnic Affairs) – Mon/Fri 9am-5pm
- Approved Māori interpreters identified by the Kaumatua Kaunihera strategic group.

The DHB encourages the use of Language Line as it is of minimal cost to the DHB, however this option is often not appropriate in the hospital setting. The 17/18 budget for face to face interpreting is \$398,000. The table below shows the actual spend for 16/17 by number of interpreter requests, language and total cost.

Waikato DHB - Interpreting Spend		
1 July 2016 to 30 June 2017		
Language	# Jobs	\$ cost
Afghan languages	273	\$30,492.30
Arabic	87	\$10,657.10
Bengali	2	\$597.45
Burmese	46	\$5,785.75
Cambodian	421	\$49,253.45
Chinese languages	1145	\$132,155.87
Cook Island Maori	2	\$224.75
Dutch	4	\$739.00
Farsi/Persian	20	\$2,581.50
Fijian	7	\$229.25
Fiji-Hindi	1	\$683.90
Filipino/Tagalog	26	\$3,600.65
French	39	\$7,121.45
Indian languages	204	\$24,653.30
Italian	2	\$183.50
Japanese	17	\$1,681.50
Kiribati	7	\$701.00
Korean	129	\$16,789.00
Laos	1	\$172.50
Lingala	3	\$344.00
Malay	1	\$186.25
Portuguese	2	\$231.50
Russian	22	\$2,054.25
Samoan	59	\$6,727.40
Singhalese	7	\$656.00
Somali	126	\$14,564.65
Spanish	546	\$56,619.65
Swahili	1	\$78.00
Tamil	1	\$78.00
Thai	58	\$6,580.55
Tongan	93	\$12,872.25
Urdu	5	\$492.65
Vietnamese	2	\$431.25
	3359	\$390,219.62

Recommendation

THAT

The Committee receives the report.

5.3

DEBORAH NELSON

DIRECTOR INTEGRATED OPERATIONS CENTRE

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE

11 OCTOBER 2017

AGENDA ITEM 5.4

UNDERSTANDING OUR POPULATION PROFILE: LOCALITY FRAMEWORK FOR POPULATION BASED REPORTING

Purpose	1) For approval
----------------	-----------------

Background

This paper provides background and an outline of the proposed approach to future reporting of financial and non-financial information using different localities within Waikato DHB.

On July 27th 2016 the Board adopted a recommendation that regular population-based financial, access, and outcome reporting is introduced in order to ensure that transparency about the DHB's patterns of investment against the Board's strategic population imperatives exists at both Board and executive level.

There is additional rationale for producing population based financial and non-financial information, namely:

1. The government itself is progressively moving towards implementing a social investment analysis framework within which clarity of the link between expenditure and individuals is a key component. This is intended to underpin prioritisation from a whole of government perspective;
2. Traditional accounting analyses in the DHB sector tend to reflect what a DHB spends on various types of providers or contracts, rather than on various types of populations. Consequently, the focus can be more on providers rather than constituents, and on repeating patterns of historic expenditure rather than on transforming how a DHB invests in its communities;
3. Immediate issues; e.g. service remodelling in rural settings, etc can occur within a fiscally bounded context so as to enhance the DHB's sustainability over time

During 2016 there was an initial pilot attempt to link DHB expenditure (actual funder external costs and actual provider arm expenditure) to rural/urban populations. That pilot demonstrated:

1. Implementing population based financial reporting is more achievable than originally anticipated
2. That the choice of geographic sub-units within the DHB has a considerable impact on both the difficulty and usefulness of the analysis;

3. Additionally, there was not a consistent methodological approach to defining geographic subunits within the DHB. Are localities defined on the basis of populations or patterns of provision, and what localities are relevant?
4. That some financial information is not available at a level that can be linked to populations or individuals;
5. The quality of information derived from costing systems may improve over time if effort is invested, and alternative approaches may be useful in the interim.

Proposed Approach to Locality Based Reporting

A working group was established with members from Population Health, Finance, and Strategy & Funding in order to develop a Locality Framework. The purpose of the group was to define the geographic sub-units within the DHB and determine the technical linkage between each geographic sub-unit to enable drill-down/up through varying levels and groupings.

It was decided that a single grouping of localities to apply to all situations would not meet the organisation's needs. Instead the framework should allow easy access for the data user to select the most appropriate level of location granularity.

The Resulting Locality Framework

Three different population views:

1. Hamilton & surrounds vs the rest (Urban vs rural using Stats NZ defined boundaries)
2. Expand on 1 to include the locations of rural hospitals and then assign catchments around them using distance. This option would also include the separation of the Hamilton and surrounds area into the northern corridor (encompassing Te Kauwhata, Huntly, and Ngaruawahia) recognising the need to ensure adequate focus for planning purposes is given to the northern corridor, and the Matamata area to the East, with Hamilton and Southern catchments (Cambridge and Te Awamutu) providing a third location. This level will be our default starting point for assigning spend by locality
3. Expand on 1 to include all towns with a GP and then assign catchments around them

The three different locality views will enable most data to be presented in a way which makes sense from a patient flow and population perspective.

Data will be captured at the lowest level possible (Domicile code or Census Area Unit) that will allow further drilldown where areas of interest are identified.

Please see the views in map form in Appendix 1.

Current data will allow us to split approximately 98% of provider arm activity and 75% of NGO activity using this method. Further work will also occur over time to improve these percentages with recognition of the capacity and capability of some providers to deliver more detailed reporting coupled with lead time required for contractual reporting requirement changes.

Reporting maps will be discussed and confirmed consistently across Population Health, Strategy and Funding, Finance, and Operations and Performance to ensure that they are applied consistently.

Iwi Boundaries

The working group examined the feasibility of producing views based on geographical Iwi boundaries. However, the list of Iwi and their respective boundaries overlap considerably. It is not possible to map any financial or non-financial information using a complete Iwi boundary view.

There is a possibility that we could look at an individual Iwi in isolation though that is still quite difficult due to their boundaries not matching to any underlying Census Area Units which is how almost all our data is contained.

Despite not being able to map to Iwi the proposed solution will still be able to contribute to and highlight Maori inequality issues. Within each of the localities we have mapped out there will be an ethnicity split where data is available. This will enable us to look at the equity gap within each locality and compare areas to see which of them have the widest disparities. We will also be able to see how Maori compare in one area to another, e.g. do Maori in the Tokoroa area have higher needs than those in North Waikato and how much do we spend on them comparatively?

Next Steps

The boundary definitions (once approved) behind the newly created maps can now be used to split financial and non-financial information, with an initial cut of both provider arm costs and NGO expenditure able to be provided to the next Committee meeting in December. Continuous improvements in both data capture at a level to allow geographical splits and in the presentation via reports to Board and Committees will be ongoing over the next year. Longer term we envisage having the data incorporated into an interactive mapping dashboard within QlikSense, our new business intelligence tool.

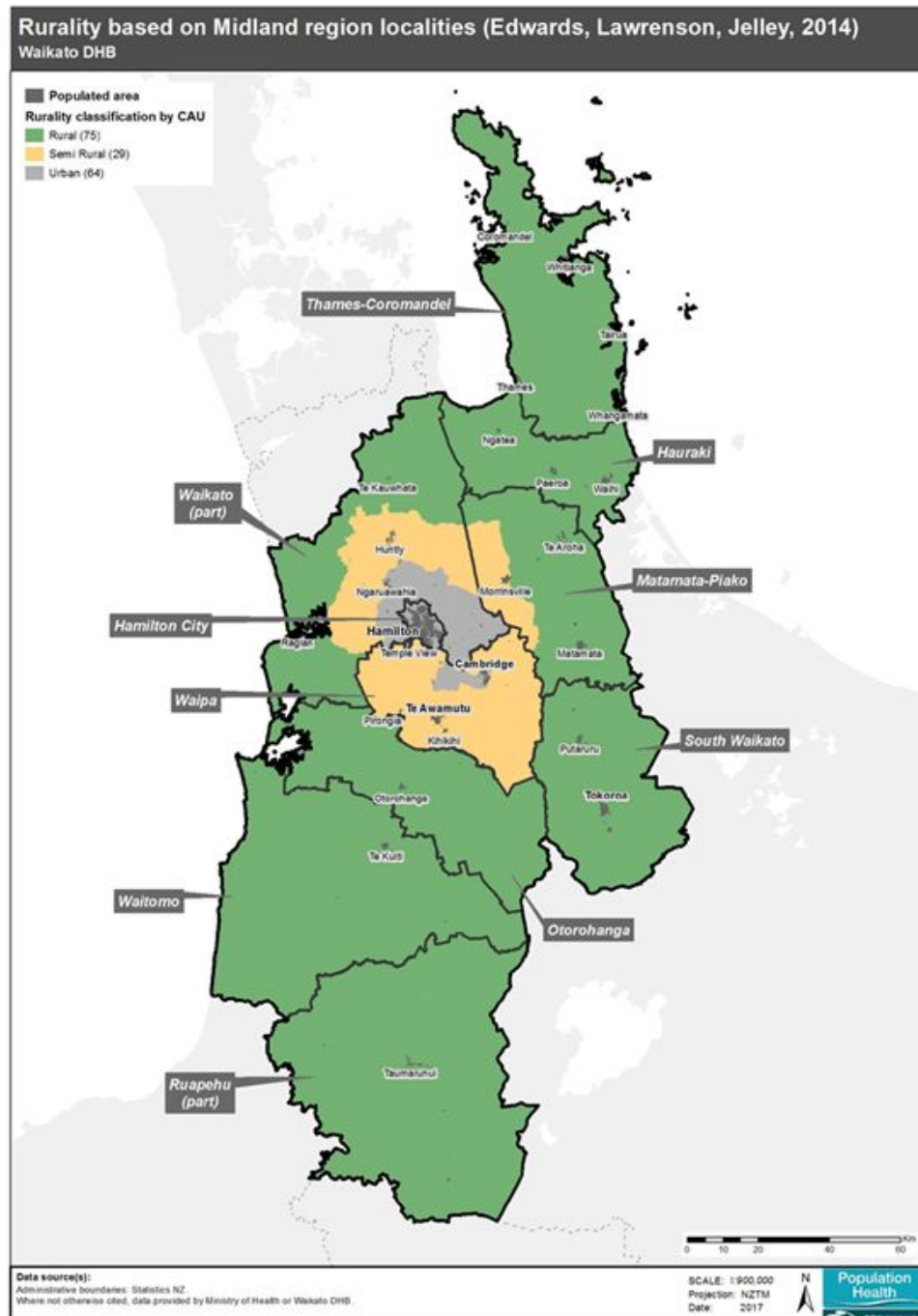
Recommendation**THAT**

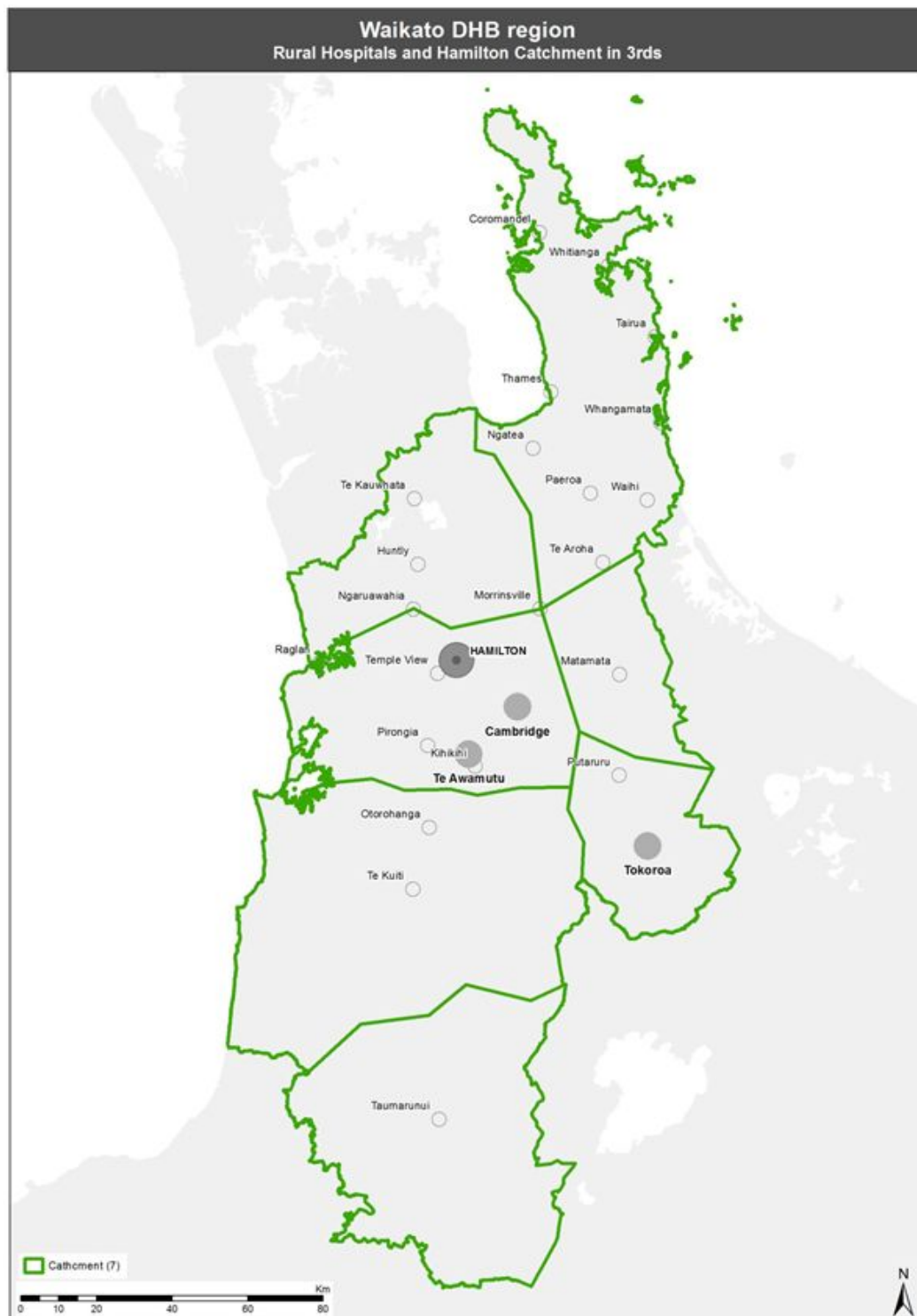
- 1) The Committee feeds back on the proposal outlined to enable any changes to be incorporated into the model for future reporting;
- 2) That option 2 of the Locality Framework be endorsed by the committee as the default tool for analysing and presenting financial and non-financial information at a locality view across the organisation;
- 3) That where possible all areas of the organisation attempt to capture and report activity data with patient location if they are not already doing so.

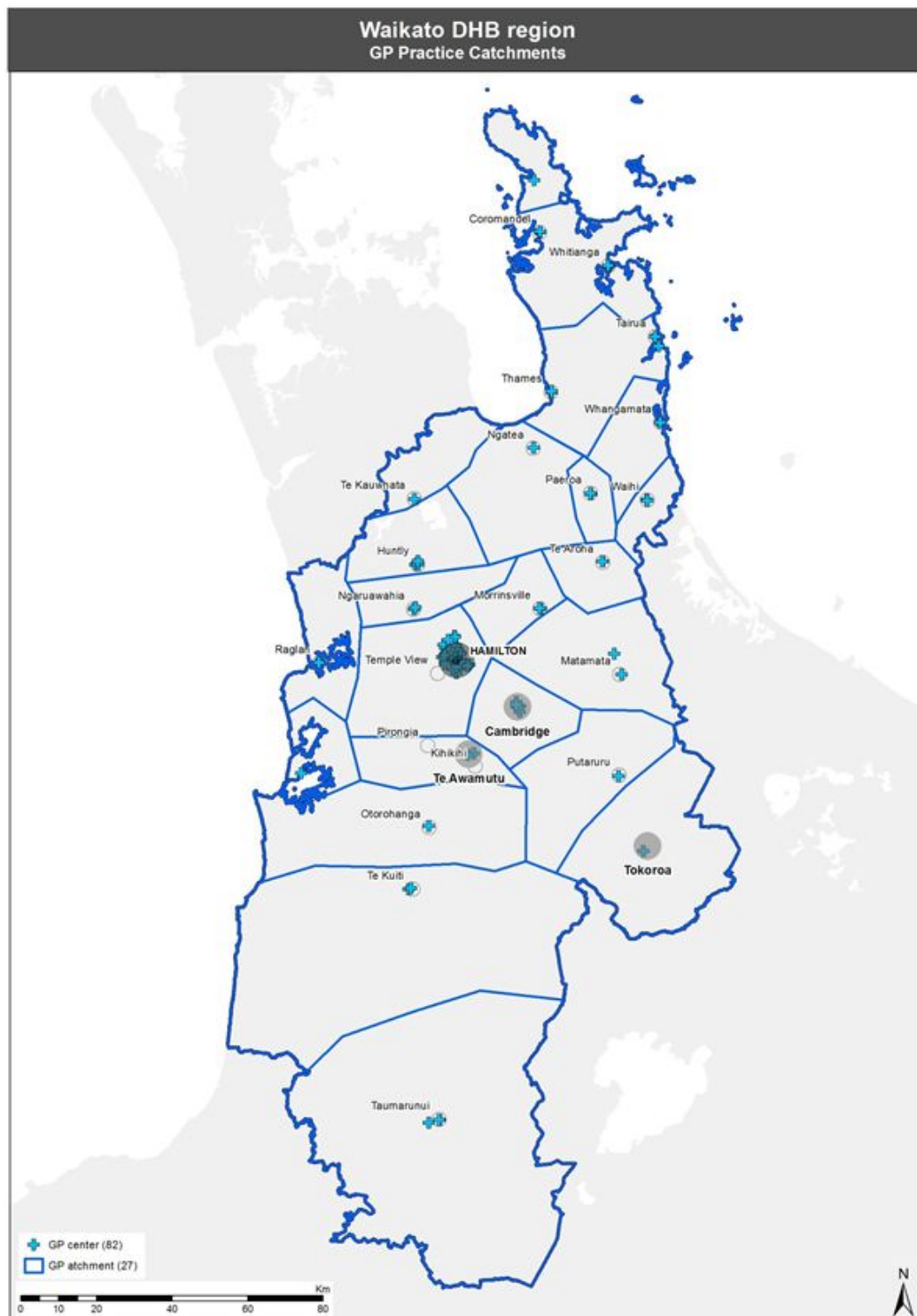
Julie Wilson

EXECUTIVE DIRECTOR, STRATEGY AND FUNDING

Appendix A - Maps of proposed locality views









Strategy and Funding Overview Report

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE

11 SEPTEMBER 2017

AGENDA ITEM 6.0

STRATEGY AND FUNDING REPORT

Purpose	1) For information
----------------	--------------------

Community Health Forum

The July/August round of Community Health Fora occurred including the new trial forum in Raglan. Overall attendance numbers at the community health forum were slightly higher than previous fora with a wide range of community member attending, including local councillors and Mayors. As noted the Raglan forum had approximately 23 attendees which was positive for an initial meeting and local GP Dr Mike Lotens has agreed to take the role of Chair. The summary of the issues raised is attached as appendix A.

The dates for the next round of Community Health Fora are:

FORUM	DATE	VENUE	TIME
Nth Waikato	9 th November 2017	Hopu Hopu Complex, Old Taupiri Rd, Hopu Hopu	10am – 12pm
South Waikato, Tokoroa	13 th November 2017	Tokoroa Hospital, Library Room, Maraetai Rd, Gate 1 Tokoroa	12 – 2pm
Hamilton,	14 th November 2017	The Link Cnrs Te Aroha St & River Rd, Hamilton	9.30 – 11.30
Matamata Piako	14 th November 2017	Mountain View Church, 5 Church St, Te Aroha	2pm – 4pm
Hauraki; Thames	16 th November 2017	Richmonds Villas, 82 Richmond St, Thames	10am – 12pm
Waitomo/ Te Kuiti	20 th November	24 Alisa St, Rotary Room, Te Kuiti	12 – 2pm

	2017	Hospital
Raglan	21 st November 2017	Raglan Community House, 45 Bow St Raglan 10am – 12pm
Ruapehu/ Taumarunui	29 th November 2017	Senior Citizens Hall Morero Terrace, Taumarunui 11am – 1pm

Committee members are requested to send through any questions/items of interest that should be considered for inclusion on the agenda.

System Level Measures (Slm) Plan

The system level measures plan for the remaining two development measures

- Proportion of infants who live in a smokefree home at 6 weeks postnatal; and
- Improved access to and utilisation of youth appropriate Health services

has been developed through the project groups and sent for sign-off to the inter-alliance forum. This has been included in the Performance Monitoring committee for feedback and endorsement.

These working groups have pulled together a broad range of people and have been exciting opportunities to look at system wide impact in these areas.

Tobacco Plan

A draft tobacco plan has been developed and will be reviewed by the Executive Group in October. As previously noted the document has been streamlined similar to the structure of the Annual plan. This plan will be submitted to the Health Strategy Committee meeting in December 2017.

Primary Maternity Care

The DHB has become aware through the Women's health Service that a number of Lead Maternity Carers (LMC) in the community intend to take a break over the Christmas period and are not accepting/restricting registrations of women who are due to birth at that time. This creates additional concern around coverage as we understand there have been a number of Lead Maternity Carers exiting the workforce in our district. These factors jointly create a significantly challenge for the DHB maternity services who will need to provide a significantly higher level of primary maternity care for women who are due to give birth over this time than normally occurs through the DHBs own services. This means providing the woman's antenatal care now, labour and birth in December and January and providing postnatal care for the six weeks following birth.

Initial discussions have occurred with the Ministry of Health who are the funder of Lead Maternity Carers. The Women's health service has developed a short term contingency plan to manage the increase in workload on the DHB maternity facilities over the Christmas period. Further considerations will however be needed to ensure there is appropriate service access for local women across the year.

Te Pae Tawhiti Programme Of Work

This programme of work is well underway with the Adult Addictions and Adult Mental Health Working Groups developing their models of care and outcomes frameworks, and the Child and Youth and Older Person's groups recently commencing.

The initial engagement with communities will occur in conjunction with 'Creating our Futures' to ensure that there is clarity around the two programmes and to ensure duplication of effort and consultation is minimised. A series of 8 or 9 meetings are being scheduled between late October and the middle of November across the district. Once confirmed these dates will be shared with Board and Committee members should they wish to attend.

Recommendation

THAT

The Committee notes the content of the report

JULIE WILSON

EXECUTIVE DIRECTOR, STRATEGY AND FUNDING

Appendix One

Community Health Forum meetings July 2017 (round 2)

Community Health Forums are a key mechanism used by Waikato DHB to engage with our communities. Waikato DHB supports Community Health Forums in the following geographic areas:

1. Thames Coromandel/Hauraki
2. North Waikato
3. Hamilton City and surrounds
4. Raglan
5. Matamata Piako
6. South Waikato
7. Waitomo
8. Ruapehu (covers the northern part of the Ruapehu District territorial local authority area)

Within some of these areas, meeting venues alternate between centres e.g. Morrinsville, Matamata and Te Aroha. This is at the request of CHF attendees. In this round, meetings were held in Taumarunui, Otorohanga, Matamata, Tokoroa, Paeroa, Hamilton, Raglan and Huntly. Following requests from the community, a further CHF venue has been introduced to support the Raglan and West Coast community. The meeting was attended by a diverse group of people and the feedback was very favourable.

Key issues from the 8 CHF meetings

Hamilton City Community Health Forum 18 July 2017

Action Points

- Elder abuse and social isolation of the elderly is an issue. Elder Abuse Service link to be included in minutes
- Public Health advice to be sought in respect to 1080 drop implications to population health
- Follow-up quit advice support to be provided by the PHO
- Waikato DHB ICT to provide overview of disaster recover/backup process
- Harti Movement details to be provided to the PHOs
- Jill Dibble to investigate alleged dental appointment issues
- Strategy and Funding to communicate and improve community understanding of the 20 pharmaceutical line item cost rule

Matamata Community Health Forum 18 July 2017

Action Points

- Homelessness - Peoples Project details to be circulated - meet Christine Hall (Link People)
- Follow up with the CEO / MH Director about next steps regarding the September 2016 Te Aroha Mayor's meeting

- Raise with Strategy and Funding and Waikato Pharmacy Group, the opportunity to, or value of, undertake an economic analysis of different approaches to managing the 6 tons of waste
- Public transport – lack of – access to WINZ, GP appointments etc.
- Inward migration impacting on health services and availability to get appointments. Seems that GP services are overloaded
- Grey power note that there are affordability issues for their membership
- Some of those that have moved into the catchment are going back to their previous GP services elsewhere in the Waikato – possibly because they can't get into services here, but also possibly because the original practice was *very low cost access*

Taumarunui Community Health Forum 2 August 2017

Action Points

- Raise Smart Health Connectivity Concerns with IT – literacy and access to hardware
- Follow up with Transport contractors about the perceived quality and safety of transport services.
- Client service quality (when people call for help around small issues) in the local Taumarunui services to be followed up by Joanne Knight
- Changes to Sleep Apnoea machine annual service – communication to patients seems to be missing

Waitomo Community Health Forum 31 July 2017

Action Points

- Better availability to and affordability of fresh food (vegetables in particular) to be raised as an issue with population health
- Follow up with Te Puna Oranga about the Healthy Housing Literacy programme
- Desiree to talk to Te Kuiti High School about the uniform issues as they apply to kids being excluded – and the risk this poses
- For Waikato Community Pharmacy – create a pharmacy waste management guide for community organisations
- Access to affordable, warm and safe rental housing – similar problems as other CHFs

Tokoroa Community Health Forum 24 July 2017

Action Points

- Synthetic drug action opportunities to be taken back to Strategy and Funding and Adult Mental Health Services – concern expressed by Youth workers and Council
- The co-design methodology to be utilised in the Maternity Services re-design to be circulated when the PID and project design is complete for the South Waikato
- Waikato Pacific Peoples Profile to be attached to the minutes
- DHB to look into the impact of population health positions no longer being located into local communities. Mark Spittal will be asked to come and talk to the next CHF

Thames - Hauraki Community Health Forum 20 July 2017

Action Points

- DHB to look into the impact of population health positions no longer being located into local communities. Mark Spittal will be asked to come and talk to the next CHF
- All people on CHF database will be notified of the timing and process for the community mental health consultation
- Warfarin protocols for those coming to hospital to be looked into
- There is an aged services day set up for Thames in August – ACP team to be linked into that to share information and education

North Waikato Community Health Forum 27th July 2017

Action Points

- Peoples Project details to be circulated
- The major issue of affordable housing, over-crowding, car sleeping and couch surfing was raised in relation to risk and to vulnerable families
- Emergency Housing – issue of people requiring emergency housing being required to get quotes every 3 days – this leads to high and continual anxiety. Raise with MSD.
- Access to GP appointments – shortage of GPs, advised by the GP practice to go to the Waikato hospital ED or Anglesea but transport is an issue from a cost and availability perspective
- Very difficult to get technology access – no phones/ data
 - Set up a booth locally? Community members suggested individuals will give access to their PCs
- Raise with Strategy and Funding the opportunity to, or value of, undertaking an economic analysis of different approaches to managing the 6 tonnes of pharmaceutical waste
- DHB to look into the impact of population health positions no longer being located in local communities. Mark Spittal will be asked to come and talk to the next CHF. CEO asked to be included in this action.

Raglan Community Health Forum 20 July 2017

Action Points

- Social isolation and loneliness – elderly, long-term mental health consumers, maternity service users.
- Access to GP appointments at the weekend – leading to access to Anglesea Clinic issues
- Affordable rental houses – quality and quantity
- Aged Residential Care- a precious complaint re patient quality and safety was raised and has been followed by Patient Quality and Safety
- Raise with Strategy and Funding the opportunity to, or value of, undertaking an economic analysis (and potential saving) of different approaches to managing the 6 tonnes of community pharmaceutical waste annually.



Papers for Action

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE

11 OCTOBER 2017

AGENDA ITEM 7.1

7.1

DRAFT SUICIDE PREVENTION AND POSTVENTION PLAN 2018-2021 AND ENGAGEMENT REPORT

Purpose

1) For information/feedback

Introduction

Over the past three years Waikato DHB has been working to our Suicide Prevention and Postvention action plan 2014-2017. We have made progress over the last three years but there is still more to be done and improvements to be made.

The current 2014-2017 plan has been reviewed over 2017, through a series of interviews, focus groups, community presentations and surveys in order to confirm our focus areas for the next three years. The Engagement Report and the list of who has been involved in the development of the new plan are shown in Appendix 1.

Rather than a 'top down' plan developed by the DHB, the draft 2018-21 Suicide Prevention and Postvention action plan attempts to truly reflect the ideas, issues and challenges from the people and groups that we met with during our engagement and to clearly show how we intend to address them.

In addition to the input received through the above process, we have ensured that our plan aligns with and reflects:

- progress made over 2014-2017;
- the Ministry of Health's draft Strategy to Prevent Suicide in New Zealand 2017;
- the current literature on both suicide prevention and postvention;
- the Waikato DHB's strategy for all people living within the Waikato DHB geographical area. These values are at the core of what we do with people at the heart of our work.

Next Steps

- Draft available on the DHB website and sent to all engagement participants – 'this is what we heard; did we get it right?' October/November 2017
- Further feedback assimilated
- Final report to Board 22 November 2017

Recommendation

THAT

The reports be received and feedback given

MO NEVILLE

EXECUTIVE DIRECTOR, QUALITY AND PATIENT SAFETY

7.1

Appendices

1. Draft Suicide Prevention and Postvention Plan 2018-2021
2. Suicide Prevention and Postvention Plan Engagement Report

2018-2021

7.1



Waikato District Health Board

Suicide Prevention and Postvention Action Plan

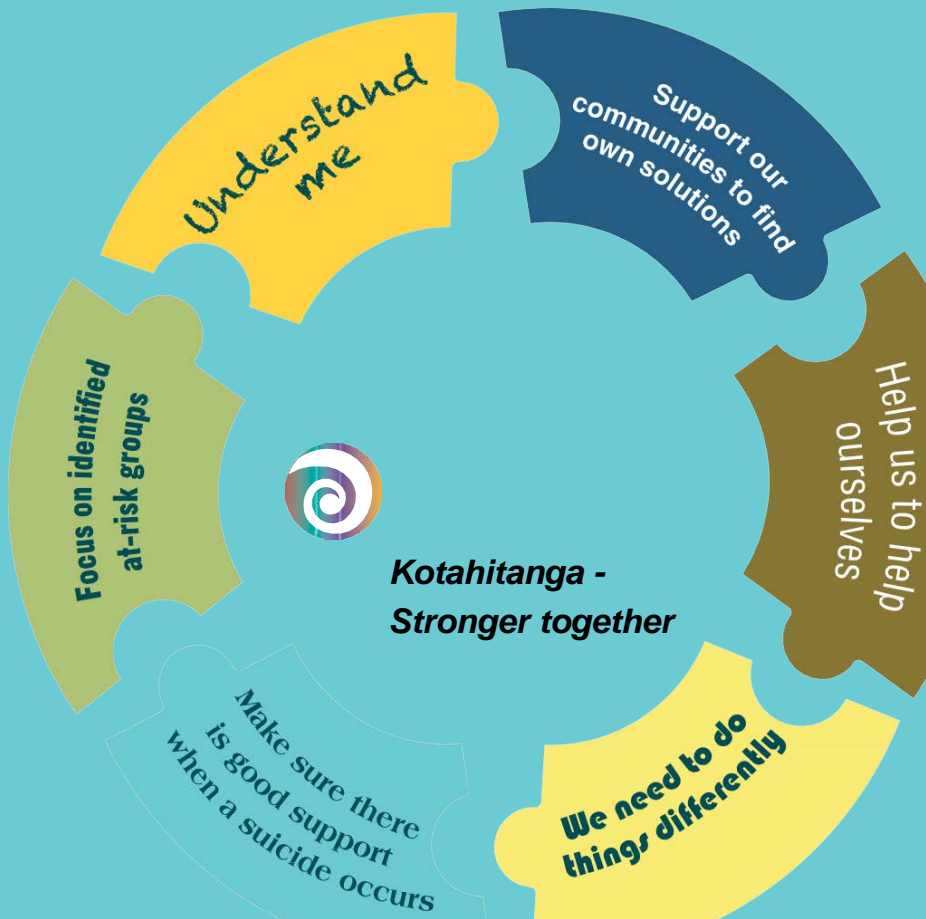


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1. Introduction

Suicide is a major issue of concern to New Zealanders. Multiple risk factors and life events are involved in a person ending their life. The link between mental illness and suicidal behaviour is well known, however many people who suicide are not mental health service users and, as the Ministry of Health¹ explain, some of those contributors include:

- individual experiences and that person's personality in respect of those experiences
- relationship issues
- the support or perceived level of support that person has
- the community in which that person lives
- the context and economic environment (such as are there jobs available) where that person lives.

While the statistics do not show that Waikato DHB is amongst the highest rates, any single suicide is devastating for those family members and friends directly affected and has reverberations far beyond in their communities. We must work hard to reduce the suicide and self-harm rates in our district, not simply because it is required of us as a DHB, but because it has the potential to save lives and reduce distress for those affected. One suicide is one too many.

Over the past three years Waikato DHB has been working to our Suicide Prevention and Postvention action plan 2014-2017. We have made some good progress and this plan builds on the progress made over the last three years but there is still more to be done and improvements to be made.

1.1 The new plan

The 2014-2017 plan has been reviewed over 2017 through a series of interviews, focus groups, community presentations and surveys in order to confirm our focus areas for the next three years. See Appendix C for the Engagement Report and the list of who has been involved in the development of the new plan.

In addition to the input received through the above process, we have ensured that our plan aligns with and reflects:

- the Ministry of Health's draft Strategy to Prevent Suicide in New Zealand 2017;
- the current literature on both suicide prevention and postvention;
- the Waikato DHB's strategy for all people living within the Waikato DHB geographical area. These values are at the core of what we do with people at the heart of our work.



¹ Ministry of Health. 2017. A Strategy to Prevent Suicide in New Zealand: Draft for public consultation. Wellington: Ministry of Health.



1.2 Information on National Suicides

Nationally the subgroups of the New Zealand population with the highest suicide mortality rates in 2016/17 were: males, Māori (compared with non-Māori), male youth (those aged 20–24 years). Māori males and Māori youth showed particularly high suicide mortality rates.

See Appendix A for further information.

Rates per 100,000 people by DHB

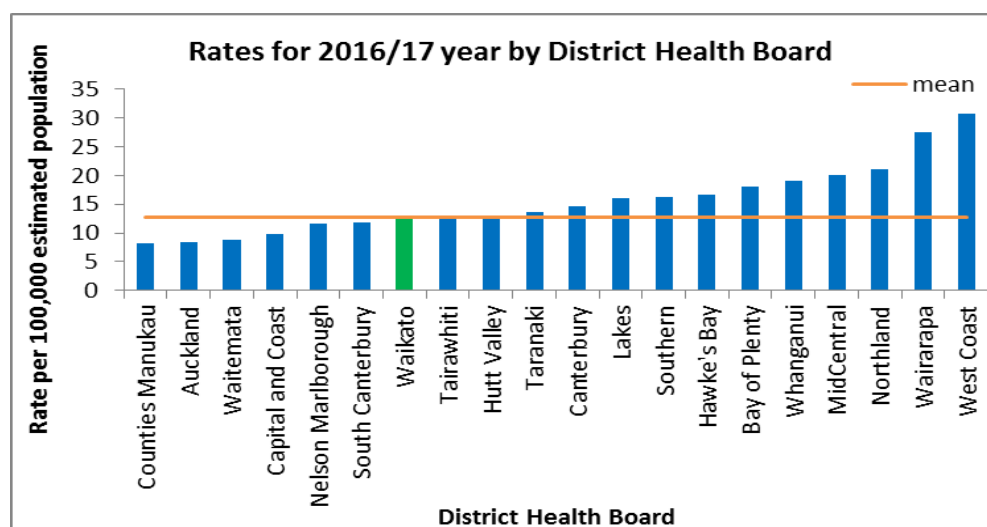


Figure 1. Provisional suicide numbers and rate per 100,000 of the estimated 2016 usually-resident population by District Health Board area. (Sources: Coronial Services of New Zealand. (2017); Statistics New Zealand. (2017)).

1.3 Information on Waikato Suicides

The Waikato DHB district has a larger proportion of people living in areas of high deprivation than NZ as a whole. More than half of the South Waikato (64%), Ruapehu (58%) and Hauraki (53%) populations are living in the most deprived NZDep quintile. While our population is getting proportionately older (the 65-plus age group is projected to increase from 15% in 2015 to 22% by 2033), the proportion of our population aged less than 25 years (slightly higher than NZ as a whole) is projected to remain relatively static. See Appendix B for further information on the Waikato DHB area.

There were 50 deaths during 2016/7 in the Waikato DHB district giving a rate of 12.52 per 100,000 people (see Table 1 above)

Suicide amongst young Māori in the Waikato is disproportionately high. In the middle and older years, the deaths are almost exclusively New Zealand European and European. The majority of people who took their lives in the Waikato in 2016/17 were male.

1.4 At-risk populations in the Waikato DHB area

A key focus for our action plan is to ensure delivery of services is targeted to those at-risk whilst ensuring the ability to also respond to those in need. When developing the action plan we considered both the Waikato DHB's demographics and the populations identified as at-risk through our data. The following table shows the link between the Waikato DHB's particular demographic features with populations at-risk of suicide. As shown, there is virtually no demographic group that is not at-risk, which is an important point to remember; that all people may at some point in their lives be at-risk of suicide.

Table 1. Most at risk populations in relation to the demographic groups within the Waikato District Health Board area.

Waikato DHB Demographics	High Māori population	High proportion of people living in areas of high deprivation	High rural population	High number of ageing population
Populations at-risk				
Males	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	✓
Māori	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rural communities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	✓
Those experiencing mental health issues or significant life stressors	✓	✓	✓	✓
People bereaved by suicide	✓	✓	✓	✓
Lesbian, Gay, Bisexual, Transgender/ Transsexual and Intersex	Not known	Not known	Not known	Not known
People 65 years and older		✓	✓	✓

☐ Actual local knowledge based on information released by the Ministry of Justice (personal communication) for suicides (some provisional) for the period 1 July 2009 to 30 June 2016.

✓ From the research

In addition to the groups listed on this table, people who have made a previous suicide attempt are at increased risk.

2. Governance

In order to successfully review progress against the Action Plan, clear lines of accountability are required.

The Waikato DHB Suicide Prevention and Postvention Plan governance is provided by Intersect Waikato, a multi-sector group of government agencies. Intersect provides oversight and guidance. The governance structure and roles is included as Appendix D.

A Waikato DHB Suicide Prevention and Postvention Health Advisory Group was established in December 2015 to provide direction to the Suicide Prevention and Postvention Coordinator. There is senior representation on the group from hospital departments which can have the greatest influence on suicide prevention, and all the Primary Health Organisations with enrolled practices within the Waikato DHB area are represented. Significant progress in supporting people who have been bereaved by suicide and initiating suicide prevention strategies has been made.

See Appendix E for achievements.



3. Putting the Jigsaw Together

We asked you as residents within the geographical area that is covered by the Waikato DHB, what we can do to help reduce suicides and to support families and friends after a death and you told us.

We have identified people at risk in our DHB population, and where there are trials or pilots to see whether ideas work, we will focus within these groups:

- young Māori, in particular young Māori men
- those living in the most deprived rural areas
- men generally
- older people
- people who have made a previous suicide attempt.

With people at the very heart of our work, using the information gained through consultation with you, and in alignment with our strategic plan, we have developed our suicide prevention and postvention plan for 2018-2021.

Taking account of the above, the section that follows outlines what you told us and what practical steps we will be taking (in partnership with communities and other organisations) over the next three years to focus on reducing suicide in the Waikato DHB.

The DHB is responsible for health-related issues and some more community-based ideas are out of our remit. However we will do what we can within our resources to support communities where they have ideas and projects they believe will make a real contribution to lowering our suicide rate.

7.1



3.1 Understand me

What you told us:

One of the big things that you felt about the services that are helping is the way you are talked to. People said that they know everyone is really busy but just pronouncing your name properly or asking you about your lives is really important.

Some people commented that when they did get someone who showed they really cared, it made all the difference.

“Stigma continues to be a barrier to prevention – it’s harder than the illness itself in some cases”

“It means a lot to be asked about my circumstances”

What you want:

Staff/people/communities that are non-judgmental.

An inclusive society; one that accepts difference.

Young people ask that their parents are informed about some things. These include the importance of talking about emotions and when necessary, suicide, as pretending that it does not exist, is not helpful. They know it is because their parents love them and want to protect them, but sometimes talking about it is needed.

The other thing that young people asked us to do was to talk to parents about how to approach LGBTI issues. “Sometimes parents just react and the result is a torn apart family.”

Clinicians need to learn about asking patients (and their families) how they are feeling emotionally. Physical health and emotional wellbeing are inter-related.

Education for health workers around the language they use to their patients; attitude and pronunciation. People explained that all these things will have an impact on an emotionally vulnerable person.

The message is that difference is okay and being different is difficult and everyone needs love and support – not exclusion.

All support for a person in distress has to be focused on them and what is going on in their lives. If we do not understand the context, then we are less likely to be able to really help them for the long term.

What we are currently doing

Translating our DHB value te iwi ngakaunui (people at heart) into action for all staff.

Setting up a Consumer Group of people with lived experience.

What we are going to do

Work with the Consumer Group to develop messages for clinicians and workers.

Explore parenting support.

Support workshops for parents run by Rainbow Youth.

Develop workshops for parents about talking to kids about suicide.

Support national campaigns to reduce the stigma around suicidal behaviour.

Explore a working group comprising mental health & addictions professionals, education specialists, local government, people with lived experience to create platform for discussion about how to destigmatise suicide in local communities.

Work with organisations such as Te Rau Matatini to develop or use existing programmes to increase cultural competence, improve pronunciation and to raise awareness of the importance of correct pronunciation.



7.1



Understand
me

Timeframes and Responsibilities

7.1

OBJECTIVE 1 Understand me						
ACTIONS	Establish a Consumer Group	Development of a resource for health workers about what really helps when they talk to someone in distress	Explore what is available for parents to be informed about the best practice of talking to their children about suicide	Explore opportunities to destigmatise suicide in local communities.	Work with Māori workforce development organisations to develop/use existing programmes to increase cultural competence, improve pronunciation and to raise awareness of the importance of correct pronunciation	Support national campaigns to reduce the stigma around suicide.
RESPONSIBILITIES	SPP coordinator SPPHG	SPP coordinator SPPHAG Consumer Group	SPP coordinator	SPP coordinator	SPP coordinator SPPHAG	SPP coordinator
COMPLETED BY	October 2017	December 2017	June 2018	March 2018	October 2018	ongoing
SUCCESS WILL BE MEASURED BY	Establishment of group Begin review of resources Feed back to Governance Group	Resource available and circulated to health facilities	Support workshops for parents	Report of findings	Workshop conducted	Gain baseline data by December 2017 and re-survey June 2018.



3.2 Support communities to find our own solutions to suicide prevention

What you told us:

Community connection was one of the main themes that came through in all the conversations during our consultation.

The reasons why a person may not have good links were wide but included being newly arrived in an area; loss of physical capacity to be able to maintain relationships; family rifts; not having a strong cultural identity; left school but can't find a job; coming out of prison or a mental health inpatient service; and for older people living in rural areas, losing the ability to drive.

The out of hours times are when people feel worst.

Māori know what is best for Māori.

What you want:

Make mental health services more accessible. "We often don't need a psychiatrist or any one like that - just someone to talk to. It's lonely and scary waiting". A buddy system would be a good approach.

People understand that crisis support is not always possible because of the geographical size of the Waikato but if a hub was available, some of that demand might be reduced and thus allow for a more consistent rapid-response when required.

Māori ask for a workforce that understands tikanga Māori, offer whānau based support and use kaupapa Māori interventions.

This would include the development of a community-based and, in some cases, less formal Māori workforce.

All those groups of our population that are most adversely affected (rangatahi, Māori men, men, the LGBTI community, older people, rural dwellers and some specific territorial authorities) want information and services that are targeted at them.

Follow up in the community after a person has been discharged from clinical services was one of the things that you felt would really help. "Being sent home is scary. I really wanted to go home but when it came to it, I was scared". This follow up could be by phone but it needs to be for a bit to make sure that things are going okay.

What we are currently doing

Translating our DHB value kotahitanga (stronger together) into action.

Health Hubs will continue to be held in communities that request them. We undertake to hold a health hub within three months of it being requested.

Working with some communities and community groups to support their local plans.

What we are going to do

Assist with the development of local social support registers to ensure people know what help is available in their communities.

Work with clinical services to improve communications and follow up when some- one has been discharged.

Partner with Māori to develop culturally appropriate strategies for suicide prevention and explore the co-design of a whānau or marae champion training package and strategy.

Partner with Māori communities to build social awareness and well-informed social attitudes around suicidal behaviour in Māori communities.

Assist communities with reducing isolation by sharing ideas and strategies, and working with identified community leaders.

Invite communities to develop circles of support and accountability for identified groups eg, people coming out of prison or mental health & addiction services.



Support our communities to find our own solutions

7.1



Timeframes and Responsibilities

7.1

OBJECTIVE 2 Support communities to find our own solutions to suicide prevention						
ACTIONS	Let's Talk Wellbeing health hubs held in communities where the community guides the health hub and which services will be represented at the event.	Partner with Māori organisations to develop culturally appropriate strategies for suicide prevention.	Encourage and support communities to have "circles of support" to ensure that everyone who wishes to be included, is part of the community.	Share initiatives used in one community with others. Support those communities that may wish to explore these options.	Explore using peer support – particularly in rural areas.	Assist in the development of local social support registers.
RESPONSIBILITIES	SPP coordinator MH&AS	SPP coordinator SPPHAG	SPP coordinator	SPP coordinator	SPP coordinator SPPHAG MH&AS	SPP coordinator
COMPLETED BY	ongoing	March 2018	June 2018	ongoing	June 2018	Dec 2018
SUCCESS WILL BE MEASURED BY	Health hub will be held in community who requested it within 3 months of request.	Formalised partnership with Māori organisations	Develop resource of an adaptable template for social inclusion	Communities that approach the SPP coordinator are supported	Peer support system in place and all involved feel the process is comfortable, safe and supportive	All communities who want a social support register, will have one in place and they will all have been uploaded to the Waikato SPP webpage.

3.3 Help us to help ourselves

Give us information and training so we can help ourselves, and give our health services information so they know how to help us.

What you told us:

You said that people living rurally and in regional towns, older people and people in crisis did not know where to find support. You asked “tell us where there is help when we need it!”

People also want to know who is most at risk and what they can do. Because there has been a lot of media coverage about teenage suicide, people think that they are the only group affected. This is not the case for the Waikato. If they had more knowledge, people say that they can help too; it shouldn't just be the DHB.

Young people told us they need to know that they are a valued and trusted member of their community.

What you want:

Local role models with lived experiences positively sharing their story to their community.

Train people through sensitive and safe workshops about the signs of distress and what to do.

Helping people to find a strong cultural identity is important to a number of groups. Opportunities to link with kaumātua and kuia and discuss suicide prevention have been suggested as being helpful.

“Saturate” with wellness messages. Both the use of traditional methods and innovative methods were suggested. Tech tikanga is one but also using a variety of media (Facebook, blogs, performing arts, the back of buses) to “as well as where to get support if required.

Another community-based initiative is that of a “safe-place”. A person could be given training and ongoing support in how to help someone who is distressed. This training might be much broader than suicide prevention but include a number of other social issues that can cause someone to

think that there is little or no hope. The “safe-place” could have a sign denoting that there is a person available to help/listen or just be a buddy.

Set up youth groups. These are where meaningful and fun activities can take place and young people know that this is their place.

Train community members and they will train whānau.

Use Māori strengths - tikanga, forums for kōrero, Māori workforce, community willingness to tautoko, entrepreneurial spirit.

What we are currently doing

Translating our DHB value whakarongo (listen to me, talk to me) into action for all staff.

Continue to hold WAVES and Safetalk training.

Continue to hold Health Hubs where communities invite them.

What we will do:

Develop a wallet card with how to recognise signs of distress and numbers to ring.

Explore the ‘safe place’ idea with communities (maybe a trial?) and community hubs.

Work with communities regarding youth groups and information about youth services.

Explore working with national campaigns around suicide prevention to develop local media messages and saturation strategies.

Work with Māori to identify how to progress Waka Hourua for our area. Work with the Rainbow community to develop information for health staff to strengthen inclusive practice.



7.1



Help us to help
ourselves

Timeframes and Responsibilities

7.1

OBJECTIVE 3 Help us to help ourselves

Give us information and training so we can help ourselves, and give our health services information so they know how to help us.

ACTIONS	Let's Talk Wellbeing stand with SPP coordinator and MH&AS clinical staff as part of a larger community event.	Explore "safe place" opportunities within communities.	Develop a wallet card that sets out how to recognise distress, what to say and what to do. This will be the type of resource which the Consumer Group will review.	Work with youth community groups to give them information about youth services.	Support the training of community-based workers in suicide prevention.	Develop workshops that are aimed at parents about how to discuss suicide with their children.	Work with Rainbow community to adapt workshop about inclusive practice for Waikato DHB staff
RESPONSIBILITIES	SPP coordinator MH&AS	SPP coordinator	SPP coordinator SPPHAG	SPP coordinator	SPP coordinator	SPP coordinator in liaison with provider services	SPP coordinator SPPHAG
COMPLETED BY	ongoing	June 2018	December 2017	ongoing	ongoing	June 2018	October 2018
SUCCESS WILL BE MEASURED BY	Let's Talk Wellbeing stand will be part of any community event in the area* *will require to know at least three weeks in advance to ensure staff available.	Member of the community trained in how to talk to a person who is in distress and establish a "safe place"	Wallet card resource developed distributed	Youth community groups are identified in each community and provided with information	By June 2018, community workers have been trained through LeVa's Lifekeepers.	Have held at least one workshop in a regional town.	Workshops held for Waikato Hospital and at least one regional hospital's staff

3.4 We need to do things differently

We need to do things differently to stop suicides. So we need to look at what works and abandon what has not worked.

What you told us:

Alcohol and other substances have been shown to be a factor in some suicides. It is important to ensure that the abuse of alcohol or the use of drugs which have been shown to increase psychosis is picked up early so that interventions can be offered.

There is lots of research that social connection is really worthwhile. Even within towns, isolation is quite common and, of course, out in the rural locations, it is also a factor for people feeling distressed or depressed. We need to find good ways to connect.

Although there are many similarities between urban and rural health, there are also many differences. Understanding these differences in relation to suicide prevention and emotional wellness is vital in order to be able to address them.

But also from the rural dwellers point of view, being able to say "what could I do to develop ways in myself to cope and if I am not coping, what am I going to do about it. Am I going to recognise it?"

What you want

New Zealand has a history for internationally renowned longitudinal studies. We have to use that information to help us learn what can help people. Often those things that can help are based on strengths rather than trying to address issues. A couple of examples of strengths are that we have a strong ability to get things done through resourcefulness and Māori can have very strong whānau based connections. Use these strengths.

One of the things that has also been clear is that we have to address the issue of men and so ensure that our suicide prevention messages are well-targeted at a male audience.

For services to work together to ensure that the person can be supported in a comfortable place - rather than trying to find help.



Raise awareness that use of drugs and alcohol will affect mood and can cause worse depression.

Strengthen the relationships between primary and secondary mental health services.

There needs to be a programme that encourages people to seek help before suicide becomes a thought. More emphasis on free and easily accessible counselling services.

Raise awareness that no matter how many times people threaten, it still needs to be taken very seriously as previous self-harm does increase likelihood of suicide.

Raise importance of being engaged with primary care. GP is usually first point of call for threats to wellbeing.

Funerals are a key risk time for families and the wider circle of friends. It would have been good to have brochures with advice on this.

Develop pathways and models that work for the most affected. These include Māori men, rangatahi, and people impacted by mental illness.

Support community workers - not qualified social workers but those who can provide early intervention.

What we are currently doing

Translating our DHB value whakapakari (growing the good) into action.

Ensuring Smarthealth availability is increased.

Developing Map of Medicine pathway for suicidal presentations at GPs.

Providing free counselling sessions via GPs.

Ensuring Funeral Directors can provide information about assistance available for the bereaved.

Holding rural wellness days where health literacy is discussed, and health checks (physical and emotional) are done (Health Hubs).

What we are going to do

Provide individuals and whānau with information about how to helpfully talk to someone who they are worried might be thinking about suicide.

Partner with Māori led services to care for and support Māori who are in distress, in particular young Māori men.

Use InterRAI assessment information to identify where older people may be at risk.

Invite the primary mental health service to join the Let's Talk Wellbeing team.

Invite primary health such as local GP practices into the Let's Talk Wellbeing team – i.e. integrate the local health services into the team.

We need to do things differently

7.1

Timeframes and Responsibilities

OBJECTIVE 4 We need to do things differently

We need to do things differently to stop suicides. So we need to look at what works and abandon what has not worked.

ACTIONS	Focus suicide prevention on men. Explore literature for language and means of delivery of message most suited to men.	Support the training of rurality-based health workers in risk screening.	Support the wider use of Smarthealth for people who are experiencing emotional distress.	Develop resources to be shared with families hosting international students.	Consolidate the primary/secondary suicide prevention subgroup of the SPPHAG including representation from the Primary Mental Health services.	Invite local primary health practice to join the Let's Talk Wellbeing team.	Exploration of a physical space where people can go for support 24/7.	Collaborate with Older Persons' Services to ensure that they are supported to assist any person whose InterRAI assessment indicates emotional distress.
RESPONSIBILITIES	SPP coordinator	SPPHAG	SPP coordinator and Smart Health	SPP coordinator in liaison with support services SPPHAG	SPP coordinator Primary/secondary suicide prevention subgroup of the SPPHAG	SPP coordinator	SPP coordinator SPPHAG External agencies	SPP coordinator
COMPLETED BY	December 2017	December 2017	ongoing	October 2018	June 2018	ongoing	June 2019	December 2018
SUCCESS WILL BE MEASURED BY	Report to Governance Group	Two Safe Hands Safe Plans workshops held	Smarthealth available for people who are experiencing emotional distress.	Development and circulation of specific information /resource	Primary Mental Health services included in Let's Talk Wellbeing team	Local GP practice involved in health hubs	The setting up of a community-based hub.	That all people whose score triggers referral for further service, are offered support.

3.5 Make sure there is good support when a suicide occurs

What you told us

We don't know what happens when there is a suicide in our community. We don't know who is involved or how to get help afterwards.

Families/whānau particularly with rangatahi are really vulnerable at this time. How do we help them?

How can we be sure the right people are involved when they need to be?

What you want

To know that when a suicide happens the right people know so they can support people and the community.

Make sure the affected people are supported so it doesn't happen again.

Make sure that all the organisations involved are co-ordinated and know what each other is doing.

What we are currently doing

Translating our DHB values Te iwi Ngākaunui (people at heart) and Kotahitanga (stronger together) into action.

We all know that the information that a person has died of *suspected* suicide is very sensitive information. The Chief Coroner has permitted the release of the name so that a small group of people in each DHB can support the bereaved and those close to the person who has died. Our small group is called the Postvention Action Team. When we learn of a death, the group is informed so that support can be offered as soon as possible to family, friends and workmates. This is usually offered by Victim Support but another agency will take over if they already know the bereaved.

Free bereavement counselling or psychological services through GPs or a social agency.

When there is a suicide Waikato DHB works with the Community Postvention Response Service to identify communities where there is risk of contagion and work with the relevant local personnel as part of the postvention process.

Relationships with the Postvention Action Team members and stakeholders are managed to ensure effective interactions and participation.

Postvention processes and outcomes are continually monitored and updated to ensure they are working so that the bereaved are offered support in a timely and appropriate way.

Providing support to communities experiencing suicide clusters² or suicide contagion.

What we are going to do

Waikato DHB will link relevant local communities into the postvention process when a death occurs.

Using recommendations that came from research about supporting grief. This research was commissioned by the Waikato DHB. Several of the recommendations have already been implemented but there are a number yet to be further explored to see how best they could be used.

Regular reviews of our postvention response to learn what could be done better so that the whānau, and wider community is supported.

Liaise with other DHBs to discuss their postvention response so we can all learn from each other.

Continue to invite community members from our most vulnerable areas to work with our Postvention Action Team. This way we can all have a deeper understanding of communities; the effects for a community when a suicide occurs and how we can best support that community in the short, medium and longer term.

Develop small cards that can be given to the bereaved family by Victim Support or the Police. These cards will give information about counselling (funded by the DHB) or other forms of no-charge bereavement support (such as the WAVES suicide-bereavement courses). We know that these cards will not be used right away but might be helpful at some point later on.

Partnering with Te Rau Matatini and Taupiripiri Trust in Northland to hold Ngā-Kuaha Tūmanako conference. This conference will be discussing grief and, in particular, suicide-related grief from a te ao Māori perspective.

Make sure there is good support when a suicide occurs

7.1

² A suicide cluster is when multiple suicides or suicide attempts, or both, occur closer together in time, geography, or through social connections, than would normally be expected for a given community.





Timeframes and Responsibilities

7.1

OBJECTIVE 5 Make sure there is good support when a suicide occurs				
ACTIONS	Continue to inform people that funded counselling or psychological services are available for bereaved families.	Implement recommendations identified through the commissioned grief and bereavement research.	Evaluation of Ngā Kuaha Tūmanako grief conference.	Ongoing review of the Postvention Action Group and the support offered following a suicide.
RESPONSIBILITIES	SPP coordinator	SPP coordinator Bereavement subgroup of SPPHAG	Evaluation presented to SPPHAG and Governance Group	SPP coordinator Postvention Action Group reporting to SPPHAG and Governance Group
COMPLETED BY	December 2017	June 2018	March 2018	Ongoing
SUCCESS WILL BE MEASURED BY	Referrals for service received. Surveyed therapists confirm they are aware of the funded service.	Recommendations implemented	Evaluation report compiled following the grief conference in October 2017	Reviews completed and recommendations implemented

3.6 Ensure a focus on identified at-risk groups

Our statistics tell us that those most at risk in the Waikato DHB area are:

- young Māori, in particular young Māori men
- those people living in the most deprived rural areas
- men generally
- older people
- people who have made a previous suicide attempt

**Focus on identified
at-risk groups**

7.1

We need to continue to focus our resources on these groups.

The previous section outlines what we will be doing over the next three years. In all actions the above at risk groups will be prioritised

Timeframes and Responsibilities

OBJECTIVE 6 Ensure a focus on identified at-risk groups				
ACTIONS	Regular review of the evidence to ensure that the most at-risk geographical locations and members of our population are prioritised for suicide prevention initiatives.	Continue to prioritise all work so that young Māori, men, those people living in the highest deprivation areas, identified geographical locations, older people are given information to help communities support them.	Work with the most at-risk groups to develop suicide prevention initiatives that will be most effective in their particular area or for that particular group of people.	Ongoing review of the evidence in relation to national evidence to determine if there are local differences. Explore the reasons for these differences. For lower than national rates, how can we use these differences for other groups? If higher than national rates, what can we do to reduce the incidence?
RESPONSIBILITIES	SPP coordinator SPPHAG	SPP coordinator	SPP coordinator	SPP coordinator
COMPLETED BY	6-weekly updates	ongoing	ongoing	ongoing
SUCCESS WILL BE MEASURED BY	Governance Group updated each meeting	All most at-risk populations and communities are supported.	All most at-risk populations and communities feel supported and empowered.	Evidence incorporated into SPP planning and implementation of any initiatives

Appendix A National Suicide Information

National suicide data² (please note this information is still provisional) for the period 1 July 2016 and 30 June 2017 shows:

- A total of 606 people died by suicide in New Zealand. This is a rate of 12.64 suicides per 100,000 population), which is 27.4 percent below the highest recorded rate in 1998
- New Zealand's suicide rate for both males and females is slightly above the median for the OECD countries.
- The male rate was 19.36 per 100,000 and the female rate was 6.12 per 100,000 of the population.
- The national rates for men 44 to 44 years were the highest at 33.90, followed by men 85 years and over (33.67 per 100,000 population) and men between 20 and 24 years old.
- The rate for Māori was 21.73 (all stated as a standardised rate per 100,000 people) whereas the rates for Asian were 5.73, 9.15 for Pasifika and 14.66 for European and other.

The Ministry of Health³ state that:

- There were also over 7200 hospitalisations (including short-stay Emergency Department events⁴) for intentional self-harm injuries in New Zealand in 2013.

Appendix B The Waikato District Health Board area

Waikato DHB serves an estimated population of 390,700 (usually resident in 2015) and covers 21,220 square kilometres across ten Territorial Local Authorities (TLA). Waikato DHB covers almost eight percent of New Zealand's population, from Northern Coromandel to close to Mt Ruapehu in the south, and from Raglan on the West Coast to Waihi on the East. It takes in the city of Hamilton and towns such as Thames, Huntly, Cambridge, Te Awamutu, Matamata, Morrinsville, Ngaruawahia, Te Kuiti, Tokoroa and Taumarunui. It extends North to Meremere. 60 percent of our population live outside Hamilton city.

We have a larger proportion of people living in areas of high deprivation than NZ as a whole. More than half of the South Waikato (64%), Ruapehu (58%) and Hauraki (53%) populations are living in the most deprived NZDep quintile. While our population is getting proportionately older (the 65-plus age group is projected to increase from 15% in 2015 to 22 percent by 2033), the proportion of our population aged less than 25 years (slightly higher than NZ as a whole) is projected to remain relatively static.

The Māori population (around 23 percent of our population in 2015) is growing at a slightly faster rate than other population groups and is estimated to be 26 percent by 2033. Pacific people represent around 3 percent of our population, and Asian 8 percent.

² Coronial Services of New Zealand (2017). Annual suicides. Retrieved on September 23, 2017 from <https://coronialservices.justice.govt.nz/assets/Documents/Publications/2016-17-annual-provisional-suicide-figures-20170828.pdf>

³ Ministry of Health. 2016. *Suicide Facts: Deaths and intentional self-harm hospitalisations: 2013*. Wellington: Ministry of Health.

⁴ Not comparable with previous years' data as this is the first time the data includes Emergency Department short stays

WAIKATO DISTRICT HEALTH BOARD SUICIDE PREVENTION AND POSTVENTION ACTION PLAN

For those identified as Māori, Pacific and Asian, the population is projected to increase in all age groups from 2015-2033. By 2033, three in five children aged 0-14 years in the Waikato DHB area are likely to be Māori, Pacific or Asian.

Note: Demographic information sourced from the document Health Needs Assessment – Waikato District Health Board Mental Health and Addiction Service Utilisation, National Institute of Demographic and Economic Analysis, University of Waikato, March 2017

Appendix C Engagement Report

[separate attachment]

7.1

Appendix D Governance structure

Role	Role Definition	Membership
Monitoring	Ministry of Health will monitor specific activities via quarterly and annual reporting	Ministry of Health
	Suicide Prevention Postvention Health Advisory Group will monitor actions in the action plan via 6 weekly meetings.	Senior DHB managers/clinicians from Strategy & Funding, Te Puna Oranga, Population Health, Mental Health & Addictions, Emergency Department along with Primary Care.
	Quality & Patient Safety will provide oversight of the Suicide Prevention Postvention Coordinator	Executive Director Quality and Patient Safety
Governance	Provides guidance and direction to the Suicide Prevention Postvention Coordinator who provides governance with information and needs of the Suicide Prevention Postvention Health Advisory Group, communities and stakeholders and people in need	Intersect Waikato - Senior managers from Government Agencies in the Waikato
		Health Strategy Committee - Waikato DHB Board members
Suicide Prevention and Postvention Coordinator	Uses the plan as their direction for activity and provides co-ordination, facilitation and information and responds to the needs of communities and stakeholders and people in need	Suicide Prevention and Postvention Coordinator
Suicide Prevention Postvention Health Advisory Group	Advises the Suicide Prevention Postvention Coordinator and approves areas of focus and activity. Reports to the Health Strategy Committee	
Communities and Stakeholders	To be kept informed of activities that are occurring. To provide specialist knowledge as required	Clinical Advisory Services Aotearoa, Police, Education, Corrections, Victim Support and others as required
People in need	Any person or group who identifies themselves or is identified through other means as being at risk of suicide, attempted suicide or self-harm.	Anyone

Appendix E Achievements 2014-17

Establishment of the Suicide Prevention and Postvention (SPP) Coordinator position

The role of the coordinator is to carry out and/or coordinate the actions set out in the SPP plan. The position is based in Quality and Patient Safety at the Waikato Hospital campus. As well as data collection, the role is largely about relationships and ensuring that all the prioritised subgroups of our population are actively engaged. The coordinator has had the benefit of working with a wide range of community agencies, service providers and individuals.

Collaboration

In particular, a good working relationship exists with the following organisations external to the DHB:

Accident Compensation Corporation
 Centre 401
 Clinical Advisory Services Aotearoa (CASA)
 Dairy NZ
 Hamilton City Council
 Huntly Rangatahi forum
 Kainga Aroha, Te Awamutu
 LeVa
 Lifeline
 Ministry of Education
 Ministry of Health
 Ministry of Social Development
 NZ Police
 Oranga Tamariki
 Progress to Health
 Raukawa Trust, Tokoroa
 Rural Health Alliance of Aotearoa New Zealand
 Rural Support Trust
 SPARX, University of Auckland
 Starfish, Matamata
 StayWell (wellness checks for the rural communities)
 Te Kuiti Community House
 Te Rau Matatini
 Tokoroa Council of Social Services
 Waikato District Council – Youth Engagement Advisor

DHB Suicide Prevention and Postvention Coordinators teleconference monthly to share ideas, provide updates and identify issues

7.1

Webpage

A series of webpages have been developed and available since the middle of 2016. In accordance with the importance placed on suicide prevention and postvention by the Waikato DHB, the SPP webpages can be accessed directly from one of the front page icons on the Waikato District Health Board website <http://www.waikatodhb.health.nz/>

Postvention

Early notifications

The process of receiving the early notifications following a suspected suicide has been in place since 2014 with the Medical Officer of Health being the nominated senior staff member to receive the alerts. The process ensures that key agencies and hospital departments are informed of the death.

Following a workshop of stakeholders in March 2016, it was recognised that several improvements could be made. These included informing Victim Support Bereavement Team directly, giving the general practitioner of the deceased the offer of emotional support and having a more formalised process of notifying key agencies and departments.

The consequence of this last improvement was the establishment of a subgroup of the SPPHAG, the Postvention Action Group in April 2016.

The members of the Postvention Action Group are:

- NZ Police, Injury Prevention
- NZ Police, Coronial Officer
- Ministry of Education, Manager Traumatic Incident
- Team Practice Leader, Child Youth and Family
- Senior administrator, Mental Health and Addictions Service
- Bereavement specialist, Victim Support Bereavement Team
- SPP coordinator

The Medical Officers of Health and the Team Leader of the Waikato DHB's Clinical Records Department are also advised when a death has occurred.

Quarterly meetings are held to ensure that the postvention process is working for all members and that the bereaved are being offered timely and appropriate support. If there are any identified barriers, these are addressed.

Further refinements continue including that the PHO with whom the deceased's GP is affiliated, is now routinely informed of the death to assist with support to the practice.

Grief support

The SPPHAG has been explicit in its intent to ensure that families bereaved by suicide, will be offered grief support rather than having to seek it for themselves. In order to achieve this:

- a discrete fund is available for bereavement counselling. All primary care practices and funeral directors within the Waikato DHB area are now informed of the availability of the fund for counselling or psychological services.
- two WAVES facilitator training courses were co-funded by the DHB— one in Hamilton and one in South Waikato. A total of 18 facilitators have been trained in running a closed suicide bereavement support group.
- the webpage has information about what is available after a death.

- research was commissioned to research four areas specifically around supporting grief. This research was undertaken to determine what would be appropriate and sustainable to ensure that people bereaved by suicide in the Waikato DHB are supported through the grieving process. Several recommendations have already been implemented and further recommendations are being considered.

Ongoing review of postvention support

The postvention process is reviewed on an ongoing basis to see what quality improvements can be made to ensure that the people most affected and also those potentially affected are given support that is timely and appropriate. Clinical Advisory Services Aotearoa (CASA) is the intermediary for the notifications from the Ministry of Justice. The Clinical Advisor of CASA is consulted when there are any possible concerns that one person's death might be connected to another death within a community.

If the SPP coordinator learns that another DHB's residents might have been close to the deceased, CASA is informed so that they can send the notification to the relevant DHB.

The Waikato DHB employs over 6,500 staff throughout the area. Of course, all these people have their own lives and situations and sometimes our staff are affected by suicide. The SPPHAG have developed a flowchart which can be used as a guide in the event of the suicide of a DHB staff member or their family member.

7.1

Waikato DHB Suicide Prevention and Postvention Plan Refresh

Engagement Summary Report



Author: Jane Hudson and Clare Simcock
Last Updated: 14 August 2017
Document Name: Engagement Summary Report
Version: V4

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7.1

Introduction

Suicide is a major issue of concern to New Zealanders. Multiple risk factors and life events are involved in a person ending their life. The link between mental illness and suicidal behaviour is well known, however many people who suicide are not mental health service users; other risk factors can include exposure to trauma, lack of social support, poor family relationships and difficult economic circumstances.

DHB requirements are articulated in the Ministry of Health's 2017/18 Service Coverage Schedule, which states:

DHBs are expected to coordinate suicide prevention activities. This includes implementing a district suicide prevention plan, facilitating and enhancing cross-agency collaboration in respect of suicide prevention and, when necessary, implementing a suicide postvention plan and a coordinated response to suicide clusters/contagion (P50).

Waikato DHB has had a Suicide Prevention and Postvention Plan in place since 2014/15 and a co-ordinator, directed by the plan and advised by the Waikato DHB Suicide Prevention and Postvention Health Advisory Group, has been in place since January 2016.

In 2017 we undertook an exercise to 'refresh' our Plan for the next 3 years by engaging with individuals and groups to understand how we could improve our approach.

Who did we talk with?

Community Health Forums

Presentations about the refresh were made at all Community Health Forums in March and again in July/August 2017

Focus Groups/Feedback from key informants

Over June to August 2017 we held focus groups with the following:

- People working with those 65 years and older
- Mental health and addictions service users
- Pacific community
- Those who work within the community in Thames/Coromandel/those with lived experience
- Te Puna Oranga (DHB Māori Health Service) staff
- Rider Against Teen Suicide (R.A.T.S.)
- Those working with ex-prisoners

On two occasions feedback was conveyed to us from people who had met on our behalf with:

- The rainbow youth community; and

- Rangatahi/young people aged 15-17

We also met with a key informant from the Māori community. Other discussions have been held with representatives from:

- Dementia Waikato
- The farming community
- A men's suicide prevention organisation
- A suicide prevention organisation
- Anglican Action

We had discussions within the Waikato District Health Board - with Population Health, Te Puna Oranga and the Waikato Child and Youth Mortality Review Group.

Choice of focus groups/key informants

Groups were chosen to particularly reflect those who have been identified from the data as at risk populations.

Feedback

There was a plea from people (often young people) for understanding. It cannot be emphasised enough how simple things like taking the time to pronounce someone's name properly and not judging people assists with building rapport and encouraging them to seek help.

Feedback has identified a service gap for those in distress whose need is not 'crisis' or even necessarily clinical, but simply 'someone to talk to before things get bad'. Ideas for this included:

- Community welcoming committees for those new to rural towns (this operates well in Whitianga)
- Monthly coffee shop drop in sessions/'natter groups' in rural towns – when someone doesn't turn up, contacting them to ensure all is ok
- Caring caller arrangements or phone trees
- A hub, or place to go in the community for young people where there are sports or creative arts programmes that are free
- Whānau champions
- 'Safe places' in the community eg, hair dressers, dairies etc where people have had training in brief intervention or listening skills – identified by a symbol in the window
- Circles of Support and Accountability – community responses for people coming out of prison

Help lines while sometimes supportive were not seen to be adequate (particularly for older people); a personal interaction was preferred. Other messages included:

- Understanding the underlying problems that people are facing
- More prevention work and strategies

- Clearer referral pathways
- Rapid follow up after discharge from inpatient services
- Trusting communities to find their own solutions
- More training (that makes sense to young people) for real jobs
- Knowing what our options are for getting help
- More 'connectedness with the community to prevent social isolation for older people and those who have been in prison of mental health inpatient services
- Changing the language – eg 'offenders', 'customers', 'service users', 'managing' people
- Enhancing humanity rather than focusing on risk factors

Submissions

Two written submissions and the brief written overview of an Australian initiative were received. The main points raised through these submissions were:

- Full participation by Māori in all things affecting Māori
- Allow for variation between urban and rural
- Upskill front line workers, whānau and community workforce
- Integration of tikanga into practice by health workers
- Promote strength based whānaungatanga
- Development for community leaders and youth ambassadors
- Pathway and models that work for most affected Māori, men, rangatahi and people with mental illness
- Mental health first aid for school students
- Template on how to keep someone safe
- Stronger use of social media

Te Turamarama Declaration, which was developed at the World Indigenous Conference in 2016 contained a number of recommendations that were also included in the collated information which is included in Appendix A.

Points that have been raised during the past 18 months of Waikato Suicide Prevention and Postvention Health Advisory Group meeting have also been included in the collated information in Appendix A.

Surveys

- A survey was available on the DHB website from 11 April to 19 May asking 'How can we best support your community to address suicide/self-harm issues'. There were 56 responses to the survey and key messages included:
 - Give the public information about the signs of distress in family/whānau/friends and how to get help
 - Hold wellness days in communities where people can pick up resources or talk to a Mental Health clinician
 - Hold wellness days in communities where people can pick up resources or talk to an Addictions clinician
- Tablets were loaded with a simple survey about what was most important to people if they or a loved one had mental health and addiction issues. This was

handed out at Field Days (14-17 June 2017). 424 responses were received. 70% of responses related to two statements:

- Knowing what our options are for getting help (36.3%)
- Having someone to talk to before things get bad (34.4%)

Other statements had the following support:

- Response first time – not being pushed from pillar to post (21.7%)
- Having follow up after an appointment to see how things are going (7.6%)

Ministry of Health

In April this year the Ministry of Health released A Strategy to Prevent Suicide in New Zealand – draft for consultation.

The community focus of the strategy is seen as encouraging and it was confirmed that our more specific local action plan could comfortably incorporate the principles listed in the Ministry's draft strategy. These principles are:

- Building positive wellbeing¹ throughout people's lives
- Recognising and appropriately² supporting people in distress
- Relieving the impact of suicidal behaviour on people's lives.

Methodology issues

Only one avenue of information proved difficult to obtain and, in the end, we did not manage to arrange the focus group of rural men. The potential group were from the Waipa District.

There was some concern raised about the appropriateness of using a questionnaire to gain responses as it was felt that face to face interaction is the most suitable for this type of sensitive discussion.

Counter to this, there were a number of people who commended us for asking for contribution so widely.

The age restriction on the survey also received conflicting opinions. We felt it was important to put a limit on who may respond (although we acknowledge that we have no way of telling the age of the respondent). Legal staff at the Waikato DHB agreed with this restriction. However, several members of the public suggested that as this was the voice that we needed to hear restricting it to 18 years and over was counterproductive. We had, however planned other strategies for reaching this age group.

¹ Here positive wellbeing means people are doing well and feeling well, and are able to cope and adapt when things happen or change in their life.

² Appropriate means the support meets the person's needs – this includes that it is culturally appropriate for them.

Although most groups were easily planned, the number of focus groups and interviews increased as we were directed to further groups/key informants. Also the amount of time involved in the meeting itself, the summarisation of the discussion and the thematic analysis took longer than initially anticipated. However it is believed that taking the time to assimilate this will greatly enrich the final plan and especially ensure both a Māori and youth voice is incorporated.

Conclusion

The overall method has proved extremely valuable in that even after nearly 20 separate streams of contribution; we are still hearing new information. We have gained wide and varied feedback although there are also, reassuringly, common themes which will provide the basis for the new plan.

Some of the points raised have already been addressed. In particular, these are:

Issue	How this has been addressed
Free postvention counselling for bereaved families	Funded bereavement counselling with an independent counsellor/psychologist is available in the Waikato DHB area
Hold wellness days in communities where people can pick	These are already taking place (Health Hubs) and we invite communities to say if they would like one in their community.
Availability of 24 hour access to professional support	Available through Smarthealth or through 'Need to talk? 1737 ' a new, free 24/7 phone line

It should be noted that some of the points raised during the engagement are outside the influence of the Waikato District Health Board or any health provider although it is fully acknowledged that these factors can have a strong bearing of sense of wellbeing. These were primarily around provision of work-ready training; recreation facilities, suitable employment opportunities and the improvement of neighbourhoods and communities.

Appendix - who has contributed

Thank you to you all who have contributed – we have a wide range of feedback. Some of it is a single suggestion but there are many recurring themes too.

We did receive some suggestions that are outside the remit of the DHB. However the DHB will partner with and support communities to achieve their own solutions as was a clear message from the engagement we had with communities in the development of our plan.

Group	Geographical area	Methodology	When
Waikato DHB Community Forums	Tokoroa, Hamilton, Matamata, Paeroa, Thames, Taumarunui, Raglan, Huntly, Ororohanga, Te Kauwhata	Presentations/discussions	6-16 March 2017
		Well-being update	18 July-2 August 2017
Te Tūramarama Declaration	National		June 16
Aged Care Sector	Thames	Focus Group (Hauraki AgeWise)	4 July 2017
Population Health	Waikato DHB area	Discussion with Public Health staff	May 17
Rainbow youth	Hamilton	Key informant who had canvassed his community	31 May 2017
NGO supporting people with chronic cognitive illness	Waikato DHB area	Key informant	Jul 17
Rangatahi/young people 15 -17 years (Maori and Pakeha)	Ngaruawahia	Written feedback from a key informant from three groups of Year 10 students (24 students. 18 boys, 6 girls)	14 June, 15 June, 21 June 2017
Māori		key informant from the Maori community	20 June 2017
Community workers/those with lived experience (Māori and Pakeha)	Thames	Focus Group	23 June 2017
Te Puna Oranga (DHB Māori Health Service) staff	Waikato DHB area	Focus group	July 2017
Mental Health & Addictions lived experience (Maori and Pakeha)	Hamilton	Focus Group	7 June 2017
Pasifika - Community workers/those with lived experience	Tokoroa	Focus Group	9 June 2017
Rural Men	Te Awamutu	Focus Group	Unable to schedule
Men's group		Key informant	July 2017
Suicide Prevention Group		Key informant	July 2017
Farming sector	Waikato DHB area	Key informant	July 2017
Mortality Review Group		Non-identifiable recommendations	July 2017

Group	Geographical area	Methodology	When
Workers transitioning people from prison to the community/or who are on bail with no safe address	Anglican Action	Key informants	11 August 2017
R.A.T.S. (Riders Against Teen Suicide)	National/local	Meeting with national and local chairs	28 July 2017
General Public	All	Survey on the Waikato DHB website (57 responses)	11 April – 19 May 2017
General Public	All	Survey at Field days in Hamilton (424 responses)	14-17 June 2017

Appendix - Feedback

1. Understanding people

- Traumas and background information – understand me
- Inclusion – acceptance of difference
 - MH issues
 - LGBTI
 - Inform parents
- Understand me – find out about my life, my situation and also my root problems
 - Don't judge me
 - Take time to pronounce names properly
 - know my culture – use tikanga Māori

2. What people believe works

- Address alcohol and substance use – in rural areas; related to trauma
- Under 40 year age group in rural setting
- Demographic specific information – men; rangatahi; elderly
- Suicide Review Committee recommendations
- Longitudinal study
- Innovative tools
- Specific focus on rural – mobility; poor diet; stress; long hours; alcohol; sleep deprivation and inaccessibility to GP
- Sleep deprivation young people
- Social connection
- Rural vs urban initiatives

3. Information and education/training

- Awareness of services
 - 24/7 helplines
 - After hours services (such as 1737)
- Accessibility to service – where the services are
 - Rural towns
 - MH services
 - Crisis support
 - Older people
 - Hub in community
- Inform people that suicide affects all
- Across all of health
- Organisations working together
- Community development
 - Empower communities
 - Find cultural identity/celebrate culture
 - Youth groups

- Through kaumātua and kuia
 - “safe places to talk” – person trained to help and then designated as such
 - What a healthy relationship is
- Innovation
 - Smarthealth
 - Spoken word
 - Saturation using various media
 - Online
 - Tech tikanga
- Social support register
 - Toolbox of help
 - HAIP
- Language
 - How we talk
 - Pronunciation
- Alcohol and other substances
- Demographic specific way of informing
 - Men
 - Māori
- Health literacy
 - Rural setting
- Nutrition
- Postvention
 - Messages – how to talk; funerals; grief support
- Signs of distress
 - Youth
 - rural
 - training all health
 - Gambling
 - Parents
 - LBGTI
 - Use FV methods
 - Pathways – google or paper
 - Privacy act overridden
 - Gateway staff
 - Schools
 - Volunteers
 - Primary care
 - Help posters
 - Crisis training 19-27 years
 - Wellness days
 - Literature at GPs/social agencies
 - Staff at schools
 - Immediate school upwards
 - Bullying
 - Relationships – breakups; parameters of a relationships
- Community connection
 - New people in district

- Hub
- Barriers for older people
- Geographical and social isolation
- People out of school
- Lift emotional intelligence
- Use community houses – workshops at each
- Peer to peer
- Local social support register
- Stigmas – scared to open up
 - National destigmatisation
 - Community conversation days
- Wellness days
- Whānau champions
- Youth voice

4. Provision of service

- 24/7 support services
- Accessibility of MH services
- Integration of primary and secondary care; departments; hospitals
- Work together across sectors
- Alcohol – screen in primary care; referral
- In schools
- Non-drinker; moderate drinker not perceived as outgroup
- Carer support
- Community development
- Community say – find own solutions
- Active say in plan and implementation of plan
- Counselling/buddy system – across health settings (especially ED, HRB, London Street, regional hosps)
- Crisis support
- Culturally sound support
- Follow up; after discharge; primary care
- Hub in community
- Feeling of inclusion within all health settings for Māori/youth/LGBTI
- Māori Community Action Plan
- More Māori practitioners for Māori
- Development of Māori informal workforce
- Wider therapies
- Smarthealth
- Social media specialist
- Facebook good medium for positive messages
- Reduce stigma
- Services are here, we just don't know about them
- Services appropriate to most affected (rangatahi, Māori, LGBTI, men)
- Use of InterRAI assessment
- Use of social connection opportunities

- Support groups
- Social services register
- Tikanga Māori interventions
- Wellness days including physical health
- Forum for hearing youth voice
- Work with Department of Corrections
- how to focus on male issues - or are there no unique issues to men/masculine people

7.1



Papers for Information



No papers for information



Strategic Programmes Update

Midland Clinical Portal

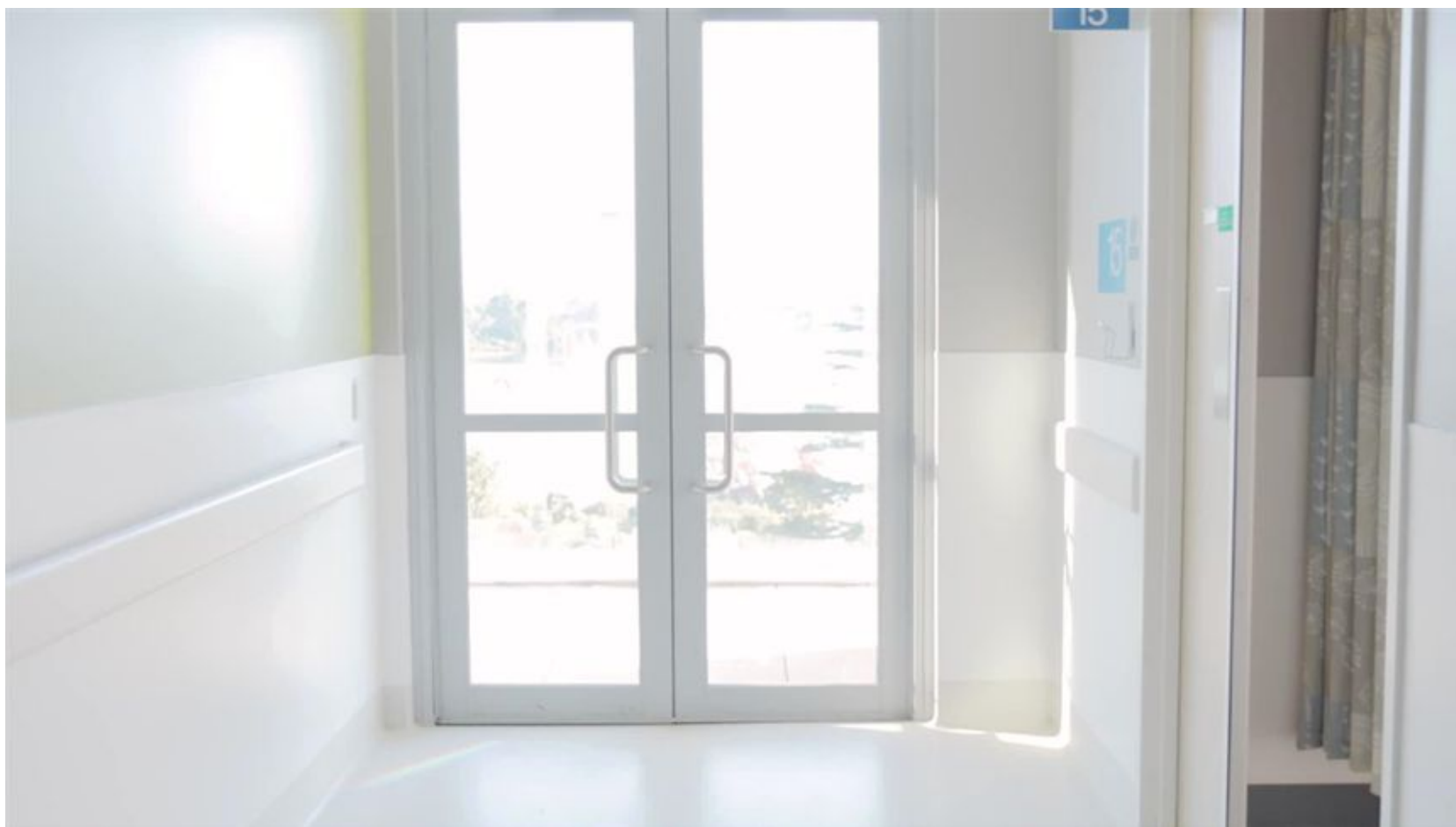
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Vision

**One patient,
one record**

9.1



9.1

Midland Clinical Portal Foundation Project (MCPFP)



“software that improves the ability of all carers to do the right thing for their patient.” Dr Ian Martin FACEM, ED CD and MCPFP Clinical Executive.

9.1

- The MCPFP technical go live was on 31st July.
- The MCPFP Clinical Go Live was on 14th August.

MCPFP Summary



As at 2nd October, Midland Clinical Portal has;

- Roll out of MCP has continued to all SMOs, RMOs, Nurses and Allied Health professionals at Waikato DHB – some 4,000 clinicians in total.
- Access has been given to 10 clinicians at Bay of Plenty DHB, with an additional 50 to be given access on 9th October. All Tairāwhiti DHB clinicians will be given access within November; Taranaki and Lakes DHBs have some specific technical issues to address first.

Total Number of Patients:	443,095
Total Number of Documents:	334,386
Total Number of ED Events:	1,345,160
Total Number of Inpatient Events:	345,060
Total Number of Outpatient Events:	303,967



**Next update at
December
meeting**



**Next update at
December
meeting**



**Next update at
December
meeting**



**Next update at
December
meeting**



**Next update at
December
meeting**

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE

11 OCTOBER 2017

AGENDA ITEM 9.7

PATIENT FLOW PROGRAMME

9.7

Purpose	1) For information
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Background

Waikato DHB, particularly Waikato Hospital, is challenged daily with sub-optimal patient flow. This occurs for a number of reasons and results in bed block, delayed assessment and processing through ED, delayed patient care, delayed treatment and ultimately delayed discharge from hospital.

This often translates into a poor patient experience, increased clinical risk, increased stress and staff frustration and inequitable workload for staff and ultimately in financial pressure on the wider organisation. The latter occurs as a result of unnecessary consumption of bed days and potential penalties associated with an inability to meet Ministry of Health (MoH) targets, namely the Shorter Stays in ED (6hr) target and the Elective Services Performance Indicator (ESPI) targets

The goal of the Patient Flow Programme of work is to provide timely, efficient patient care to enable better flow through our hospital system, reduce non-value added time in hospital and reduce non-value added staff activity. This will enable the organisation to more effectively meet MoH targets and deliver a reduced average length of stay, which in turn frees up bed capacity.

Programme objectives

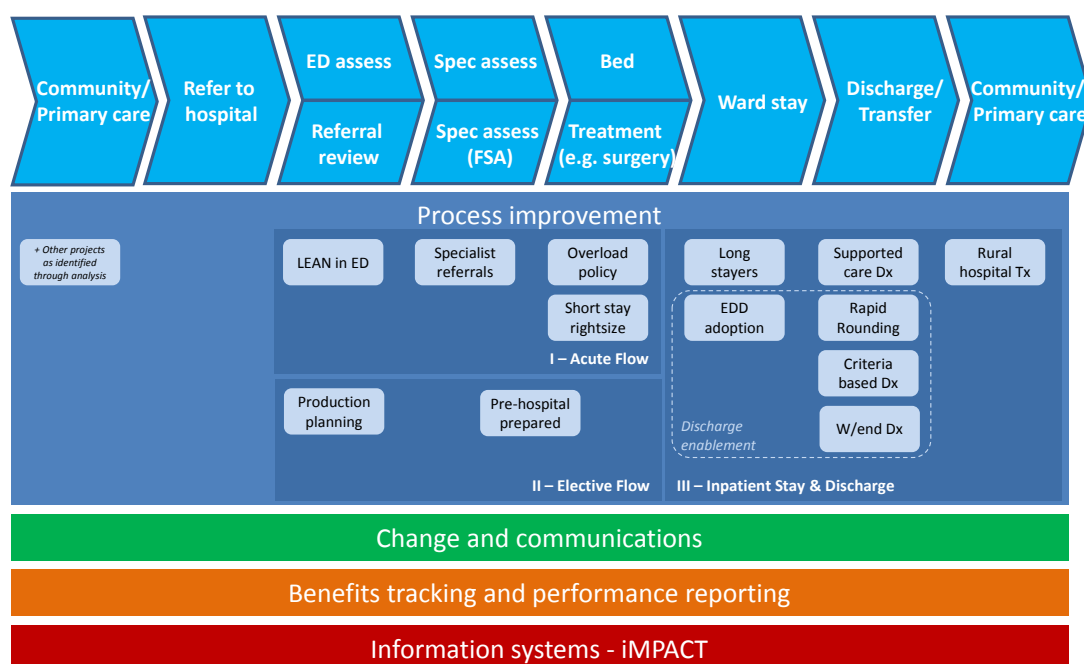
The objectives of the Patient Flow Programme are to:

- Improve patient flow from presentation at ED through to discharge.
- Improve the patient journey by providing the appropriate continuum of care i.e. the right care in the right place at the right time.
- Support the organisation to meet patient service timeliness MoH targets.

Programme approach

The approach for the performance improvement programme has seen the establishment of a number of individual projects to address patient flow problems identified. The initial set of projects was formed by pulling together several existing initiatives and localised problems. Project teams were formed for each of these and assistance from the change team was secured in October 2016 and projects were then managed under the Waikato Way programme management methodology. It was however recognized that the level of familiarity of this team with performance improvement methods (LEAN, six sigma, and co-design) was limited. Some changes were made to embed key principles from improvement science into the project methodology, such as problem statement, key measure and control measurement.

The diagram below shows the process improvement initiatives, as well as the supporting workstreams of Change and communications, Benefits tracking and performance reporting and Information systems. Further detail and current status for each of these projects is covered in the next two sections.



9.7

Achievements and completed initiatives since programme start

Since the inception of the Programme in October 2016, several changes have been implemented:

Initiatives completed (Oct 2016 – May 2017)		
Operationalised full capacity procedures Launched acute flow performance dashboards Established weekly DHB wide demand and capacity meeting Implemented speciality referral guidelines and escalation		
Recently completed initiatives (May 2017 – Sept 2017)		
Initiative	Deliverables	Benefits
Elective Flow – Production Planning Design and establishment The project is to address long standing issues associated with the planning and co-ordination of discharges from the Waikato DHB inpatient services. This lack of planning and co-ordination contributes to increased patient	<ul style="list-style-type: none"> FY18 Delivery plan completed for all volumes in DHB Elective surgery outsourcing requirement defined Theatre master 	<ul style="list-style-type: none"> Bed and theatre capacity planning more integrated with patient volumes Delivery planning learnings incorporated in future production

wait times for elective treatment, and in unforeseen capacity constraints causing budget deficits or patient flow delays.	schedule changes	planning capability (process, team, system)
Elective Flow – Pre Hospital Preparedness (PHP) Optimising the elective patient journey by implementing a protocol driven framework that shifts the preparation aspects to the beginning of the patient's journey. By doing so this ensures patients are prepared and ready for their procedure and cancellation is much less likely.	<ul style="list-style-type: none"> • New form for elective surgery patient information • Dedicated resource for anaesthetic clinics • New process and system changes 	<ul style="list-style-type: none"> • Project was closed 31st July 2017. • Improvements to day of surgery cancellations being monitored • Post project lessons learned being shared
Inpatient Stay and Discharge Phase 1: Discharge enablement for routine discharges: SAFER policy roll out SAFER is an evidence based model drawn from the UK that operates as a standardised set of activities/rules applied in the clinical setting to ensure all patients are allocated an estimated date of discharge (EDD) within 24hrs of admission and that patients are reviewed daily in a structured way.	<ul style="list-style-type: none"> • Launched on 4 September • 'Criteria based discharge' criteria • System changes to enable day before discharge documentation • Revised whiteboard information • Ward rapid rounds 	<ul style="list-style-type: none"> • SAFER launched in September and was well received by staff across the DHB • Project closure underway, lessons learned and recommendations being documented • Significant increase in patients with estimated discharge dates (EDD)

Current projects and project status

Key projects that are currently underway in the programme are listed below, with recent progress updates.

Patient Flow – Current Projects	Progress Updates
Acute Flow - Lean in ED Short stay right size, Waikato Hospital The aim is to enhance the patient flow	<ul style="list-style-type: none"> • Business case completed and approved July '17

Patient Flow – Current Projects	Progress Updates
<p>through ED by increasing capacity in an SSU observation area. This will ensure that low acuity ambulatory patients are located in seats rather than beds, thus freeing bed space in the main department and also reducing overcrowding and waiting times in the waiting room.</p>	<ul style="list-style-type: none"> • Increase SSU by 6 chairs • Relocation of existing radiology equipment commenced • Final minor building work to commence 25.09.17
<p>Acute Flow – ED Improvements Streaming, Waikato Hospital The aim is to improve the flow of patients through the ED department, working with staff to identify opportunities for removal of waste in staff time and the patient's journey.</p>	<ul style="list-style-type: none"> • Re-naming the project “ED Improvements” (formerly Lean in ED) and narrowing down the scope to focus on 2 key areas has re-energized the project. The PM has also taken a number of improvement opportunities provided by staff and used these to engender buy-in e.g. Front of house queuing • A number of staff workshops have been completed to define access criteria, patient flow and resourcing for the “see & treat” process. • The new ‘see & treat’ process was launched on 1 September and will be evaluated after 1 month. • The new triage process is now in development.
<p>Inpatient Stay and Discharge Phase 2: Complex discharges (supported care discharges)</p>	<ul style="list-style-type: none"> • Not started, will follow implementation of Phase 1 (SAFER). • Project manager currently being recruited.
<p>Inpatient Stay and Discharge Rural Transfers Patients from rural areas are spending longer than they need and/or want in Waikato Hospital, causing unnecessary travel and accommodation costs for relatives, isolation from friends and family. This also results in unnecessary stress on Waikato Hospital and under-utilisation of patient beds in rural hospitals.</p>	<ul style="list-style-type: none"> • Co-design paper submitted to Lynne Maher to be presented at Quality forum 30/10 • Admission criteria developed for all rural facilities and district nursing published and on the intranet with road shows completed. • Reporting developed to aid patient

Patient Flow – Current Projects	Progress Updates
	<p>transfers (appendix 4)</p> <ul style="list-style-type: none"> • Reporting - Length of stay and transfer volume data to be used for review in demand and capacity meeting • Virtual rounding process to be designed in spring/summer.
<p>Long stayers Patients with a long length of stay are at times in the hospital unnecessarily, and due to services outside the hospital not being in place or other (non-medical) factors. Regular comprehensive review of these patients, their wishes, and their options outside the hospital can identify and address the reason for their extended stay.</p>	<ul style="list-style-type: none"> • Weekly reporting improved with changes to reason codes • Weekly review of >10 day length of stay patients now included in SAFER bundle
<p>Information Systems - Patient Flow Tool IMPACT We cannot currently provide staff with real-time visibility of patients' journeys and where the patient is at, resulting in: a) Patients experiencing multiple delays in getting the right treatment in the right place at the right time. b) Delays in the patient journey leading to poor patient experiences and increase in the likelihood of poor patient outcomes. c) Delays in discharge leading to longer stays and sub-optimal use of beds. d) Waikato DHB struggles to consistently meet Ministry of Health mandated targets.</p>	<ul style="list-style-type: none"> • Business case was approved by the MOH. • Project has formally commenced and project team established. • Engagement of staff and prototype configuration is the first deliverable. • Deployment will start in Thames Hospital in early 2018, followed by Waikato Hospital, then Mental Health and community care.
<p>Rapid Improvement Event 'Acute medical admission to bed' 3-day process improvement workshop held end of October, with objective to improve the time from 'Decision to Admit' in ED until 'Patient admitted to Ward'. Scope includes Respiratory and General Medicine patients. Process mapping, identification of key reasons for delays, identifying and implementing solutions.</p>	<ul style="list-style-type: none"> • Workshop team formed. • Governance established. • Workshop planned. • Process mapping workshop scheduled.

Patient Flow – Current Projects	Progress Updates
Benefits tracking and Performance reporting	<ul style="list-style-type: none"> • Dashboard has now been developed for Patient Flow Programme • Attached in report appendix

Assessment and next steps

A number of initiatives have been completed and changes made to various parts of the patient flow process. Key learnings for the team have been to ensure there is appropriate support and time available in the services to progress project work quickly. A new project approach using a 3-day workshop format will be trialled in October. This approach, based on Kaizen, has been recognized to work in other organisations where staff time is at a premium and there is difficulty coordinating multi-disciplinary input in problem solving.

Also, as part of project reconfiguration, the Patient Flow Programme governance group have chosen to streamline project effort in ED into two specific initiatives.

Going forward, the iMPACT patient flow manager toolset will require significant input from services, and surgical services will be focused on the surgical re-invention work. Hence new improvement project effort will need to be tailored to support this or tackle areas not covered by either of these two large projects.

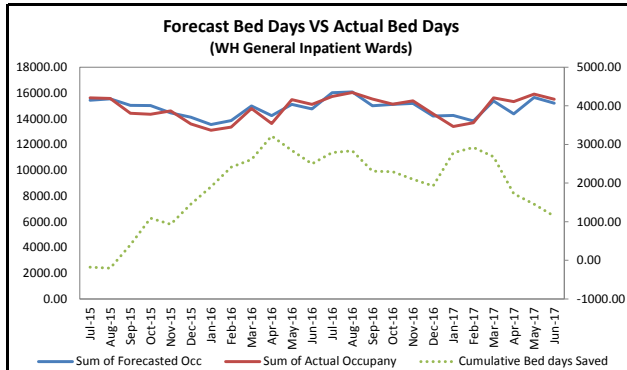
Recommendation THAT

The Committee receives and notes the progress and next steps for the programme

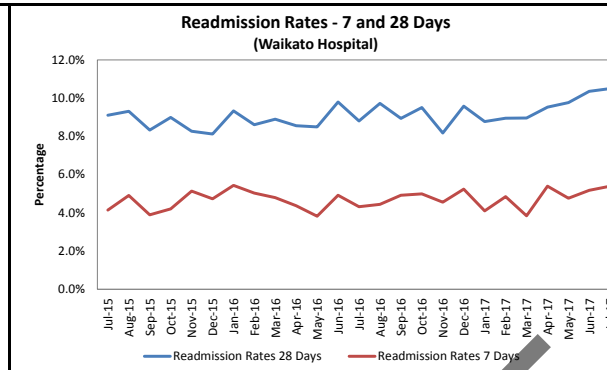
MARC TER BEEK
EXECUTIVE DIRECTOR OPERATIONS & PERFORMANCE

Appendices:

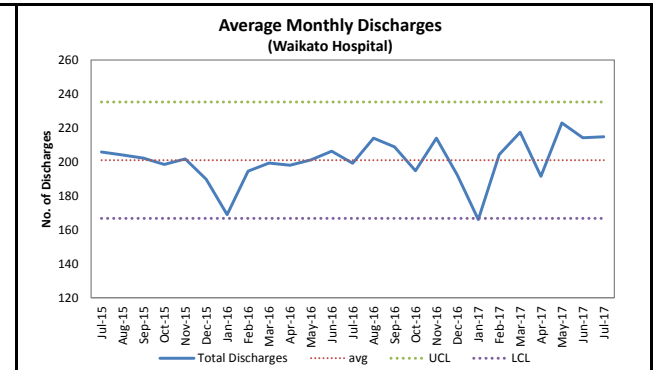
1. Patient Flow Programme Reporting (DRAFT)



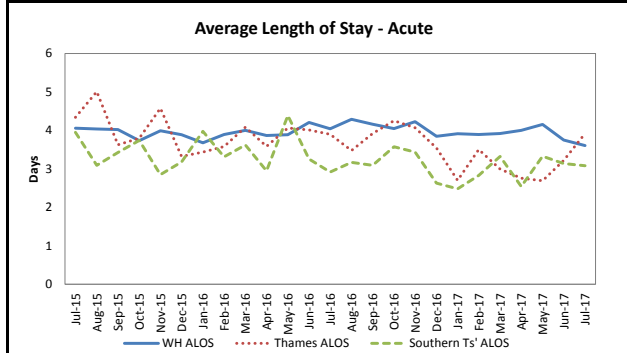
Comments: The graph shows the difference between the Forecast bed days and the Actual bed days. The Actual rolling 12 Month is showing up trend.



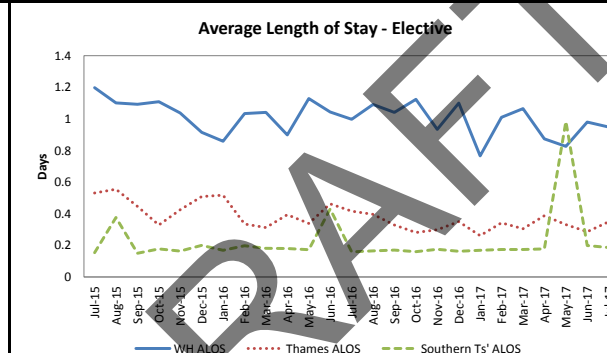
Comments: Unplanned Readmissions is stable, showing some growth.



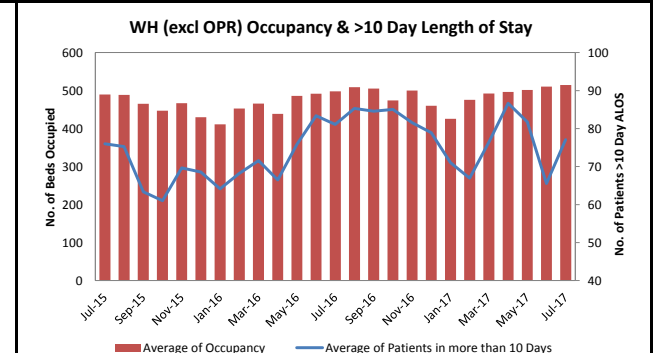
Comments: Total Discharges are following the seasonal pattern with growth



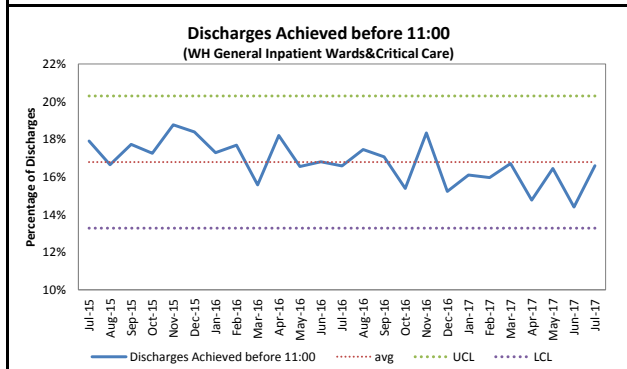
Comments: Acute ALOS is stable with down trend since Nov 2016.



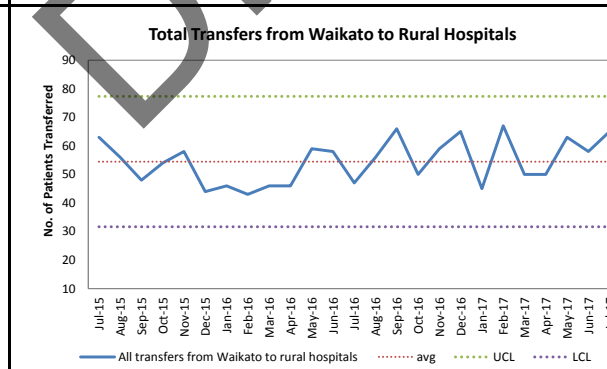
Comments: WH and TH Elective ALOS is stable with down trend since Nov 2016.



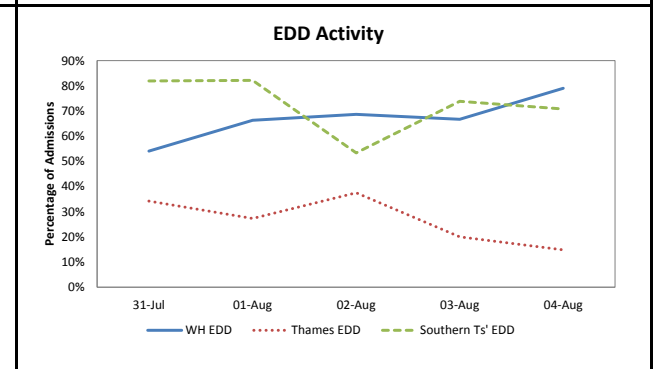
Comments: WH Occupancy and number of patients over 10 days are gradually going up.



Comments: The number of Discharges before 11 am is stable with down trend.



Comments: The number of transfers from WH to Rurals is going up.



Comments: DRAFT Graph, as EDD data officially started to collect from July 2017.

<p>Forecast Bed Days VS Actual Bed Days</p> <p>This graph shows the Actual bed days compared to the forecasted usage (Which was from each year's Bed planning). If the actual is less than the forecast then we will have bed day gain.</p> <p>Operational Definition Actual Bed Days: Sum of Actual Bed Days in a month. (From Costpro)</p> <p>Forecast Bed Days: Based on Bed Planning model (previous years' Actual occupancy modeled by the Delivery plans) , taking from Capplan.</p> <p>Bed days saved: Forecast Bed Days less Actual Bed Days</p> <p>Criteria WH General Inpatient (Cardio Respiratory Services, Internal Medicine, Oncology, OP&RS, Orthopaedics, Paediatrics, Surgery, Womans Health) wards, all specialties.</p>	<p>Unplanned Re admission</p> <p>This graph shows the readmission rate over 7 and 28 days.</p> <p>Operational Definition Re-admission: An unplanned acute readmission as discharged within 28 days. (as KPI Report Method, from Costpro)</p> <p>Criteria All Waikato Hospital wards, all specialties.</p>	<p>Total Discharge</p> <p>This graph shows the Total Discharge of patients from Waikato Hospital.</p> <p>Operational Definition Discharge: Patient Discharged from or last treated in Waikato Hospital. (From Costpro)</p> <p>Criteria All Waikato Hospital wards, all specialties.</p>
<p>Average Length of Stay (ALOS)</p> <p>This graph reflects the Acute ALOS over a period of time.</p> <p>Operational Definition LOS: Days between Acute admission to discharge. (as KPI Report Method, from Costpro)</p> <p>Criteria Waikato, Thames and Southern T Hospitals (Tokoroa, Taumarunui & Te Kuiti), all specialties.</p>	<p>Average Length of Stay (ALOS)</p> <p>This graph reflects the Elective ALOS (Excl Arranged Admission) over a period of time.</p> <p>Operational Definition LOS: Days between Elective admission to discharge. (as KPI Report Method, from Costpro)</p> <p>Criteria Waikato, Thames and Southern T Hospitals (Tokoroa, Taumarunui & Te Kuiti), all specialties.</p>	<p>WH (excl OPR) Occupancy & >10 Day Length of Stay</p> <p>This graph reflects the occupancy across all Waikato Hospital wards (Excl OP&R patients) , and the number of patients have stayed over 10 days in hospital.</p> <p>Operational Definition Occupancy : How many ward beds have been occupied by patients. (From Capplan) LOS: Days between Elective admission to discharge. (From Capplan)</p> <p>Criteria WH General Inpatient Wards, Critical Care and Transit Lounge, all specialties except OP&R.</p>
<p>Discharges Achieved before 11:00</p> <p>This graph reflects the percentage of patients have been discharged before 11 am.</p> <p>Operational Definition Discharge: Patient Discharged from or last treated in Waikato Hospital. (From Enterprise Report)</p> <p>Criteria WH General Inpatient Wards&Critical Care, all specialties.</p>	<p>Total Transfers from Waikato to Rural Hospitals</p> <p>This graph reflects the number of rural patients have been transferred to rural hospitals for further treatment after discharging from Waikato Hospital.</p> <p>Operational Definition Rural Hospitals: Taumarunui ,Thames ,Te Kuiti and Tokoroa</p> <p>Criteria All Specialities (excl Mental Health, Maternity and Gynaecology)</p>	<p>EDD Activity</p> <p>This graph reflects the percentage of patient admissions with an EDD (Estimated Date of Discharge) assigned.</p> <p>Operational Definition EDD : Estimated Date of Discharge (EDD) recorded in iPM and the patient whiteboard within 24 hours of admission, to facilitate discussions with the multidisciplinary team and the patient/whanau.</p> <p>Criteria Waikato, Thames and Southern T Hospitals (Tokoroa, Taumarunui & Te Kuiti), all specialties.</p>



9.8

**Next update at
December
meeting**

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE 11 OCTOBER 2017

AGENDA ITEM 9.9

CBD ACCOMMODATION UPDATE

9.9

Purpose	1) For information
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General

Since the last update in June, the Board approved additional funding in July to an aggregate project cost of \$14,700,000 for the clinical and workspace fit outs.

Landlord work on site is progressing well with the future physical appearance of the building now apparent with the new curtain wall in place, external sun shade structural elements and verandahs will follow over the next month.

DHB project work streams continue to be focussed on translating user requirements into developed design. User group feedback and input has been very positive.

We expect key users groups to have signed off their requirements and plans by mid-October.

On completion of detailed design, final pricing will be completed in December.

Lessor Program

Lessor works incorporating the podiums new façade and seismic upgrading is very close to completion. Focus will turn in October to vertical transportation, services and construction of bathrooms and other amenities under the lessors works program.

DHB Fit Out Program

Commencing in February 2018 hard fit out will commence with partitioning and ceiling works.

Delivery of phased occupation of site is expected from September 2018 aligned to current site lease expiries.

Activity Snapshot Dashboard

Key Element	% Complete	Status	Comments
Lessor Base Build - Building Fabric	90%		<ul style="list-style-type: none"> New building façade now in place Seismic upgrade for the podium now above 80% NBS, further uplift pending completion of works to the associated office towers
Lessor Base Build - Services Works	50%		<ul style="list-style-type: none"> To be integrated with Tenant fit out On track, noting bulk of work takes place Q1 2018
Fit out concept design	100%		<ul style="list-style-type: none"> Structure plan and key space allocations completed
User Group Sign Offs	80%		<ul style="list-style-type: none"> Approval from user groups is well advanced
Detailed Design	25%		<ul style="list-style-type: none"> November target on track Services design well advanced Governance Group to sign off
Final pricing based on detailed design	-		<ul style="list-style-type: none"> December target on track Governance Group to sign off
Fit out construction commencement	-		<ul style="list-style-type: none"> February target on track
Business Support Planning	-		<ul style="list-style-type: none"> Facilities management, security, parking and transport planning underway
Budget	6%		<ul style="list-style-type: none"> Spend to date aligned with spend plan for consultants appointed to the Project Control Group
There are no red flags			

Fitout Design

The design team is led by Jasmax Architects under the direction of our Project Director within our Project Control Group.

Design Themes

While work in progress, the foregoing imagery, focused on practical space planning and development, finishes proposals and layout configurations provide flavour and current direction of travel. These also indicate the scale and complexity of the facility. Further development and iterations of the design are under development and are to incorporate Maori and consumer inputs and themes.

Plans and Graphical Materials

These are included as Appendix One.

Recommendation**THAT**

The Committee notes the content of the report.

CHRIS CARDWELL

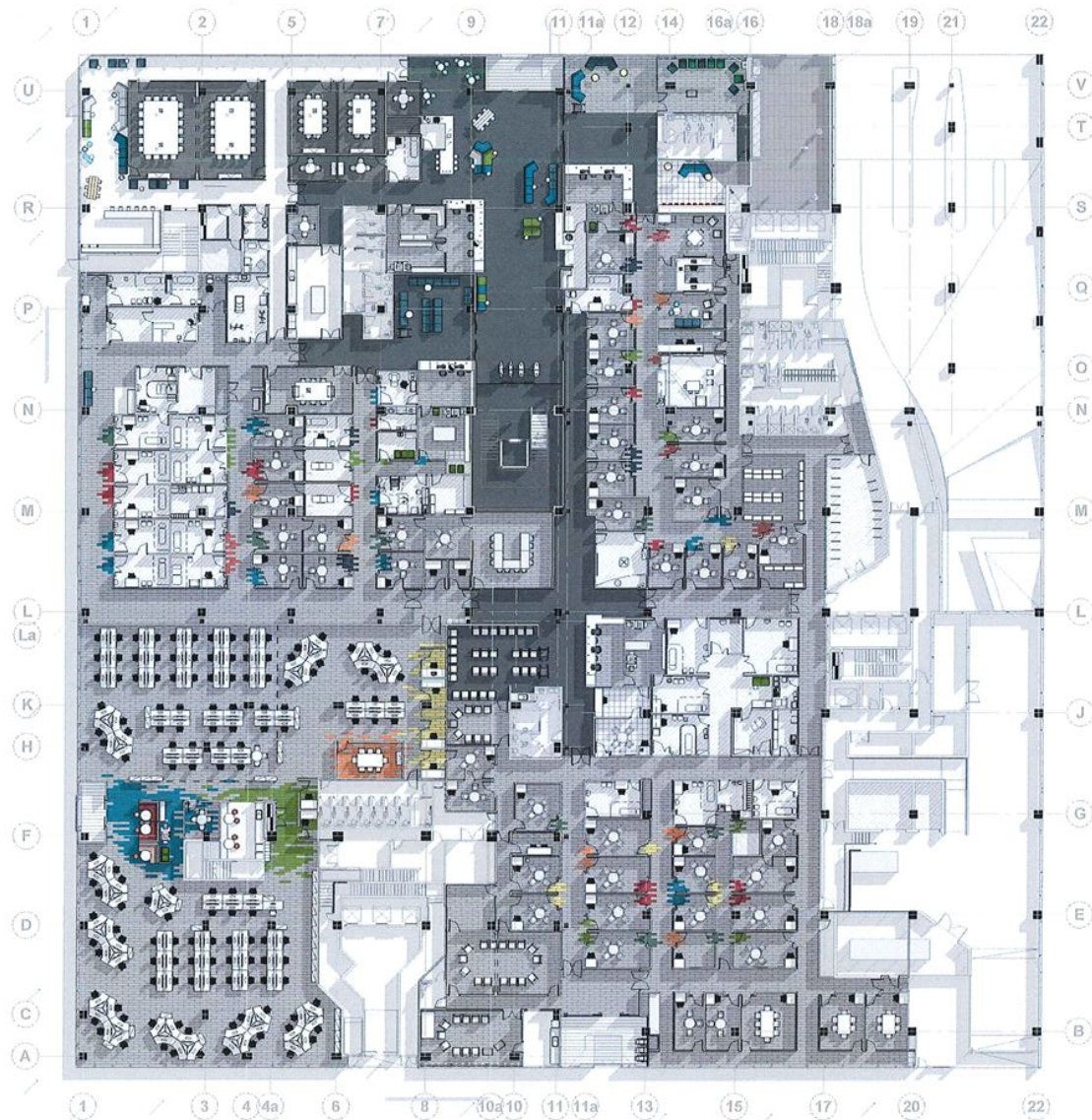
EXECUTIVE DIRECTOR, FACILITIES AND BUSINESS

7.0 Ground Floor

7.11 Floor Finishes plan

The floor finishes are a mix of tiles in public spaces and service receptions with vinyl and carpet to the clinical spaces and carpet to the workspace.

Colour is used to identify entrances into clinical and interview rooms and around shared meeting and beverage bays.



7.0 Ground Floor
7.3 Main Foyer and Enquires

Jasmax



9.9

3.0 Mental Health Design
Imagery of Nature

Jasmax



9.9

7.0 Ground Floor
7.5 Clinical Corridors and Wayfinding



9.9

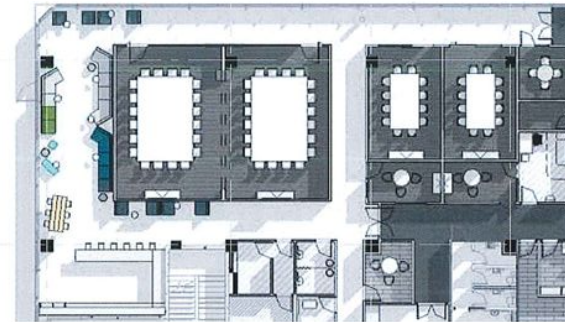
7.0 Ground Floor

7.7 Client Meeting and Kitchenette plan and finishes

A range of client meeting rooms and a kitchenette for catering and meeting breakout are provided within close proximity to the main entry.

These spaces have AV and conference facilities with acoustically designed walls and ceilings.

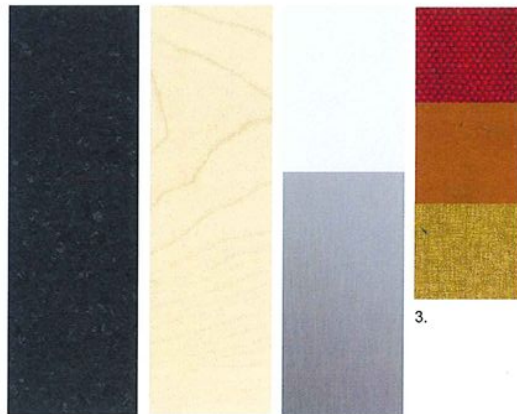
The 'look and feel' is more formal, the use of colour in furnishings and acoustic treatment to the walls while the base palate is neutral with the warmth of timber joinery.



5.



5.



4.

1. Vinyl flooring
2. Ply, Stainless Steel & LPL Joinery
3. Upholstery
4. Wall Colour
5. Precedent Imagery

1.

2.

3.



4.

1. Carpet flooring
2. Ply Joinery
3. Upholstery
4. Wall Colour
5. Precedent Imagery

1.

2.

3.

7.0 Ground Floor

7.8 Clinical Reception and Waiting Areas plan and finishes

The Reception spaces for Adult Mental Health, ICAMHS and Diabetes have been designed with a similar look and feel to the main enquires counter. This will assist in outpatient wayfinding when entering the building for the first time.

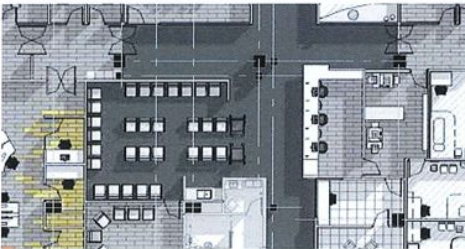
Each of the Waiting areas have been designed individually to suit the need of the outpatients specific to the service. For ICAMHS, we have allowed a separate childrens area with a play space and a teenage area with a bar learner and phone charging points. For Diabetes bariatric seating has been allowed for and individual seating for the Adult Mental Health waiting space.



Diabetes



ICAMHS

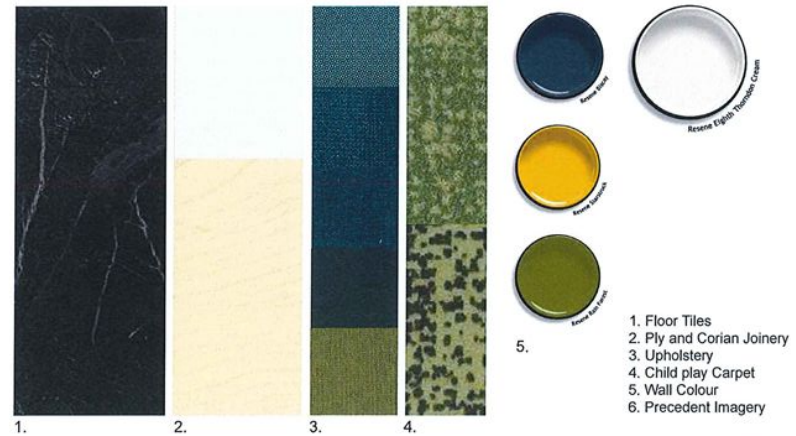


Adult Mental Health



5.

Jasmax



1. Floor Tiles
2. Ply and Corian Joinery
3. Upholstery
4. Child play Carpet
5. Wall Colour
6. Precedent Imagery

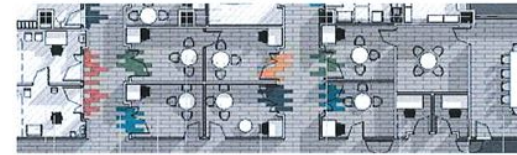
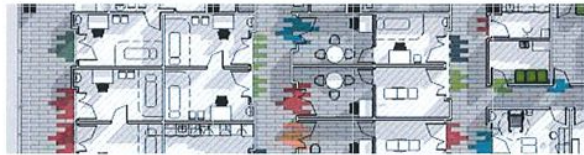
7.0 Ground Floor

7.9 Clinical Spaces and Interview Rooms plan and finishes

Jasmax

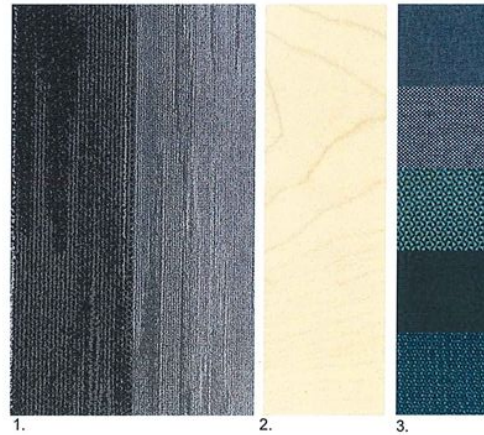
The clinical spaces are designed in accordance with the AHFG Room Data Sheets and with alignment to Waikato DHB services requirements.

The 'look and feel' is relaxed the use of colour in furnishings and acoustic treatment to the walls while the base palate is neutral with the warmth of timber joinery.



3.

1. Vinyl flooring & Vinyl highlights
2. Upholstery
3. Wall Colour
4. Precedent Imagery



4.

1. Carpet flooring
2. Ply Joinery
3. Upholstery
4. Wall Colour
5. Precedent Imagery

9.9

8.0 Level 1

8.10 Floor Finishes plan

Carpet tiles are allowed for throughout the Level 1 workspace with vinyl flooring to the staff kitchen and beverage bays.

Colour is used to identify both formal and informal meeting spaces and soft seating near to the beverage bays.



7.0 Ground Floor

7.10 Staff Workspace finishes

Jasmax

The staff workplace is a special area, the base building has high ceilings and a central stair linking the floors. Teams are placed around the perimeter to maximise the natural light. Bright colours are used for furniture and carpets in the meeting and beverage bays, with lighter grey carpets in the staff work areas. Screens have been allowed for between the teams with a mix of mesh screening, pinboard and whiteboards. All services are exposed with acoustic baffles to the underside of the floor above.



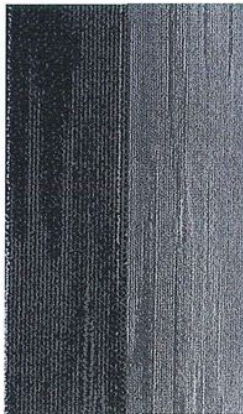
6.



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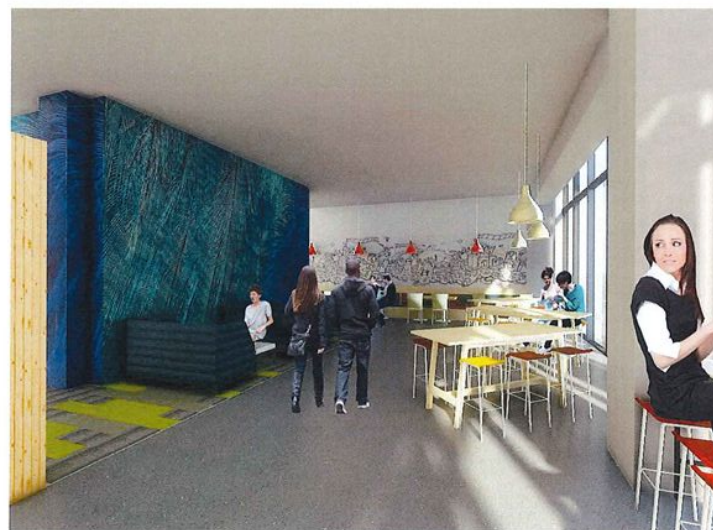


5.



1. Ply Wall Lining
2. Glass
3. Carpet
4. Upholstery
5. Wall Colour
6. Precedent Imagery

8.0 Level 1
8.3 Staff Kitchen



9.9

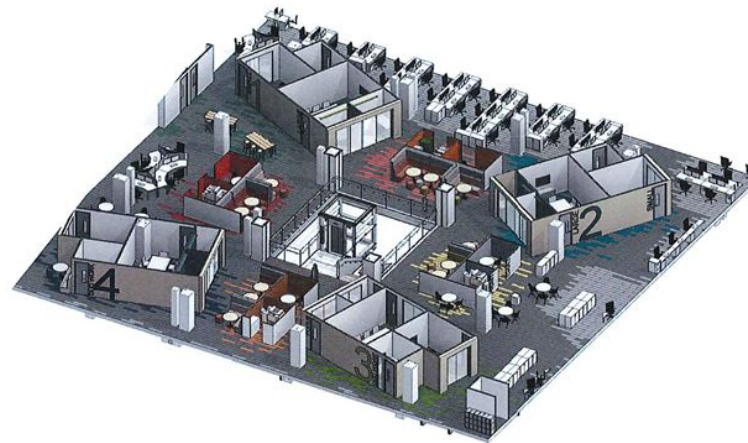
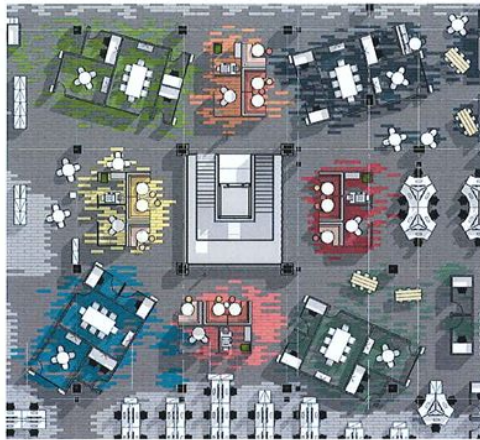
8.0 Level 1

8.4 Central Core plan and finishes

Jasmax

The busiest space in the building, the central stair links the ground floor and level 1. Surrounding this stair are standardised meeting pods, huddle and utility bays. Radiating out from these pods are a collection of collaboration spaces with a mixture of seating styles and sizes. Located centrally are drop in workpoints.

The look and feel is bright pops of colour interlinked with warm timbers. Fixed wall heights are in layers with huddle and utility bays at 1500mm high, meeting pods at 2950mm high, and the ceiling level maintained at 4235mm with exposed services.



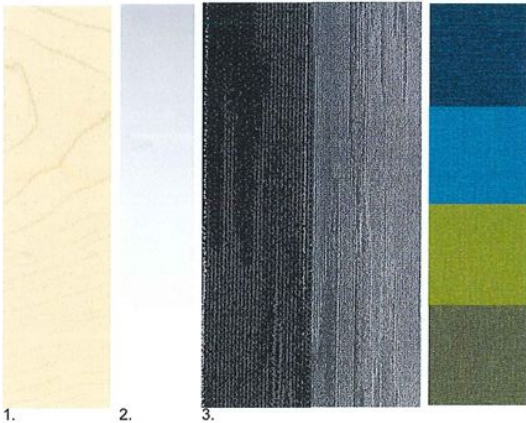
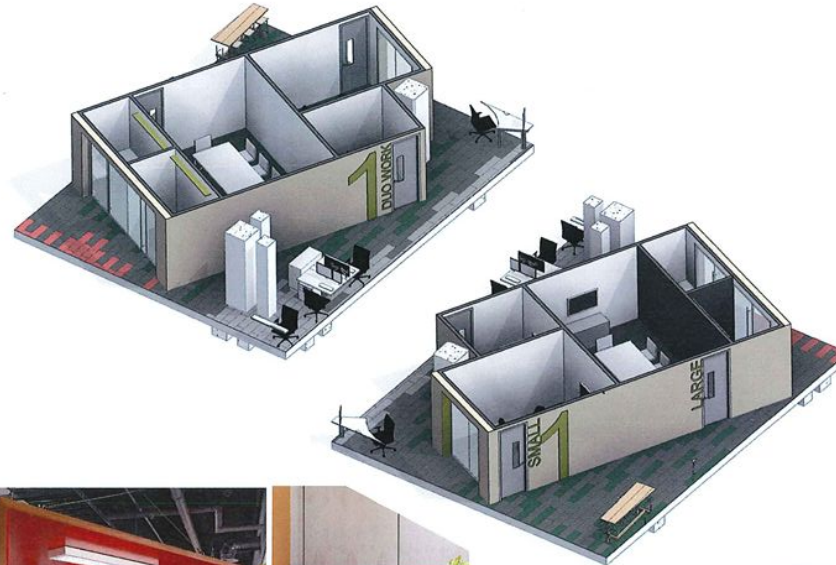
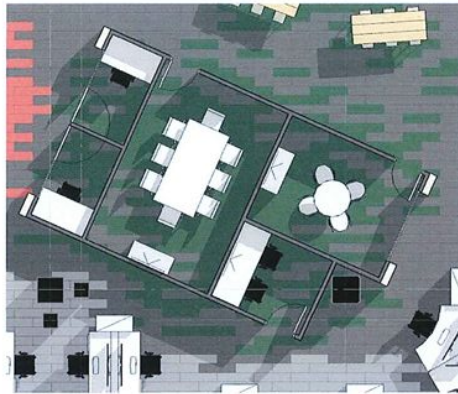
8.0 Level 1

8.5 Meeting Room Pods plan and finishes

Jasmax

Standardised meeting pods align the central core and circulation pathways. Each pod has a 6-8 person meeting room, 4 person meeting room and an enclosed dual tele-conference room. The intent is all rooms within the pods will have AV and conference facilities. These meeting pods are shared by all of the teams on level 1.

The finishes are timber to the exterior, a bold cooler colour is assigned to each pod to assist with way-finding and the interior of the spaces have a mix of coloured acoustic panels and whiteboards to the walls, carpet tones tie into the acoustic panels and fabric tones. The interior ceiling height is 2600mm.



1. Ply Wall Lining
2. Glass
3. Carpet
4. Upholstery
5. Wall Colour

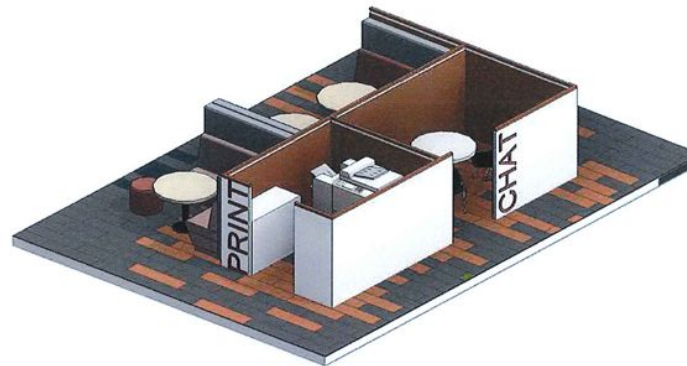
8.0 Level 1

8.6 Huddle and Utility plan and finishes

Jasmax

Standardised huddle and utility pods are the centralised home of copiers, an informal chat meeting space and 4-8 person informal meeting booths. These pods are shared by all of the teams on level 1.

The finishes are concrete look to the exterior to align with the base building, with bold use of warm colours to the interior of the bays, carpet tones tie into the paint and fabric tones. The walls are just 1500mm high.



1.



2.



3.



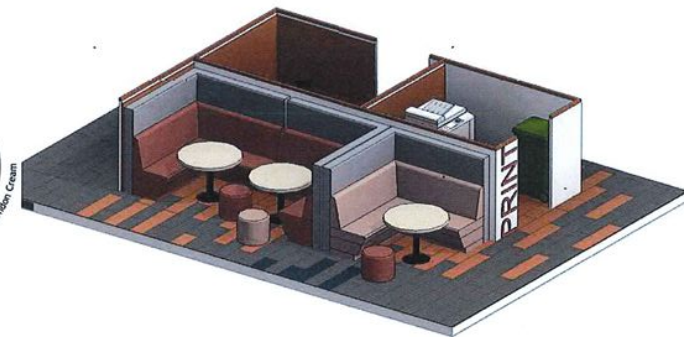
4.



5.



1. Way-finding
2. Carpet
3. Furniture
4. Upholstery
5. Wall Colour



8.0 Level 1

8.11 Precedent Images

Some 'look and feel' images for the Level 1 spaces, using soft master palette of colours with bold colour within the graphic imagery and way-finding.

Jasmax



9.9

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE 11 OCTOBER 2017

AGENDA ITEM 9.10

PRIMARY CARE INTEGRATION

9.10

Purpose	1) For information
----------------	--------------------

Development of a primary and community care plan

On the 25th of August 2017 two workshops were held to discuss Primary and Community care and some of the key challenges facing the broader sector in terms of demand. The workshops were separated into two sessions to enable General practitioners and pharmacists who would not otherwise be able to attend a day time session to be involved.

There was good turnout across the two sessions. Attendees at the workshop included General practitioners, pharmacists PHO representation, Community Pharmacy group, aged care, urgent care practitioners, community health services, St Johns, K'aute Pasifika, South Waikato Pacific Island Community Group, Te Kohao, Raukawa, Board members and a range of DHB staff.

These workshops were facilitated by Graham Scott who provided valuable insights into the challenges that were being faced. A summary of the feedback from the workshop is attached as Appendix A.

Brief discussion has occurred at the Waikato inter-alliance forum with agreement that a smaller group would be established to identify the appropriate next steps. These are expected to be finalised at the Inter-Alliance forum at the beginning of November 2017 and will be reported back to the December 2017 Health Strategy Committee.

Review of emergent and urgent care

Terms of reference for a review of emergent and urgent care across the district are currently being developed. This will consider the model of care that is in place across the district and the extent to which this appropriately meets the needs of the Waikato population. The terms of reference should be finalised before the end of the calendar year with the review completed by the end of June 2017.

Recommendation

THAT

The Committee notes the content of the report.

DAMIAN TOMIC
CLINICAL DIRECTOR
PRIMARY AND INTEGRATED CARE

JULIE WILSON
EXECUTIVE DIRECTOR
STRATEGY AND FUNDING

Primary Care – Feedback Summary

Daytime Workshop

Session One – Present and Future

Blockages/ Issues

- Health literacy
- Social determinates – Poverty/Housing/Education
- Cost
- Sometimes providers too close to Whanau
- Fatalism
- Silos – struggling with integration
- Survival mode
- Enrolment
- Patient behaviour – not putting self first – not self managing
- Transport
- Insufficient Maori rep in workforce
- Institutional racism/bias
- Models of Care – pakeha centric
- VLCA – abuse of funding?
- Dental access

Solutions

- Community Nurse and social work teams
- Shared care records
- Workforce matched to population
- Incentivisation (Comm/provider)
- Social investment approaches
- Education – parenting etc
- Navigation
- Cultural competency
- Strengths based approaches to changing behaviour
- Locality based services
- Improving patient choice
- Building relationships with Iwi
- Strengthening relationships between services
- Using Iwi to spread message
- Bottom up health literacy – teach kids then whanau
- Direct funding for scripts from WINZ
- Housing WOF/ Policy support/sugar tax
- Living wage/policy support/sugar tax
- Funding following patients vs VLCA
- Longer appointments
- Food/nutrition education
- Funding for driving training

Session Two – Acute Demand

Blockages/Issues

- System is geared toward episodes of care – not maintenance
- Affordability/perceived cost

- Funding system is not supporting primary practice sufficiently
- Triage in community
- Is acuity increasing because: Iller, Demographics, Less Health Literate
- Patient bouncing across system – acuity
- Driven by unmanaged social determinants
- Capacity (workforce) still chronic
- Transport
- Patient behaviour
- Cultural competencies
- Attractiveness of ED

Solutions

- Better screening and support from Pharmacy
- Wound maintenance at pharmacies/triage/minor issues
- Better shared care record
- Services going to patient
- Practices to better engage community and social services
- Improving continuity of care – often young and generally well drop off
- Better telephone triage
- Health literacy
- Improve CSC uptake
- IT solutions
- Focus on oral health – turning up at ED for pain management

Session Three – Inequalities

- Maori navigation would be useful across the system
- Need to work around Maori view of hospitals being places to die
- Continually look at service through pakeha lens
- Whanau ora
- Intersectorial work – health homes – smoking cessation – poverty (barrier)
- Targetted funding does work
- Rural and urban service models
- The way we work
- Better training to workforce
- Pacifica and refugee
- System itself creates inequality
- Take services to the people
- Accept data and do something to make a difference
- Connections – between BMFM and mainstream, social services
- Committing to cultural competency
- Contracting must be more Maori-centric
- Early interventions
- Enrolment in primary care
- Institutional racism/bias – cultural change
- Social media usage
- Best use of communications targeting + using role models
- Improving transportation
- Understand how Maori want to engage
- Negative language used in health eg non-compliant
- Right to good health – sad fact that people accept fate
- Maraes as healthcare destination
- Maori workforce environment

- Contracts are not culturally safe – pakeha perf reference
- Where are the community leaders in Maori health
- Clinical focus only has 30% impact – 70% relates to social determinants – employment – talk to contract holders about influencing living wage and composition

Session Four – Mental Health

- Whanau-centric
- More GP involvement
- Social isolation – better use of technology
- Transition back needs to be stronger
- Early identification and prevention
- Technology driver of bullying
- Community based interventions
- Better AOD
- Hubs in community
- Hidden conditions – personality disorder
- Negative impacts of medications
- Mental health services become a catch all
- There is no health without mental health
- We need holistic approaches to health and wellbeing
- 40% of population experience mental health episode
- 50% of Maori experience mental health episode
- Improving awareness and destigmatised
- Note that mental health takes time
- Mental health conditions are ok
- The more we lock up the more ill we create
- Better integration between primary and secondary care
- GP training – do we have enough for mild to moderate

Building resilience

- Co-location of day care and elder care
- In working families – kids raise themselves – this is creating a lack of resilience

Resourcing

- Continues to be an issue

Evening Workshop

Session One – Key Themes

- Health literacy – ensuring people know what is available and what options there are in accessing care and advice – navigation
- Re-thinking service configuration – consumer driven
- Fragmentation of services
- Integrated health records
- Intersectorial approaches
- Developing approaches to different populations
- Joint governance
- Incentivising
- Planning based on future demographic change
- Access –time of availability – rural – cost as a barrier – urban difference – about the person not the system
- Wellness approaches – allowed not incentivised by capitation
- ED growth – linked to access
- IT – better linkages and utilisation – better sharing of data
- Contracting models – do they ensure responsiveness
- Integration within DHBs is poor – messaging to communities need to improve
- Funding models
- Social determinants cant be addressed with clinical responses – better links health and social
- We need stronger clinical networks that link technical capability to community providers and vice versa
- Contracts too rigid for holistic care
- Family based systems of care works – not service fee based system
- We are driven by how we provide services – not what is needed
- Strategic communication – changing behaviour and what is expected
- Wastage – to address
- Supply and demand – workforce – changing nature of provision – solutions require investment in scale

9.10

Session Two – Acute Demand

- ED redirection
- Affordable urgent care
- Access to appointments
- Senior medical triage – streamlining
- Increased nurse practitioners
- Stronger mental health in community support
- Strengthening primary options
- Funding models – not ideal to stop referrals and walk in – it should focus upstream
- Our system – worsens peoples acuity
- Need for GP service close to ED front door
- Workforce appropriate to community need
- No capacity in primary care for acute – disputed – it is changing/ exists un some practices
- Rural and urban differences
- Money barrier to care
- 'Earlier intervention'

- Advance care planning
- Wellness approaches
- Expectations – managed
- Skilled community networks
- Building life resilience

Communications and Health Literacy

- Changing how and why people use ED
- Population doesn't understand 'acute'
- Need to change peoples' perspective of ED care better

Prevention

- Prioritisation population
- Social determinants focus
- Upstream investment



Priority Programme Plans



No papers for information



General Business



**Date of next
meeting
13 December 2017**