Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**AGENDA** Held on Thursday 5 November 2019 Lecture room, CSSB, Wairarapa DHB 10.30am
COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE	**PUBLIC SESSION**

	Item	Action	Presenter	Min	Time	Pg
1. PROCEDURAL BUSINESS						
1.1	Apologies	ACCEPT	Derek Milne	10min	10.30am	
1.2	Continuous Disclosure 1.2.1 Interest Register 1.2.2 Conflict of Interest	CONFIRM / ACCEPT	Derek Milne	"		
1.3	Minutes of Previous meeting	APPROVE	Derek Milne	"		
1.4	Schedule of Action Points		Derek Milne	"		
1.4.1	Work programme					
2. DISCUSSION						
2.1	Strategic Direction update	DISCUSS	Sandra Williams	40min	10.40am	
2.2	Pacific Health Action Plan	DISCUSS	Sandra Williams	10min	11.20am	
3. INFORMATION						
3.1	Regional Public Health report	NOTE	RPH rep	10min	11.30am	
3.2	Local Mental Health work update	NOTE	Sandra Williams	10min	11.40am	
3.3	Regional Growth Framework (Greater Wgtn Council) - planning for the population growth in the wider region	NOTE	Sandra Williams	10min	11.50am	
3.4	Review – 48hr Readmissions	NOTE	Sandra Williams	5mins	12.00noon	
3. OTHER						
3.1	General Business			10min	12.05pm	
CLOSE						

Wairarapa CPHAC INTEREST REGISTER

AS AT 29 NOVEMBER 2019

Name	Interest
Mr Derek Milne *Chair*	• Member of 3DHB DSAC • Brother-in-law is Chairman of Health Care NZ • Daughter, GP at Masterton Medical Ltd (MML)
Mr Alan Shirley *Member*	• Member, Wairarapa District Health Board • Member, Wairarapa, Hutt Valley and CCDHB DSAC • Surgeon at Wairarapa Hospital • Wairarapa Community Health Board Member • Wairarapa Community Health Trust Trustee (*15 September 2016)*
Ms Jane Hopkirk *Member*	• Member, Wairarapa District Health Board • Member, Wairarapa, Hutt Valley and CCDHB Disability Support Advisory Committees (30 March 2016) • Member, Wairarapa Te Iwi Kainga Committee • Analyst, Takiri Mai Te Ata, Kokiri Hauora
Ms Kristina Perry *Member*	• Member, Wairarapa Te Iwi Kainga Committee
Dr Nicholas Crozier *Member*	• Board Member Compass Health • Branch Medical Advisor ACC • GP Masterton Medical • Board Member Cancer Society
Diana Sotiri *Member*	• Member of Wairarapa DHB's Consumer Council

Wairarapa DHB Executive Leadership Team - Interest Register

Name	Interest
Dale Oliff *Chief Executive Wairarapa DHB*	• No interests declared
Sandra Williams *Acting Executive Leader Planning & Performance*	• No interests declared
Jason Kerehi *Director Maori Health Wairarapa DHB*	• Negotiator – Rangitane Settlement Negotiations Trust • Trustees – Rangitane Tu Mai Ra – Post Settlement Governance Entity • Partner is employed as a school nurse by Compass

COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE **PUBLIC**

Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**MINUTES** Held on Tuesday 24 October 2019 Lecture room, CSSB Wairarapa District Health Board 9.00am
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE	**PUBLIC SECTION**

PRESENT

Derek Milne	Chair
Nick Crozier	Member
Jane Hopkirk	Member

ATTENDANCE

Dale Oliff	Chief Executive, Wairarapa District Health Board (CE)
Sandra Williams	Acting Executive Leader Planning & Performance (ELPP)
Jason Kerehi	Executive Leader, Māori Health (ELMH)
Joanne Edwards	Service Development Manager, Planning & Performance (P&P)
Lisa Burch	Service Development Manager, Planning & Performance (P&P)
Jen Bergantino	Minute taker, Planning & Performance

Diane Sotiri, a representative from the Consumer Council, was in attendance.

1.0 PROCEDURAL BUSINESS

1.1 APOLOGIES

Apologies were received from Alan Shirley (Member) and Kristina Perry (Member).

1.2 CONTINUOUS DISCLOSURE

1.3 CONFIRMATION OF MINUTES

RESOLVED
MOVED Derek Milne **SECONDED** Nic Crozier
CARRIED

The following correction is to be made to the Minutes as follows:

Item 2.1 Presentation from Wairarapa PHO – Note that the Chair would like to know what is the PHO's end state vision and milestones for Health Care Homes at the end of 5 years. This is to be reported regularly to CPHAC by way of quarterly reports on progress reports including performance indicators.

DRAFT

COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE **PUBLIC**

2.0 DECISION

2.1 COMMUNITY AND PUBLIC HEALTH COMMITTEE REFRESH

NOTE that for particular meetings the DHB may co-op different people into the meeting dependent upon the agenda and expertise that is required.

NOTE that it would be beneficial to have a PHO representative, whom has an overview of primary care, on the committee as well as a primary care clinician.

NOTE that it was suggested that two Māori representatives, one from each iwi, be appointed members of the committee. The Executive Leader Māori Health informed the committee that Iwi Kāinga is in the process of refreshing themselves. Jane Hopkirk advised that with more Māori sitting around the table our decisions would be better informed.

AGREED that there should be two Māori representatives for this committee.

NOTE that the minutes from the Alliance Leadership team (ALT) meetings are to be presented at this committee. The Chief Executive advised the Committee that the ALT is currently being refreshed and a discussion with the ALT Chair, Bob Francis, has already taken place.

NOTE that regular reporting from the PHO, on what they are undertaking and progress, should be reported back through this committee.

NOTE that IT and innovation is what the DHB needs to be thinking about for the future.

NOTE the terms of reference reflect the statutory responsibilities of a Community and Public Health Advisory Committee as set out in the New Zealand Health and Disability Act 2000.

NOTE the proposed meeting schedule of up to 10 meetings per year (monthly except for January and December).

NOTE the proposed work programme.

AGREED to recommend to the Board its endorsement of the Terms of Reference.

AGREED to recommend to the Board additional members for the Committee be appointed.

2.2 WAIRARAPA DHB 2019/20 TOBACCO CONTROL PLAN

Jane Hopkirk declared a conflict of interest. The sub-regional provider Tākiri Mai Te Ata is a whanau ora collective with multiple services. She is currently working in the collective in the whanau ora service and is not part of the Regional Stop Smoking Service.

TAKEN AS READ.

NOTE that the DHB receives funding from the Ministry of Health for the planning and coordination of activities designed to reduce the uptake of smoking and support current smokers to quit.

NOTE that in 2019/20 the DHB intends to consolidate its health promotion activities and significantly increased support for Māori, particularly whanau with babies.

AGREED to endorse to the Wairarapa Board the approval of the 2019/20 Tobacco Control Plan.

Jane Hopkirk moved the recommendations.

Jane Hopkirk left the meeting 10.00am

NOTE that the use of vaping and other therapies used to help people quit smoking is evolving and over time may change. Wairarapa DHB will ensure it keeps up to date with the recommended therapies and treatments.

Action: Executive Leader Planning & Performance is to provide the Committee with a revised prioritised list of actions out of the tobacco control plan.

COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE **PUBLIC**

3.0 INFORMATION

3.1 STRATEGIC DIRECTION FOR THE WAIRARAPA DISTRICT HEALTH BOARD

ENDORSED the work underway on the plan to outline the strategic direction for health services in the Wairarapa and the timeframes for delivery with final versions approved in March 2020.

3.2 3DHB PACIFIC HEALTH ACTION PLAN UPDATE

NOTE the progress made to develop a draft 3DHB Pacific Health Action Plan to guide the work of the Wellington Sub-Region in attaining optimum health outcomes for its Pacific communities.

NOTE that the plan will come through the committee for endorsement

3.3 ADMISSIONS OF PEOPLE 65+ TO ED AND READMISSIONS FOR OLDER MAORI

NOTE the rate of ED visits for Māori 65+ has been increasing over the past 3 years and is higher than the rate of ED visits for other older people.

NOTE that there is no significant difference between the proportion of older Māori who present to ED and are admitted to hospital and the proportion of older others who present to ED.

NOTE that all readmissions of Māori 75+ for the year 2017-18 have been reviewed by a senior RN who has concluded that readmission rates for this group does not display cultural inequity.

Action: Provide a copy of the Rapid Readmissions report prepared by Michele Halford, Executive Leader Nursing, to the CPHAC members.

MEETING CLOSED AT: 10.45am

Reopened Public meeting at 10.55am
MOVED from Public Excluded meeting - *Feedback on Item 2.1 Child and Youth.*

NOTE that the DHB is working with Featherston School, Meta Riddiford Kindergarten and Featherston Medical Centre to implement a school based telehealth service for these two schools.

NOTE that planning for the longer term for the Masterton iMOKO schools is underway.

MEETING CLOSED AT: 11.00AM

Date of next meeting: 5 December 2019

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

DATED this day of 2019

DEREK MILNE
Chair, Community & Public Health Advisory Committee (CPHAC)
Wairarapa District Health Board

DRAFT

WAIRARAPA DISTRICT HEALTH BOARD PUBLIC CPHAC

Schedule of Actions

Meeting Date	Action	Person Responsible	Status
24 October 2019	Provide the Committee with a revised prioritised list of actions out of the tobacco control plan.	Executive Leader Planning & Performance	Plan is being revised in line with the Boards recommendations
24 October 2019	Provide a copy of the Rapid Readmissions report, prepared by Michele Halford Executive Leader Nursing, to the CPHAC members.	Executive Leader Planning & Performance	Agenda Item 3.4 mtg 5 Dec

Community and Public Health Advisory Committee Work Programme

This programme will continue to be updated in line with the new Strategic Direction work

	October	November	February	March	April	May	June	July	August
System and service planning	-Strategic Direction -Pacific Health Strategic Refresh -Tobacco Control Plan	-Pacific Health -Strategic Direction -Maori Health	-Annual Plan -Strategic Direction	-Maori Health -Annual Plan -Clinical Services/ Wellbeing Plan -Planned Care	-Annual Plan	-Annual Plan -Maori Health	-Clinical services and Wellbeing Plan - System Level Plan	-Equity Approach - Long term conditions	-Clinical Services and Wellbeing Plan
System & provider performance		-Regional Public Health	-Health of Older People - Health Equity report	- SLM and Alliance - Primary and Community	- Mental Health and addictions	- Child and Youth (includes oral health) -Planned Care	- SLM and Alliance	-Pacific -Maori	-Regional Public Health
Investment and prioritisation						-Investment & Prioritisation	-Investment & Prioritisation		

PUBLIC

Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**CPHAC DISCUSSION PAPER**
	Date: 27 November 2019
Author	Sandra Williams, Acting Executive Leader Planning & Performance
Endorsed By	Dale Oliff, Chief Executive
Subject	**Strategic Direction for the Wairarapa District Health Board**

RECOMMENDATION

It is recommended that the Community & Public Health Advisory Committee:

NOTES the work underway on the plan to outline the strategic direction for health services in the Wairarapa and the timeframes for delivery with final versions approved in March 2020.

1 PURPOSE

The purpose of this paper is to update the Community and Public Health Advisory Committee (CPHAC) on the work underway to develop a plan outlining the strategic direction for health services in the Wairarapa DHB. CPHAC will be kept abreast of the work as it progresses.

2 BACKGROUND

There are a multitude of documents about the Wairarapa direction, many of them produced some years ago including the last strategic plan. As outlined by the Chief Executive in her report to the September Board meeting in order to support the DHB into the future a transformation strategy is needed to guide the development of a clinical services and well-being plan for the Wairarapa. The Pacific Strategic Health Plan refresh and the development of a clear strategy for Maori will also support our new strategic direction for health services.

The Pacific Health Plan is a joint 3DHB plan and during November is being considered by all three District Health Boards. The Wairarapa Board considered and approved the plan at its meeting on the 25 November 2019. The plan is on the agenda for CPHAC for information this month as a key support for our vision for change.

3 THE DEVELOPMENT OF THE STRATEGIC DIRECTION

Sapere has been commissioned to support our approach to developing a common sense of purpose and direction for health services in the Wairarapa and enabling us to increase the pace of change.

Data gathering and analysis was undertaken in October and November. More work is planned on the Health Needs Assessment with some areas of analysis yet to be completed.

We have been meeting with a range of stakeholders since the last update including our hospital clinicians, primary care, Tihei members and other DHB staff.

PUBLIC

3.1 Drawing a picture of population need and service demand

Attached as Appendix 1 is the analysis Sapere is using in the engagement process with stakeholders and Appendix 2 is our preliminary analysis which will be used in the Health Needs Assessment document.

The ageing population has been identified as a key driver of the forecasted demand for services and is not dissimilar to what we expected to see. The increase in our Maori population across all age groups and its expected impact on service demand compared with our 'other' population and our current poor health outcomes for Maori highlights clearly a need for a more person and community centred approach to designing and implementing services to meet our communities' needs.

3.2 Building a common sense of purpose

A number of small groups meetings have already taken place and the will continue through December to understand the particular service sustainability issues. At the meeting on the 10 December we will bring together a wide range of stakeholders from across the Wairarapa health system to discuss, debate and prioritise the key strategic themes in a large group workshop.

A workshop is being planned early in the new year for the Wairarapa Board to consider the outcomes of the strategic direction work.

4 TIMEFRAMES

Work	Timeframe	Update on activity
Data Requests	September/ October	Completed
Service utilisation modelling	October	Completed
Population health status and inequities analysis and report	9 September to December	Underway
Engagement with services (primary care and hospital will be main focus)	Early November	Underway
Strategic themes development	Late November	Underway
Engagement on strategic themes	Early December	Meeting planned for 10 December 2019
Resourcing and benefit realisation measurement implementation planning	Early December	
Draft documents	End December 2019	
Board and other stakeholder Workshop	February 2020	
Documents finalised	March 2020	
Clinical services and wellbeing plan work begins (report to CPHAC in March on the timeframes and process)	March 2020	

Direction for health services in Wairarapa

Problem definition and themes so far…

26 November 2019

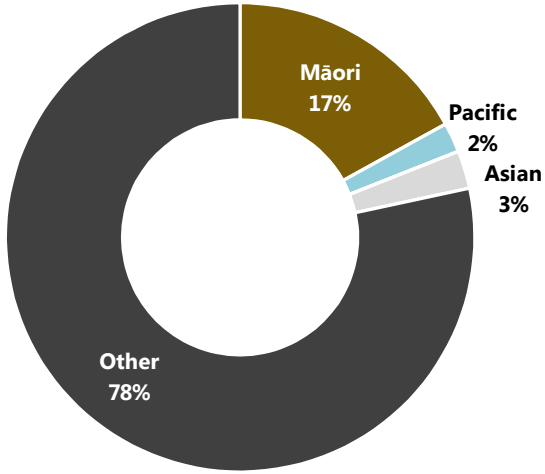
Service demand

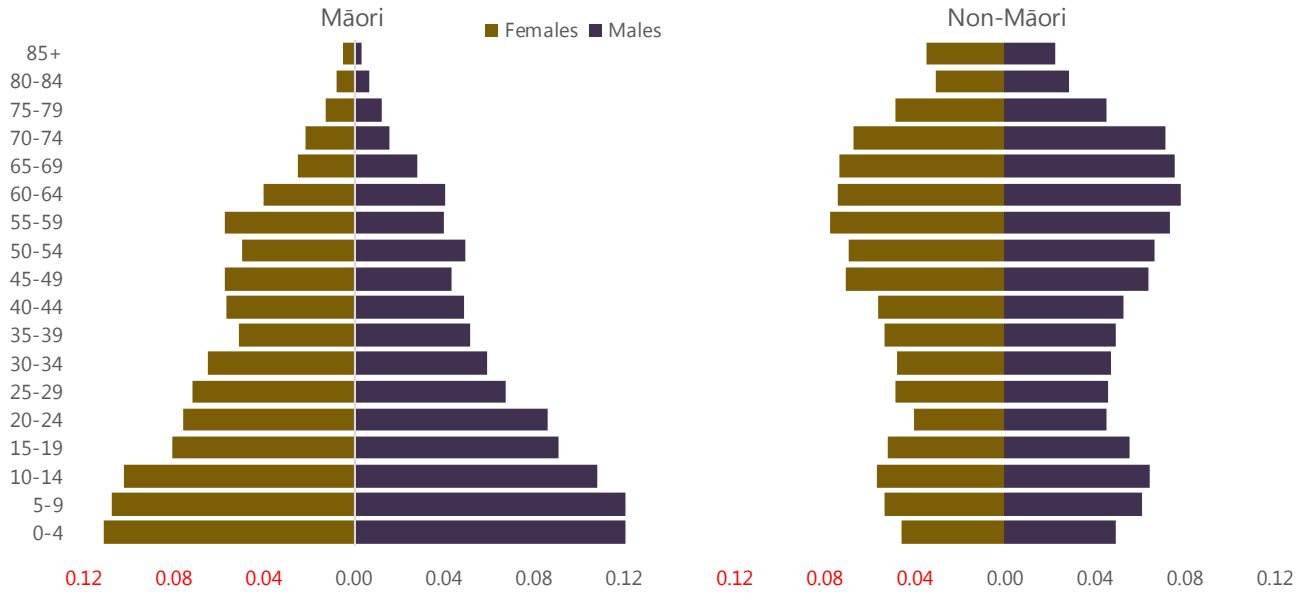
The information in this pack is draft and subject to change. The information may be subject to artefacts of data collection, coding and extraction, and requires the involvement of informed clinicians, analysts and service managers for meaningful interpretation.

Data sources
Statistics New Zealand population projections, Tū Ora Compass Health enrolment & consultation data, Wairarapa DHB hospital service volumes, Health Roundtable benchmarking reports, Ministry of Health benchmarking reports.

46,000 people enrolled in 7 practices

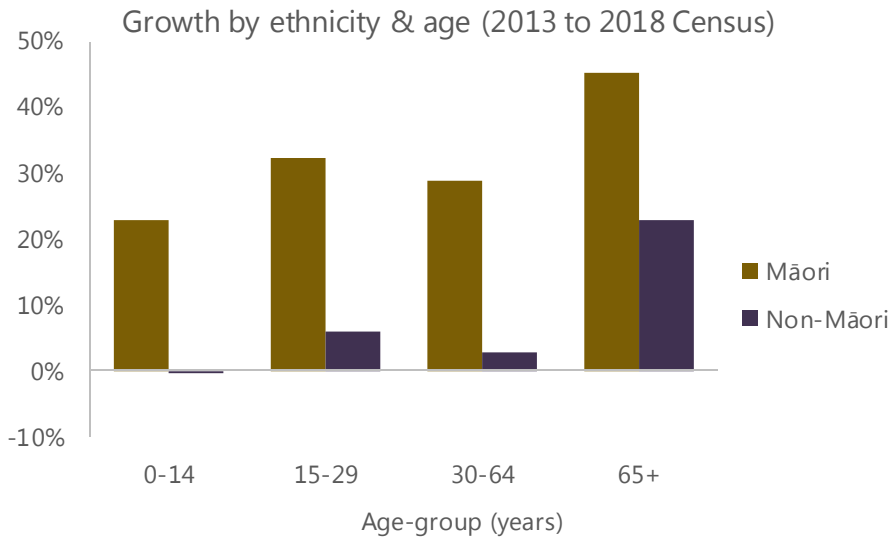
Practice	People	High-need
Masterton Medical	22,243	35%
Whaiora	3,729	62%
Kuripuni Medical Centre	1,823	23%
Carterton Medical Centre	6,932	19%
Greytown Medical Centre	3,346	16%
Featherston Medical Centre	4,475	35%
Martinborough Medical Centre	3,015	19%
Total	**45,563**	**32%**





Higher than expected population growth in recent years

- Between 2013 and 2018 the usually resident population grew 10.3%
- Growth for Māori was 28%
- Growth for 65+ was 24%

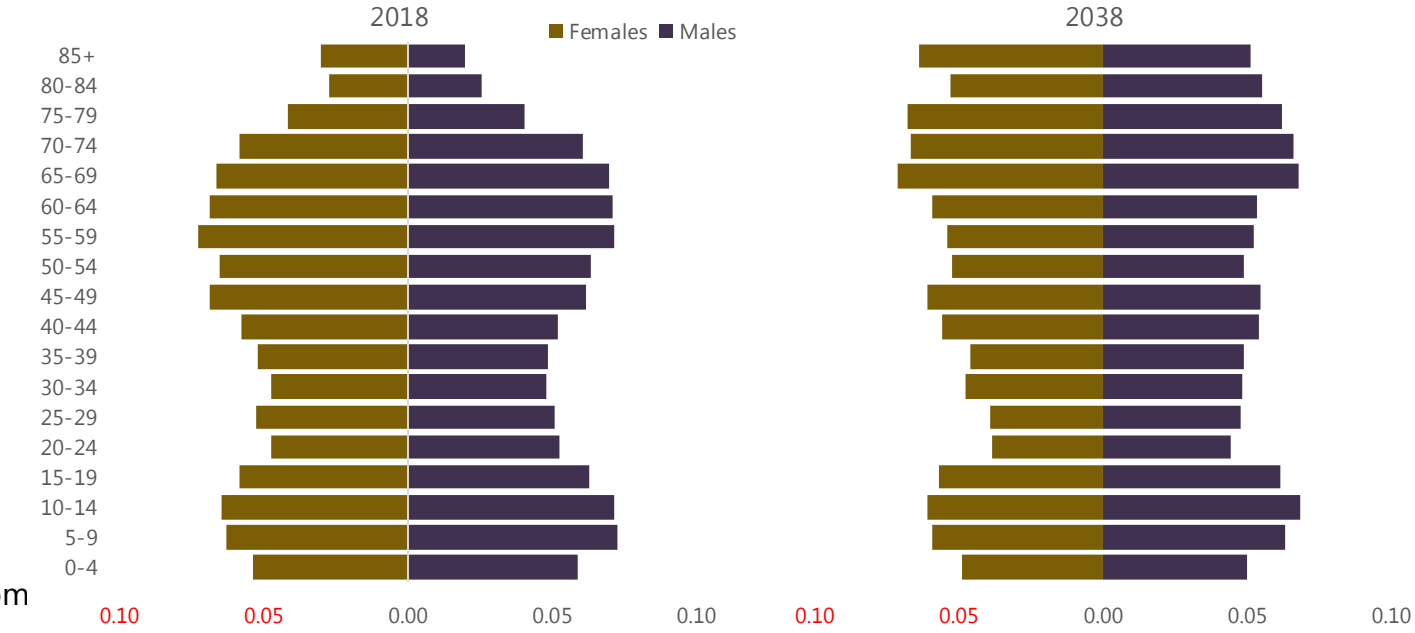


	Year	2006	2013	2018
Area	**Ethnic group**			
Wairarapa	Total people	38,613	41,112	45,327
	Maori	5,496	6,360	8,169

data extracted on 17 Nov 2019 01:22 UTC (GMT) from NZ.Stat

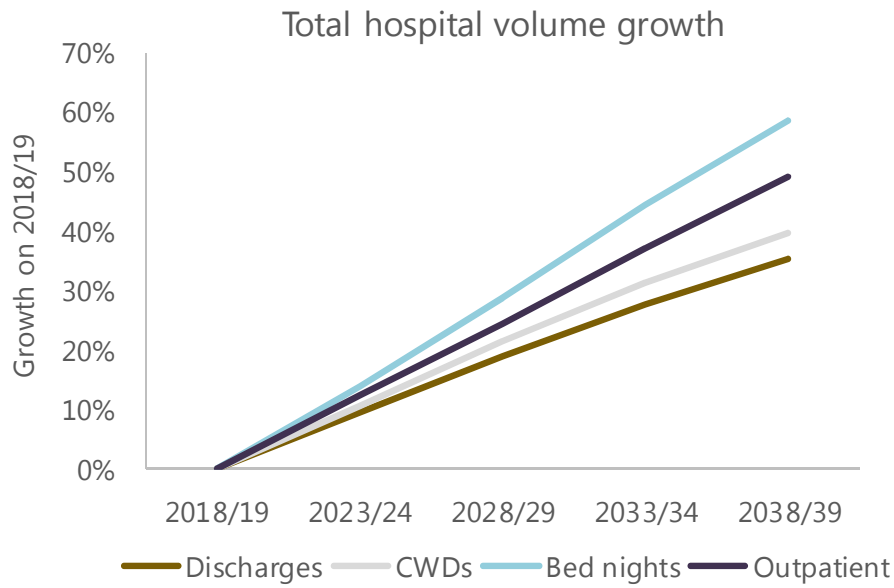
High population projections would see the register grow to ~52,000

Practice	2018	2028	2038	% over 20 yrs
Masterton Medical	22,125	23,735	24,757	12%
Whaiora	3,613	4,284	5,006	39%
Kuripuni Medical Centre	1,846	1,934	1,889	2%
Carterton Medical Centre	6,982	7,810	8,386	20%
Greytown Medical Centre	3,146	3,417	3,591	14%
Featherston Medical Centre	4,128	4,488	4,752	15%
Martinborough Medical Centre	2,896	3,187	3,417	18%
Total	**44,736**	**48,854**	**51,797**	**16%**



www.thinkSapere.com

Population growth & ageing will drive demand for hospital services



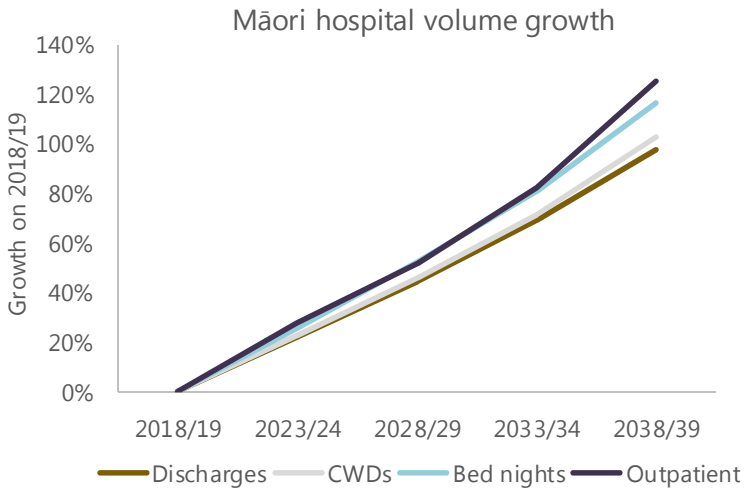
- Discharges would grow 35%
- Caseweights would grow 40%
- Outpatient volumes would grow 49%
- Bed nights would grow 59%

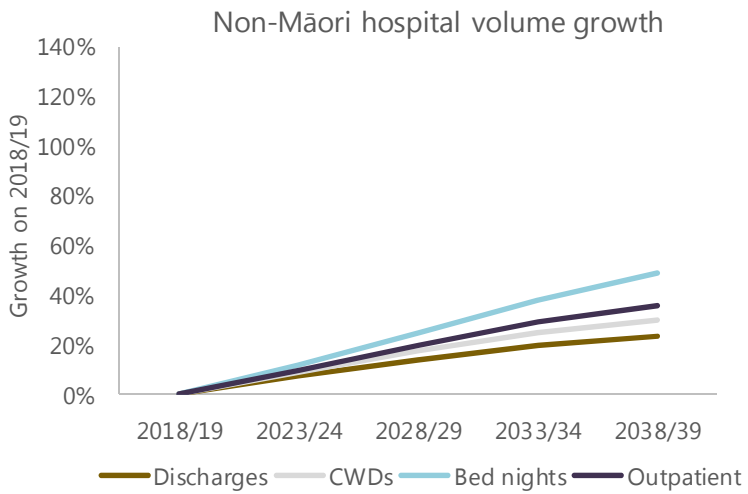
The 'status quo' projection – if we do nothing differently…

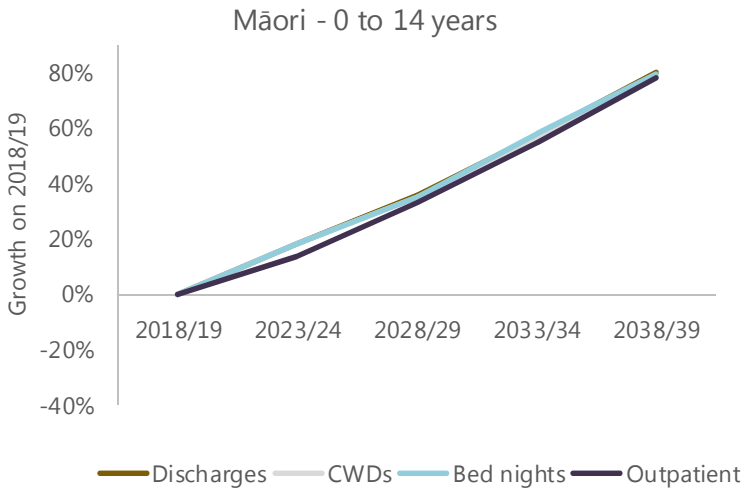
Assumes current (2018/19) intervention rates by domicile, age-group, gender, ethnicity; and projects forward based on expected population growth in each of those demographic categories.

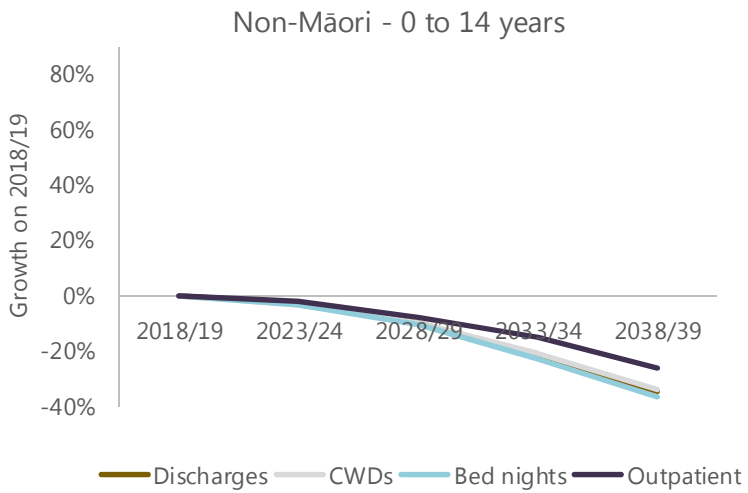
Population projections are still based on the 2013 Census—we have used the 'high' series for the Wairarapa population, to more closely align to actual growth 2013 to 2018, and other projections of the Wairarapa population used by district councils.

Māori will represent an increasing proportion of patients

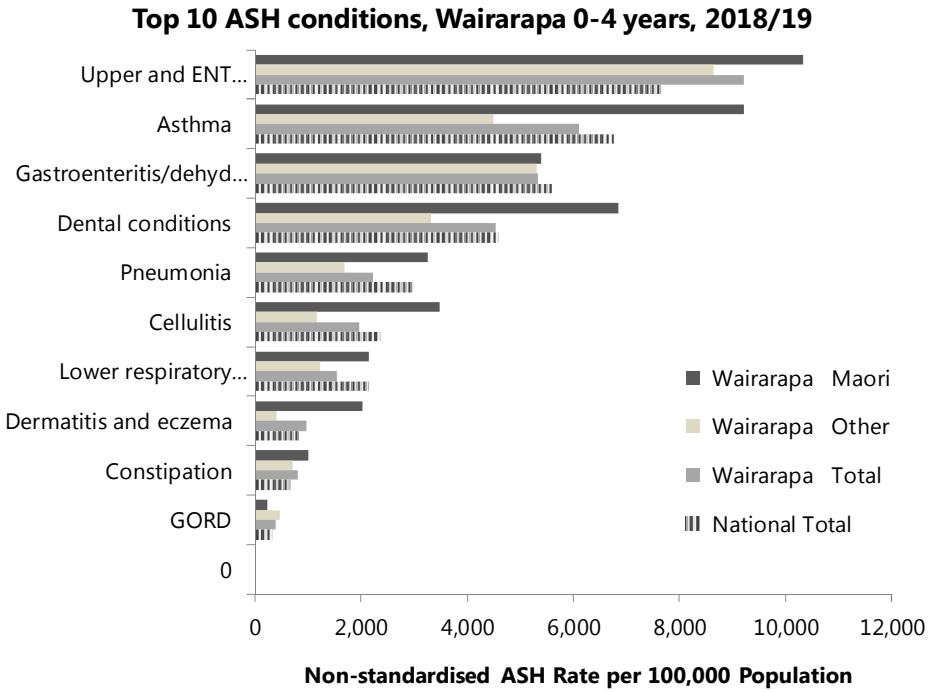


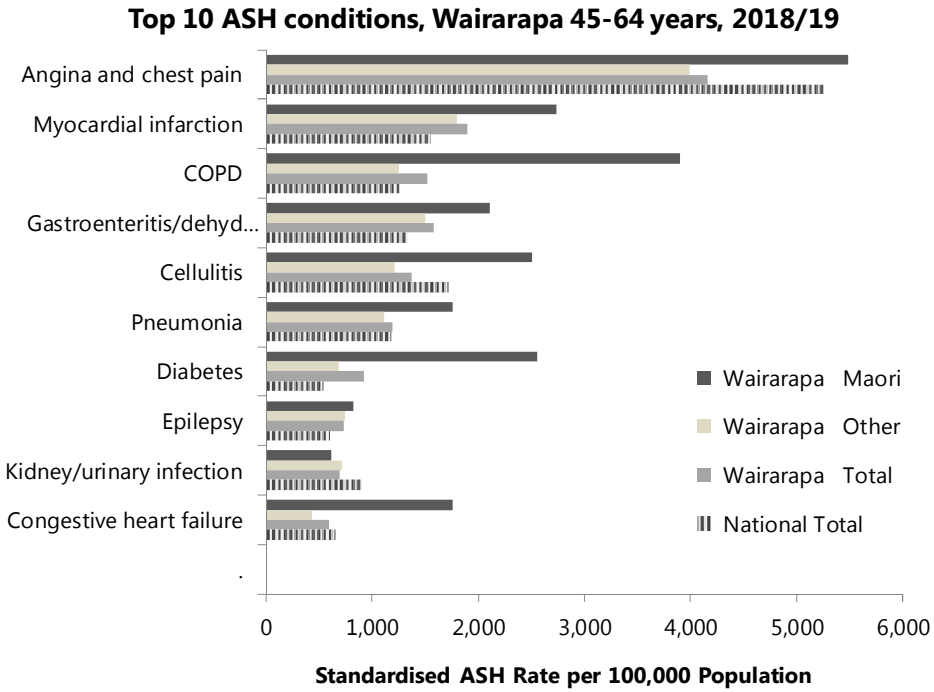




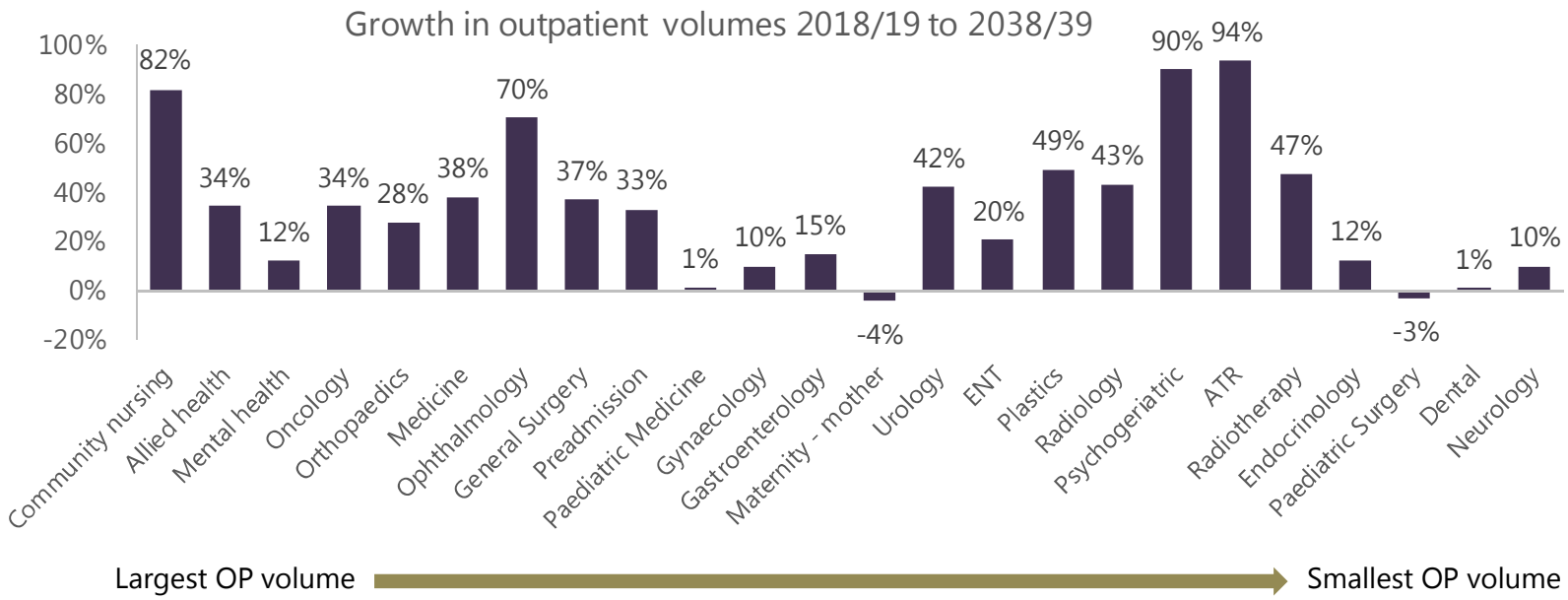


Higher rates of avoidable morbidity among Māori children & adults

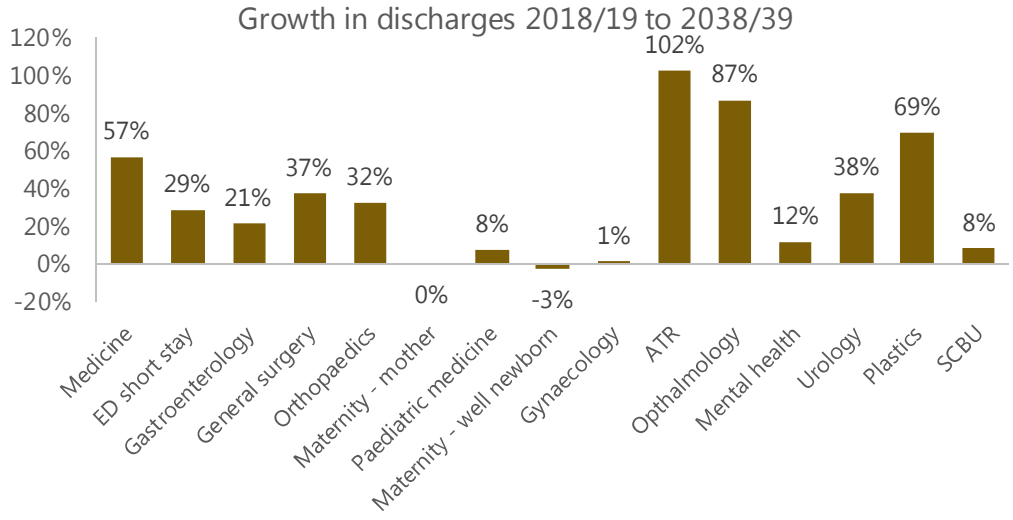


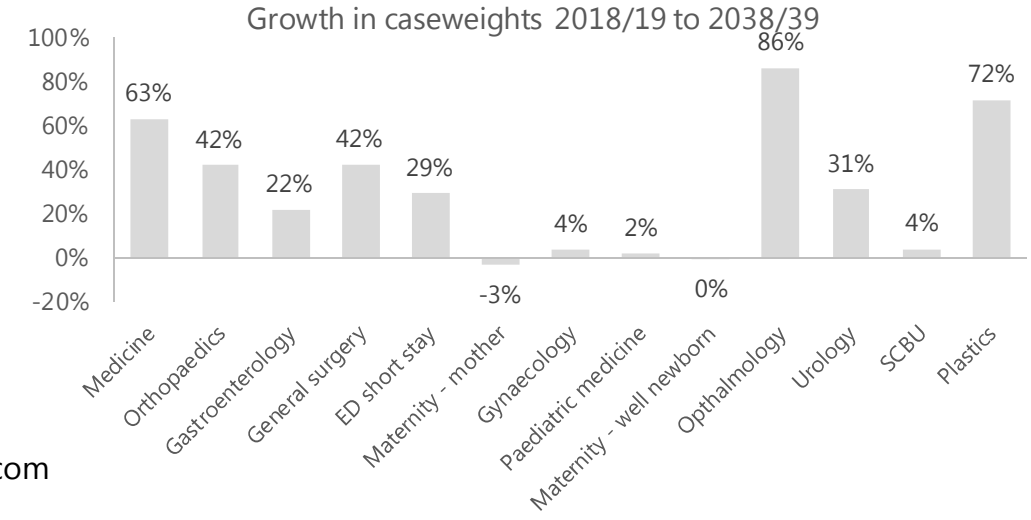


Substantial pressure on services caring primarily for older people

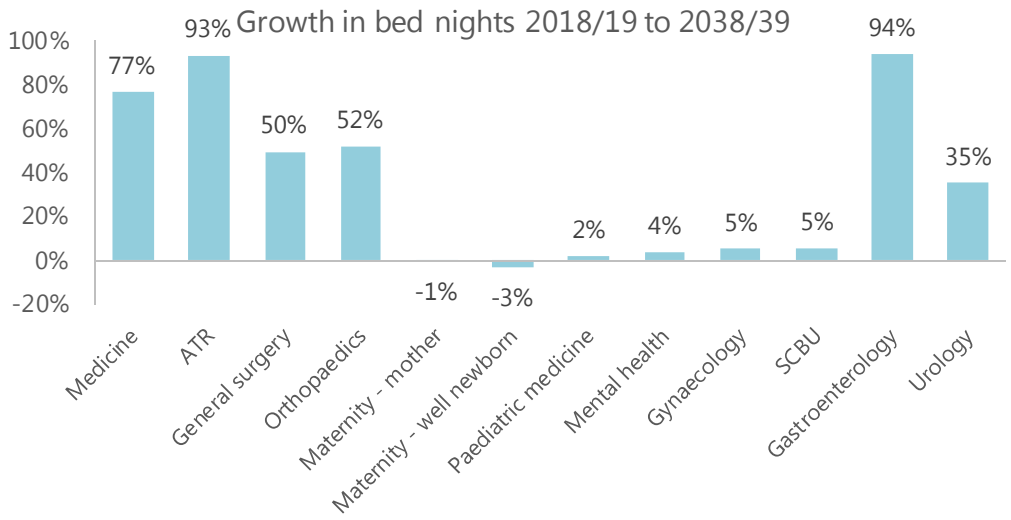


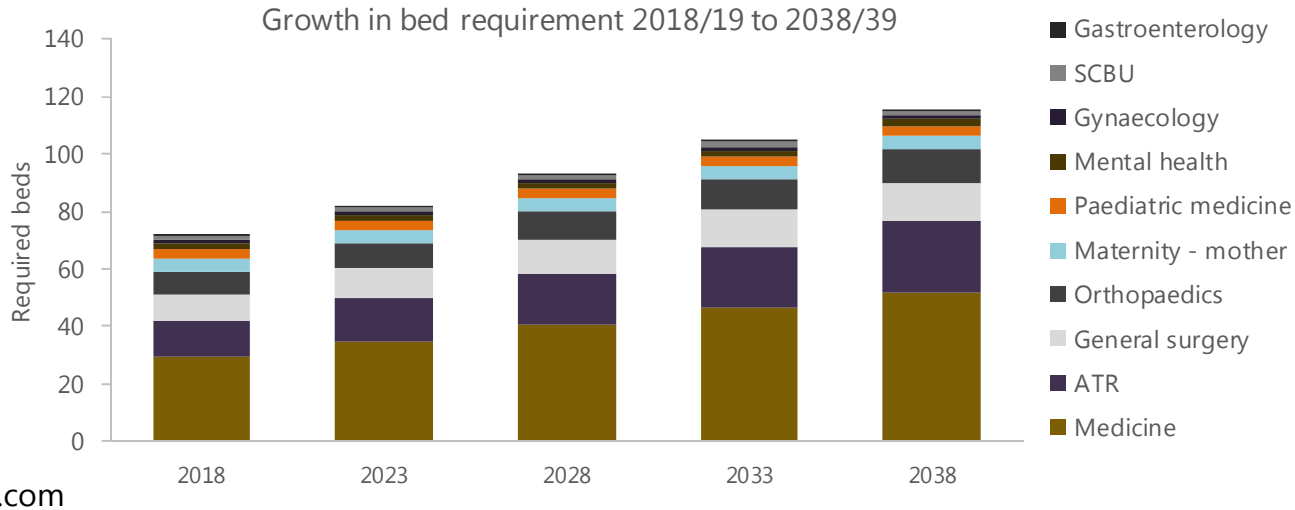
Substantial pressure on services caring primarily for older people





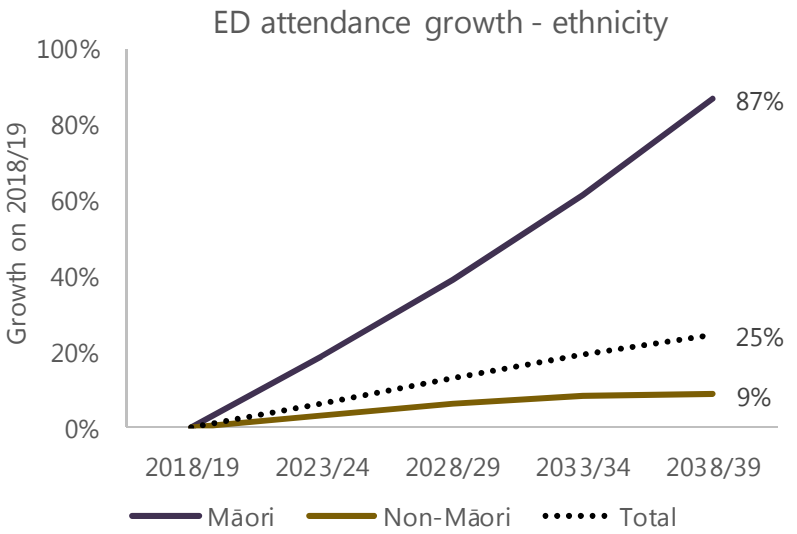
Bed block and capacity exceeded in the near term…

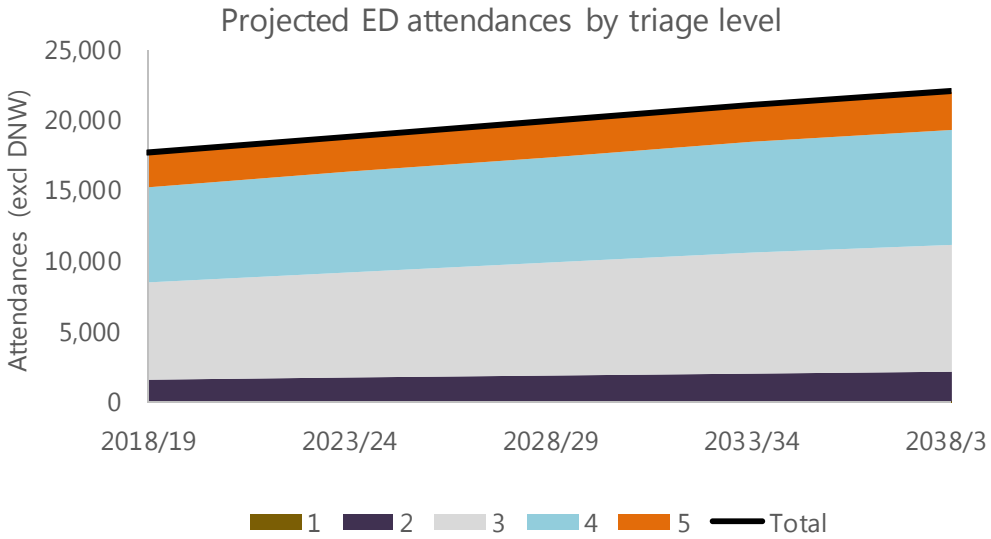


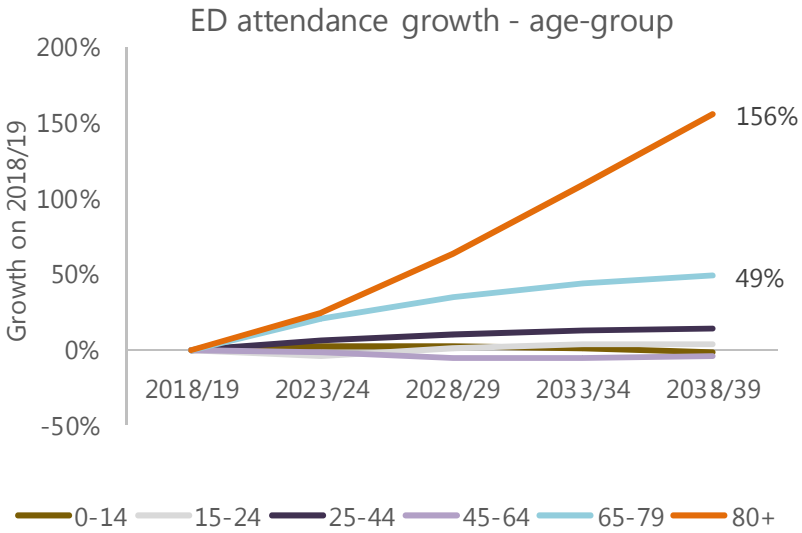


…the Emergency Department will be full…

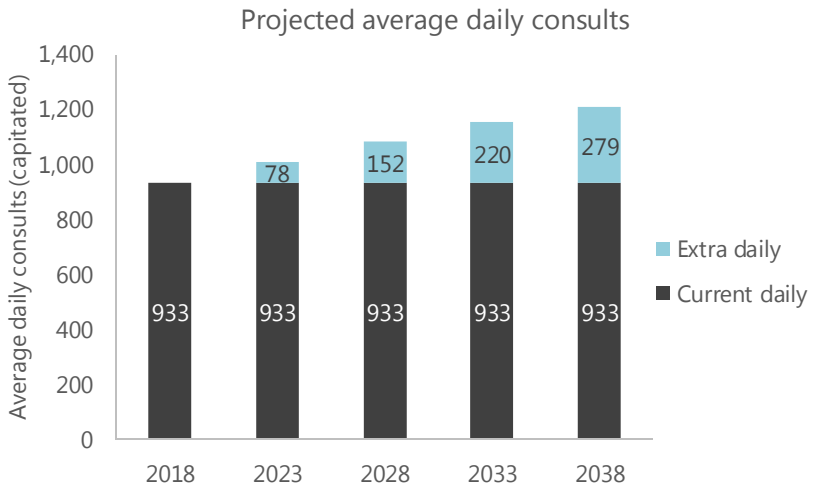
- Total ED attendance growth would be 25%
- Faster growth among Māori and older people, and in triage levels 2 & 3

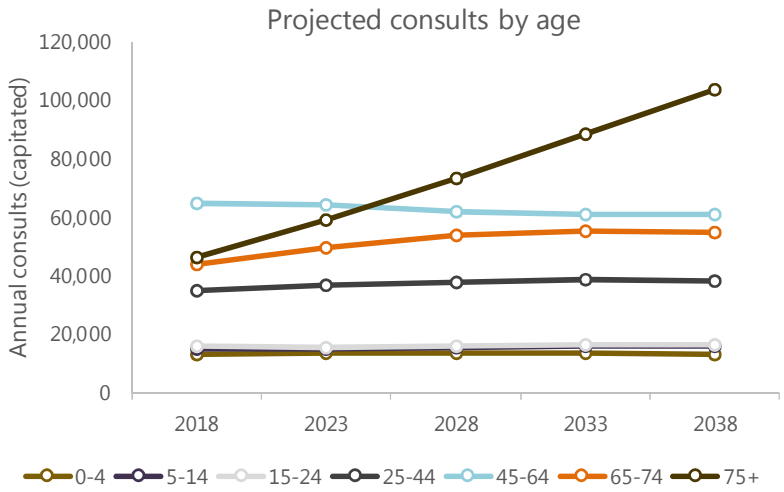


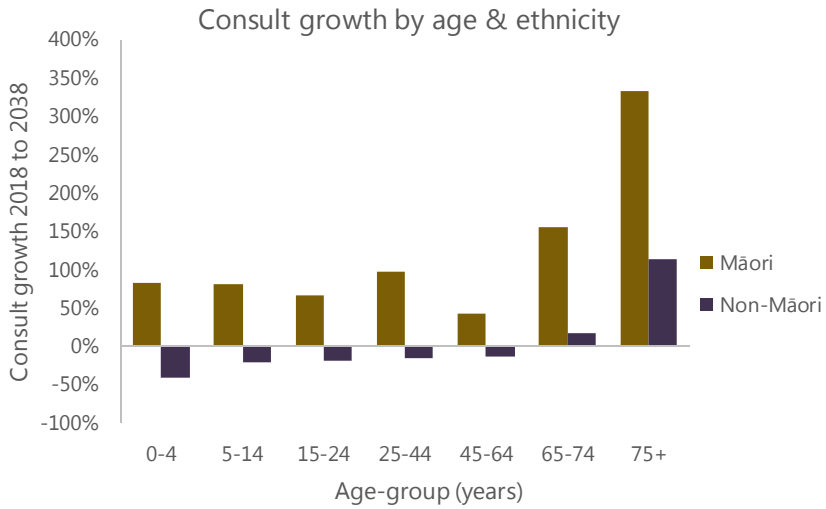




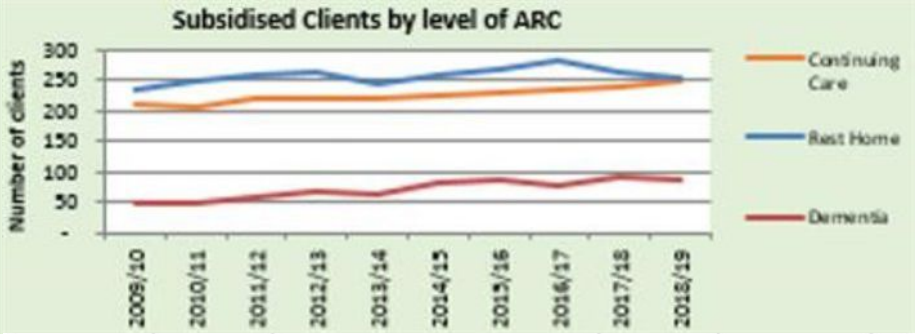
...and primary care would need to deliver an extra 279 consults each day

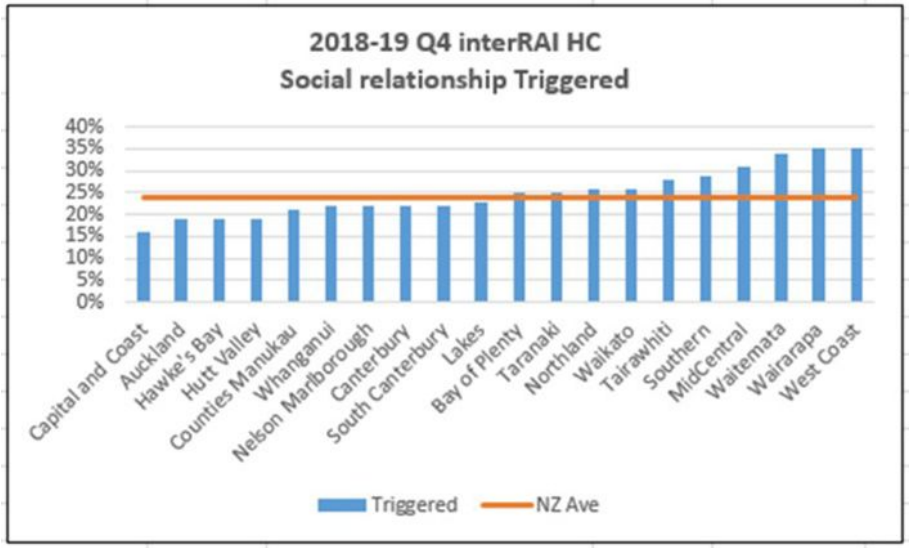






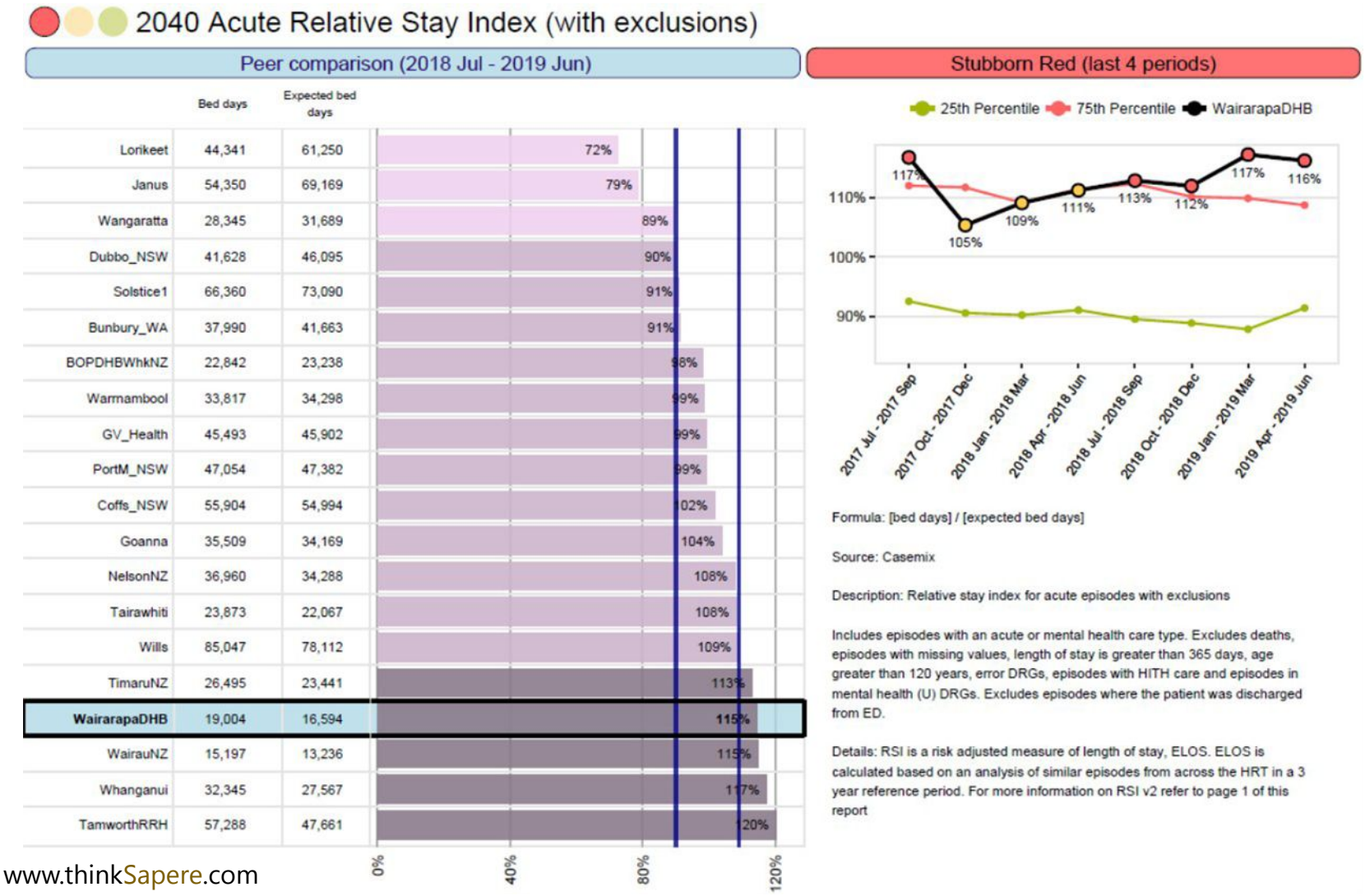
Demand for home support for older people will continue to increase





- The number of people in aged residential care is increasing – particularly at hospital and dementia level
- Number of clients and hours of home and community support are increasing
- Wairarapa has a high proportion of older people living at home who 'feel lonely or are distressed by declining social activity and are alone for long periods of time' (interRAI social relationship clinical assessment protocol)

The Health Roundtable suggests we could reduce hospital length-of-stay…



…we are not seeing enough ED patients within clinically recommended times

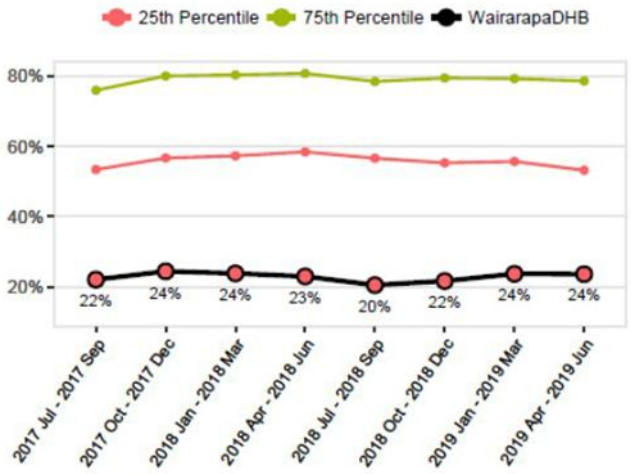
3010 Percentage of ED patients seen within clinically recommended time

Peer comparison (2018 Jul - 2019 Jun)

	Patients seen within time	Total presentations	
Solstice1	36,815	45,398	81%
Lorikeet	39,473	48,920	81%
Wangaratta	20,143	25,541	79%
Goanna	21,092	27,056	78%
Coffs_NSW	31,865	41,082	78%
PortM_NSW	29,194	37,856	77%
Warrnambool	17,782	23,807	75%
WairauNZ	12,520	16,917	74%
TimaruNZ	15,610	21,219	74%
Janus	35,671	49,573	72%
Bunbury_WA	29,344	41,641	70%
Dubbo_NSW	23,673	33,980	70%
TamworthRRH	28,750	41,389	69%
NelsonNZ	17,956	26,292	68%
Tairawhiti	13,984	20,656	68%
Wills	28,541	44,515	64%
GV_Health	20,402	33,254	61%
BOPDHBWhkNZ	15,528	27,086	57%
Whanganui	6,216	20,344	31%
WairarapaDHB	3,575	16,007	**22%**

0% 20% 40% 60% 80%

Stubborn Red (last 4 periods)



Formula: [patients seen within time] / [total presentations]

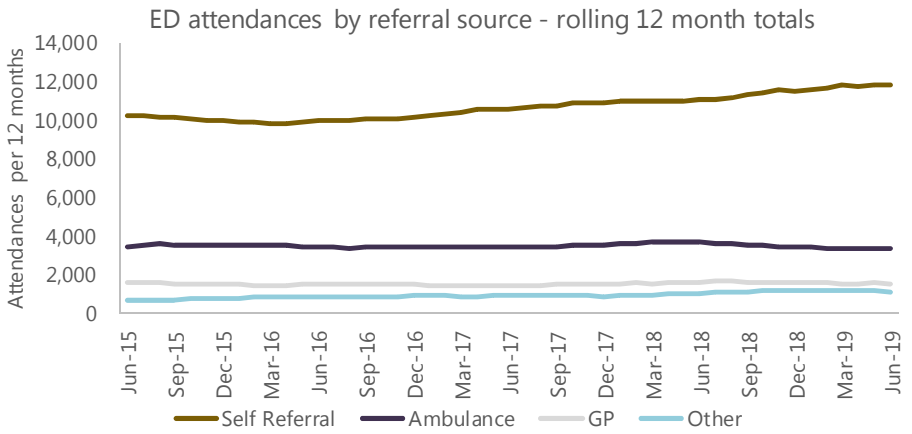
Source: ED

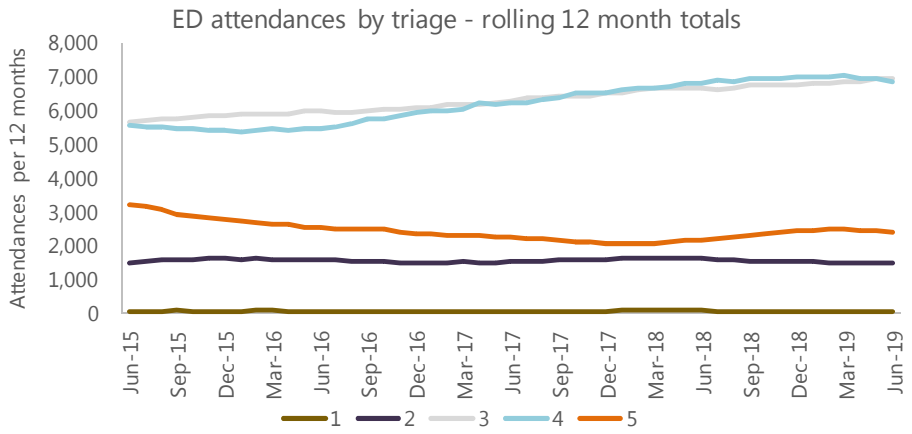
Description: % of ED presentations that were seen within the clinically recommended time for the triage category. Includes all triage categories.

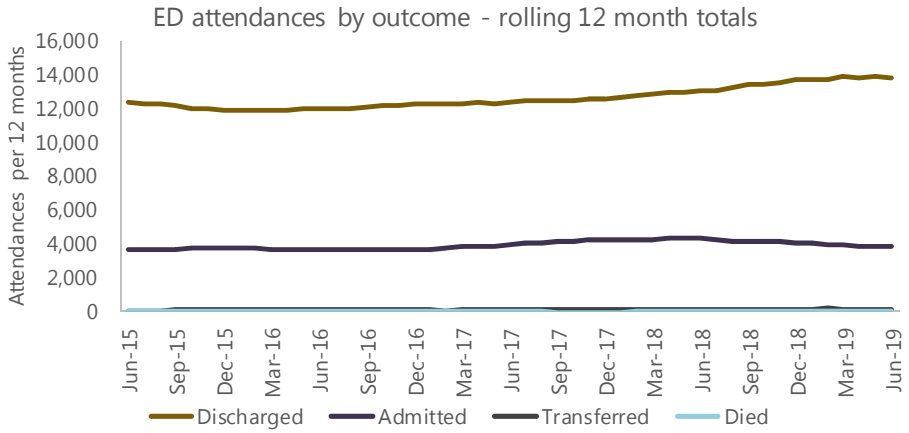
Excludes DNW, DOA, death in ED & unplanned / transit patients who were not included in the emergency department data.

Details: Based on triage time to time of first care given, treatment or diagnostic started. The benchmark times for each triage category are:
- category 1: seen within seconds, calculated as less than or equal to 2 minutes
- category 2: seen within 10 minutes
- category 3: seen within 30 minutes
- category 4: seen within 60 minutes
- category 5: seen within 120 minutes

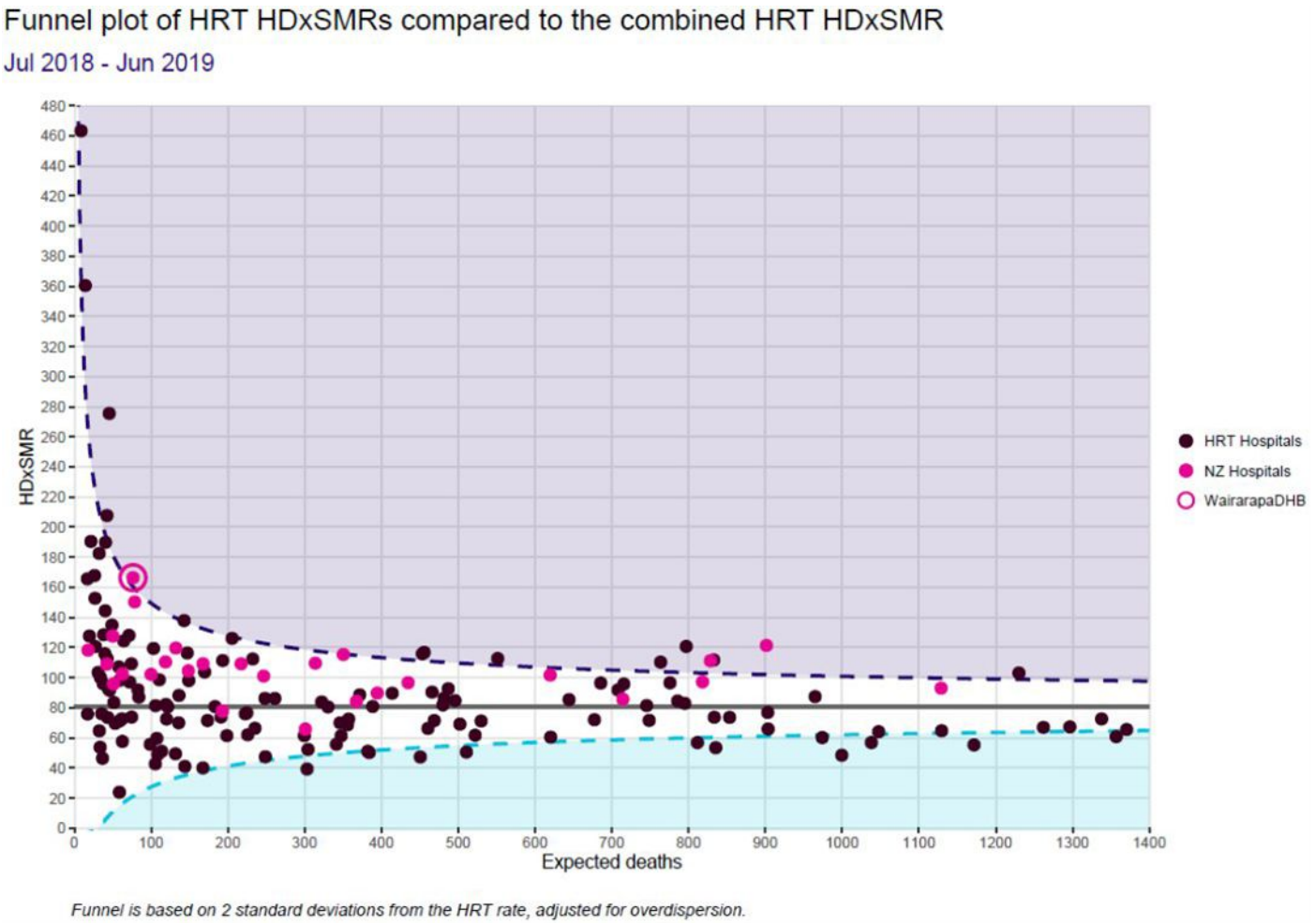
ED volumes by referral source, triage and discharge disposition



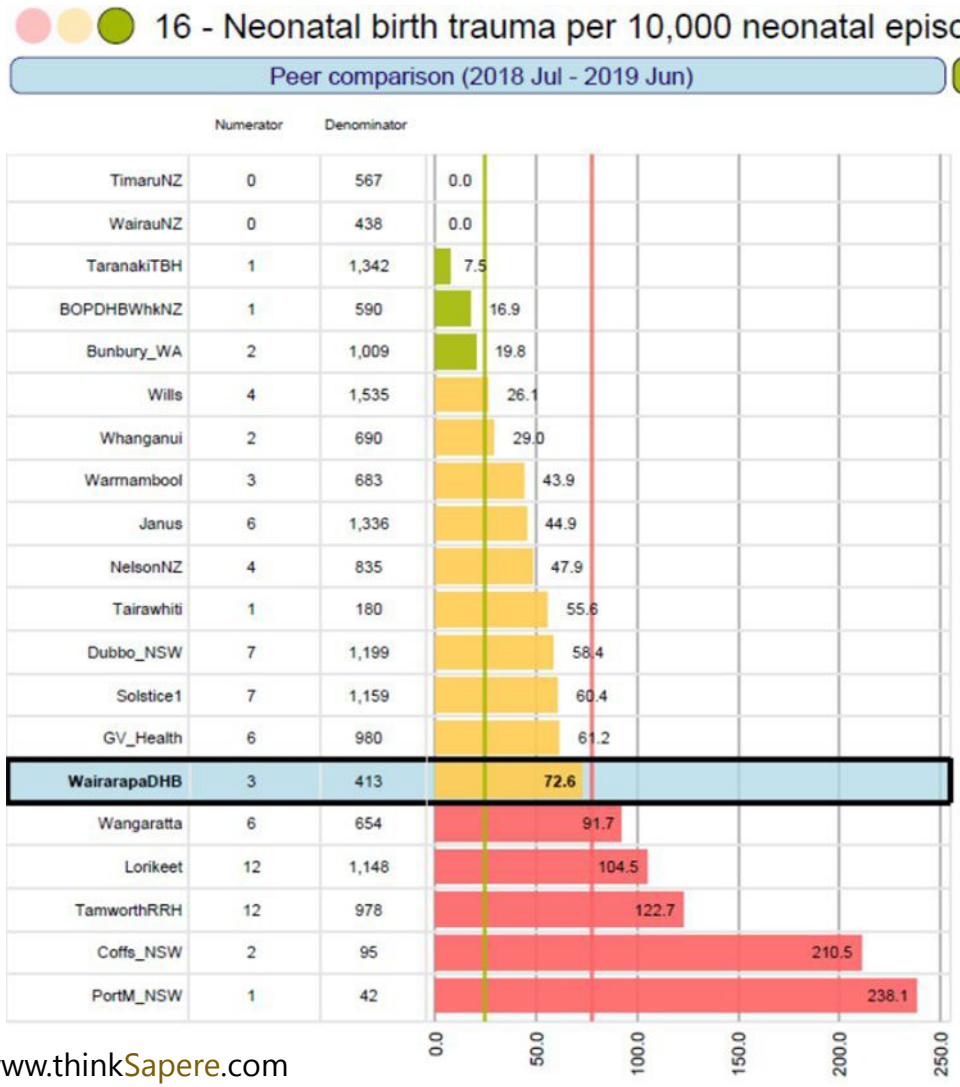


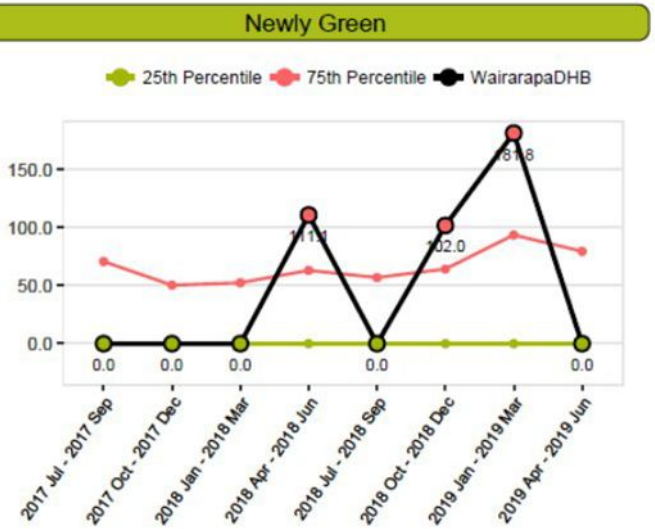


HRT also highlights some areas of risk – hospital mortality ratio



HRT also highlights some areas of risk – neonatal birth trauma





Formula: [Neonatal birth trauma episodes]/[total neonatal episodes] *10,000

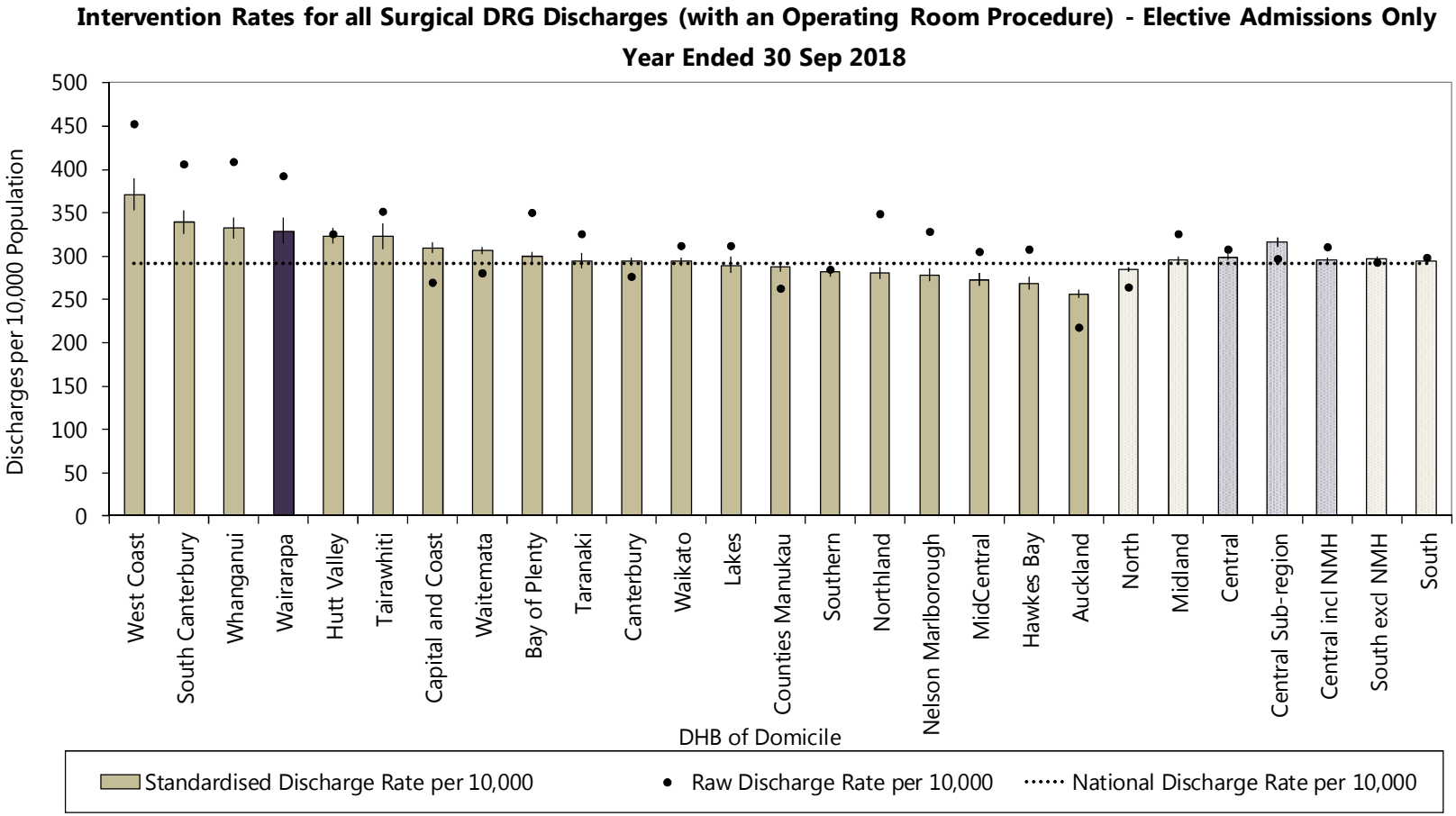
Source: Casemix

Description: Includes the diagnosis groups: 16.1 Neonatal birth trauma

Denominator: Count of neonatal episodes excluding episodes with ANY of the following: 1.Preterm infants with birth weight less than 2,000 grams. 2.Cases with injury to brachial plexus or osteogenesis imperfect. 3.Admission mode =1 (Admission mode is 'Admitted patient transferred from another hospital'). 4.Care type 9: Organ procurement-posthumous or Care type 10: Hospital boarder.

Numerator: Episodes that meet the denominator conditions and have an additional diagnosis ICD code for neonatal birth trauma(P10x, P11x, P13x, P122, P142, P148, P149, P150, P151, P152, P153, P155, P156).

Surgical intervention rate is significantly higher than average

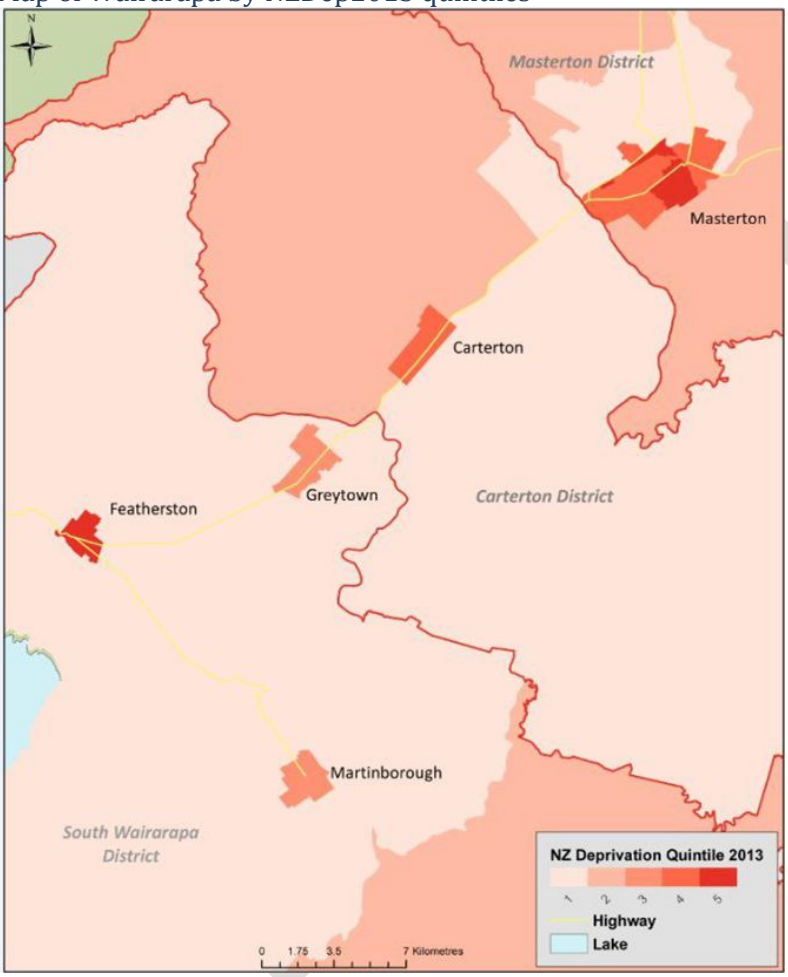


Wairarapa Health Needs Assessment- Early analysis

About us and how we live

It is well known that Social and economic factors have a major impact on the health of our population.

Map of Wairarapa by NZDep2013 quintiles



The median household income is well below the national average in all 3 council areas especially in Masterton. However it grew at around the national rate between 2006 and 2013, except in South Wairarapa where it grew well above the national rate.

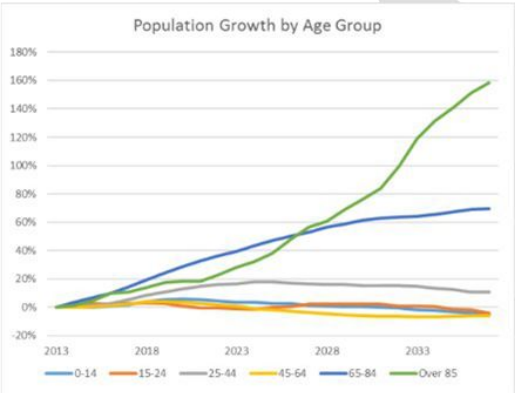
Median Household Income	2006	2013	Change	% change
Masterton	39,800	48,500	8,700	22%
Carterton	43,800	55,100	11,300	26%
South Wairarapa	43,900	57,800	13,900	32%
National	*51,400*	*63,800*	*12,400*	*24%*

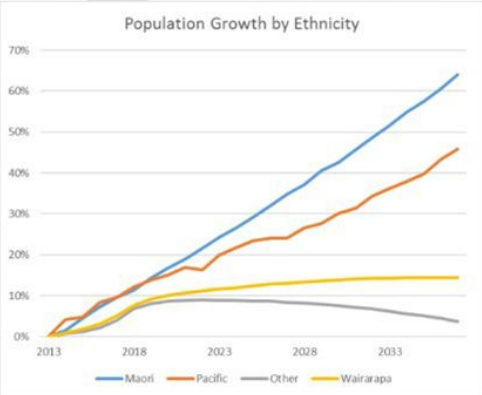
Household income >$70k	2006	2013
Masterton	18%	28%
Carterton	21%	33%
South Wairarapa	24%	35%
National	29%	39%

The percentage of Wairarapa households with income over $70,000 grew between 2006 but remains below the national average.

Wairarapa households receiving some sort of benefit is similar to New Zealand at 25%. Just under 3,000 Wairarapa working age residents receive a benefit 42% of those are receiving the job seeker benefit. This number has remained relatively constant since September 2014.

By 2037 it is estimated[1] our population will have grown by 14% an additional 6130 people. The largest growth rate will be in those over 85 (158% - 1,500 people) with those age 65-84 growing by 70% (4,965 people). Children age 0-14 will reduce by 5%. Our Maori population will grow 64% (4,500 people).





% of School Leavers Attaining NCEA level 2 and above 2018

	All Leavers	Gender		Ethnic Group					
		Female	Male	Māori	Pacific	Asian	MELAA	Other	European/ Pākehā
Masterton District	86.2	87.0	85.4	79.6	81.8	100.0	x	x	86.3
Carterton District	50.0	x	50.0	n	n	n	n	n	50.0
South Wairarapa District	79.8	76.5	83.3	73.7	62.5	x	x	n	84.5
Wairarapa Electorate	83.2	83.9	82.5	77.4	76.5	94.1	100.0	x	84.8
New Zealand Total	**79.4**	**82.3**	**76.7**	**65.8**	**74.6**	**90.6**	**83.7**	**81.4**	**82.4**

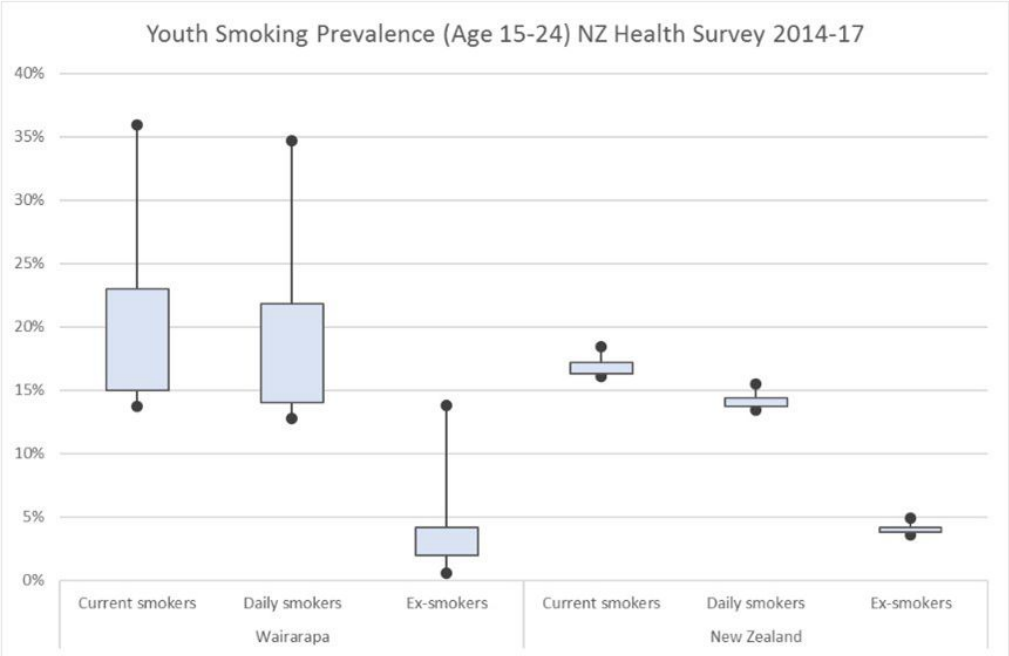
Young people in Wairarapa are above average in gaining NCEA level 2 although those from the Carterton district are less likely to achieve it.

[1] Stats NZ population projections for Ministry of Health September 2018.

In the last 12 months 28% of the women having babies at Wairarapa hospital were smokers, this rises to 56% for Maori women having babies.

Smoking in Wairarapa youth (age 15-24) is higher than the national average but not significantly.

Youth smoking rates

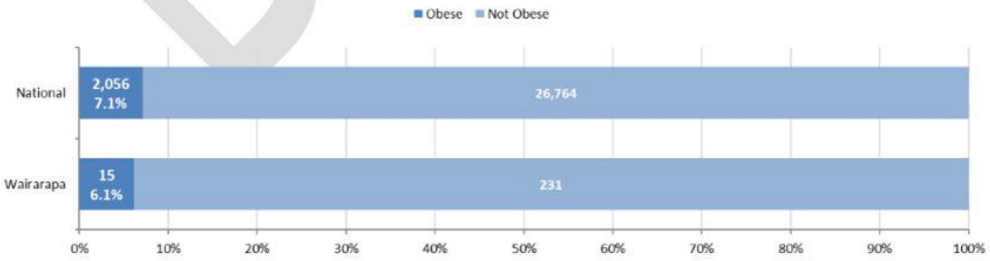


Hazardous drinking in the Wairarapa is lower than the national average but not significantly

People in Wairarapa are similar to the whole of New Zealand for eating fruit and vegetables across adults and children Maori and non-Maori.

Number and Rate of Children identified as Obese

Q1 - Data for the 6 months to the end of August 2019



Wairarapa adults have slightly lower rates (but not significantly) of obesity then the national average especially Maori adults.

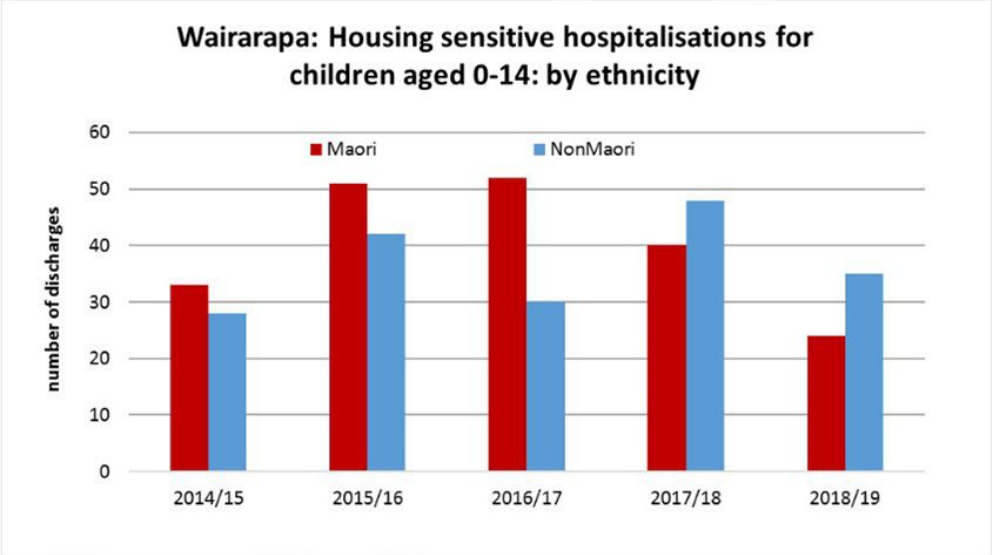
Adults and Children in Wairarapa physical activity levels are not significantly different to the national average.

Childhood

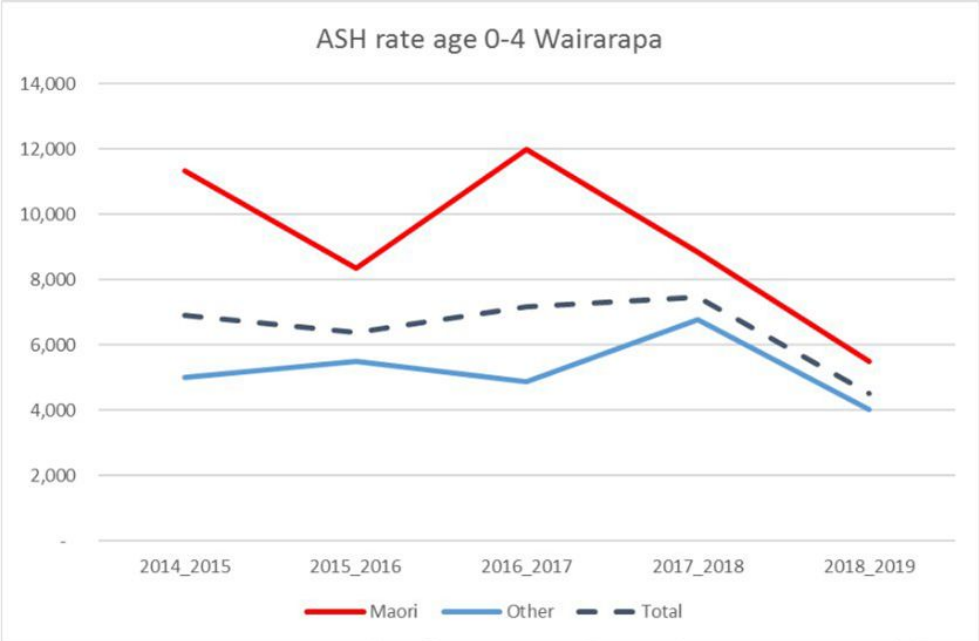
There are around 9,000 children age 0-14 in Wairarapa making 5% of the population. It is in the first years of life that people are set up for good health in later years.

Immunisation rates are below target. In 2018/19 Wairarapa children averaged 92% at 8 months and 93% at 2 years. Maori children had slightly better rates at 94% at both milestones and Pacific children had lower rates at 8months (88%) but did better at 2 years 97%.

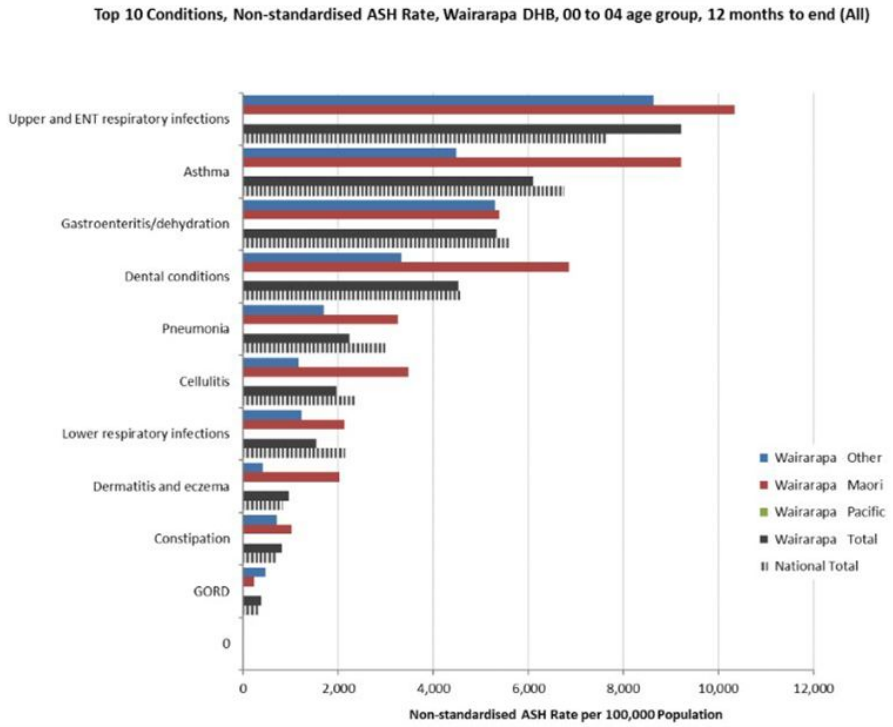
58% of children are fully or exclusively breastfed at 3 months this slightly above the national average. Only 43.5% of Maori and 50% of Pacific were breastfed at 3 months.



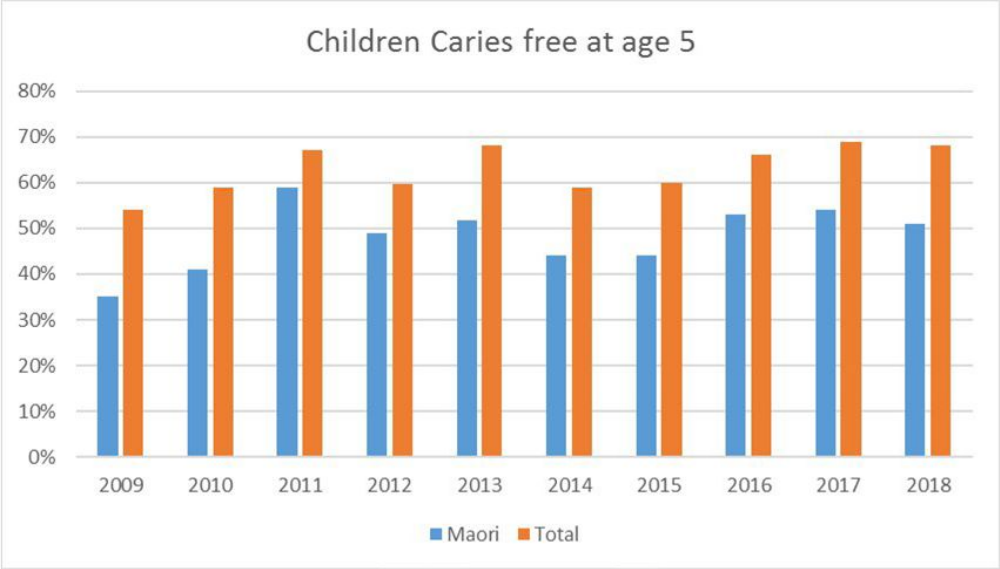
Poor housing contributes to some hospitalisations (housing sensitive hospitalisations) those conditions are mostly respiratory illnesses. The number of admissions for housing related conditions has reduced for Maori children but has been increasing for non-Maori.



In the last year the rate of children being admitted for ambulatory sensitive hospitalisations has reduced for both Maori and total. It is similar to the national rate.

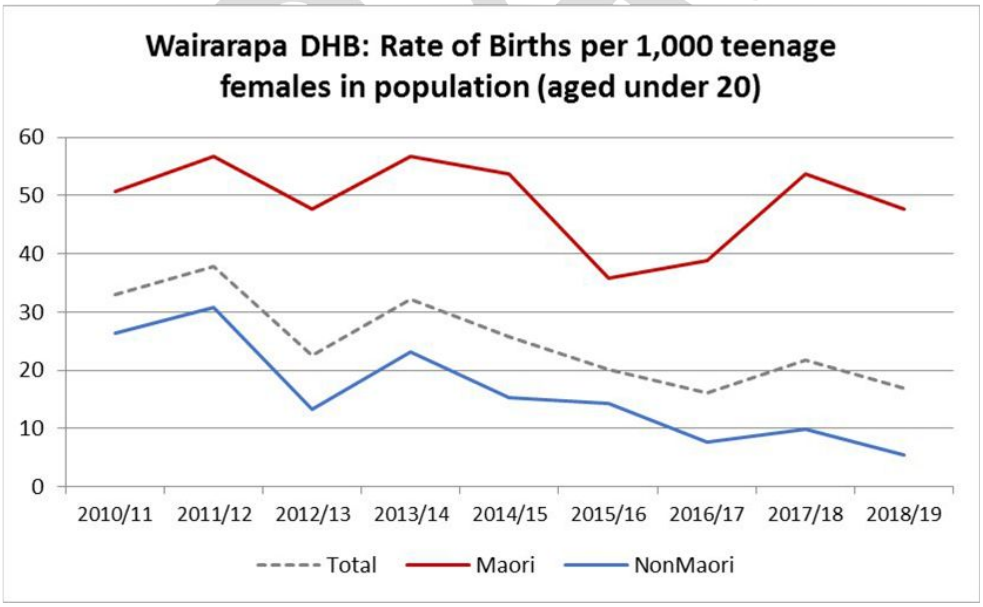


The percentage of children who do not have tooth decay at 5 years of age remains similar. The total rate is 68% however Maori children are more likely to have decay with only 51% being caries free.

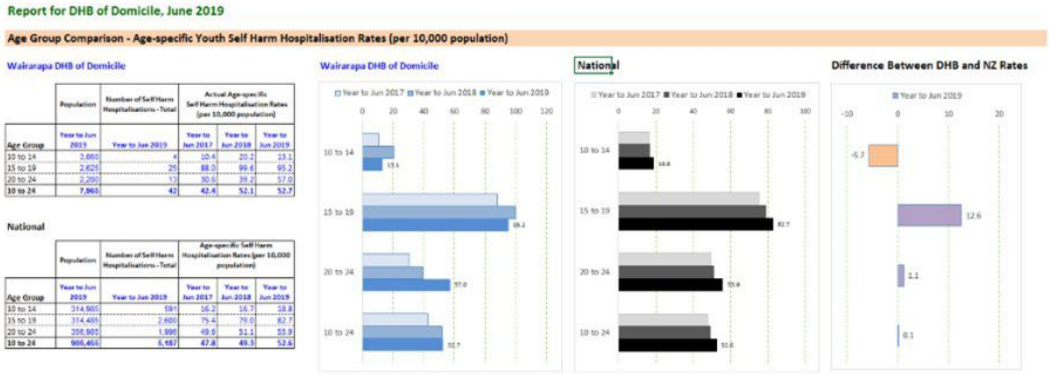


Youth

There are around 5,000 young people age 15-24 Wairarapa. At this age young people are testing their boundaries and often partake in risky behaviours.



Wairarapa youth have similar rates of Chlamydia to the national rate. However rates are much higher in Maori then European youth.


Report for DHB of Domicile, June 2019

Age Group Comparison - Age-specific Youth Self Harm Hospitalisation Rates (per 10,000 population)

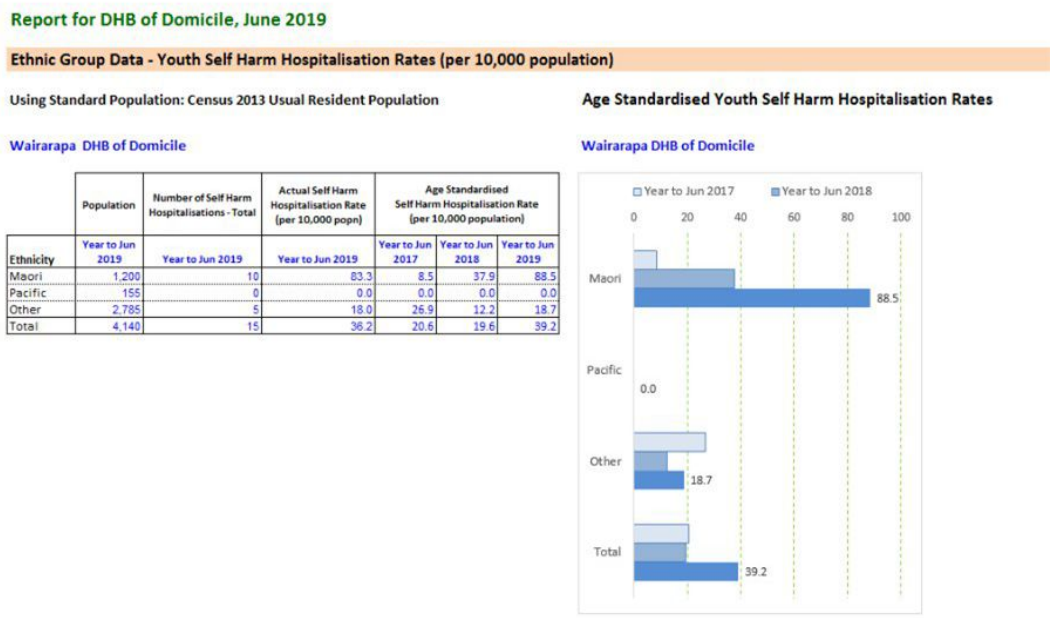
Wairarapa DHB of Domicile

Age Group	Population Year to Jun 2019	Number of Self Harm Hospitalisations - Total Year to Jun 2019	Actual Age-specific Self Harm Hospitalisation Rates (per 10,000 population) Year to Jun 2017	Year to Jun 2018	Year to Jun 2019
10 to 14	2,060	4	10.4	20.2	13.1
15 to 19	2,629	25	88.0	99.6	95.2
20 to 24	2,280	13	30.6	39.2	57.0
10 to 24	7,965	42	42.4	52.1	52.7

National

Age Group	Population Year to Jun 2019	Number of Self Harm Hospitalisations - Total Year to Jun 2019	Age-specific Self Harm Hospitalisation Rates (per 10,000 population) Year to Jun 2017	Year to Jun 2018	Year to Jun 2019
10 to 14	314,905	591	16.2	16.7	18.8
15 to 19	314,485	2,600	75.4	79.0	82.7
20 to 24	356,905	1,990	49.6	51.1	55.9
10 to 24	986,465	5,182	47.8	49.3	52.6

Self-harm hospitalisations are higher in the 15-19 age group but not significantly different in other age groups. Rates are higher for Maori youth than non-Maori.


Report for DHB of Domicile, June 2019

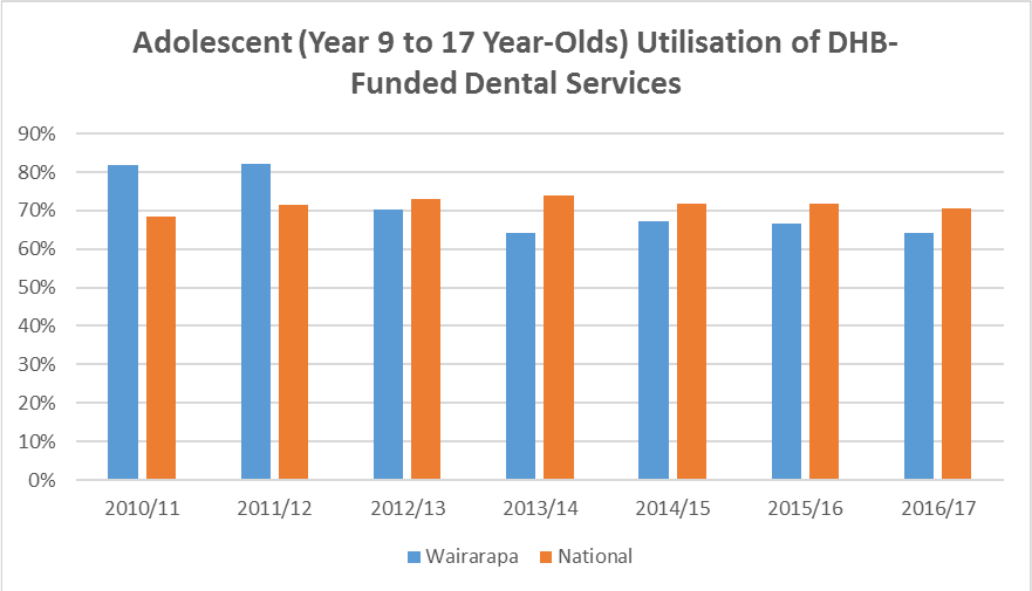
Ethnic Group Data - Youth Self Harm Hospitalisation Rates (per 10,000 population)

Using Standard Population: Census 2013 Usual Resident Population

Wairarapa DHB of Domicile

Ethnicity	Population Year to Jun 2019	Number of Self Harm Hospitalisations - Total Year to Jun 2019	Actual Self Harm Hospitalisation Rate (per 10,000 popn) Year to Jun 2019	Age Standardised Self Harm Hospitalisation Rate (per 10,000 population) Year to Jun 2017	Year to Jun 2018	Year to Jun 2019
Maori	1,200	10	83.3	8.5	37.9	88.5
Pacific	155	0	0.0	0.0	0.0	0.0
Other	2,785	5	18.0	26.9	12.2	18.7
Total	4,140	15	36.2	20.6	19.6	39.2

Age Standardised Youth Self Harm Hospitalisation Rates



The rate of Wairarapa Adolescents engaged with Oral Health providers is falling in Wairarapa and is now below the national average.

Adult

Wairarapa residents have a similar life expectancy to the New Zealand average with Masterton residents being lower and South Wairarapa higher.

Life expectancy at birth by territorial authority

	Life expectancy at birth					
	2005–07			2012–14		
	Estimated credible interval (percentile[3])					
	2.5th	50th (median)	97.5th	2.5th	50th (median)	97.5th
Male (years of life)						
New Zealand[4]		78.0		79.4	79.5	79.6
Masterton District	76.2	77.0	77.9	77.0	77.8	78.5
Carterton District	76.5	77.7	78.8	77.6	78.6	79.8
South Wairarapa District	78.0	79.3	80.5	79.1	80.3	81.5
Female (years of life)						
New Zealand[4]		82.2		83.1	83.2	83.3
Masterton District	80.6	81.3	82.2	81.3	82.0	82.7
Carterton District	80.6	81.6	82.7	81.7	82.8	83.9
South Wairarapa District	82.1	83.2	84.3	82.6	83.8	84.9

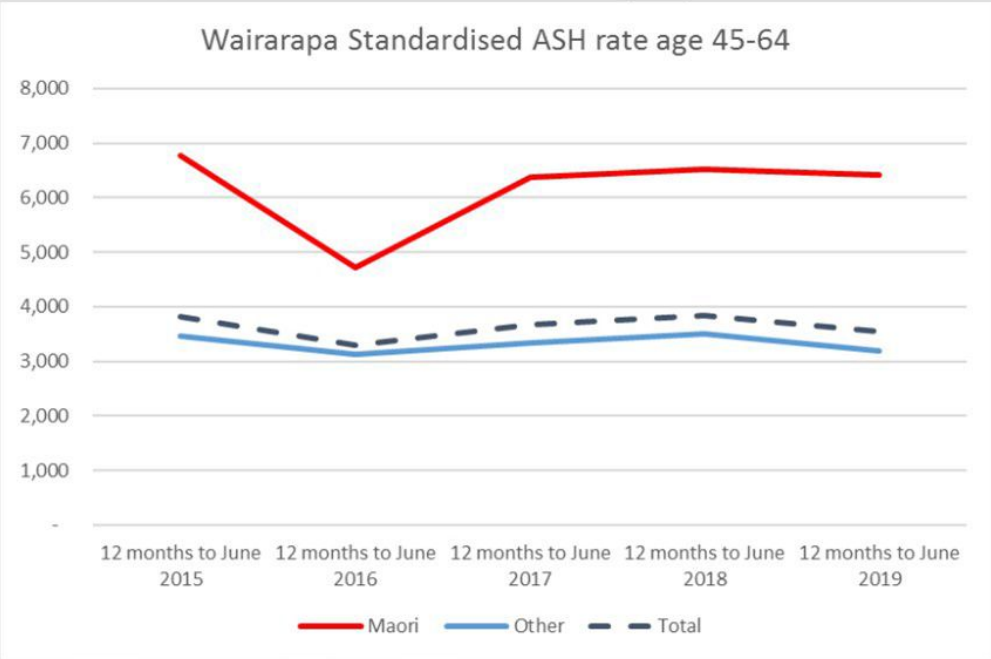
77% of Wairarapa women had received a cervical screen in the 3 years to June 2019. This is below the national target of 80%. Maori women had a much lower rate at 68%.

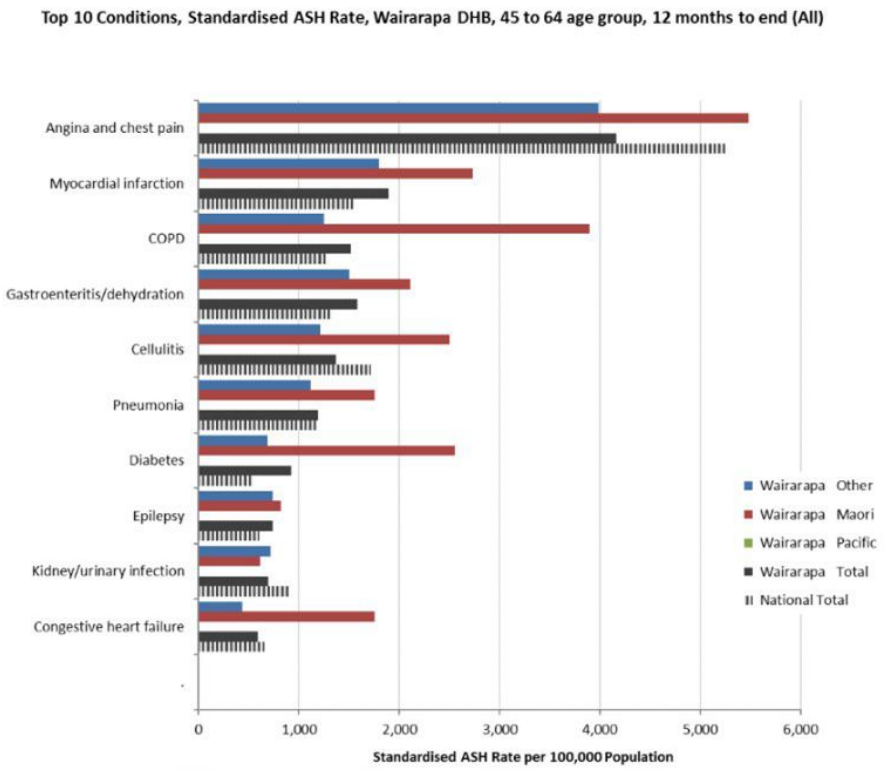
77% of Wairarapa women had a breast screen in the two years to June 2019. This is above then national target of 70%. Maori women had a lower rate with only 66% being screened.

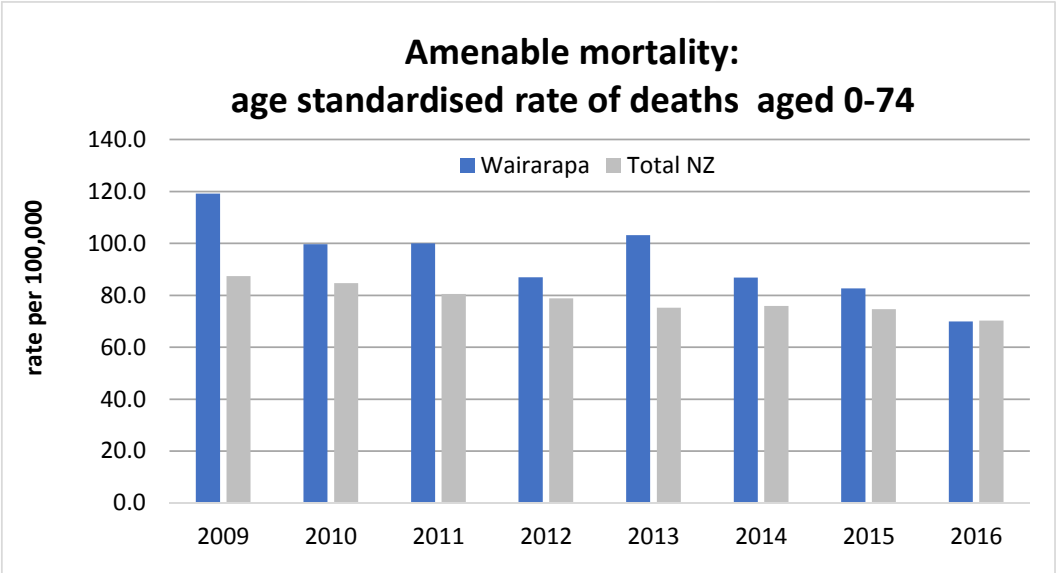
Good management of diabetes is important through adult life.

Diabetes Good Control - % of Diabetics with % HbA1c ≤ 64mmol

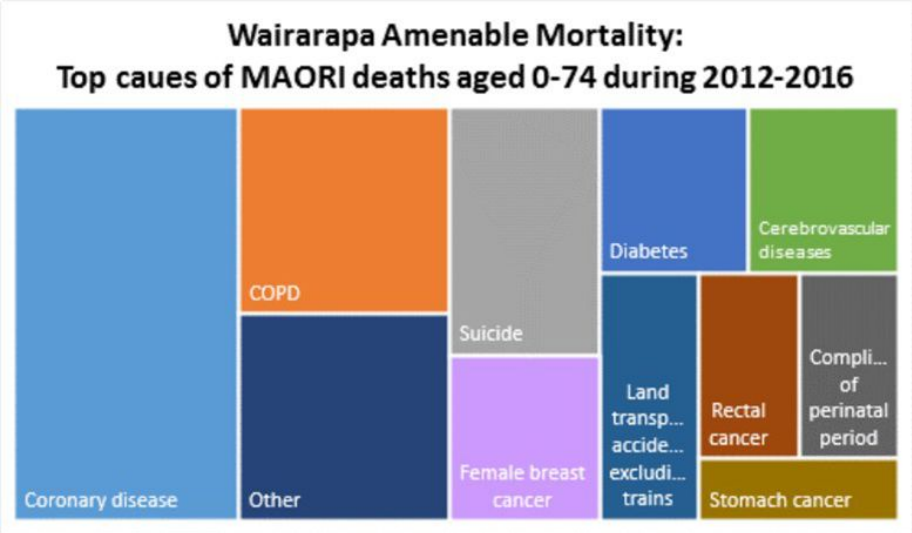
	Q2 1819	Q4 1819
Māori	**63%**	**59%**
Pacific	**60%**	**58%**
Other	**66%**	**68%**
Total	**66%**	**66%**

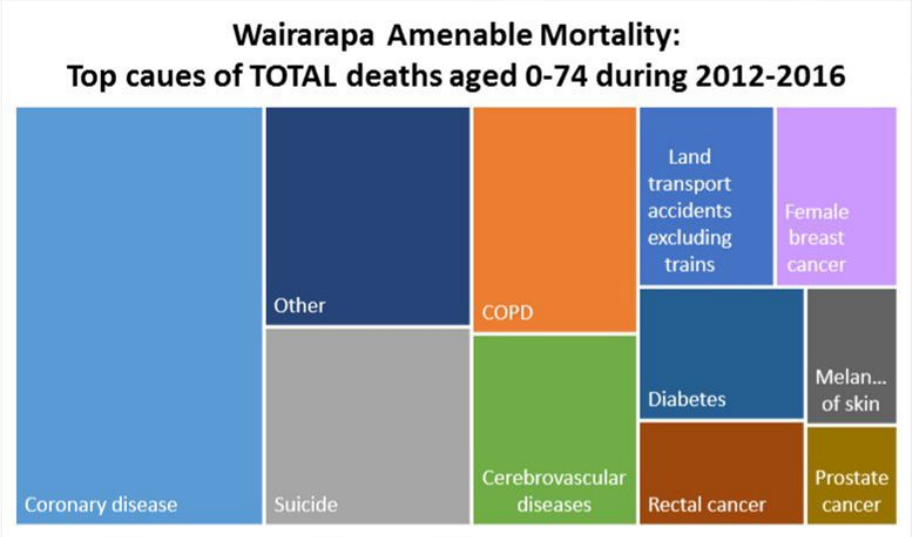






Amenable mortality is described as early deaths (before age 75) that could potentially be avoided given effective and timely healthcare. Historically Wairarapa residents had high rates however by 2016 this had fallen to the national average. Maori rates are higher than non-Maori. Coronary disease is the biggest group.





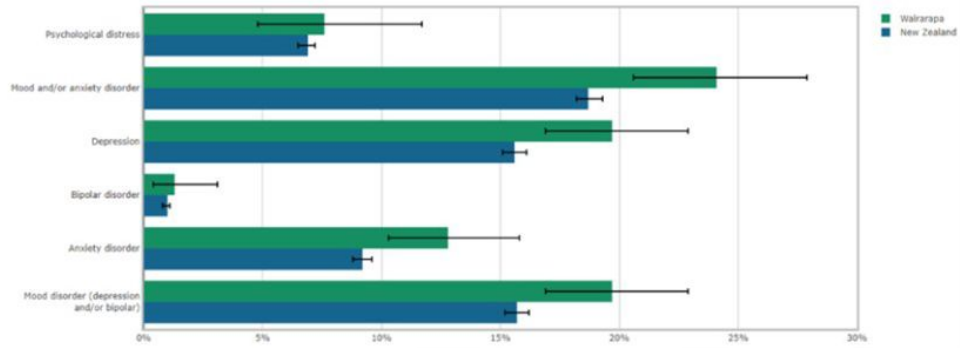
Mental Health

87% Wairarapa residents rated their health to be good or excellent which is similar to the national average. Similar to the rest of New Zealand less Maori rated the health to be good (75%) however this was not statistically different.

However Wairarapa residents experience more mental health issues especially mood and anxiety disorders.

Regions: Wairarapa and New Zealand

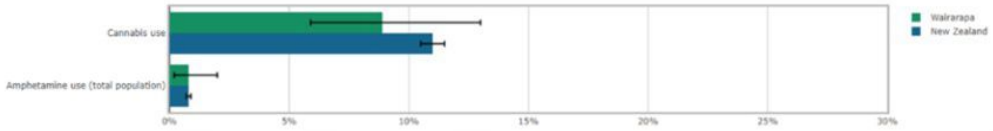
District Health Boards (DHBs)
Adults
Topic: Mental health
Pooled year data: 2014-17
Sociodemographics: All
Unadjusted data
Source: New Zealand Health Survey



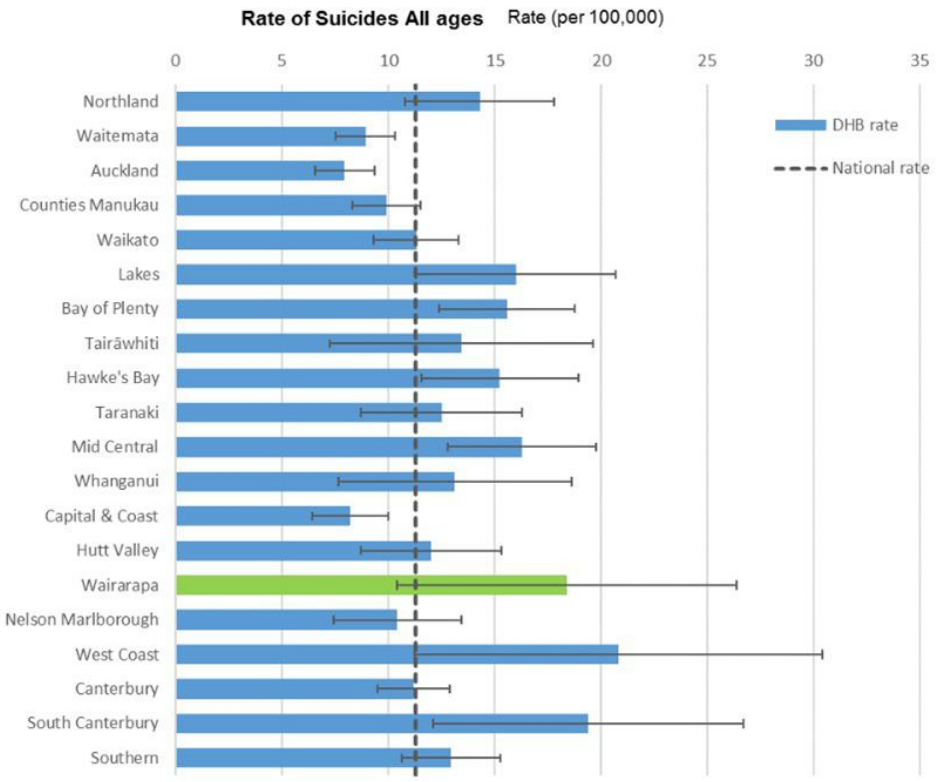
Harmful drinking is below the national average but not significantly. Cannabis use is also lower (not significantly) and Amphetamine use is average.

Regions: Wairarapa and New Zealand

District Health Boards (DHBs)
Adults
Topic: Illicit drug use
Pooled year data: 2014-17
Sociodemographics: All
Unadjusted data
Source: New Zealand Health Survey



DRAFT

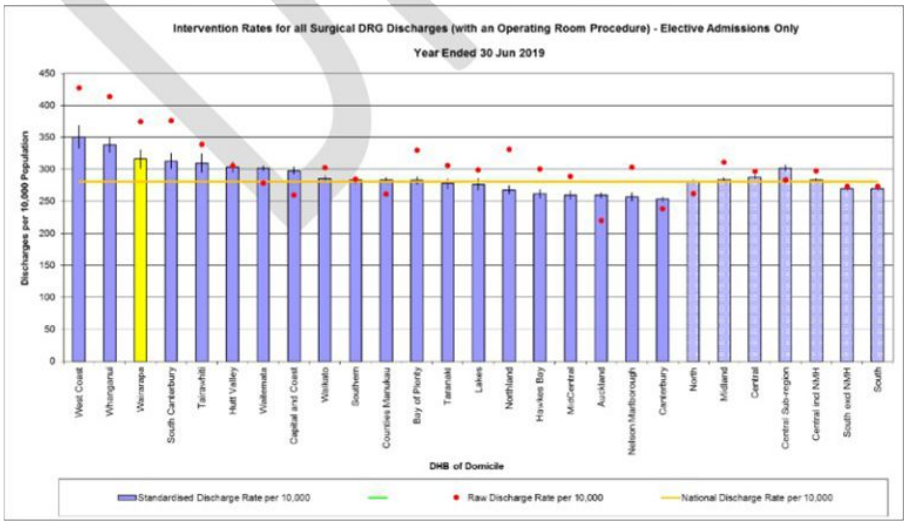


Family Violence

The number of assaults in Wairarapa has not significantly changed in the last 5 years.

Elective Surgery

Since 2015 Wairarapa residents have had better than average access to all elective surgery.



Standard Intervention rates per 10,000 pop

	Year ending				
	Jun-15	**Jun-16**	**Jun-17**	**Jun-18**	**Jun-19**
Cardiology	4.26	7.98	5.91	6.51	4.70
Cardiothoracic	6.32	4.69	2.56	4.87	4.90
Dental	29.99	20.64	22.18	18.01	20.64
ENT	40.40	35.43	30.70	**27.83**	30.38
General Surgery	74.94	70.10	71.02	71.65	72.49
Gynaecology	60.94	54.27	55.18	44.00	42.21
Neurosurgery	2.27	1.26	2.45	3.12	3.14
Ophthalmology	59.01	49.40	54.17	57.27	**43.31**
Orthopaedics	50.28	57.34	51.27	58.78	49.63
All Plastics	21.41	35.71	29.02	27.43	32.51
Plastics excl Skin Lesions	17.34	31.13	23.72	20.86	24.45
Urology	23.34	23.20	18.23	23.96	20.23
Vascular Surgery	8.52	**4.65**	5.11	6.15	6.29
All Surgical DRGs	**352.10**	**347.12**	**326.79**	**337.48**	**315.94**

Significantly above National Average
Significantly below the national Average

DRAFT

Most of the increase in proportion of the working-age population receiving Jobseeker Support has occured in the North Island/Te-Ika-a-Māui. Northland had the highest proportion of the working-age population receiving Jobseeker Support, **at 9.2 percent** as at the end of September 2019. **Wellington and Southern had the lowest percentage point increase of any region, by 0.1 percentage points as at the end of September 2019**, when compared with September 2018.

Work and Income has 11 geographical regions. An extra category, 'other region', is used to count people managed by national units, for example contact centres and processing centres.

All percentages have been rounded to the nearest decimal point. As a result, a percentage point change may be displayed as zero.

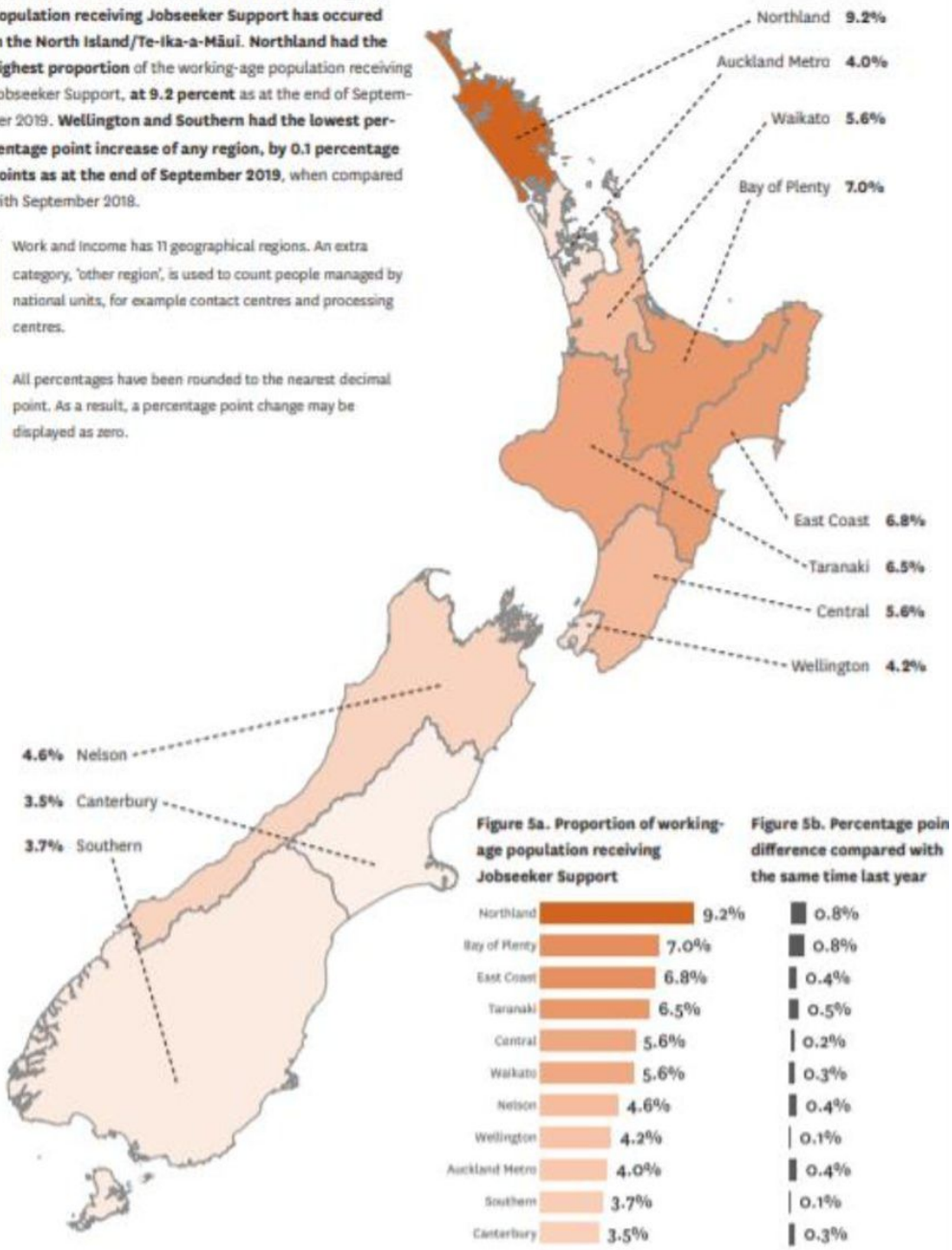


Figure 5a. Proportion of working-age population receiving Jobseeker Support

Figure 5b. Percentage poin difference compared with the same time last year

Sole Parent Support regional distribution as a proportion of the working-age population, by Work and Income Region, as at September 2019

Most of the increase in proportion of the working-age population receiving Sole Parent Support has occured in the North Island/Te-Ika-a-Māui. Northland had the highest proportion of the working-age population receiving Sole Parent Support, **with 3.8 percent** as at the end of September 2019. However, **Northland and Southern had the largest decrease by 0.1 percentage points when compared to September 2018**. Both Bay of Plenty and Taranaki had an increase of 0.1 percentage points compared with September 2018, as at the end of September 2019.

Work and Income has 11 geographical regions. An extra category, "Other region" is used to count people managed by national units, for example, contact centres and processing centres.

All percentages have been rounded to the nearest decimal point. As a result, a percentage point change may be displayed as zero.

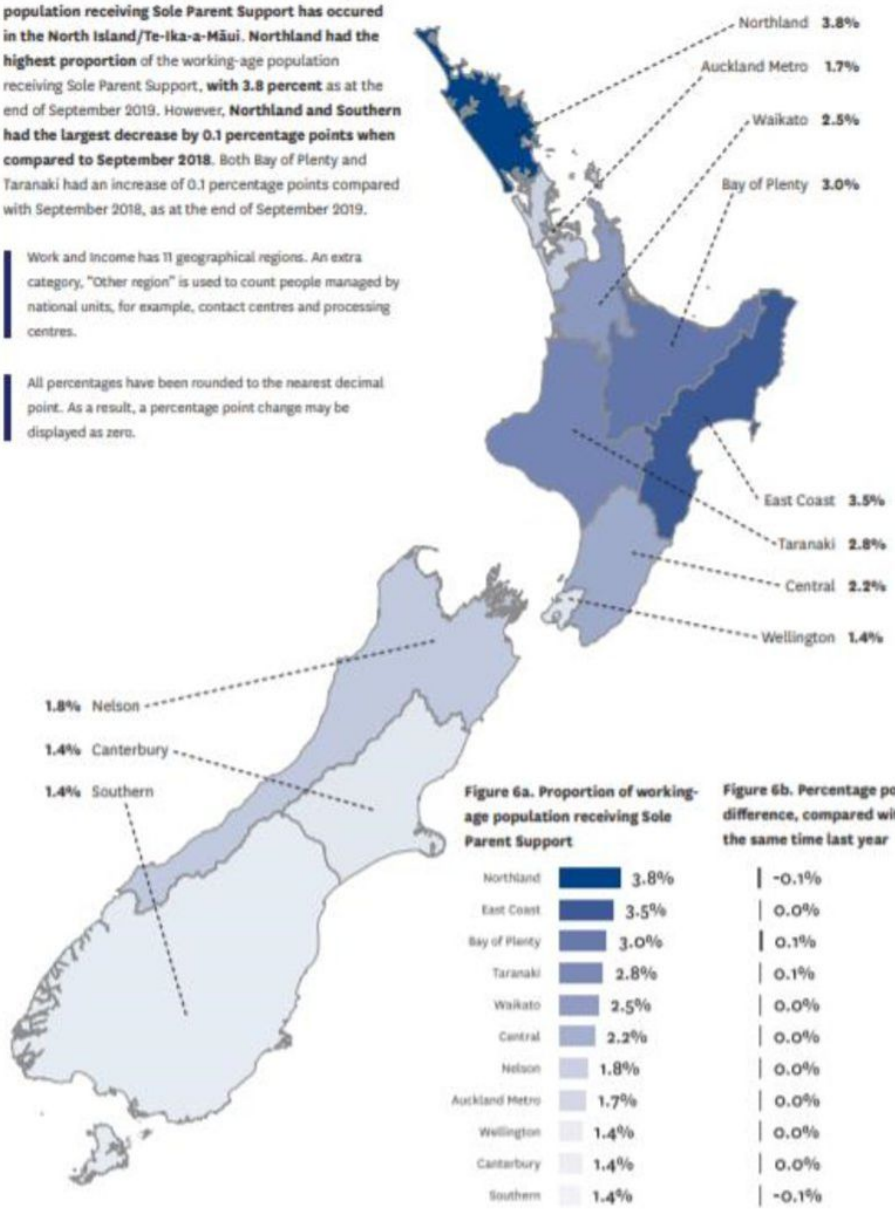


Figure 6a. Proportion of working-age population receiving Sole Parent Support

Figure 6b. Percentage point difference, compared with the same time last year

PUBLIC

Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**CPHAC INFORMATION PAPER**
	Date: 27 November 2019

Author	Sandra Williams, Executive Leader Planning & Performance
Endorsed By	Dale Oliff, Chief Executive
Subject	**Pacific Health and Wellbeing Strategic Plan 2020 - 2025**

RECOMMENDATION

It is recommended that CPHAC:

Notes the Wairarapa Board, at its November 2019 meeting, endorsed the draft sub regional Pacific Health and Wellbeing Strategic Plan 2020-2025

Notes the sub regional Pacific Health and Wellbeing Strategic Plan is one of the key supporting plans for the Wairarapa strategic direction and transformation change work being undertaken.

APPENDIX: BOARD PAPER AND DRAFT SUB REGIONAL PACIFIC HEALTH AND WELLBEING STRATEGIC DIRECTION

PURPOSE

The purpose of this paper is to inform CPHAC of the decision the Wairarapa Board has made to support the draft sub regional plan for Pacific Health and Wellbeing 2020-2025. This plan is also being presented to the Capital and Coast and Hutt Valley District Health Boards this month.

Attached as appendices are the cover paper for the plan and the sub regional draft plan.

The plan is a key document supporting the strategic direction Lin the Wairarapa district as noted in the Strategic Direction paper also on the agenda for CPHAC.

PUBLIC

Date:25 November 2019	**BOARD DECISION**
Author	Tofa Suafole Gush, Director Pacific Health, Candice Apelu Mariner, Integration Lead
Endorsed by	Dale Oliff, Chief Executive Officer Fionnagh Dougan, Chief Executive Officer
Subject	**Draft - Sub Regional Pacific Health and Wellbeing Strategic Plan 2020-2025**

RECOMMENDATIONS

It is **recommended** that the Boards:

a. **Note** the contents of the Draft Plan

b. **Note** the extensive community consultation undertaken by the DHB with the support of the Sub-region Pacific Heath Advisory Group

c. **Endorse** the Draft –Sub Regional Pacific Health & Wellbeing Strategic Plan 2020-2025.

d. **Agree** to disseminate the Draft–Sub Regional Pacific Health & Wellbeing Strategic Plan 2020-2025 to stakeholders for their feedback

APPENDICES

1. Draft Sub Regional Pacific Health and Wellbeing Strategic Plan 2020-2025

2. 3DHB Pacific Plan 2019 - Data

1. INTRODUCTION

1.1 Purpose

The purpose of this paper is to provide a six monthly Pacific Health update on progress for the 3DHBs and seek the endorsement of all three Boards to the Draft - Sub Regional Pacific Health & Wellbeing Plan 2020-2025.

1.2 Previous Board Discussions/Decisions

The Wairarapa and the joint Capital Coast and Hutt Valley District Health Boards in their respective meetings of February 2019 approved the approach to develop a 'One Pacific Health and Wellbeing Plan' for the sub region to guide and inform decision making around Pacific people's health in all 3 District Health Boards.

2. BACKGROUND

The Hutt Valley and Wairarapa DHBs Pacific Plan **(*Paolo mo Tagata ole Moana*)** expired in 2018. A performance review on the implementation of the expired strategy was tabled and approved by the Boards in November 2018. The visual presentations made to community and stakeholders were well received. Discussions with Pacific stakeholders also provided us with feedback on what we need to do more to benefit the Pacific people and its communities. The CCDHB Pacific Plan ***(Toe timata le Unpeg***) is due to expire in 2020.

The national Pacific strategy ***'Ala Moui'-Pathway to Pacific Health and Wellbeing 2014-2018*** sets out the strategic direction and actions for improving health outcomes for Pacific peoples and reducing inequalities. The development of **a single plan** for all three DHBs has been closely aligned to the national strategy and is consistent with what our local communities needs are, and what has been fed back during the community consultation /fono process.

The accompanying Pacific Population Health Profile of the 3DHBs is the first we have done. It collates demographic and health information for this population and was used to inform this current draft 3DHB Pacific Health and Wellbeing Plan. It will also inform future Health Needs Assessment of the Pacific population in our sub region.

2.1 CONSULTATION – THE VOICE OF THE COMMUNITY

The development of the Sub Regional Pacific Health & Wellbeing Strategic Plan 2020-2025 is the result of six months' work including extensive community and stakeholder fono/meetings to ensure the voice of communities have been heard. Feedback identified key opportunities for joint work with PHOs, Pacific providers, Regional Public Health and NGOs.

3. THE PLAN

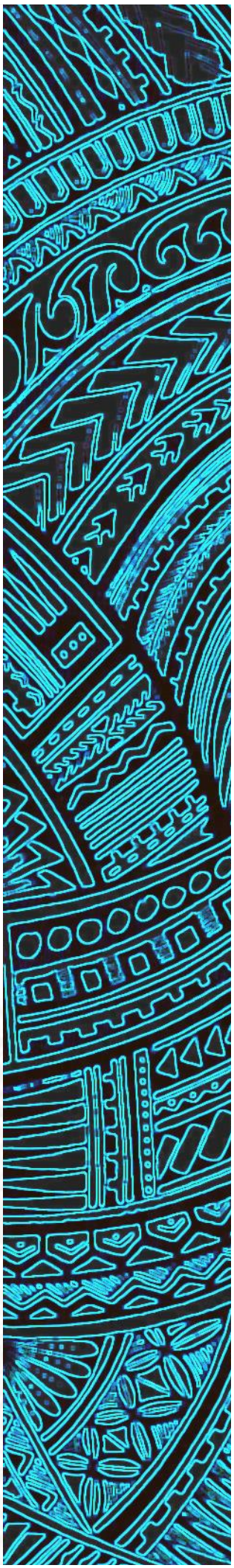
There are six priorities to action in this Plan. We have intentionally selected this number of priorities from what the community have said during the consultation process as well as what our Pacific data has confirmed are areas of health need. The same priorities are closely aligned to what we are required by the Ministry to report on under the equity indicators. The Plan also adopts the strategic directions as outlined in key strategic documents of our 3DHBs to guide our response to improving the health and wellbeing of the Pacific communities in the sub-region.

4. NEXT STEPS

With the Boards endorsement we will arrange for the draft to be disseminated to the key stakeholders, Pacific Providers & NGOs for their feedback before a formal launch of the document in the community in May, in time for the start of the financial year.

1. consult on the draft with a key group of stakeholders
2. refine the plan based on this feedback
3. seek the 3 Boards' approval of the final plan
4. formal launch

The funding for the implementation of the Plan is expected to be from the DHBs baseline in 2019/20 and out-years with most initiatives building on existing DHB and PHO programmes for improvement of the health of the Pacific population.



DRAFT SUB REGIONAL PACIFIC HEALTH AND WELLBEING STRATEGIC PLAN 2020-2025

DRAFT

Capital & Coast District Health Board
Wairarapa District Health Board
Hutt Valley District Health Board

Contents

Acknowledgement 1
Foreword 1
Introduction 2
Our Vision for Pacific in the Sub Region 4
Our Strategic Outcome 4
System Enablers 4
Principles of Pacific Healthcare delivery across the 3DHBs 5
So'oso'o Le Upega Framework for guiding this Plan 6
Our Strategic Priorities and Measuring Progress 7
Priority One: Pacific Child Health & Wellbeing 11
Rationale: 11
What the data tells us: 11
What we are going to do? 14
What is working well: Case Study 15
Priority 2: Pacific Young People 16
Rationale: 16
What the data tells us: 17
What we are going to do? 18
What is Working Well: A Case Study 19
Priority 3: Pacific Adults and Aging Well 20
Rationale: 20
What the data tells us? 20
What we are going to do? 21
What is working well: Case Study 22
Priority 4: Pacific Health Workforce & Pacific Providers/NGOs 23
Rationale 23
What the data tells us? 24
What we are going to do? 25
What's working well: Case Study 26
Priority 5: Culturally Responsive & Integrated Health System 27
Rationale: 27
What we are going to do? 28
What's working well: Case Study 29
Priority 6: Social Determinants of Health 30
Rationale 30
What the data tells us? 31
What we are going to do? 32
What's working well: Case Study 33
APPENDIX: Pacific Health Data across the Sub-Region 34

DRAFT

Acknowledgement

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

Foreword

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

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

We acknowledge that a range of factors such as education, housing, income, employment and social policies have a significant impact on achieving better health outcomes for Pacific peoples. We also recognise that we are operating in an increasingly complex and challenging health environment, with competing financial pressures and health interests, emerging health technologies and pharmaceuticals, shortages of health workforce, and changing demographics.

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

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

- *Pacific Child Health and Wellbeing,*
- *Pacific Young People,*
- *Pacific Adults and Ageing Well,*
- *Pacific Health Workforce & Pacific Providers/NGOs,*
- *Culturally Responsive & Integrated Health System,*
- *Social Determinants of Health*

The above strategies do not cover all possible approaches to reducing health inequalities, but rather the emphasis is on priorities where there is good reason to believe action by the DHBs and its partners outside of health will lead to the attainment of better health and wellbeing outcomes for our Pacific people.

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

Fionnagh Dougan

Chief Executive
Capital & Coast District Health Board
Hutt Valley District Health Board

Dale Oliff

Chief Executive
Wairarapa District Health Board

DRAFT

Introduction

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

"Paolo mo Tagata o le Moana" HVDHB & WrDHB Pacific Health Action Plan 2015-2018,

"Toe timata le Upega" CCDHB Pacific Health Action Plan 2017-2021.

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

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

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

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

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

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

2ibid

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

Key Strategic Directions

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

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

The Key strategic directions include:

1) Equity – advancing decisions, solutions and innovations that eliminate health inequalities for Pacific people.

2) Collaboration– strengthening partnerships including integrated planning and service delivery with both health and non- health partners across different sectors AND Pacific communities themselves.

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

4) Building the Pacific workforce - strengthening Pacific health providers providing sustainable resources for long-term, rather than short-term funding.

5) Inclusiveness – ensuring that Pacific disabled children, youth and adults and their families are also at the centre of service and programme decision making and are not left behind. Recognising that those with a disability may have extra barriers to overcome in accessing health services than most.

6) Robust Evidence Base- Implementing and investing in what is already working and building evidence through research, monitoring and evaluation.

7) Integrated Planning - Strengthening integrated planning and service delivery and accelerating the shift of services closer to home.

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

DRAFT

Our Vision for Pacific in the Sub Region

Our Pacific peoples are enabled and empowered to live longer and enjoy meaningful physical, mental, emotional and spiritual wellness supported by a culturally responsive health system.

Our Strategic Outcome

To work in partnership, collaboration and in an integrated way with Pacific communities, Pacific providers, health and multisector partners to deliver culturally responsive, fanau centred, accessible, appropriate, quality and timely health care services that meet the needs of the Pacific peoples.

System Enablers

Partners and Networks

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

Commissioning

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

Influence & Advocacy

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

ICT and Knowledge Resource

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

DHBs as an employer

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

DRAFT

Principles of Pacific Healthcare delivery across the 3DHBs

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

By making this the focal point, we commit as District Health Boards to ensure that Pacific people are actively involved in co-designing services and programmes that help address difficulties based on "one size does not fit all" due to the growing diversity of Pacific peoples and their ability to access quality and responsive services. We are putting a stake in the ground and acknowledging that as navigators of this wide ocean that we call the health system, we owe it to our Pacific communities and other indigenous ethnicities to reconstruct a system that they can voyage through without difficulty.

We have chosen five key principles or values common across Pacific cultures which have been weaved through this plan, and will guide our work alongside the input of Pacific communities through community leaders, churches, providers and others.

The Five key Principles include;

Family. Family underpins identity, genealogy, relationships and a sense of belonging for Pacific people. It lies at the heart of who Pacific people are as every Pacific person belongs to an aiga or kainga.

Environment. Built and natural environments is important to Pacific people. Their connectedness and experiences of both plays a huge role in the holistic approach to health and wellbeing.

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

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

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

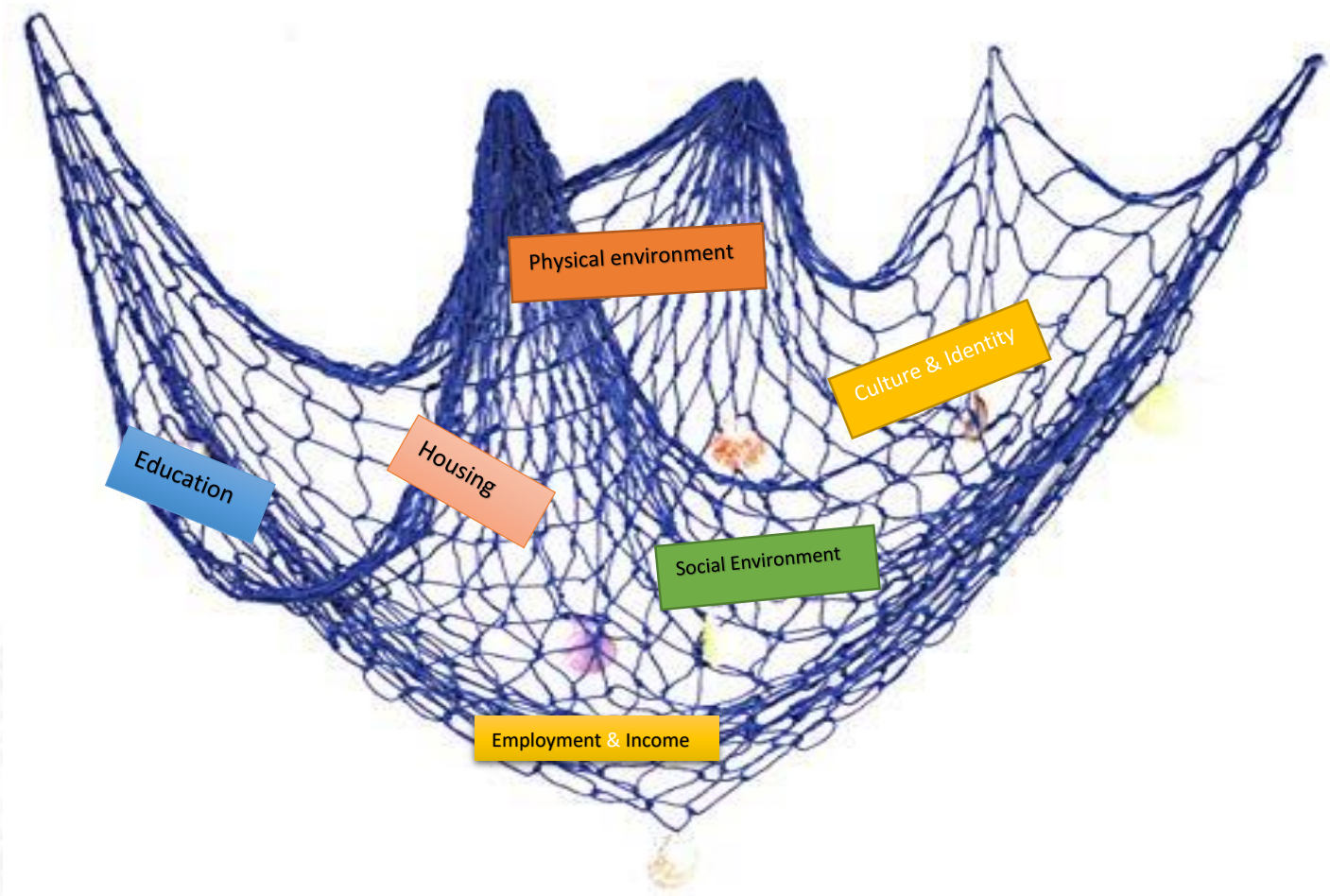
DRAFT

So'oso'o Le Upega Framework for guiding this Plan

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

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

So'oso'o le Upega Framework



Our Strategic Priorities and Measuring Progress

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

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

These strategic priorities and priority actions, activities and performance indicators with accompanying budgets will be embedded into the Annual Plan and existing performance and accountability mechanisms of each District Health Board. Indeed, accountability and responsibility towards reporting against this strategic Pacific health and wellbeing plan and achieving measurable outcomes for Pacific peoples should be the responsibility of all levels of management.

We know we have been successful when we see improvements in the following areas;

Priority One: Pacific Child Health & Wellbeing

	Measures
1.	Increased uptake of antenatal and postnatal maternity services that are culturally responsive and wrapped around needs of Pacific mothers and children.
2.	A decrease in Ambulatory Sensitive Hospital Admissions (ASH) rates for Pacific children and adults through improved coordination between community, primary care and secondary care providers and other sector partners.
3.	Coordinated approach with stronger links across health, education and social service providers to reach greater number of Pacific families through home visiting programmes, culturally appropriate parenting education and support.
4	Increased number of Pacific families accessing warmer drier homes through the Well Homes Healthy Housing initiative
5	Increased number and uptake of Pacific mothers, infants and children with disabilities and their families accessing the right maternity and services and receiving funded disability support services.
6.	Support increased uptake of healthy lifestyles programs targeting nutrition, exercise, sleep, smoking and mental for Pacific families in the communities and in schools.

DRAFT

Priority Two: Pacific Young People

	Measure
1.	Increased number and uptake of Pacific young people with disabilities and their families accessing the right services and receiving support
2.	Support existing and new programmes and initiatives like the Piki free youth Mental Health services, community driven mental health programmes like Taiala mo le Ola Manuia (A Guide to Healthy Living) Mental Health project with Church communities.
3	Encourage and better use of social media to promote health messages and campaigns to reach Pacific young people
4.	Establish collaborations with Health & P.E & Science Heads of Departments in Colleges to promote health as a career in schools but also to collaborate on health promotion initiatives driven by Pacific young people

Priority Three: Pacific Adults and Aging Well

	Measures
1.	Improved access to primary, secondary and tertiary health care closer to home and in the communities
2.	Increase in accessibility to medications and faster treatment pathways for Pacific patients
3.	Increase uptake of healthy lifestyle programmes and early prevention health promotion programmes
4.	Increase and improvement in early screening rates for cancer such as Bowel, Breast and Cervical screening programmes, uptake of diabetes checks and early intervention programs for diabetes, cardiovascular, respiratory, smoking and high blood pressure.
5.	Decreased number of prescriptions unfilled due to cost and increased access to Pharmacies and Pharmaceuticals
6.	Ensure new funding in early intervention mental health services meets the needs of Pacific people and is appropriate
7	Reduced ASH rates and Pacific people admitted to hospital due to complications from chronic conditions

DRAFT

Priority Four: Pacific Health Workforce & Pacific Providers/NGOs

	Measures
1.	Increase in Pacific skilled workforce being interviewed for positions and employed within the District Health Boards in different areas.
2.	A review of commissioning and contracting processes within the DHBs is undertaken to ensure Pacific providers are utilized and resourced to support primary and secondary care to reach and serve Pacific peoples.
3.	Work with Pacific health workforce community organisations e.g. Tausi Soifua Samoa Nurses Association, Tongan Nurses Association, Tokelau Nurses, Pacific Social Workers Association, Pacific Pharmacy Association, to provide mentoring & scholarship support not only to students undertaking nursing and social work studies. But also work across to mainstream providers to ensure there are pathways in place for mentoring and leadership trainings for the current workforce.
4	Strengthen reporting mechanisms through ensuring the right support with Technology and backroom admin support to our Pacific providers and NGOs as required

Priority Five: Culturally Responsive and Integrated System

	Measures
1.	Increase in the number of specialist and health care services closer to home and out in the community
2.	Strengthen connection and support of Pacific providers to mainstream services for example Health Care Homes and Community Integration projects in primary care.
3.	Number of Mandatory Cultural Competency trainings rolled out across Secondary and Primary care services.
4.	Scale up support for Integration projects that are working and across the Sub-region
5.	Establish a Pacific specific sub regional health pathways for the 3D Health Pathways programme.

Priority Six: Social Determinants of Health

	Measures
1.	Strengthening partnerships and work in collaboration with housing organisations, Ministry of Social Development, Ministry of Pacific Peoples, Ministry of Education, Pasifika Future, Local councils and other sectors and leverage off programmes such as Pasifika PowerUP Education programmes and Living wage
2.	Advocate for free or cheaper visits to general practice and prescriptions for 15-18 year olds, especially for large families with three or more children.
3.	Promote the Well Homes service to Pacific families and services, which helps families' access housing interventions such as insulation, heating, curtain banks, beds, bedding, and carpets.

DRAFT

Our Pacific peoples in the Wellington Sub Region

The Wellington Sub-Region is home to an estimated **35,165 Pacific people** which is 8% of the total population. This is higher compared to the national average of 6.5%. We have a youth bulge with an increasingly aging population. There has also in the last 5 years been a steady number of live births across the sub-region. The greatest proportion of Pacific people across the sub-region reside in Lower Hutt and Porirua City.

Porirua City and Lower Hutt City have the greatest portion of Pacific peoples

Life Expectancy has increased by 7-8 years

4% Increase in population over next 5 years

29% Of Pacific population in the Wellington SubRegion are Under 15 years old

60% New Zealand Born,40% born in the Islands but have lived in NZ for over 10 years and through Quota system

99% Pacific people in the Wairarapa enrolled with a PHO

98% Pacific people in the Hutt Valley enrolled with a PHO

97% Pacific people in Capital & Coast enrolled with a PHO

The largest ethnic groups are Samoan, Cook Island Maori, Tongan, Niuen, Fijian, Tokelauan

Our Pacific Peoples Health Status

51% CCDHB, 40% HVDHB, 36% WrDHB Pacific living in the most deprived áreas.

Top ASH Conditions for Pacific Children (0-4years)

Asthma, Dental conditions, Gastroenteristi/dehydration, Upper Respiratory Tract infections and Cellulistis

Top ASH Conditions Pacific Adults

Angina & Chest Pain, Cellulistic, Pneumonia, Stroke, Myocardial Infarcion, Chronic Obstructive Pulmonary Disease, Gastroenteritis/dehydration

Pacific enrolled with Compass PHO in the Wairarapa saw a GP or Nurse 5 times

Pacific enrolled with Compass or Ora Toa PHOs in Wellington saw GP or nurse 4.5 times

Pacific enrolled Te AHN PHO and Cosine PHO saw GP 3.5 times

Pacific aged 65 and over had the most visits to GPs on average followed by Ages 45-64 and Pacific children Under 5.

Priority One: Pacific Child Health & Wellbeing

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

Rationale:

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

What the data tells us:

Latest data tell us that children aged under 15 years, make up 33% of the Wairarapa Pacific population, 29% in the Hutt Valley and 27% for Capital & Coast DHB respectively. And that over 60% of the Pacific population in the Wellington Sub-region are now New Zealand born. There have been improvements in health outcomes as evidenced by a decrease in ASH rates for Hutt Pacific and Capital & Coast for Pacific children in the last 5 years. Including increased newborn enrolment with a General Practice and Community Oral health service. Also improvements in immunisation rates, increased percentage receiving WellChild or Tamariki Ora core checks in their first year and B4 School Checks by the time they are four years old.

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

Most of the ASH presentations of Pacific children to hospital were for asthma, dental conditions, gastroenteritis/dehydration, upper respiratory tract infections and cellulitis across the three DHBs.

There also remains a disparity in the percentage of Pacific children being caries free by the age of five, higher rates of obesity or overweight and Pacific children turning 1 year old were less likely to have had all their scheduled core checks than children of other ethnicities excluding Maori. For Wairarapa Pacific children, 70% had received all their core checks, 57% of Hutt Pacific and 69% of Capital & Coast Pacific.

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

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

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

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

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

DRAFT

What we are going to do?

Support and invest in new initiatives and support programmes already working that are fanau centred and targeted at addressing;

- First 1,000 days of life
- Healthy relationships, healthy pregnancy, positive parenting, parents and child mental health
- Healthy nutrition, sleep and physical activity
- Parenting programmes that support mothers and fathers focused on pre-conception, antenatal and postnatal
- Safe environments for bringing up Pacific children including warm homes, safe sleeping, reducing smoking and alcohol consumption
- Ensuring 100% of Pacific newborn's in the Wellington sub-region are enrolled with a General Practice, AND Well Child Tamariki Ora service by 3 months of age
- Focused on making sure 100% of Pacific infants and pre-school aged children receive oral health checks by 1 years of age.
- Improved and timely immunization uptake and rates
- Invest in programmes that build capacity and capability of primary and secondary workforce to build relationships with parents and families.
- Support investment in services and initiatives that provide home visits to families.
- Investigate initiatives and improve access to information and services that address Family violence and work with relevant stakeholders
- Strengthened approach to working across agencies to address timely access to maternity services and birthing options
- Support Pacific families through a inter-sectoral model for health education in schools and in the communities.
- Leverage off Pacific specific Well Child services and build up these providers to reach the most vulnerable families.
- Support the Well Homes initiative to ensure Pacific families have access to warm dry homes
- Implement strategies to increase rates and duration of breastfeeding
- Integration with general practice & Health Care Homes, PHOs and other services with shared plans and ability to cross-refer electronically.

What is working well: Case Study

Thriving Cores Pacific Well Child Tamariki Ora is the only Pacific run WellChild Tamariki Ora service provided through Pacific Health Service Hutt Valley (PHSHV) in the Wellington Sub-region. PHSHV is a not-for-profit agency based in Naenae in the Hutt Valley. The Thriving Cores service is a mobile service that has successfully worked with over 1,000 Pacific families over the years by conducting Core checks in people's homes and also running out of hours clinics to suit working mothers and parents.

They have provided social services support and working alongside Lead maternity carers to offer educational support to the families. They have also facilitated a lot of Pacific infants through provision of transportation to get infants and parents to their dental and specialist appointments. This service also helps with Car seat rental discounts, and provision of free Pepi Pods for safe sleeping for babies. They also offer a range of culturally appropriate parenting programmes and support groups. The service is fanau focused, strengths based, relational and the programmes provided are complementary and are designed to improve the outcomes for families/aiga and children.

DRAFT

Priority 2: Pacific Young People

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

Rationale:

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

What the data tells us:

Various school based health services are provided in low decile colleges, Teen parent units and alternative education centres delivered by Regional Public Health, VIBE, Evolve and some specific DHBs health services across the sub-region. Doctors and Nurses provide students with advice, treatment and referrals to other services on problems including general health, sexual health, and mental health. They also provide routine Health assessments to Year 9 students. Based on the most recent data available for the 2017 calendar year, in Wairarapa 27 Pacific students were seen by School based health services (79% of eligible students) and had on average 2 visits. Hutt Valley School Based health nurses saw 133 Pacific students (28% of eligible students) who had on average 2 visits. 100 Pacific Year 9 students in Hutt Valley received a routine health assessment. Capital & Coast School based health nurses saw 589 Pacific students (94% of eligible students) who had on average almost 2 visits.

Even though we see improvements and the availability of youth centred health services and programmes targeted to our young people in schools, we are seeing a rise in mental health issues, suicide attempts, sexually transmitted infections, smoking, preventable injuries, obesity and family violence. Our young people identified during the consultations the close

DRAFT

link between mental health issues and the result of identity crises, poverty, lack of cultural sensitive health care models, stigmatisation and discrimination.

Tackling the risk factors associated with these issues alongside sufficient investment to advancing progress made in some areas and investment in new and innovative ways to support our young people to thrive is our goal. Particularly given that across the Sub-Region in the next 10 years most of the Pacific growth will be in the age groups 15-29 years a 8% increase4

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

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

DRAFT

[4] 3DHB Pacific Plan Data sets 2019

What we are going to do?

- Support and strengthen initiatives that encourage young Pacific people to adopt healthy lifestyles, make informed choices about sexual health, smoking, and risk taking behaviors
- Accelerate strategies and innovations that focus on Pacific young people's improving access to appropriate and timely primary and secondary mental health services.
- Implement programs that prevent and address the problems caused by self-harm and violence
- Strengthen partnerships and collaborations with youth specific health, social and educational service providers
- Implement initiatives that promote strengthening pride in culture and identity
- Interventions and Cultural sensitive models of care are utilised when dealing with mental health, sexual and reproductive health issues of young people
- Encouraging parents and families to be positive role models;
- Strengthen the participation of Pacific young people in dialogue and decision-making opportunities and activities for monitoring of their health.
- Support programs that will focus on sensitizing and training health and disability workforce who with Pacific youth

What is Working Well: A Case Study

Evolve and Vibe Youth Health Services are providing free and confidential health care across the Sub-region including general, sexual and mental health, counselling, social support and youth development activities reaching low decile schools that have high percentage of Pacific students. These services also offer support for young people not in education, employment or undertaking any formal trainings who are between 16 or 17 years old amongst others. Pacific young people interviewed during the consultation phase identified that they were confident in the services provided through these school based clinics.

Regional Public Health through their School based health nurses and Social workers in schools are also reaching low deciles primary and intermediate schools and provide onsite health and social support to Pacific families and children.

Priority 3: Pacific Adults and Aging Well

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

Rationale:

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

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

What the data tells us?

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

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

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

amenable mortality is higher for Pacific than non-Maori non Pacific people in Capital & Coast and Hutt Valley.

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

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

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

What we are going to do?

- Implement early prevention, health education and promotion programmes that draw on Pacific traditional wisdom, languages and cultural strengths to address risk factors and treatment of long term conditions.
- Work in partnership with key stakeholders to increase and encourage participation in early screening programs (s cervical, bowel, breast and other cancers) AND cessation support (smoking and drugs).
- Continue to support healthy lifestyle programmes focussed on improving accessibility and affordability of nutritious food, sleep and increased physical activities for Pacific adults and elderly.
- Continue to complement system-wide health service delivery with targeted activities specifically aimed at chronic disease treatment and prevention
- Continue to fund the important 'Catalyst' Pacific radio programme and develop comprehensive social media campaigns to promote key messages and health information in the different Pacific languages that will raise awareness and support Pacific people to make the right lifestyle changes
    - Promote links across mental health and drug and alcohol services and continue to increase community awareness and education about the range of options for dealing with the impact of the use of drugs, alcohol and tobacco.
    - Implement strategies to promote resilience, empowerment and positive mental health
    - Strengthen healthy aging initiatives and optimise on opportunities to support Pacific elderly live quality lives in their homes.
    - Effectively integrate and socialise the idea of Advanced Care Planning with Pacific families and communities.
    - Continue to identify change levers in programme and service design which will make the greatest impact on a given health condition or issue including cultural competency training for non-Pacific workforce that work with Pacific people.

DRAFT

What is working well: Case Study

Pacific Nurse Led Services and Navigation services out in the communities are achieving transformational cultural clinical and social outcomes for our Pacific peoples with long term conditions. These mobile nursing and social support services work with General Practices, Specialist services in the Hospitals and sectoral partners to wrap services in a culturally appropriate way around the patient and taking this care directly to their homes.

Examples of these Pacific services the Pacific Health Service Hutt Valley Primary Nursing Service and Vaka Atafaga, alongside Taeaomanino Trust, Vaka Tautua to name a few are reaching and supporting patients to complete and re-engage with their General Practices.

Priority 4: Pacific Health Workforce & Pacific Providers/NGOs

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

Rationale

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

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

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

What the data tells us?

The Central Region District Health Boards Pacific Workforce Report as at 30 June 2019[5] identified that across the Wellington Sub Region, the Pacific workforce was spread across with the highest reported proportion of Pacific peoples in the Care and support occupation group with 20% in CCDHB, 2% in HVDHB and 0% in WrDHB. Followed by those working in Corporate, Admin and other, Nursing and with the lowest proportions in Midwives, Resident and Senior Medical Officers.

Across the Central Region, the proportion of Pacific staff with more than two years of accrued annual leave was typically lower than the proportion of all employees with this level

[5] TAS Central Region District Health Boards Dashboard Pacific Workforce Report June 2019,

of accrued leave, with no Pacific staff in the Midwifery, Resident Medical Officer or Senior Medical Officer Occupation groups reportedly accruing more than two years of annual leave. A cause for concern was the reported number of sick leave hours taken in April-June 2019, as a proportion of total paid hours, was typically higher for Pacific employees than the rate across all DHB employees.

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

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

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

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

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

DRAFT

What we are going to do?

- Increasing and attracting our Pacific human capital by targeting students via formal education settings, such as secondary schools to tertiary institutions. This pipeline needs to be socialised as well with the education sector. Explore and invest in cadetship programmes.

- Build effective pathways from schools to promote careers in health and focus on students, to transition with ease into higher education and professional institutions.

- Influence HR recruitment policies and processes across the 3DHBs to improve Pacific employment opportunities including increasing number of Pacific on shortlisting, interview panels, Steering groups and governance

- Focus on overseas/island trained health professionals with overseas training and qualifications and the pathways to get them qualified in the NZ health system

- Continue to fund and support improvement of “Pacific by Pacific” Pacific Health Service providers in the community and recognise the crucial part they play within the health system and the achievement of health outcomes.

Retention & Sustaining & Career Development:

- Retaining and supporting our current Pacific workforce includes looking at

1. mentoring programmes and support not only for current workforce, but those undertaking studies

2. flexible working arrangements to allow our Pacific workforce to focus on meeting their family/community obligations AND allow for family support

3. encouraging and developing succession plans for retention and professional pathways for Pacific health workforce alongside employment

What's working well: Case Study

The recruitment process in the Hutt Valley District Health Board has changed since 2018 to reflect the need to increase the number of Pacific in the nursing workforce by interviewing all Pacific and Maori applicants at the entry point of the process. There is still some fine tuning to this process and small positive changes are happening. But it is a process that needs to be scaled up and embedded across the sub region.

In addition, health specific scholarships through the Aniva Health Scholarships offered through the Ministry of Health as well as HVDHB specific Oral health Scholarships for three students over the last five years provide opportunities to grow our workforce.

Priority 5: Culturally Responsive & Integrated Health System

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

Rationale:

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

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

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

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

What we are going to do?

- Develop and Implement a Sub-regional Cultural Competency Framework, Checklist and Training Package that nurtures a culturally responsive work environment and improve capacity of the health workforce to deliver culturally sensitive services.

- Build accountability and leadership for Pacific health outcomes by embedding accountability at all levels of management within the DHBs and also reporting requirements on health impact of Pacific across services.

- Strengthen and support Pacific Health Providers and align their work with General Practices and hospital services in particular with a focus on Health Care Homes and Integrated family health centres in primary care and the community.

- Strengthen links across the health system from clinical and nonclinical work streams and focus on better access to coordinated and multidisciplinary care.

- Establish a mechanism for collaborative operational planning, strategy development and service design across the 3DHB Pacific directorates

- Develop opportunities for regular consultations with Pacific communities to establish and hear views about healthcare delivery

- Embed Pacific cultural training as a key component of new employees orientation programme

- Explore opportunities for research that promote cultural responsiveness and safety in the workplace.

- Continue to support integrated programmes in primary care and hospital/specialist services focussed on early identification, treatment and support for individuals with risk factors such as the Community Integration initiative.

- Maintaining trusted relationships within the Pacific community such as Churches and with providers.

- Continue to give priority to improving quality of hospital care and specialist services and primary health care systems to ensure they are culturally sensitive and safe for Pacific people.

What's working well: Case Study

The Cultural Competency Mandatory Training programme currently being implemented in the Hutt Valley District Health Board and as part of the Cornerstone Accreditation Scheme for General practices through Te Awakairangi Health Network in Primary Care is proving to be a huge success. It has trained over 400 Community Pharmacists, GPs, Radiologists, Theatre staff, Regional Breast and Cervical Screening Services, Community Dental Therapists, Allied Health staff, Practice Managers, Nurses, Strategy and Planning staff, Administrators since it was put in place in 2018.

The Training programme is completed and delivered in two phases.

1) Mandatory Training for all Employees E-Learning Module
2) Face to face 2 hour Training

The training was implemented to support and equip non-Pacific colleagues across the hospital and community settings with practical tools, sound knowledge and understanding of Pacific people. Furthermore it was created out of a need to create a "Culturally Responsive" environment within the hospital and general practice settings with a strong equity focus to enhance how people engaged, worked and support both Pacific patients and staff.

Priority 6: Social Determinants of Health

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

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

Rationale

The health and wellbeing of our Pacific communities is heavily influenced by the underlying social determinants of health. These include, housing and employment, health behaviours, clinical care and the physical environment.

What the data tells us?

A higher proportion of Pacific people are living in more deprived areas according to the NZ Deprivation Index. Based on the 2013 Census population, 51% of Capital & Coast Pacific people were living in the most deprived areas, 40% of Hutt Pacific people and 36% of Wairarapa Pacific people.

Research suggests that only about 20 percent of a person's health is determined by access to health care. The other 80 percent is determined by health behaviours and the social and environmental conditions where they live, work and play.6 The feedback from our Pacific people provided valuable insight on how the social determinants of health were impacting on their health and wellbeing.

Most importantly, the feedback highlighted what we need to prioritise to improve the health and wellbeing of our Pacific Peoples across Wellington, the Hutt Valley and Wairarapa.

It is well known that income is associated with health and wellbeing. Families on low incomes may struggle to pay all their bills, which can cause stress and tension within a family. The rise in housing costs in recent years, in particular, has put many families under financial strain – with a significant proportion of their income having to be spent on rents or mortgages. This may mean they are unlikely to afford items and activities that can have a positive impact on health and wellbeing. These may include, for example:

- healthy foods, like fruits, vegetables and milk
- team sports and other outdoor activities
- school outings and events
- joining and participating in local cultural or religious groups, hobby groups, or clubs
- appropriate clothing and bedding
- travel or holidays
- electricity for heating
- household items to help keep homes warm and dry, like heaters, curtains, draft stoppers and insulation.

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

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

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

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

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

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

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

DRAFT

What we are going to do?

- Support initiatives and innovative programs that promote effective partnerships between local services from different sectors that address the social determinants of health
- take action across key social determinants such as health, housing, education and employment;
- align program goals across sectors and leverage off existing partnerships, frameworks and programmes that are in place for example working with Pacific Whanau Ora collectives
- Strengthen working relationship with the Ministry of Social Development and Work and Income New Zealand to help them promote and inform Pacific people about the support that is available to them and help make their processes for applying for support easier and more user-friendly.
- Work with our health providers to ensure that they know what Government supports are available to their clients and can help people apply
- Support Pacific people and work alongside them and other agencies to help them apply for the Government support and help that they are entitled to.
- Advocate for free or cheaper visits to general practice and prescriptions for 15-18 year olds, especially for large families with three or more children.
- Promote the Well Homes service to Pacific families and services, which helps families' access housing interventions such as insulation, heating, curtain banks, beds, bedding, and carpets.

DRAFT

What's working well: Case Study

Pasifika PowerUP is an education programme that aims to actively support Pacific parents, families and communities to champion their children's learning out in the communities and close to where they live. Delivered through the Ministry of Education, PowerUp stations sessions have been delivered all over New Zealand and have proven to be very successfully in accelerating the learning and achievements of Pacific students. The sessions are delivered in a safe learning environment either through Church partnerships or within school settings, this programme also provides academic support to primary and secondary students using trained Pacific teachers.

The Pacific PowerUP Au Lotu model was launched this year as a partnership with Congregational Christian Churches in Wellington. This is a 10 week parent only programme delivered by key churches in specific communities. Au Lotu means the "church" group and is designed to work through the churches influence in Pacific communities. This model harnesses the strength of church pastoral care, inter-faith connections and networks.

DRAFT

APPENDIX: Pacific Health Data across the Sub-Region

APPENDIX

DRAFT

3 DHB Pacific Plan 2019 – data

Population

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

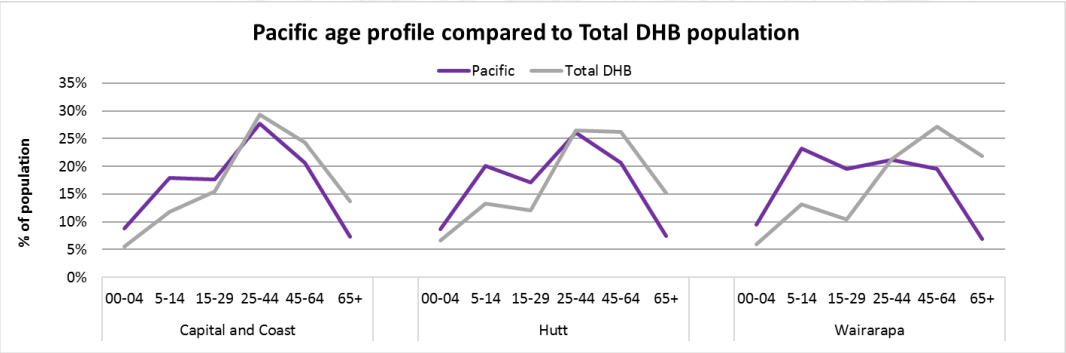
Number of Pacific people in 2019/20 (StatsNZ population estimate 2018)

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

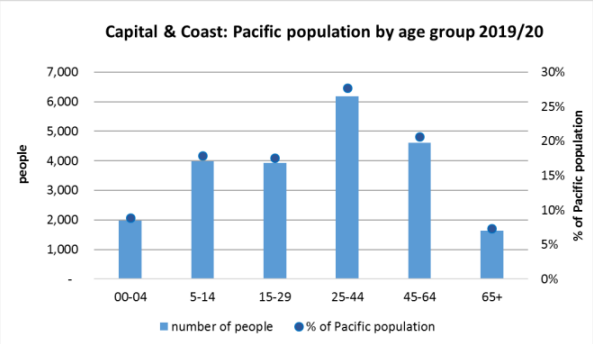
Age profile of Pacific

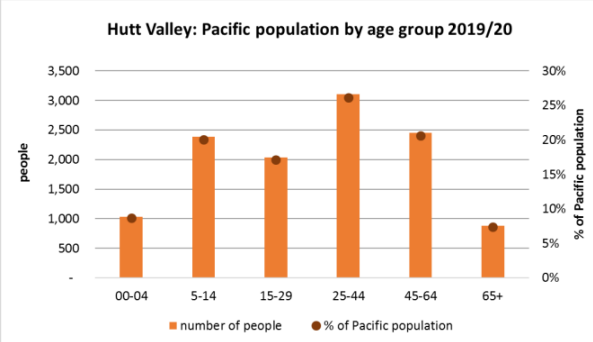
Pacific are a much younger population than the Total DHB population. In 2019/20 Children aged under 15 years, make up 33% of the Wairarapa Pacific population compared to 19% of the total DHB population. For Hutt Valley, children under 15 years make up 29% of the Pacific population, whereas they make up 20% of to the total population. For Capital & Coast, children under 15 years make up 27% of the Pacific population, whereas they make up 20% of the total population. Whereas, people aged 65 and over made up only 7% of the Pacific population in each DHB which was much lower than proportion in the total population.

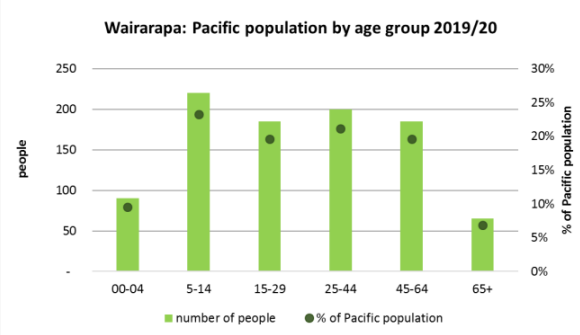
Age profile: % breakdown of Pacific population in 2019/20 compared to Total DHB



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

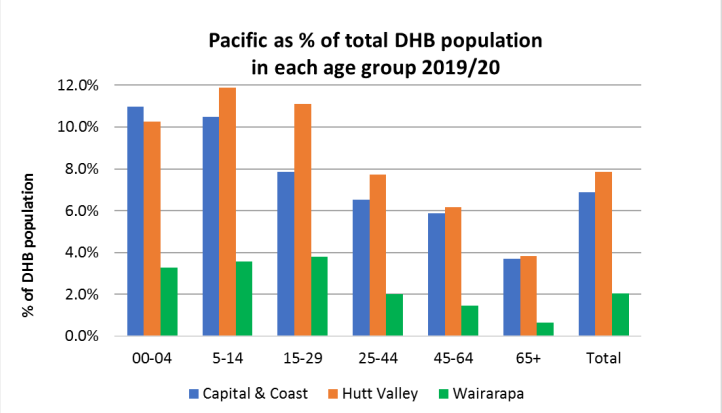






Although Pacific make up 7-8% of the total population of Hutt Valley and Capital & Coast DHBs, Pacific make up a higher proportion of the DHBs' children and young people because they are a younger population. Of the children aged under 15, Pacific make up more than 10% of the Hutt Valley and Capital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

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



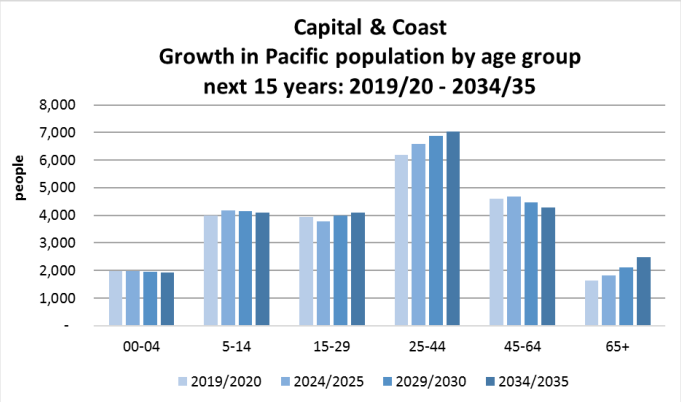
Future Population growth

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

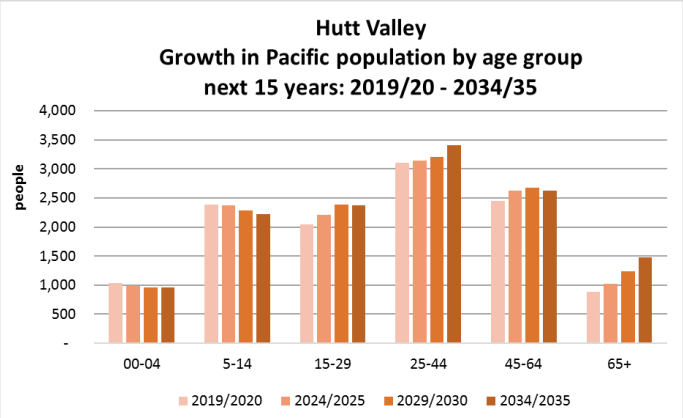
Pacific population growth in next 5 years 2024/2025

	2019/2020	2024/2025	Growth in people in next 5 years	% growth in next 5 years
Capital and Coast	22,320	23,000	680	3.0%
Hutt	11,900	12,350	450	3.8%
Wairarapa	945	995	50	5.3%

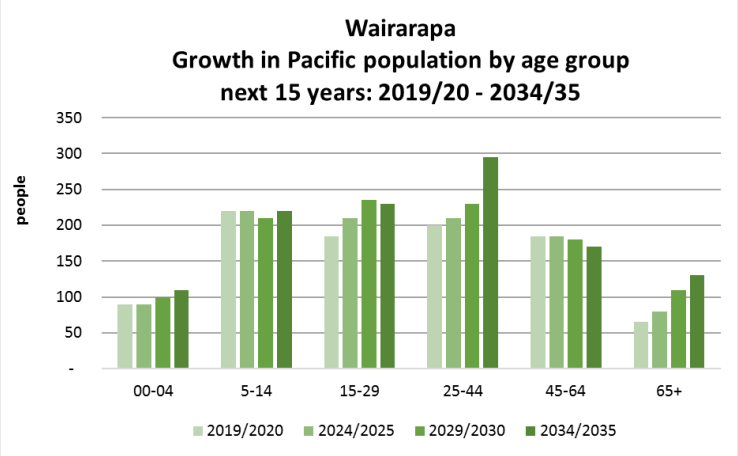
Most of the Capital & Coast growth in the next 15 years will be in the age groups 25-44 and 65+. In the next 5 years, Pacific aged 25-44 are expected to grow by 400 people (6.5%) and Pacific aged 65+ will grow by 180 people (11%).



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



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



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

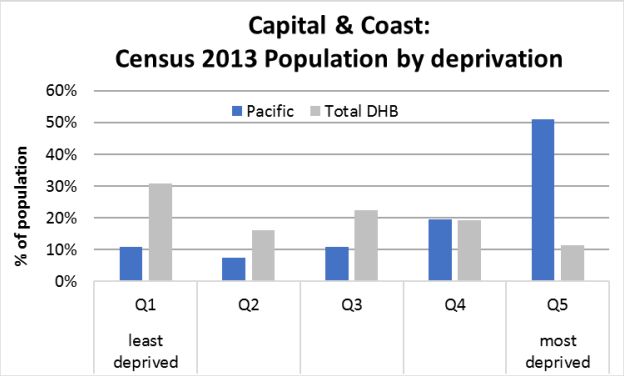
	Capital and Coast	Hutt	Wairarapa
00-04	1980	1030	90
05-09	2060	1160	110
10-14	1930	1230	110
15-19	1910	1070	110
20-24	2020	970	75
Total	**9900**	**5460**	**495**

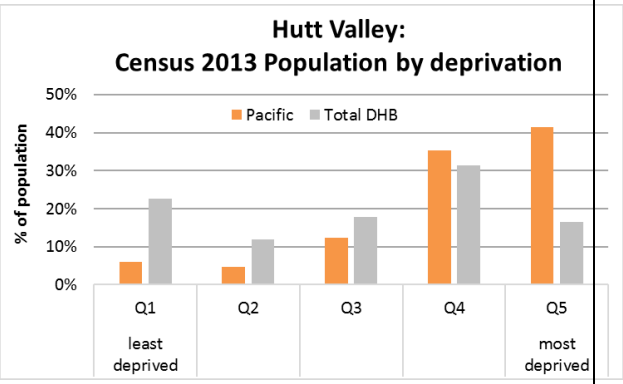
Population by Deprivation Index 2013

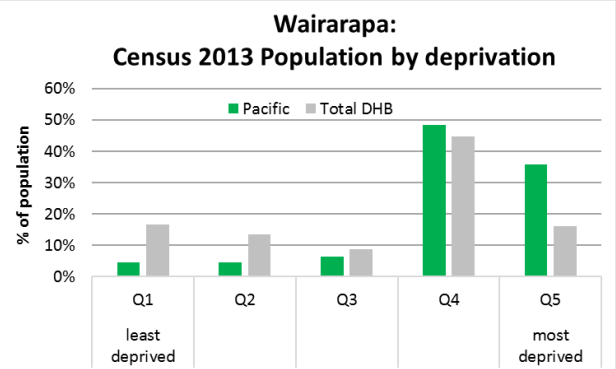
A higher proportion of Pacific people are living in more deprived areas according to the NZ Deprivation Index 2013. The NZ Deprivation Index is based on variables that reflect socioeconomic factors that have significant influence on health such as income, employment, home ownership, and overcrowding.[1]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

57% of Capital & Coast Pacific adults aged 65 and over were living in the most deprived areas. 47% of Hutt Pacific adults aged 65 and over and 50% of Wairarapa Pacific aged 65 and over were living in the most deprived areas.

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





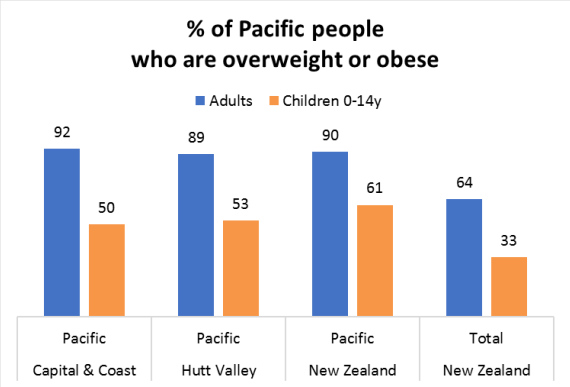


[1] https://www.otago.ac.nz/wellington/departments/publichealth/research/hirp/otago020194.html

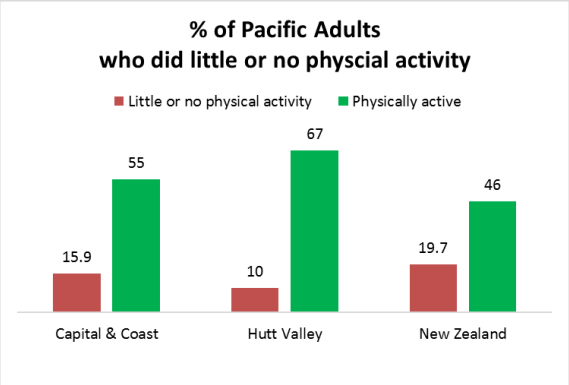
https://www.otago.ac.nz/wellington/otago069936.pdf - page 8 - list of variables

Risk factors

Obesity & Physical activity

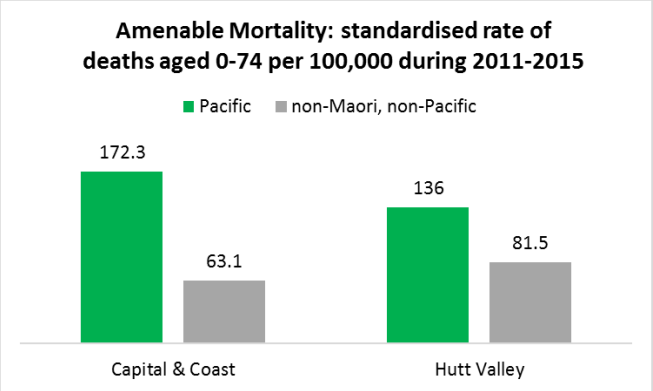


Based on the NZ Health survey standardised rates, 92% of Pacific adults in Capital & Coast are overweight or obese and 89% of Hutt Valley Pacific. This is similar to all Pacific in New Zealand. Around half of Pacific children aged 0-14 years are overweight or obese in Hutt Valley and Capital & Coast,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



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

Health Outcomes: Amenable Mortality



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

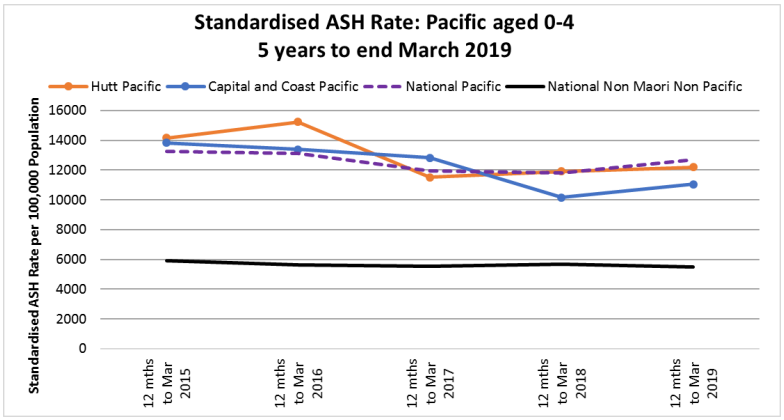
Based on coroner's information on suspected suicides, over the four years from 2014/15 to 2018/19, 5% of Hutt Valley deaths were Pacific people, 7% of Capital & Coast and none of the deaths in Wairarapa were Pacific people.

Health Outcomes: Hospitalisations

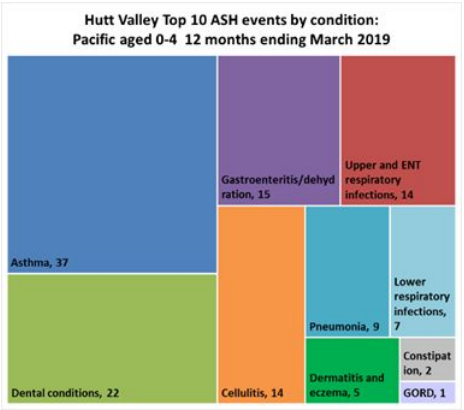
Ambulatory Sensitive Hospitalisations (ASH)

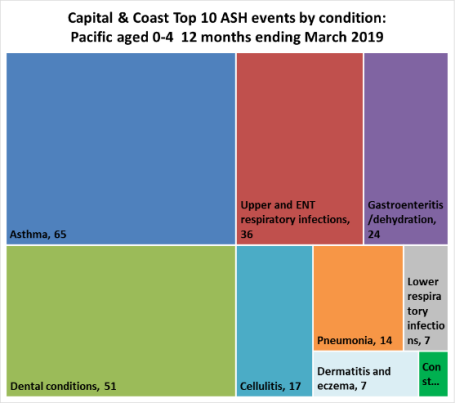
Ambulatory Sensitive Hospitalisations (ASH) are certain conditions where the hospital admission could have been prevented if the person had received appropriate care earlier in community services. The Ministry uses ASH rates as a measure of how the DHB system as a whole is working for the population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

Hutt Pacific and Capital & Coast ASH rates for Pacific children have decreased in the last 5 years but are still much higher than the National rate for children of Other ethnicities (nonMaori nonPacific). Rates for Hutt Pacific children were 2.2 times higher than the rates for National Non Maori non Pacific children in the year ending March 2019. Rates for Capital & Coast Pacific children were 2.0 times higher than the rates for National Non Maori non Pacific children.

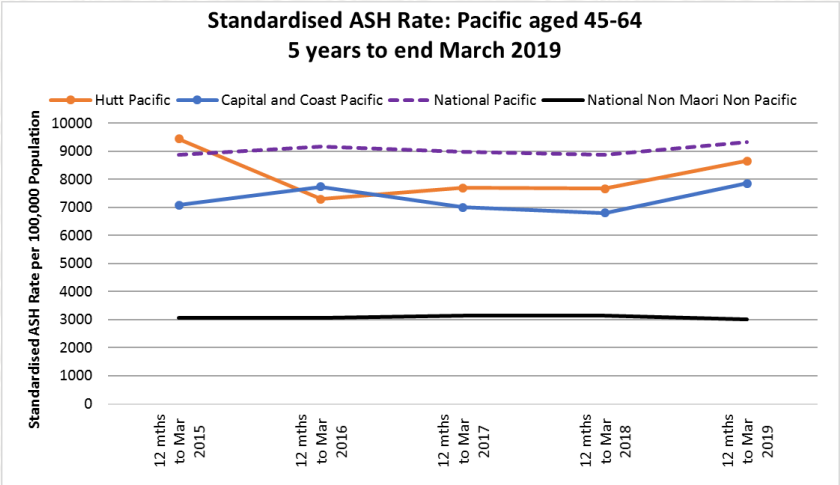


Most of the ASH events in the 12 months ending March 2109 for Hutt and Capital & Coast Pacific children were for Asthma, Dental conditions, gastroenteritis/dehydration, Upper respiratory tract infections and Cellulitis.

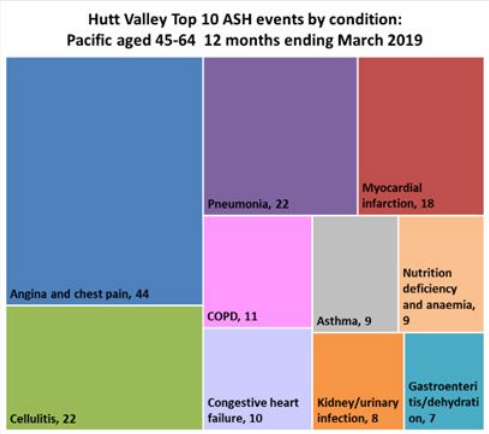


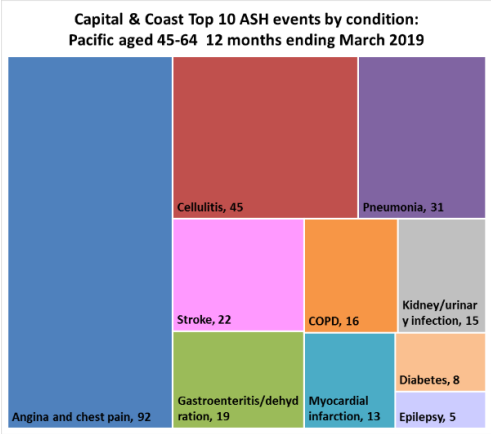


Hutt Pacific and Capital & Coast ASH rates for Pacific Adults aged 45-64 years have been fairly stable in the last 5 years but are much higher than the National rate for Adults of Other ethnicities (nonMaori nonPacific). Rates for Hutt Pacific Adults were almost 3 times higher (2.9) than the rates for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



Most of the ASH events in the 12 months ending March 2109 for Hutt Pacific Adults were for Angina & Chest pain, Cellulitis, Pneumonia, Myocardial Infarction and Chronic Obstructive Pulmonary Disease (COPD). Most ASH events for Capital & Coast Pacific Adults were for Angina & Chest pain, Cellulitis, Pneumonia, Stroke and Gastroenteritis/dehydration.





All ages and Child & Youth

PHO enrolment

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

Pacific people enrolled with a PHO July 2019

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

Most Wairarapa Pacific people are enrolled with the Compass Wairarapa PHO. 87% of Hutt Pacific are enrolled with Te Awakairangi Health Network while 1,398 (12%) Hutt Pacific people are enrolled with one of the PHOs with a contract with Capital & Coast. Note that Cosine PHO includes the practice Ropata Medical which is located in the Hutt Valley. 98% of Capital & Coast Pacific people are enrolled with Compass Capital & Coast, Ora Toa and Cosine. 263 (1.2%) Capital & Coast Pacific people are enrolled with Te Awakairangi Health Network.

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

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

All ages and Child & Youth

Practice visits

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

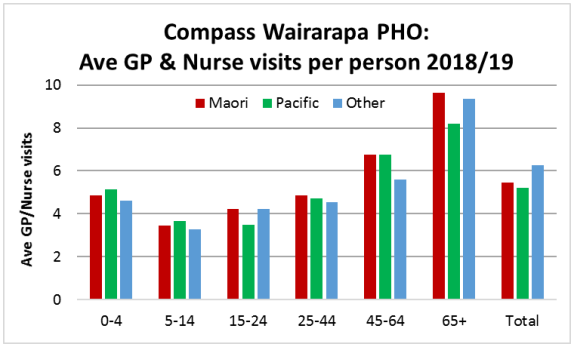
For all PHOs, Pacific aged 65 and over had the most visits on average, followed by people aged 45-64 and children aged under 5. Pacific Adults aged 45-64 in Compass Wairarapa and Te Awakairangi PHOs had slightly more visits on average than other ethnicities including Maori adults.

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

Average GP/Nurse visits per person enrolled

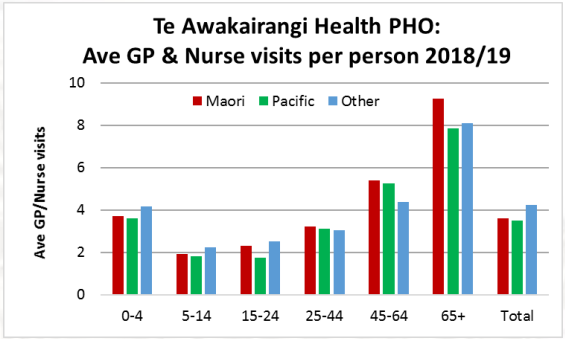
Compass Wairarapa 2018/19

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



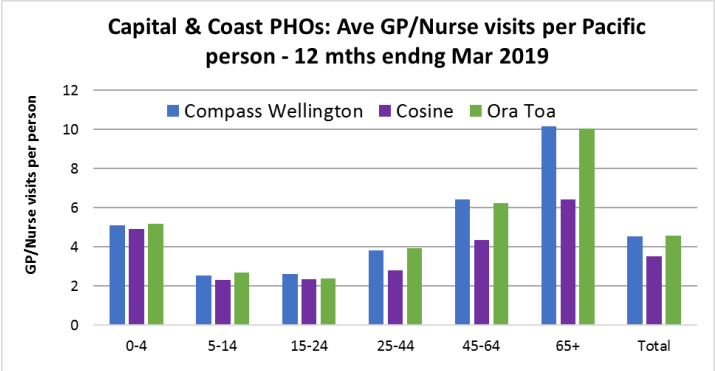
Te Awakairangi Health 2018/19

Age Group	Maori	Pacific	Other
0-4	3.72	3.61	4.16
5-14	1.93	1.83	2.24
15-24	2.30	1.73	2.52
25-44	3.21	3.11	3.06
45-64	5.39	5.25	4.36
65+	9.27	7.85	8.10
Total	**3.62**	**3.52**	**4.23**



Ave visits per Pacific person enrolled 12 months ending Mar 2019 – Capital & Coast PHOs

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

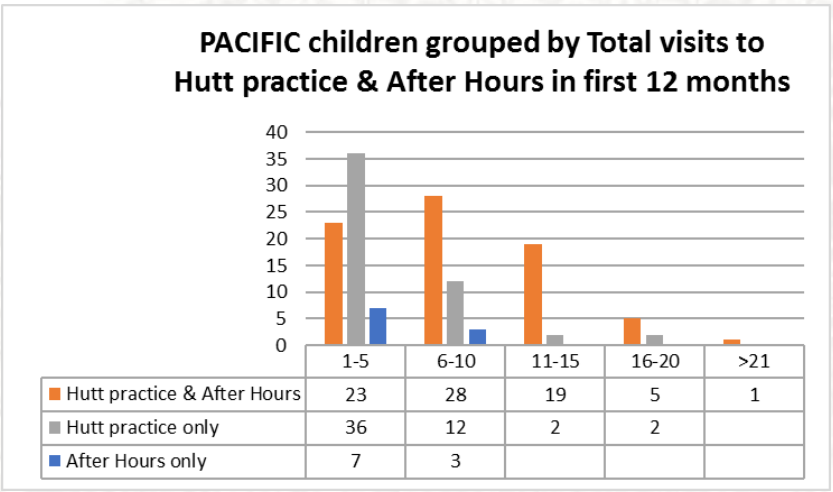


Child & Youth

After Hours - Hutt Valley birth cohort study

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

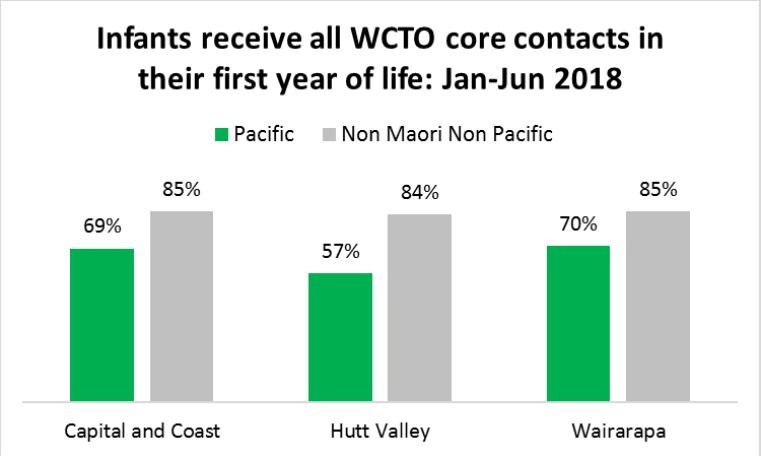
Hutt Valley 2013 Birth cohort – Pacific children using Lower Hutt After Hours and Hutt practices in first 12 months of life



Child & Youth

WellChild/Tamariki Ora Checks

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

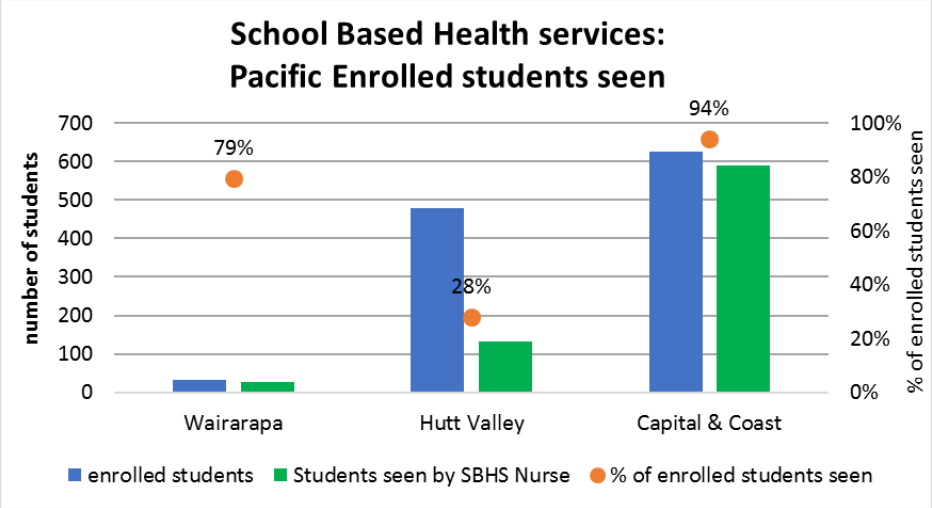


Child & Youth

School Based Health services

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

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



Seen in 2017 Calendar year by School Based Health services at Decile 1-3 schools, Teen Parent units and Alternative Education centres

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

Prevalence of Mental Health disorder

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

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

Primary Mental Health

Primary Mental Health is provided by PHOs and other community services for people with mild to moderate mental health issues. Capital & Coast services saw 363 Pacific people in the 2018/19, Hutt Valley services saw 304 Pacific people and Wairarapa services saw less than 5 people.

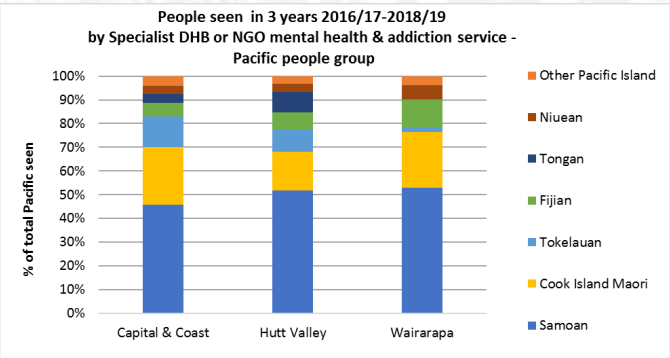
Pacific people seen by Primary Mental Health services in 2018/19 year			
	Wairarapa	**Hutt Valley**	**Capital & Coast**
Youth: 12-19 years	<5	131	70
Adults: 20+ years	0	173	293
Total	**<5**	**304**	**363**
% of total people seen by service	0.1%	6.6%	7.4%
% of DHB Pacific population	0.2%	2.6%	1.6%

Specialist Mental Health services

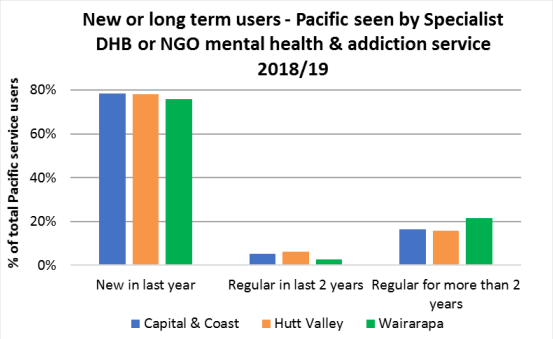
Specialist Mental Health services are targeted at people with serious mental health issues. They are provided by DHB and NGO services. Services include acute inpatient services, community services and rehabilitation services for addiction. In Capital & Coast, 811 Pacific people (3.6% of the population)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

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

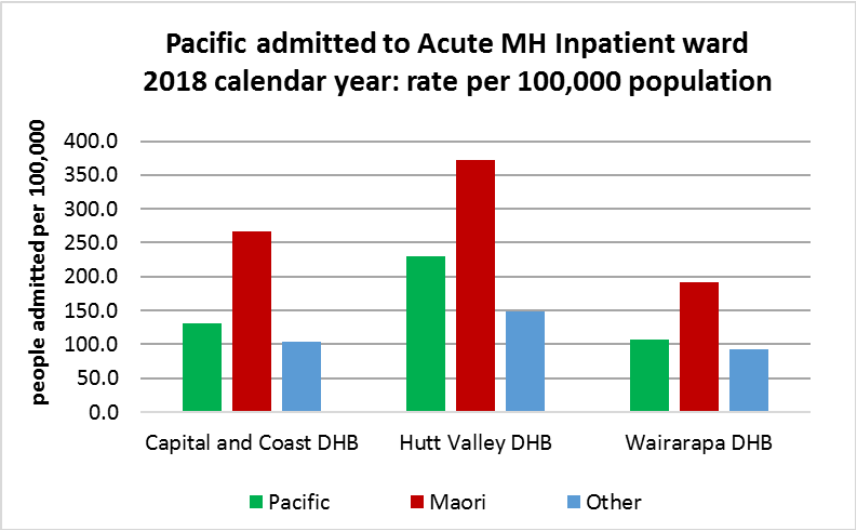
Most of the Pacific people seen in the 3 years 2016/17 to 2018/19 by Specialist Mental Health and Addiction services were Samoan or Cook Island Maori.



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



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



Long term conditions – Cardiovascular disease

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

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

People diagnosed with Cardiovascular disease or assessed as high risk as at Sept 2019

		Diagnosed with CVD	% of enrolled people	High risk of CVD	% of enrolled people
Compass Wairarapa	Pacific	24	3%	42	4%
	Total	2,546	6%	2,324	5%
Te Awakairangi	Pacific	420	4%	732	7%
	Total	6,550	5%	6,563	5%

Long term conditions – Diabetes

As at June 2018/19, there were 2,254 Capital & Coast Pacific (10%) diagnosed with diabetes, 1,118 Hutt Pacific (9%) and 59 Wairarapa Pacific people (6%). For more than half of Wairarapa Pacific people with diabetes (58%) their condition was well managed with their HbA1c levels less than 65 mmol. For Capital & Coast Pacific, 49% had results indicating their condition was well managed and 44% of Hutt Pacific.

People with diabetes as at June 2018/19

	Pacific people with diabetes (PHO data)	% of total enrolled population		Well managed condition: % HbA1c ≤ 64mmol	
		Pacific	Total	Pacific	Other (non Maori non Pacific)
Capital & Coast	2,254	10%	4%	49%	67%
Hutt Valley	1,118	9%	5%	44%	63%
Wairarapa	59	6%	5%	58%	68%

REGIONAL PUBLIC HEALTH MONTHLY SUMMARY

OCTOBER 2019

QUICK LINKS

COMMUNICABLE DISEASES AND HOUSING TEAM	HEALTH PROTECTION TEAM	HEALTHY COMMUNITIES TEAM	TOBACCO, ALCOHOL AND DRUGS TEAM
CHILD HEALTH HUTT VALLEY TEAM	CHILD HEALTH PORIRUA TEAM	CHILD HEALTH WAIRARAPA TEAM	CHILD HEALTH IMMUNISATION TEAM
	ANALYTICAL AND POLICY TEAM	MEDICAL TEAM	

Working with other agencies to make our Drinking Water safe

There are many moving parts that contribute towards achieving safe drinking water for the region. Oversight of safe drinking water is a key area of work for the Medical Officers of Health. *More on page 11.*

Wainuiomata Mainland Island Aerial 1080 project

Regional Public Health's Senior Health Protection Officer, Nicola Esson, visited the site of the Wainuiomata Mainland Island operation to view the operation and audit compliance with relevant permit conditions. *More on page 3.*

#TAGs – Child Rights International

Public Health Advisors Leah Clark and Sisi Tuala Le'afa supported the #TAGs at a workshop facilitated by the Children's Rights Alliance Aotearoa New Zealand (formerly Action for Children and Youth Aotearoa, ACYA). The Children's Rights Alliance is made up of non-government individuals and organisations advocating for children's rights. They report children's quality of life, and children's rights in Aotearoa, New Zealand, to the United Nations.

Jacqui Southey, Child's Rights and Advocacy Research Director, facilitated the workshop; brain storming the important issues for tamariki and rangatahi in Aotearoa, New Zealand. The workshop was attended by a diverse group of people from universities, non-government organisations, law firms, church groups, and health and education organisations.

The #TAG's were the only youth in attendance, and were recognised for their contribution. They were encouraged to write their own report to the Convention on the Rights of the Child, and were offered support from the Children's Rights Alliance members.

#TAGs at the Children's Rights Alliance Aotearoa New Zealand Report Workshop Wellington

Measles

From 1 January 2019 to 1 November 2019, there have been 1969 confirmed cases of measles notified across New Zealand, based on ESR reporting from District Health Boards. From April to November 2019, RPH has investigated 144 cases of measles, of which 111 were denotified post public health follow-up.

43 suspected cases of measles were notified to RPH in October, of which 36 were denotified after laboratory results were available. October was the busiest month for measles notifications/investigation since April 2019. The Communicable Disease and Housing team worked tirelessly to contain and eliminate measles in the greater Wellington region, at the same time maintaining daily business as usual, and at all times delivering the highest level of patient care. It has been a substantial, well-coordinated and very effective effort, involving teams from right across the service.

Work will continue with our Pacific communities and Pacific health providers to ensure information on the measles outbreak in New Zealand, Tonga and Samoa and MMR vaccination are reaching Pacific families, who may be travelling home for the holiday period.

Refugee Health

From June 2020, quota refugees will start resettlement in the Wairarapa region. It was confirmed in October that Red Cross and Connecting Communities would share community support for these new arrivals. Work continues through community meetings with relevant parties, in preparation for the region to accept the refugees in a supported way. An article appeared in the Wairarapa Times titled "Refugees will get helping hand to settle in region", the article can be read here.

Refugee Health & Wellbeing Workshop

On 22 November RPH will host a Refugee Health & Wellbeing workshop. This workshop will inform and support health professionals and covers aspects of refugee resettlement. If you are interested in attending please click here for registration information.

COMMUNICABLE DISEASE NOTIFICATIONS

for the month of October 2019

Enteric Disease ( ) = not a case	DHB Region	No. of cases
Measles	Greater Wellington Region	7
Pertussis	Greater Wellington Region	23
Meningococcal Disease	Greater Wellington Region	2
Tuberculosis	Greater Wellington Region	5
Total		**37**

Chemical incident at a school

On 1 October 2019 Nicola Esson (Senior Health Protection Officer) was called out by Fire and Emergency NZ (FENZ) to a chemical incident at a school. Two workers had been exposed to chlorine gas in a confined space following the mixing of two chemicals.

Nicola ensured that, where necessary, people had been evacuated or moved elsewhere and that technical advice was sought to neutralise the chemicals to ensure no one else was at risk of exposure. Breathing in chlorine gas in a confined space has the potential to be fatal. As a precaution, the Early Childhood Centre on site was relocated elsewhere on the grounds and people in neighbouring houses were advised to shelter inside with windows and doors closed and air conditioning units turned off. The two affected workers were treated by Wellington Free Ambulance and decontaminated by FENZ, then transported to Hutt Hospital. The investigation into this type of incident is completed by WorkSafe NZ.

Hospital Water Storage System commissioning

On 11 October 2019 the Health Protection team was notified that a new 800,000 litre storage tank had been installed at a hospital to provide emergency drinking water storage and was ready for commissioning. It is usual practice for Drinking Water Assessors to be notified about a new reservoir and to review the results of pre-commissioning water samples.

Samples taken over three days had no free available chlorine (FAC). FAC is required to provide residual disinfection to protect the water from bacterial contamination it may pick up as it passes through the network of pipes and storage.

Health Protection staff worked with Wellington Water and the installing company to resolve the issue. Although the company felt there was a likely explanation for the lack of detectable chlorine, they understood the need to verify that the water was compliant with safe drinking water standards, and decided to refill and resample the reservoir. On Thursday 31 October 2019 sample results showed a suitable chlorine level and RPH advised that they were happy for the system to go on-line.

Wainuiomata Mainland Island Aerial 1080 project

While the main regulatory control for hazardous substances lies with the Environmental Protection Agency and WorkSafe NZ, Public Health Units have discretion to issue permits for certain vertebrate toxic agents. The purpose of these permits is to impose additional controls to ensure that the public health risks associated with an operation are adequately communicated and controlled.

In September 2019, Greater Wellington Regional Council were granted a permit to apply sodium fluoroacetate (1080) aerially to an area east of Wainuiomata and within the Wainuiomata-Orongorongo catchment.

The Wainuiomata Mainland Island operation took place on Monday 7 October 2019. Nicola Esson, Senior Health Protection Officer visited the site to view the operation and audit compliance with relevant permit conditions.

Enteric Diseases for October 2019

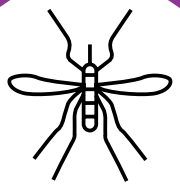
Enteric Disease	No. of cases
Campylobacteriosis	52
Cryptosporidiosis	8
Gastroenteritis	5
Giardiasis	13
Yersiniosis	25
Salmonellosis	10
Total	**113**

Serious Enteric Diseases for October 2019

Enteric Disease ( ) = not a case	No. of cases
Hepatitis A	1
Shigellosis	2
VTEC/STEC infection	14
Total	**17**

for the month of October 2019

Environmental Health Activity	No. of activities
Burial & cremations enquiries	0
Repatriations	4
Potential mosquito detection	0
Mosquito surveillance traps checked	45
Mosquito surveillance samples positive	7
Ministry for Primary Industry referrals	0
Radio Pratiques issued (Ship & Aircraft)	10
Ship Sanitation inspections	0
Report of illness on-board aircraft	0
Emergency response notification/call-out	1
Interagency meetings	4
National Health advisories & warning	0
Emergency/temporary sewage discharge notifications	7
Lead notifications	3
Call centre calls	20
Vertebrate Toxic Agent (VTA) audit	1
Drinking water WSP report	4
Drinking water contamination events	1
Drinking water audits	0
Drinking water compliance reports	3
VTA permission	1
Hazardous substance reports	6
Worksafe referrals	3
Submissions	1
Total	**121**

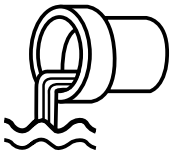


Mosquito surveillance traps checked

45

Call centre calls

20



Emergency/temporary sewage discharge notifications

7

Hazardous substance reports

6

Interagency meetings

4

Drinking water compliance reports

3

VTA

Vertebrate Toxic Agent (VTA) audit

1

Mosquito surveillance samples positive

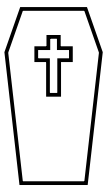
7

Lead notifications

3

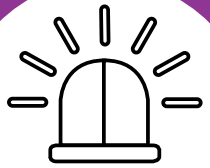
Radio Pratiques issued (Ship & Aircraft)

10



Repatriations

4



Emergency response notification/call-out

1

First 1000 days

Brianna Tekii, Public Health Dietician and Sarah Taylor-Waitere, Public Health Advisor have been running the hospital-based Tuesday Little Latch On to build confidence in Mums who breastfeed.

They are now extending the program into the community and Little Latch On Fridays will be held at a local café. Holding the sessions in the community and creating a space where all issues, big or small are shared will help develop Mums' confidence to breast feed in public.

This is fully supported by the Breastfeeding Peer Counselors and the Wairarapa DHB Lactation Consultant. RPH will be subsidising the coffee/hot drink for the trial to encourage attendance.

Rimutaka Whānau Day

The Rimutaka Prison Whānau Day was held in October 2019 to support whānau who have transitioned into Upper Hutt from across New Zealand to be near their incarcerated partner. The event focused on strengthening the families connections to Hutt based health services.

Regional Public Health shaped the event and coordinated a range of health services. The day was supported by Salvation Army, Vibe Youth Health Service, Kokiri Marae Health and Social Services, Family Start (Naku Enei Tamariki), Life Unlimited Hearing, Regional Screening, Work and Income (Upper Hutt) and Regional Public Health Well Homes programme.

Prison Management identified the need for co-ordinated information for whānau moving into the area, and the day was declared a success by the CEO Rimutaka Prison, Christine Stephenson. Plans for next year's event are already underway.

The East Porirua Regeneration Project

Recently Regional Public Health hosted two Dietetic Students to support their final requirements for their Otago University degree. The students, Brianna Menzies and Marieke Flatt, undertook a food environment scan for Porirua City Council to support their East Porirua Regeneration Project.

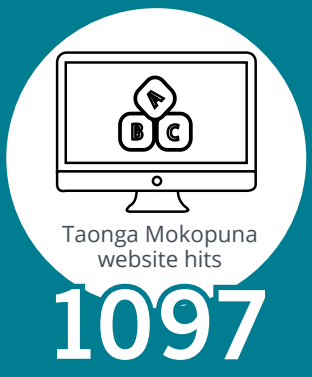
The project involved confirming the existence of all retail food outlets, food pantries, food banks and liquor outlets in Eastern Porirua by physically sighting them. Fiona Wild, Public Health Analyst will be converting this data into a geographical map which will be presented to Council in November.

Pēpe Ora flip chart

Following the success of the Pēpe Ora website a Pēpe Ora Flip Chart has been developed. This will be initially distributed to the Pēpe Ora working group and at the upcoming Takitaki Mai and key messaging workshop for health professionals.

for the month of October 2019

Healthy Community Activity	No. of activities
Ministry meetings	1
Submissions	5
Council meetings	3
NGO/Community meetings	35
PHO/DHB meetings	4
Workplace Wellness queries/support	2
Workshops/Trainings	1
Food and Beverage Policy meetings	4
Real Good Kai sessions	4
Taonga Mokopuna website hits	1097
Early Childhood visits or licensing requests	1
Total	1221



ALCOHOL LICENCE APPLICATIONS RECIEVED BY DHB

for the month of October 2019

CCDHB 26 On-Licence	CCDHB 17 Off-Licence	CCDHB 66 Special Licence
HVDHB 6 On-Licence	HVDHB 0 Off-Licence	HVDHB 22 Special Licence
WrDHB 7 On-Licence	WrDHB 9 Off-Licence	WrDHB 11 Special Licence

Liquor Licenses processed

The number processed over this month is consistent with the previous month.

Alcohol Controlled Purchase Operations – Licenced premises visited

There were no Controlled Purchase Operations (CPO) conducted this month. These happen at the request of the Police.

Bottle-O Khandallah

In August 2019, Vanessa Young (Health Protection Officer) and Dr Palmer (Medical Officer of Health) attended the District Licensing hearing for Bottle-O Khandallah. The Medical Officer of Health did not oppose this application but due to strong community oppositions chose to attend and give evidence.

The District Licensing Committee declined the application on the basis of suitability of the applicant, amenity and good order and the object of the Act. This is a great result and showed the strength and value in the community voicing their concerns.

Shalimar Hearing

Jem Pupich (Team Leader) attended the hearing for Shalimar store which focused on whether the store met the criteria of a grocery store (where food sales make the greatest revenue). Under the Sale and Supply of Alcohol Act 2012 a store must meet the criteria for a grocery store in order to hold an off-licence to sell alcohol. An investigation into Shalimar's accounts found evidence that food was not the biggest seller. The District Licensing Committee declined the renewal of the store's liquor license. They found that the volumes for poppy seeds sold were questionable as to their purpose as food.

This is a very positive outcome as Shalimar store is situated in an area with a high proportion of young people, tertiary students, and social housing; all of whom are at higher risk of experiencing alcohol related harm. Considerable work was undertaken by Dr Jill McKenzie, Jayne Parris, and Jem Pupich. There is an appeal period in which the applicant could appeal the decision.

Tobacco controlled purchase operations – premises visited

HVDHB	CCDHB	WrDHB
2	16	0

Tobacco controlled purchase operations – sales made

HVDHB	CCDHB	WrDHB
0	0	0

We are pleased that no sales were made during either of the CPOs. This demonstrates the stores were compliant with the Act at the time.

Synthetic Cannabinoid Drugs

Catherine Whitley (Public Health Advisor) delivered a presentation to the Hutt Valley Hospital House surgeons on synthetic drugs. The session was an overview of New Psychoactive Substances and feedback from the session was positive.

Oceania Tobacco Control Conference 2019 – Making Tobacco Control a priority

Leah Clark, Public Health Advisor, and Shane Bradbrook, Senior Public Health Advisor, attended the Oceania Tobacco Control Conference (OTCC). Leah and the #TAGs (Holistic Action Sustainable Health-Through All Generations) presented on the 'Smokefree Car Campaign', which received positive feedback as a community action model for youth civil leadership.

The #TAGs were the only rangatahi attending the conference. Tamara Mana and Robin Harris-Samiu (#TAGs) answered many questions from the attendees and were offered support from Associate Professor Stella Bialous (Keynote Speaker) with evidence for their government submissions on vaping and e-cigarettes in 2020.

EMPOWER Youth & #TAGs

Sisi Tuala Le'afa and Leah Clark held a number of youth education sessions this month. One session focused on careers in emergency services and included a visit to the Wainuiomata Fire Brigade. This positive experience gave youth the opportunity to try on gear, and enter a simulated smoke filled building. This sparked discussions about their personal experiences within their whanau about adults being drunk and falling asleep with lit cigarettes causing fires.

EMPOWER youth and #TAGs at Wainuiomata Fire Bridge

Back to the Future

Child Health Cluster Clinical Nurse Specialist (CNS) Leaha North attended the College Child Youth Nurses Symposium in Hawkes Bay recently after being awarded a $450 scholarship from NZ Nurses Organisation.

The theme of the Symposium was, "Back to the future – building on foundations". There were a number of presentations focusing on a range of issues from reducing inequities to the use of Public Health frameworks for sustainable programmes.

CNS Leaha North at the Symposium in Hawkes Bay

Our Vision Hearing Technicians

RPH Hutt Valley have three Vision Hearing Technicians (VHT) who deliver vision and hearing screening in early childhood settings, schools and community clinics. This month they attended the Lower North Island Vision Hearing Technicians Hui. Held every six months, the Hui is an opportunity for VHTs to come together to provide a Regional roundup, undertake specific training and have practice conversations.

Year 7 vision statistics project proposal

Gail Ratana VHT has been approached by Mr Graham Wilson, Ophthalmologist at Tairawhiti DHB to support his research through the collecting of Year 7 data to establish the association between children diagnosed with myopia (near-sightedness) at an early age, and the increased risk of serious eye conditions such as retinal detachment later in life.

The collection of local data of children with near-sightedness at B4SC, and possible continuation of eye problems at Year 7 could support the need for earlier intervention in screening programmes, and the use of newly developed equipment that could better capture more eye conditions sooner rather than later. Watch this space!

CHILD HEALTH CLUSTER

CHILD HEALTH PORIRUA TEAM

Robyn Kelly
Team Leader
04 587 2912

Support for Medical ad Nursing Students

The final University of Otago medical students completing their paediatric community placements for the 2019 academic year came to the Porirua base at the start of the month. The Public Health Nurses have received extremely positive feedback from the 24 medical students they have supported over the course of the year. Both Massey University and Whitirea nursing students are also supported with clinical placement.

Porirua Children's Ear Van Service

As well as providing a range of booked and drop-in clinics in community settings Ear Nurse Specialist Claudia Schötz and Specialty Ear Nurse Erika Ware provided checks for pre-schoolers in five Porirua early learning centres.

Each month GP registrars spend time with the Ear Van Service nurses, building their skills and knowledge of ear diseases in childhood.

Vision and Hearing Technicians support weekend clinics

This month Vision and Hearing Technician Erin Sole supported the Ora Toa B4 School Check Saturday clinic as well as the B4 School Check twilight clinics. Weekend and late clinics help with meeting targets and improves access to child health services for working parents.

Classroom Oral Health education

Public Health Nurse Cara Jones provided oral hygiene talks for the majority of classes at Rangikura School. Health education in the classroom provides an opportunity for children to develop a relationship with the Public Health Nurse, as well as providing important oral health information.

Support for Oral Health

PHN Judi Harding has been supporting the oral health service to follow up children who have not been engaging with the service. This involves contacting families to make appointments, sending reminders and, in some cases, transporting children to appointments. The result has been a number of children being seen and treated after a delay of up to two years, with one child requiring several visits to complete treatment.

Childhood caries is a significant problem – research shows that the "actual annual accumulation of caries progresses linearly throughout life" (Sheiham & James, 2014). There is also considerable cost to the health budget for remedial work carried out for tooth decay. New Zealand spends approximately $20,000,000 on 35,000 tooth extractions under general anaesthetic every year (Thornley et al. 2017). This evidence highlights the importance of ensuring equitable access to dental care for our tamariki and is an example of taking an integrated approach to whanau wellbeing, by collaborating with other service providers (Pathway 3, RPH Strategic Direction 2018 – 2023).

Addiction knowledge to support affected families

Public Health Nurses Jenny Clarke and Judi Harding attended a workshop on Methamphetamine which was held in the Wairarapa. This was a joint initiative between RPH's Sarah Taylor-Waitere (Health Advisor) and Ko Te Aroha Children's Centre manager Suzie Wilmshurst.

The workshop provided the opportunity to hear from professionals working directly with those in our community affected by addiction. NZ P-Pull, Pathways Addiction & Mental Health Services, and the Masterton Police Prevention Unit combined to provide clear insight as to 'What our tamariki and whānau are faced with, when addiction is present in their lives'. As methamphetamine addiction appears to be a growing problem, Jenny and Judi feel better equipped to support those who are struggling with an addiction.

CHILD HEALTH CLUSTER

CHILD HEALTH IMMUNISATION TEAM

Maureen Stringer
Team Leader
04 587 2951

Measles is still a priority topic

The Ministry of Health (MoH), requires a Single Point of Contact, (SPOC). Liz Grinlinton, HVDHB Immunisation Co-ordinator is the SPOC for HVDHB. Practices in the DHB region advise Liz on a weekly basis the usage and/or requirements of vaccine for the following week. Liz can be contacted on Elizabeth.Grinlinton@huttvalleydhb.org.nz for further information.

National Immunisation Register

We are preparing for the 2020 Influenza programme. Some departments in the DHB are planning to offer these immunisations to patients attending an outpatient clinic or admitted to a ward. The work required to enable this plan to move forward is quite complicated as the MoH has very strict rules regarding access to NIR. Early planning allows time to establish a robust process for recording on to NIR, giving health providers access to up to date records.

School based immunisation programme

Clinics continue to be held in schools enrolled in the Programme, which successfully delivers Year 7 and Year 8 immunisations in schools. Primary Health Providers will be contacted soon with names of children who have not completed the programme. We appreciate the work of practices to ensure all children receive full coverage of these immunisations by entering a recall on the Patient Management System.

BCG service

The team are still receiving referrals for children who missed their vaccination when supplies were unavailable in 2016-2018. The BCG programme is able to vaccinate children up to the age of 5 years. However the child requires a Mantoux screening first, which is read 72 hours later. If the test is negative the child receives the BCG vaccine; if the result is positive the child is referred to the RPH paediatrician.

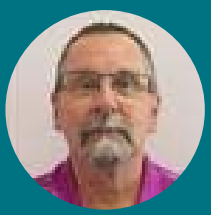
for the month of October 2019

157	102	25	20	6
Normal ears	Otitis Media with Effusion	Retracted Eardrum	Wax	Dull Eardrums

PUBLIC HEALTH NURSES IN SCHOOLS REFERRALS – 3DHB

for the month of October 2019

New referrals **48** CCDHB	Open cases **262** CCDHB	Closed **94** CCDHB
New referrals **52** HVDHB	Open cases **191** HVDHB	Closed **60** HVDHB
New referrals **3** WrDHB	Open cases **45** WrDHB	Closed **8** WrDHB



Advocacy successes

In September 2019, Dr Jill McKenzie (Medical Officer of Health) and Anna Robertson-Bate (Public Health Advisor) attended a hearing for the Hutt City Council's proposed Plan Change 43 which deals with housing intensification. RPH supports the plan change in light of the high need for housing in the Hutt and impact this has on population wellbeing.

The hearing panel presented their decision in October approving the plan change saying, "the evidence we found overwhelming was that residential intensification must occur, especially to address social issues and enable reasonable foreseeable future generations (and current generations) to live in Hutt City.

Housing choice and affordability is, from the evidence we heard, a significant intergenerational issue in Hutt City."

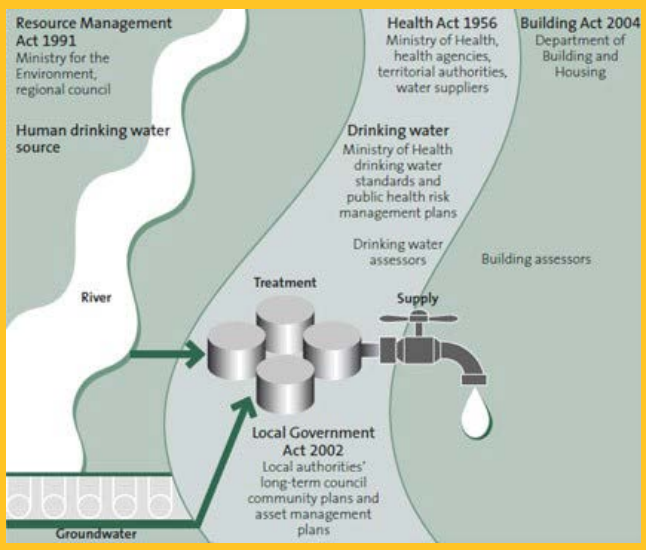
RPH was mentioned several times in the report with reference to the health benefits of compact growth and the importance of insulation in ensuring healthy homes. Other wins include the inclusion of a design guide into the district plan so that it is possible to regulate some elements of the design.

MEDICAL TEAM

Jill McKenzie
Medical Officer of Health
04 570 9735

Working with other agencies to make our Drinking Water safe

In 2016, New Zealand experienced one of the largest ever recorded outbreaks of campylobacter as a result of contaminated drinking water. The Inquiry into the Havelock North Campylobacter outbreak has resulted in many changes and proposed changes to the way we ensure safe drinking water.



Establishment of the Wellington Region Drinking Water joint working group

One of the recommendations was to establish Joint Working Groups with councils, water suppliers and public health unit staff. The purpose of these groups is to ensure collaboration and information sharing to protect drinking water from its source to the point where it is delivered to people's properties.

The need to establish such a group became even more critical following our own regional issues with contamination detected in the Lower Hutt bores in 2017 and 2018.

The Wellington Region Drinking Water Joint Working Group consists of all council water suppliers (operators and management), Wellington Water (a council controlled organisation responsible for all water infrastructure for 5 local councils and the regional council bulk water supply), the Regional Council resource consent/compliance and water quality environmental science staff, and RPH staff involved with drinking water (Drinking Water Assessors, Medical Officer of Health, Health Protection Officers and Management).

Aims of the group

Already we have seen the benefit of meeting regularly, sharing information and expertise, and forming specific working groups.

- We have an agreed shared vision and are finalising our lines of accountability via a Memorandum of Understanding document.
- Methods to assess risk within the pipework and storage systems of drinking water supplies is being shared between different water suppliers. This will support better efficiency with shared knowledge and agreement on best practice.
- Frameworks for development of emergency response plans to drinking water major incidents have been work-shopped and shared, to align between different agencies, ensuring rapid and effective interagency response to water emergencies.
- All agencies are informed about groundwater quality monitoring being planned by the Regional Council, the results of which can then be shared with everyone, so the response to any unfavourable results can be collaborative.
- Identify opportunities for other areas to join an existing project utilising new technology to better understand groundwater flow and security. This information will help suppliers to better protect the catchment area of their water sources.
- Reviewing together new information about the regulatory environment for drinking water or expert technical advice, so we are on the same page regarding best practice and our respective roles and responsibilities. This is important during the current period of drinking water regulatory review.

Strong collaborative approach

This year the response to the contamination detected in the Martinborough town supply was strengthened by a collaborative approach.

There are many moving parts that need to align to protect our drinking water. The collaborative approach engendered through the Joint Working Group is one of the important activities that contributes towards achieving safe drinking water.

PUBLIC

Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**CPHAC INFORMATION PAPER**
	Date: 27 November 2019

Author	Sandra Williams, Executive Leader Planning & Performance
Endorsed By	Dale Oliff, Chief Executive
Subject	**Mental Health & Addictions – local activity update**

RECOMMENDATION

It is recommended that CPHAC:

Notes and discusses the update in this report

1 PURPOSE

The purpose of this paper is to update CPHAC on local mental health and addictions service development work. The agenda for CPHAC has an update on performance of providers and the mental health system scheduled for May 2020. In addition to this an update on the local review work will be provided in the new year. DSAC receives regular reports on the work underway through the 3 DHB mental health and addictions work programme and this report will also highlight areas of local activity.

2 WORK UNDERWAY ON MENTAL HEALTH AND ADDICTIONS SERVICES

2.1 Updates from DSAC

The papers for the DSAC meeting can be found at this link for those members who do not have access through Boardbooks on the link below[1].

Living Life Well

In August the DSAC reviewed the outcomes framework and approved it for further consultation with our local stakeholders. At a local level we took the outcomes framework to our local MHALG group which is made up of our local Mental Health and Addiction NGOs, PHO, local DHB provided community mental health services, and a local people with lived experience. The group considered the outcomes framework and said we could work with the framework at a local level and agreed to begin to consider how the principles could be brought to life at the local level.

As noted in the papers at DSAC the additional Ministry of Health funding is a welcome addition but does mean our own investment planning is being delayed whilst we consider where the new development will be. Our local Maori health providers have responded to the latest RFP request (due this week) to extend and replicate existing primary mental health services.

We are still waiting to hear from the Ministry as to whether the 3DHB Request for Proposal response has been accepted and what that will look like for the Wairarapa.

The Wairarapa intends to be an early adopter of the well being networks approach outlined in the DSAC papers and we will build on the MHALG network we already have in place.

[1] The link to these papers is 3DHB DSAC public agenda - 10 September 2019

PUBLIC

2.2 The Local Wairarapa Review

Wairarapa DHB reviewed its local service provision in 2018 with a report published in December 2018[2]. Whilst the review was being completed the He Ara Oranga: report of the Government Inquiry into Mental Health and Addiction was also underway.

We have been reviewing the recommendations of our local Mental Health and Addictions review against those of the government inquiry. It is no surprise that most of the themes align between the two reports and this indicates that our local actions will be on track to meet the expectations of the government.

We have begun an exercise to look at each of the 59 recommendations in our local review and start both prioritising and phasing these activities over the next few years. Some are already underway; either as actions in our 2019/20 Annual Plan, or part of various work streams that are in train including the implementation of the "Living Life Well" strategy, the Acute Continuum of Care project led by HVDHB and the AOD model of care work led by CCDHB.

It is our intention to provide CPHAC with a detailed summary of our plan on how to progress each of our local review recommendations in the new year.

2.3 Investment in Opioid Substitution Treatment Services

Our investment in our local Mental Health and Addiction services has largely remained unchanged since the services were consolidated in 2010. Our local provider of Opioid Substitution Treatment (OST) is Pathways and they advised that they had seen an increase in the number of people they were treating and their complexity. There have been on going difficulties in recruiting and retaining their senior medical officer role (0.4 FTE). Wairarapa DHB is the only DHB with an NGO provided OST service with most DHBs providing through their own DHB provider arm specialist mental health services.

Currently around 106 people are supported through this service with 10 in GP shared care at an investment of $405.6k per annum. Nationally the average percentage of people in GP shared care is 28%.

Options were explored with MHAIDs and the current service provider. MHAIDs was prepared to provide a service for the Wairarapa DHB. The model would be different to the current model which is a locally provided service and would be the same satellite clinic model provided to the Capital and Coast and Hutt Valley populations. The MHAIDs option does come with pros in terms of easier recruitment and retention of senior medical officers. The cons include the reduction in integration opportunities and an increased cost structure.

Investment has been approved to increase the level of investment in the senior medical officer FTE to a 1 FTE with Pathways. The additional investment will be offset by other areas of lower expenditure within the funder budget.

[2] The link to the report is http://www.wairarapa.dhb.org.nz/news-and-publications/reports-and-publications/publications/mental-health-and-addiction-service-review-report-wrdhb-12-dec-2018.pdf.

PUBLIC

Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**CPHAC INFORMATION PAPER**
	Date: 27 November 2019

Author	Sandra Williams, Executive Leader Planning & Performance
Endorsed By	Dale Oliff, Chief Executive
Subject	**Greater Wellington Regional Council Growth Framework**

RECOMMENDATION

It is recommended that CPHAC:

Notes the work underway by the Wellington Regional Council and that it will be kept abreast of developments to ensure that our health service planning stays current in the longer term.

APPENDIX:

1. **10 OCTOBER MEETING PRESENTATION**
2. **NOTES FROM THE MEETING**

1 PURPOSE

The purpose of this paper is to inform CPHAC of a meeting held on the 10 October by the Wellington Regional Council and work that is underway to consider the framework for growth in the greater Wellington area. We are already thinking 10 years out for our strategic direction but also need to continue to keep abreast of future developments as well. As more information becomes available CPHAC will be kept updated in order to inform future thinking.

2 BACKGROUND

The proposed National Policy Statement on Urban Development requires Councils to undertake a Future Development Strategy. The DHB was invited to attend a workshop by the Wellington Regional Council along with other stakeholders including Wairarapa local councils, Regional Public Health and other. We were invited to the session to input into the regional growth plan for the next 30 years and 100 years for the wider region.

3 DETAIL

3.1 Workshop 10 October

The region is expecting population growth between 50,000 and 61,000 more dwellings and 90,000 to 140,000 more people over the next 30 years.

All councils and agencies including health are facing a number of challenges such as housing supply and affordability challenges, increased congestion on our roads, the need for significant investment in infrastructure to facilitate growth and sea level rise.

The objective of the work is to establish a joint long term vision that will form the basis of long term collaboration across boundaries and entities to deliver better outcomes and ensure optimal impact of already planned investment.

PUBLIC

Much of the conversation on the day was about where people will live, both rurally as well as in urban environments and the infrastructure that would be important in the future to ensure thriving communities.

We can expect to see people living closer to where they work and an increase in people working remotely. A need to protect our fertile lands for food production including those in the Wairarapa (the corridor running up to Masterton) will impact where we might see housing and commercial activity develop in the future. Transport out of Wairarapa to Wellington, Hutt and Palmerston North will see further development as well. It was noted that considerable investment would be required in the Wairarapa for infrastructure such as water, sewage, housing, health services and roading.

3.2 Update on the work 22 November 2019

Current Phase of work – Foundation Report
The WRC is working on the Foundation Report which is due to be complete by the end of 2019. This will be an agreed regional evidence base and will include identification of the key challenges for the region. These challenges are being developed from the great input from the Mapping and Ideas workshop. The document being published in early 2020.

Evolving Phase of work – Scenarios Planning
This phase of work commenced at the beginning of November and is due to be finished by the end of February 2020. This will see the WRC developing and testing a range of scenarios (4 or 5) for the region.

Further engagement is planned once the scenarios are further developed in early 2020 and the Wairarapa DHB can expect to engaged again at that point.

WRGF governance
The first "governance level" meeting was held Friday 15th November with the Executive Review Group (ERG). This Group includes the CEOs of the ten Councils involved in this project, high level representatives from Housing and Urban Development and NZTA and will include representatives from Iwi organisations once selected.

4 CONCLUSION

A key consideration for Wairarapa DHB in the future will be future growth and population increases with the resulting demand on health services. Physical environment factors have a large impact on health outcomes (10%) along with social determinants (40% impact on health outcomes) and the response to the future population growth in terms of where people will live and the transport infrastructure will be important to how we provide health services.

Staff will stay involved with the work as it develops to ensure that we are to inform our own health services planning and will keep CPHAC updated as more information on the work comes to hand.

Wellington Regional Growth Framework workshop 10 October 2019

– report back on afternoon discussion

Table 1 – January

- Discussion guided by water, thinking about from mountains to sea and how might spatial planning need to reflect that
- If so, Tararua green catchment and waters that come from there is important – where rain falls and where it ends up – and people and ecology
- Urban growth areas similar – but form different
- Principles – growth and intensification – different attitudes about what is density for average kiwi and how may change over years
- Dense urban environment – access to parks and open spaces important
- What do we want to protect – green corridors built around catchments
- Areas where we might be restoring – looks like this now, how can we rehabilitate?
- If we want healthy water quality – connections between eradicating pests, rehabilitating trees, improving water quality
- Broad systemic ways to get to your outcomes
- Investing in Kenepuru Hospital – resolve problem of people travelling long distances to get to other places and how that can support intensification
- Good growth intensification, good restoration principles, good investment priorities
- [linear urban form]

Table 2 – February

- Didn't draw on map. 3 key things:
- Is there anything missing that would drive us in a radically different direction?
- Acknowledging there is a range of things we could do that would make sense – eg, central areas of wellington, up Kapiti Coast, in Wairarapa, - what would we need to do to make that work – problem is a range of things that attract, but also risky environment in terms of SLR, and earthquake risk – need a plan for dealing with disaster; design led and how we build infrastructure and housing and how we build to weather storms and rebuild afterwards, rather than quantities;
- Risk in Wairarapa less acute but not non-existent, current approach is focused around central govt employment, sub-regional centres at scale in upper Hutt and Porirua that can be reached on train network and roads – if making a new bunch of urban areas etc, need to think about how it works in the future for a range of different people, scenarios, transport modes etc – enabling things are different
- Diversity of people and needs in housing space – there is an aggregate question – do we have enough so everyone can get housed, with inflating all the time; do we have enough of a range of types, emerging housing models like papakainga development – if we could extend these in different ways to meet the needs of people who don't have the expectations of living on Mori owned land, or may be climate refugees – range of ways from planning, development economic sense etc.
- Potential for disruption – 3 things that may happen or likely to happen to push us from a BAU approach – seismic risk and impact from insurance markets – everything changes; or large portion of infrastructure – and no plan to rebuild – govt has to look for alternative place; 3 – population growth – how much and where it is from. Aggregate question – is welly a place of 1m or will it shrink – what their needs are, and jobs,
- Could all work, much won't happen, understand scenarios as much as possible

Table 3 – March

- Focused on where development should go – similar to first group around areas of intensification
- Existing urban areas and greenfield areas for development
- Looked at why those areas – eg, close to CBD, close to services, transport links
- Making sure we avoided areas where we have highly productive land, avoiding hazard areas, coastal and areas of HPL
- Looked at what was coming through from national direction, eg, NPS on freshwater
- Identified principles – focus development around transport nodes and corridors
- How improve these – eg to Wairarapa high speed connections and again to Palmerston North
- Avoiding areas of parks eg Tararua ranges
- Dispersing employment to discourage longer distance travel
- Waste mgmt. issues – and what that might look like in the future
- What engineering solutions we might need to open up development in places where access or flood issues that need to be addressed.
- New areas – Makara and Ohariu; talked about Judgeford and what that might look like with SH58 – but with a question mark – as while roading improvements, but challenge around a lack of public transport and connectivity – and associated funding issues about how that might be addressed
- New blob between Masterton and Carterton as an unconstrained area from HPL
- [spots for intensification]

Table 4 – October

- Our assumptions are our principles; marked what was in development etc, avoided existing hazards etc, connect to existing urban framework; avoid assets eg recreational, amenity, water; Make better use of existing urban footprints
- Challenges
    - competing priorities – where should development go? Cost of infrastructure if you are intensifying development where for transport is far more efficient
    - difficult to control stormwater, flooding when in storm events;
    - from infrastructure perspective, have to use roads and parks for stormwater – so give roads and parks and small urban streams more room
    - if you intensify people become very reliant on people helping them, eg, solar to cut down
    - what can we do better? Housing affordability, different models for land ownership; lease or alternatives; papakainga housing or co-ownership; renting models archaic
    - increasing incomes provides more choices
    - medium density needs to be way better
    - behind 8-ball in managing growth as haven't had much
    - connectivity and building closer to transport etc
    - changing demographic, and sense of isolation
    - self-sufficiency
    - how expensive it is and needing to do it right
- biggest hazard flooding from stormwater and river

Table 5 – April

- lots of discussion, less agreement
- we did question why we wanted growth at all
- looked at challenges of growth and investment required – much of it funded out of local government, planning for new infrastructure, renewal, existing less adaptive to changes we face
- current regulatory framework does need to change – sense of urgency
- some of changes will bedriven by things beyond our control
- where is our economic base going to come from in the future – will underpin our growth and investment in the region
- needing to plan better for hospitals, quarries, waste and three waters
- areas that have supported growth are not necessarily where we want to growth in the future – which areas?? Reinforces need for greater regulatory planning
- many decisions at local level – not necessarily best
- lots of discussion about housing in Porirua
- region of hills and constrained by ranges and for many ways it has been good to protect things that are important for us; quality of our natural environment; importance of protecting larger landscape areas
- also had a discussion around choice – it would be a mark of success in a project like this – if people were living where they chose to live it would be successful growth

Table 6 – May

- 5 key drivers
- The two north-south rail lines
- Employment – CBD the key future service centre for the region, but opportunity for more expansive land uses and employment in other parts of region
- Conscious of cost of infrastructure – and whether it is affordable – concentrate in key places rather than spread everywhere – join us E-W
- Opportunities – turning n-s corridors into high-speed rail, joining economies together
- High-speed rail lines – joining up with new high-speed tunnel through middle of Belmont regional park
- New road tunnel to Wai
- Keep airport in same place – ferry from airport to Hutt; new fast ferry to south
- SH58 S-W Judgeford corridor – concentrating growth along corridor
- Wellington, Hutt, Palmerston
- Resilience – policy of coastal retreat, not allowing development in vulnerable areas eg Petone, Paraparaumu
- Role of economy critical to Hutt – look at other options
- More truffle farms in Wairarapa

Table 7

- Assumptions – housing affordability – destabilising and requires paradigm shift
- Climate change is critical to accept that
- Start funding major infrastructure asap
- Environmental degradation starting to get worse
- Retreat from coast
- Protect high quality soils
- Up rather than out
- Land banking
- Reverse environmental decline
- For urban growth – looked at corridors through Wairarapa, connecting Hutt Valley, Wellington Tawa to Porirua

- Restreeting from coast and growing forest environment
- Better in leadership and governance
- Forum good example of excellent collaboration – heartened by large measure of agreement
- Hard to plan in long 100-year timeframe – likely to experience disasters, and new technology
- Housing, environment and waste mgmt. paradigm shifts needed

Table 8

- Organising principle around communities that are inclusive, resilience, degree of self-sufficiency
- Intensification urban centres where there are good public transport connections
- Containing towns so they can't impinge on highly productive soils
- But still intensifying within those boundaries
- Principles of protecting biodiversity, social cohesion, natural landscapes etc
- How do we get communities working really well?
- Other centres like Hutt etc as complementary ser ice hubs, with different specialiations
- How protecting public assests and community facilities and future changes of use, but also having different communities accessible
- Home ownership and tenure models more flexibility in types of models
- But need for shift in central govt model – current regulation around tenancy letting us down
- Iwi have a role in co-housing etc – if move commercial imperative by having different types of developers in mix, can make them more viable
- In planning requirements – need to make more provision for green infrastructure, so self-sufficient, so have mixed communities, rather than urban ghettos;
- Funding gap and need to address – 3-waters, communities, and parks
- Energy efficiency and use of buildings etc. – reuse of buildings rather than just survival;
- What does it look like when you do medium-density?
- Changing land use – more resilient infrastructure etc
- *Ernst: sustainable development comes through strongly*

Table 9

- Started talking about climate resilience
- Looking forward 100 years – took out west coast as might be flooded asked what it looks like in 100 years? What protections will be put in place to protect it?
- Points of resilience critical now and as we move forward
- Assume some protected, some mitigated, we talked around intensifying development, identified places through valley, and towns in Wairarapa, and talked about infill development
- Interesting conversation about purpose of growth; if we could slow down growth we could plan for in a different way – no conclusion on tis
- Polycentric corridors, qualifications around infill development, without it being too scary in terms of the densifies required
- Big infrastructure items like relocating the airport, travel across the harbour
- Principles underpinned were creating vibrancy beyond Wellington CBD, creating equity, getting meaningful ownership in communities that will change – how they will own change for themselves.
- Talked about treaty commitments
- Talked about what we name the area – assumes wellington the centre – should we rename for planning purposes?

Table 10 – August

- Few central themes:
- More people are living close to where they work – you need sub-regional centres that have enough opportunities for that to work – employment, government, business, industrial that allow people to work in them as well as live in them
- Still retained wellington city, gave palmy big-ups – had as two of the larger cities
- Also talked about Paraparaumu and Masterton and the Hutt as sub-regional centres
- Then another tier down of sub-regional centres
- Lots about connectivity across region to city
- Also talked about choice – share vision that success means that people do have choices
- Have options about where they would want to live and work – long term vision
- Have also focused on intensification with greenfield secondary where it makes sense in terms of consolidation to existing areas and consolidation around transport hubs

Table 11 – commented on process

- Not going to repeat technical aspects
- But ow capitalised on morning's discussion
- 100 years for mana whenua; planners; bean counters 3 years
- Took time to listen to each other – realised we had such overlap from different disciplines from what we thought the regional growth was, but also had a lot of value add
- Getting range of views early enough at table – so can build on those
- Eg, cultural impact assessment when digger already there

Table 12 – June

- Conceptually maps probably very similar, including on transport links
- Key points of difference – where not develop? After hazard and green space, not much left, so not much choice
- Accepting that will intensify let's do that thoughtfully – European and other developments that are well done in their make ups
- Can build nicely around communities
- How deal with equality and house affordability – didn't' get very far down that route

Wellington Regional Growth Framework

Workshop 10th October 2019

Welcome and Introduction

Why are we all here?

- Opportunity to input into a regional growth plan for the next 30years and 100years for the wider region
- To provide multi disciplinary views
- The work you do today will be used at different stages of the project particularly the Foundation Report which is the first product

Why do this and why now?

1. The region is expecting between 50,000 and 61,000 more dwellings and 90,000 to 140,000 more people over the next 30 years
2. We are all facing a number of challenges such as housing supply and affordability challenges, increased congestion on our roads, the need for significant investment in infrastructure to facilitate growth and sea level rise – we are better to work on these together.
3. The Urban Growth Agenda has 5 pillars including spatial planning. The proposed National Policy Statement on Urban Development requires Councils to undertake a Future Development Strategy – the RGF will include this
4. Establish a joint long term vision that will form the basis of long term collaboration across boundaries and entities to deliver better outcomes
5. Ensure optimal impact of already planned investment eg NPS-UD Future Development Strategy, LGWM, Vulnerability Assessments, local growth plans

Context and Background

Our approach to urban growth management has been unsuccessful

A snapshot of our urban areas

- Land prices are too high
- Productivity is flat
- Income is not growing as it should
- Housing costs are rising
- Traffic congestion is getting worse

Key changes are needed to how we manage growth

Making room for growth

True costs of growth

Transport of modern cities

The Urban Growth Agenda (UGA) strategy

Designed to create the conditions for the market to respond to growth, bring down the high cost of urban land to improve housing affordability and support thriving communities.

The five pillars of work:

- **Infrastructure funding and financing**
- **Urban planning**
- **Legislative reform**
- **Transport pricing**
- **Spatial planning**

Urban Planning: National Policy Statement on Urban Development (NPS-UD)

NPS-UD requires decision-makers to provide for the social, economic, environmental and cultural wellbeing of communities and future generations, and to take into account the national and regional benefits and costs of urban development.

New direction to describe quality urban environment features that decisions shall contribute to.

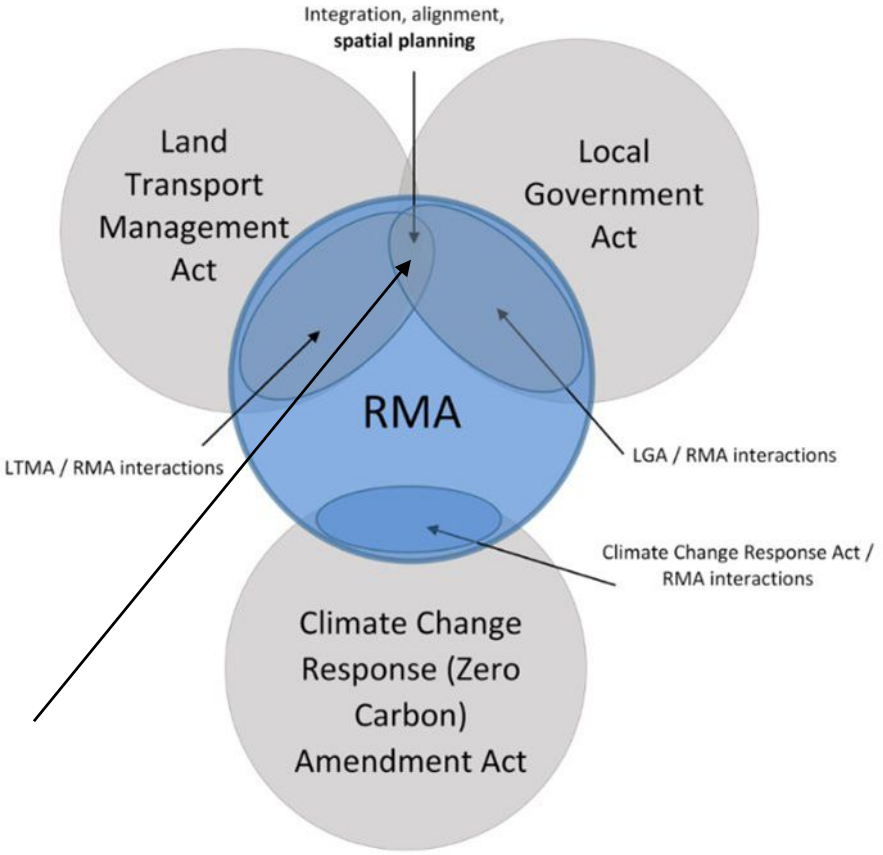
New direction would:

- **require plans to enable intensification in beneficial locations**
- **enable greenfield development when it contributes to quality urban environments**
- take into account diverse and changing ways that different groups value amenity
- limit the ability to regulate car parking through specifying parking requirements
- require zones to describe expected development and ensure that plan content enables it.

Legislative reform: Improving our resource management system

Comprehensive review to examine the broader and deeper changes needed to support the transition to a more productive, sustainable and inclusive economy.

The aim is to improve environmental outcomes and enable better and timely urban development within environmental limits. Focus is on the RMA, and how it interacts with other key legislation such as the LGA, LTMA, Zero Carbon AA.



Signals an increased role of **spatial planning** to help make better and more strategic decisions about resources and infrastructure over longer timeframes.

Spatial Planning

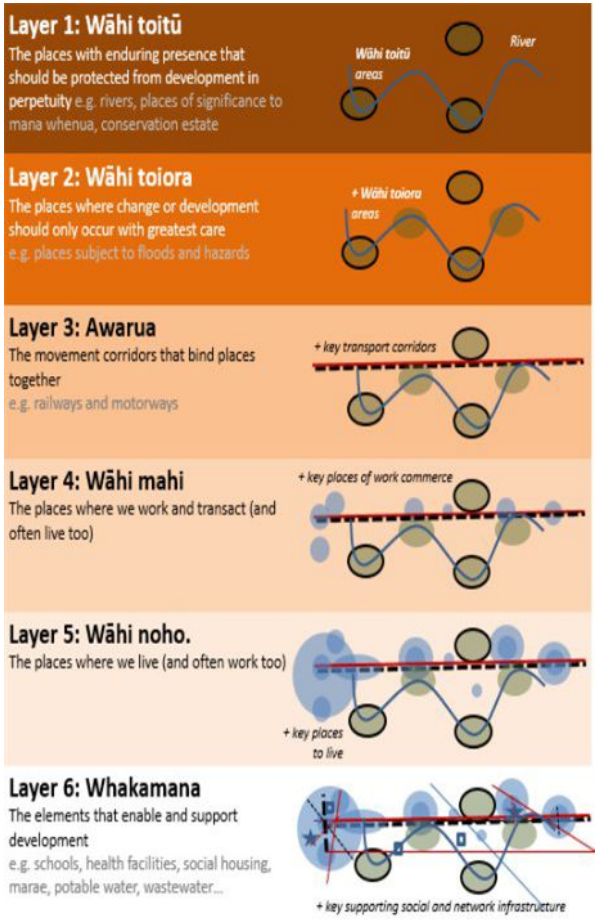
Spatial planning is about coordination and integration

The new generation spatial plans are both bold <u>and</u> minimalist.

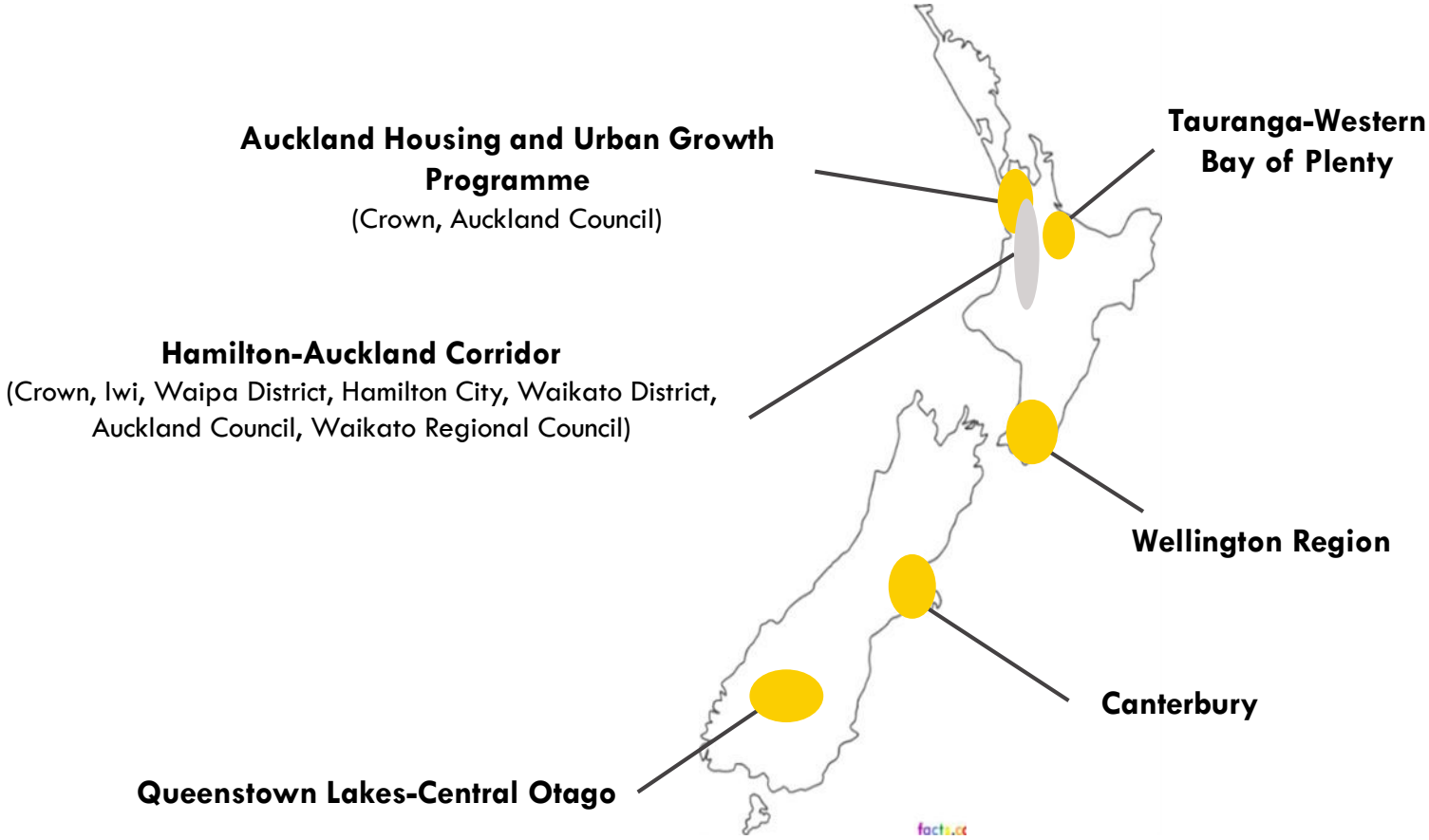
They will set out the **long term (100 year) spatial form** of an area and the **priority development areas and priority infrastructure for next 30 years** or so.

The key layers or components are:

1. 'No-go' areas that are not suitable to urban development
2. Areas for mitigating development impacts or restoring environmental qualities
3. Strategic transport and blue-green corridors
4. Future urban areas (communities)
5. Future urban areas (business land)
6. Priority development areas and the required lead and enabling infrastructure



Applying the new approach and tools: Examples of new regional growth management partnerships



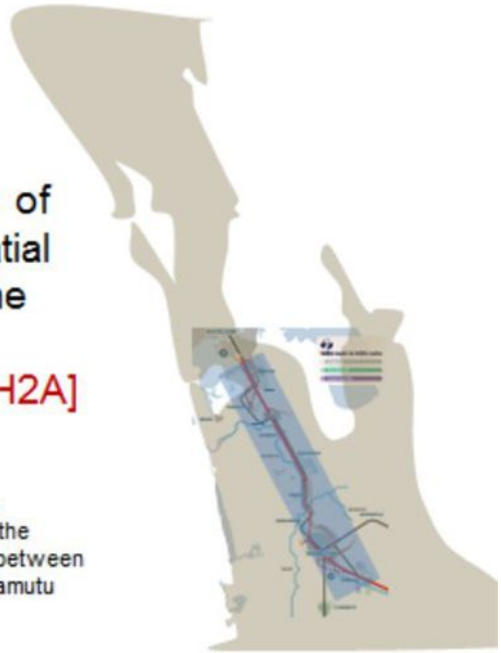
Hei Awarua ki te Oranga

Corridor for Wellbeing

NOT GOVERNMENT POLICY OR THE VIEW OF ANY ONE ORGANISATION

12 February 2019

AMI18/19010053



A summary of shared spatial intent for the Hamilton-Auckland [H2A] Corridor

Encompassing the settlements along the transport corridor between Cambridge-Te Awamutu and Papakura

A Strong Growth Management PARTNERSHIP *that enables…*

JOINT, INTEGRATED SPATIAL PLANNING *which unlocks…*

A TRANSFORMATIVE PROGRAMME *realised through…*

Focus areas

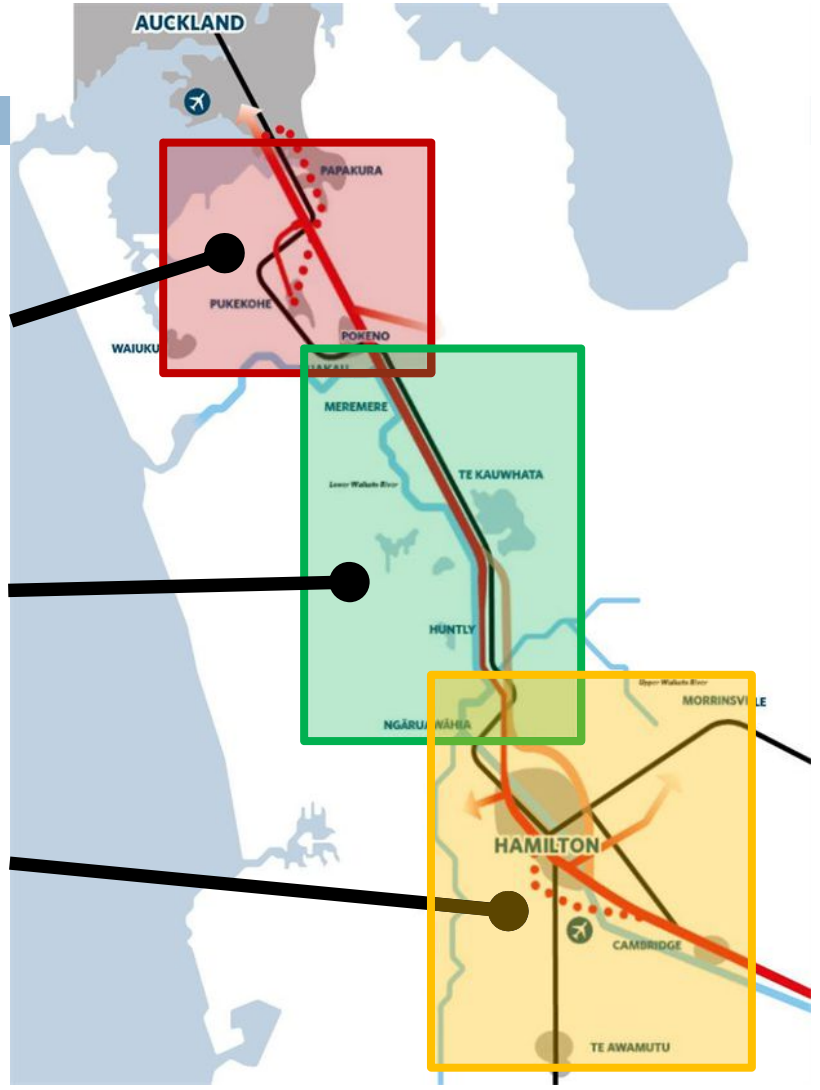
Rivers Four Waters

Stronger corridor connections

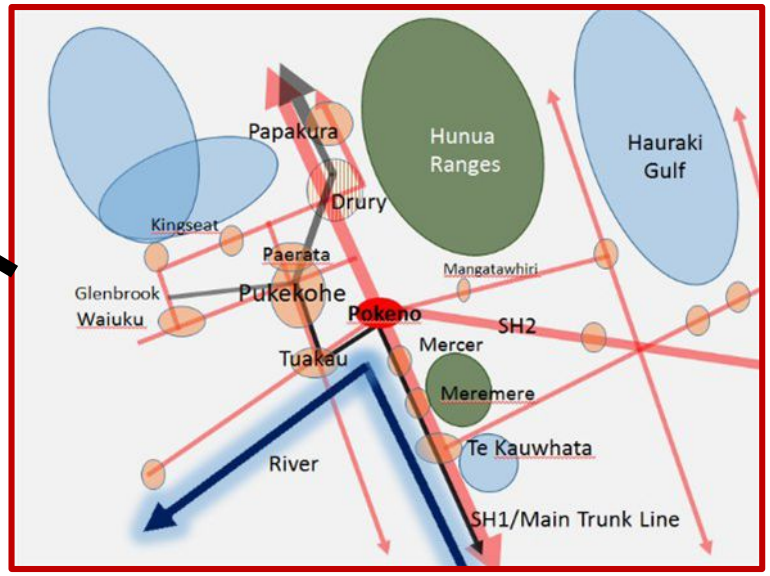
Papakura-Pokeno corridor

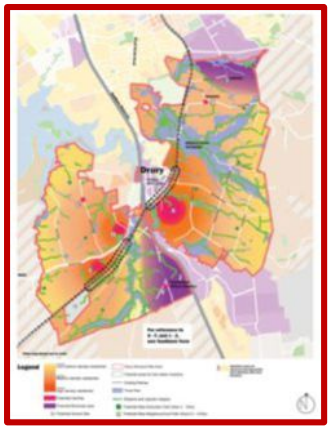
River communities

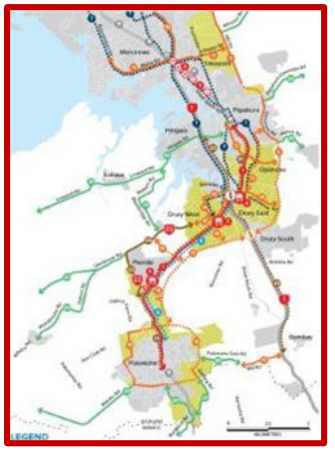
Hamilton-Waikato metro area



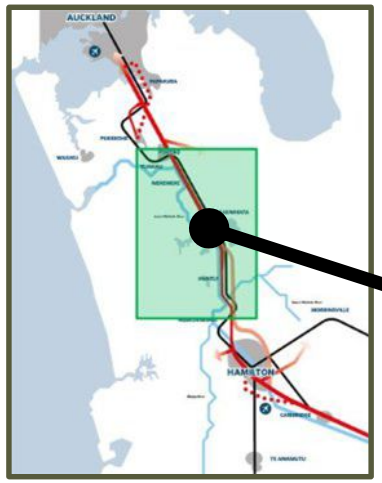
Papakura-Pokeno corridor

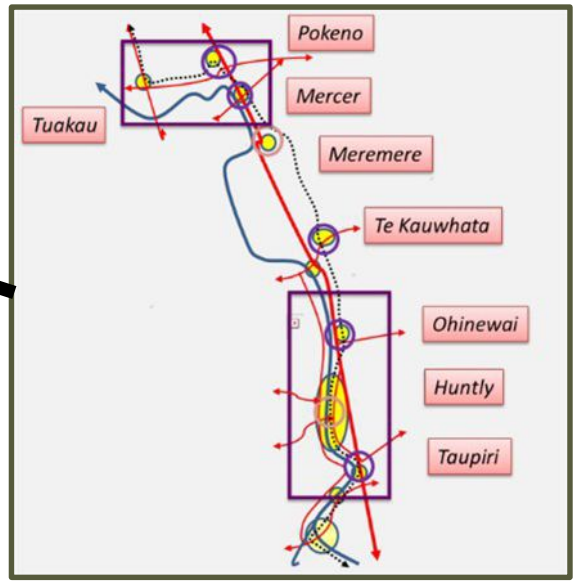


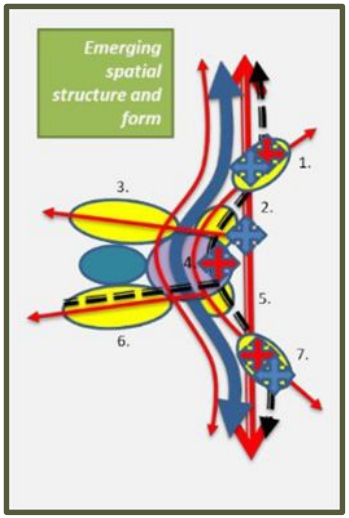


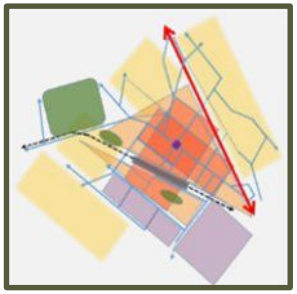


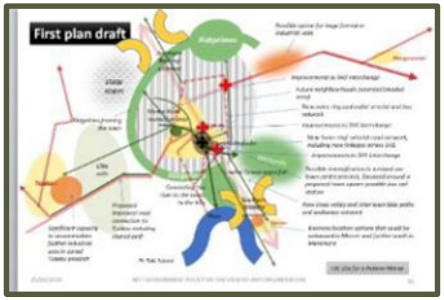
River Communities



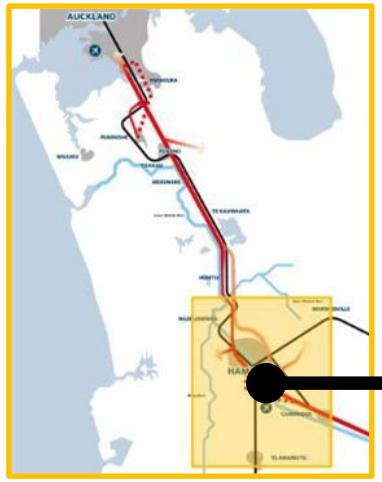


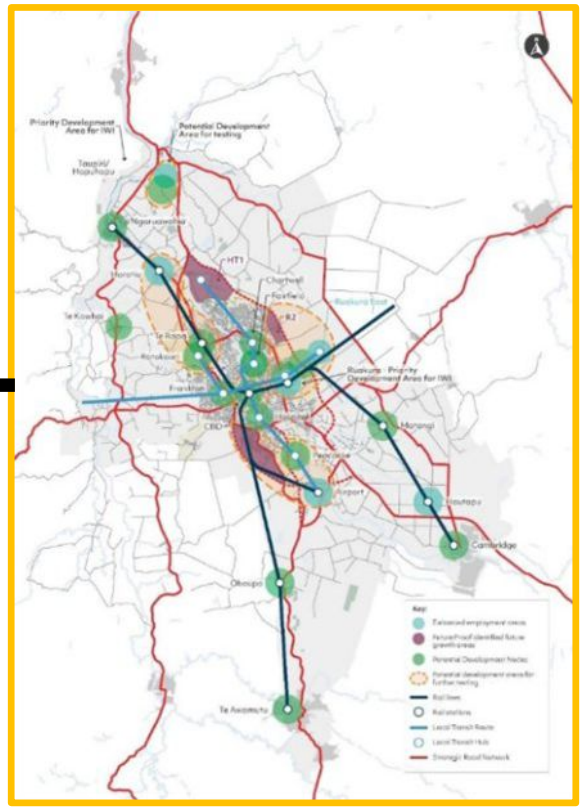






Hamilton-Waikato metropolitan area





Agenda

- Morning is focused on being in groups related to your specialist topic – both a round table and a mapping exercise
- Afternoon we will mix people up and have a “cross topic” discussion
- There will be an opportunity towards the end of the working session for groups to present to each other and discuss the findings

Way of working today

- Take a regional lens and not too much detail at the local level
- Don’t compromise your specialist views
- 30year and 100year views with 100year views framing the urban form, not the detail
- Will be doing mapping and we also want you to capture non-spatial thinking

Overview - RGF

Project Outcome

– what do we want at the end of this work

A Regional Growth Framework that:

- Is developed, owned by local government, central government and Iwi

Includes:

1. A 30 and 100 year horizon
2. Regional and joint challenges and opportunities
3. A spatial plan/a plan that includes spatial representation
4. A programme of projects to resolve growth issues and other challenges including relevant analysis
5. Scenario development and analysis

Draft Project Objectives

- what are we wanting to achieve – will need to be confirmed

1. Improve housing affordability
2. Enable growth that protects and enhances the quality of the natural environments and accounts for a transition to a low/no carbon future
3. Improve access to and between housing, employment, education and services utilising all multi-modal transport choices
4. Encourage sustainable, resilience and affordable settlement patterns/urban form that make efficient use of existing infrastructure and resources
5. Build climate change resilience and avoid increasing the impacts and risk of natural hazards
6. Create employment opportunities

Scope

- what is included in this project?

1. Wellington region plus Horowhenua
2. Critical areas for protection eg conservation areas, natural hazards/sea level rise – natural environment
3. Housing intensification, growth areas and urban development authority opportunities – quality, price points, numbers, location, type
4. Regional growth related issues eg insurance, medium density acceptance, building sector capacity
7. Transport – road, PT (rail, bus and other), active modes
8. Impact on Infrastructure – 3 waters, electricity
9. Social Infrastructure and Outcomes eg education and health, community facilities
10. Employment centres and growth
11. Costs and benefits and understanding the investment needed

Indicative Staging and Timing

Stage	Timing
Set up	Complete
Develop Foundation Report	September – December 2019
Develop Options Report	November 2019 – February 2020
Draft Regional Growth Framework	February – April 2020
Finalise Regional Growth Framework for consultation	April – June 2020
Consultation	July onwards
Embed Implementation Plan	October onwards

Round Table Session 1

- For your specialist topic, discuss and agree the key issues/challenges and opportunities.

Mapping Session 1

- Drawing on the issues, challenges and opportunities from Round Table Session 1

a) Agree as a group, related to your specialist topic "What are we aiming for in 30/100 years' time? What does the world look like spatially?

b) Then map:

   a) Where geographically should the region's growth and change not go?

   b) Where geographically do you think the region's growth and change should occur over the next decades?

c) Standing back, what are the principles that underpin your spatial drawing?

Top Issues, Challenges and Opportunities

Feedback Session

Top Issues/Challenges

- Housing and Urban Growth
  - Housing spectrum – housing affordability
  - Funding model – parity and type
  - Capacity challenge
  - Developer availability
  - Technology changes – businesses should not be the future shaper of growth; spatial pattern challenges
  - Natural hazard constraints
  - Development costs and risks including insurance and finance
  - NIMBYism
  - Sea level rise – impact on coastal areas
  - Housing cost, quality, planning, provision and affordability
  - Infrastructure – past poor investment; cost and provisioning

Top Opportunities

- Housing and Urban Growth
  - Inclusive cities
  - Integrate with infrastructure
  - Vibrant local centres
  - Space – our advantage
  - Connected urban centres/nodes
  - Future housing – access to amenity, typologies
  - Opportunity to explore and find acceptable urban form (demand led rather than imposed)

Top Issues/Challenges

- Transport
  - Climate change – opportunity as well as challenge
  - Distribution and design of growth
  - Constrained capacity caused by geography and funding constraints
  - Public transport – capacity, infrastructure availability and connectivity
  - Resilience/natural hazards/climate change – short term, high impact
  - Missing connections – north/south and east/west

Top Opportunities

- Transport
  - Momentum/appetite for change - as social licence grows through urgency (eg climate change and housing) – we are able to go faster
  - Mode shift
  - Public transport – mode shift, infrastructure upgrades and development
  - Travel demand management – behaviour change, co-working, technology and flexibility
  - Transport/land use planning – integration, growth management, service and employment location

Top Issues/Challenges

- Natural Environment and Heritage
  - Climate change and habitat
  - Biodiversity loss
  - Agriculture (popn growth)
  - Urban development (popn growth)
  - Different definitions and ideas – what is heritage? What is natural environment?
  - Integrating built and natural environment
  - The old model isn't working – environmental quality is still going down

Top Opportunities

- Natural Environment and Heritage
  - Restoration as well as protection. Determining priorities for enhancement and restoration – protecting and growing
  - Engaging communities
  - Integration of natural environment in existing urban footprint
  - Recognising that all our policies are part of a bigger system
  - Reposition our perspective: part of, not distinct from the environment

Top Issues/Challenges

- Employment/Business
  - Infrastructure investment
  - Confidence in the region amongst resilience, seismic etc risks
  - Aspiration/commitment and addressing needs and developing new employment and skills pathways

Top Opportunities

- Employment/Business
  - Smarter distances between homes and jobs
  - Using our brains trust – including new technologies

Top Issues/Challenges

- Resilience/Climate Change
  - Who pays for mitigation and adaptation?
  - We are still building in places that are at risk
  - More "nuisance" events – more pressure on councils to address this
  - Access to information to make informed decisions
  - Changing national and regional psyche (what we think about risks/hazards)
  - Safety, security and who pays?

Top Opportunities

- Resilience/Climate Change
  - Transition to zero carbon – more sustainability in terms of land use changes
  - Co-benefits/more active transport options
  - Designing for risk eg more resilience/retreat
  - Communication of information (single portal for hazards info)
  - Long-term planning/managed retreat – over what timeframe?
  - Smarter development (not no development) +/or avoidance of high hazard areas
  - Manage emissions to help reduce the impact of climate change

Top Issues/Challenges

- Infrastructure
  - Developable land – difficult to develop and access and service
  - Infrastructure renewal bow wave over next 30 years
  - Coastal infrastructure and flood plains becoming unusable

Top Opportunities

- Infrastructure
  - Integrated planning between recreational, roading and 3 waters services
  - Scale and efficiency enabled by intensification and as new transport corridors open up land

Top Issues/Challenges

- Social Outcomes
  - Growth forgets our most vulnerable (equity, wellbeing and people)
  - Isolation, displacements, lack of social connectivity
  - Affordability of housing and community social infrastructure
  - Population growth (projections not always accurate) and aging population and loneliness
  - Uncertainty as to what life will be like in 100 years including technology changes
  - Sustainable food systems – how to protect highly productive land

Top Opportunities

- Social Outcomes
  - Collective, cross agency approach to shared issues and palling to embed wellbeing into all aspects of spatial planning
  - Grow in a way that addresses inequities
  - Shared spaces (multi use places and spaces) and innovative use of green spaces – leads to improved wellbeing and connectedness
  - Equity lens placed over the plan
  - Indigenous framework
  - Social procurement embedded in all tender documents
  - Resilience – social capital, social cohesion, community resilience, community safety
  - Sustainable and adaptive physical infrastructure for community cohesion

Top Issues/Challenges/Opportunities

- Iwi
  - Tumatauenga > Manaaki > Rongo
  - Mana Motuhake – how to survive and thrive
  - Poutiria – how to achieve a balance
  - Mahi tuhono – how to get people out of their private spaces to build a community
  - Browning – becoming more Maori. How will population change over time? Planning/building for us or future generations? Youth voice

Mapping Session 2

- Where geographically should the region's growth and change not go?
- Where geographically do you think the region's growth and change should occur over the next decades?
- What do we think should change in the next 30 years? 100 years? – tell us a story about this
- What assumptions have you used?
- What could we do better?

Presentation and Discussion 1

- What can you see on the maps?
- What insights about the region do you get from this?
- Recommend any further changes

Next Steps and Wrap Up

What we have heard today

- Ernst to summarise

Indicative Staging and Timing

Stage	Timing
Set up	Complete
Develop Foundation Report	September – December 2019
Develop Options Report	November 2019 – February 2020
Draft Regional Growth Framework	February – April 2020
Finalise Regional Growth Framework for consultation	April – June 2020
Consultation	July onwards
Embed Implementation Plan	October onwards

Next Steps

- Feedback from today will be provided
- Monthly email update
- Foundation Report
- Stakeholder Engagement
- Follow up questions and information

- Contact me – kim.kelly@gw.govt.nz

PUBLIC

Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**BOARD DISCUSSION PAPER** **Date: 5 September 2019**

Author	Michele Halford, Executive Leader Nursing
Endorsed By	Dale Oliff, Chief Executive Wairarapa District Health Board
Subject	Review 48 Hour Readmissions – 3 December 2018 – 7 March 2019

RECOMMENDATION It is recommended that the Board:

a. **NOTES** this paper and discusses as appropriate

1. EXECUTIVE SUMMARY

- Readmission of patients is a national focus and is monitored by both the DHB and Ministry as it is considered to be an indicator of how effective the whole discharge process is across the sector – from hospital to community and primary care
- Readmission is defined as being readmitted to hospital within 28 days for the same diagnostic code. This project looked at the cohort of patients who had been readmitted to Wairarapa Hospital during the period from 1 December 2018 to 10 March 2019 less than 48 hours following discharge
- The numbers of patients readmitted to Wairarapa Hospital during this three month time period are within accepted parameters and small numbers make it difficult to find any particular pattern
- Māori patients make up only a small proportion of this cohort i.e. three out of fifteen patients
- Some of these cases are representative of patients who, on the face of it, appear to have been at the receiving end of less than optimal care and / or discharge process
- All patients were flagged as routine discharges and none identified as requiring extensive or complex discharge planning
- Recommendations include:
    - To conduct a multidisciplinary review of the discharge process and implement strategies to enable appropriately targeted discharge plans to be developed from time of admission. This will link with the Bed Flow Improvement Project led by Vicki Hookham, Associate Leader Nursing
    - All patients admitted within 48 hours of discharge are reviewed by Senior Medical Officer SMO and senior nurse. This will enable us to identify issues from a quality improvement focus

PUBLIC

2. INTRODUCTION

Readmission of patients is a national focus and is monitored by both the DHB and Ministry as it is considered to be an indicator of how effective the discharge process is across the sector – from hospital to community and primary care. Without more in-depth analysis it is difficult to identify any aspects of this journey which are working well and not so well, and therefore opportunities for system improvement are limited to high level data.

For regular reporting purposes, readmission is presented as a standardised rate for the population and is defined as being readmitted to hospital within 28 days for the same diagnostic code.

This project investigated a cohort of patients who had been readmitted to Wairarapa hospital during the period from 1 December 2018 to 10 March 2019.

Recent national data (to December 2018) shows Wairarapa has the third lowest readmission rate across New Zealand (NZ) DHBs. All age groups (children, youth, adults and older people) are below the national standardised readmission rate. Māori standardised readmission rates are well below the national average but Pacific Island rates are proportionally higher. 18 Pacific Island people were discharged from hospital for the first half of 2018-19 and it is likely that this small number is distorting the picture.

Although the DHB level data does not indicate any particular problem area for acute readmissions, there appeared to be a local concern which needed to be explored, especially with regard to rapid readmissions. This data based approach can therefore enable informed discussion for service development. The patient sub-group that is therefore the focus of this project are those who are readmitted within a short period of time (e.g. 48 hours).

3. METHODOLOGY:

The following methods were used to evaluate the services:

3.1 Identify NHIs and ages of this cohort

3.2 Review each set of clinical notes to identify

- **a.** living situation – alone/with other(s)/ own home / ARC / village unit
- **b.** Discharging clinician

3.3 Identify interface with other health services

- **a.** Primary care
- **b.** Community Nursing
- **c.** FOCUS
- **d.** Support Services
- **e.** Health Recovery Programme

3.4 Identify key indicators and trends/issues relating to hospital discharge – e.g. timing of discharge, information or advice given, medication management, referral to other services, family support

3.5 Identify any potential areas for improvement

4. FINDINGS:

4.1 Patient demographics:

- **a.** A data search of Concerto records identified a total of 15 patients who had been readmitted to Masterton Hospital within 48 hours of discharge. The dates of first admission were from 3 December 2018 until 7 March 2019, however, only two patients had their first admission after 10 February 2019

b. All age demographics were represented:

- **i.** 0-15 = **1**;
- **ii.** 16-25 = **2**;
- **iii.** 26-64 = **6**;
- **iv.** 65-80 = **3**;
- **v.** 80+ = **3**

c. Three patients identified as NZ Māori, one as Other European and the remainder as New Zealand European

d. Nine patients were male and six female

4.2 Living situation:

a. The majority of patients lived with others

b. One patient lived in aged residential care

c. Five patients lived alone

4.3 Discharging clinicians:

a. Nine patients were admitted medically
b. Four surgical
c. One paediatric
d. One Obstetric & Gynaecological
e. Three patients were admitted under the same consultant for both admissions

4.4 Discharging service:

a. High Dependency Unit (HDU) = one patient
b. Paediatric = one patient
c. Medical Surgical Ward (MSW) = 13 patients
d. Most (12) discharges occurred on the morning shift, primarily after midday and the remainder between 1500hrs and 1700hrs
e. TrendCare data showed that on the day of discharge the time allocated to these patients varied from 0.45 to 2.25 hrs. (11 of the patients required 1.55hrs or more of care). All were flagged as routine discharges, none were identified as requiring extensive or complex discharge planning

4.5 Factors of note:

a. Readmissions within the 48 hours over this time period (i.e. three months) accounted for an additional 45 bed days
b. In addition to this, 39 patients presented to Emergency Department (ED) within 48 hours of discharge and were not readmitted to an inpatient ward
c. The patient admitted to HDU was cardioverted for Paroxysmal Atrial Fibrillation (PAF) Medications to control his heart rate weren't altered until after readmission
d. In five patients' notes it was documented that the patient was advised to return to Emergency Department if symptoms or concerns worsened
e. Four patients had at least one other recent readmission (within three months)
f. No patients had any documented referral to, or liaison with, a support service following initial discharge, and only three had new referrals following their second admission
g. Several of these patients required transfer of care to Capital Coast DHB or Hutt Valley DHB on readmission, indicating the severity of their conditions

PUBLIC

5. DISCUSSION:

The numbers of patients readmitted to Wairarapa Hospital during this three month time period are within accepted parameters and small numbers make it difficult to find any particular pattern, however some of these cases are representative of patients who, on the face of it, appear to have been at the receiving end of less than optimal care and / or discharge process. Of significance is that no patients from the Assessment and Rehabilitation Service are among this number. This may be reflective of the emphasis which this service places on the discharge process for all patients as well as the longer average length of stay (ALOS). Conversely, the largest number of readmissions follow discharge from MSW where the ALOS is shorter and patient turnover and discharges significantly higher.

Five patients were advised to return to Emergency Department if symptoms or concerns worsened rather than to contact their General Practitioner. This may indicate uncertainty of the behalf of the clinician as to whether or not the patient was ready for discharge. Also of interest is the number of patients who returned to ED within the 48 hours following discharge.

All patients were flagged as routine discharges and none identified as requiring extensive or complex discharge planning.

6. RECOMMENDATIONS:

1. Conduct a multidisciplinary review of the discharge process and implement strategies to enable appropriately targeted discharge plans to be developed from time of admission[1]. This will link with the Bed Flow Improvement Project led by Vicki Hookham, Associate Leader Nursing
2. All patients admitted within 48 hours of discharge are reviewed by SMO and senior nurse. This will enable us to identify issues from a quality improvement focus

7. ADDENDUM:

A previous project was undertaken which included case review of all Māori 75+ who readmitted within 28 days for the same condition during 2017-18 and thematic analysis of findings. All readmissions of Māori 75+ for the year 2017-18 (eight) have been reviewed by a Senior Registered Nurse who concluded that readmission rates for this group does not display cultural inequity.

While this project did not look specifically at cognitive status, some work has been done recently to look at the prevalence and impact of dementia in the community. The study does show a link of those with mild impairment with readmission within 28 days. This paper is due to go to the Community and Public Health Committee (CPHAC) in October 2019.

Project team:

Michele Halford; Sponsor

Joanne Edwards: Advisor

Holly Brindle: Reviewer

---

1. [1] The Advisory Board has published *The On-Time Discharge Toolkit* which provides some strategies to address common discharge delays in the acute setting and *The New Normal* – guide to re-designing care around the complex multi-morbid patient