Community and Public Health Advisory Committee Agenda

Location:	Board Room Level 1 Hockin Building Waikato Hospital Pembroke Street HAMILTON		
Date:	12 December 2018	**Time:**	1:00 pm

Committee Members:	Dr C Wade (Chair) Ms T Hodges (Deputy Chair) Mr M Arundel Ms C Beavis Ms S Mariu Mrs P Mahood Mr J McIntosh Mr D Slone Ms J Small Ms TP Thompson-Evans Mr R Vigor-Brown Ms S Webb
In Attendance:	Ms T Maloney, Executive Director Strategy, Funding and Public Health, and other Executives as necessary

Next Meeting Date:	12 December 2018	
Contact Details:	Phone: 07 834 3622	Facsimile: 07 839 8680

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Community and Public Health Advisory Committee Agenda

Item	
1.	Apologies
2.	**INTERESTS**
	2.1 Schedule of Interests
	2.2 Conflicts Related to Items on the Agenda
3.	**MINUTES AND MATTERS ARISING**
	3.1 Waikato DHB Community and Public Health Advisory Committee; 8 August 2018
	3.2 Lakes DHB Community and Public Health Advisory Committee; 8 October 2018
	3.3 Lakes DHB Disability Support Advisory Committee; 5 November 2018
	3.4 Bay of Plenty DHB Community & Public Health and Disability Advisory Services Committee; 3 October 2018
4.	**DISABILITY SERVICES**
	4.1 Disability Responsiveness Plan Update
5.	**PAPERS FOR DECISION**
	5.1 Draft Committee Schedule for 2019/20
6.	**PAPERS FOR INFORMATION**
	6.1 Immunisation Coverage Update and Actions to Improve Coverage
	6.2 Waikato DHB Submission Draft 2018-2028 Waikato Regional Transport Plan
	6.3 Waikato DHB Submission on Strategy to Prevent and Minimise Gambling Harm 2019/20 to 2021/22
	6.4 Waikato DHB Submission on Healthy Homes Standards
	6.5 Waikato DHB Submission on the Reform of the Residential Tenancies Act 1986
7.	**PRESENTATIONS**
	7.1 Review of Waikato DHB Position Statements on Tobacco Control, Alcohol Harm, and Psychoactive Substances
	7.2 Waikato Health System Plan Update
	7.3 Tamariki and Rangitaahi Health and Wellbeing
8.	**GENERAL BUSINESS**
9.	**DATE OF NEXT MEETING**
	9.1 13 February 2019

Apologies

Interests

SCHEDULE OF INTERESTS AS UPDATED BY COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE MEMBERS TO DECEMBER 2018

Clyde Wade

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

Tania Hodges

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Chair, Maori Strategic Committee, Waikato DHB	Non-Pecuniary	None	
Deputy Chair, Community and Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Chief Executive Performance Review Committee, Waikato DHB	Non-Pecuniary	None	
Member, Iwi Maori Council, Waikato DHB	Non-Pecuniary	None	
Director/Shareholder, Digital Indigenous.com Ltd (contracts with Ministry of Health and other Government entities)	Pecuniary	Potential	
Director, Ngati Pahauwera Commercial Development Ltd	Pecuniary	None	

Note 1: Interests listed in every agenda.
Note 2: Members required to detail any conflicts applicable to each meeting.

Director, Ngati Pahauwera Development Custodian Ltd	Pecuniary	None	
Director, Ngati Pahauwera Tiaki Custodian Limited	Pecuniary	None	
Trustee, Ngati Pahauwera Development and Tiaki Trusts (Deputy Chair)	Pecuniary	None	
Member, Whanau Ora Review Panel	Non-Pecuniary	None	
Trustee and Shareholder, Whanau.com Trust	TBA	TBA	

Sally Webb

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

Crystal Beavis

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Deputy Chair, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Community and Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Chair, Chief Executive Performance Review Committee, Waikato DHB	Non-Pecuniary	None	
Director, Bridger Beavis & Associates Ltd, management consultancy	Non-Pecuniary	None	
Director, Strategic Lighting Partners Ltd, management consultancy	Non-Pecuniary	None	
Life member, Diabetes Youth NZ Inc	Non-Pecuniary	Perceived	
Trustee, several Family Trusts	Non-Pecuniary	None	
Employee, Waikato District Council	Pecuniary	None	

Pippa Mahood

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Community and Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Iwi Maori Council, Waikato DHB	Non-Pecuniary	None	

Note 1: Interests listed in every agenda.
Note 2: Members required to detail any conflicts applicable to each meeting.

Chair, Waikato Health Trust	Non-Pecuniary	None	
Life Member, Hospice Waikato	TBA	Perceived	
Member, Institute of Healthy Aging Governance Group	TBA	Perceived	
Board member, WaiBOP Football Association	TBA	Perceived	
Husband retired respiratory consultant at Waikato Hospital	Non-Pecuniary	None	
Member, Community and Public Health Committee, Lakes DHB	Pecuniary	Potential	
Member, Disability Support Advisory Committee, Lakes DHB	Pecuniary	Potential	
Member/DHB Representative, Waikato Regional Plan Leadership Group			

Sharon Mariu

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

John McIntosh

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

Note 1: Interests listed in every agenda.
Note 2: Members required to detail any conflicts applicable to each meeting.

David Slone

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

Te Pora Thompson-Evans

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Member, Community and Public Health Advisory Committee, Waikato DHB **Member, Iwi Maori Council Representative for Waikato-Tainui, Waikato DHB** **Iwi: Ngāti Hauā** **Member, Te Whakakitenga o Waikato** **Trustee, Ngāti Hauā Iwi Trust** **Trustee, Tumuaki Endowment Charitable Trust** **Director, Whai Manawa Limited** **Director/Shareholder, 7 Eight 12 Limited**	Non-Pecuniary	None	Refer Notes 1 and 2

Rob Vigor-Brown

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

Mark Arundel

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Member, Community and Public Health Advisory Committee, Waikato DHB **Board member, Bay of Plenty DHB** **Member, Pharmaceutical Society of NZ**	Non-Pecuniary	None	Refer Notes 1 and 2

Note 1: Interests listed in every agenda.
Note 2: Members required to detail any conflicts applicable to each meeting.

Trustee, TECT (Tauranga Electricity Consumer Trust) **Wife is an employee of Toi Te Ora (public health)**		Potential	

Judy Small

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Member, Community and Public Health Advisory Committee, Waikato DHB **Member, Consumer Council, Waikato DHB**	Non-Pecuniary	None	Refer Notes 1 and 2

Note 1: Interests listed in every agenda.
Note 2: Members required to detail any conflicts applicable to each meeting.

Minutes and Matters Arising

MEMORANDUM TO THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
12 DECEMBER 2018

AGENDA ITEM 3

COMMITTEE MINUTES

Attached are the following minutes from the Committee meetings:-

- Waikato DHB Community and Public Health Advisory Committee; 8 August 2018
- Lakes DHB Community and Public Health Advisory Committee, 8 October 2018
- Lakes DHB Disability Support Advisory Committee, 5 November 2018
- Bay of Plenty combined Community & Public Health Advisory and Disability Support Advisory Committee 3 October 2018.

Recommendation
THAT

The minutes be noted.

CLYDE WADE
CHAIR
COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE

WAIKATO DISTRICT HEALTH BOARD
Minutes of the Community and Public Health Advisory Committee held on 8 August 2018 commencing at 1.00pm

Present: Dr C Wade (Chair)
Mr M Arundel
Ms C Beavis
Mrs P Mahood
Ms S Mariu
Mr J McIntosh
Mr D Slone
Ms TP Thompson-Evans

In Attendance: Ms T Maloney, Executive Director, Strategy & Funding
Dr D Tomic, Clinical Director Primary and Integrated Care
Mr W Skipage, Strategy and Funding
Mrs MA Gill, Waikato DHB Board member
Mr M Gallagher, Waikato DHB Board member
Ms M Neville, Director Quality and Patient Safety
Ms L Elliott, Executive Director Maori Health

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

The Community and Public Health Advisory Committee and Disability Support Advisory Committee currently have three community representatives in addition to the Consumer Council representative. The Waikato DHB Board has recently agreed to reorganise community representation to ensure there is one non-Board member for each statutory committee. As a result, Mr F Mhlanga will now be the representative on the Health Advisory Committee and no longer a CPHAC/DSAC Committee member. The chair acknowledged Mr Fungai's contribution to the CPHAC/DSC committee.

The chair also congratulated Mr J McIntosh for being the recipient of the Paul Keesing award for his contribution to community health.

The Chair tabled a memo from Tania Hodges outlining her comments on a number of items on the agenda.

ITEM 1: APOLOGIES

Apologies from Ms S Webb, Ms T Hodges, Ms J Small, Mr Rob Vigor Brown and Mr F Mhlanga were received.

Resolved
THAT
The apologies were received.

ITEM 2: INTERESTS

2.1 Register of Interests
Mr M Arundel has supplied an update to his interests which would be reflected in the next agenda.

2.2 Conflicts Relating to Items on the Agenda
No conflicts of interest relating to items on the agenda were foreshadowed.

ITEM 3: MINUTES OF PREVIOUS MEETING AND MATTERS ARISING

The chair highlighted that Lakes DHB were undertaking a media campaign regarding smoking cessation and suggested that there may be opportunities for Waikato DHB to collaborate on this venture.

Resolved
THAT
1) The minutes of a meeting of the Waikato DHB Community and Public Health Advisory Committee held on 13 June 2018 be confirmed as a true and correct record.
2) The minutes of a meeting of the Lakes DHB Community and Public Health Advisory Committee held on 11 June 2018 be noted.

ITEM 4: DISABILITY SERVICES

4.1 Waikato DHB Disability Responsiveness Plan Terms of Reference

The updated Terms of Reference (TOR) for the Waikato DHB Disability Responsiveness Plan were provided to the Committee. The TOR now included a link to the national Whai Te Ao Marama Plan. A direction setting workshop with the wider sector will be convened where details around specific actions would be determined.

Resolved
THAT
The Committee noted the Terms of Reference

4.2 Committee Representation on the Disability Responsiveness Plan Reference Group

Whilst it was agreed that it was opportunistic to have a Committee representative that was part of the Consumer Council, the Committee highlighted that there were also benefits of having a non-Consumer Council representative. Accordingly it was decided that there would be two CPHAC representatives.

Resolved
THAT
The Committee approved Ms J Small and Mr D Slone as the Committee representatives on the Disability Responsiveness Plan Reference Group.

ITEM 5: PAPERS FOR DECISION

5.1 2018-21 Suicide Prevention and Postvention Plan

Ms M Neville and Ms J Hudson attended for this agenda item. An updated 2018-21 Waikato Suicide Prevention Plan was brought to the Committee which now included a zero suicide aspiration. The intention was for the Plan to remain a living document. The first intersectoral workshop had received positive feedback, however Committee members emphasised the importance of having the right people in attendance which needed to include connecting with the group of people who were not currently under any services if a zero suicide rate was to be achieved. Increased engagement with the Iwi Māori Council was also required to ensure attendance reflects the communities where the wananga are being held.

Resolved
THAT
The Committee endorsed the 2018-21 Waikato Suicide Prevention Plan.

ITEM 6: PAPERS FOR INFORMATION

6.1 Proposal for Change to Strategy, Funding and Public Health

Presented by Ms T Maloney, members discussed and provided feedback on the change proposal with a focus on the commissioning approach. It was noted that the Public Health Unit would now be subject to a separate review and would not be part of the current Strategy and Funding review.

Resolved
THAT
The Committee provided feedback on the Proposal for Change.

6.2 Health Improvement Settings Approach

An overview was presented by Ms D Penjueli, Ms R Black and Ms C Dargaville of the Health Improvement service activities.

Mrs P Mahood left the meeting.

Resolved
THAT
The Committee noted the Health Improvement Settings Approach update.

6.3 Ki Te Taumata o Pae Ora Update

Resolved
THAT
The Committee noted the update progress report.

6.4 Waikato DHB Tobacco Control Action Plan

An updated Waikato DHB Tobacco Control Action Plan was submitted to the Committee for noting. It was highlighted that submission of the plan was a Ministry requirement and met the minimum requirements; however the intention was to do further work over the coming months, with a stronger focus on Māori and on reducing smoking initiation.

It was noted that the maternal smoking rate differed between the Plan and the Strategy Paper.

A paper will be brought to a future committee by the Public Health Unit in respect to a position statement on vaping.

Resolved
THAT
The Committee noted the content of the report.

ITEM 7: PRESENTATIONS

7.1 Oral Health Services Update

Presented by Ms J Dibble, Dr K Ayers and Ms D Pevreal, members were provided with an overview of Waikato oral health services.

Committee members requested a breakdown of the presented data by ethnicity.

Members also suggested an oral health review and plan for adults could be beneficial, albeit was noted that if oral health care for 0-18 year olds succeeded in 100% coverage, long term adults would be covered.

Resolved
THAT
The Committee noted the presentation.

Ms TP Thompson-Evans left the meeting.

7.2 Project Energize, Update from Sport Waikato

Presented by Mr M Cooper, Mr R Batersby, Ms J Scott, Ms M Nightingale-Pene, and Mr A Corkill from Sport Waikato, members were provided with an update of the Project Energize programme.

Sport Waikato will be undertaking a full evaluation of the Project Energize programme in 2019. Accordingly the data presented was based from the last evaluation in 2011. It was suggested that the evaluation should include a longitudinal element, determining the long term success of the programme for those who started the programme in the early years and were now adults.

Resolved
THAT
1) The Committee noted the report and presentation.
2) The Committee noted the evaluation currently being developed.
3) The Committee noted the gaps in the current approach and opportunities for increased impact through expansion of the programme.

ITEM 8: GENERAL BUSINESS

There were no general business items raised.

ITEM 9: DATE OF NEXT MEETING

10 October 2018

Meeting finished at 4:15 pm

LAKES DISTRICT HEALTH BOARD

MINUTES OF A MEETING OF THE COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE HELD MONDAY 8th OCTOBER 2018 at 1.00pm BOARDROOM, ROTORUA HOSPITAL, PUKEROA HILL, ROTORUA

Meeting: **[147]**

Present: L Thurston (Chair), D Shaw, M Raukawa-Tait (until 2.10pm), D Epp, J Morreau, P Mahood, S Te Moni and A Pedersen

In Attendance: R Dunham, A Morgan, Dr J Miller, E Tapsell (in lieu of M Grant), J Hanvey, Tuwharetoa representatives K Gosman and T Takau, K Rex, S Wilkie, P king, P Tangitu, D Oldershaw (CEO Pinnacle MHN), P Blackmore (Clinical Manager, Taupo), L Pritchard and L Watt presenting on Lakes Baby, W Brinkler presenting on Antibiotic Resistance and B E Harris (Board Secretariat)

1.0		**MEETING CONDUCT**
		The Chair welcomed everyone to the meeting dispensing with Standing Orders to allow Tuwharetoa representatives, Kim Gosman and Tania Takau to participate in the meeting both public and public excluded. He asked P Tangitu to lead the opening karakia.
		Resolution:
		THAT the meeting dispense with Standing Orders to allow full participation of Kim Gosman and Tania Takau, advisors to Ta Tumu Te Heuheu's Office.
		L Thurston : M Raukawa-Tait
		CARRIED
1.1		Apologies: W Webber, B Edlin, K Stone, M Grant, B Bayne & A Wray
		Resolution:
		THAT the apologies be received.
		L Thurston : D Epp
		CARRIED
1.2		Schedule of Interests Register
		The register was circulated during the meeting with an entry made by P Mahood regarding her membership on the Waikato Regional Plan Leadership Group and a deletion by A Pedersen as the TNKOT iwi representative for Mangakino.
1.3		Conflict of Interest related to items on the agenda
		➢ L Thurston – item 6.4 School-based Health Services (Chair of John Paul College Board of Trustees) ➢ D Shaw – items 6.4 School-based Health Services (Mrs Shaw teaches at Western Heights High School) & 2.1.2 RAPHS Report (son works for RAPHS)
1.4		Items for General Business : Nil
1.5		Presentations by Leonie Pritchard and Laurie Watt on Lakes Baby (an example of local integration) Laurie Watt presented in the absence of Amy Wray who was on annual leave at the time of this meeting. The Kia Wana presentation highlighted:-

		➢ Vision and kaupapa ➢ Aims ➢ Key concepts for Lakes Baby ➢ Referrers ➢ Weaving Wananga-Tuituia ➢ Kuia – traditional birthing ➢ Ipu whenua ➢ Feedback ➢ Breastfeeding Service Rotorua The Chair thanked both Leonie Pritchard and Laurie Watt for their informative presentation, noting the positive feedback received on what had been learnt. and Waverley Brinkler on Antibiotic Resistance This presentation covered:- ➢ The threat of antimicrobial resistance (AMR) ➢ Treating infections ➢ Brief history of antibiotics and resistance ➢ NZ one health approach ➢ Declining new antibiotic approvals 1983-2010 ➢ Resistant organisms in NZ ➢ Stewardship of antimicrobials ➢ AMS at Lakes ➢ After-hours access point ➢ Setting the baseline ➢ Rotorua Hospital NAPS antibiotic audit November 2017 ➢ Restricted antibiotics audit L Thurston in thanking W Brinkler for her excellent presentation noted that in the summary, international, national and local work in this space needed more conversation and publicity. We needed to make the antibiotics we have work, until new ones were created. NZ had made some steps in the right direction and government funding is required to enable the plans to be implemented.
2.0		**SIGNIFICANT ISSUES**
2.1		**Primary Health**
2.1.1		Pinnacle Midland Health Network report (attached to item 6.3 below pages 128-143)
		P Blackmore took members through the Pinnacle MHN report briefing on:- ➢ Achievement of goals ➢ Long Term Conditions programme ➢ Taupo children's inter-agency group ➢ True partnerships with iwi ➢ Maori health action group quarterly meetings ➢ Tuwharetoa Health ➢ Community outreach collaboration ➢ Whanau Ora approach ➢ Opportunities to integrate and collaborate K Gosman commented that a huge step forward had been achieved between Tuwharetoa and key primary care groups, opening the door for primary care to move into the community. It was good to report that all were working together for better outcomes and

		strengthening of relationships. Joining up contract thinking might also help. It was noted that Waikato DHB had the same issues and were trying to improve on these.
		Resolution:
		THAT the Pinnacle MHN report be received.
		P Mahood : A Morrison
		CARRIED
2.1.2		RAPHS report
		Resolution:
		THAT the RAPHS report be received.
		L Thurston : J Morreau
		CARRIED
2.1.3		Te Arawa Whanau Ora report
		Members noted that:- ➢ Whanau Ora is under review – outcomes unknown at this point ➢ TPK housing - Mangakino : project for 20 homes for urgent and critical repairs is nearing completion ➢ Cervical Screening contract on target ➢ Breast Screening is well above target ➢ Mala Grant is currently presenting on Whanau Ora with Cathy Cooney at an international conference in Australia
		Resolution:
		THAT the Whanau Ora report be received.
		L Thurston : D Shaw
		CARRIED
2.2		**Maori Health**
2.2.1		Maori Health report
		P Tangitu advised that the above report had been addressed at other Lakes DHB meetings and she was available to take any questions.
2.2.2		Te Iti Me Te Rahi Memo
		The above is a Maori Health Workforce survey developed by Te Rau Matatini. This survey will build on the knowledge gained through Te Rau Matatini profiling the Maori Health Workforce 2017 report, a national endeavor to increase the number of Maori working in health.
		Resolution:
		THAT the Maori Health report be received.
		D Epp : P Mahood
		CARRIED
2.3		**Public Health**
2.3.1		Toi Te Ora Public Health Service
	2.3.1.1	Public Health Services report
		J Hanvey briefly spoke to her report highlighting:- ➢ Toi Te Ora is working closely with the Kai Rotorua initiative to support their work ➢ Healthy Families Rotorua is finalising its staff appointments ➢ A grant has been received from the Healthy Promotion Agency to support TTO's development of resources and activation of alcohol harm prevention activities in the Marae setting through Hapu Hauora ➢ At some stage in the future a presentation on Hapu Hauora will be given to a

		CPHAC meeting
		Resolution:
		THAT the Public Health Services report be received.
		J Hanvey : J Morreau
		CARRIED
	2.3.1.2	Public Health Medical Officer report
		Dr J Miller spoke to the above report expressing the following concerns of syphilis, a re-emerging infectious disease:- ➢ Over the last two to three years, the number of syphilis incidences have sharply increased in New Zealand which is evident in the Bay of Plenty and Lakes areas ➢ Local actions have included the formation of a working group to talk about awareness of sexual health services and understanding of sexual health practices to deal with issues ➢ Toi Te Ora is aware that 40 cases have surfaced ➢ The DHB needs to be aware of this national problem – There is a need to look for appropriate funds R Dunham advised that he and Dr Jim Miller have already held a conversation on this matter.
		Resolution:
		THAT the Medical Officer report be received.
		J Morreau : S Te Moni
		CARRIED
3.0		**SECRETARIAL**
3.1		Minutes of Community and Public Health Advisory Committee meeting 6th August 2018
		Resolution:
		THAT the minutes of the Community and Public Health Advisory Committee meeting of 6th June 2018 be confirmed as a true and accurate record.
		D Shaw : D Epp
		CARRIED
3.2		Matters Arising : Nil
3.3		Schedule of Tasks
		➢ Media campaign "stop/quit smoking" and community initiatives this year – P King to advise Secretariat as to presentation date.
4.0		**REPORTS**
4.1		Community representative reports : Nil
5.0		**INFORMATION AND CORRESPONDENCE**
5.1		Draft public Waikato DSAC/CPHAC minutes 8th August 2018
		The above minutes were provided for the information of committee members. It was noted that Lakes DHB has a Suicide Prevention Plan.
6.0		**PUBLIC EXCLUDED:**
		Resolution:
		THAT the committee move into Public Excluded at approximately 2.15pm
		L Thurston : D Shaw
		CARRIED

LAKES DISTRICT HEALTH BOARD

SCHEDULE OF TASKS FROM THE COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE

8th October 2018

Agenda Item	Action	Responsibility of	Timeframe
PRESENTATIONS			
Media campaign "stop/quit smoking and community initiatives this year	Presentation by Lakes DHB	Pip King	P King to advise Secretariat of presentation date
Hapu Hauora	Presentation on Hapu Hauora	Toi Te Ora	2019 CPHAC meeting
ITEMS			

LAKES DISTRICT HEALTH BOARD

MINUTES OF THE DISABILITY SUPPORT ADVISORY COMMITTEE MEETING HELD IN THE BOARDROOM, ROTORUA HOSPITAL, PUKEROA HILL, ROTORUA MONDAY 5th NOVEMBER 2018 AT 10.00AM

MEETING: **[No. 142]**

PRESENT: R Vigor-Brown (Chair), M Raukawa-Tait, D Shaw, D Epp (from 10.30am), S Burns, J Horton, P Mahood, B Edlin, C Cockburn, M Barnett and S Westbrook

IN ATTENDANCE: D Sorrenson, K Stone, V Russell, M Ranclaud & B E Harris (Board Secretariat)

1.0 MEETING CONDUCT *(Agenda Item 1.0)*

The Chair welcomed everyone to the meeting, and welcomed Kirsten Stone to the meeting. He asked M Ranclaud to lead the opening karakia.

1.1 **Apologies** *(Agenda Item 1.1)* : R Dunham, P Tangitu, K Evison
Resolution:
THAT the apologies be received.
J Horton : M Raukawa-Tait
CARRIED

1.2 **Schedule of Interests Register** – This was circulated during the meeting with no entries made.

1.3 **Conflict of Interest related to items on the agenda** - Nil

1.4 **General Business** - Nil

1.5 **The NZ Disability Strategy 2016-2026 : 8 Outcomes**

2.0 WORKPLAN : DISABILITY SUPPORT ADVISORY COMMITTEE

2.0.1 2016-2026 NZ Disability Strategy – feedback from committee
On reflection it was felt that insufficient time had been given for the working party (J Horton, D Epp, S Westbrook, M Barnett and V Russell) to consider far reaching issues relating to the NZ Disability Strategy.

It was agreed that feedback be submitted to the DSAC meeting of 18th February 2019. DSAC members were asked to provide to the working party any issues they wished to be considered.

V Russell advised in having conversations with J Horton and others, key points relating to health were summarised in the November 2018 Health of Older People update.

M Raukawa-Tait suggested that with Government having a focus on wellbeing and being committed in its widest sense, we should:-

- Include a brief comment on education
- look at where we have influence
- highlight areas of concern i.e. rights protection etc.

2.1 **~ Disability Support Services**

2.1.1 Rotorua Access Group Minutes 8th August 2018

S Burns advised that the next meeting will be held in November. Items raised at the August meeting were:-

- 3rd December is International Day for Persons with Disabilities – Promoting the idea with Rotorua Lakes Council and possibly with the assistance of People First.
- After Hours Mobility parking – is an issue of concern with photos of offending car registration plates being sent to RLC.
- Wheelie bins – option for smaller bins for recycling and review of arrangements

2.1.2 Access Taupo Minutes 22nd August and 26th September 2018 :

C Cockburn reported that most issues raised by Rotorua Access Group were similar to those of Access Taupo. Other points made were:-

- C Cockburn involvement in writing a submission to change the Building Code Standard E2 on shop entrances re raised threshold strips across shop entrances being a health and safety issue of concern.
- Transport Strategy – the next meeting will workshop on this strategy.

Resolution:

THAT the Rotorua Access Group minutes 8th August 2018 and the Access Taupo minutes 22nd August and 26th September 2018 be received.

C Cockburn : S Burns

CARRIED

2.1.3 CCS Disability – Action Mobility Parking App : BoP

The meeting was informed that the new parking meters will have a range of facilities to address the concerns expressed in the communication from CCS Disability.

Resolution:

THAT the information be noted.

M Barnett : B Edlin

CARRIED

2.2 **~ Health of Older Persons**

2.2.1 Health of Older Persons & Disabilities update

V Russell highlighted the following Access to Dental Services. Discussion covered:-

- The majority of disabled people don't access community dental care because of costs
- Healthy Ageing Strategy has a section on increasing access to dental care
- For people with intellectual disability there are increasing issues relating to consent for treatment
- Following operation, recommendation of 24 hours hospital care – not ideal for people with a disability and who don't have care at home either
- Access to Community Services Card requires three forms of identification – many older people and disabled people don't have three ID documents
- Health Review Labour Conference introduced a new policy to provide universal free dental care – may including funding
- Suggestion made that the Board should write to the Minister of Disability to highlight barriers to access of services and elevate the issue to the Board for immediate action
- Midland Regional Governance meeting held 2nd November 2018 agreed to a joined up approach relative to a submission to the Health Review. Joined up approach is more powerful

Other issues raised were:-
- Falls and fracture prevention work
- 2018 influenza rates for all ages in NZ and in Lakes were below minimum reported levels and lowest for many years – maybe data capture issue
- Current contract rates for people living in residential care cover standard requirements. People asked to pay for extra services which can be difficult. Members considered a toilet in a room should be standard. V Russell to raise with DHB HOP Steering Group and provide feedback.

Resolution:
THAT the HOPs report be received.
D Epp : S Burns
CARRIED

2.2.2 Recent reports of interest to DSAC members – NZ Human Rights
V Russell advised that the overview of the report was very good reading and highlights where NZ is sitting around capacity and areas that need dealing with. It focusses on people who are moving into residential care but don't have processes to review whether or not they wish to remain or leave.
Resolution:
THAT the Recent reports of interest be noted.
J Horton : P Mahood
CARRIED

2.3 **~ Mental Health**
2.3.1 Te Ara Tauwhiriotanga Summary
M Ranclaud spoke to the above item explaining the details of the themes/principles of the model of care graphic poster.

The meeting also noted:-
- An excellent model of care based on people and kindness which should be embedded in everything we do. A lot of work yet to be done to implement.
- Model of Care has been signed off by the Board which allows it to go into planning phase and business case to Treasury.
- History of potential sites for new build to be prepared for next Mauri Ora Governance Group meeting
- It's too good an opportunity to miss to not have this model embedded in all services as much can be implemented right now
- Some of the real gains to be made are still to be debated
- Biggest risk is what this document articulates and how it influences everything else
- Collective impact can be had – model is portable and presented in a way that it can be picked up – will make a significance difference. Needs to be discussed with CE.
- Ensure all partners are involved in the journey
- Strategically this is a Midland session opportunity for higher level collaboration
- Board may wish to consider DSAC's comments and give direction.

Resolution:
THAT the Te Ara Tauwhirotanga Summary paper be received.
M Raukawa-Tait : D Epp
CARRIED

3.0	**SECRETARIAL**
3.1	Public minutes of previous meeting held 6th August 2018
	Resolution:

THAT the public minutes of the DSAC meeting held 6th August 2018 be approved as a correct and accurate record.
S Burns : M Raukawa-Tait
CARRIED

3.2 Matters Arising :
- Homelessness – things have changed in that no meetings have been held as such. Homes First has taken focus in getting people into homes with support around them.

3.3 Schedule of Tasks : All tasks have been actioned.
3.4 Copy of presentation slides on Reviva and Lake Taupo Hospice : Noted

4.0 REPORTS

4.1 Community representative reports
Reports were given after the conclusion of the Public Excluded section.

5.0 INFORMATION AND CORRESPONDENCE

5.1 BoP CPHAC/DSAC minutes 3rd October 2018
It was noted:-
- Bay of Plenty DHB and Waikato DHB have a Suicide Prevention Postvention Action Plan.
- Lakes DHB does not have a Suicide Prevention Postvention Action Plan or a suicide co-ordinator – Lakes DHB Planning and Funding is working on this with pressure from the Ministry of Health to produce one.
- Cross membership of committees – Matter raised by BoP and having discussion regarding benefits (cost, availability and value) at the Midland DHB Development Days 6/7 December 2018.
- B Edlin and R Vigor-Brown believed cross membership of committees was valuable and important to them personally

5.2 Waikato CPHAC/DSAC Minutes 8th August 2018
P Mahood commented briefly on the Project Energize programme.
Resolution:
THAT the BoP CPHAC/DSAC minutes 3rd October and Waikato CPHAC/DSAC minutes 8th August 2018 be received.
J Horton : D Shaw
CARRIED

5.3 Letter dated 6th July 2018 to RLC regarding Community House
M Barnett advised that the community groups each sought their own legal advice with groups looking to go elsewhere. She stated that the Rotorua Health hub accommodated five community groups.

Members noted the above information.

5.4 Lakes DHB Schedule for 2019 Board and Advisory Committee meetings
5.5 Letters of appreciation to S Kuper and C Noble dated 16th August 2018
The above items were noted by members for their information.

5.6 Midland HealthShare Newsletter – Spring 2018
The meeting acknowledged the excellent work carried out by the Midland Trauma System clinicians.

5.7 Taupo District Transport Strategy
The above strategy was noted by members.

6.0	PUBLIC EXCLUDED

Resolution:
THAT the committee move into Public Excluded at 11.45am
R Vigor-Brown : S Westbrook
CARRIED

4.2 **Community representative reports**

B Edlin
- Challenging issues ahead for all DHBs
- What is the technology of the future that will make a difference?

S Westbrook
- TRHOTA meeting 6th November 2018
- Signing of TRHOTA and Lakes DHB Memorandum of Understanding scheduled for Friday 16th November 2018

D Sorrenson
- Nationally, MoH changing carer support subsidy scheme
- $75 a day subsidy payment will be changed to up to $5,000 a year paid into client's bank account based on client's needs for accessing care while carer has a break.
- Change will occur within the next year. DHB now considering impact for their carer support services.

M Barnett
M Barnett tabled her report. Some of the highlights were:-
- Encouraging people to refer to Facebook re new system transformation rolled out in October – new way of supporting people with a disability
- Lakeland Disability Support Trust in partnership with the Turangi RSA Community Networking Committee hosted an information support services drop-in day on 26th October. Response received from 41 support/service groups
- Health shuttle services – contract with Turangi Transport group to provide free service – concern expressed re timing issue can involve a whole day

B Edlin
- Thinking out of Canada - Value in mental health approach – how it acts and helps to overcome different barriers
- Emphasis on wellness rather than illness
- The importance of communities

C Cockburn
- Tabled booklet "A Guide to SMA" produced by the Muscular Dystrophy Assn of NZ
- Tabled his paper 17 October 2018 on "new life-saving treatment for spinal muscular atrophy needs Pharmac funding" and the response of 30 October 2018 from PHARMAC
- Wrote a submission to PHARMAC in support of the funding application for Spinraza for the treatment of Spinal Muscular Atrophy (SMA). Up for consideration this month (November).

K Stone
- Changes to GP funding 1 December 2018 to target holders of Community Services card. Clearly this card reduces barriers to services

and costs. Card requires three forms of ID. Initiating the removal of barriers as a great number of people who are eligible, don't have a card. Multi-agency response is to make it as easy as possible to access the Community Services Card.

LAKES DISTRICT HEALTH BOARD

LAKES DHB SCHEDULE OF TASKS : DISABILITY SUPPORT ADVISORY GROUP
5th November 2018

Item	Action	Responsibility	Time Frame
PRESENTATIONS			
TASKS			
2016-2026 NZ Disability Strategy	Sub-Committee to review strategy and identify key health-related priorities and report recommendations for future action back to DSAC	J Horton, D Epp, S Westbrook, M Barnett, V Russell	18th February 2019
Additional Charges in age-related residential care	DHB HOP Steering Group to be advised of the view that a standard room should include a toilet	V Russell to action response and keep committee informed	2019
Te Ara Tauwhiroranga Summary	To be discussed with the CE	M Ranclaud	a.s.a.p.

Minutes

Bay of Plenty Combined Community & Public Health Advisory Committee/ Disability Advisory Services Committee Members

Venue: 889 Cameron Road, Tauranga
Date and Time: 3 October 2018 at 10.30 am

Board: Ron Scott (Acting Chair), Marion Guy, Judy Turner, Sally Webb (per VC), Anna Rolleston, Mark Arundel, Mary-Anne Gill (Waikato DHB Rep), Janine Horton (Lakes DHB Rep)

Attendees: Helen Mason (Chief Executive), Simon Everitt, (GM Planning & Funding), Pete Chandler (Chief Operating Officer)

Item No.	Item	Action
	The meeting opened with the Karakia.	
1	**Apologies** Apologies were received from Bev Edlin and Paul Curry **Resolved** that the apology from B Edlin and P Curry be received. Moved: M Guy Seconded: J Turner	
2	**Interests Register** M Gill had advised of a change to her Interests.	
3	**Presentation** 3.1 First 1000 Days – Unbroken Chain of Care Sarah Stevenson (Project Manager P&F) and Tim Slow (Portfolio Manager P&F) GMPF introduced the 1000 days programme which is one of a group of targeted priorities within the SHSP. P&F have worked through what it means for the BOP to create a Childhealth framework. First 1000 days goes across all portfolios, Maori Health, Mental Health, Population Health, etc. P&F have tried to shape evidence and service development and is able to see from a big picture / whole of system view. Wanting to integrate services and contracts for best outcomes. First 1000 days is a period of critical brain development.	

	First 1000 days started a year ago and breastfeeding support in the Eastern Bay is the first initiative to be worked on. Parenting education is also a vital part of the whole process. Breastfeeding is a critical factor to post natal development. The programme is looking at the complexities of LMCs, breastfeeding and lack of breastfeeding support, post natal care and the length of time that is applied to post natal care by LMCs. A 3 year plan has been developed to drive the programme. The byline is an 'unbroken chain of care'. – "passing the batten and not letting go of it" Maternal Mental Health initially listed as Year 3 development is now a national priority and therefore should be across all years, and be a higher priority. First 100 days is a systematic review, setting up a programmatic process of working with Whanau and their family where there is a need to build strength and capability. Query was raised on relationship with PHOs. EBPHA is closely associated with current work. Other PHOs receive minutes of meetings. Engagement does need to be built with PHOs/GPs. Query was also raised with regard to current pregnancy rates and the role of the Kaiawhina and how that is seen going forward. Advice was given that the Kaiawhina contract is currently being tendered. The Kaiawhina is a very important aspect to integral care within the programme, for Maori mothers and babies. GMPF advised that this in an investment in the SHSP that has been applied with good result. *Positives:* Communication –everyone knowing where to go, who to contact, how it all works. *Negative* Lack of Trust and understanding between service providers. Committee Chair thanked Sarah and Tim for coming along to present and asked if there was anything the Committee could do. Sarah and Tim advised that Committee's support would greatly assist.	
4	**Minutes** 4.1 <u>Minutes of Previous CPHAC/DSAC Meeting</u> **Resolved** that the minutes of the meeting held on 4 April 2018 be confirmed as a true and correct record, noting that the meeting of 4 July had been cancelled due to impending strike action. Moved: S Webb Seconded: M Guy 4.2 <u>Lakes DHB CPHAC Meeting - 11.6.18</u> The minutes of the Lakes DHB CPHAC meeting of 11.6.18 were received by the Committee	

	4.3 Lakes DHB CPHAC Meeting - 6.8.18 The minutes of the Lakes DHB CPHAC meeting of 6.8.18 were received by the Committee 4.4 Lakes DHB DSAC Meeting - 6.8.18 Lakes DHB rep advised of redevelopment of their mental health facility and model of care. Meeting with MOH and Treasury. Very exciting and well needed. Lakes has developed a sub-committee to work on particular issues, the first of which is health literacy. The minutes of the Lakes DHB DSAC meeting of 6.8.18 were received by the Committee	
5	**Matters Arising** There were no issues from Matters Arising	
6	**Review of** 6.1 Disability Issues – Strategic Discussion R Scott and M Gill declared Conflicts of Interest GMPF advised that the CPHAC/DSAC Committee has had varying views about their role with the Disability Community. Discussion was needed on the Committee's perspective, perhaps with input from the Disability Community on their needs, wants and interface with the health system. Who do we need to talk to? How could the disability aspect of the Committee be strengthened? CEO commented on the reasoning behind the combination of CPHAC/DSAC. When DSAC was operating separately, there were issues raised outside the ability of the DHB to influence. Historically, the MOH had been invited to attend DSAC meetings which did not always occur. It was decided to bring the Committees together to work on what the DHB could influence. As the pathway forward is chartered, thought needs to be applied to how the most gain can be made. There are approximately 100 organisations across the community. Disability does not want to be medicalised. Comment was made that the new DG is intending to appoint a Disability Director with his change in structure of the Ministry. CEO will circulate to Committee. There has also been re-establishment of a Maori Health Directorate. Advice was given of a Community group in Whakatane, "Inclusion Whakatane", looking at such things as the difficulties the Disabled have in accessing BOPDHB facilities - Mobility, Sensory, writing a Disability Strategy across many aspects, including the role of the Community Council in Disability Services. Information Technology would seem to fit well there. Comment was made of another DHB's Community Council who had established a sub group to deal with specific disability issues.	CEO

	"The Transformation" that is coming which will see the Disabled having a budget to apply to providers of their choice. The Committee favoured putting the query to the Consumer Council. A request was made for the GMPF to contact other DHBs and their CPHAC/DSAC committees – what has been successful for them. GMPF will report back to the Committee. The Committee considered Disability issues needed a driver. Comment was made that as a good employer we also need to consider our disabled employees. CEO advised that BOPDHB's disability responsiveness was a query that had arisen at Health Select Committee, which was acknowledged as meeting requirements. BOPDHB should be delivering health services to the Community rather than stepping outside those boundaries.	AGC GMPF
6.2	<u>TTHW – Toi Te Ora Monthly Report</u> TTO Business Manager commented on the 5201 initiative. Increased interest coming from outside the region. There is a Te Reo version which is more popular. Connectedness between TTO and P&F is helping immensely. Query was raised on Smokefree and vaping. Extensive discussion was had. CMA advised that there has been a Grand Round on vaping. Clinicians consider vaping can be harmful but not as much as smoking. Can be seen as a tool to reduce smoking and/or stop smoking. Reference was made to the 6.5 agenda item – Reducing Tobacco in which MOH refers to vaping replacing smoking. The Committee discussed immunisation and declines and the recent actions of the anti-vaccers. GMPF advised of work being undertaken looking at such things as leadership from MOH. **Resolved** that the Committee receive the report Moved: M Arundel Seconded: M Gill	
6.3	<u>BOPDHB Suicide Prevention Postvention Action Plan 2018-2019</u> **Resolved** that the Committee endorse the plan Moved: J Turner Seconded: S Webb	
6.4	<u>Preventing Cancer</u>	
6.5	<u>Reducing Tobacco – 2018 Update</u> GMPS advised that the Smokefree space is very busy. The challenge is to try and make a difference and aligning effort to such as indicated within the First 1000 days presentation this morning talking about education from Kaiawhinas in not only influencing breastfeeding rates but also smokefree household, immunisations etc.	

7	***Matters for Noting:*** 7.1 Draft Work Plan 2018-2019 (amended) Homelessness to go to February 2019. 7.2 Correspondence Caring for our Older Kiwis – NZ Aged Care Association – 9 May 2018. GMPF advised of a review of Aged Residential Care currently being undertaken by EY. Comment was made on lack of dementia care facilities. GMPF advised that work is being undertaken on different processes for dementia care going forward. The Committee noted the papers.	
8	**General Business** There was no general business	
9	**Next Meeting –** Thursday 7 February 2019	

The meeting closed at 12.05 pm
The minutes will be confirmed as a true and correct record at the next meeting.

Waikato District Health Board

Te Hanga Whaioranga Mō Te Iwi – Building Healthy Communities

Disability Services

MEMORANDUM TO COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
12 DECEMBER 2018

AGENDA ITEM 4.1

DISABILITY RESPONSIVENESS PLAN UPDATE

Purpose	For information

Background

Strategy and Funding is leading the process to develop a Disability Responsiveness Plan that will provide direction that delivers our strategic priority *remove barriers for people experiencing disabilities.*

Our intention to have a draft plan completed by the end of December 2018 has been revised to accommodate for changes within Strategy and Funding, advice from members of the Consumer Council and to ensure alignment with the Health Services Plan. The revised timeframe for completion of the draft plan is April 2019.

The development of the plan will now be led by Rachel Poaneki, Director Māori Health and Equity, in partnership with the Consumer Council.

Prior to the development of the plan, a community stakeholder meeting will be arranged to establish the aspirations of the community for such a plan. The community stakeholder meeting will be held in late January 2019.

The draft Health Service Plan is expected to be completed in March 2019. Alignment between the draft Health Services Plan and the draft Disability Responsiveness Plan will be made at this time.

Subject to completion of the above, a draft Disability Responsiveness Plan will be ready for presentation to the CPHAC April 2019 meeting.

Recommendation
THAT

The Committee notes the Draft Disability Responsiveness Plan will be brought to the April 2019 meeting.

TANYA MALONEY
EXECUTIVE DIRECTOR, STRATEGY, FUNDING AND PUBLIC HEALTH

Waikato District Health Board

Papers for Decision

MEMORANDUM TO THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
12 DECEMBER 2018

AGENDA ITEM 5.1

DRAFT COMMITTEE SCHEDULE FOR 2019/20

Purpose	For information and discussion

The following draft committee schedule has been prepared for the 2019/20 year. The six goals of the Care in the Community Plan have been included in the years' schedule in anticipation that this will provide the focus for our work over the next year and beyond. There will inevitably be additional topics for discussion raised either by the Committee or by the Executive over the course of the year. Sufficient time has been left in each meeting to add additional topics as required.

Recommendation
THAT

The Committee provide feedback on the draft schedule for 2019/20.

TANYA MALONEY
EXECUTIVE DIRECTOR, STRATEGY, FUNDING AND PUBLIC HEALTH

Draft CPHAC Schedule for 2019/20

February

- Rurality and Health Needs
- Public Health Position Statements (continuation)
- Te Pai Tawhiti, Integrated Waikato Mental Health Framework - Next Steps
- 2019/20 Annual Planning Overview

April

- Draft Health System Plan (incorporating the Care in the Community Plan)
- Draft Disability Responsiveness Plan
- Our approach to Community Engagement and Partnering with Māori
- Addressing Urgent and Emergency Care – Findings from the Review

June

- Addressing the Determinants of Health
- Final Disability Responsiveness Plan
- Dental Health Strategy
- Prevention and Management of Long Term Conditions
- 2019/20 Annual Plan

August

- Immunisation – Performance and Service Overview
- Older Peoples Services – Comprehensive Model of Care
- Disability Support Services – Overview
- Addressing Acute Demand

October

- Locality Health Needs Assessments
- Enhancing the Capacity and Capability of Primary and Community Care
- Intersectoral Strategy
- 2018/19 Annual Report
- Other

December

- Mental Health Services – Investment and Service Overview
- Understanding Unmet Need
- Smoking Cessation Service and Performance Overview
- Other

Papers for Information

MEMORANDUM TO THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
12 DECEMBER 2018

AGENDA ITEM 6.1

IMMUNISATION COVERAGE UPDATE AND ACTIONS TO IMPROVE COVERAGE

Purpose	For information and discussion

Background

The eight month immunisation coverage target is set by the Ministry at 95%. The DHB's result up until the end of October is similar to previous quarters with 89% of all eligible babies fully immunised, and 83% of Tamariki Māori fully immunised. National results to the end of September were 91% and 86% respectively, which shows an equity gap exists both nationally and locally. At the time of this report there were 92 Waikato babies not immunised on time. Of these, 61 were Tamariki Māori.

PHOs have failed to reach targets as listed below:

- 91.1 % of all their enrolled babies (87.6% of Tamariki Māori) were vaccinated by Hauraki PHO;
- 90.8 % of all their enrolled babies (86.1 % of Tamariki Māori) were vaccinated by Midlands Health Network;
- 86.2 % of all their enrolled babies (73.3 % of Tamariki Māori) were vaccinated by the National Hauora Coalition Waikato based GP Practices.

Babies who are not enrolled with a PHO continue to fare the worse as less than 50% are immunised. This confirms our intention to prioritise work to increase new born enrolments, which is currently at 78% for non-Māori and 83% for Māori.

Actions to Improve Coverage

The report to the August Committee outlined the Annual Plan actions approved by the Ministry of Health to improve immunisation coverage. The actions reported to the committee are summarised below with comments about what has happened since August 2018.

1. <u>Progress on Actions in the Annual Plan</u>

Increasing Opportunistic Immunisations:
There has been progress in this area as we have re- engaged with the Immunisation Advisory Centre (IMAC) to access their health education resources and improve communication to general practice, afterhours, and the Hauora ihub about the importance of opportunistic immunisations.

All Children in Family Start are Fully Immunised:
We remain involved with Oranga Tamariki and have ensured all Family Start providers have clear lines of communication with local general practices and Well Child/ Tamariki Ora providers to facilitate access to health care. We anticipate Family Start providers will assist families / whānau to enrol with general practice the key activity to improve immunisation coverage.

Incentives for families / whānau who complete their children's immunisations on time:
Whilst there is international evidence that incentives improves coverage, communication with other DHBs and discussions with IMAC have indicated this approach can create perverse incentives as well. DHBs and PHOs which have piloted such actions have discontinued incentives. Further work needs to be done to develop a Waikato model which improves access for Māori.

2. <u>Additional Activities</u>

Vaccinations by Pharmacists
We are taking steps to enable pharmacists to provide early childhood vaccinations.

Progress is being made in this area as pharmacists are clear they want to provide this service, as happens in countries such as England, Denmark Ireland and the USA, all of which report success with pharmacists vaccinating children. The steps required include:

- pharmacists would be accredited by our Medical Officer of Health
- need to use the National Immunisation Register,
- have access to the vaccines
- relationship with the family's general practice.

We have also met the Pharmacy Council (the pharmacist regulators), who are supportive of this change. We are awaiting a proposal from the Districts pharmacy network to undertake a small pilot.

Immunisation Improvement and Missing Events Service
As reported to the August Committee meeting we have exited the Waikato Child Health Coordination Service as of 17 December 2018. This service was delivered by Midlands Health Network. The key components of this service which are achieving immunisation coverage and increasing new born enrolments with PHOs have transferred to the National Immunisation Register (NIR) team at Waikato DHB consistent with services elsewhere in New Zealand. This service is in the process of recruiting the team including one FTE lead health professional, one senior administrator (who will run the missing events service) and an 0.5 FTE administer to work alongside the NIR team and deliver improved results.

Radical Improvement for Māori

All actions noted above have a specific focus on improving responsiveness to Māori and eliminating the equity gap in vaccination coverage.

Recommendation
THAT

The Committee receive this report.

TANYA MALONEY
EXECUTIVE DIRECTOR, STRATEGY, FUNDING AND PUBLIC HEALTH

MEMORANDUM TO THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
12 DECEMBER 2018

AGENDA ITEM 6.2

WAIKATO DHB SUBMISSION DRAFT 2018 – 2028 WAIKATO REGIONAL PUBLIC TRANSPORT PLAN

Purpose	For information

Background

"Health is created and lived by people within the settings of their everyday life; where they learn, work, play, and love"
(Ottawa Charter for Health Promotion, p.3) [1].

This imperative informs the Waikato District Health Board (DHB) and Waikato Public Health Unit's advocacy work on draft policy and plans at national, regional and local levels.

Our intentional emphasis on health equity, particularly for Māori and other vulnerable peoples and communities and productive partnerships underpins our advocacy work. This emphasis was reinforced in the Waikato DHB Strategy released in July 2016.

Figure 1: Strategic framework Waikato District Health Board Strategy, 2016, p.16

The Waikato Regional Council has a statutory responsibility under the Land Transport Management Act 2003 to prepare a Regional Public Transport Plan (Plan). This Plan sets out the objectives and policies for public transport in the Waikato region, and contains details of the public transport network and development plans for the next 10 years (2018-2018). The Plan has been developed in collaboration with regional transport partners and key stakeholders from the education, health and access and mobility sectors.

Key submission themes and opportunities

With community place-making and wellbeing in mind, the consideration of health and wellbeing in policy development is a core component of the Waikato DHB's role. Therefore, the Waikato DHB adopted a Position Statement on Land Transport

[1] WHO (1986) *The Ottawa Charter for Health Promotion*. First International Conference on Health Promotion, Ottawa: World Health Organisation

(Waikato DHB, 2013) which forms the basis of this submission to the Waikato Regional Council (WRC).

To create transport environments that are supportive of health improvement the following key themes have been included in the DHB's submission response on the WRC Draft Plan:

- transport, and by proxy levels of physical activity, is a key determinant of community health and wellbeing outcomes;
- transport responses need to be layered to deliver the most appropriate transport solutions for different communities to meet their needs to ensure positive impacts on health and wellbeing;
- Waikato DHB would like to discuss transport partnership opportunities with WRC and other interested parties where there is potential benefit for Waikato DHB staff and customers e.g. enhanced access, affordability, and/or flexibility to improve health and wellbeing; and
- accessible or universal design - i.e. physical design standards - of public transport infrastructure to enable access and social inclusion for all public transport users, including those with limited physical mobility.

Recommendation
THAT

The Committee notes the paper.

TANYA MALONEY
EXECUTIVE DIRECTOR, STRATEGY, FUNDING AND PUBLIC HEALTH

ATTACHMENT 1:

Submission on the Waikato Regional Council's Draft 2018-2028 Regional Public Transport Plan

To:	Waikato Regional Council Private Bag 3038 Hamilton 3240 C/- Tracey.Deane@waikatoregion.govt.nz
Details of Submitter:	Waikato District Health Board
Address for Service:	Waikato Public Health Waikato District Health Board Private Bag 3200 HAMILTON 3240
Contact Persons:	Dr Richard Vipond Medical Officer of Health Richard.Vipond@waikatodhb.health.nz Greg Morton Senior Health Improvement Advisor, Healthy in all Policies Greg.Morton@waikatodhb.health.nz
Date:	19 September 2018

Submission Form

Do you wish to be heard at the hearings? (Start 1 October 2018) Yes

Section 2: Overall vision and strategic responses

Do you support the overall vision and strategic responses?	Yes
Do you support the proposed network concepts?	Yes

Waikato DHB supports the overall vision and strategic responses identified in the Draft Plan.

The move towards a mass transport system will enable improved liveability and health and wellbeing particularly for those living within the greater Hamilton area, and along the Hamilton to Auckland growth corridor. Working in partnership with others to expand the public transport network and coordinate this with other more flexible transport approaches and choices will help better meet local needs and improve access to essential services for everyone. Improving access to healthcare, education, employment and social services will help enhance health and wellbeing for communities across the Waikato region.

Transport is linked to seven of the top 10 causes of illness and early death in the Waikato DHB District. For example, transport is linked to physical activity opportunities, injuries, air quality (Hamilton), and severance health impacts (physical inactivity sits at number 10 in the list of causes). Seven of these causes are related to chronic conditions such as heart disease and diabetes, and they all have links to levels of physical activity. Evidence suggests that cars are a sedentary form of transport, minimising physical activity by allowing travel from door to door. Using public transport, targeted transport and community transport will often involve walking to and from the vehicle or stops and may help otherwise inactive groups become more physically active. This in turn can have positive impacts on physical and mental health and wellbeing and social connectedness (Canterbury DHB, 2016). Ride share schemes may also have similar positive health impacts but his is yet to be demonstrated.

We are particularly pleased to see the future regional network concept (section 2.4) include Taumarunui and linkages between it and southern rural towns such as Te Kuiti as these localities have communities with higher levels of socio-economic deprivation and need. We are interested in discussing Hamilton's future network concept with Waikato Regional Council to see what opportunities there may be for future major transport hubs e.g. a hub linked to the Waikato Hospital campus.

Section 3: Objectives and policies

OBJECTIVE 1: Deliver a layered network of public transport services that meets a diverse range of travel needs.

Please comment here on this objective or the related policies:

Policy P1 recognises the need for a layered network of public transport services to deliver the most appropriate transport solution for different communities to meet their diverse needs. This includes giving consideration to coverage and targeting and the need for integration of services. Mass transit and frequent services make sense for the greater Hamilton and north Waikato area which are both experiencing high levels of population and employment growth. We note that the majority of service layers in Table 3.2 identify a need to ensure access to walking and cycling networks and high quality stops. We support these provisions as, for example, walking and cycling enables increased levels of physical activity.

We note that DHB is involved in providing community health transport services across the Waikato DHB District to enable access to hospital-based health services via funding from the Ministry of Health. We see these as an integral component of the public transport services system in the Waikato.

We see public-ride share as an excellent initiative as it helps transport users to transition to a likely future transport system which has a focus on transport as a service, rather than personal vehicle ownership.

The transport disadvantaged user groups identified in P2 correlate well to priority population groups identified in the Waikato DHB Strategy (Waikato DHB, 2016). These priority groups experience higher health risks and health inequities relative to the wider population - examples include: people with disabilities, older people, and people living in rural communities. In addition, we note for Waikato Regional Council that Waikato DHB identify Māori as a further priority population group who are also likely to experience transport disadvantage due to higher health risk and health inequities when compared to other groups. Our strategy identifies a commitment to radically improve health outcomes by eliminating health inequities for Māori.

OBJECTIVE 2: Transition to a mass transit-oriented network over time.

Please comment here on this objective or the related policies:

We support Objective 2 and associated policies identified in the Draft Plan, including P39-43.

We recommend that these, and other policies where appropriate, be amended to reference and provide for outcomes identified in the Hamilton to Auckland Corridor Plan which include consideration of passenger rail between the two cities and mass transit. Growth along this corridor will see demand pressures on the transport system, and the likely development of new health facilities and services.

OBJECTIVE 3: Provide the infrastructure necessary for an accessible, effective and efficient public transport network.

Please comment here on this objective or the related policies:

We support Objective 3 and associated policies identified in the Draft Plan.

We support in particular P46-47, as evidence suggests designing and implementing accessible infrastructure, or adopting a universal design approach will help enable safe access for all users including those with a disability or limited mobility. Examples include caregivers with babies/toddlers in buggies and older people with limited mobility.

OBJECTIVE 4: Provide high quality and intuitive public information.

Please comment here on this objective or the related policies:

We support Objective 4 and associated policies identified in the Draft Plan, subject to the following amendments.

We recommend that Waikato Regional Council consider assessing and amending P48 and P50-53 where appropriate to ensure that these policies will meet the diverse transport range of needs for all users. We note that the transport disadvantaged may not have ready access to a smart phone, or the internet. As an example, those users living in remote rural localities who want to access information on targeted and/or community transport services.

OBJECTIVE 5: Provide a fares and ticketing system that is easy to use and affordable for passengers.

Please comment here on this objective or the related policies:

We support Objective 5 and associated policies identified in the Draft Plan.

We support in particular the inclusion on P65 which enables Waikato Regional Council to work with third party entities to contribute to additional fare concessions for particular user groups. This provides for other service development opportunities in which a third party can help meet a particular access and/or user affability need(s) that may not otherwise be met.

OBJECTIVE 6: Provide public transport services that are affordable for passengers and funders.

Please comment here on this objective or the related policies:

We support Objective 6 and associated policies identified in the Draft Plan.

We support in particular P73 which recognises the need to ensure fare level adjustments take account of user affordability. For many existing and possible future users, public transport or targeted services could be their only available transport option to enable them to access essential services such as health care, education or employment.

OBJECTIVE 7: Develop and maintain partnerships that obtain best value for money in the delivery of transport solutions.

Please comment here on this objective or the related policies:

We strongly support Objective 7 and associated policies identified in the Draft Plan -in particular P75-76, P81 and P83-84.

Waikato DHB would like to discuss partnership opportunities with Waikato Regional Council and others to determine if there are ways to make transport choices more accessible and enable greater flexibility for both DHB staff and customers. We are a large employer in the region with over 6,000 staff of which 700 will move from various locations into a facility the CBD area in the near future. We commend Waikato Regional Council for its successful and innovative public transport partnership with the University of Waikato and South Waikato District Council to establish a service between Tokoroa and the University campus in Hamilton. Education is recognised as a primary determinant of health and wellbeing. This service enables affordable access to tertiary education for students located in Tokoroa and the surrounding local area.

We also commend Waikato Regional Council for including P83 in the Draft Plan as it recognises the value of trying new services or approaches to test their viability. To achieve success in meeting emerging needs within a changing transport system environment, there may be a need to be innovative, and challenge and amend some national standards.

Section4: Monitoring, review and appendices

We strongly support the performance monitoring framework and associated key performance indicators identified in the Draft Plan.

Monitoring travel to work mode share in Hamilton and in rural communities will help support and inform future planning, policy and evaluation for public, targeted and community transport services. This, along with monitoring increased access to community services, and to employment and education in rural communities, will help provide data on these transport choices.

We seek clarity on what is meant by "inclusive infrastructure in Hamilton and rural towns" (KPI 2.2.2). If this is about accessible or universal design to enable accessibility for all transport services users, we suggest that this policy is amended to make this clear.

Finally, we thank Waikato Regional Council staff and Council for their work in preparing this Draft Plan, and for providing the opportunity for Waikato DHB to make this submission response.

MEMORANDUM TO THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
12 DECEMBER 2018

AGENDA ITEM 6.3

WAIKATO DHB SUBMISSION ON STRATEGY TO PREVENT AND MINIMISE GAMBLING HARM 2019/20 TO 2021/22

Purpose	For information and discussion

"Health is created and lived by people within the settings of their everyday life; where they learn, work, play, and love"
(Ottawa Charter for Health Promotion, p.3) [1].

This imperative informs the Waikato District Health Board (DHB) and Waikato Public Health Unit's advocacy work on draft policy and plans at national, regional and local levels.

Our intentional emphasis on health equity, particularly for Māori and other vulnerable peoples and communities and productive partnerships underpins our advocacy work. This emphasis was reinforced in the Waikato DHB Strategy released in July 2016.

Background

The Gambling Act 2003 (The Act) is the primary legislation that regulates gambling in New Zealand. The Act is administered by three regulatory agencies; Department of Internal Affairs (DIA), Ministry of Health, and Gambling Commission New Zealand.

The Act sets out requirements for an integrated problem gambling strategy focused on public health. The Ministry of Health is responsible for developing the strategy at three-yearly intervals and for implementing it. The Act specifies consultation requirements for the development of the strategy and levy rates.

The Gambling Commission will undertake an analysis of the submission feedback and provide its own advice to the Associate Minister of Health and Department of Internal Affairs. Cabinet will make the decisions on the shape of the strategy and the levy.

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[1] WHO (1986) *The Ottawa Charter for Health Promotion*. First International Conference on Health Promotion, Ottawa: World Health Organisation

Key submission points

Waikato DHB advocates for a true sinking lid policy where neither machine nor venue is replaced as surrendered. This means that our organisation supports policy that prevents class 4 gambling venues from merging and relocating. Waikato DHB also advocates a shift towards reducing reliance on class 4 proceeds towards other models of sustainable community funding not built on harm as stated in its Position Statement on Gambling 2015.
Public Health's advocacy position is to raise awareness of the connections between health and gambling to ensure health remains a mainstream consideration in decision making at the population health level.

Key submission points included:

- Opposing any approach to incentivise operators of class 4 venues to move from lower socioeconomic areas to high socioeconomic areas.
- Supporting the overall strategic direction outlined in the Ministry's proposed Strategy to Prevent and Minimise Gambling Harm 2019/20 to 2021/22 but recommending the public health approach be strengthened where applicable and that gambling-related harm be positioned within a long-term health inequities approach with consideration of poverty as well as ethnicity.

Recommendation
THAT

The Committee notes the paper.

TANYA MALONEY
EXECUTIVE DIRECTOR, STRATEGY, FUNDING AND PUBLIC HEALTH

ATTACHMENT 1:

Submission on the Strategy to Prevent and Minimise Gambling Harm 2019/20 to 2021/22

To:	Strategy to Prevent and Minimise Gambling Harm Consultation Ministry of Health PO Box 5013 Wellington 6140 gamblingharm@moh.govt.nz
Details of Submitter:	Waikato District Health Board
Address for Service:	Public Health Unit Waikato District Health Board Private Bag 3200 HAMILTON 3240
Contact Person:	Dr Richard Wall Richard.wall@waikatodhb.health.nz
Date:	25 August 2018

1 Introduction

1.1 Waikato District Health Board (Waikato DHB) presents this submission through its public health unit. The Public Health Unit is the principal source of advice within Waikato DHB regarding matters concerning Public Health. Waikato DHB has responsibility under the New Zealand Public Health and Disability Act 2000 to improve, promote and protect the health of people and communities. Additionally there is a responsibility to promote the reduction of adverse social and environmental effects on the health of people and communities. With nearly 7000 staff, Waikato DHB delivers health services to a population of more than 400,000 people across the Waikato region.

1.2 This submission is intended to provide general commentary regarding the Strategy to Prevent and Minimise Gambling Harm in New Zealand, followed by specific comments and recommendations.

2 General comment

2.1 Waikato DHB's position

For a number of years, Waikato DHB has strengthened its position on class 4 gambling by advocating for a true sinking lid policy approach where neither machine nor venue is replaced as surrendered. This means that our organisation supports policy that prevents class 4 gambling venues from merging and relocating.

2.1.1 We continue to advocate a shift towards reducing reliance on class 4 proceeds towards other models of sustainable community funding not built on harm. Through its Position Statement on Gambling adopted in September 2015, [2] the Waikato DHB made a conscious decision not to support any Waikato DHB Charitable Trust or similar group operating under the Waikato DHB name to either apply for or receive funds derived from class 4 gambling. Those groups outside of the organisation that are funded by the Waikato DHB are encouraged to decrease their reliance on class 4 gambling proceeds where applicable.

2.1.2 The Gambling Act 2003 mandates a public health approach, and this is seen in its purpose, definitions, and risk-based approach.

The purpose of the Gambling Act 2003 is to:

- Control the growth of gambling
- Prevent and minimise the harm caused by gambling
- Authorise some gambling and prohibit the rest
- Facilitate responsible gambling
- Ensure the integrity and fairness of games
- Limit opportunities for associated crime or dishonesty
- Ensure that gambling revenue benefits the community
- Facilitate community involvement in decisions about the provision of gambling. [3]

2.1.3 A public health approach helps to better understand and consider the diverse range of gambling harms on the multiple domains of health and wellbeing. [4]

2.1.4 Public Health's advocacy position is to raise awareness of the connections between health and gambling to ensure health remains a mainstream consideration in decision making at the population health level. Our service offers to support and partner councils in impact assessments to better determine and understand the impact of gambling at the local and district level.

2.2 The Ministry's Strategy to Prevent and Minimise Gambling Harm 2019/20 to 2021/22

2.2.1 In principle, Waikato DHB supports the intent of the eleven strategic objectives that guide the strategic direction for the actions in the service plan, but **recommends** the public health approach be **strengthened** across the key strategic objectives as relevant. The public health approach focuses on the continuum of harm created through gambling participation rather than a focus at the problem gambling end of the spectrum.

2.2.2 In our view, the public health approach to gambling has been weakened by inappropriate industry input and an over-reliance on industry profits at the

[2] Waikato DHB Position Statement on Gambling, September 2015
[3] Purpose s3 Gambling Act 2003
[4] Browne, M.; Bellringer, M.; Greer, N.; Koandai-Matchett, H.; Rawat, V.; Langham, E.; Rockloff, M.; Palmer Du Preez. K.; Abbot, M. (2017). Measuring the burden of gambling harm in New Zealand. Central Queensland University and Auckland University of Technology. Gambling & Addictions Research Centre.

local and government levels. The community's voice and concern about how much gambling they want in their communities is frequently ignored by decision makers, despite the Gambling Act 2003 making provision for this.

3 Specific comments and recommendations

3.1 This section of our submission addresses the public health component of the document as relevant to class 4 gambling, and focuses on two key areas; incentivising class 4 venue operators to relocate, and the Ministry's strategic direction.

3.2 Consultation questions:

Concentration of class 4 NCGMs in lower socioeconomic areas (section 1.9)

Q1: Do you think operators of class 4 venues should be incentivised to move from lower socioeconomic areas to higher socioeconomic areas?

3.2.1 Waikato DHB advocates for a true sinking lid policy approach where neither machine nor venue is replaced as surrendered. This means that our organisation opposes all opportunities for class 4 venues to either relocate or merge. Waikato DHB therefore **opposes** any approach to incentivise operators of class 4 venues to move from lower socioeconomic areas to higher socioeconomic areas. Incentivising class 4 operators:

- Is not a public health approach and contravenes the purpose of The Gambling Act 2003.
- Provides opportunities for venues to remain open when they might otherwise close.
- Will do little to reduce accessibility to gaming machines.
- Ignores local authorities' responsibilities under the Gambling Act 2003.

3.3 <u>Incentivising class 4 operators is not a public health approach and contravenes the purpose of The Gambling Act 2003.</u>

3.3.1 Incentivising class 4 operators to relocate to higher socioeconomic areas as a strategy to target high-risk populations, is not a public health approach and contravenes the main purpose of The Act which is to control the growth of gambling; and prevent and minimise harm from gambling, including problem gambling.[1] Class 4 gambling causes significant harm within communities. [5] Efforts need to be made to reduce harm across all communities, in addition to

[5] New Zealand 2012 National Gambling Study: Gambling harm and problem gambling. Gambling and Addictions Research Centre, Auckland University of Technology. Final Report Number 2, 1 July 2014

addressing health inequities. Relocating electronic gaming machines risks moving the harm to new communities.

3.4 Incentivising relocation provides opportunities for venues to remain open when they might otherwise close.

3.4.1 Allowing relocation of class 4 gambling venues provides opportunities for these venues to remain open when they may otherwise close for reasons such as declining use or deteriorating facilities. We believe that allowing the natural closure of venues over time, in addition to a sinking lid policy, will have a greater benefit to public health than simply moving them to other areas, by reducing access to gaming machines across all communities. Incentives for relocation would provide even greater opportunities for venues to remain open when they may otherwise close, and will make it more difficult for councils to prevent relocations in their class 4 venue policies.

3.5 Incentivising relocation will do little to reduce accessibility to gaming machines.

3.5.1 Populations are highly mobile and in many districts it is easy to get from a low socioeconomic area to a higher socioeconomic area. Relocations in such areas would do little to reduce accessibility to gaming machines for the population of concern, but may introduce the machines and associated harm to a new population. The best way to reduce accessibility to all populations is a gradual reduction in the number of electronic gaming machines and gaming venues through the use of a strong sinking lid policy.

3.6 Incentivising relocation ignores local authorities' responsibilities under the Gambling Act 2003

3.6.1 An incentivised approach of this nature ignores a local authority's responsibilities under the Gambling Act 2003 to adopt a class 4 gambling venue policy of which consideration of relocation and mergers are part, taking into account the social impact of gambling within their communities. Providing incentives may undermine the work that councils are doing to reduce harm within their districts through their class 4 gambling venue policy. Relocating venues to a higher socioeconomic area may not even be possible within council's polices and gambling permitted areas.

3.6.2 We are noticing a trend across our DHB region, in that a growing number of councils are placing and proposing greater emphasis and restrictions on class 4 gambling particularly in relation to club mergers and relocations. For example, Waipa District Council's operative policy does not permit club mergers and Hamilton City Council recently signalled support for a policy that did not permit either mergers or relocations. While, this policy approach was not successful at this time, there are indications from our leading councils that more thought is being applied to this area of class 4 gambling policy. This is encouraging and will go some way to reducing gambling-related harm over time.

4 Concluding comment

Public health can lead the way in creating a more equitable, healthier society by continuing to look for long-term solutions through sound public health research and by encouraging health-focused policy across disciplines. Incentivising operators of class 4 venues to move from lower to higher socioeconomic areas is not a solution to reducing gambling-related harm.

5 Consultation questions

Sections 1 and 2: strategic direction
Q 1: Do you support the strategic direction outlined in the proposed strategy?

5.1 In principle, Waikato DHB **supports** the overall strategic direction outlined in the proposed strategy but **recommends** the public health approach be strengthened where applicable and **recommends** gambling-related harm be positioned within a long-term health inequities approach/framework with consideration of poverty as well as ethnicity. Problem gambling rates are highest among people living in socioeconomically deprived areas as well as amongst Māori and Pacific peoples. [5]

5.2.1 Within the current framework proposed in the Ministry's Strategy to Prevent and Minimise Gambling Harm, Waikato DHB provides the following comments for consideration.

5.3 Strengthen objective 3: *People participate in decision-making about activities in their communities that prevent and minimise harm*.

5.3.1 We felt that the wording of this objective needs clarifying. *Activities* could be taken to mean health promotion events, such as Gambling Awareness Week. This objective could be re-worded to better reflect the intent outlined in the Ministry's consultation document. Communities must be able to protect their wellbeing in environments of high-intensity gambling or any gambling as mandated in s3(h) Gambling Act 2003. We have seen little evidence of this across our Waikato DHB region and our organisation recommends a stronger alignment to the purpose of the Gambling Act 2003. We have suggested a rewording of this objective.

5.3.2 Objective 3: *People participate in decision-making about the provision of gambling in their communities along with activities that prevent and minimise gambling-related harm.*

5.4 Strengthen objective 4: *Healthy policy at the national, regional and local level prevents and minimises gambling* harm.

5.4.1 This objective provides an opportunity to incorporate a health inequities approach and focus. We suggest the following wording to support this:

5.4.2 Objective 4: *healthy policy, incorporating a health inequities approach, at the national, regional and local level prevents and minimises gambling-related harm*.

5.5 Strengthen objective 8: *gambling environments are designed to prevent and minimise gambling harm.*

5.5.1 In principle, our organisation supports gambling intervention at all levels across the continuum including improved access to gambling harm prevention services and facial recognition software. We support the Ministry's intention to support Department of Internal Affairs to judiciously and effectively use its regulation tool to deal with operators or venues that do not meet legal requirements.

5.5.2 However, a lot more could be done to strengthen the gambling environment by reducing access to class 4 venues and machines through prioritising a true sinking lid approach in policy. We also recommend communities be empowered to participate in decision making about the provision of gambling in their communities. We recommend objective 8 be strengthened to incorporate a stronger focus on prevention.

5.6 Strengthen objective 9: *Services raise awareness about the range of gambling harms that affect individuals, families/whānau and communities.*

5.6.1 We have understood objective 9, as worded, to mean that it is the responsibility of counselling services to raise awareness about the range of gambling harms that affect individuals, families/whānau and communities. In our view, this places unfair burden on services to raise awareness of the range of gambling harm that affects individuals, families/whanau and communities. Our organisation would recommend that this objective be reworded to better reflect the collaborative role of the Ministry of Health; Department of Internal Affairs, and Health Promotion Agency required to raise awareness of gambling harm at all levels.

5.7 Objective 11: *A programme of research and evaluation establishes an evidence base that underpins all activities to prevent and minimise gambling harm*

Waikato DHB supports this objective for a programme of research and offers the following ideas for future research. We would however **recommend** that any funding for future research is not derived from the gambling industry as this will jeopardise academic integrity.

5.7.1 Gaps in local level knowledge about gambling-related harm

5.7.1.1 As an organisation that actively advocates for a true sinking lid policy approach across our DHB region, we have noticed gaps in research that informs city and district council decision-making. For example, the National Gambling Studies allude to a concerning level of gambling harm across the New Zealand population, but at the local authority decision-making level, this national data is often disregarded. Elected representatives continue to ask for evidence of gambling harm at the local level to inform their decision-making. This information is difficult to obtain. We are not sure how future research can address this gap, but we were keen to use this opportunity to inform the Ministry of Health that this gap exists and impedes good decision making at the local level.

5.7.2 Research on developing sustainable community funding models not built on harm

5.7.2.1 The over-reliance on funds derived from class 4 gambling at the government and local levels conflicts with meaningful progress in reducing the harm caused by gambling and may even drive gambling expansion. Waikato DHB continues to advocate a shift towards reducing reliance on class 4 proceeds and advises sourcing other models of sustainable community funding not built on harm.

5.7.2.2 An example of sustainable community funding models not built on harm can be found in the Kereru Station; a large sheep and beef property located west of Hastings owned by two charitable trusts set up in 1968. Together these trusts distribute profits of around $400,000 a year back to the local community, in addition to providing employment and training opportunities[6].

5.7.2.3 Opportunities to investigate the development of other models of sustainable community funding not built on harm is well overdue and our organisation sees value in strengthening the public health approach through independent research in this area.

Conclusion

Waikato DHB wishes to thank the Ministry of Health for the opportunity to provide comment on the Strategy to Prevent and Minimise Gambling Harm 2019/20 to 2021/22.

Leadership and direction set through policy at the national and local levels shape the culture and expectation of what a public health approach can deliver to reduce gambling-related harm and improve the health and wellbeing of populations as mandated through the Gambling Act 2003.

Dr Richard Wall

Medical Officer of Health
Public Health
Waikato District Health Board

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[6] NZ Farmer. Charities benefit from farmers' toil. Retrieved from http://www.stuff.co.nz/business/farming/agribusiness/70054303/Charities-benefit-from-farmers-toil

MEMORANDUM TO THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
12 DECEMBER 2018

AGENDA ITEM 6.4

WAIKATO DHB SUBMISSION ON HEALTHY HOMES STANDARDS

Purpose	For information and discussion

"Health is created and lived by people within the settings of their everyday life; where they learn, work, play, and love"
(Ottawa Charter for Health Promotion, p.3) [1].

This imperative informs the Waikato District Health Board (DHB) and Waikato Public Health Unit's advocacy work on draft policy and plans at national, regional and local levels.

Our intentional emphasis on health equity, particularly for Māori and other vulnerable peoples and communities and productive partnerships underpins our advocacy work. This emphasis was reinforced in the Waikato DHB Strategy released in July 2016.

Background

The Healthy Homes Standards consultation sought submissions on improving the quality of rental properties by establishing minimum standards to allow New Zealand tenants to live in warm and dry rental homes. On average, private rental dwellings are in worse condition than owner-occupied homes. The Healthy Homes Act 2017 sets a legislative framework that enables government to improve the overall standard of rental homes in New Zealand.

Key submission points

Through its position statement on Housing, Waikato DHB recognises housing as a key determinant of health and an important mediating factor in health inequalities and poverty. Access to safe, warm, dry and affordable housing is essential for health and wellbeing. Vulnerable population groups such as Māori, Pacific, older people, children and those with pre-existing medical conditions are the most vulnerable to the

[1] WHO (1986) *The Ottawa Charter for Health Promotion*. First International Conference on Health Promotion, Ottawa: World Health Organisation

health impacts of poor quality housing. Waikato DHB supports initiatives that improve housing quality, access to affordable housing and tenure security for renters. These are cost effective measure to improve population health and reduce avoidable hospital admissions. This submission draws from the Position Statement on Housing (Waikato DHB 2014).

Key submission points include:

- Supporting heating options in living rooms and bedrooms that are capable of achieving an indoor temperature of at least 18^0 as recommended by the World Health Organisation.
- Agreeing that unflued gas heaters are not acceptable for the heating standard.
- Supporting the move to meet the R-values of the minimum level of ceiling and underfloor insulation for new homes built between the years of 2001 and 2008.
- Supporting the installation of appropriate extractor fans particularly in areas of heavy moisture build-up such as kitchens, bathrooms and laundry areas.
- Agreeing that landlords provide efficient drainage and guttering, downpipes and drains and ensure the subfloor has a ground moisture barrier.
- Supporting the necessity for landlords to stop unnecessary gaps or holes that cause noticeable draughts.
- Supports a compliance date set for the healthy homes standards in line with the Healthy Homes Guarantee Act 2017.
- Supports the monitoring, enforcement and evaluation of housing improvement requirements to ensure standards are being implemented.

Recommendation
THAT

The Committee notes the paper.

TANYA MALONEY
EXECUTIVE DIRECTOR, STRATEGY, FUNDING AND PUBLIC HEALTH

ATTACHMENT 1:

Submission on Healthy Homes Standards

To:	Healthy Homes Standards Ministry of Business Innovation & Employment 15 Stout Street PO Box 1473 Wellington 6140 healthyhomes@mbie.govt.nz
Details of Submitter:	Waikato District Health Board
Address for Service:	Public Health Unit Waikato District Health Board Private Bag 3200 HAMILTON 3240
Contact Person:	Dr Richard Vipond Richard.vipondl@waikatodhb.health.nz
Hearing:	Waikato DHB does not wish to verbally support its submission
Date:	25 September 2018

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1 Introduction

1.1 Waikato District Health Board (Waikato DHB) presents this submission through its Public Health Unit. Regarding matters concerning public health, the Public Health Unit is the principal source of advice within Waikato DHB. Under the New Zealand Public Health and Disability Act 2000, Waikato DHB has responsibility to improve, promote and protect the health of people and communities.[1] Additionally, there is a responsibility to promote the reduction of adverse social and environmental effects on the health of people and communities. With nearly 7000 staff, Waikato DHB delivers health services to a population of more than 400,000 people across the Waikato region.

1.2 The Healthy Homes Act 2017 enables government to improve the overall standard of rental homes in New Zealand. Two discussion documents; the review of the Residential Tenancy Act 1986 and the Healthy Homes Standards intend to progress both the quality of housing and tenure security for renters in New Zealand.

1.3 Waikato DHB congratulates the government for this first step initiative. Our organisation supports the overarching objective to establish minimum standards to allow New Zealand tenants to live in warm and dry rental homes.

1.4 We appreciate that a more detailed and personal response is being asked for to guide government progress in this area. Our submission will provide general commentary on the proposed Healthy Homes Standards followed by more specific comment as appropriate at our organisational level.

2 General comment

2.1 Waikato DHB's position

2.1.1 Through its position statement on housing, Waikato DHB recognises housing as a key determinant of health and an important mediating factor in health inequalities and poverty. Access to safe, warm, dry, and affordable housing is essential for health and wellbeing. Vulnerable population groups such as Maori, Pacific, older people, children and those with pre-existing medical conditions are the most vulnerable to the health impacts of poor quality housing. Our organisation supports initiatives that improve housing quality, access to affordable housing, and tenure security for renters. We recognise these as cost-effective measures to improve population health and reduce avoidable hospital admissions. [2]

3 Specific comments

3.1 This section of our submission provides more specific comment on improving the overall standard of rental homes in New Zealand.

3.2 Consultation questions

3.2.1

Section 1: Heating 1.1: Do you support option one or two for location of heating devices that landlords must provide in rental homes? Please explain your reason?

3.2.1.1 Waikato DHB supports Option 2: heating in living rooms and bedrooms.

Much of New Zealand's housing stock is old and aging with low levels of insulation, single glazing, and inadequate window treatments. Effective and efficient heating needs to be available in the rooms most needed such as living and sleeping areas and able to reach and sustain minimum temperatures for a healthy indoor environment. Cold bedrooms can have significant respiratory consequences particularly for children, older people and those with pre-existing respiratory conditions.[3] It is therefore preferable to ensure tenants have access to heating in bedrooms as well as living rooms.

3.2.2

Section 1.3: Do you support option one or two above on whether landlords should provide heating devices that are capable of reaching 18^0C or 20^0C in room(s) covered by the heating standard? Please explain?

3.2.2.1 Waikato DHB supports Option 1: heaters must be capable of achieving an indoor temperature of at least 18^0 C.

The World Health Organisation recommends a minimum indoor temperature of 18^0C and ideally 20^0C for the very young, the very old, those that are sick or disabled. Our current average winter temperature in New Zealand is 16^0C. [4] As a first step, 18^0C is a practical solution given the running costs required to achieve higher temperatures within our current and often substandard housing stock. Over time this should be reviewed and raised to meet WHO recommendations of 20^{0}C.

3.2.3

Section 1.5: Do you agree that a class of acceptable heating devices is created for those devices that are efficient, healthy and affordable for the heating standard?

3.2.3.1 Waikato DHB agrees that a class of acceptable heating devices is included in the heating standards such as unflued gas heaters,

Unflued gas heaters are not acceptable for the heating standard. About one third of New Zealand households have unflued gas heaters. Exposure to nitrogen dioxide (NO_2) from unflued gas heaters can reduce immunity to lung infections and increase the severity and duration of an influenza or other upper respiratory tract infection. NO_2 inflames the lining of the lungs which can cause problems such as wheezing, coughing, colds, flu and bronchitis.[5] In her randomised controlled trial, Howden-Chapman (2008) concluded that while installing non-polluting, more effective heating in the homes of children with asthma did not significantly improve lung function, it did significantly reduce symptoms of asthma, days off school, healthcare utilisation, and visits to the pharmacist. [5]

3.2.4

Section 2: Insulation 2.1: Which of the options (one, two, or three) for the minimum level of insulation required do you support? Please explain.

3.2.4.1 Waikato DHB supports Option 2: Existing insulation must be replaced or topped up if below 1.9 if the home is located in zones 1 or 2 and 2.5 if located in zone 3 (ceiling). Existing insulation must be replaced or topped up if below 1.3 (underfloor).

As a first step, Waikato DHB supports the move to meet the R-values of the minimum level of ceiling and underfloor insulation for new homes built between the years of 2001 and 2008 as a significant number of rental homes (10,000-70,000) will benefit from this option.[6] However, as housing standards and compliance with housing standards progress, we would support moving to at least option 3 as a longer term solution. Our organisation would also support thermal curtains or other suitable window treatments being included as part of a home's insulation requirements. We support ongoing subsidies to landlords to encourage compliance with the new standards and to minimise the risk of costs being passed onto tenants.

3.2.5

Section 2.2: Do you support option one or two to assess a 'reasonable condition' for insulation? Please explain.

3.2.5.1 Waikato DHB supports option 2: insulation must meet the reasonable criteria described.

Our organisation recognises that insulation is the primary measure to support a warm dry home and we agree with the Ministry of Business, Innovation & Employment that option two will better help meet the objective of making rental homes warm and dry. However, we would support option 3 as a longer-term solution particularly in New Zealand's colder regions.

3.2.6

> Section 3: Ventilation.
>
> 3.1: Do you support option one, two or three to provide adequate ventilation in rental homes? Please explain.

3.2.6.1 Waikato DHB supports Option 3: openable windows and extractor fans in rooms with a bath, shower or indoor cooktop.

Our organisation supports the installation of appropriate extractor fans particularly in areas of heavy moisture build-up such as the kitchen, bathroom and laundry areas.

Moulds thrive in unventilated areas. Improved design for ventilation such as extractor fans can improve air quality thereby reducing health risks.[7]

There is also a responsibility on the tenant to ventilate their property to prevent a build-up of moisture and mould particularly in bathrooms. BRANZ recommends that doors and windows are regularly opened for around 10-15 minutes a day to ensure properties are ventilated.[8] This is not an excessive amount of time but some promotion and education may be needed to ensure tenants regularly ventilate their properties.

3.2.7

> Section 4: Moisture ingress and drainage
>
> Do you support option one or two to address the problems identified with moisture ingress and inadequate draining in NZ rental homes? Why/Why not?

3.2.7.1 Waikato DHB supports Option 2: Landlords provide efficient drainage and guttering, downpipes and drains and ensure that the subfloor has a ground moisture barrier, unless there is already adequate subfloor ventilation.

Waikato DHB supports options to achieve the overall aim of warm and dry homes. Landlords must meet requirements set out in the Building Code, Residential Tenancies Act, and the Housing Improvement Regulations. As this is not currently the case in all cases, it would suggest either existing regulations are inadequate or not enforced. Improved protection against moisture ingress would have benefits beyond their direct health effects including reduced heating costs.

3.2.

> Section 5: Draught stopping.
>
> 5.1: Do you support option one or two to stop draughts and create warm and drv rental homes? Whv?

3.2.8.1 Waikato DHB supports Option 2: stop unnecessary gaps or holes that cause noticeable draughts.

Research from the Department of Public Health University of Otago, Wellington found that by applying simple minor interventions to block draughts in a number of social housing units, made a relatively big difference to indoor temperature and comfort of those living there. [9]

Under Option 2, the Ministry proposes to publish guidance which would set out examples of gaps and holes that would require to be remedied. Our organisation supports this initiative. A publication of this nature would be helpful in pointing out common sources of noticeable draughts that could be easily remedied.[6]

3.2.9

Section 6: Date to comply with the standards. Do you support option one, two or three above for the date that landlords need to comply with the standards for their rental homes? Why/why not?

3.2.9.1 Waikato DHB <u>supports</u> Option 3 Sub-option A: compliance date set by healthy homes standards.

Waikato DHB supports the quality of New Zealand's' current rental stock being markedly improved. The Healthy Home Guarantee Act 2017 already makes provision for a phased implementation of the healthy homes standards; between 1 July 2019 and 30 June 2024. A staggered approach for healthy homes standards over a five-year period would allow for housing improvements to occur relatively quickly and for tenants to expect and experience warmer drier homes sooner.

3.2.10

Section 7: Implementation

3.2.10.1 As a general comment, our organisation supports the monitoring, enforcement, and evaluation of housing improvement requirements to ensure standards are being implemented. Substandard housing has been identified as the most important risk factor in a range of childhood respiratory diseases. It is therefore important, that the quality of our rental homes is markedly improved as quickly as possible.

4 Conclusion

4.1 Waikato DHB wishes to thank the Ministry of Business Innovation & Employment for the opportunity to comment on this document. Rental homes that meet a standard of quality which supports a healthy living environment lead to reduced costs for both the tenants and the health system.

Dr Richard Vipond

Medical Officer of Health
Public Health
Waikato District Health Board

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[6] Ministry of Business Innvoation & Employment, "Creating Healthy Rental Homes Discussion Document," 2018.

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MEMORANDUM TO THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
12 DECEMBER 2018

AGENDA ITEM 6.5

WAIKATO DHB SUBMISSION ON THE REFORM OF THE RESIDENTIAL TENANCIES ACT 1986

Purpose	For information and discussion

"Health is created and lived by people within the settings of their everyday life; where they learn, work, play, and love"
(Ottawa Charter for Health Promotion, p.3) [1].

This imperative informs the Waikato District Health Board (DHB) and Waikato Public Health Unit's advocacy work on draft policy and plans at national, regional and local levels.

Our intentional emphasis on health equity, particularly for Māori and other vulnerable peoples and communities and productive partnerships underpins our advocacy work. This emphasis was reinforced in the Waikato DHB Strategy released in July 2016.

Figure 1: Strategic framework Waikato District Health Board Strategy, 2016, p.16

Background

The Reform of the Residential Tenancies Act 1986 provides an opportunity to consider whether the law governing New Zealand's rental market strikes an appropriate balance between protecting a landlord's interest in their property and ensuring tenants receive fair rights for the rent they are paying.

As the rate of home ownership in New Zealand continues to fall, renting has become a lifelong reality for many. In general, tenants live in poorer quality housing and pay more of their income in housing costs than home owners. While Waikato DHB supports the overarching objective to make renting more stable and secure, we advocate for and recommend that investment in affordable housing remains a key focus of policy making now and into the future.

[1] WHO (1986) *The Ottawa Charter for Health Promotion*. First International Conference on Health Promotion, Ottawa: World Health Organisation

Key submission points

Through its position statement on Housing, Waikato DHB recognises housing as a key determinant of health and an important mediating factor in health inequalities and poverty. Access to safe, warm, dry and affordable housing is essential for health and wellbeing. Vulnerable population groups such as Māori, Pacific, older people, children and those with pre-existing medical conditions are the most vulnerable to the health impacts of poor quality housing. Waikato DHB supports initiatives that improve housing quality, access to affordable housing and tenure security for renters. These are cost effective measure to improve population health and reduce avoidable hospital admissions. This submission draws from the Position Statement on Housing (Waikato DHB 2014).

Key submission points include:

- Improving tenants control over their housing to increase tenancy security and benefits such as maintaining schooling and employment, family and social networks, contact with essential services and community connectedness.
- Supporting affordable housing by prohibiting the request for and acceptance of rental bids.
- Supporting the introduction of a Warrant of Fitness for boarding houses and their operators and ensuring a nationally consistent enforcement approach occurs.

Recommendation
THAT

The Committee notes the paper.

TANYA MALONEY
EXECUTIVE DIRECTOR, STRATEGY, FUNDING AND PUBLIC HEALTH

ATTACHMENT 1:

Submission on the Reform of the Residential tenancies Act 1986

To:	Residential Tenancies Act Reform Ministry of Business Innovation & Employment PO Box 1473 Wellington 6140 RTAreform@mbie.govt.nz
Details of Submitter:	Waikato District Health Board
Address for Service:	Public Health Unit Waikato District Health Board Private Bag 3200 HAMILTON 3240
Contact Person:	Dr Richard Vipond Richard.vipondl@waikatodhb.health.nz
Hearing:	Waikato DHB does not wish to verbally support its submission
Date:	25 September 2018

---

1 Introduction

1.1 Waikato District Health Board (Waikato DHB) presents this submission through its Public Health Unit. Regarding matters concerning public health, the Public Health Unit is the principal source of advice within Waikato DHB. Under the New Zealand Public Health and Disability Act 2000, Waikato DHB has responsibility to improve, promote and protect the health of people and communities.[1] Additionally, there is a responsibility to promote the reduction of adverse social and environmental effects on the health of people and communities. With nearly 7000 staff, Waikato DHB delivers health services to a population of more than 400,000 people across the Waikato region.

1.2 The Healthy Homes Act 2017 enables government to improve the overall standard of rental homes in New Zealand. Two discussion documents; the review of the Residential Tenancy Act 1986 and the Healthy Homes Standards intend to progress both the quality of housing and tenure security for renters in New Zealand.

1.3 Waikato DHB recognises that the Residential Tenancies Act 1986 (RTA) is the principal Act regulating residential tenancies in New Zealand. It defines the rights and obligations of residential landlords and tenants, sets out dispute resolution procedures and established a fund into which tenancy bonds are paid and held in trust.[2]

1.4 Waikato DHB congratulates the government for this first step initiative. Our organisation recognises that the provision of social housing has declined from 4% in 2008 to 3.4% in 2017.[3] Renting has become a life-long reality for many New

Zealanders and tenants generally live in poorer quality housing and pay more of their income in housing costs than home owners. Our current housing situation is far from socially optimal.

1.5 Our organisation recognises that New Zealand's current housing landscape of predominantly private sector rental housing, places landlords in a stronger negotiating position regardless of law changes and this is often at the expense of tenants.

1.6 While in principle, Waikato DHB supports the overarching objective to make renting more stable and secure and to improve the rental experience for both landlords and tenants, we recommend that investment in affordable housing remains a key focus of policy making now and in the future.

1.7 Our organisation appreciates that the Ministry of Business, Innovation and Employment (MBIE) is asking for a more detailed and personal response from landlords and tenants to guide government progress in this area. Our submission will provide a high level response on some aspects of the proposed reform of the Residential Tenancies Act as appropriate, in recognition of the complexities involved in our current housing policy landscape.

2 General comment

2.1 <u>Waikato DHB's position</u>

2.1.1 Through its position statement on housing, Waikato DHB recognises housing as a key determinant of health and an important mediating factor in health inequalities and poverty. Access to safe, warm, dry, and affordable housing is essential for health and wellbeing. Vulnerable population groups such as Maori, Pacific, older people, children and those with pre-existing medical conditions or disabilities are the most vulnerable to the health impacts of poor quality housing. Our organisation supports initiatives that improve housing quality, access to affordable housing, and tenure security for renters. We recognise these as cost-effective measures to improve population health and reduce avoidable hospital admissions. [4]

3 Summary comments

3.1 This section of our submission provides more specific comments on the reform of the Residential Tenancies Act 1986.

4 Section 2: Modernising tenancy laws so tenants feel more at home

2.1 Improving tenants' choice and control over their housing

2.1.1 Waikato DHB **supports** the current practice that requires a notice to remedy. This is a fair practice and allows a situation to be remedied as a first-step approach. In addition, Waikato DHB **supports** a Tenancy Tribunal order to terminate where there is evidence of ongoing anti-social behaviour and property damage.

2.1.4 Waikato DHB **supports** a vacant possession notice period of 90 days.

2.1.5 Waikato DHB **agrees** that the new owner only be able to require vacant possession if they want to use the property for a purpose that can't reasonably be accommodated with the existing tenants in place.

4.1 **Key points: Tenure security**

4.1.1 Improving tenants control over their housing can result in tenants staying in a place longer which can lead to improved health and wellbeing outcomes at the individual and community levels.

4.1.2 Tenure security is one of the main benefits of home ownership. A stable living environment is equally beneficial for tenants. Housing tenure is a significant factor for positive social and economic outcomes.[5] Tenure security helps maintain schooling and employment, family and social networks, contact with essential services such as health professionals, and community connectedness. Families with young children, older people, people with disabilities and those who are no longer able to afford to purchase a home, are vulnerable population groups and particularly impacted by tenure insecurity. Poor social outcomes result in increased economic costs at a government, community and individual level. It is therefore important that tenants' rights to housing security are enhanced and protected through legislation.

5 Section 3 Setting and increasing rent

Option 2: prohibit the request and acceptance of rental bids

Waikato DHB **supports** option 2 that prohibits the request for and acceptance of rental bids.

5.1 Key points: Affordable housing

5.1.1 The Residential Tenancy Act 1986 currently allows landlords and tenants to agree on the amount of rent required for a property. In high demand areas where there is a shortage of rentals, competition for rental properties increases dramatically. People with more disposable income are invariably in a position to offer higher rents to secure properties than those on lower incomes. Smartphone applications have entered the NZ market. They offer a price negotiation platform where tenants and landlords can negotiate rent. These apps have the ability to drive rents up particularly in areas of high demand. It is therefore important that tenants are protected through legislation and the current practice of request for and acceptance of rental bids is prohibited.

5.1.2 Affordable housing is an essential component of healthy communities. With more than a third of New Zealand's population renting, risks associated with unaffordable housing increase, resulting in overcrowding or people living in substandard housing including their vehicle. Communicable diseases such as meningococcal disease, acute rheumatic fever and tuberculosis are linked to poor and substandard housing.

6 Section 4: Boarding Houses

> 4.1.1 Waikato DHB **does not think** the current responsibilities on tenants and landlords for boarding houses are fit for purpose.
>
> 4.1.3 Waikato DHB **supports** the need for stronger enforcement powers to improve the quality of boarding houses.
>
> 4.1.8 Waikato DHB **supports** the introduction of a Warrant of Fitness for boarding houses and their operators to improve the quality of boarding houses, and **supports** a nationally consistent approach to enforce a Warrant of Fitness for boarding houses and their operators.

6.1 Key points: Boarding houses

6.1.1 Boarding Houses typically house the most vulnerable of our society; single foreign students; those receiving an invalids, sickness, unemployment or superannuation benefit; those with a poor tenancy record, and those with substance abuse and mental health issues.[6]

6.1.2 A Mental Health Commission report published in 1999 found that the quality of Boarding Houses varied enormously and that boarding house environments can be unsafe and exploitive for some groups of people such as those with mental illness.

6.1.3 Research and investigations by Anderson 2016, Newport 2017, and Martin 2018, found boarding houses across Auckland, Dunedin, Queenstown and Whanganui were of poor physical standards and provided substandard social conditions for vulnerable tenants. Complaints to the Tenancy Tribunal by a tenant concerned about overcrowding in a boarding house in Queenstown were not considered valid by either the Tenancy Tribunal or the local council.[7-9]

6.1.4 It is therefore important that our most vulnerable population groups be offered protection through appropriate legislative change such as the introduction and enforcement of a Warrant of Fitness for boarding houses and their operators.

7 Enforcing Tenancy Laws

> 5.1.4 Waikato DHB **supports** MBIE to have the power to enter the common spaces of boarding houses without the prior agreement of at least one of the tenants.

7.1 Key points: Tenancy Laws

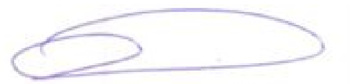
7.1.1 Measures contained in s66B Residential Tenancies Act 1986 (RTA) require boarding-house landlords to provide clean, well maintained accommodation and comply with existing statutory obligations. However, research suggests that many boarding houses do not comply with legislation and that the reality for boarding house tenants is that accommodation offered is extremely substandard. A 2013 study of boarding houses in Wellington found that the majority were described by tenants as being of poor or very poor standard. Additionally, toilet, bathroom and kitchen facilities were inadequate for the number of people living in the boarding houses. [10]

7.1.2 Currently, the Ministry of Business, Innovation and Employment has the power to investigate severe alleged breaches of the RTA. It is unclear how often MBIE has investigated boarding houses. Vulnerable tenants are often afraid to complain for fear of eviction.

8 Conclusion

8.1 Waikato DHB wishes to thank the Ministry of Business Innovation & Employment for the opportunity to comment on this document. We have provided a high level response to some aspects of the reform of the Residential Tenancies Act 1986 as appropriate for our organisation. Rental homes that provide tenure security and meet a standard of quality which supports a healthy living environment lead to reduced costs for both the tenants and the health system. In recognition of the complexities involved in our current rental climate, our organisation recommends that affordable housing remains a key focus of policy making now and into the future.

Dr Richard Vipond



Medical Officer of Health
Public Health
Waikato District Health Board

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[5] Charles Waldegrave and M. Urbanava., "Social and Economic Impacts of Housing Tenure. Family Centre Social Policy Research Unit.," 2016.

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Presentations

MEMORANDUM TO THE COMMUNITY AND PUBLIC HEALTH COMMITTEE
12 DECEMBER 2018

AGENDA ITEM 7.1

REVIEW OF WAIKATO DHB POSITION STATEMENTS ON TOBACCO CONTROL, ALCOHOL HARM, AND PSYCHOACTIVE SUBSTANCES

Purpose	For approval

Background

In 2009, the Public Health Unit on behalf of Waikato DHB developed a set of position statements on identified public health issues. The purpose of these position statements is to provide high level documents representing Waikato DHB's position as an organisation on these issues and to clarify the organisation's position for DHB staff.

Waikato DHB has adopted position statements on tobacco control, alcohol harm, psychoactive substances, land transport, urban environments, fluoride, immunisation, gambling, housing, and physical activity and nutrition.

Position statements also support formal advocacy activities such as submissions. Position statements are reviewed every three years.

Several position statements have been reviewed, three are presented today: tobacco control, alcohol harm, and psychoactive substances.

Changes since the last review

<u>Waikato DHB Position Statement on Tobacco Control</u>

Waikato DHB's position on tobacco control remains largely unchanged; Waikato DHB continues to support the Government's vision for a Smoke-free Aotearoa 2025.

The position statement has been amended to ensure that all Waikato DHB smoke-free environments that apply to smoked tobacco, apply equally to e-cigarettes (vaping) and heated tobacco products.

<u>Waikato DHB Position Statement on Alcohol Harm</u>

The DHB's position on alcohol harm remains largely unchanged; Waikato DHB continues to support measures in the Sale & Supply of Alcohol Act 2012 aimed at minimising harm, and to advocate for other measures to further reduce alcohol-related harm.

The position statement has been amended to reflect legislative changes to the Land Transport Amendment Act (no 2) 2014, by removing reference to reducing the blood alcohol limit whilst driving, and by making reference to Public Health's "settings approach" where alcohol harm has been identified as a priority.

Waikato DHB Position Statement on Psychoactive Substances

The DHB's position statement continues to recognise the use of psychoactive substances as a risk factor in a wide range of adverse health conditions.

Changes to the position statement have been made to reflect amendments to the Psychoactive Substances Act 2013. Amendments include strengthening the DHB's areas of action and updating background information in line with legislative changes.

Radical Improvement in Māori Health Outcomes by Eliminating Health Inequities for Māori

Health disparities are significant contributors to the burden of disease. Waikato DHB positions statements contribute to the DHB's commitment to reducing health inequalities as part of the Health Equity Assessment Tool's Intervention Framework to improve health and reduce inequalities. These high level documents guide service response and opportunity to advocate for stronger health and wellbeing in policy development and practice.

Recommendation
THAT

The Committee adopts the reviewed position statements.

RICHARD HOSKINS
CLINICAL DIRECTOR

ATTACHMENT 1:

Waikato District Health Board

Position Statement

TOBACCO CONTROL

Introduction

The following is a position statement on tobacco control prepared by the Public Health Unit for Waikato District Health Board (Waikato DHB).

The Waikato District Health Board's position

The Waikato DHB supports the Government's vision of a Smoke-free Aotearoa 2025, where less than 5% of adult population will use tobacco and it will be extremely difficult to manufacture, market, sell and supply tobacco[1].

The Waikato DHB supports action at a national level to achieve this vision, including regular increases in tobacco taxation, reduced marketing of tobacco, reduced access to tobacco, plain packaging and ongoing legislative controls on the manufacture and sale of tobacco[2].

The Waikato DHB supports the Midlands Smoke-free 2025 vision statement and action plan[1].

The Waikato DHB supports activities to improve smoking cessation within the adult population, in particular to reduce disparities for Maori and Pacific, and reduce the uptake of smoking by young people.

The Waikato DHB supports measures that protect non smokers from second hand smoke – especially vulnerable population groups (e.g. children and pregnant women including protecting children from tobacco smoke in vehicles)

The Waikato DHB supports and actively encourages current smokers including DHB employees, contractors, patients and carers on all DHB sites to quit smoking and stay quit.

The Waikato DHB will actively work towards achieving the "Better Help for Smokers to Quit" target in secondary and primary care settings.

The Waikato DHB will actively work towards ensuring all DHB property, facilities, buildings and vehicles are Smoke-free environments through policy development, active encouragement, education, advice and enforcement.

The Waikato DHB recognises that e-cigarettes containing nicotine ("vaping") may be an option for nicotine replacement therapy for some people. However, this does not mean e-cigarette use should be permitted in Waikato DHB smokefree areas. Thus any DHB policies that refer to the management and or restriction of tobacco products also refer to e-cigarettes and heated tobacco products.

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The Waikato DHB supports various sectors to plan for, promote and support Smokefree environments and interventions through partnerships based on shared strategic vision and coordinated investment.

The Waikato DHB supports the role of Smoke-free Officers employed by the DHB and designated by the Director-General of Health to ensure that the Smoke-free Environments Act 1990 is administered through education, advice, enforcement and initiation of prosecutions as necessary.

The Waikato DHB supports the continuation of the making of submissions on tobacco issues to district and regional councils and government select committees when appropriate; the provision of input into district and regional council tobacco policies and plans, including Smokefree open spaces; and the provision of ongoing promotion of tobacco harm reduction strategies to health care professionals and the public.

The Waikato DHB recognises that

The World Health Organisation (WHO) has estimated that tobacco kills up to half of its users and is responsible for approximately one in 10 deaths worldwide or 7 million deaths per year[3]. It is the leading cause of preventable death in New Zealand killing approximately 4500 people each year, 13 people a day, plus an estimated 400 people a year from second hand smoke[4].

One in four of all New Zealand cancer deaths are caused by smoking and it is a major contributor to cardiovascular disease, chronic pulmonary disease, acute respiratory infections and asthma particularly in children, strokes and the impact of diabetes. These chronic conditions place a major burden on the wellness of the population of Waikato and they contribute a significant cost to the health service[4].

While overall smoking rates are declining, there are significant health inequalities associated with tobacco use nationally and in the Waikato. Almost half of all Maori smoke and just over a third of Pacific compared to a quarter of the overall New Zealand population. This disparity in smoking rates is a significant contributor to observed disparities in related disease burden. Approximately a fifth of all deaths in Maori are attributable to tobacco use[5].

Smoking during pregnancy is a source of considerable and serious negative health outcomes for babies and women in New Zealand. Smoking during pregnancy reduces the growth and health of babies and increases the risk of complications and illnesses to both mother and baby.

Comprehensive tobacco control programmes are effective and should include a mix of health promotion, tobacco taxation, smoking cessation, research, legislation and enforcement.

References

[1] Ministry of Health. (2017). *Smokefree New Zealand*. Available: https://www.health.govt.nz/our-work/preventative-health-wellness/tobacco-control/smokefree-aotearoa-2025

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[5] Ministry of Health. (2017). *Tobacco control*. Available: https://www.health.govt.nz/our-work/preventative-health-wellness/tobacco-control

ATTACHMENT 2:

Waikato District Health Board

Position Statement

ALCOHOL HARM

Introduction

The following is a position statement on alcohol harm prepared by the Public Health Unit, Waikato District Health board (DHB).

The Waikato District Health Board's position

The Waikato DHB recognises alcohol consumption as a significant risk factor in a wide range of adverse conditions. Alcohol has the potential to harm individuals acutely by means of intoxication, alcohol poisoning or accidental harm while drunk, and chronically by means of long term damage to organ systems. Alcohol related harm also can often affect those who are not even consumers, but third parties affected by drinking decisions of others. The burden of alcohol on the Waikato Hospital Emergency Department presentations is substantial.

The purpose of New Zealand's Sale and Supply of Alcohol Act 2012 is to minimise harm created by excessive or inappropriate alcohol consumption[1].Waikato DHB supports measures in the Act aimed at minimising harm and advocates for further measures to reduce alcohol related harm further.

Waikato DHB recognises the need to reduce the accessibility and availability of alcohol[2] 'and thus Waikato DHB supports the following measures:

- Reduce trading hours and density of alcohol retailers
- Increase the price of alcohol
- Increase the purchase age of alcohol to 20 years.

Waikato DHB supports other measures that contribute to a reduction in alcohol related harm such as reducing or restricting alcohol marketing, and sponsorship including social media[3].

Waikato DHB will utilise resources to help contribute to the purpose of the Sale and Supply of Alcohol Act 2012. This will be achieved through the following actions:

- Work with Territorial Authorities in the development and implementation of Local Alcohol Policies and other licensing issues
- Continue to provide policy and planning advice on issues of alcohol related harm, using the most current evidence and research
- Provide health promotion focussing on addressing and reducing alcohol related harm where that is an identified priority within a specific setting
- Provide treatment services for those suffering from the effects of alcohol related harm

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- Continue monitoring of licences within the district and provide assistance with regulatory issues as required.

The Waikato DHB is committed to working with other agencies to reduce alcohol related harm. Waikato DHB will make all efforts to provide regional information on alcohol related harm to inform policy in the region.

Background information: Alcohol consumption and associated harm

Alcohol is the most commonly used drug in New Zealand, with over 80% of the adult population drinking at least occasionally. New Zealanders spend an estimated $85 million a week on alcohol[4]. However, a significant number of New Zealanders consume alcohol at an excessive rate. National drinking surveys show that around a quarter of drinkers consume in excess – or at least seven standard drinks per drinking session[5].

In New Zealand about 1,000 people die each year secondary to alcohol use[6]. Over half of alcohol related deaths involve injury, a quarter is due to cancer and the final quarter is related to other chronic disease. The link between alcohol and health is dependant both on the volume of alcoholic units consumed and the pattern of consumption, with binge drinking being particularly dangerous[7].

The adverse health outcomes resulting from alcohol use are not distributed equally amongst the population. The New Zealand health survey states that almost 40% of Māori and Pacific people drink hazardously, compared with 20% of European/Other people and 10% of Asian people.

Alcohol related harm is of particular concern for young people. Youth drinking is a problem in New Zealand with over 70% of secondary school students having drunk alcohol, and 46% of student drinkers consuming over five units the last time they drank[8]. Groups most likely to drink heavily are males aged 18 to 24 years and Māori males aged 18 to 30 years[9]. Young people drink less frequently than older drinkers, but at a higher volume[8]. Acute alcohol related hospital admissions in the Waikato DHB region are predominantly from people in this younger age group.

References

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ATTACHMENT 3:

Waikato District Health Board

Position Statement

PSYCHOACTIVE SUBSTANCES

Introduction

The following is a position statement on psychoactive substances prepared by the Public Health Unit, Waikato District Health Board (DHB).

The Waikato District Health Board's position

The Waikato DHB recognises the use of psychoactive substance as a risk factor in a wide range of adverse health conditions. Although the Psychoactive Substances Act 2013 legalises the use of these products, psychoactive substances have the potential to harm individuals both acutely and through long term use. Psychoactive substance use can often affect those who are not even consumers, but third parties affected by decisions of others.

Waikato DHB will:

- Support Territorial Authorities in achieving the purpose of the Act through information provision.
- Perform regulatory role in terms of monitoring licences with partner agencies.
- Monitor evidence of health related harm associated with Psychoactive Substance use.
- Provide health related assistance to users of Psychoactive Substances as appropriate.

Background

Psychoactive substances have been present in New Zealand since the early 2000's. These substances mimic the effects of illegal products such as cannabis and ecstasy. Successive governments have banned ingredients of these products as they were found to cause harm, only for new ingredients to replace them.

The health impacts of psychoactive substance use are still relatively unknown, but there is growing evidence that use may have several adverse health effects. These include cardiovascular problems, psychological disorders including psychosis, seizures and severe withdrawal symptoms upon ceasing use[1]. The long term health effects are hard to determine, given to the nature of products, which can vary in ingredients from packet to packet[2].

The Psychoactive Substances Act 2013 legalises the sale, supply and use of approved psychoactive substances in New Zealand.

The purpose of the Act is to minimize harm to the user of psychoactive substances[3]. A large number of measures have been introduced in order to achieve this purpose:

Date Issued: June 2018	Review Date: June 2021	Version 1.0
Adopted by Waikato District Health Board: TBC		Page 1 of 3

- Restrictions on locations of sale of products, including a ban on all dairies, petrol stations and alcohol outlets. A licence will be required to sell psychoactive substances. This has led to a 95% reduction in premises selling psychoactive substances.
- Products must be tested and proven to pose no more than a low risk of harm to the user before they can be sold. All products must have health warnings.
- Purchase age of 18
- Labelling and packaging requirements and restrictions on advertising

The Act reverses the onus of proof onto manufacturers, who must prove their products are "low risk" before they can be sold.

The Act also allows Territorial Authorities to create their own Local Approved Products Policy (LAPP). The policy may not limit the number of licences in the district, but can restrict where in the district products can be sold.

There are currently 12 interim licences to sell psychoactive substances in the Waikato DHB region. Licences for sale of psychoactive substances will be granted by the Ministry of Health.

Public Health has staff that have been appointed staff as enforcement officers, and are charged with monitoring licensees to ensure they are meeting their obligations under the Act.

References

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Waikato DHB: CPHAC

Position Statement:

- Alcohol
- Tobacco
- Psychoactive Substances

Waikato District Health Board

Position Statements

- Why am I here?
  - Many of the 10 previously approved PS have been updated in the last year, and thus need re-approval
- What are they for:
  - To provide high level documents representing Waikato DHB's position as an organisation on these issues
  - To clarify the organisation's position for Waikato DHB staff
  - Facilitate submission preparation
- What else do you do?

Waikato District Health Board

Updates (all minor)

- Tobacco:
  - Ensure smokefree includes vaping and heated products
- Alcohol
  - Reference to lowering blood alcohol while driving no longer required (new law)
  - Including public health “settings” approach
- Psychoactive Substances
  - Amendments to reflect legislative changes

Waikato District Health Board

Alcohol

- 1172 applications for licence (On, Off, Club, Special)
- 1196 inquired into (some received in previous year)
- 99 had "matters raised in opposition" (100% within statutory time limit). At end of period:
  - 27 still to be heard by District Licensing Committee
  - 63 oppositions withdrawn after applicant made changes
  - 3 applications withdrawn
  - 3 applications granted with conditions
  - 3 applications declined/refused
- 32 premises had CPOs, 28 compliant (88%)

Waikato District Health Board

Local Alcohol Policy (Councils)

A local alcohol policy may include

- location of licensed premises by reference to broad areas/proximity to premises or facilities
- whether further licences should be issued
- maximum trading hours
- discretionary conditions
- one-way door restrictions

Steps to LAP:

- Analysis, (consult with MOoH, Police, Inspectors)
- Draft, then consult widely
- Provisional, subject to appeal
- Amend – subject to appeal again, Adopt, or Abandon

LAPs in our region

- 8/10 Councils have LAPs, but not Hamilton ☹
- All reduce maximum trading hours a bit
- Some have discretionary One-Way-Doors
- Others have CPTED principles for Offs
- 1 has proximity for Offs (schools, ECEC, playgrounds, other Offs)
- 1 has restricted types of alcohol in Offs

Waikato District Health Board

Tobacco

In last year:

- 282 Education visits to retailers
- 163/180 (91%) compliant as tested by “Controlled Purchase Operation” (sting) with Police

- Also note current work with councils and esp HCC on smokefree policy, aiming to:
  - include lessons from hospital campus
  - protect Waiora CBD environs and include iHub/cessation
  - move from unsuccessful ‘enforcement’ to ‘brief advice’ and referral

Waikato District Health Board

MEMORANDUM TO THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
12 DECEMBER 2018

AGENDA ITEM 7.2

WAIKATO HEALTH SYSTEM PLAN UPDATE

Purpose	For information

Introduction

The Health System Plan (HSP) is intended to identify the actions needed across the broader health and social system that will enable achievement of the outcomes described in the DHB's strategy, Healthy People, Excellent Care. It will encompass the Care in the Community Plan (CCP) actions and align with actions needed to support DHB services and enablers. Direction from DHB services is being taken from hospital clinical service plans from different departments, plus service strategies/plans e.g. Health of Older People, Mental Health and Addictions. Hospital clinical service planning is currently in progress and scheduled for completion in December.

Process to Date

The following table summarises the status of the development process for the CCP outlined in Appendix 1.

Activity	Status	Comment
Strategic context	Completed	
Literature scan	Completed	
Stakeholder feedback	Completed	6 key themes identified as problem statements (see Appendix 2)
Analytical profile	Completed	
Case studies	Completed	
Services stocktake	Completed	
Planning framework	Completed	6 goals and 5 enablers identified (see Appendix 3 & 4). Principles drafted (see Appendix 5)
Focus area workshops	Completed	6 workshops; one for each goal
Strategic Options workshop	Completed	Draft CCP actions tested with workshop participants
Care in the Community Plan	In progress – on track	
Roadmap of Actions	In progress – on track	

Appendix 2 describes the themes arising from the stakeholder engagement process described as “problem statements”. These have formed the basis for six goals (see Appendix 3) and five enablers (see Appendix 4) that have been identified for the CCP. A set of principles that have been informed by discussions with DHB governance groups and the stakeholder engagement have been formed to frame actions that will deliver on the goals (Appendix 5). The draft actions have been informed by the focus area workshops and these will be tested at a strategic options workshop (13 December) with the feedback used to inform the Care in the Community Plan and roadmap. Iwi Māori Council, the Māori Strategic Committee and the Waikato DHB Board will consider the draft CCP at their February meetings.

Demonstrating our Leadership Role in the Sector

Throughout the course of stakeholder engagement and the various workshops much has been made of the leadership role of the DHB and needing to “walk the talk” particularly on the role of the DHB in prioritising Māori equity and influencing actions taken by our own services as well as those we commission with other providers. Leadership roles apply to all stakeholders in the sector but will be followed up with DHB management as ways the DHB could lead by example.

The HSP is Strategic and Directional

The HSP is not about specific initiatives in individual service areas but identifies the directions to be taken to deliver on our vision described in the strategy, Healthy People, Excellent Care. For example, how we integrate clinical service coordination with whānau ora navigation. It will have an orientation to the community given the wish to shift the balance of focus to wellness rather than treatment.

The intention is to give the HSP a bi-lingual title. Advice is being sought from the Kaunihera kaumātua forum on this.

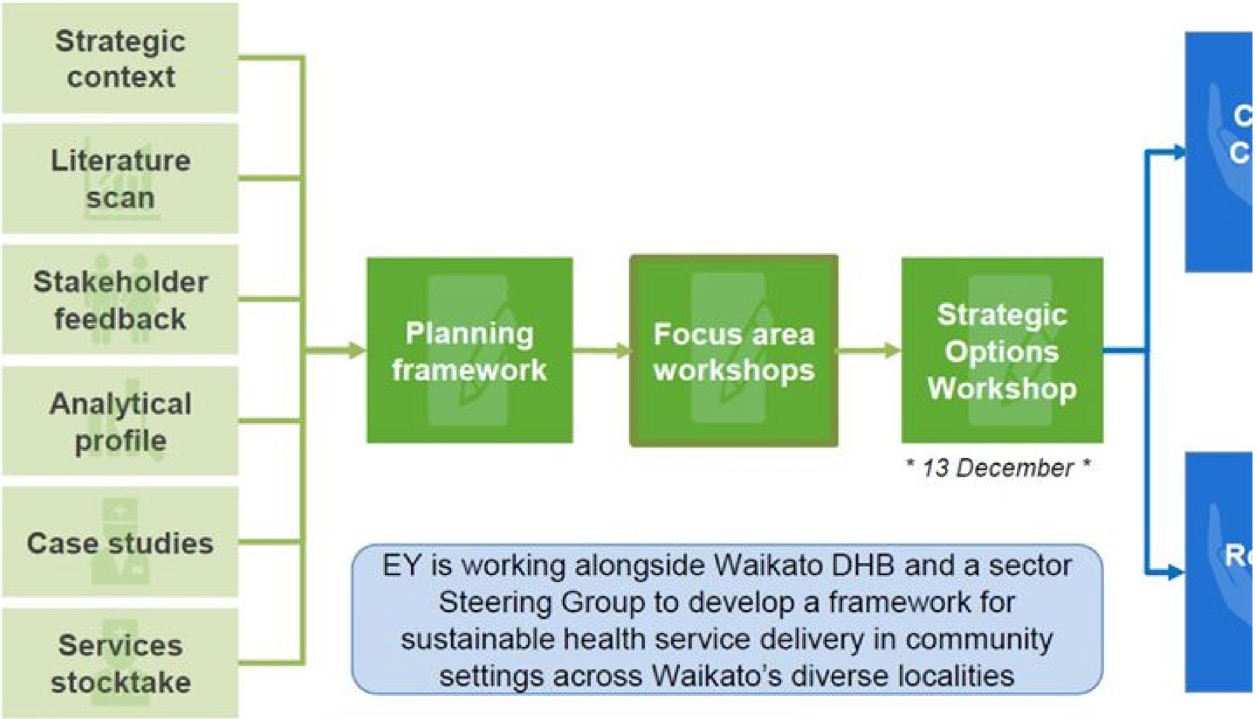
Recommendation
THAT

The Committee receive this report.

DANNY WU
PROGRAMME DIRECTOR

Appendix 1

Care in the Community – Plan development process



Appendix 2

Themes from stakeholder engagement process – problem statements

Improving responsiveness to Māori	Empowering communities	Healthy liv
Most health services are not designed to meet the needs of Māori. They do not respect tikanga Māori, are not focused on whānau wellbeing, and are not delivered in accessible settings	Resource allocation and service design are controlled by health care organisations. Health system planning and decision-making isn't responsive to local community needs	People anc access to t wellness. T informatior personal h
Enhancing primary health care	**Developing our workforce**	**Improving**
Funding, professional and organisational boundaries across the services that should be most responsive create barriers to positive consumer experiences and improved outcomes	Increasing population demand and constrained workforce availability will threaten service access for consumers and intensify pressure on already vulnerable community care workers	The current delivery cre people – ge inter-sector

Appendix 3

Goals of the Care in the Community Plan

Goal 1: Partner with Māori in the planning and delivery of health services

The DHB and providers will have collaborative partnership arrangements with Māori

This will mean:

- Māori participate in the planning, delivery, monitoring and improvement of health and social services across the Waikato district
- Tikanga Māori is normalised in the Waikato health system, and underpins a way of working
- Differences in equity for Māori are measured, used as improvement indicators across multiple levels of the system, and shared widely including with the public, providers and practitioners. Both process and outcome measures are used
- Partnerships operate at multiple levels of the system (management, clinical) as well as across organisations, and across the Waikato, and will be part of engagement and leadership frameworks
- All planning processes in the Waikato health system will give effect to He Korowai Oranga, and its goal of Pae Ora - healthy individuals, healthy families and healthy environments

Goal 2: Empower whānau to achieve wellbeing

Whānau are supported to define and achieve their wellbeing goals, can access their own health information and can shape the services they require

Consumers and whānau will:

- Have access to assessment to identify whānau wellness priorities, plans to achieve those priorities, and services are resourced to support this
- Be supported by health and social services to care for their own whānau
- Have access to culturally-appropriate information to improve their health literacy, develop their self-care skills, and to tools that support wellbeing
- Have an online portal to access their health records and shared care plans; virtual care for initial diagnosis, treatment and advice; and other reliable health-related information as part of a digital strategy
- Be able to control who has access to their personal health records
- Participate in developing shared care plans when chronic and complex conditions arise, and have ongoing control over them
- Be able to participate in peer groups of consumers via social media, community meetings, and professional-led sessions (e.g. hapu wānanga)

Goal 3: Support community aspirations and address determinants of health

The Waikato health system is reoriented to ensure equitable access to the resources and environments that keep people well

This will mean:

- Iwi, the DHB, health service providers, other government agencies and non-governmental organisations form intersectoral collaborations to coordinate their efforts and provide local leadership
- These collaborations support community development activities that enable local communities to identify and address the social and environmental determinants of health important to them
- Iwi and hapū in particular are supported to develop their own environments, communities and institutions
- Māori strategies for health promotion such as Te Pae Mahutonga are employed to improve health equitably
- Local communities shape the improvement of primary and community health care through co-design of services, regular feedback mechanisms, and access to provider performance results

Goal 4: Improve access to services

Health services are configured to remove geographic, cultural, financial, timeliness and complexity barriers for consumers and whānau

This will mean:

- Inequitable gaps in access to services for Māori are eliminated
- Navigation support is accessible to consumers or whānau who require this service
- Innovative community care approaches to improving access for vulnerable populations are supported and evaluated
- Urgent care and after-hours services are affordable and accessible, particularly for rural consumers
- Support is provided to improve access to structured screening programmes
- Where feasible, services for people with long term conditions are decentralised
- Health and social service providers are inter-connected, ensuring ‘every door is the right door’ for consumers and whānau to simplify access
- Care is delivered in a range of settings that are accessible for consumers and their whānau (e.g. marae, homes, workplaces, schools, digital)
- A model of virtual primary and community care, co-designed with consumers and caregivers, operates to bridge geographic barriers

Goal 5: Enhance the capacity and capability of primary and community care

Primary care adopts key components of an enhanced general practice model of care, and community services work together as one team

This will mean:

- Primary and community care give priority to eliminating barriers and lifting outcomes for Māori
- Co-design and implementation of a framework of minimum standards for an enhanced general practice model, tailored to the needs of the Waikato that includes, but is not limited to:
    - Working with Māori consumers to improve services

- Triage to ensure rapid problem resolution and access to timely primary care
- An increased proportion of consumer contact is proactive, planned and structured (rather than reactive, ad hoc and episodic)
- An easily-navigable and universally accessible digital health platform including a consumer portal
- Increased range of delivery media (e.g. online; telephone) and settings
- Consumer health information is shared in a manner that enables timely care and effective coordination of activity
- Risk stratification and stepped care models direct resources to people with higher needs
- A description of minimum service requirements expected of general practice in the Waikato

- An interdisciplinary team approach to community care is co-designed and implemented
- Within the community care team, an optimised mix of regulated and non-regulated roles working to top of scope to make best use of the available professional workforce
- A framework is established to facilitate primary care rights of referral to NGO services
- Community care services are co-located to improve access for consumers and foster teamwork
- Co-design with communities of a Waikato community pharmacy model of care that incorporates wellbeing, with a one team focus.
- Primary care clinicians have access to appropriate diagnostics (e.g. ultrasounds, cardiac investigations) through defined, resourced pathways
- Community care professionals have access to rapid specialist service advice, (e.g. through defined locality-to-specialist relationships)
- Initiatives to manage acute hospital demand co-designed with stakeholders

Goal 6: Strengthen intermediate care

The gap between primary and secondary care is bridged through accelerated development of alternative community care services and settings that avoid unnecessary travel and acute hospital utilisation

This will mean:

- Primary and community care services are delivered in the home if this is possible
- Rural hospitals and selected aged residential care facilities provide accessible local sites for bedded intermediate care, including a focus on rehabilitation and re-ablement
- Local community involvement with these facilities is strengthened through co-creation
- GPs' and NPs' admitting rights for short stays in intermediate care facilities are expanded

- Specialist services that can be decentralised are delivered in local facilities, either in person or virtually (e.g. nurse specialists, chemotherapy delivery)
- Local intermediate care facilities are utilised for safe, supported early discharge from secondary care, and respite care as part of enhanced carer support

<u>Appendix 4</u>

Enablers of the Care in the Community Plan

1. Leadership and Partnerships
2. Commissioning
3. Workforce Development
4. Technology and Information
5. Quality Improvement

<u>Appendix 5</u>

Principles for the Care in the Community Plan

1. Direct resources to those population groups (in particular Māori) that are unders
eliminating inequities
2. Prioritise wellbeing and prevention, and reduction in avoidable unplanned servi
3. Co-design sustainable whānau-centred services with the community that are de
aspirations
4. Work as a single coordinated system to efficiently deliver health services across
5. Deliver services in community settings unless there are compelling reasons for
6. Build supportive partnerships between organisations and communities across t
7. Build a culture that supports quality improvement, innovative approaches, and
pace and scale
8. Operate with accountability and have courage to disinvest where resources cou

MEMORANDUM TO THE COMMUNITY AND PUBLIC HEALTH COMMITTEE
12 DECEMBER 2018

AGENDA ITEM 7.3

TAMARIKI AND RANGITAAHI HEALTH AND WELLBEING

Purpose	For information and discussion

Background

The presentation is an over view of current services and investment in child and youth services by the Waikato DHB. We are working towards new approaches that will align with the new national Child and Youth Wellbeing Strategy currently in development by the Ministry of Health, our Health System Plan and the outcomes of our Care in the Community engagement process.

Whilst our current purchasing approach includes access to universal services such as well child checks, we also fund additional services for high needs children who face difficulty in accessing health care as a result of barriers such as cost or transport, as well as those children who have complex medical or surgical needs.

There are a wide range of service's and NGO providers with the total investment in child health amounting to $91,603,144 per annum.

The presentation will outline

- Social, cultural and economic determinants of health
- Health disparities – child health indicators
- Population data
- Current service framework
- Discussion: our future approach

Radical Improvement in Māori Health Outcomes by Eliminating Health Inequities for Maori

It is clear from the health outcomes that we are failing to meet the needs of Māori Tamariki and Rangitaahi. There is a strong commitment to improving responsiveness to Māori in all services that we fund.

Recommendation
THAT

The Committee notes and discusses this presentation

DAMIAN TOMIC
CLINICAL DIRECTOR, STRATEGY, FUNDING AND PRIMARY CARE

Waikato District Health Board

General Business

Date of next meeting
13 February 2019